2011

EQUITY WATCH

Assessing progress towards equity in health

Uganda

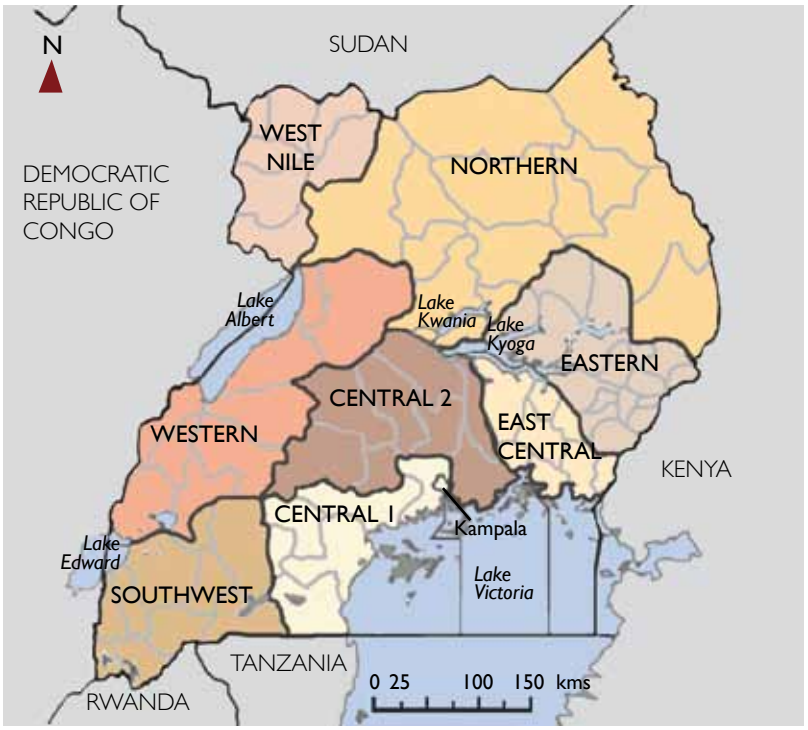
Healthnet Consult

Training and Research Support Centre

Coalition for Health Promotion and Social Development

In co-operation with
Ministry of Health, Uganda
in the Regional Network for Equity in Health in East and Southern Africa (EQUINET)

Map of Uganda showing districts



Source: Adapted from Uganda Bureau of Statistics (UBOS) and Macro International Inc., 2007

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Foreword

The *National health policy II* explicitly identifies *equity* as one of the key social values guiding health sector processes and notes that: 'Government shall endeavour to achieve equal treatment for equal need and for equal access to health care according to need.' In developing its strategic direction for the period 2010/11 to 2014/15, the health sector explicitly lists *improving equity in access* as one of the strategic objectives. For example, one of the equity-related interventions cited in the *Health sector strategic and investment plan* is *to improve access to equitable and quality clinical services at all levels in both the public and private sectors and institutions*.

An *Equity Watch* is a country report that monitors progress on health equity, more specifically, the health system's progress and responsiveness in promoting and achieving equity in health and health care. The *Equity Watch* framework has been developed by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and implements a resolution of the East and Southern African Health Community to monitor progress in health equity. The *Equity Watch* assesses progress against commitments and goals in four major areas, namely: equity in health, household access to the resources for health, equitable health systems and global justice.

In Uganda, eliminating differences in access to resources and services requires systems that facilitate the processes and mechanisms to execute and achieve the targets and objectives set to achieve equity in health. This entails establishing and strengthening appropriate systems and structures, and having in place appropriate policies and adequate monitoring systems to provide an enabling environment for the achievement of the health equity objectives. Specifically, Uganda seeks to: reduce demographic-related differences (including gender, race, age, disabilities and marital, socio-economic and employment status) in availability, access to and use of health care services; eliminate geographical differences (rural, urban, provincial and district) in availability, access to and use of health care services; and improve financial and material resource allocation (human resources for health, drugs, equipment and medical supplies) across demographic and geographic lines.

This report provides an array of evidence on the performance of Uganda's public policies and systems in promoting and attaining equity in health, in the social determinants of health and in health care, using the *Equity Watch* framework. The evidence presented in this report indicates progress in some key areas, such as in closing social and geographical gaps in access to education, safe water, immunisation and other areas of primary health care. However, challenges remain, including in coverage of maternal health services and in the distribution of health workers. The findings in this report require concerted effort by various stakeholders to address the health equity issues in Uganda, including by civil society, academia, parliament, the private sector and the public sector as a whole.

I wish to thank the team of researchers and all those who have contributed to this work. I look forward to the work being disseminated and used to support our policy and planning processes in Uganda.

Dr Asuman Lukwago
Ag. Permanent Secretary
Ministry of Health
Kampala, Uganda, November 2011

About the equity watch

An Equity Watch is a means of monitoring progress on health equity by gathering, organising, analysing, reporting and reviewing evidence on equity in health. *Equity Watch* work is being implemented in countries in eastern and southern Africa in line with national and regional policy commitments. In February 2010 the Regional Health Ministers' Conference of the East, Central and Southern Africa (ECSA) Health Community resolved that countries should 'report on evidence on health equity and progress in addressing inequalities in health'.

Using available secondary data, the *Equity Watch* is implemented by country personnel with support and input from EQUINET through Training and Research Support Centre and peer review from the University of Cape Town Health Economics Unit. The aim is to assess the status and trends in a range of priority areas of health equity and check progress on measures that promote health equity against commitments and goals.

This first scoping report uses a framework developed by EQUINET in cooperation with the ECSA Health Community and in consultation with WHO and UNICEF. The report introduces the context and the evidence within four major areas: equity in health, household access to the resources for health, equitable health systems and global justice. It shows past levels (1980–2005), current levels (most current data publicly available) and comments on the level of progress towards health equity with a coloured bar down the side of each page indicating whether the situation is broadly:

 Improving

 Static, mixed or uncertain

 Worsening

Where clear, the postive or negative relationship to the average in the eastern and southern African region is also shown at the top of each colour strip (and left blank where comparisons are difficult or uncertain):

 Above the regional average

 Below the regional average

EQUINET defines equity as follows:

> *'Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. Equity motivated interventions seek to allocate resources preferentially to those with the worst health status. This means understanding and influencing the re-distribution of social and economic resources for equity-oriented interventions, and understanding and informing the power and ability people (and social groups) have to make choices over health inputs and to use these choices towards health.'*
>
> EQUINET STEERING COMMITTEE, 1998

We explore in particular the distribution of health, ill health and specific determinants, including those relating to employment, income, housing, water and sanitation, nutrition and food security, and those within the health system. The *Equity Watch* examines the fairness of resource generation and allocation, and the benefits derived from consuming the resources for health. We also explore the governance of the health system, given that the distribution and exercise of power affects how resources are distributed and strategies designed and applied towards ensuring access to the resources for health.

Key areas

Introduction

EQUITY WATCH

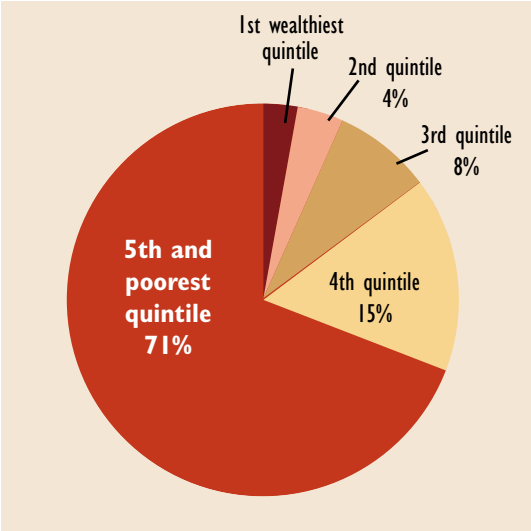
Uganda is a low income landlocked country in East Africa, bordered by Kenya, Tanzania, Rwanda, the Democratic Republic of Congo and Sudan. It has rich physical features and a warm, high rainfall climate (UBOS, 2008). Uganda has one of the highest population growth rates (3.5 per cent), with the population estimated to reach 46.3 million by 2020 (UNDP, 2009). The population in 2010 of 33.5 million is unevenly distributed, with most people living in rural areas and only 15 per cent living in urban areas (UBOS and Macro Int., 2010). Life expectancy fell to 42 years in 2000, mainly due to AIDS, but rose to 51.7 years in 2007 (UBOS, 2009). A high share of the population is young, with 49 per cent below 15 years in 2005. There are many ethnic groups but the major ones are the Baganda, Banyankore, Basoga, Bakiga, Iteso, Langi, Acholi, Bagisu and Lugbara (UBOS, 2008).

Uganda has had a multiparty parliamentary democracy since 1995 with decentralised district level local governments in 112 districts across four regions. A rapid multiplication of districts has raised governance issues and has had implications for efficiency and service delivery. Local governments have powers for secondary legislation and duties for service delivery in line with national budgets and plans, including health services (UBOS, 2008). Local governments are responsible for recruiting, deploying, developing and managing health workers, passing health-related by-laws and monitoring health sector performance. They manage public general hospitals and health centres and monitor all health activities (including those in the private sector) in their areas. While decentralisation has strengthened institutions and enhanced participation in delivery of and access to primary health care, universal primary education, water and sanitation services (Okidi and Guloba, 2006), there have also been reports of inadequate human and financial resources, poor governance, low morale among health workers and reluctance at central level to decentralise authority, thus undermining the overall benefits of decentralisation (Anokbonggo *et al.,* 2004; Steiner, 2006).

Most people in Uganda are involved in agriculture and although its share of gross domestic product (GDP) fell from 42 per cent in 1966 to 15 per cent in 2009, most of the country's industries and services are still based on agriculture (UBOS, 2008, UBOS and Macro Int., 2010). Industry has grown as a share of gross domestic product and, together, industry and services have become a major driver of growth (GoU, 2010; MoFPED, 2010a). Uganda's human development index (HDI), a composite of life expectancy, education and per capita national income, rose from 0.312 in 1995 to 0.380 in 2005 and to 0.422 in 2010 (UNDP, 2010). The drivers of improvements in the index appear to have been increases in GDP growth and improvement in education (UBOS and Macro Int., 2010).

Uganda's strategic location on the trade corridor for the Great Lakes region positions it well for economic growth. From the mid-1990s there were two decades of uninterrupted growth to a per capita GDP of US$368 (at 2002 constant prices) (Keane *et al.*, 2010). While the recent global economic downturn was expected to have negative effects in reduced private remittances, foreign direct investment and loans, the effects have been less significant than anticipated, with foreign direct investment falling from 5.3 per cent of GDP in 2007/08 to 4.6 per cent in 2008/09 and development partners continuing to meet their obligations (MoFPED, 2010b). The overall literacy rate of 69 per cent (76 per cent in males and 63 per cent females) and net primary school attendance of 82 per cent in males and 81 per cent in females have also improved, as discussed later in this progress marker section (UBOS and Macro Int., 2006). The evidence suggests that girls have had access to these improvements and women comprise 51 per cent of the labour force (2005/2006) (UBOS, 2008).

Figure 1: Share of wealth by quintiles



Nevertheless there is an unequal distribution of economic wealth, with a gini coefficient of 0.426 in 2009/10 (UBOS and Macro Int., 2010). In 2009/10 survey data, 24.5 per cent of Ugandans or 7.5 million people were estimated to be poor (UBOS, 2010). Households in the highest (first) wealth quintile shared 71 per cent of the country's total wealth while those in the lowest (fifth) shared only 2 per cent of total wealth (see Figure 1). Nearly half (48 per cent) of households in the two lowest quintiles are in rural areas compared to only a quarter (25 per cent) in urban areas. The Eastern and Northern regions had higher shares of households in the lowest wealth quintiles (UBOS and Macro Int., 2010). Household consumption increased and poverty declined in all parts of the country in the past decade, showing initial improvements in income inequality (the gini coefficient fell from 0.428 to 0.408 from 2002/03 to 2005/06). However, income inequality rose between 2005 and 2009, with the gini coefficient rising from 0.408 to 0.426 in the period (UBOS and Macro Int., 2010).

Significant regional disparities in poverty persist, with highest levels in the north of the country, where nearly 90 per cent of people have been living in internally displaced people's camps for two decades due to civil war. Inequalities are found across regions, between rural and urban areas, between crop farming and non-crop farming (livestock and fishing) households, and between the urban poor and wealthy (UBOS and Macro Int., 2010).

Disease is a significant determinant of wellbeing and in 2010 malaria was found to be the most prevalent illness reported by households in a national household survey (UBOS and Macro Int., 2010). Uganda is often held up as a model for Africa for its important turnaround in the past decade of the AIDS epidemic, through strong leadership, broad-based national and international partnerships and effective public campaigns and service outreach (Avert, 2008; UNAIDS, 2008). It now faces challenges in reaching under-served groups, as discussed in this report, and in sustaining prevention and treatment. Service outreach has faced challenges of under-funding, past corruption in use of public funds has undermined credibility and trust in public administration, and poverty and conflict in the northern part of the country have undermined access. Fiscal limits have also limited service expansion, while growth in private sector services has raised concerns of unequal access, as profit motives exclude vulnerable groups who have highest health need.

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Uganda has many features that signal a potential for improved health and the country has experienced economic growth and an improving human development index in the past decade. Nevertheless there are indications of recent increases in inequality in wealth. This report explores further to what extent these social inequalities are associated with inequalities in health and in access to health care. It tracks progress in implementing measures that address inequalities in health through investments in households and in redistributive health systems to overcome the impoverishing effects of ill health. We explore trends on selected equity-related progress markers over the period 1995–2005 and the current period 2006–2010.

EQUITY WATCH

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Advancing equity in health

Progress markers

- Formal recognition and social expression of equity and universal rights to health
- Achieving the Millennium Development Goal of reducing by half the number of people living in poverty
- Reducing the gini coefficient to at least 0.4
- Eliminating differentials in maternal mortality, child mortality (neo-natal, infant and under five) and under five years under-nutrition
- Eliminating income and urban/rural differentials in immunisation, antenatal care and attendance by skilled personnel at birth
- Achieving UN and WHO goals of universal access to prevention of vertical transmission, condoms and antiretrovirals

EQUITY WATCH

Advancing equity in health

This section presents various markers of progress in health equity, in terms of the values that underpin it, and the progress in addressing socio-economic and health inequalities.

Formal recognition and social expression of equity and universal rights to health

PAST LEVELS (1980–2005)

- Uganda is signatory to the International Covenant on Economic and Social Rights (1987), the Convention on the Rights of the Child (1986) and the African Charter on the Rights and Welfare of the Child (1990), among other international conventions. These conventions need to be domesticated through national law to become effective.
- Objective XIV(b) in the Constitution of Uganda sets out the state's duty to ensure that all Ugandans enjoy access to health services (GoU, 1995). Article 39 affirms every Ugandan's right to a clean and healthy environment, article 26(2) provides that a person can be deprived of property in the interest of public health and the constitution requires the Ugandan state to guarantee and respect the independence of non-governmental organisations that protect and promote human rights. It provides that districts are free to cooperate in the areas of culture, development and health (GoU, 1995).
- The 1995 Health Services Bill, proposed to replace the Public Health Act of 1964, intended to consolidate all health-related laws and become the over-arching law governing health service delivery. The process was, however, halted in 2002 after the Ministry of Health was advised to 'unbundle' the Bill into its various elements (MoH, 2008b).
- Uganda's first national health policy in 1999 called for health education, health promotion and community involvement in prevention, care and planning, and in managing health care (MoH, 1999). Proposals were made for a community-based health information system and information dissemination to stakeholders (MoH, 1999). Despite this, locally-elected leaders have dominated decision making, with economic and social barriers to community participation (Kapiriri *et al.*, 2003).

CURRENT LEVEL: 2006-2010

- The 1995 constitution remains in force but it provides some specific protection for vulnerable groups. Under article 33(3), the state is required to protect women and their rights, taking into account their unique status and natural maternal functions. Children are protected under article 34(3) which provides that no child should be deprived of medical treatment, while article 34(4) provides that children should not be employed in or required to do work that is likely to be harmful to their health (GoU, 1995).
- The 2010 *National health policy II* and the *Health sector strategic and investment plan*, explicitly mention equity in health as a key value guiding service delivery (MoH, 2010a). Qualitative information from community participation interventions suggests that communities are able to claim their rights if local leaders and communities are involved in participatory processes (Muhinda *et al.*, 2009).
- The village health team strategy aimed to encourage community participation in health through training and empowering a trusted community member selected by the community. However, the strategy has faced implementation challenges, including lack of funding, leading to gaps in districts covered and inadequate means to sustain the strategy (MoH, 2010e).

Progress

Ugandan law does not explicitly include the right to health or the communities' right to participate directly in the health system but it does provide related rights. National policy documents give more explicit policy support to health equity and community participation but implementation remains weak. It would be useful to audit the range of international conventions affecting health that Uganda is signatory to and review their domestication and implementation.

Achieving the Millennium Development Goal of reducing by half the number of people in poverty (and living on less than US$1 per day)

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Yearage of
% population living on less than US$1.25 a day	not available		not available	
*Percentage of population in income poverty	56 44 34 38 31	1992 1997 1999 2002 2005	25	2009/10
– rural poverty	43	2002	23	2009
– urban poverty	14	2002	9	2009
– rural : urban ratio	3.07	2002	2.56	2009
Range: of highest to lowest poverty by province % points difference	41	2002	36	2002
Human poverty index	66	2005	not available	

*Poverty trend estimates focused on the cost of meeting caloric needs and some allowance for non-food needs. Official Government of Uganda reports do not report poverty in terms of the UNDP $1.25 threshold.

Source: UNDP 2005, 2007; MoFPED, 2006; UBOS and Macro Int., 2010

PAST LEVELS (1980–2005)

- As shown in the summary table above, poverty rates fell between 1992 and 1999, rose in 2002 and fell again in 2005 (UNDP, 2007; MoFPED, 2006). Rural poverty levels in 2002/03 were three times higher than urban poverty levels and were higher in the Northern and Eastern regions (UBOS and Macro Int., 2010).
- Poverty levels were associated with costs of and returns from farming, access to public goods like health care, electricity and infrastructure, as well as with people's initial endowments of physical and human capital (Okidi and McKay, 2003).
- There were significant regional disparities in poverty levels which were persistently highest in the north of the country, where there are many internally displaced people due to civil war. Levels were lower in the West and Central regions of Uganda, where poverty declined by around 60 per cent between 1992 and 2005 (Okidi *et al.*, 2003).
- The five-year *Uganda poverty eradication action plan* (PEAP), developed in 2004, recognised the need to address regional inequity (MoFPED, 2004). A poverty monitoring and evaluation strategy and working group were set up, the latter to focus on cross-cutting issues, including gender, environment, AIDS, employment, population, social protection, income distribution and regional equity.

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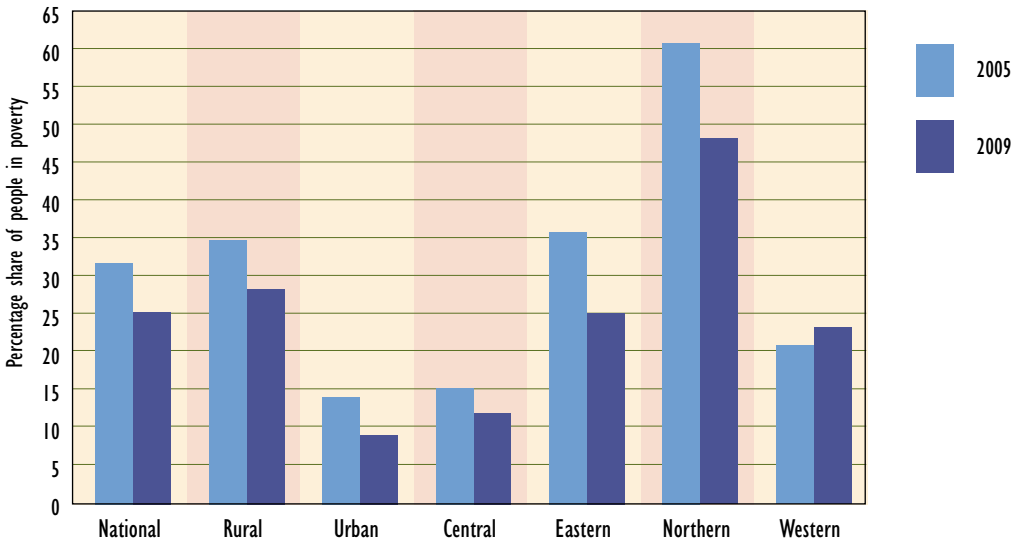
CURRENT LEVEL: 2006-2010

- Uganda's human development index (HDI) trends, outlined in the introduction, highlight the improvements as well as the still large gap in wellbeing and life chances. The recently concluded Uganda national household survey (2009/10) indicated that income poverty fell by 8 percentage points between 2005/6 and 2009/10 (Ssewanyana, 2010). As shown in Figure 2, income poverty has declined more in rural areas than in urban areas, reducing the rural to urban ratio from 3.1 to 2.6, and the gap across regions also narrowed (see summary table on page 4). Nevertheless the differentials remain high across residence and region.
- There has been a consistent reduction in poverty over the past decade. The reduction between 2002/3 and 2005/6 appears to have been greater than between 2005/6 and 2009/10, although northern Uganda registered its biggest poverty reduction in the past five years (UBOS and Macro Int., 2010). Central region (where the capital, Kampala, is located) has lowest poverty levels and Northern region has the highest, associated with two decades of conflict in that area. Poverty fell in Northern region in 2009/10, partly due to the recent return of peace and the efforts of state and non-state agencies to improve living conditions, including through resettling internally displaced people from camps to their villages or homes.
- Ssewanyana *et al.* (2006) argued that growth alone would not adequately improve the incomes of less advantaged people between 2006 and 2015 and that any increase in inequality hurts the 'ultra' poor more than the poor. They proposed a direct cash transfer scheme to curb the further marginalisation of this group. In 2010, Ssewanyana (2010), examining the factors behind the reduced poverty levels between 2005/6 and 2009/10, found that growth contributed more to the reduction in poverty levels than redistribution of income. On the other hand, income inequalities were the key factor limiting poverty reduction in the Western and Central regions. The *National development plan 2009/10–2014/15* articulates the need to balance wealth creation with sustainable poverty reduction through growth and equity. The plan suggests linking improving socio-economic indicators with reducing the number of people living below the poverty line and reducing infant mortality, with creating employment a critical mediating factor.

Figure 2: Trends in poverty by residence and region, 2005–2009



Source: UBOS and Macro Int., 2010

Progress

Income poverty reduced after 2005 but, while gaps have narrowed, Northern region and rural areas continue to have higher levels of poverty. Growth appears to have been the general driver of poverty reduction but, as discussed in the next progress marker, inequality has apparently limited reductions in poverty levels in rural areas and in Western and Central regions.

Reducing the gini coefficient to at least 0.4

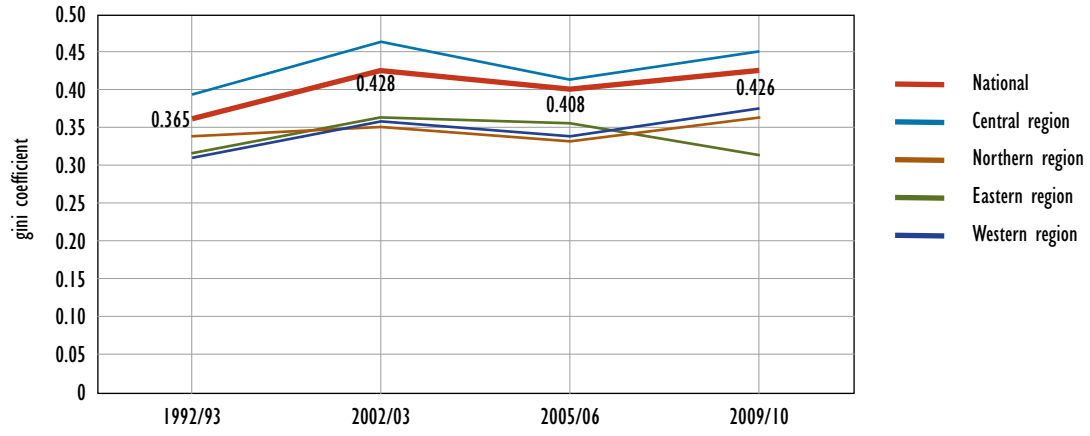
INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Gini coefficient	0.365 0.428 0.408	1992/3 2002/3 2005/6	0.426	2009
– rural	0.363 0.363	1992/3 2005/6	0.375	2009
– urban	0.483 0.432	1992/3 2005/6	0.447	2009
– urban : rural ratio	1.33 1.19	1992/3 2005/6	1.19	2009

The gini coefficient is a measure of the inequality of a distribution, a value of 0 expressing total equality and a value of 1 maximal inequality.
Source: UBOS, 2010

PAST LEVELS (1980–2005)

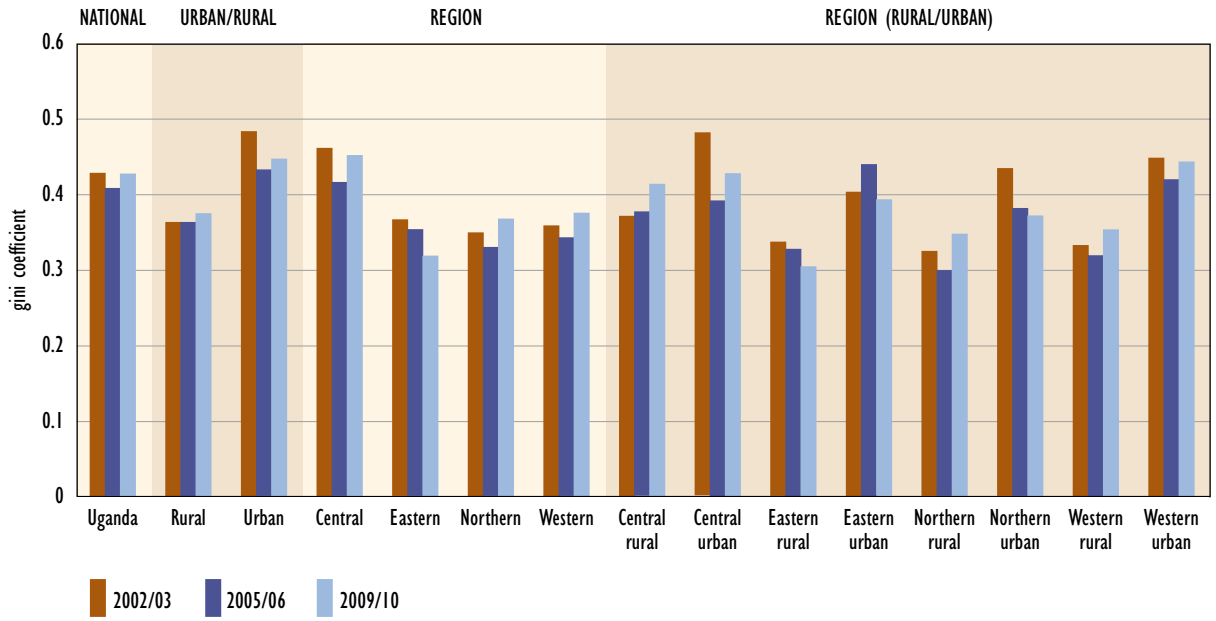
- The relatively higher but declining levels of poverty in the 1992–2002 period appear to be associated with increasing income inequality (see summary table above). At both national level and within each sub-region the gini coefficient increased between 1992 and 2002 and then declined between 2002 and 2006. The decline seems to have been driven by falling inequality levels in urban areas in all regions, as income inequality remained the same in rural areas in the period (see Figure 3; UBOS, 2008).
- Levels of inequality were higher in northern regions, between rural and urban areas, between crop farming and non-crop farming (livestock and fishing) households and between urban poor people and the wealthy (UBOS, 2008; MoF, 2004/05).
- Gender analysis of the demographic and health service data for the 1992–2003 period showed also that female-headed households were disproportionately represented among poor households (MoFPED, 2003).
- The Central region has substantially higher disparities nationally. This reflects the higher share of urban households and higher inequality in urban areas, as Kampala, the capital city, is located there.

Figure 3: Trends in inequality by region, Uganda, 1992–2010



Source: UBOS, 2008, 2010

Figure 4: Inequality (gini coefficient) by residence and region, Uganda, 2002–2010



Source: UBOS 2008, 2010

CURRENT LEVEL: 2006-2010

- Income inequality rose between 2005/6 and 2009/10, particularly in urban areas (see summary table on page 6 and Figure 4 above). Higher income groups, possessing more income-generating assets (productive assets, human assets or both), were in a better position to benefit from the aggregate increase in national income.
- Differences in gini coefficients across the regions were attributed to the differences in the access to social services, income and the economic activities of the regions (MoFPED, 2006).

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CURRENT LEVEL: 2006-2010 continued

- Inequality within rural and urban areas and regions is reported to have contributed more to overall inequality than the inequality between these areas (Figure 4; Table 1; Ssewanyana, 2010).
- As Table 1 shows, income inequality is driven predominantly by inequalities within determinants such as where people are living, how educated they are and whether they live in rural or urban areas. There is also an interaction between poverty and inequality in Uganda. The central statistics office noted in 2010 (UBOS, 2010) that economic growth has generally been associated with poverty reduction. However it also noted that increased income inequality has undermined the positive impact of growth on poverty. In the 2002 to 2006 period positive growth and falling inequality had combined positive effects on poverty reduction. From 2006 to 2010, while growth continued to contribute to poverty reduction, rising inequality produced the opposite effect. Further, the trends within rural areas and regions showed the same relationships: where inequality was rising, poverty reduction was compromised. Hence, for example in Eastern region, even in a period of generally rising inequality, the fall in inequality in this region shown in Figure 4 meant that there was still a reduction in poverty.

Table 1: Decomposition of income inequality Uganda, 1992–2010

Sub-grouping		1992/93	2002/03	2005/06	2009/10
Rural/urban	Between	14.6	20.7	15.6	17.1
	Within	85.4	79.3	84.4	82.9
Regions	Between	8.7	17.0	19.6	20.7
	Within	91.3	83.0	80.4	79.3
Education attainment level	Between	14.6	27.3	25.4	28.6
	Within	85.4	72.7	74.6	71.4

Progress

The uneven experience of rising inequality in the 1990s, declining inequality between 2000 and 2006 and increases thereafter means that Uganda has not been able to attain its original 1992/93 levels. By 2009/10, the evidence shows that inequality is a rising and significant problem in Uganda that prevents growth from translating into poverty reduction. Most affected by this were urban areas and the Central region. Inequality within rural and urban areas and within regions contribute more to overall inequality than the inequality between these areas. As noted for the poverty data, this suggests that in addition to the broad measures for geographical allocation of resources to needs, further measures are needed to reach the poorest households within areas to protect them against impoverishment caused by ill health. It will also be useful to disaggregate income and wealth inequalities by gender in future analyses to explore the role of gender in these inequalities.

Eliminating differentials in maternal mortality, child mortality (neonatal, infant and under five) and under five year under-nutrition

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Infant mortality rate (IMR) per 1,000				
– total	85	1995	75	2006
	89	2001		
– rural	93.7	2001	88	2006
– urban	54.5	2001	68	2006
– rural : urban ratio	1.72	2001	1.29	2006
– male : female ratio	not available		1.25	2006
– high : low regions ratio	not available		2.28	2006
– lowest : highest wealth quintile ratio	not available		1.62	2006
Child mortality rate 1–5 yrs per 1,000 (CMR)	160	1990		
Under-5 mortality rate (U5MR) per 1,000				
– total	187	1988	137	2006
	156	1995		
	158	2001		
– rural	164	2001	153	2006
– urban	101	2001	114	2006
– rural : urban ratio	1.62	2001	1.34	2006
– male : female ratio			1.22	2006
– lowest : highest wealth quintile ratio	1.81	2001	1.69	2006
Maternal mortality rate / 100 000	527	1995	435	2006
	505	2001	430	2008
Stunting in children under 5 years (height for age <2SD)				
– % total children	39.1	2001	38	2006
Underweight in children under 5 years (weight for age <2SD)	23.0	1995-2003	16.0	2006
	22.8	2001	16.8	2008
Lowest :o highest quintile ratio	1.4	2001		
Wasting in children under 5 years (weight for height <2SD)	4.1	2001	3.9	2006

Sources: UBOS and Macro Int., 2001; 2006: UNDP, 2010

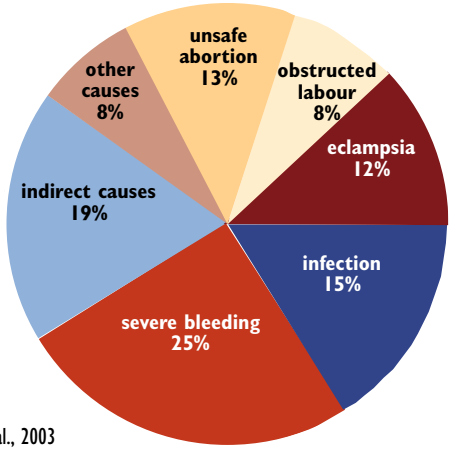
PAST LEVELS (1980–2005)

- During the development of the *Health sector strategic plan* (HSSP II), a set of 25 indicators was selected for national level sector monitoring and eight of these indicators were further selected for monitoring under the Uganda Poverty Eradication Action Plan. This progress marker includes most of the health outcome related indicators used in this sector monitoring.
- As shown in the summary table above, infant mortality and under five year mortality rates rose between 1995 and 2000. Infant and child survival were associated with gender (higher in males), mother's age (higher among children born to mothers under age 20 and over age 40), birth order (higher in first births and births of order seven) and shorter birth intervals. Rural areas had higher under five year mortality rates but the differential by wealth quintile was even higher with the highest quintile having 1.8 times the mortality rates of the lowest (UBOS and Macro Int., 2006).

PAST LEVELS (1980–2005) continued

- In 2004, the Child Days Plus programme was integrated into the child survival strategy to reduce child mortality through improved health, high coverage of cost effective interventions and integrated delivery at family or community and institutional level. The prioritised interventions included a revitalised extended immunisation programme, the newborn survival strategy, the Child Days Plus, integrated management of newborn and child illness and home-based management of fever. This evolved into integrated community case management, including nutrition of infants and young children, and prevention and treatment of HIV.
- There is limited reliable and accurate data on maternal mortality rates available country-wide in Uganda, with available data shown in the summary table suggesting that the rate has remained high in the period. A study done in 30 hospitals in 2000 estimated the maternal mortality rate as 846 per 100,000 live births (Ssengooba *et al.*, 2003). The major causes of this mortality in 1995/06 found in the study included poor fertility regulation of early pregnancy in adolescents, limited health facilities to manage abortion or miscarriage complications, prevalence of HIV among pregnant women and malaria (Ssengooba *et al.*, 2003). Government data show a declining trend in maternal mortality rates (see Figure 6a) and a government target was set of 131 per 100,000 live births by 2015 (EASSI, 2010).

Figure 5: Causes of maternal death, Uganda, 1995/96



Source: Ssengooba et al., 2003

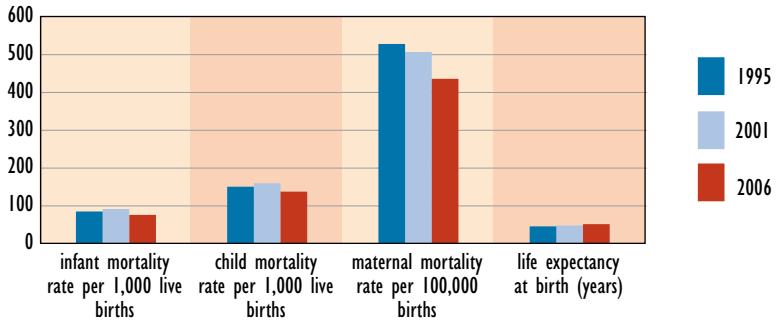
CURRENT LEVEL: 2006-2010

- As shown in the summary table, infant mortality rates fell from 2001 to 2006, as did the under five year mortality rate. Geographical differences in infant mortality rates were high (over twofold) with the highest rates in the Southwest region (109/1000, 2006) – attributed to high malaria prevalence, low literacy levels and poor health service provision – and the lowest rates in Kampala (54/1000) (UBOS and Macro Int., 2006). Rural to urban and male to female disparities narrowed after 2000 (see summary table on page 9) but, as shown in Figure 6b, social disparities in infant and under five year mortality remained wide, across wealth, residence, gender and mothers' education.
- Under-nutrition persists as a problem although there was a small decrease after 2000 (see summary table). The problem of under-nutrition starts at the foetal stage, with an overall rate of 11 per cent of babies weighing less than 2.5 kg at birth. Rates are worse among children born to women with no education (23 per cent) and children born to women in rural areas (12 per cent compared to 9 per cent in urban areas) (UBOS and Macro Int., 2006).
- The 2006 Uganda demographic health survey showed that underweight and stunting among children was more prevalent in Southwest, North, West Nile and Central regions compared to the other regions, with Kampala recording the lowest levels (UBOS and Macro Int., 2006). Under-nutrition in children under five years was also more common in poor households and in households where mothers had lower education levels (UBOS and Macro Int., 2006). Uganda is not performing as well on nutrition as its per capita gross national income would suggest although it has improved in the past two decades, partly through pro-poor economic growth and partly through higher agricultural production (UNDP, 2010).

CURRENT LEVEL: 2006-2010 continued

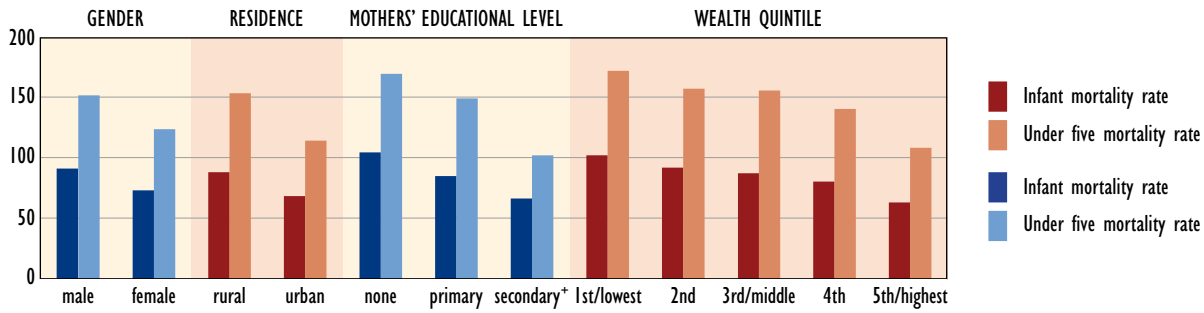
- Between 2004 and 2009, various interventions were implemented to improve child health. Vitamin A supplementation uptake increased from 60 to 69.5 per cent and household salt iodisation was maintained at around 96 per cent (UBOS and Macro Int., 2006). Bi-annual child days increased coverage of selected interventions to improve child health (see Table 2) and infant and young child feeding policy guidelines were disseminated.
- Maternal and childhood illness still constitute the biggest proportion of the national disease burden. The maternal mortality rate decreased from 505 per 100,000 in 2001 to 435 per 100,000 in 2006 although with a wide variance of 345 to 524 (UBOS and Macro Int., 2006). The further decrease in maternal mortality up to 2008 suggests the situation is improving but there is sill a wide gap between this and the target set in the Millennium Development Goals (see Figure 8). As discussed in the next progress marker, one reason for this is that access to maternal and reproductive health services for girls and women is still limited.

Figure 6a: Infant, child and maternal mortality trends, 1995–2006



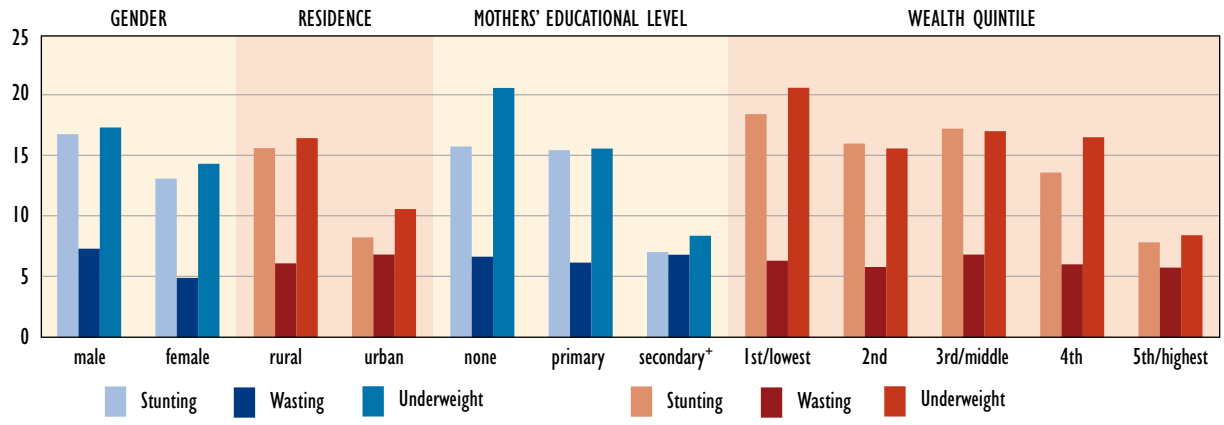
Source: MoH, 2010a; UBOS and Macro Int., 2006

Figure 6b: Social inequalities in infant and under five mortality rate, 2006



Source: UBOS and Macro Int., 2006

Figure 7: Social inequalities in malnutrition among children under five, 2005



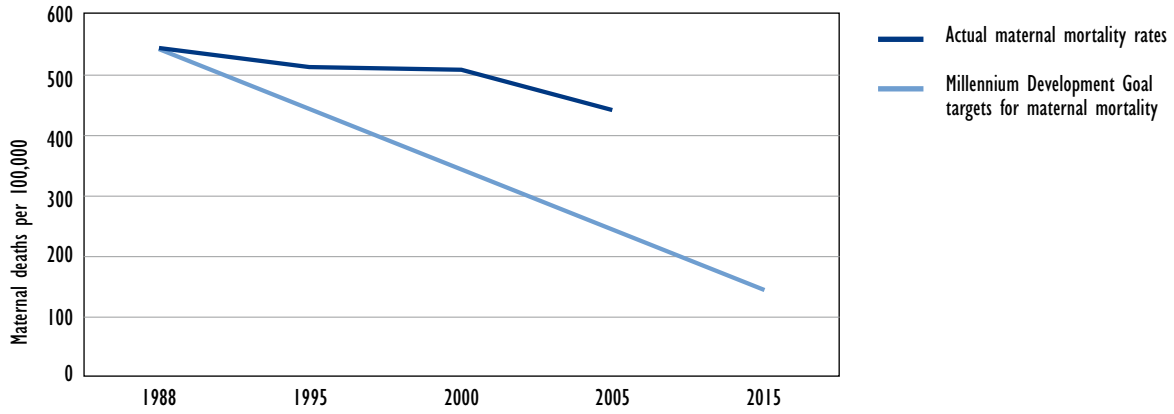
Source: UBOS and Macro Int., 2006

Table 2: Bi-annual Child Days performance

TARGET OUTPUTS	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	HSSP II TARGET
HEALTH SECTOR STRATEGIC PLAN (HSSP) II INDICATORS							
Children 6–59 months received two vitamin A doses	37%	69%	61%	57%	70%	46%	80%
Children 1–5 years dewormed twice	60%		69%	61%	62%	37%	100%
CENTRAL LEVEL PROGRAMME PERFORMANCE INDICATORS							
Central district supervision/ monitoring during Child Days Plus	2	2	2	1	1	1	bi-annually
Audit Child Days Plus data and performance indicators + re-planning	Y	–	–	Y	–	–	annually
Communication and mobilisation for Child Days Plus	Y	Y	Y	–	–	–	bi-annually
DISTRICT LEVEL (SERVICE DELIVERY) INDICATORS							
Children 6–14 years dewormed twice	65%	61%	54%	66%	53%	40%	80%
Districts with micro plans for Child Days Plus	15%	21%	30%	30%	46%	48%	100%
Districts with adequate drugs for Child Days Plus	30%	40%	45%	50%	50%	55%	100%

Source: MoH, 2009a

Figure 8: Maternal mortality rates in Uganda, 1988–2006



Source: UBOS, 2006, 2010

Progress

For this progress marker there are mixed results, with positive trends in infant mortality but limited improvement in maternal mortality and nutrition, hence the mixed colour for the rating of the progress marker. There have been improvements in child survival and in maternal mortality but the current trends suggest that unless special efforts are made, Uganda is unlikely to meet its global and national targets. In reviewing the evidence, stakeholders raised concerns about maternal mortality levels. Available evidence suggests wide regional differentials in infant mortality and wide social (residence, wealth) differentials in child mortality and nutrition. This calls for resources and interventions to be targeted geographically but also for additional community level support for uptake of child health days and other measures in the poorest households. Improving nutrition, especially among the poorest groups, demands inter-sectoral coordination across government and non-state institutions to identify and address the barriers to improved children's diets and nutrition. As noted in a later progress marker, this includes supporting women small-scale farmers producing food for local markets.

Eliminating income and urban/rural differentials in immunisation, antenatal care and attendance by skilled personnel at birth

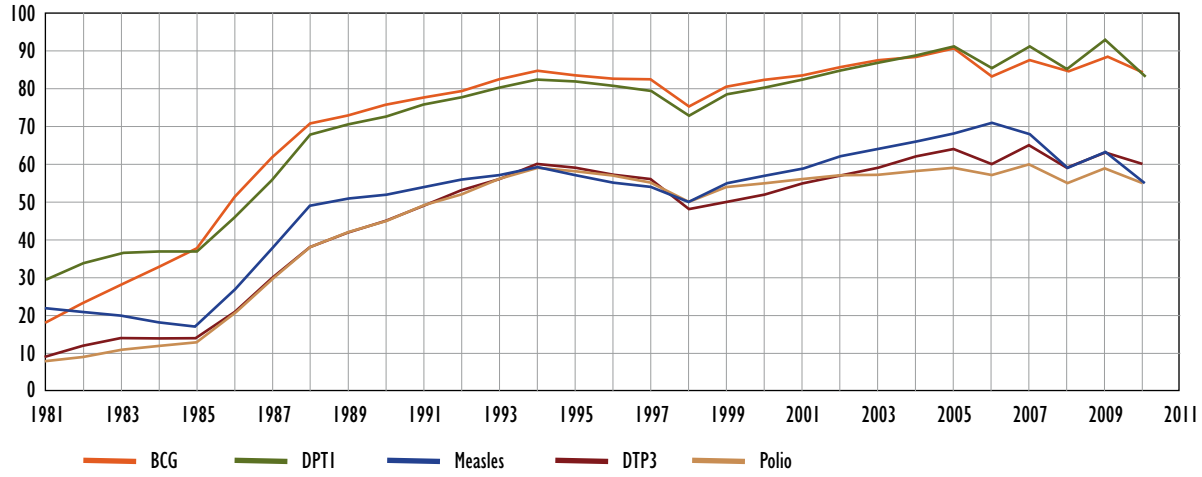
INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Measles immunisation % coverage in < 1 year	56.8	2001	88.0	2006
– rural	55.3	2001	76.7	2006
– urban	68.4	2001	67.1	2006
– lowest wealth quintile	49.1	2001	66.3	2006
– highest wealth quintile	64.5	2001	73.0	2006
– highest : lowest wealth quintile ratio	1.31	2001	1.10	2006
– urban : rural ratio	1.23	2001	1.14	2006
– highest : lowest region ratio	1.98	2001	1.45	2006
Full immunisation % coverage	36.7	2001	46.0	2006
– rural	36.0	2001	45.7	2006
– urban	42.1	2001	51.1	2006
– urban : rural ratio	1.17	2001	1.06	2006
– lowest wealth quintile	26.5	2001	41.4	2006
– highest wealth quintile	42.6	2001	47.9	2006
– highest : lowest wealth quintile ratio	1.61	2001	1.14	2006
% of women with >= 4 antenatal care visits	42.0	2001	56.0	2007/8
– rural			45.3	2006
– urban			59.6	2006
% births attended by skilled personnel	39.0	2001	42.1	2006
			44.0	2007/8
– rural	34.0	2001	37.3	2006
– urban	80.5	2001	80.0	2006
– urban : rural ratio	2.38	2001	2.14	2006
– lowest (1st) wealth quintile	19.7	2001	28.4	2006
– highest (5th) wealth quintile	77.4	2001	76.6	2006
– highest : lowest wealth quintile ratio	3.93	2001	2.70	2006
– highest : lowest region ratio	4.23	2001	5.00	2006
– highest region – Kampala	89.6	2001	89.7	2006
– lowest region	21.2	2001	18.1	2006
Contraceptive prevalence among all women			52.0	2006
– rural			15.1	2006
– urban			36.5	2006
– lowest wealth quintile			7.20	2006
– highest wealth quintile			37.9	2006
– highest : lowest wealth quintile ratio			5.26	2006
– urban : rural ratio			2.41	2006
– highest : lowest region ratio			4.96	2006

Source: UBOS and Macro Int., 2001; 2007; MoH, 2008b

PAST LEVELS (1980–2005)

- The Uganda National Expanded Programme on Immunisation (UNEPI) integrates immunisation within primary health care services. As shown in Figure 9, immunisation coverage rose in the 1980s and then plateaued or declined in the 1990s, falling as much as 30 per cent in some districts (MoH, 2006a; UBOS and Macro Int., 2006). A knowledge, attitude and practices survey in 1998 found low levels of community participation in immunisation programmes (UBOS and Macro Int., 2006). A top-down approach and health workers' lack of training in interpersonal skills were found to underlie these problems (MoH, 2006a).
- Measles immunisation rates showed wider regional than wealth variations (see summary table on page 13).
- As the summary table on page 13 indicates, both antenatal care uptake and delivery at health facilities were low in the early 2000s, with the first antenatal care visit at 5.5 months – relatively late in pregnancy (UBOS and Macro Int., 2006). This coverage of maternal health services has remained unchanged and at relatively low levels since 1988, varying by residence (higher in urban women) and region. The rich to poor ratio in deliveries attended by a skilled health worker worsened between 1995 and 2000/01 (EQUINET SC, 2007). In 2001, wealth, residence and regional differentials in assisted delivery were amongst the widest for all health indicators, with fourfold regional and wealth differentials (see summary table).

Figure 9: Immunisation levels, 1981–2010



Source: WHO, 2011

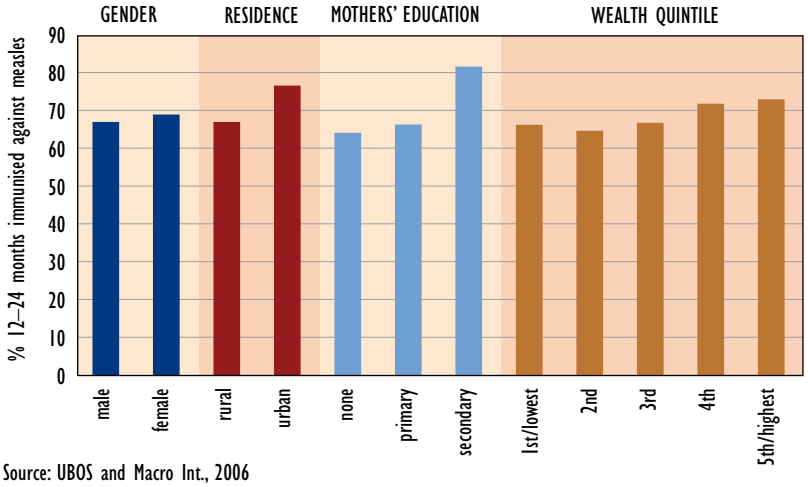
CURRENT LEVEL: 2006-2010

- An immunisation revitalisation plan was initiated to reverse the declining trend and immunisation levels improved in 2006 (see summary table on page 13) although with differentials in coverage by birth order (first-born children were more likely to be fully immunised) and by region. Rates were lowest in Central 1 region (41 per cent) and Karamoja (48 per cent) (UBOS and Macro Int., 2006). As shown in Figure 10a on page 15, immunisation coverage increased with mother's education and household wealth.
- The number of static immunisation service delivery points increased from 1,950 to 2,100 during the implementation of the *Health sector strategic plan II,* making services more accessible (MoH, 2010a). Countrywide campaigns promoted uptake of immunisation services and measures were taken to improve the cold chain and vaccine supply and management with support from the Global Alliance for Vaccines and Immunisation (GAVI). Improved immunisation coverage had reportedly reduced measles morbidity and mortality by 90 per cent by 2009 (MoH, 2010a).
- The summary table suggests limited improvement in maternal health indicators in 2006. The 2006 demographic health survey found that 51 per cent of women used public health centres for antenatal care and government hospitals were frequented more by urban women with secondary or higher education and in the highest wealth quintile. While 42.1 per cent of births were delivered with the assistance of a trained health professional, 23 per cent were delivered by a traditional birth attendant. Delivery at health facilities was higher in urban areas and among wealthier women (see summary table; UBOS and Macro Int., 2006).

CURRENT LEVEL: 2006-2010 continued

- In the same survey, while all women interviewed had heard of a method of family planning, only 52 per cent of currently married women had ever used a contraceptive method, with higher proportions among urban women and in wealthier groups (see summary table; UBOS and Macro Int., 2006). Deliveries in a health facility, attendance at antenatal care and contraceptive use improved up to 2007/08 (see summary table). However, women still face physical and financial barriers to accessing maternal health services, contributing to the low uptake (MoH, 2008b).

Figure 10a: Differences in immunisation coverage by different stratifiers, 2006

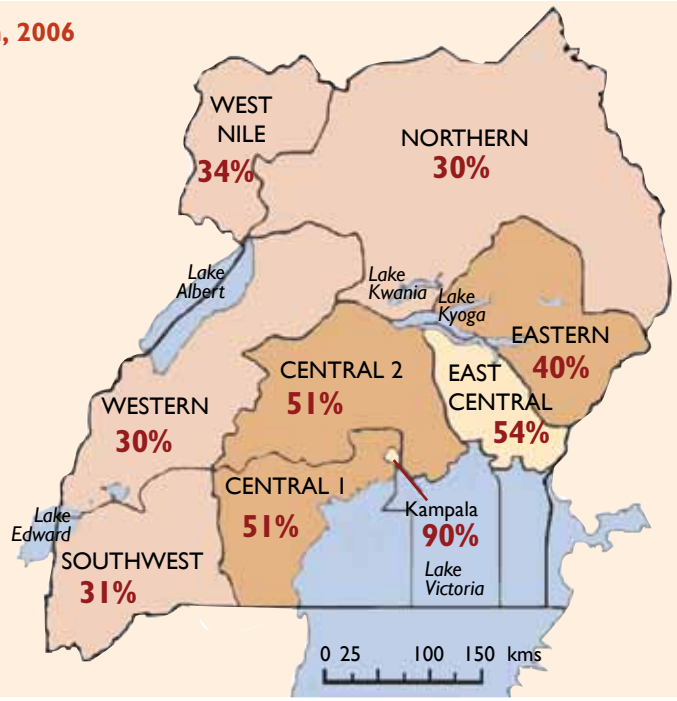


Source: UBOS and Macro Int., 2006

Figure 10b: Assisted deliveries by region, 2006

NATIONAL RATE = 41%

Among women aged 15–49 years who had a live birth in the five years before the survey, the map shows the percentage who gave birth in a health facility



Progress

The evidence shows that immunisation coverage has improved. Inequalities by region persist although they fell in the past decade with more intensive efforts to strengthen service delivery. Maternal health service coverage has made less progress but the greater improvement in the lowest wealth group has closed wealth differentials slightly. The share of pregnant women who deliver using skilled personnel and the prevalence of contraceptive use have remained low. The need for family planning has remained high (MoH, 2010a). Overall, differentials in maternal health service coverage remain wide by region and wealth.

Achieving UN and WHO Goals of universal access to prevention of vertical transmission, condoms and antiretrovirals

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Adult HIV prevalence rate (%)	29 15 5	1987 1992 2000	6.4	2009
% of women attending antenatal care, counselled and tested			39.4	2006
– urban			65.2	2006
– rural			36.2	2006
– urban : rural ratio			1.8 :1	2006
– highest : lowest wealth quintile ratio			1.9 :1	2006
– highest : lowest region ratio			2.4 :1	2006
% adults and children with advanced HIV infection receiving antiretroviral (ARV) therapy – adults – children			53.5	2009
% HIV-positive pregnant women who received antiretroviral drugs to reduce risk of mother to child transmission	No data		51.6	2007
Condom use at last high risk sex in past year %				
– urban	137.1	2001	48.4	2006
– rural	10.3	2001	29.2	2006
– urban: rural ratio	3.6 :1	2001	1.7 :1	2006
– highest : lowest wealth quintile ratio	not available		3.5 :1	2006
– highest : lowest region ratio	6.2 :1	2001	3.2 :1	2006

Source: UBOS and Macro Int., 2001, 2007; UBOS, 2010; MoH, 2002

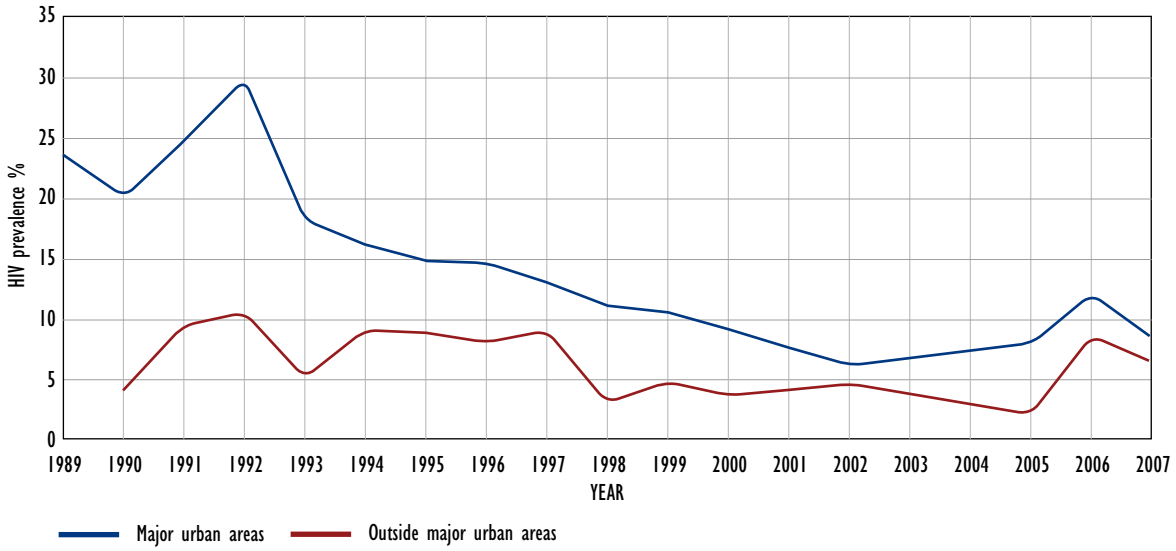
PAST LEVELS (1980–2005)

- Uganda's success in reducing HIV prevalence is internationally known and the data in the summary table above and Figure 11a show the reduction from 29 per cent in 1987 to 5 per cent in 2000. This was accredited to a well-funded government prevention programme supported by international funders and civil society (MoH, 2002). Despite these great strides, the HIV/AIDS epidemic in Uganda is still severe with the national adult HIV prevalence estimated at 6.4 per cent in 2009 (see summary table). Since 2000, adult HIV prevalence has remained at between 5 and 7 per cent with large regional differences. Prevalence rates are higher in Mid-north and Central regions and Kampala city and lower in Karamoja and West Nile region (Figure 11b). In all regions, women have consistently had higher HIV prevalence than men and urban residents have had higher prevalence than rural residents (GoU, 2010).
- Condom use among 15–24 year olds rose from 49.8 per cent in 2002 to 55.1 per cent in 2003 and dropped to 52.9 per cent in 2005 (UBOS and Macro Int., 2010). While government did not have provision for free antiretroviral therapy at that time, there were also efforts in place to manage sexually transmitted diseases and opportunistic infections. After June 2004 the public sector offered free antiretroviral treatment to people living with HIV, with support from the World Bank, the Global Fund and the PEPFAR initiative. With the timing of the incubation period of the virus from first infection, the pool of people in need of antiretrovirals rose from 12 per cent in 2004 to 21 per cent in 2005 and 27 per cent in 2006 (UNAIDS, 2008).

PAST LEVELS (1980–2005) continued

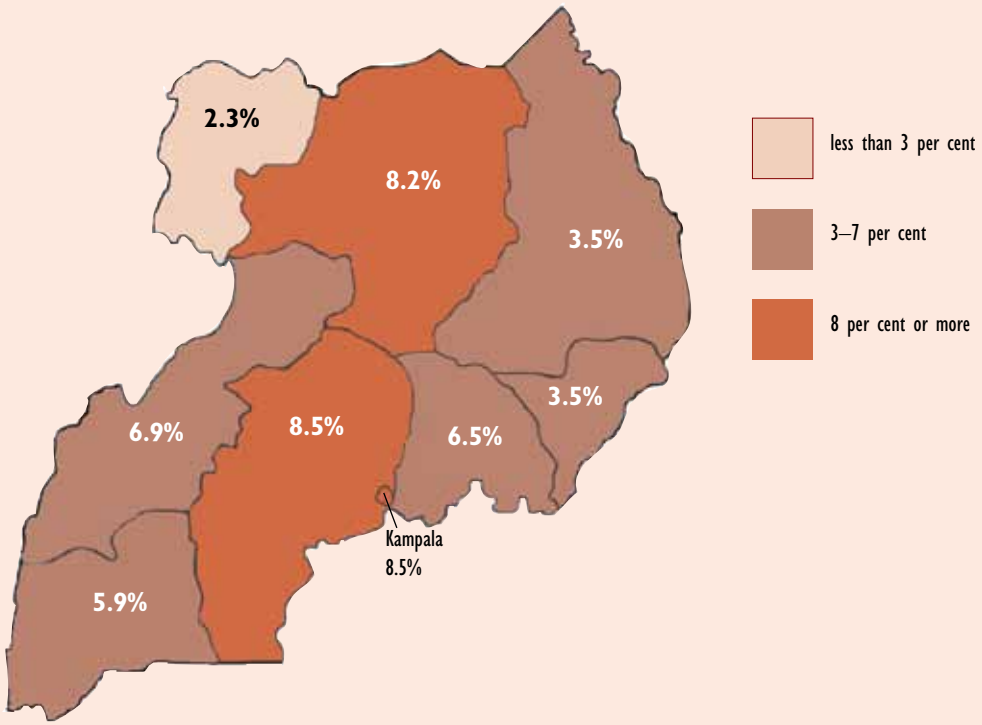
- In the 1990s about 21 per cent of HIV transmission in Uganda was estimated to be through vertical transmission (mother-to-child during pregnancy and childbirth) (MoH, 2002). The government launched a prevention of mother to child transmission (PMTCT) programme in 2005, targeting women delivering in government health facilities. However, only 38 per cent of pregnant women in Uganda delivered in health facilities at that stage and there was no comprehensive plan to reach out to the community settings where most women delivered their babies (UAC, 2007).

Figure 11a: HIV prevalence in urban and rural communities, 1989–2007



Source: GoU, 2010

Figure 11b: Geographic distribution of HIV prevalence, 2007

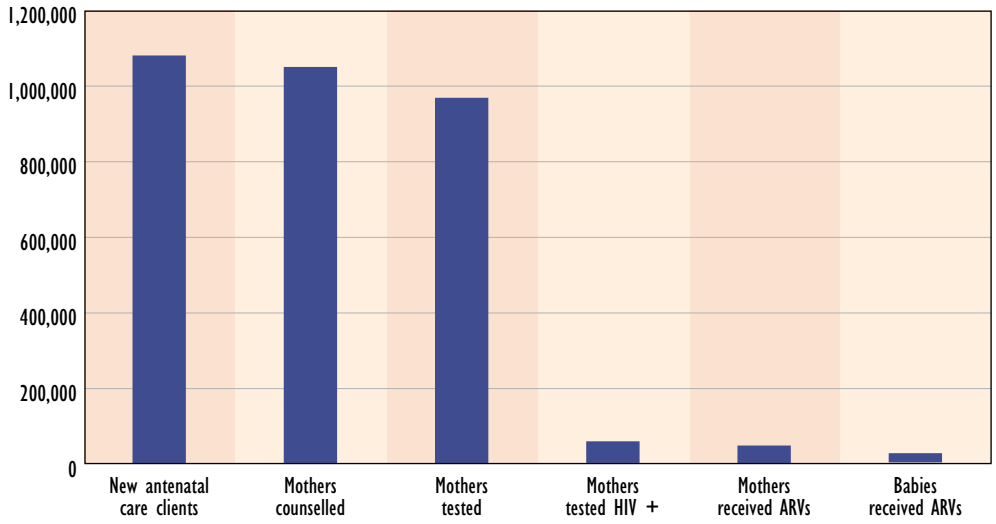


Source: GoU, 2010

CURRENT LEVEL: 2006-2010

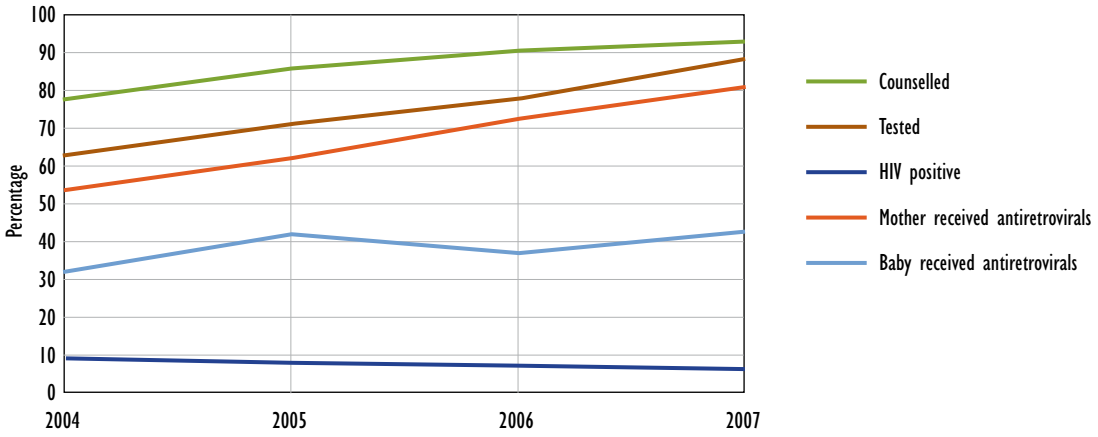
- Uganda's HIV prevalence remained at relatively low levels after 2006, although the estimate of 6.4 per cent adult prevalence in 2009 is higher than levels in 2005 (see summary table on page 16). The prevalence has recently shifted from unmarried young adults to older adults (30–35 years) who are married or in long-term relationships (UNAIDS, 2008b).
- Women, urban dwellers and residents of post-conflict northern Uganda have higher rates of infection and there is a gradual increase in HIV infection with wealth quintile (GoU, 2010). The target set in the *Health sector strategic plan II* aimed to reduce adult HIV prevalence to 3 per cent and prevalence among pregnant women to 4.4 per cent by 2009/10 but this was not achieved.
- Antiretroviral treatment rates have risen to 53.5 per cent of those in need (see summary table).
- Of the new infections in 2007, 18 per cent were due to vertical transmission (mother to child), 37 per cent were due to multiple partnerships, 34 per cent of those infected were in monogamous discordant couples and 9 per cent arose from commercial sex networks (MoH, 2010a). It is estimated that up to 25,000 HIV infections occur through vertical transmission annually (UBOS and Macro Int., 2006; UAC, 2007). Since the launch of the prevention of mother to child transmission (PMTCT) programme in 2005, progress has been achieved, with 68 per cent of level III health centres offering these services, against a target of 50 per cent. Furthermore, 90 per cent of level IV health centres now offer comprehensive antiretroviral treatment against a target of 75 per cent (GoU, 2010). As the summary table indicates, half of the pregnant women who tested positive for HIV received antiretrovirals to reduce vertical transmission, although, as Figure 11c shows, there is still a fall off between those being counselled and those being tested.
- Levels of knowledge of available services was higher in urban areas than in rural areas while in some regions, like Karamoja, only one in ten women (11 per cent) and 14 per cent of men knew about prevention of mother to child transmission drugs (GoU, 2010).
- There is also a gap to be addressed between follow up treatment of mothers and their children, as shown in Figure 11d, with children having less access to treatment.
- Condom distribution and HIV counselling and testing services have expanded (MoH, 2009a) but with mixed results in access to condoms. This is due to the following reasons: insufficient targeting of services at those at high risk, limited use of condoms in long-standing relationships, inconsistent prevention programmes, inadequate rural distribution, limited uptake of female condoms and gender differentials in condom use (GoU, 2010).

Figure 11c: Proportion of women according to intervention coverage in prevention of mother to child transmission programmes, 2009



Source: UNGASS, 2010

Figure 11d: Uptake of prevention of mother to child transmission services by antenatal care clients, 2004–2007



Source: MoH, 2008b

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Progress

Adult HIV prevalence has fallen to low levels and the evidence suggests that progress has been made. However, there are signs of an increase in new infections and consequently some concern about a loss of momentum for prevention that was pivotal in Uganda's turnaround of the epidemic. An increase in the number of people infected with HIV is projected, complicating the attainment of targets for universal access to care and treatment (GoU, UAC, 2011). This will need to be monitored in future. There have been significant improvements in access to services for prevention of mother to child transmission and antiretrovirals although with still substantial unmet need, including among children. Those not yet accessing antiretrovirals and prevention of mother to child transmission services need to be identified to support long-term control of the epidemic and its health burdens. For example, the 2010 UNGASS report indicated that antiretroviral treatment was still mostly available at hospitals and level IV health centres. This poses inevitable access barriers and subsequent inequity in access. Some populations with high risk are under-served, such as commercial sex workers, fishing communities and people with disabilities (GoU, 2010). More predictable long-term funding is needed to address both health system and social barriers.

EQUITY WATCH

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Household access to the national resources for health

Progress markers

- Achieving and closing gender differentials in attainment of universal primary and secondary education
- Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
- Increasing the ratio of wages to gross domestic product (GDP)
- Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems
- Abolishing user fees from health systems backed up by measures to resource services
- Overcoming the barriers that disadvantaged communities face in access to and use of essential health services

EQUITY WATCH

Household access to the national resources for health

This section explores progress in selected parameters of how far households are accessing the educational, environmental, income, health care and social protection resources they need to improve their health and close the differentials in the social determinants of health. The parameters indicate the wider spectrum of such resources.

Achieving and closing gender differentials in attainment of universal primary and secondary education

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
% net enrolment in primary school	87	2001		
– total	90	2003	96.1	2008
– female	87.3	2001	95.0	2008
– male	86.9	2001	97.4	2008
– male : female ratio	1.00	2001	1.03	2008
% net enrolment in secondary school				
– total	15.4	2005	23.5	2008
			24.1	2009
– student : teacher ratio	19	2005	18	2009
Primary to secondary school transition rates (%)				
– total	46.9	2006	69.7	2008
% adult literacy (overall)	54.0	1991	87.0	2009
	68.0	2002	73.0	2009/10
– male : female ratio	not available		1.25	2008

Source: UBOS and Macro Int., 2006, 2010; MoES, 2004, 2010; UNDP, 2007,2008; Kasente, 2003

PAST LEVELS (1980–2005)

- Adult literacy rose markedly between 1991 and 2002. Primary school enrolment rose between 2000 and 2002 but fell between 2003 and 2005 (see Figure 12a on page 24).
- The top factors affecting girls' enrolment in school were concerns about their safety, the need for their labour and monetary costs, while for boys barriers included the costs and distances involved (Kasente, 2003).
- Government introduced the policy of universal primary education in 1997, increasing its share of budget support to primary schools. The School Facility Grant scheme was used to construct new school classrooms and grant assistance was extended to community and private schools in a bid to improve school learning environments and attract and retain children in schools. This nearly doubled primary school enrolment between 1996 and 1997 (Figure 12a, MoES, 2004). The universal primary education policy provided that two of four children per family that benefited from the policy had to be female, if the family included female children. After this policy was introduced, the gender gap closed slightly (see summary table; UBOS and Macro Int., 2006).

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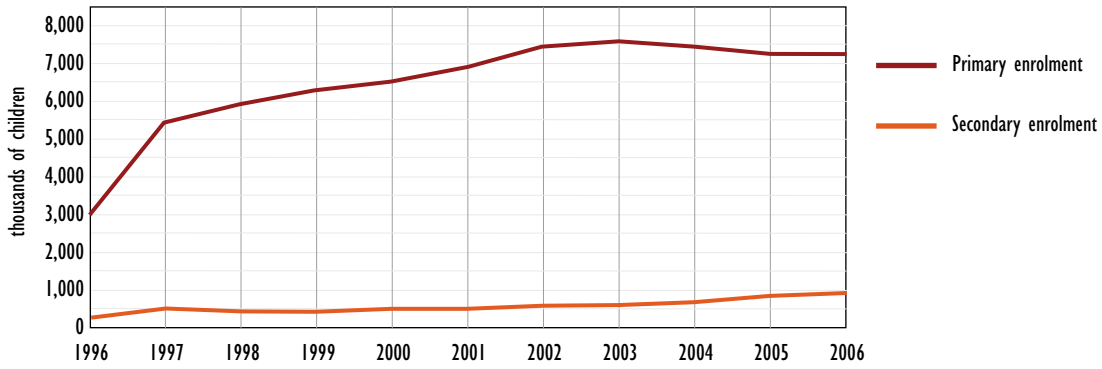
Figure12a: Total enrolment in primary and secondary schools, 1996–2006

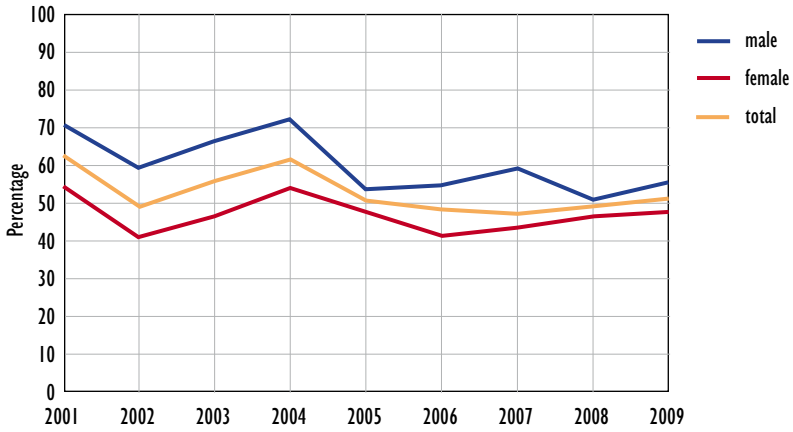


Source: UNDP, 2007; UBOS, 2008

CURRENT LEVEL: 2006-2010

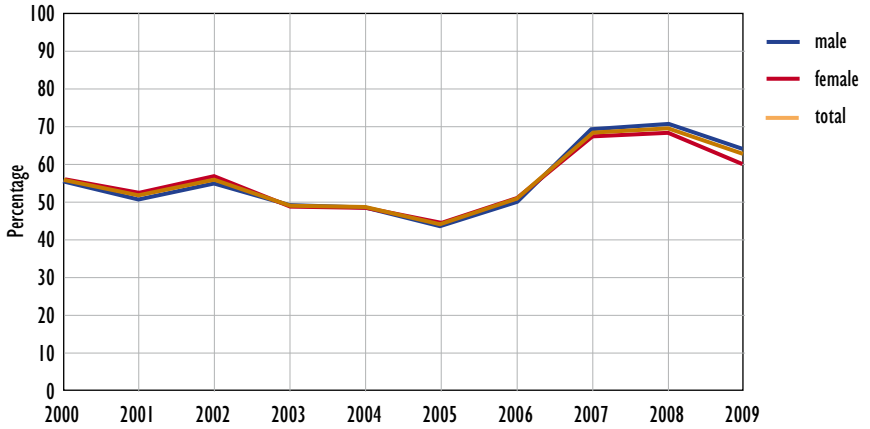
- While literacy rates have continued to improve, gender differentials in literacy remain relatively wide, with the male to female ratio at 1.25 in 2008 (UNDP, 2008).
- Net primary enrolment remained at about 96 per cent and the gender differential closed further (see summary table) (UBOS and Macro Int., 2010).
- The transition rates from primary school (P7) to secondary school (S1) rose markedly between 2006 and 2007, as shown in the summary table. This was an effect of introducing the universal secondary education policy and was linked to the Poverty Eradication Action Plan (PEAP) (which prioritised education as a strategy to eradicate poverty) and the Millennium Development Goal commitments. The universal secondary education policy covered costs directly related to the teaching and learning process in the first four years of secondary education (UBOS and Macro Int., 2010).
- Completion rates for both boys and girls, which had fallen in the early part of the decade, rose after 2007 and transition rates to secondary school increased after 2006 (see Figures 12b and 12c).
- Enrolment has thus risen and gender disparities have closed. With the number of qualified teachers rising from 74,000 in 1995 to 158,110 in 2009, the student to teacher ratio improved (see summary table).
- Emphasis was also given to providing facilities for learners with special needs, such as students with disabilities, with a 20 per cent increase in students with special needs and a 5 per cent increase in orphaned children in secondary school between 2008 and 2009 (UBOS and Macro Int., 2010).

Figure 12b: Education trends 2001–2009 – completion rates to primary seven



Source: MoES, 2009

Figure 12c: Education trends 2001–2009 – transition from primary to secondary school



Source: MoES, 2009

Progress

Uganda has made progress in literacy and increased net enrolment in primary school and transition rates to secondary school, with clear benefits from specific policies designed to reduce cost barriers to education and greater investment in schools, teachers and materials. Specific measures to lower cost barriers to girls' enrolment have also reduced gender disparities and measures to help vulnerable children have enhanced their enrolment in secondary school. Given the importance of education in closing other inequalities affecting health, sustaining these policies and closing the gender differentials are the main challenges.

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Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
% of households with safe water	62.6	2003	67.6	2006
			73.8	2010
– rural	41.0	1990-7	63.8	2006
	57.6	2003	69.5	2010
– urban	77.0	1990-7	86.8	2006
	86.9	2003	92.3	2010
– urban : rural ratio	1.88	1990-7	1.36	2006
	1.51	2003	1.33	2010
% of households with safe sanitation				
– rural	1.6	2001	67.6	2010
– urban	17.0	2001	73.8	2010
– urban : rural ratio	10.63	2001	1.33	2010

Source: UBOS and Macro Int., 2001, 2007, 2010; UNICEF, 1999

PAST LEVELS (1980–2005)

- Access to safe water improved between 1990 and 2003, as shown in the summary table above. However, the urban population still had greater access to safe water than the rural population, although the differential narrowed from 1.88 to 1.51 between 1990 and 2003 as the share of the rural population with access to safe water rose from 51.2 per cent to 60.8 per cent between 2002 and 2005 (MoFPED, 2009).
- One of government's objectives on water resource management, instituted in 2004, was: 'a sustainable provision of safe water within easy reach and hygienic sanitation facilities, based on management responsibility and ownership by the users, to 77 per cent of the population in rural areas and 100 per cent of the urban population by the year 2015 with an 80–90 per cent effective use and functionality of facilities' (MWLE, 2004a).
- Safe sanitation coverage was extremely low, with wide urban-rural differences (UBOS and Macro Int., 2001).

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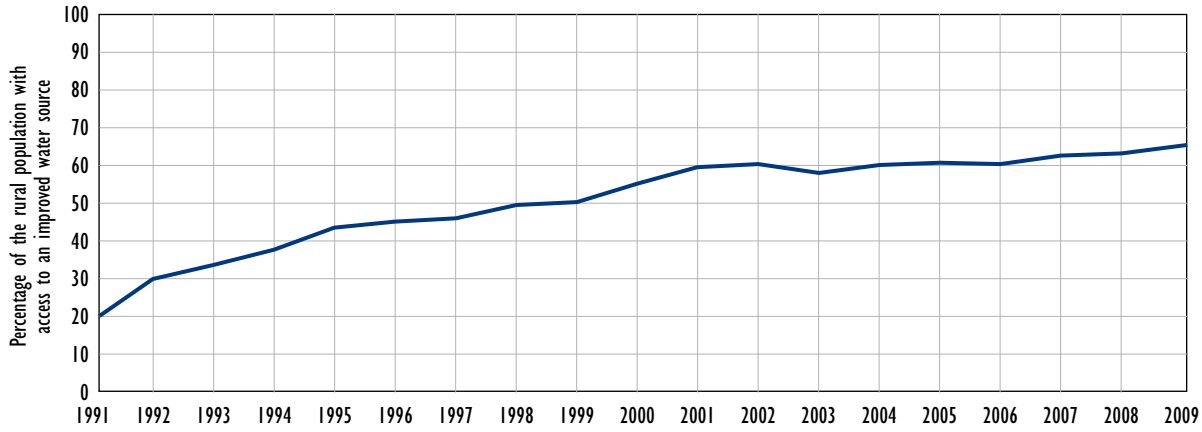
CURRENT LEVEL: 2006-2010

- The *National development plan* (2011–2015) aims to uplift living standards by providing decent housing and safe water (MoFPED, 2010b). It projects that 89 per cent of the population should have access to safe water by the financial year 2014/15. The definition of improved water sources used in Uganda differs from the international definition in that it excludes rain water. In the 2005/06 demographic and health survey, access to safe water had improved overall in both urban and rural areas, and the rural to urban differential had further closed (see summary table; UBOS and Macro Int., 2006). Access to safe water in small towns, at 35 per cent, was half the level of large towns at 71 per cent (MoH, 2005a). Most households (58 per cent) did not treat their drinking water, although urban households more commonly boiled water (69 per cent) than rural households (34 per cent) (UBOS and Macro Int., 2006).
- As shown in Figure 13, access to an improved water supply continued to improve up to 2009, although with wide differences across districts (reported to range from 12 to 95 per cent coverage) and with 4 per cent of sub-counties in Uganda having less than 20 per cent households accessing an improved water source (MoWE, 2009). By 2009/10, 74 per cent of households had access to improved water sources, highest in urban areas (90 per cent) but with gains in rural areas up to 70 per cent.
- Overall, 62 per cent of households travelled up to 0.5 km to the main source of drinking water, with water closest to homes in urban areas. In 2009/10 the average distance to the main source of drinking water was about a kilometre (0.7 km – 0.2 km in urban areas and 0.8 km in rural area), while the average waiting time for water was almost half an hour (27 minutes). While rural to urban differentials persisted, there was an improvement both in the average distance travelled for water and the average waiting time spent at the main source of drinking water between 2005 and 2009/10 (UBOS and Macro Int., 2010).
- Household surveys indicate that sanitation coverage has improved significantly and rural to urban gaps have narrowed.

Figure 13: Trend in access to improved rural water supply, 1991–2009



Source: MoWE, 2010

Progress

Overall, access to safe water and sanitation improved between the two time periods and differentials between rural and urban areas reduced from 1.88 in 1990 to 1.33 in 2010. Hence while inequities remain between rural and urban settings and the country targets have not yet been met, there is progress towards these targets and evidence that the urban to rural gap is closing. Further evidence is needed to determine whether the wide gap in access across districts is also being addressed.

Increasing ratio of wages to gross domestic product (GDP)

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year*
*Labour force participation rate	73.2	1995	71.8	2006
	73.8	2000	78.7	2009
– male	78.0	1995	72.2	2006
	77.8	2000	77.9	2009
– female	68.4	1995	71.4	2006
	69.7	2000	79.4	2009
% self employed	81.2	2005/6	76.4	2009/10
% working for pay for someone else	18.2	2005/6	23.6	2009/10

*'Labour force' refers to the economically active population, including people aged between 14 and 64 years who were either employed or unemployed during the seven days prior to the survey. The labour force participation rate is the number of people in the labour force expressed as a percentage of the working-age population.

Source: UBOS, 2006c, 2010b; World Bank, 2011

PAST LEVELS (1980–2005)

- The share of wage and salary earnings in non-agricultural employment is small in Uganda, at only 27 per cent, and only 27 per cent are in paid employment (MoFPED, 2010b).
- An even smaller share of women in wage and non-agricultural employment (28 per cent) signifies that there are limited formal sector employment opportunities, especially for women.
- Employment opportunities for young women (15-24 years) are about 10 per cent lower than for men. This suggests that employment is constrained as a vehicle for wider growth in household incomes, especially for women.

CURRENT LEVEL: 2006-2010

- The summary table above suggests employment for young adults has improved. Between 2006 and 2009 the labour force participation rate grew faster than the national population rate which was 3.2 per cent per year, with double the rural rate evident in urban areas (UBOS and Macro Int., 2010). All regions experienced growth in employment.
- Nevertheless the benefits of this growth appear to be unequal. In 2009, women were more commonly employed in lower paying sectors (agriculture, household and mining and quarrying). In the private sector, women are paid lower wages than men for the same work. In a third of identified occupations, women earn less than 75 per cent of the average male wage (MoFPED, 2009). Hence for example, most houses are owned by men, although family houses are by law considered matrimonial property, partly due to this income disparity between men and women (MoFPED, 2010b).

Progress

A drop in self employment and increase in paid employment between 2005 and 2009 corresponded with the falling share of agricultural employment. Employment in industry may be associated with improved wages. However women's work is in lower paying sectors and women receive lower wages for the same work. The *National development plan* (2011–2015) aims to address this situation by creating employment and raising average per capita income levels (MoFPED 2010b). While the proportion of self-employed people fell between 2005 and 2010, it remains high at 76 per cent, suggesting low growth in formal jobs and high dependency on the informal economy.

Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems

INDICATOR s	PAST LEVELS (1980–2005) Level	 Year	CURRENT LEVEL (most recent data) Level	 Year*
Per 10, 000 people, total medical personnel				
– doctors	0.4	2002	1	2010
– dentists			<0.5	2010
– nurses and midwives	6.1	2002	13	2010
– pharmacists			<0.5	2010
Median availability of selected generic medicines (%)				
– public sector			20	2001–2008
– private sector			80	2001–2008
% health units without monthly stockouts of any indicator medicines	35 27	2004/5 2005/6	35	2006/07
% indicative cash budget for medicines spent by districts at national medical stores and joint medical stores	51 60	2004/5 2005/6	58	2006/07

Source: WHO, 2011; MoH, 2006b, 2007

PAST LEVELS (1980–2005)

- Density of doctors in Uganda was below that of neighbouring Kenya in 2002 (1:7 100) although nurse density in Uganda was better than in Kenya (1: 1 877). Uganda's health worker densities are below the WHO standards for adequacy. The *World health report 2006* estimates that countries with a density below 2.28 combined physicians, nurses and midwives per 1,000 population generally fail to achieve a targeted 80 per cent coverage rate for skilled birth attendance and child immunisation (WHO, 2006). Urban areas had a higher share of health workers (61 per cent of doctors in 2004) and low levels of health personnel were associated with low attendance by a skilled person at birth (EQUINET SC, 2007).
- By 2003, the districts were reported to have only 86 per cent of medical staff needed and only 48 per cent of the required nurses (Maniple, 2004). While decentralising the health system in the early 2000s brought many benefits, it brought frustration for health workers who described feeling trapped into a district system with no institutional or budget arrangements to grow beyond what the district could offer. Workers in under-served areas felt particularly underprivileged due to stringent controls against them taking annual leave and undergoing further training (Ssengooba *et al*., 2006).
- The *Health services strategic plan I* aimed to ensure that essential drugs were consistently available. The strategies proposed for this included the following: developing a drug policy; coordinating and quantifying selection, needs, procurement, storage and distribution; ensuring rational drug use; recovering costs; controlling quality; and regulating drug supplies (MoH, 2006a). However, medicine stockouts were still reported in 2002/03 at all levels of the health system, creating a barrier to access and use of health services. The stockouts were mainly at level II and III health centres and ranged between 5 and 50 per cent for essential drugs (MoH, 2003/04). In the 2004/05 period, 65 per cent of health units experienced a monthly stockout of an indicator drug, a deteriorating situation compared to the year before, particularly at level IV health centres and particularly in relation to antimalarials and oral rehydration solution. Stockouts were primarily due to inadequate supplies from pharmaceutical manufacturers to national medical stores and a change in malaria treatment policy (MoH, 2005b).

CURRENT LEVEL: 2006-2010

- The shortage of health professionals in Uganda continues to adversely affect health service delivery, with ratios of personnel well below WHO standards at all levels and particularly at level IV health centres (MoH, 2009a).
- Health workers are unequally distributed by region and district, by rural and urban residence and by level of care, with skilled cadres like doctors, specialised nurses or midwives, pharmacists, dentists and diagnostic personnel being concentrated in urban areas. The urbanised central region, with 27 per cent of the population, has 64 per cent of qualified nurses and midwives, 71 per cent of medical doctors, 76 per cent of dentists and 81 per cent of pharmacists (Nabyonga and Zikusooka, 2010). Furthermore, these shares do not relate to the WHO norms noted above but to the posts available which are limited by the budget allocated for wages. Efforts are being made to attract and retain health workers, including through better salaries, a 'hard-to-reach' scheme aimed at attracting health workers to underserved areas and more training for nurses and other crucial primary health care workers. However health worker wages continue to be low and remain a push factor for out-migration. Laboratory and pharmaceutical staff also need further training opportunities. An in-service training strategy was developed and implemented to address continuing education and specific skills gaps identified, including the public health, planning and management skills needed to support the delivery of plans (MoH, 2009a). A human resource information system has been established in cooperation with partners.

CURRENT LEVEL: 2006-2010 continued

- Government has reiterated its commitment to ensuring adequate quantities of good quality essential medicines and health supplies at all levels of the health system, funded through government budget lines and external funding, including global health initiatives. According to the strategic plan, US$ 2.40 per capita is needed for these basic supplies, excluding antiretrovirals, artemisinin combination therapies (ACTs – anti-malarials), insecticide-treated bed nets and the pentavalent vaccine. In 2006/07, US$0.72 per capita was spent on these basic supplies and US$4.06 per capita on all medicines and supplies, including antiretrovirals and artemisinin combination therapies (anti-malarials) (MoH, 2008b).
- Drug stockouts at health centres fell from 35 per cent in 2006/07 to 28 per cent in 2007/08 and, for anti-malarials, to 28 per cent of health facilities in 2008/09 (MoH, 2008b, 2009). However, health centres continued to report drug stockouts and irregular attendance by many health workers at their duty stations in 2009, with drug stockouts reported to be a barrier to services coverage at public facilities (MoH, 2009a).
- In the *Health services strategic plan II*, Ministry of Health changed the drug ordering system from a push to a pull (order-based) system and established a dedicated essential drugs account to service credit lines at national medical stores and joint medical stores. The new mechanism aimed to channel and integrate all funds for public sector essential medicines and health supplies procurement. This, together with capacity building at the National Medical Stores and National Drug Authority, support for laboratory functions and equipment support, has reportedly significantly improved efficiency in medicines management and regulation and in availability of essential medicines at facility levels (MoH, 2009a).
- The ministry has in the period reviewed the National Drug Authority statute and promulgated the Pharmacy Profession and Pharmacy Practice Bill (MoH, 2008b). However the role of externally-funded programmes and parallel procurement approaches is noted to complicate the approach and create a complex environment for planning and managing essential medicines. Hence, despite a national policy and costed plan for medicines, there is an identified need for an effective and appropriate mechanism to coordinate, support, supervise and monitor implementation of policies and plans.
- The shortfall in pharmacists is a further constraint identified.

Progress

The shortage of health workers and essential medicines remains a challenge, as does the concentration of skilled health workers in urban areas and the stockouts of essential drugs. The medium-term review of the *Health services strategic plan II* identified issues relating to availability, quality and regulation of essential medicines and health supplies. Medicines were not consistently available in public health facilities, procurement and logistics posed challenges and funding for medicines was inadequate – especially for essential medicines and health supplies. This was particularly of concern as the demand for medicines has increased due to both non-communicable diseases and to the scale up of HIV/AIDS, malaria and TB programmes and also because of an estimated reallocation of more than 20 per cent of the regular budget for essential medicines and health supplies to other expenditure items. The review also identified concerns about the rational management and use of medicines at various levels of the health system, with reports of leakages of publicly-funded medicines from and between the national level, local governments and health facilities (MoH, 2008b).

The role and skills of community health workers remain relatively informal. The country has set targets for the proportion of approved posts filled by health professionals to increase to 90 per cent by 2009 and to have levelled out the variations in staffing levels between districts and health units so all have staffing levels above 80 per cent (MoH, 2009a). It is important for information on the delivery on these goals in all districts and on the impact of efforts made to attract and retain health workers to be made public regularly. This information is not only needed at central level but within communities and districts, given the spectrum of actions, from local to central, needed to address the constraints to the effective distribution of medicines and retention and deployment of health workers.

Abolishing user fees from health systems backed by measures to resource services

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
*Out of pocket spending as a percentage of total health expenditure	55.7	1995	37.2	2006
	50.7	1998	37.6	2007
	41.5	2000	39.5	2008
	36.1	2002		
	36.0	2004		
	35.9	2005		

* Fair financing is based on principles of financial protection: no one in need should be denied access due to inability to pay and households' livelihoods should not be threatened by the costs of health care; progressive financing – contributions should be distributed according to ability-to-pay and those with greater ability should contribute a higher share of their income; and cross-subsidies from the healthy to the ill and from the wealthy to the poor. Out-of-pocket spending through fees and other charges can impoverish households (Wagstaff and van Doorslaer, 2003). Hence the 58th World Health Assembly urged countries to reduce out of pocket spending in favour of prepayment schemes (WHO, 2005b).

Source: WHO, 2011b

PAST LEVELS (1980–2005)

- When government implemented the decentralisation policy in 1993, local governments were mandated to decide on financing options for health care in their districts, supported by Ministry of Health guidelines. By 1997, public health facilities in all but two districts charged fees. User fees in public facilities provided less than 10 per cent of recurrent costs and contributed less than 5 per cent to total health expenditure (Okuonzi, 2004).
- In the 2001 presidential campaign, all presidential candidates opposed fees in public health facilities and user fees at first level government health facilities in Uganda were abolished (Ssengooba and McPake, 2006). Government increased funding to district health services to mitigate the loss of revenue from fee abolition. Out of pocket spending fell in 2002 (see summary table). There was little change in catastrophic health expenditures but improvements in service uptake were found, more in lower than in higher income groups (Xu *et al.*, 2005). Payment for health care is said to be catastrophic when it exceeds a defined level of household income and leads the household to sacrifice consumption of other items that are necessary for their wellbeing, such as shelter or education.

CURRENT LEVEL: 2006-2010

- Catastrophic health spending actually increased from 8 to 28 per cent between 1996 and 2006, despite the elimination of user fees in 2001, with 2.3 per cent of households found to have been impoverished because of medical bills (Okwero *et al.*, 2010). This may have been due to the frequent unavailability of drugs at government facilities after 2001, forcing patients to purchase these from private pharmacies and offsetting the benefits of reduced payments for consultations (WHO, 2005). Catastrophic payments varied by wealth (24.8 and 29 per cent households for lowest and highest quintiles, respectively) and across regions (Okwero *et al.*, 2010).

Progress

Progress has been made by abolishing fees in public facilities and allocating additional funds to services. This appears to have lifted barriers to uptake, particularly for the poorest, but catastrophic spending has increased, primarily due to private payments for medicines. Ensuring medicine supplies to public health facilities is important in yielding the benefits of fee abolition. The effects of fee charges at private health facilities also need to be assessed.

Overcoming the barriers that disadvantaged communities face in access to and use of essential health services

PAST LEVELS (1980–2005)

- While the *Health services strategic plan I* aimed to ensure the delivery of the minimum health care package nationwide (MoH, 2006a), numerous access barriers were reported which limited access to only 49 per cent of households (MoH, 2006a). The majority rural population faced distance and other physical barriers, such as rivers, marshes and hills, and only 42.7 per cent of parishes in the country had a health facility (MoH, 2000). By 2004/05 only 48 per cent of the population lived within 5 kms of a public or not for profit health facility (Nabyonga and Zikusooka, 2010).

CURRENT LEVEL: 2006-2010

- During the *Health services strategic plan* II period (2005/06–2009/10), government aimed to build, upgrade and manage health infrastructure to make health services and the Uganda national minimum health care package more available. The proportion of government health units located within communities was reported to have doubled from 7 per cent in 2005/06 to 14 per cent in 2009/10. The availability of private clinics and pharmacies has also increased. Infrastructure appears to have improved and the distances to public health facilities are reported to have fallen (UBOS, 2010b). The challenge now remains to ensure quality of service provision by overcoming the shortages of health workers, equipment and medicines. Between 2005/06 and 2009/10 there was a 2 per cent shift in the proportion of people seeking medical care from private clinics to public clinics, possibly due to the improvement of services and free supply of essential drugs at health centre level (UBOS and Macro Int., 2010).
- However, inequities in the infrastructure remain. While the national average is 8,785 people per facility (including public, private and non-governmental organisation facilities), this varies from 20,376 per facility in some rural districts to 5,295 per facility in Kampala, the capital city. While 20 per cent of districts have no hospital, several districts have more than two and Kampala has eight (Nabyonga and Zikusooka, 2010). The Eastern region appears to be better served while the Northern region is most poorly served (UBOS, 2010).
- Stakeholders reviewing the report suggested a deeper assessment of the social barriers to service uptake in Northern region was needed. While community mobilisation has increased awareness and use of health services, barriers to health care uptake are still found for all wealth categories in relation to geographical access, availability and the assets to overcome cost barriers. Income, transport ownership and health literacy were found to be important in overcoming barriers to uptake for poor households who were keen to use public health services. However, public services were also perceived to offer low quality care due to gaps in essential supplies (Bakeera *et al.*, 2009). HEPS Uganda, a civil society health coalition, has begun to implement health literacy programmes.

Progress

Government policy and investments have improved the health infrastructure, overcoming distance barriers to access, while lifting fees, discussed earlier, has reduced cost barriers. However, effective coverage is still limited by shortages of health workers and shortfalls in medicine supplies to services as well as by social barriers to uptake. The social inequalities in coverage of key services have been described in earlier progress markers and these perceived barriers call for further measures to enhance uptake of services among vulnerable groups, including through health literacy. A more comprehensive audit of the availability of essential services, such as emergency obstetric care, would provide better evidence to analyse access, as some hospitals may not offer a service that is available at a lower level, for example, at level IV health centres.

EQUITY WATCH

Resourcing redistributive health systems

Progress markers

- Achieving the Abuja commitment of 15 per cent government spending on health
- Achieving US$60 per capita public sector health expenditure
- Increasing progressive tax funding to health and reducing out of pocket financing in health
- Harmonising the various health financing schemes into one framework for universal coverage
- Establishing and ensuring a clear set of comprehensive health care entitlements for the population
- Allocating at least 50 per cent of government spending on health to district health systems (including level 1 hospitals) and 25 per cent of government spending to primary health care
- Implementing a mix of non–financial incentives for health workers
- Formally recognising and supporting mechanisms for direct public participation at all levels of health systems

EQUITY WATCH

Resourcing redistributive health systems

For health systems to promote health equity they need to work with other sectors to improve household access to the resources for health (for example, safe water and education) discussed in the previous section. Health systems also need to 'get their own house in order', to promote the features that enhance health equity. This section presents selected parameters of progress in this direction, for example: in the benefits, entitlements and framework for achieving universal coverage; in mobilising adequate resources through fair, progressive funding; in allocating resources fairly on the basis of health need; and in investing in the central role of health workers, people and social action in health systems.

Achieving the Abuja commitment of 15 per cent government spending on health

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
% of government spending on health excluding external project funding*	7.5	2000/1	8.9	2005/6
	8.9	2001/2	9.3	2006/7
	9.4	2002/3	9.0	2007/8
	9.6	2003/4	8.3	2008/9
	9.7	2004/5	9.6	2009/10
Total health spending as % of GDP	6.6	2000	6.3	2007

* Excludes external project funding but not external funding through budget support

Sources: WHO, 2006, 2011; MoH, 2006a, 2009

PAST LEVELS (1980–2005)

- As shown in the summary table, the share of government spending on health improved from 2000 to 2005, although it was still below the Abuja target of 15 per cent. In 2005 Uganda needed to spend another US$9 per capita to reach the Abuja target (EQUINET SC, 2007). The national health accounts study for 2000/01 indicated that 8.1 per cent of GDP was spent on health in total in that financial year of which public expenditure constituted 42 per cent (MoH, 2004).

CURRENT LEVEL: 2006-2010

- In the last decade government has provided new institutional arrangements in the public sector for planning and resourcing health which included: the sector-wide approach (SWAp), the medium-term expenditure framework, the Poverty Action Fund, the fiscal decentralisation process and the national development plan. These approaches sought to increase transparency and participation in the budget process, together with budget framework papers prepared at national, sectoral and local government levels.
- Despite these measures to boost accountability, government share of financing to health has remained at around 9 per cent in the period up to 2010, still below the 15 per cent committed in Abuja in 2001 or the *Health sector strategic plan II* target of 13.2 per cent government spending (MoH, 2005a).

Progress

The share of government allocation to health has not significantly increased. This could limit the effectiveness of the measures introduced to improve coverage, such as lifting fees and strengthening availability, and constrain the public sector leadership needed for equity. In 2008 members of the Uganda parliament pledged to promote the implementation of the Abuja commitment indicating their support for improvement in this area (PPD ARO, EQUINET, APHRC, SEAPACOH, 2009).

Achieving US$60 per capita public sector health expenditure

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Public sector per capita spending on health (US$) nominal*	5.9	2000/1	14.8	2005/6
	7.5	2001/2	7.8	2006/7
	7.3	2002/3	8.4	2007/8
	7.7	2003/4	10.4	2008/9
	8.0	2004/5	11.4	2009/10
Total health spending per capita (including external funding) (US$)	20.00	2000/1	33.00	2008

*Nominal expenditure refers to values converted to US$ at current rates and not adjusted for inflation.

Sources: World Bank, 2010; MoH, 2002, 2010

PAST LEVELS (1980–2005)

- The per capita expenditure on health increased between 2000 and 2005, as shown in the summary table, in part due to increasing contributions from external funders (see Figure 14a; MoH, 2009a,2010).
- The national health accounts (NHA) study for 2000/01 found that public and private sources combined translated to US$20 per capita (MoH, 2004). This suggests that funding remained in the period well below the US$60 recommended by WHO or the US$28 per capita estimated in the *Health sector strategic plan I* as needed to deliver the Uganda minimum health care package (excluding vaccines, antimalarials, antiretrovirals and insecticide-treated nets) (MoH, 2002).

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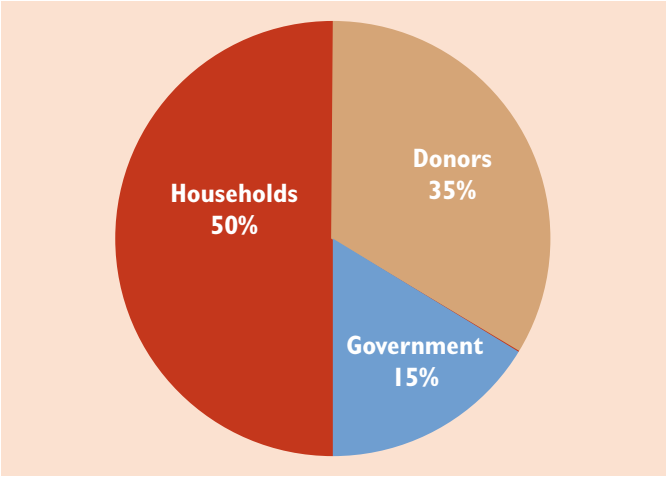
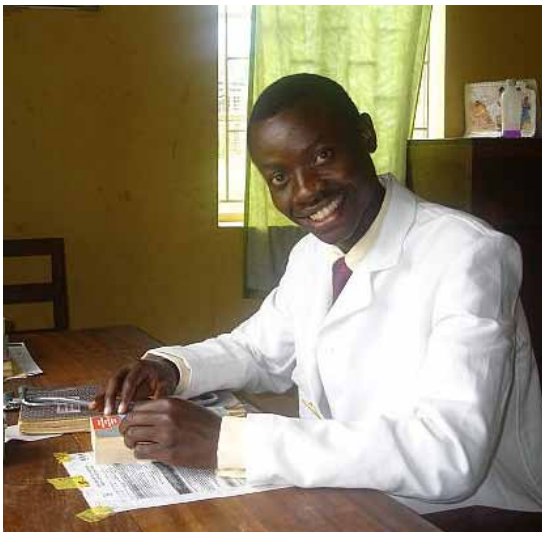
Figure 14a: Sources of funding for the health sector, 2001

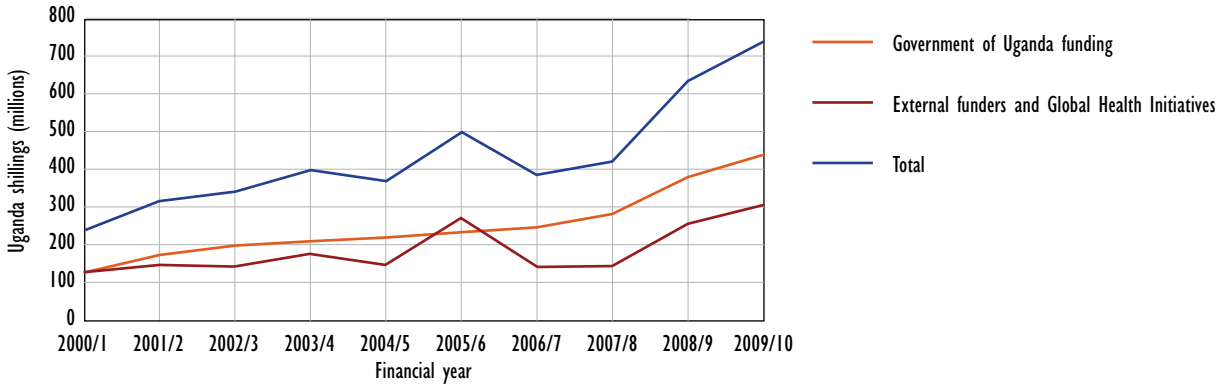


Source: MoH, 2010a



Wangwe Rogers, health worker © buhugu.org's photostream on Flikr.com

Figure 14b: Trends in health financing, 2000–2010



Source: MoH, 2010a

CURRENT LEVEL: 2006-2010

- Total per capita health expenditure was estimated to have risen to US$33 in 2008, still below the US$60 target (World Bank, 2010). This was also below the revised costing for Uganda's minimum health care package which was re-estimated at $41.2 per capita in 2008/09 and at US$47.9 in 2011/12 (MoH, 2008c). Development assistance continues to play a major role in financing health services but a large share of this is off-budget. According to the Ministry of Finance, Planning and Economic Development report (MoFPED, 2009), off-budget funding constituted US$440 million in 2008/09, while the overall health budget stood at US$628 million (MoFPED, 2009).
- While Figure 14b shows that government and external funding improved over the period, the shortfall in the total and public budget per capita over requirement has left households to take on a higher level of health financing. In 2008/09, for example, households were estimated to have contributed US$16.5 per capita (MoH, 2009a) and about 9 per cent of their consumption expenditure on health (World Bank, 2010). This is discussed further in a later progress marker.

Progress

While overall and public spending on health per capita has improved, the funds available do not cover the cost of the basic health package or the US$60 target, leaving households exposed to additional spending. Government spending on health is highly dependent on external funds which are unpredictable. Much external funding is off budget, making it difficult to apply to public sector policy tools for universal coverage or equity.

Increasing progressive tax funding to health and reducing out of pocket financing in health

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year*
Total expenditure on health as % of GDP	5.4 6.6 6.4	1995 2000 2005	6.6 6.3	2006 2008
External resources on health as % of total health expenditure	14.0 28.3 35.0	1995 2000 2005	30.5 32.2	2006 2008
General government expenditure on health as % of total health expenditure	29.4 26.8 29.7	1995 2000 2005	27.0 22.6	2006 2008
Private expenditure on health as % of total health expenditure	70.6 73.2 70.3	1995 2000 2005	73.0 73.4	2006 2008
General government expenditure on health as % of general government expenditure	10.1 7.3 10.4	1995 2000 2005	9.7 10.3	2006 2008
Private insurance as % of private expenditure on health	0.3 0.1 0.2	1995 2000 2005	0.2 0.2	2006 2008
*Out of pocket expenditure as % of private expenditure on health	78.9 56.7 51.0	1995 2000 2005	51.0 51.0	2006 2008

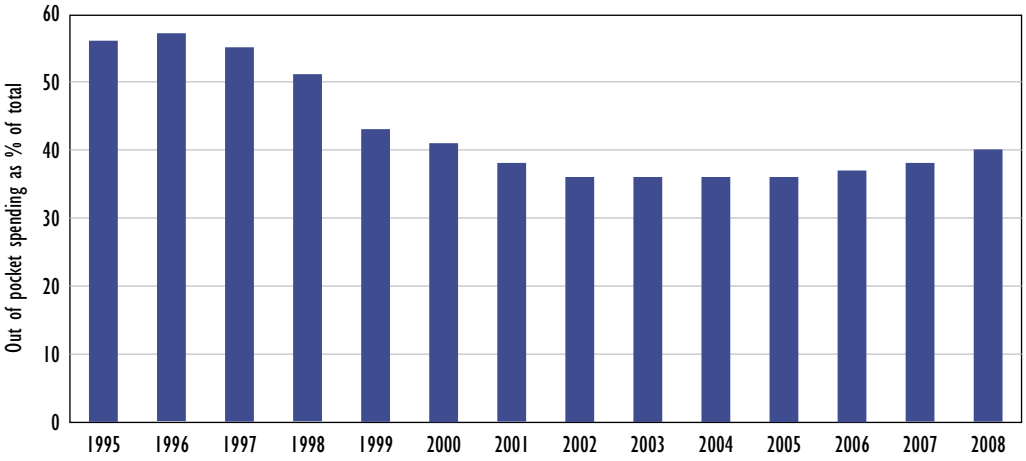
* Note this data shows trends for out of pocket spending as a percentage of private health expenditure while the data on page 32 and Figure 15 are for out of pocket spending as a share of total health expenditure.

Source: WHO, 2011; NHA database 1995–2005

PAST LEVELS (1980–2005)

- As noted earlier, households or individuals, external funders and central government between them accounted for 86 to 91 per cent of total health expenditure in the 1998 to 2001 period (MoH, 2004). Individuals or households contribute out of pocket spending through user fees (formal and informal), community financing schemes and private health insurance. The summary table highlights that government funding for health as a share of total health spending remained relatively static between 1995 and 2005 but out of pocket health spending fell markedly (from 79 per cent to 51 per cent) primarily balanced by the increase in external funding (from 14 per cent to 35 per cent) over the period. This has made the reduction in out of pocket spending quite externally dependent.
- One way of increasing domestic resources is through insurance but no social insurance existed in the period, although employers do often contribute to the medical expenses of their employees and efforts were made to explore possible options. In urban areas, voluntary private prepayment schemes cover less than 1 per cent of the population and are mainly provided by companies for their employees and their dependants (MoH, 2004). In rural areas, community-based insurance initiatives cover about 2 per cent of the catchment population. Most schemes faced severe sustainability problems and a number were subsequently closed (Kyomugisha *et al.*, 2008).

Figure 15: Out of pocket spending as a share of total health spending, 1995–2008



Source: WHO, 2011b

CURRENT LEVEL: 2006-2010

- As shown in the summary table, government spending as a share of total health spending fell between 2006 and 2008, while the out of pocket and external shares were relatively constant. Uganda's share of external funding on health was amongst the highest in the region.
- This was partly due to government's overall low tax revenue since domestic revenue as a share of gross domestic product only rose from 11.2 per cent in 2000 to 12.9 per cent in 2009 (WHO, 2005). This makes the continued stability of the tax system and improvement in collections from other revenue sources key areas of focus to improve government health financing. Non-tax revenue currently contributes about 1 per cent of total domestic revenues which could be increased if rates were reviewed. Government has indicated its intention to do this, to streamline existing exemptions and tax incentive policies and to improve tax administration and enhance the compliance rate. More focus will be placed on the retail sales end of value added tax (VAT).
- There are other sources of earmarked public financing. At local government level, districts are allowed to spend 10 per cent of their resources on health, while those implementing the *Peace and recovery development plan* had the extra flexibility of spending 50 per cent and 65 per cent on health in 2006/07 and 2007/08. In the health sector, a district private, not for profit subsidy, a district hospital grant and a district primary health care grant are ring-fenced from the flexibility to ensure that they address targeted needs (GoU, 2011).
- The heavy reliance on out of pocket funding and absence of more integrated financing mechanisms for the health sector (discussed later) pose a challenge for health equity. While government health facilities (the lower levels I to IV health centres) do not charge fees, as noted earlier, the relatively poor quality of services in public health facilities has created a two-tier system in access to services. This has led to household catastrophic expenditure remaining high, as discussed earlier.
- External funding comes through budget support and through specific programmes or projects that target specific regions or districts in the country. The benefit incidence of this spending is not assessed. Uganda is proposing to establish social health insurance as a source of additional domestic funding for the health sector and to shift high out of pocket payments towards pre-payment arrangements that could include cross subsidies across wealth and risk levels.

Progress

While out of pocket financing on health decreased between 1995 and 2005, it then remained static up to 2008 while catastrophic expenditures have been increasing. Tax funding has declined as a share of total spending and the share from external funds overshadows the government share. Equitable options for progress would include improving domestic financing from more efficient tax and other government revenue, including from earmarked taxes, particularly given the general economic growth, together with advancing the proposals for a national health insurance scheme.

Harmonising the various health financing schemes into one framework for universal coverage

PAST LEVELS (1980–2005)

- As noted earlier, health sector resources in Uganda come from government (central government funds – mainly from taxes – and local government funds), external funders, households, private firms and not for profit organisations. External funding comes through projects, direct district support and the global health initiatives. Efforts to coordinate and harmonise these various sources of financing are noted in the *National health policy* (1999) and the *Health sector strategic plan* (2000–2005 and 2005–2010) (MoH, 2001, 2005a). In the public sector a sector-wide approach (SWAp) was used to collectively set priorities, collect funds and support expenditures in line with policies, with external and domestic funds managed by government through a common approach across the health sector (Zikusooka, Tumwine and Tutembe, 2009).
- In 1995, the Ministry of Health identified community health insurance through prepayment schemes as an option, and piloted the first scheme, the Kisiizi Hospital Society Health Plan. It was modelled on a similar facility-based scheme in Kenya (PHRplus, 2006). At the time, individuals paid user fees for government services. The community-based health insurance schemes (seven in total) remained small with low coverage levels and enrolment (400-8000 members) and limited sustainability (Derriennic *et al,*. 2004; Kyomugisha *et al*., 2008).
- In 1997, the Uganda Health Cooperative formed a partnership with 59 existing micro-finance groups, tea and coffee cooperatives, schools and *engozi* societies to create a pool through which comprehensive health services would be 'prepaid'. However, in June 2004, the organisation scaled back operations, limiting assistance to schemes in the western part of Uganda, and while the remaining schemes have continued to function, they are not receiving external funding support (PHRplus, 2006).

CURRENT LEVEL: 2006-2010

- Out of pocket payments have fallen (see earlier discussion) although the private wings of public hospitals, and private for profit and not for profit health providers continue to be financed through user fees (MoH, 2010a). However with national health insurance debated over the past seven years but not introduced, and a low 0.13 per cent contribution to health financing by private health insurance schemes, financing for Uganda's health sector is largely not pre-paid.
- Cross-subsidies are limited and fragmentation is high between the different health financing mechanisms. Specifically, this fragmentation occurs between government and external project funding but also within external funders project funds. This negatively impacts on the creation of larger funding pools. When external funding and global health initiative resources are channelled through projects or targeted at specific diseases and are not coordinated, they can undermine government's plan to allocate resources based on need within the system and across geographical areas.

Progress

With limited prepaid financing and financial protection due to high out of pocket spending, fragmentation within and between financing mechanisms and limited cross-subsidies across funding sources, it is difficult to address equity or ensure universal coverage through health care financing. The current situation needs to be able to move progressively towards a more harmonised universal framework, for example, by strengthening tax-based funding and widening and making links across prepaid pools.

Establishing and ensuring a clear set of comprehensive health care entitlements for the population

PAST LEVELS (1980–2005)

- Uganda has a decentralised health care delivery system. In 1999 government policy provided for health service zones, called health sub-districts, to be established within districts. These sub-districts were to be functional subdivisions of the district health system and aimed to increase equity in access to essential health services (MoH, 1999).
- The national health policy also defined a minimum health care package of interventions to address the major causes of morbidity and mortality. This package is a tool for prioritising health sector resource allocation to the districts and health sub-districts. It incorporates the following twelve technical programmes: control of communicable diseases such as malaria; integrated management of childhood illness; sexual and reproductive health and rights; immunisation; environmental health; health education and promotion; school health; epidemic and disaster prevention, preparedness and response; improved nutrition; interventions against diseases targeted for elimination or eradication; strengthening mental health services; and essential clinical care (MoH, 1999).

CURRENT LEVEL: 2006-2010

- The *Health services strategic plan II* (2005/06–2009/10) committed to delivering the minimum health care package as described above. This remains the reference point for allocating public funds and is the primary focus of the health sector strategic plan (MoH, 2005a). Due to bottlenecks in delivering the minimum package under the first plan, the *Health services strategic plan II* intended to focus on a limited set of evidence-based, cost effective interventions, grouping the twelve technical programmes into four clusters in order to enhance the integrated approach to service delivery and foster better coordination in planning, budgeting and implementing the interventions at all levels of care (MoH, 2004).
- In the mid-term review of the *Health services strategic plan II*, the sector was on track for several core and programme targets, particularly with respect to the following: disease prevention and control; reduction of maternal and new-born baby morbidity and mortality; child survival strategies; and epidemic and disaster preparedness and response. However, scaling up the plan's targets has been inhibited by inadequate resources to implement plans at all levels. Hence, while the package is intended for the whole population, inadequate funding has meant that the quality and scope of services provided at health facilities is below the levels described in the strategic plan (MoH, 2007).
- The *National development plan* (2010–2015) and the *Health services strategic plan III* still recognise the importance of the minimum health care package as a policy tool guiding provision of cost-effective health care services and interventions. Stakeholders in the review of the evidence also noted, however, that communities lack information and poor public accountability limits demand for and delivery of the minimum package.

Progress

Uganda has been committed to its comprehensive minimum health care package since 1999. While the package has been a point of reference for resource allocation, delivery has been hampered by inadequate resources and the public are still generally unaware of it. Consequently there seems to be little demand or pressure from communities or civil society for effective delivery of the package or pubic monitoring of its delivery. There is thus need to widen awareness and social demand around the package and strengthen the demand for its effective resourcing and delivery in all communities.

Allocating at least 50 per cent of government spending on health to district health systems (including level 1 hospitals) and 25 per cent to primary health care

Allocation to	PAST LEVELS 2005/06		2006/07		CURRENT LEVEL 2007/08		2008/09	
	BnUgsh	%	BnUgsh	%	BnUgsh	%	BnUgsh	%
Ministry of Health headquarters	41.23	18	40.75	16	64.69	24	99.87	27
Central hospitals	37.36	16	36.51	14	40.96	15	52.61	14
Other agencies	6.11	3	5.71	2	5.87	2	6.59	2
Regional hospitals	21.27	9	24.73	10	25.75	10	44.56	12
District health services (total for 3 sub–areas below)	123.9	54	146.3	58	131.6	49	165.7	45
District primary health care	96.83	42	101.8	40	106.1	39	165.7	45
Private not for profit	16.69	7	16.78	7	15.93	6	0	0
District hospitals	10.37	5	27.73	11	9.61	4	0	0
Total	229.9	100	254	100	268.9	100	369.3	100

Note: Expenditure and allocations are different. The government might have allocated larger amounts to lower levels of care but the same may not have been spent for various reasons, including timing and lack of absorptive capacity, among others.

Source: MoH, 2010a

PAST LEVELS (1980–2005)

- Health financing in local governments, under which the districts lie, was mainly through central government primary health care grant transfers. These primary health care grants included conditional grants for wages, non-wage grants, non-governmental organisation facilities non-wage grants, development grants, non-governmental organisation subvention grants, general hospitals non-wage grants, project funds from donors, the Northern Uganda Social Action Fund and local government services delivery and management. Government expenditure increased at the district level from 1999/10 levels of 32 per cent to 54 per cent by 2005/06 (MoH, 2006b). Some expenditure at referral hospital level (regional and national) also covered primary health care related services, even though it is not documented as primary health care spending.

CURRENT LEVEL: 2006-2010

- The *Health services strategic plan II* (2005/06-2009/10) called for more funding to primary health care services in both absolute and relative terms. It envisaged the need to increase the proportion of resources allocated to the district health services where the majority of the population lives (MoH, 2006a). Despite this policy commitment, as the summary table indicates, the allocation of public resources to district health systems fell from 58 per cent in 2006/07 to 45 per cent in 2008/09 (MoH, 2009a).

Progress

Government spending on district level services and primary health care increased up until 2006/07 but declined consistently thereafter. While some primary health care services are provided at referral facilities, the drop in the share of spending to district level, in contrast to the policy commitments, weakens services availability for low-income communities, increasing travel costs to referral services where the costs of providing services are also higher. Delivering on the policy commitment to increase spending at primary and district levels is important in enhancing equity.

Implementing a mix of non–financial incentives for health workers

PAST LEVELS (1980–2005)

- Uganda has faced both internal and external health worker migration and the latter has particularly related to highly qualified personnel (MoH, 2002; Derriennic *et al.*, 2004). User-fee revenues in the 1990s were used to fund incentive payments for health workers to increase their motivation (Kipp *et al.*, 2001). Other incentives designed to retain health workers included training for new programmes and interventions. The beneficiaries were usually predetermined by the facility, health centre or hospital and all expenses were paid. Other non-financial benefits for health workers include medical care coverage for beneficiaries in private sections in public hospitals which was restricted to health workers in the payment scale U4 and above.

CURRENT LEVEL: 2006-2010

- In November 2008, 51 per cent of approved positions at national level in the public sector were filled, with some districts, such as Pader, having only 35 per cent of posts filled (MoH, 2008a). The reasons for so many vacancies include insufficient training capacity, unattractive remuneration and non-retention of health workers with the right skills. Also, attrition in private, not for profit organisations is high as health workers have in the past few years increasingly joined the public sector following government's decision to increase salaries and incentives for civil servants (MoH, 2009a).
- Migration of health workers is occurring at an alarming rate due to more attractive salaries and opportunities abroad. Uganda offers a number of financial incentives to retain health workers, including enhanced salaries, lunch allowances, dual practice and sponsorship for further training. Non-financial incentives for health workers include training and career path opportunities and AIDS treatment and care (EQUINET SC, 2007). The government has institutionalised accommodation for health staff at facility level to improve living conditions. It has promoted equitable continuing professional development and in-service training and career progression for health workers at all facility levels both for public and private, not for profit facilities (MoH, 2008a).
- As a financial incentive, government pays hardship allowances for staff in the public sector (including the health sector) working in areas defined as hard to stay and work in due to remoteness, insecurity and poor infrastructure. Of these areas, 13 are in northern Uganda, five in central Uganda (mainly islands in Lake Victoria) and four are in the west and south-western areas which have poor infrastructure (MoPS, 2010). Sustaining this incentive scheme remains a challenge.
- Other health worker incentives include safe workplaces, annual paid leave for all cadres, sustainable employment that is pensionable after 15 years of service, paid study leave when seconded by the health facility to go for studies, equal opportunities at work and parental leave for pregnant mothers.

Progress

Incentives have been listed for health workers but many of them, such as staff housing, apply to all civil servants so health workers compete for limited available resources with other workers. While incentives to attract and retain workers in remote areas are being applied, they still face a challenge of sustainability.

Formally recognising and supporting mechanisms for direct public participation at all levels of health systems

PAST LEVELS (1980–2005)

- The 1999 *National health policy* called for intensified public information and health education and community mobilisation. The policy required government to establish and operate a community-based health information system and to disseminate information to stakeholders (MoH, 1999). It sought to promote community involvement in caring for people with AIDS and in planning, managing and delivering health care (MoH, 1999).
- The constitution requires the state to guarantee and respect the independence of non-governmental organisations that protect and promote human rights and provides that districts are free to cooperate in the areas of culture, development and health (GoU, 1995).
- The policy also provides for boards to regulate and monitor authorities, with stakeholder involvement (MoH, 1999). However, without specific legal backing for the full community roles in the policy and the unwillingness of some health officials to provide information, effective participation in health was found to be variable (MoH, 1999).

CURRENT LEVEL: 2006-2010

- There are gaps in legal provisions for the direct participation of communities in running health services, making decisions, cooperating and coordinating between sectors, monitoring and evaluating services and ensuring the accountability of health services. At national level, a sessional committee on social services is mandated by parliament to oversee the activities of the Ministry of Health, the Uganda AIDS Commission and the Health Service Commission, among other government bodies in health. It consists of twenty members selected from members of parliament on the basis of the parties or organisations represented in parliament. The committee has, as outlined earlier, taken up the issues of health financing, meeting the Abuja commitment and delivering on maternal and child health commitments.
- However, for wider community roles, barriers remain. Social relationships in rural areas of Uganda are still affected by stigma, communities lack systematic health literacy processes and strategies are needed to influence community and individual norms and values that address social barriers in health and use of health care services (Nyakoto, 2008).
- Civil society networks in health exist and they have played a role in the areas of health rights, health literacy, monitoring and input into health systems, as well as in strategic planning in health. Many of these networks, though, are limited by their geographical scope or their focus on specific issues.

Progress

While there has been consistent policy commitment to supporting community and social participation in the health system in Uganda, this is yet to be backed by a comprehensive legal framework of roles and duties or the resources to build capacities for effective participation. Communities still lack a systematic and comprehensive health literacy programme to facilitate informed action on health.

EQUITY WATCH

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A more just return from the global economy

Progress markers

- Reducing debt as a burden on health
- Allocating at least 10 per cent of budget resources to agriculture, particularly for investments in smallholder and women producers
- Ensuring health goals in trade agreements, with no new health service commitments to GATS and inclusion of TRIPS flexibilities in national laws
- Entering into bilateral and multilateral agreements to fund health worker training and retention
- Including health officials in trade negotiations

EQUITY WATCH

A more just return from the global economy

Household access to the resources for health and the promotion of equitable health systems are both increasingly influenced by policies, institutions and resources at the global level. The final section examines selected parameters of the policy space and support for health equity at the global level. These include the debt burden on health, the use of flexibilities in world trade agreements, the support from international institutions for health worker incentives, protecting women smallholders' food production in trade policies and including health officials and health protection in trade negotiations and agreements.

Reducing debt as a burden on health

PAST LEVELS (1980–2005)

- Uganda is one of the largest beneficiaries of the IMF/World Bank's heavily indebted poor countries (HIPC) initiative. A debt buy-back in 1993, followed by the HIPC initiatives in the 1990s and, more recently, the multilateral debt relief initiative, significantly reduced Uganda's external debt burden in the period. Uganda's external debt fell to US$4,416 milllion in 2004/5 with a still high debt stock to gross domestic product ratio of 50 per cent, although lower than the previous year (see Table 3). The cost of servicing the external debt remained high (MoFPED, 2007).

Table 3: Key debt indicators, 2003–2008

Key debt indicators	Fiscal years (%)				
	2003/04	2004/05	2005/06	2006/07	2007/08 (Est)
Total goods and non-factor service exports US$million	1,011.13	1,308.66	1,523.86	1,998.01	2,293.95
Total external debt stock US$million	4,464.92	4,416.30	4,464.38	1,466.83	1,899.93
Total debt stock to GDP ratio	65.45	50.64	48.25	13.33	14.64
External debt service payments (US$million) exclusive of HIPC relief	172.0	192.7	194.8	184.8	n/a
External debt service, after HIPC relief (US$million)	78.8	97.0	96.6	n/a	n/a
Debt service to export of goods and services	10.45	9.79	8.40	4.58	4.14
Debt service as a % of GDP	1.55	1.47	1.38	0.83	0.73
Total external reserves in months of imports of goods & services	7.52	6.94	6.05	7.35	6.93

Source: GoU, MoF, 2007, 2009

CURRENT LEVEL: 2006-2010

- The Uganda government published a new debt strategy in December 2007, updating its 1995 strategy. While the 1995 strategy had focused on external debt, the 2007 strategy included domestic arrears and public domestic borrowing. The strategy limited the extent to which government can acquire external debts which may affect funding to social services such as health (MoFPED, 2009). It provided measures to address public debt sustainability in terms of domestic arrears, external debt and domestic debt in the public sector. As shown in Table 3, the total external debt fell sharply up to 2007/08 as did the cost of servicing external debt relative to GDP, reducing the external debt burden in Uganda (MoFPED, 2007). Uganda continued to benefit from the multilateral debt relief and the HIPC initiatives in the period and government pursued a strategy of increasing domestic revenues and minimising commercial loans in preference for grants. The ratio of debt service (excluding IMF payments) to exports of goods and services thus fell to 4.1 per cent by 2007/08 (MoFPED, 2009). Support from the two initiatives was projected in 2009/10 to have provided debt relief savings of US$58.9 million from HIPC initiatives and US$ 67.8 million from the multilateral debt relief (MoFPED, 2011).

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CURRENT LEVEL: 2006-2010 continued

- Evidence shows that from 2000 to 2008 government spending on external debt was lower than it was for health and education, as shown in Table 4. A direct shift of debt to health spending is also evident. In 2000 when Uganda accessed debt relief under an enhanced heavily indebted poor countries debt relief initiative, government met with 45 civil society organisations in a consultative meeting with World Bank officials. For the Uganda Debt Network, formed in 1996 to campaign for debt relief, the priority was to ensure that savings from debt relief were spent on poverty eradication, especially on education and health. The government set up a Poverty Action Fund, ring-fencing a set of costed expenditures for 'directly reducing poverty' in certain areas. In the 2000/01 budget government reprioritised expenditures, increasing the budget for primary health care by 50 per cent and the water and sanitation budget by more than 40 per cent, in both cases using debt relief funds through the Poverty Action Fund (Freer, 2002).

Table 4: Public expenditures on essential services vs external debt service, 2000–2008

Year	Health expenditure % GDP	Education expenditure % GDP	External debt service % GDP
2000		2.46	0.76
2001			0.52
2002			0.79
2003	2.16		0.90
2004	1.93	4.65	0.83
2005	1.90		1.46
2006	1.78		1.09
2007	1.65		0.50
2008		3.77	0.47

Source: ODI, 2010

Progress

Significant progress has been made in reducing unsustainable external debt with the support of the international community. There is evidence that this saving has been used for health, although the low returns in terms of share of government spending on health and still low public sector per capita domestic spending on health, discussed earlier, suggest that the gains are relatively limited in terms of overall funding. This needs to be further assessed. The organisation of civil society debt monitoring provides an important mechanism for social accountability in this area.

Allocating at least 10 per cent of budget resources to agriculture, particularly for investments in smallholder and women producers

PAST LEVELS (1980–2005)

- In the last twenty years, agriculture has rarely received more than 4 per cent of the national budget. There was a steady decline in agriculture's share of the government budget allocation in the 1980s, from 9.6 per cent in 1980/01 to 3.8 per cent in 1985/86 (UNDP, 2007).
- From 1991/92 onwards, agriculture did not receive more than 3 per cent of government spending in any year and in 1996/97 the share fell even further from below 2 per cent to 1.6 per cent (UNDP, 2007). The share of labour force engaged in agriculture increased from 66.4 per cent in 2002/03 to 75.1 per cent in 2005/06 but the share of agriculture in the GDP fell, indicating low productivity in the sector, limiting the returns to households and adding to food insecurity.

CURRENT LEVEL: 2006-2010

- Recently compiled data indicates some increase in the budget allocation to the agriculture sector between 2000 and 2005 but with the allocation remaining static thereafter at about 3 per cent (UNDP, 2007). Women comprise 70 per cent of the workforce in agriculture but experience unequal access and control over important productive resources like land, limiting their productivity and returns to farming (GoU 2010).
- The 2008 population policy notes that agriculture is primarily carried out on smallholdings that account for over 90 per cent of total agricultural output. Most households (68 per cent) derive their livelihoods from subsistence farming which contributes 77 per cent of the total employment. However a growing landlessness amidst large and poor families, over-cultivation of small landholdings and the split between women's roles as main food producers and men's responsibilty for marketing and decision making were noted as undermining economic and food security (MoFPED, 2008).
- Government's 2010–2015 *National development plan* proposes to improve access to productive resources and services for women farmers so that they can play a larger role in commercial agriculture, particularly through improving access to credit, business skills training and market information (MoFPED, 2010b).

Progress

The public sector budget allocation to agriculture falls well below the recommended 10 per cent and has been static at 3 per cent. While government has recently acknowledged the fall in agricultural productivity as a concern, including for food security, and noted the need for further investment in women farmers, this needs to be followed up to assess the extent to which it translates into improved investment in women farmers and particularly improved food production.

Ensuring health goals in trade agreements, with no new health service commitments to GATS and inclusion of TRIPS flexibilities in national laws

PAST LEVELS (1980–2005)

- The Uganda Patent Act (1993) section 29 allows the Minister of Justice to exploit a patent in the public interest without the authority of the patent owner. This provision allows the production of more affordable generic medicines. By 2001, Uganda had limited its General Agreement on Trade in Services (GATS) liberalisation commitments to the tourism sector, making no commitments in the health sector. Uganda has been deliberately cautious about such commitments. In October 2001, Uganda, with Cuba, Dominican Republic, Haiti, India, Pakistan, Peru, Venezuela and Zimbabwe, submitted a joint communiqué to the World Trade Organisation raising questions about the impact of GATS on rural communities: 'For the rural sectors in many developing countries, these basic services may not even be provided by the state, but by communities and local authorities which use currently common resources, such as water….' (WTO, 2001).

CURRENT LEVEL: 2006-2010

- As a 'less developed' country Uganda has until 2013 to be TRIPS compliant and until 2016 to be compliant with TRIPS for pharmaceuticals. Uganda is currently involved in legislative reform to include its TRIPS obligations in national law. Sections 58–66 of the Industrial Property Bill (2008) contained provisions granting compulsory and government use licences, implementing the TRIPS flexibilities, although granting compulsory licences under section 62 calls for a long court process.
- The Industrial Property Bill, 2008 is being reviewed by a TRIPS task force composed of representatives from government ministries, the public sector and a national non-governmental organisation forum. However, health issues may be given less priority than trade measures, given the need to promote foreign direct investment (ULRC, 2004). Use of TRIPS flexibilities has facilitated South-South cooperation in local manufacture of generic drugs. A joint venture between Uganda and Cipla, an Indian generic producer, has led to antiretrovirals being manufactured locally. Concerns have thus been raised about proposed counterfeit legislation. Government needs to ensure that it excludes generic medicines from its definition of counterfeits and that concerns around sub-standard and falsified medicines are addressed through the medicine control authorities and laws which protect against trademark infringements (CEHRUD, 2010).
- There has been discussion in the East African community on trade in services as part of the negotiations under the Economic Partnership Agreements. This has raised the export potential of Uganda's services sector, including in relation to skilled personnel. It has also raised questions about the institutional and regulatory framework and development assistance needed for a developmental approach to these issues and to the flexibilities, regulatory prerogatives, autonomy and policy space that need to be retained to benefit Uganda. There is no evidence of further GATS commitments being made in the health sector.

Progress

Although government has developed a Bill to replace the current Patent Act, this Bill has not been enacted and it still has gaps on fully using the TRIPS flexibilities. It has in the past avoided committing its health services under GATS. With economic negotiations encouraging liberalised trade in services and new counterfeit laws having potential impact on access to generic medicines, there is need to monitor trade negotiations to ensure that they do not limit the national authorities and measures needed to ensure access to health services.

Bilateral and multilateral agreements to fund health worker training and retention

PAST LEVELS (1980–2005)

- The gap in health worker numbers against standards, especially in marginal areas, was discussed in an earlier progress marker. Given that health worker out-migration to higher income countries is one driver of this inadequacy, there has been some debate about the role of formal trade in health professional services and how to manage the situation. Government implemented measures to formalise the flow of health workers under bilateral agreements over this period. Hence, for example, during the Pan-Commonwealth Conference on Trade in Professional Services, a scheme was developed whereby 30 nurses from each of the beneficiary Commonwealth countries, including Uganda, were given a number of four-year work placements for health personnel, mainly in the United Kingdom and Northern Ireland. The Uganda Medical Workers Union welcomed the initiative as one which could improve the welfare and advancement prospects for the individual beneficiaries. Nevertheless any wider application of this approach raised questions about its impact on health care service delivery, given the acute shortage of public sector health professionals (Butagira and Mucunguzi, 2008).

CURRENT LEVEL: 2006-2010

- A human resources for health policy was developed in 2006 which asserts that national priorities and needs will guide interactions in global, continental and regional institutional arrangements on health workers (MoH, 2006a). The policy explicitly requires government to ensure mitigation of adverse effects of global recruitment of Uganda-trained health workers by promoting appropriate local and international regulations, memoranda of understanding with receiving governments, including strategies such as return circulation through temporary return of health professionals in the diaspora. The human resources for health policy requires training of locally relevant health workers, as well as measures that will make local working conditions attractive.
- The *Health sector strategic plan III* (2010–2015) focused more on strategies for health worker retention and included mechanisms and incentives to attract, recruit and retain health workers, especially in hard to reach areas (MoH, 2010a). Neither the *Health sector strategic plan III* nor the *National health policy II* specifically refer to bilateral or multilateral agreements to support policies for training, deployment or retention of health workers. However a compact was signed with international partners to implement the plan. The compact includes the need for alignment with government policies and plans and improved access to 'quality health services for underserved communities, households and individuals in particular' (MoH, 2010d). The extent to which this memorandum and the human resources for health policy has translated into specific commitments to finance health worker training and retention still needs to be assessed.

Progress

There is greater policy attention to retaining and training health workers and a compact with international partners on the *Health sector strategic plan III* includes a focus on this area. While policy measures are in place for agreements in support of health worker training and retention, the specific measures or investments made in practice need to be assessed to review how far they align with national programmes.

Health officials included in trade negotiations

PAST LEVELS (1980–2005)

- The Ministry of Health has in the past not engaged in trade negotiations and trade issues affecting health such as intellectual property were left to the Ministries of Trade and Foreign Affairs. The Ministry of Health had no specific department for health foreign policy or legal issues and relied on advice given by the Ministries of Justice and Foreign Affairs, while noting that these ministries had no specific expertise in health.

CURRENT LEVEL: 2006-2010

- In this period the ministry has been increasingly involved in trade and health matters. The pharmacy division of the Ministry of Health has taken up training and discussions on the impact of intellectual property rights on access to medicines. Uganda was represented by this division of the ministry in the East African Community regional meetings on the development of the 'East African Community regional intellectual property policy on the utilisation of public health related World Trade Organisation (WTO) – TRIPS flexibilities and the approximation of national intellectual property legislation'. It was also involved in 2010 in the negotiations on the Draft East African Community Regional Protocol on Public Health Related WTO–TRIPS Flexibilities (EAC, 2010). As a result, follow up activities are being supported to incorporate these documents into the national systems.

Progress

There has been limited progress in engagement between the ministry of health and that of trade, with interaction particularly around issues of intellectual property and access to medicines.

PROGRESS MARKERS	STATUS AND TRENDS	PRIORITY AREAS FOR ACTION
EQUITY IN HEALTH		
Formal recognition of equity and health rights	Ugandan law does not explicitly include the right to health but provides related rights. National policy explicitly supports health equity.	Strengthen community awareness on and mainstream right to health and its delivery in policy, strategy and service delivery.
Halving the number of people living in poverty	Growth was a major driver of poverty reduction after 2005. Inequality limited reductions in poverty in rural, Western and Central regions.	Address poverty in Northern region and rural areas and link poverty reduction to addressing inequalities.
Reducing the gini coefficient of inequality	Inequality rising and a factor limiting growth translating into poverty reduction. Most affected are urban areas and Central region.	In addition to geographical allocation of resources to needs, further measures needed to reach the poorest households
Eliminate differentials in child, infant and maternal mortality and undernutrition	Improved child survival and maternal mortality rate but wide regional and social differentials in infant mortality, in child mortality and nutrition. Distribution and current maternal mortality levels unclear.	Geographically allocated resources need community level support and involvement for uptake in the poorest households. Need to monitor social and regional distribution of maternal mortality.
Eliminate differentials in access to immunisation, antenatal care and skilled deliveries	Immunisation coverage has improved, Challenges and inequalities persist but lower due to intensive service delivery. Maternal health service coverage low, no improvement, although wealth differentials slightly lower.	Sustain child health outreach through PHC and multi-sectoral approaches. More focused attention to improving maternal health, especially in Western and Northern regions and poor social groups.
Universal access to PMTCT, ART and condoms	Adult prevalence fallen to low levels but concerns on prevention and HIV incidence. Significant improvements in access to services for PMTCT and ART, although with substantial unmet need, including in children and delivery at hospitals and health centre IVs.	Assess the distribution of ART and PMTCT to identify those not accessing services Predictable long term funding to address system barriers. Need to strengthen prevention interventions as a priority.
HOUSEHOLD ACCESS TO RESOURCES FOR HEALTH		
Close gender differential in education	Improved literacy, enrolment in primary school and transition to secondary school, with greater gender equity due to investments in reducing costs and in schools, teachers, materials.	Education vital in closing other inequalities affecting health, so sustaining these policies and closing the gender differentials are the main challenges
Halve the share without safe water and sanitation	Improved access to safe water and sanitation and rural–urban gaps reduced, although country targets have not yet been met.	Further evidence is needed on whether the wide gap in access across districts has also been addressed.
Increase ratio of wages to GDP	Fall in self employment and rise in paid employment 2005–2009 but women's work in lower paying sectors, with lower wages for the same work. Dependency on informal jobs high.	National development plan aims to create employment and raise average per capita income. Need to target improvements in women's incomes.
Adequate health workers and drugs at primary level	Inadequate health workers and essential medicines. Health workers concentrated in urban areas, stockouts of essential drugs. Targets set for districts and health units to all be above 80% posts filled.	Make public information on the delivery on goals in districts and on the impact of efforts made to attract and retain health workers, to discuss, review and implement retention strategies.
Abolish user fees	Public facility fee abolition and additional funding lifted barriers to uptake for the poorest. Catastrophic spending increased, with private payments for drugs and use of private sector services.	Ensuring medicine supplies to public facilities important to yield the benefit of fee abolition. Assess the effects of fee charges at private health facilities and unofficial fees in public facilities.
Overcoming barriers to use of services	Availability, cost and distance barriers reduced but barriers still in shortfalls of health workers and medicines and social barriers to uptake.	Further measures needed to enhance uptake of services in vulnerable groups, including through health literacy

PROGRESS MARKERS	STATUS AND TRENDS	PRIORITY AREAS FOR ACTION
REDISTRIBUTIVE HEALTH SYSTEMS		
Achieving 15 per cent government spending on health	The share of government allocation to health has not increased significantly.	Uganda parliament and civil society to promote implementation of the Abuja commitment
Achieving US$60 per capita health funding	Improved overall and public health per capita spending, but below the basic package cost and the $60 target, and dependent on external funds.	Strengthen domestic financing, reduce off-budget external funding to apply public sector policy tools to finances.
Improve tax funding and reduce out of pocket funding for health	Out of pocket financing static to 2008 and catastrophic expenditures increasing. Tax funding has declined as a share of total spending and less than external funds,	Improve domestic financing from improved tax and other government revenue, earmarked taxes, advance proposals for national health insurance.
Harmonise financing into a framework for universal access	Limited prepaid financing, limited financial protection, fragmentation within and between financing mechanisms and limited cross-subsidy across funding sources.	Progressively move towards more harmonised universal framework, such as through strengthening tax based funding and widening and making links across prepaid pools.
Establish and ensure clear health care entitlements	Uganda minimum health care package is comprehensive and a consistent commitment of government for resource allocation since 1999. Delivery hampered by inadequate resources and little demand or pressure from communities.	Widen awareness, social demand around and monitoring of the package, to strengthen the demand for its effective resourcing and delivery in all communities.
Allocate at least 50 per cent of public finances to districts, 25 per cent to primary health care	Government spending on district level services and primary health care increased up to 2006/7 and declined thereafter, in contrast to policy commitments.	Delivery on the policy commitment of improved spending to primary and district levels important for enhancing equity.
Implement incentives for health personnel	Incentives have been applied for health workers. Some applied to all civil servants so health workers compete for the limited resources.	Strategies needed to sustain and assess the impact of incentives to attract and retain workers in remote areas.
Recognise and support mechanisms for public participation	Consistent policy commitment to support community and social participation yet to be backed by law, training or resources	Develop a comprehensive legal framework of roles and duties, resources to build capacities and health literacy to facilitate informed action on health.
A JUST RETURN FROM THE GLOBAL ECONOMY		
Reduce the debt burden	Significantly reduced external debt supported by the international community, some use for health, although limited overall improvement in government spending on health	The gains to health spending from debt relief need to be assessed. Sustain civil society debt monitoring for social accountability.
Allocate resources to agriculture and women smallholders	Public sector budget allocation to agriculture below 10% (static at 3%). Government has noted falling agricultural productivity, including for food security, and the need for investment in women farmers.	Follow up government position on investment in women farmers to assess implementation and impact on food production.
Ensure health goals in trade agreements	Government still to enact the proposed Bill to use TRIPS flexibilities. It has in the past avoided committing its health services under GATS.	Ensure negotiations on new trade and counterfeit laws don't limit national authorities and measures needed to ensure access to health services.
Bilateral and multilateral health worker agreements	A compact with international partners on the Health sector strategic plan III includes a focus on this area.	Further assessment needed of the measures or investments made to review alignment to national programmes
Include health workers in trade negotiations	Limited engagement between the health and trade ministries; Interaction around issues of intellectual property and access to medicines.	Strengthen capacities and links for global heath diplomacy

KEY Improving Static, mixed or uncertain Worsening

NOTE: In one case red is blended with yellow as the situation is not clear-cut – worsening in some issues and static in others.

Conclusions

Uganda emerged from conflict in the 1980s and has had greater political continuity since the 1990s. Government was careful to decentralise authority to district level local government, including in the health sector. From the mid-1990s there were two decades of uninterrupted growth of the primarily agriculture-based economy and a growth in industry as a share of gross domestic product. The recent discovery of oil indicates the potential for greater economic growth. There is evidence that the country has benefited from debt relief and used a share of resources from this saving for health and education.

Nevertheless there is an unequal distribution of economic wealth as households in the highest wealth quintile shared 71 per cent of the country's total wealth while those in the lowest shared only 2 per cent of total wealth. Disparities also exist between rural and urban areas and across regions, with the north of the country negatively affected by civil war and a majority of people there living in internally displaced people's camps for the past two decades. Hence while Uganda has many features signalling a potential for improved health, this report, covering the period 1995 to 2010, examined whether these social inequalities are also found in health and in access to health care. It sought to assess what progress is being made in addressing these inequalities in health through investments in households and in redistributive health systems.

The report exposes an odd combination of progress in poverty reduction linked to consistent economic growth, against challenges to poverty reduction posed by recent rising economic inequality. It appears that growth and inequality need to be tackled in Uganda for sustained improvement in household incomes and in health. The trends towards low wages for women in employment and low housing ownership by women suggests one way in which gender inequality is growing. The sustained low public spending on agriculture suggests that while increased investment in women farmers is a policy goal, it has not led to significant new public resource flows. Rural areas, female-headed households and the Northern region continue a longer term trend of having the highest levels of income poverty. However, inequality has also grown more recently in urban areas and in the Central region, raising new concerns about the growth of poverty within social groups in higher income areas. Inequality within areas is now a greater contributor to overall inequalities than that between areas. This has implications for how health systems reach those with greatest health need.

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The report also shows that the determinants of health lie beyond the health sector and that addressing them calls for efforts from many sectors. It highlights areas where intersectoral collaboration needs to be operationalised, for example: around women's farming, food and nutrition; around improving access to safe water; and in integrating a human rights framework within health programming. We hope that the stakeholders' meeting will delve deeper and inform ways of integrating responsibilities for health within sectors like water, agriculture, education and justice, so that health sector efforts are backed by the investments in these sectors.

As in many countries in the region, Uganda has had a long-standing policy commitment to promoting equity in health. While it does not provide explicit constitutional protection of the right to health, it provides for everyone's right to a healthy environment and sets the state's duty to ensure access to health services. It also provides specific protections for women and children. The report describes the state's explicit policy measures to realise these rights, such as by abolishing user fee barriers to access to care, improving access to safe water and improving gender equity in access to education. At the same time, gaps in implementing these policy commitments to health equity are also exposed.

A number of areas of progress present opportunities for health equity:

- Explicit policy measures, resource investments and strategies to reduce cost barriers have improved the social determinants of health, for example by closing gender differences in access to primary education or closing significant rural–urban differences in access to safe water and sanitation. The positive gains of these investments, including on health, need to be profiled, to secure commitment to sustaining and widening them, not only to meet policy targets but also to continue to overcome disparities across districts and social groups. The health sector has the opportunity to demonstrate the positive health outcomes of such investments by other sectors but also to use these areas of positive change in schools and communities as a lever for wider health promotion.

- Child and maternal mortality rates have improved although not at the pace needed to meet the Millennium Development Goals. Disparities in child mortality rates have narrowed between urban and rural areas in the past decade. Nevertheless social disparities (wealth, mothers education) in mortality remain wide, as do differences across regions.

- The fall in HIV prevalence in the 1990s has had significant health dividends, although women, urban dwellers and those living in post-conflict Northern Uganda are still more affected by HIV.

- Areas where strong investment has been made in prevention and care – immunisation, and AIDS treatment, for example – have steadily improved towards universal coverage. For immunisation, where this has been delivered through primary level systems and social engagement, there is evidence of social differentials falling to almost parity. For AIDS treatment where delivery is still through higher level services, social differentials remain wide. Strengthening primary health care and the frontline interface with the community is important in increasing coverage and closing social gaps in coverage.

- Government has taken measures to address a number of barriers to access to health care, including immunisation outreach, improved district and primary level infrastructure, abolition of fees, improved funding to district and primary care levels; and improved incentives for health worker deployment to and retention in underserved areas.

There are also areas where progress has been slow or reversals have taken place:

- Progress in improving coverage of maternal health services has been limited, according to 2009/10 data, and differentials in coverage remain high by region and wealth.

- Despite explicit policy commitments and investments, the adequacy and distribution of health workers continues to be inverse to need, with more highly skilled health workers in the urban and Central regions which have lower health need. Drug stockouts and health worker gaps or absences are reportedly barriers to care for communities in more remote areas where health need is generally higher. Policies and costed plans have been developed for both of these key areas but ensuring and monitoring delivery is the challenge.

- Although many areas have wide social differentials in health and access to health care, social roles are under-valued and under-resourced and a comprehensive investment in health literacy or in community health workers could make a difference. Given the opportunity of a decentralised system and the importance of social participation and accountability in advancing health equity, this is an area where there is room for greater national dialogue and action, to exchange and learn from initiatives within communities and to organise and resource the role of communities more formally.

- The health sector has laid down policies and drawn up measures to address social and regional differentials in health. Many of these depend on additional public resources and, as shown in

the areas of progress, comprehensive investments can reverse declines for all social groups (as for immunisation), close gaps (as for gender parity in school) and reduce impoverishing costs of ill health to households. It is thus problematic for these measures and disappointing for the wider public sector leadership in health that total health spending has not risen as fast as gross domestic product and that the share of government spending does not meet the Abuja 15 per cent commitment and remains well below the required per capita levels. Furthermore, the dependency on external funding is still amongst the highest in the region.

- The fall in the share of public spending on services at district level and below weakens the progressive measures noted in the report for improving availability, access and coverage. The evidence suggests that there is reasonable potential for improved tax revenue as one means of strengthening domestic public financing in health.

In some cases, the available evidence was insufficient to assess progress and further review or research is needed to better understand the situation:

- There is inadequate household survey information to understand the social and regional distribution of maternal morbidity and mortality and thus to address this specific distribution of health need in maternal health services. This is not unique to Uganda and raises a wider concern of how disaggregated data will be obtained.

- Greater gains in nutrition would be expected than those found, given the strong economic growth and improved agricultural production. It is important to understand the reasons for the limited improvements in stunting and wasting among children under five years, not only in terms of their dietary patterns but also in terms of gender equity in access to resources for agriculture and household food security.

- The specific implications of inequality within areas and the increase in social exclusion within higher income urban areas need to be investigated. Who is at risk and how do health systems combine geographical targeting and regional allocations with measures directed to specific vulnerable households with greatest health need?

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While data quality and availability can be a constraint, the evidence is sufficient to highlight the differential opportunities for health, access to services and health outcomes in Uganda and how these are changing. The evidence shows positive aggregate and distributional gains from specific areas of investment in health and the social determinants of health that prevent or reduce the impoverishing impact of ill health and level up the opportunities for health. Given that inequality is rising in Uganda, putting constraints on poverty reduction, these findings provide an argument for addressing the limited gains to the health sector of the growing gross domestic product, the need to improve the share of public revenue to health and the need to prioritise district levels and below in the health budget.

This also depends on effective engagement and wider social awareness and advocacy on these benefits by parliament, civil society and communities. In places it depends on communities and civil society more actively monitoring and engaging on who is accessing the benefits of the public resources for health.

Bibliography

Anokbonggo W.W., J.W.Ogwal-Okeng, C.Obua, O.Aupont and D.Ross-Degnan (2004) 'Impact of decentralisation on health services in Uganda: a look at facility utilisation, prescribing and availability of essential drugs', *East African Medical Journal* 2004 Feb;Suppl:S2-7

Appleton S (1999) *Changes in poverty in Uganda, 1992-1997*, Centre for the Study of African Economies working paper no 106, Kampala, accessed online 10 November 2008 at: www.bepress.com/csae/paper106

AVERT (2008) *HIV and AIDS in Africa*, available online at: http://www.avert.org/aidsinafrica.htm.

Bakeera S., S. Wamala, S.Galea, A.State, S.Peterson and G.Pariyo (2009) 'Community perceptions and factors influencing utilisation of health services in Uganda', *International Journal for Equity in Health* 8:25.

Byakola T. and P.Mukhebir (2009) *Energy systems: vulnerability, adaptation and resilience. Regional focus: sub-Saharan Africa: Uganda*, Helio International, Kampala.

Butagira T., J.Mucunguzi (2008) 'Uganda: country to export nurses to Europe', *The Monitor*, 22 February 2008, accessed online August 2011 at: www.afrika.no/Detailed/16073.html

Centre for Health, Human Rights and Development (CEHRUD), EQUINET, TARSC (2010) *Anti-counterfeiting laws and access to essential medicines in East and Southern Africa*, Policy brief 22, EQUINET, Harare.

Derriennic Y, K. Wolf and P. Kiwanuka-Mukiibi (2004) *An assessment of community-based health financing activities in Uganda*, Partners for Health Reform Plus, Kampala.

Devarajan S., D. Dollar and T. Holmgren (2001) *Aid and reforms in Africa: lessons from 10 cases studies*, World Bank, Aid Effectiveness Research, Development Research Group, New York.

Deininger K. and P. Mpuga (2004) *Economic and welfare impact of the abolition of health user fees: evidence from Uganda*, World Bank, Washington DC.

Dhillon, I,. M.Clark and R.Kapp (2010) *Innovations in cooperation: a guidebook on bilateral agreements to address health worker migration*, Realizing Rights/Global Health & Development at the Aspen Institute, accessed August 2011 online at: www.aspeninstitute.org/sites/default/files/content/docs/pubs/Bilateral%20Report_final%20code.pdf

East African Community (EAC)(2010) *Draft EAC regional protocol on public health related WTO-TRIPS flexibilities*, EAC, Tanzania.

East African Sub-regional Support Initiative for the Advancement of Women (EASSI) (2010) *Monitoring maternal health and safe motherhood policies: policy-making in practice: what can be learned from Uganda's national budget implementation?*, EASSI, Kampala.

EQUINET Steering Committee (SC) (2007) *Reclaiming the resources for health: a regional analysis of equity in health in east and southern Africa*, EQUINET in association with Weaver Press, Fountain Publishers and Jacana, Harare, Kampala and Cape Town.

Ekirapa E. (2008) 'Equity in the allocation of primary health care resources in Uganda', Makerere University School of Public Health, Kampala, Masters thesis submitted to University of Cape Town, unpublished.

Freer M. (2002) *Tearfund advocacy case study. Debt relief in action: Uganda*, Tearfund/tilz, Teddington, available online at: http://tilz.tearfund.org/webdocs/Tilz/Topics/Advocacy%20case%20study%20-%20Debt%20relief%20Uganda.pdf.

Global Hunger Index (2010) *The challenge of hunger: focus on the crisis of child undernutrition*, GHI, Washington DC.

Government of Uganda (GoU) (1995) *The Constitution of the Republic of Uganda*, Government of Uganda, Kampala.

– (2010) *UNGASS progress report 2009*, Government of Uganda, Kampala.

– (2011) *Peace, recovery and development plan* (PRDP), PRDP financing, Kampala, available online at: http://www.prdp.org.ug/content.php?Submenu_id=55

Government of Uganda, Ministry of Education and Sports (MoES)(June 2004) *Education sector strategic plan*, Ministry of Education and Sports, Education Sector Planning Department, Kampala.

– (2009) *Education management information system data*, Ministry of Education and Sports, Kampala.

– (2010) *Education and sports sector annual performance report FY 2009/10*, Ministry of Education and Sports, Kampala.

Government of Uganda, Ministry of Finance Planning and Economic Development (MoFPED) (2000) *National health accounts*, Ministry of Finance Planning and Economic Development, Kampala.

– (2001) *Background to the budget 2001/2002*, Ministry of Finance Planning and Economic Development, Kampala.

– (2002) *Uganda poverty strategy paper progress report*, Ministry of Finance, Planning and Economic Development, Kampala.

– (2002) *Summary of background to the budget 2001/02*, Ministry of Finance, Planning and Economic Development, Kampala.

– (2002b) *Background to the budget 2002/2003*, Ministry of Finance Planning and Economic Development, Kampala.

– (2002c) *Public expenditure review 2001: report on the progress and challenges in budget reforms*, Ministry of Finance Planning and Economic Development, Kampala.

– (2003) *Uganda participatory poverty assessment report*, Ministry of Finance Planning and Economic Development, Kampala.

– (2004) *The poverty eradication action plan 2004/5-2007/8*, Ministry of Finance Planning and Economic Development, Kampala.

– (2005) *Background to the budget 2004/2005*, Ministry of Finance Planning and Economic Development, Kampala.

– (2006) *Background to the budget 2005/2006*, Ministry of Finance Planning and Economic Development, Kampala.

– (2007) *Concept note on the revision of the poverty eradication action plan*, Ministry of Finance Planning and Economic Development, Kampala.

– (2008) *National population policy for social transformation and sustainable development*, Population Secretariat, Kampala.

– (2009) *Background to the budget 2008/2009*, Ministry of Finance Planning and Economic Development, Kampala.

– (2010a) *Background to the budget 2010/11*, Ministry of Finance Planning and Economic Development, Kampala.

– (2010b) *The national development plan 2010/2015*, Ministry of Finance Planning and Economic Development, Kampala.

Government of Uganda, Ministry of Health (MoH) (1999) *The national health policy*, Ministry of Health, Kampala.

– (2000) *A national roll back malaria strategic plan, 2001/2002–2004/2005*, Ministry of Health, Kampala.

– (2000) *The malaria in pregnancy control strategic plan, 2000*, Ministry of Health, Kampala.

– (2001) *Annual health sector performance report, 2001*, Ministry of Health, Kampala.

– (2001) *National malaria control strategic plan 1, 2001–2005*, Ministry of Health, Kampala.

– (2002) *Health financing strategy, volume 1: the case for a bigger health budget*, Ministry of Health, Kampala.

– (2002) *Statistical abstract, 2002*, Resource Centre of the Ministry of Health and Partner Agencies, Ministry of Health, Kampala.

– (2002) *HIV/AIDS surveillance report: June 2002*, STD/AIDS Control Programme, Ministry of Health, Kampala.

– (2003) *The national policy on public/private partnership in health (draft 2003)*, Ministry of Health, Kampala.

– (2004) *Financing health services in Uganda, 1998/99 to 2000/01*, Ministry of Health, Kampala.

– (2004) *Health sector budget framework paper 2004/05 to 2006/07*, Ministry of Health, Kampala.

– (2005a) *The health sector strategic plan II 2005/06 – 2009/2010* (HSSP), Ministry of Health, Kampala.
– (2005b) *Mid-term review report of the 'Health sector strategic plan II, 2005/06 – 2009/2010'*, Ministry of Health, Kampala.
– (2005c) *The national hospital policy*, Ministry of Health, Kampala.
– (2006a) *The Uganda national expanded programme on immunisation policy*, Ministry of Health, Kampala.
– (2006b) *Annual health sector performance report, 2005/06*, Government of Uganda, Kampala.
– (2007) *Annual health sector performance report, 2006/07*, Government of Uganda, Kampala.
– (October 2008a) *Motivation and retention strategy for human resources for health*, Government of Uganda, Kampala.
– (October 2008b) *Mid-term review report for the 'Health sector strategic plan II'*, Government of Uganda, Kampala.
– (2008c) *Development of the minimum service standards in Uganda's health sector*, Ministry of Health, Kampala.
– (2009a) *Annual health sector performance report, 2008/09*, Government of Uganda, Kampala.
– (2009b) *The patient charter, 2009*, Ministry of Health, Kampala.
– (2010a) *The draft national health policy II*, Ministry of Health, Kampala.
– (2010b) *The health sector strategic and investment plan III, 2010*, Ministry of Health; Kampala.
– (2010c) *Human resource for health policy*, Ministry of Health, Kampala.
– (2010d) *Compact between Government of Uganda and partners for implementation of the health sector strategic and investment plan 2010/11–2014/15*, Ministry of Health, Kampala.
– (2010e) *Village health teams: strategy and operational guidelines*, Ministry of Health, Kampala.

Government of Uganda, Uganda Aids Commission (UAC) (2007) *National HIV and AIDS strategic plan 2007/08-2011/12, draft 2*, Uganda Aids Commission, Kampala.
– (2011) *Uganda AIDS Commission institutional review, July 2011*, Uganda AIDS Commission, Kampala.
– (2007) National HIV and AIDS Strategic Plan 2007/08-2011/12, Draft 2, Uganda Aids Commission, Kampala.

Government of Uganda, Ministry of Public Service (MoPS) (2010) *Circular standing instruction No. 2 of 2010, PMD 80/80/02*, Ministry of Public Service, Kampala.

Government of Uganda, Ministry of Water, Lands and Environment (MoWLE) (2004a) *Uganda water and sanitation sector performance measurement report 2004*, Ministry of Lands and Environment, Kampala.

Government of Uganda, Ministry of Water and Environment (MoWE) (2009) *Uganda water and sanitation sector performance report 2008*, Ministry of Water and Environment, Kampala.
– (2010) *Development partners joint review of the water and environment sector*, Ministry of Water and Environment, Kampala.

International Monetary Fund (IMF) (May 2010) *Uganda: poverty reduction strategy paper*, IMF country report No. 10/141, IMF, Washington DC.

Kasimbazi E, M.Mulumba, R.Loewenson (2008) *A review of Kenyan, Ugandan and Tanzanian public health law relevant to equity in health*, EQUINET discussion paper 63. Faculty of Law, Makerere University, Training and Research Support Centre and Regional Network for Equity in Health in East and Southern Africa (EQUINET), Harare.

Kapiriri L., O.F.Norheim, K.Heggenhougen (2003) 'Public participation in health planning and priority setting at the district level in Uganda', *Health Policy Plan* 18:205-13.

Kasente D. (2003) *Gender and education in Uganda: a case study for EFA monitoring report*, Makerere University, Kampala.

Kipp W, J.Kamugisha, P. Jacobs, G.Burnharm and T. Rubaale (2001) 'User fees, health staff incentives and service utilisation in Kabalore district', *Uganda Bulletin of the World Health Organization* 79 (11); 1032-1037.

Kyomugisha E. (2008) *Building strategies for sustainability and equity of prepayment schemes in Uganda: bridging the gaps*,EQUINET discussion paper 59, EQUINET/ Health Economics Unit, University of Cape Town, Harare and Cape Town.

Keane J., J.Kennan, M. Cali, I. Massa and D. Willem te Velde with S.Ssewanyana and J. Wokadala (May 2010) *Uganda: case study for the MDG gap task force report*, Overseas Development Institute, London.

Maniple E. (2004) 'Export health workers? For Uganda an indecent proposal, until …', *Health Policy and Development* 2(3): 227-235.

McIntyre D. (2007) *Learning from experience: health care financing in low and middle income countries*, Global Forum for Health Research, Geneva.

Muhinda A, M. Mulumba, J.Mugarura, P.Akakwasa and J.Kabanda (2009) *Prevention of vertical HIV transmission in Kamwenge and Kiboga districts, Uganda*, EQUINET PRA paper, HEPS Uganda, TARSC, EQUINET, Kampala and Harare.

Nabyonga J. and C.M.Zikusooka (2010); Health financing reform in Uganda: How equitable is the proposed National Health Insurance scheme. International Journal for Equity in Health 9:23.

Nyakato V. and W. Pelupessy (2006) *Not by money alone: the health poverty trap in Uganda*, Mimeo, Faculty of Development Studies, Mbarara University of Science and Technology (MUST), Mbarara, availabale online at: http://www.capabilityapproach.com/pubs/ViolaNyakato.pdf

Okidi J.A and A.McKay (2003) *Poverty dynamics in Uganda: 1992 to 2000*, Working paper, Chronic Poverty Research Centre, Kampala.

Okidi J.A. and M. Guloba (2006) *Decentralisation and development: emerging issues from Uganda's experience*, Occasional paper 31, Economic Policy Research Centre, Makerere University, Kampala.

Okwero P., A.Tandon, S.Sparkes, J.McLaughlin and J.G. Hoogeveen (2010) *Fiscal space for health in Uganda*, Working paper 186, World Bank, New York.

Okuonzi S.A. (2004) 'Dying for economic growth? Evidence of a flawed economic policy in Uganda', *The Lancet* 364, 9445: 1632–1637.

Omaswa F., G.Burnham, G.Baingana, H.Mwebesa and R.Morrow (1997) 'Introducing quality management into primary health care services in Uganda,' *Bulletin of the World Health Organization* 75(2): 155-161.

Omaswa F. (2006) *Health sector reforms in Uganda. Reform model in the context of post-conflict national reconstruction*, presentation to All Party Committee of Parliament, Ministry of Health, Kampala.

Overseas Development Institute (ODI) (2010) Uganda case study for the MDG Gap task force report, ODI, London.

Pearson M. (2005) *Abolishing user fees in Africa? It depends…*, Technical approach paper, HLSP Institute, London, available online at www.hlspinstitute.org/files/project/83490/abolishing_user_fees.pdf.

PHRplus (2006) *Catalogue of community based health financing schemes, Uganda*, PHR plus, USAID, Bethesda.

Population Reference Bureau (2008) *World population highlights: key findings from the 2008 world population data sheet*, available online at: www.prb.org/Publications/Datasheets/2008/2008wpds.aspx.

PPD ARO, EQUINET, APHRC, SEAPACOH (2009) *Report on the regional meeting of parliamentary committees on health in Eastern and Southern Africa*, Munyonyo, Kampala, Uganda, 21 September, PPD ARO/EQUINET, Kampala.

SIDA (1999) *Health profile Uganda*, Health Division document 2000:4, Uppsala.

Southern and East African Parliamentary Alliance of Committees on Health (SEAPACOH), PPD ARO, EQUINET, APHRC, UNFPA, DSW, Venture Strategies (2008) *Resolutions: regional meeting of parliamentary committees on health in east and southern Africa. Health equity and primary health care: responding to the challenges and opportunities, Munyonyo, Uganda, September 2008*, EQUINET/PPD ARO, South Africa.

Ssengooba F. , S.Neema, A.Mbonye, O.Sentumbwe, V.Onama (2003) *Maternal health review Uganda*, Health Systems Development Programme, Makerere University Institute of Public Health working paper HSD/WP/04/03, available online at: www.who.int/rpc/evipnet/Maternal%20Health%20Review%2004-03_uganda.pdf

Ssengooba F. and P.McPake (2006) *Case example: financing maternal health services in Uganda*, Makerere University School of Public Health, Kampala.

Ssengooba F., S. Azizur Rahman, C. Hongoro, E.Rutebemberwa, A.Mustafa, T.Kielmann and B.McPake (2006) 'Health sector reforms and human resources for health in Uganda and Bangladesh; mechanisms of effect', *Human Resources for Health* 2007, 5:3.

Ssewanyana N.S, A.J.Okidi, D.Angemi, V. Barungi (2006) *Understanding the determinants of income inequalities in Uganda*, CSAE working papers, CSAE WPS/2004-29, Makerere, Kampala, available online at: www.csae.ox.ac.uk/workingpapers/pdfs/2004-29text.pdf

Ssewanyana S. (2010) *Household expenditures and income poverty trends for Uganda: preliminary findings*, Presentation, October 2010, Kampala, available at: www.ubos.org/onlinefiles/uploads/ubos/UNHS0910/Povertyprofile_Oct2010.pdf

Steiner S. (2006) *Decentralisation in Uganda: exploring the constraints for poverty reduction*, GIGA working papers: GIGA-WP-31/2006, GIGA German Institute of Global and Area Studies, Hamburg.

Syngellakis K. and E.Arudo E (2006) U*ganda health sector policy overview paper*, IT Power, United Kingdom available online at: www.who.int/rpc/evipnet/Health_Policy_Overview_Uganda.pdf (Accessed October 25, 2008)

Uganda Bureau of Statistics (UBOS) (2006) *National household survey 2005/06: report on the socio-economic module*, UBOS, Kampala,

– (2006a) *Statistical abstract 2006*, UBOS, Kampala.
– (2006b) 2002 *Uganda population and housing census: analytical report*, abridged version, UBOS, Kampala.
– (2006c) Uganda national household survey: report on the social economic module, UBOS, Kampala.
– (2008) *Statistical abstract 2008*, UBOS, Kampala.
– (2010) *Statistical abstract 2010*, UBOS, Kampala.
– (2010b) *Uganda national household survey 2009/2010: report on the social economic module*, UBOS, Kampala.

UBOS and Macro International (2001) *Uganda demographic and health survey, 2000/01*, UBOS/Macro Int,, Kampala and Fairfax.

– (2006) *Uganda demographic and health survey (UDHS) 2005/6*, UBOS/Macro Int,, Kampala and Fairfax.
– (2010) *Uganda demographic and health survey (UDHS) 2009/10*, UBOS/Macro Int, Kampala and Fairfax.

Uganda Law Reform Commission (ULRC) (2004) *Study report on the implementation of the WTO agreement,* Uganda Law Reform Commission, Kampala.

United Nations General Assembly (UNGASS) (2008) *Country progress report Uganda, January 2006 to December 2007*, available online at: www.unaids.org/en/CountryResponses/Countries/Uganda.asp

UNAIDS (2008) *2008 Report on the global AIDS epidemic*, available online at: www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp

– (2008b) *Uganda modes of HIV transmission study*, UNAIDS, Geneva.

United Nations Development Programme (UNDP) (2005) *Human development report 2005*, UNDP, New York.

– (2007) *Uganda human development report 2007. Rediscovering agriculture for human development*, UNDP Uganda, Kampala.
– (2008) *Human development report 2008*, UNDP, New York
– (2009) *Human development report 2009*, UNDP, New York.
– (2010) *Human development report 2010. The real wealth for nations: pathways to human development*, 20th Anniversary edition, available online at: http://hdr.undp.org/en/media/HDR_2010_EN_Complete_reprint.pdf

UNICEF (1999) *The state of the world's children 1999*, UNICEF, New York, available online at: http://eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/17/40/1b.pdf

– (2005) *Guide to monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS*, UNICEF, New York.
– (2008) *Monitoring and statistics*, UNICEF, New York, available online at: www.unicef.org/statistics

Wagstaff A. and E.van Doorslaer (2003) 'Catastrophe and impoverishment in paying for health care with applications from Vietnam 1993–1998', *Health Economics* 12:921-34.

Wangwe S. *et al*. (2002) *Country case study for Study 9. Institutional issues for developing countries in IP policy-making, administration and enforcement,* Commission on Intellectual Property Rights and Economic and Social Research Foundation, Dar es Salaam.

Whitehead M. (1990) *The concepts and principles of equity and health*, report, WHO Regional Office for Europe, Copenhagen

World Bank (1999) *Aid and reform in Uganda; country case study*, World Bank Group; available online at: http://go.worldbank.org/P4QFSTE1D0 (Accessed December14, 2008)

– (2010) *World development indicators database*, accessed July 2011, available online at: www.go.worldbank.org/1SF48T40L0-50k
– (2011) *World development indicators database*, accessed July 2011, available online at: www.go.worldbank.org/1SF48T40L0-50k

World Trade Organisation (2001) *Trade policy review body: review of Uganda TPRB'S evaluation*, World Trade Organization, Geneva, available online at: www.wto.org/english/tratop_e/tpr_e/tp183_e.htm

– (2001) *Assessment of trade in services, special communication to the World Trade Organization*, October 9, 2001.

World Health Organisation (WHO) (2005) *The elimination of user fees in Uganda: impact on utilisation and catastrophic health expenditures*, Discussion paper 4–2005, Geneva, available online at: www.who.int/health_financing/The%20elimination%20of%20user%20fees%20in%20Uganda

– (2005b) *58th World Health Assembly Resolution 33 on sustainable health financing, universal coverage and social health insurance*, WHA58.33, WHO, Geneva.
– (2006) *Core health indicators database 2006*, WHO, Geneva.
– (2011) *Core health indicators database 2011*, WHO, Geneva, available online at: http://www.who.int/whosis/en/
– (2011b) *National health accounts database 2011*, WHO, Geneva, available online at: www.who.int/nha/en/

Xu K., D. Evans, P. Kadama, J.Nabyonga, P.Ogwal and A. Mylena Aguilar (2005) *The elimination of user fees in Uganda: impact on utilisation and catastrophic health expenditures*, Discussion paper 4–2005, WHO, Geneva.

Zaramba S. (2008) *Malaria situation analysis and the road to malaria elimination*, presentation to legislators, Ministry of Health, Kampala.

Zikusooka C.M., M. Tumwine M, P. Tutembe (2009) *Financing for HIV, AIDS, TB and malaria in Uganda: an equity analysis*, Discussion paper 75, HealthNet Consult, EQUINET, Harare.

EQUITY WATCH

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. It is achieved through the distribution of societal resources for health, including but not only through the actions of the health sector. All countries in eastern and southern Africa have policy commitments to health equity, as do the regional organisations, the Southern African Development Community and the East, Central and Southern African Health Community. In February 2010, the ECSA Regional Health Ministers resolved to track and report on evidence on health equity and progress in addressing inequalities in health. EQUINET is working with countries and the regional organisations to implement the *Equity Watch*, to monitor progress on health equity by gathering, organising, analysing, reporting and discussing evidence on equity in health at national and regional level.

This report of the Uganda Equity Watch has been produced by Healthnet consult, HEPS Uganda and Training and Research Support Centre in EQUINET. The summary table below shows the progress markers that were assessed, the trends, with green for improving progress, red for worsening trends and yellow for uncertain or mixed trends. The report provides the evidence on these trends and proposes areas for action.

PROGRESS MARKER	
EQUITY IN HEALTH	
Formally recognising equity and health rights	
Halving the number of people living on US$1 per day	
Reducing the gini coefficient of inequality	
Eliminating differentials in child, infant and maternal mortality and under nutrition	
Eliminating differentials in access to immunization, antenatal care, skilled deliveries	
Universal access to prevention of vertical transmission, antiretroviral therapy and condoms	
HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH	
Closing gender differentials in access to education	
Halving the proportion of people with no safe drinking water and sanitation	
Increased ratio of wages to gross domestic product	
Provide adequate health workers and drugs at primary, district levels	
Abolish user fees	
Overcoming barriers to access and use of services	
REDISTRIBUTIVE HEALTH SYSTEMS	
Achieving the Abuja commitment	
Achieving US$60 per capita funding for health	
Improve tax funding and reduce out of pocket spending to health	
Harmonize health financing into a framework for universal coverage	
Establish and ensure clear health care entitlements	
Allocate at least 50% public funding to districts and 25% to primary health care	
Implement non-financial incentives for health workers	
Formal recognition of and support for mechanisms for public participation in health systems	
A JUST RETURN FROM THE GLOBAL ECONOMY	
Reducing the debt burden	
Allocate resources to agriculture and women smallholder farmers	
Ensure health goals in World Trade Organisation (TRIPS, GATS) agreements	
Bilateral and multilateral agreements to fund health worker training	
Health officials included in trade negotiations	