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Department for Democracy and
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Health Division

The views and interpretations expressed in this document are the authors', and do not necessarily reflect those of the Swedish International Development Cooperation Agency, Sida.

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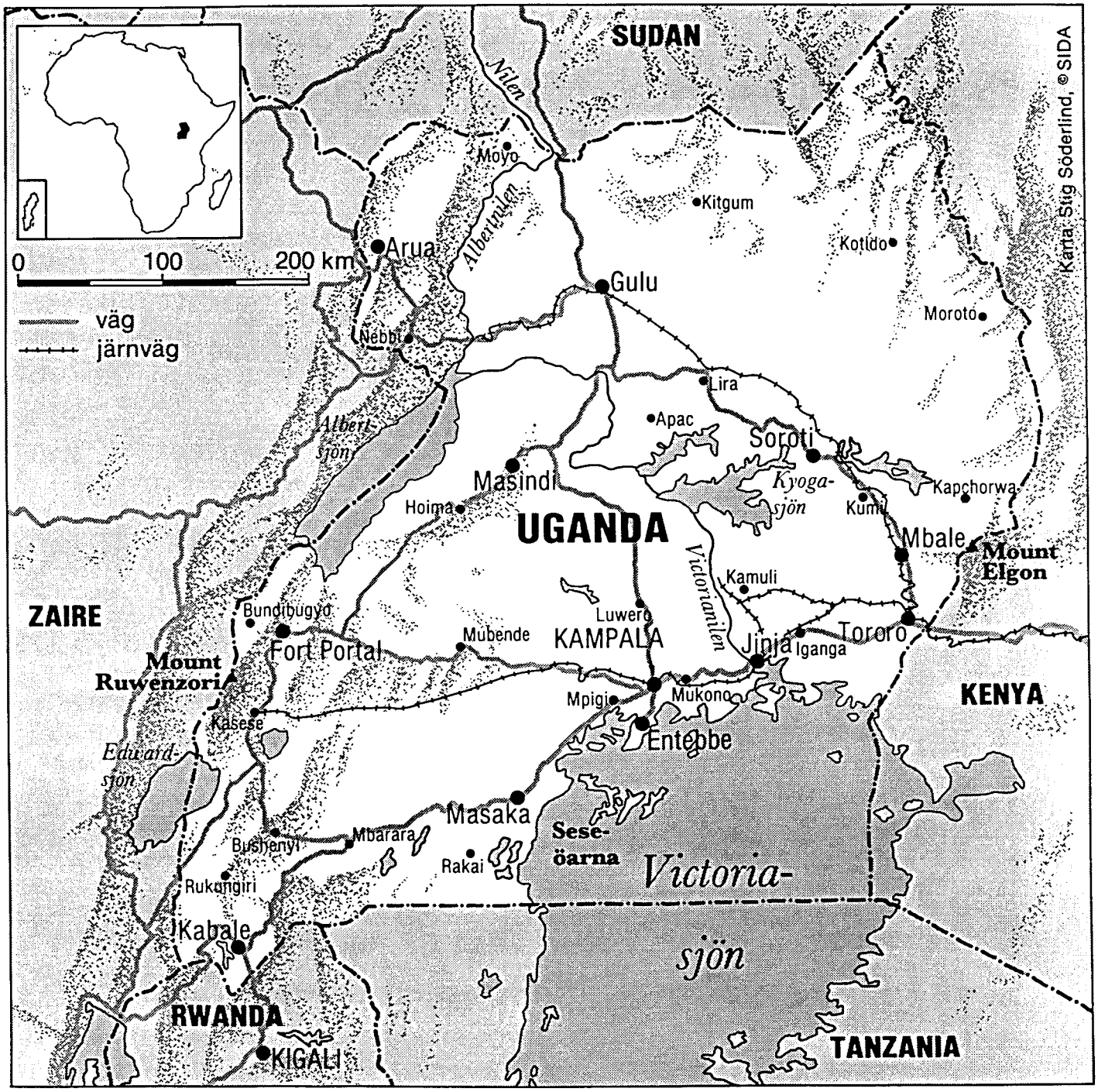
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Contents

Preface

This document is part of a series encompassing the countries and regions with which Sida collaborates in the field of health. The purpose with the series is to provide comparable information on the different settings in which Swedish health development co-operation takes place.

General country documents usually have a focus on macroeconomic issues. This is an effort to complement other information about collaborating countries with specific facts about their health situation and the health care sector.

Sida has decided on the format and outline for these profiles and has commissioned a number of consultants to write them. Each author is responsible for her/his text. The intention is, with time, to revise and update figures and facts in pace with accessible information.

For specific information about the Swedish health assistance please contact the Health Division within the Department of Democracy and Social Development at Sida.

It is hoped that these country and regional health profiles will be useful to both Sida's own staff and consultants and to others with a special interest in health and development co-operation in health.

Anders Nordström
Head of Health Division
Department for Democracy and Social Development, DESO

1 Macro-economic context

Uganda is an agricultural country, mainly dependent on peasant farming. More than 85% of the country's population is rural based. Following independence in 1962, Uganda initially experienced a period of considerable economic progress. Between 1963 and 1973, the annual average rate of real GDP growth was 6% and the balance-of-payment was in surplus (International Monetary Fund, 1995). However, the Amin era of the 1970's and the civil wars of the 1980's under the Obote regime left the country's economic infrastructure completely devastated and greatly affected agricultural industrial production. The National Resistance Movement (NRM), which took power in January 1986, inherited an extremely difficult economic situation, with a real GDP that had declined by about 40% per capita between 1971 and 1986 (World Bank, 1996). By 1985, government expenditure on education and health, in real terms, amounted to about 27% and 9% of the 1970's level. By June 1987, the annual inflation rate had risen to 240% (World Bank, 1996).

In mid-1987, the government embarked on a comprehensive economic recovery programme aimed at reducing poverty by restoring fiscal discipline and monetary stability, and designed to deregulate the economy, eliminate direct state involvement in most public services, and improve institutional efficiency. These measures were designed to make the private sector the engine of growth in the economy. This strategy has been accompanied by supportive public investment, rehabilitation of public infrastructure, and a rationalisation of the public sector through such programmes as army demobilisation, civil service reform, public enterprise divestiture and constitutional reform, resulting in the launching of the new constitution in 1995.

Only slow progress was made on stabilisation and economic reform from 1987 to 1992. Since then, there has been substantial progress in achieving these goals within an environment of rising foreign inflows and coffee booms. Real GDP growth in 1998/99 was 7.8%, and was spread across all sectors of the economy (Ministry of Finance, Planning and Economic Development, 1999). Inflation was low at 3.8% in average in the same financial year. However, despite showing some increase, the national revenue base collectable through taxes is small. In 1997/98, government revenue as a percentage of GDP was 11.5%. This is still low compared to elsewhere in Sub-Saharan Africa, where the average is well above 20%. Thus there is high dependence on external aid and loans to meet public sector deficits. Uganda's stock of external debt amounted to USD 3.4 billion – over 76% of GDP – in mid 1995 (World Bank, 1996). Uganda's debt burden was unpayable. In 1998, the International Monetary Fund and the World Bank confirmed that Uganda had qualified for the Highly Indebted Poor Countries Initiative (HIPC). Over a period of 30 years, debt relief will amount to USD 650 millions.

Macro-economic Indicators, several years

Indicator	Year		
	1990	1993	1997
GDP Growth, %	5.5	6.3	5.2
GDP per capita index (1960 = 100)	69	73	86
Export/GDP, %	7.0	8.0	11.8
Total external debt, million USD	2,668.7	3,055.5	3,606.0
Agerage GDP growth, %, 1992-97			6.5
Agerage Inflation rate, %, 1992-97			Below 10.0
Per capita income, USD, 1997			300

Source: Ministry of Finance, Planning and Economic Development, 1997.

2 Socio-economic context

2.1 Socio-economic Development

There are many examples in the world to show how economic development has contributed to improving quality of life and health status, via indicators such as increased life expectancy, falling infant, child and maternal mortality and enhanced access to services. However, there is also growing realisation that macroeconomic changes may not always benefit all of the population, and that many policies can have devastating human effects in increasing poverty and unfair distribution. Uganda is no exception from this trend.

The Human Development Index indicates that Uganda continues to register a steady, albeit slow, improvement in human development since 1993. The index has risen from 0.329 in 1992 to 0.34 in 1995. This has mainly been attributed to the growth within the economy and the increase in school enrolment. The distribution of wealth is unevenly spread. The number of people living below the absolute poverty line has dropped from 56% of the population in 1992 to 46% in 1995/96, but the relative distribution of poverty has worsened with the poorest 20% becoming even poorer. Distributional changes accounted for only 4% of the total decline as the GINI coefficient for that period showed a minimal decline from 0.380 in 1992/93 to 0.379 in 1995/96.

In an attempt to fight the negative consequences of the economic recovery programme, the government, in connection with the elections of 1996, formulated a Poverty Eradication Action Plan (PEAP). The plan aimed at increasing income and well-being of the poor in the country through co-ordinated strategies in key sectors; primary education, primary health care, water, road infrastructure and agriculture. Following the Action Plan, the Uganda Poverty Participatory Assessment Project was set up to consult poor people and to give them a voice in planning for poverty eradication. In order to secure funding to these key sectors a Poverty Action Fund has been set up. The fund comprises both donor and government resources. Savings made from the HIPC Debt Relief Programme are channelled straight to the Poverty Action Fund. Recently, a review of the progress of the implementation of the Poverty Eradication Action Plan and the status of poverty indicators was undertaken (Ministry of Finance and Economic Planning, 1999). This review supported the trends reflected in the UNDP Human Development Index.

2.2 Gender and Equity

As in most African countries, a female Ugandan's life is harder than that of her male counterpart. She works longer hours and has additional health risks because of child bearing. She is less likely to go to school and she has few opportunities to participate in

community activities. Women have the double burden of doing most of the agricultural jobs, in addition to caring for the children, the sick and the elderly, as well as preparing food, fetching water and gathering fuel. Despite their contributions, women are still not regarded as equal to men. As a result there is still a low percentage of females in higher education and top positions.

Sending young girls to school would have a great impact on their lives in the future. It has been proved that educated women are likely to have smaller families and healthier children. Over time, lower child mortality would lead to behavioural change, lowering fertility. Lower fertility would not only reduce the size of the households, but would improve care of the children and make it possible for more children to attend school.

There is a growing recognition in Uganda of the need to focus on women and their life situation. Much has improved since 1985 when the convention on elimination of discrimination against women was signed. The convention has mainly been activated by the 1995 Constitution that promotes equal rights to men and women, and women participation in politics.

However, the messages in the Constitution were not implemented when the new land law was passed in 1998. In Uganda, family land is most often inherited by sons, omitting wives and daughters from heritage. The new land law had in the country had been promoted as a pro-poor measure. The purpose with the law was to give smallholders the right to ownership of the land they are cultivating. As many smallholders are women, often widows, the law would have been very important to them. Women's associations had been very active in lobbying for an amendment to the law giving women co-ownership rights in the marital home and in land used by the family. The amendment was tabled and passed in Parliament on June 25, 1998. However, when the Land Statute came out there was no trace of the amendment. Since then, it has been referred to as the "Lost Amendment". The new law still holds that land cannot be leased, mortgaged or sold without consent of a spouse of the owner. In reality, the law does therefore not provide adequately rights for women's land ownership.

In the beginning of 1998, the Ministry of State for Women was integrated in a Ministry of Gender, Labour and Social Development. The ministry plays a great role in assembling, documenting and disseminating data that brings out gaps and helps identify gender based barriers, to be used for gender responsive development planning.

2.3 Education

Education in Uganda is based on seven years of primary school, six years of secondary school and tertiary education covering two to five years. The primary school enrolment ratio (gross) was in 1990–96 about 73. Only about half of the children reached grade five. As a result the adult literacy rate was in 1995, 62% (UNICEF, 1999). Only about 50% of women know how to read.

In 1995, girls comprised 45% of primary, 30% of lower secondary and 205 of upper secondary pupils. Girls and boys enter grade one in nearly equal numbers, but seven years later there are two boys for every girl in school. Preference to educate boys, early marriages, and early pregnancy explains this difference.

The government in Uganda has previously identified five main problems concerning the education system: unequal access to education, high costs for education, poor delivery system, weak financial accountability, and low quality of education (IMF 1997). The problems of access and high costs are being addressed through the ongoing Universal Primary Education Program (UPE), under which the government is providing costs for

teaching and some of the material costs for primary education for four children of every family. When the program started in 1997 it immediately doubled the number of students in first grade (IDS, 1998). In addition, the government provides conditional grants to district to be used for improving teacher training and the quality of educational materials. Finally, a complete reform of the management of the education sector is being implemented in the context of decentralisation.

Education Indicators

Indicator	%
Adult literacy rate 1995, women	50
Adult literacy rate 1995, male	74
Prim. School enrolment ratio (gross) 1990-96, women	67
Prim. School enrolment ratio (gross) 1990/96, male	79
School entrants reaching grade 5, 1990–95	55

Source: UNICEF (1999).

2.4 Environment

One of the main environmental concerns in Uganda today is the current and future impacts of the tree cutting. Forest cutting is being done to clear land for cultivation and grazing. Much of the tree cutting is destroying tropical rainforests and promoting erosion. A large part of the wood is also being used for cooking. Most of the firewood is taken from unprotected public lands with no management in place to ensure sustainability. If firewood is scarce, women and girls have to walk further to collect wood. This adds to their workload and the erosion reduces cultivable land, which makes work harder for women and means potential food insecurity. Where firewood is scarce and such as valuable commodity, it might even be difficult to justify boiling of drinking water.

The spread of water hyacinth weeds in Lake Victoria has become a serious environmental problem as well. The weeds make it difficult for fishermen and for lakeside pumping stations. The lake is also infested with biharzia parasites. The problems of Lake Victoria are being tackled jointly by the countries surrounding the lake through the Lake Victoria Initiative.

Priority environmental problems and strategies to tackle them have been identified in the National Environmental Action Plan of 1994. The National Environmental Management Authority (NEMA) was established to co-ordinate inter-ministerial implementation of the plan. In addition, special attention has been given to the management of conservation areas with a view to exploit environmentally oriented tourism as an income-generating activity for communities. The co-ordinating body for such activities is the Uganda Wildlife Authority.

2.5 Water and Sanitation

Safe drinking water and adequate sanitation are important determinants of health. During the period 1990 to 1997, 77% of the population had access to safe water in urban areas, and in rural districts only 41% (UNICEF 1999). Women and children are usually responsible for water collection. Water per person collected per day is generally low; 6–10 litres per person, mainly due to long distance to water point (Barton, T et al, 1994). This is much lower than the 20 litres per person per day recommended by WHO for adequate drinking and hygiene.

Population with access to adequate sanitation was in urban areas 75% and in rural areas 55% (UNICEF, 1999). Although more than half of the families have a functioning latrine, these are not being used by everybody, and especially not by very young children. Children walk and play on contaminated ground, thus risk contracting worms and other parasites.

Attempts are being made to improve the water and sanitation situation. The national water delivery policy focuses on the extension of urban and rural water networks. The Directorate of Water Development (DWD) is rehabilitating the water system in over 200 towns.

2.6 Working Environment

Out of the total labour force, around 80% are engaged in the agricultural sector. Another 6% in the industry sector. The remaining 14% are working in services and other sectors (Ministry of Foreign Affairs, 1995). Limited information is available on the working environment of the labour force in Uganda. However, the Constitution of 1995 pleads for people's rights to work under healthy and safe conditions, and the right to acceptable working hours. It is also illegal to employ people under the age of 18. However, an analysis of the 1991 census and the 1992–93 Integrated Household Survey found that 23.2% of children 10–14 years old were involved in various work activities (Barton, T. et al, 1994). Working children are at great risk of disease and malnutrition, because their work is often both heavy and dangerous.

2.7 Nutrition

Despite Uganda's fertile soil and productive agricultural sector, the nutritional status is not satisfactory. Ugandan children get a good nutritional start with almost universal breastfeeding at birth. But soon after this, up to 38% of the children under age of five begin to show stunting (short for age), and about 26% are underweight (UNICEF, 1999).

Several factors contribute to poor nutritional status among children, such as shortage of food, cultural feeding practices and negative food beliefs within in the households. Intestinal parasites and worms affect the ability of children's bodies to use the nutritive that food bring. Vitamin A and iodine deficiencies are common. Goitre due to iodine deficiency was estimated at 7% among children in the age group 6–11 years during the time 1985–97. However, more than two thirds (69%) of the households consumed iodised salt (UNICEF, 1999).

The government has recognised that the nutritional status of especially children and women is poor, and has therefor decided to embark on a combination of strategies including awareness building, case management, rehabilitation and diet diversification. Plans are also under way to collaborate more closely with the Uganda National Bureau of Standards and to set up a National Food and Nutrition Council. The results of these efforts remain yet to be seen.

Nutrition Indicators

Indicator	%	Period
Stunted children <5 (short for age)	38	1990–97
Children <5 underweight (moderate & severe)	26	1990–97
Infants with low birth weight	13	1990–97
Goitre rate (children 6–11 years of age)	7	1990–97

Source: UNICEF, (1999).

3 Population

In 1997, the population was estimated at 20.8 millions, with an annual growth rate of about 3.2% in the past seven years. Over half the population comprised children under the age of 18. The life expectancy is one of the lowest in the world; 50.4 years in 1995.

Despite an increasing movement of populations into urban areas, Uganda is still one of the least urbanised countries in Africa. Only 13% of the population lived in urban areas in 1997. The average annual growth rate of urban population was in 1970 to 1990 about 4.3% and from 1990 to 1997 5.6% (UNICEF, 1999). Population density is highest in Kampala and the east and south-west. Population per square kilometre of land was in 1990 in average 85.

The population in Uganda consist of more than 40 ethnic groupings. The main differences are between the Nilotic groups in the north and the Bantu groups in the south. Major language groups include various Bantu dialects (mainly Luganda), Luo and Lugbara. The official language of Uganda is English.

Past conflicts in neighbouring countries have resulted in large numbers of internally displaced persons and refugees, which Uganda is currently hosting. According to UNICEF Uganda's estimated refugee population is 185,000 comprising mainly Sudanese, Congolese and Rwandese.

Population Indicators

Indicator		Period
Total population, million	20.8	1997
Pop. Under 18 years of age, million	11.6	1996
Population per square meter	85	1994
Average annual growth rate, %	3.2	1990–97
Fertility rate (per women)	7.1	1997
Life expectancy at birth	41	1997
Crude birth rate (per 1,000 population)	51	1997
Crude death rate (per 1,000 population)	21	1997

Source: UNICEF (1999) and Barton, B. and Wamai, G. (1994).

4 Health Development

4.1 Burden of Disease Patterns and Trends

Life expectancy in Uganda is one of the lowest in the world; 41 years in 1997. Communicable diseases are causing the heaviest burden on the health system. According to the Burden of Disease studies of 1996 and 1997, the ten top diseases (all ages-groups included) dominating morbidity and mortality statistics in 1995 were; malaria, HIV/AIDS, Tuberculosis (TB), acute respiratory tract infections, diarrhoea diseases, malnutrition, anaemia, intestinal infections, trauma/accidents and skin infections. Ones of the most difficult health issues in Uganda is the AIDS endemic. Because of its effects on immunity, AIDS has led to recurrence of diseases such as tuberculosis which were otherwise being brought under control (Ministry of Health, 1999).

Malaria is endemic in Uganda and is also the leading cause of morbidity and mortality. Up to 30% of all deaths among 2–4 year old children in health units are due to malaria (Barton, T. et al, 1994). However, over diagnosing of malaria is common in Uganda,

both by health care providers and patients themselves. One should be aware that the malaria situation appears to be worsening in much of Africa as malaria parasites become more resistant to Chloroquine and other malaria drugs. In an attempt to fight malaria, the Malaria Control Programme was introduced. The programme among others focus on interventions such as: improvement of case management at all health care levels; early detection and control of epidemics; and promotion of personal protective measure (Ministry of Health, 1999).

Except from above mentioned communicable diseases Uganda is also facing increasing problems with non-communicable diseases such as hypertension, cancer, diabetes, mental illness and chronic heart diseases. These diseases will need increased attention in the future.

Health Indicators

Indicator	%
Population with access to safe water	46
Population with access to adequate sanitation	57
1-year-old children immunised against DPT	58
1-year old children immunised against measles	49
1-year old children immunised against polio	59
1- year old children immunised against TB	84
Pregnant women immunised against tetanus	45
Births attended by trained health personnel	38

Note: The percentages refer to the averages during the period 1990-97.

Source: UNICEF (1999), "The State of the World's Children".

4.2 Children's Health and Rights

Uganda has a high infant and under five mortality compared to neighbouring countries. In 1997 the infant mortality rate (IMR) was 86/1,000 and the U5MR 137/1,000 (UNICEF, 1999). The estimations carried out by Ministry of Health are higher; 97/1,000 and 143/1,000 respectively. The same figures for Kenya was lower; 57/1,000 and 87/1,000 (UNICEF, 1999).

The diseases causing the largest amount of deaths today among children under five are: malaria, acute respiratory infection and intestinal infestations (Ministry of Health, 1999). Recently, the coverage of fully immunised one-year-old children was: TB 84%, DPT 58%, polio 59% and measles 60% (UNICEF 1999). Increased measles immunisation coverage has reduced the number of cases in last ten years.

Integrated Management of Childhood Illnesses is a recently introduced approach intended to provide children health services in a holistic manner. It is especially trying to integrate CDD/ARI, immunisation and case management of malaria and nutrition in children, since these diseases are estimated to account for 70% of all childhood illnesses in Uganda.

There are several social factors affecting children's health, for example child labour. It is natural that children take part in domestic activities, but work can become excessive or exploitative; it can as well prevent children from going to school. In addition, many children are orphans. Although no comprehensive data is available, there are several disabled children. These children have limited access to rehabilitation and few are attending school. Ugandan children are also discriminated due to sex and age. A girl is less likely to

be sent to school than a boy. A child is usually not allowed land or property, and is considered as a property of a family – the father's family.

To fight the unequal life situation for children, Uganda signed the UN Convention on the Rights of the Child in 1990 and the African Charter on the Rights and Welfare of the Child in 1992. To improve the situation for children a National Plan of Action for Children and the Children's Statute were launched in 1993 and 1996 respectively. Ministry of Gender, Labour and Social Development is responsible for implementation and monitoring the children's rights.

4.3 Sexual and Reproductive Health and Rights

In average the Ugandan women give birth to 7.1 children. In neighbouring countries, Tanzania and Kenya, the fertility rate is 5.5 and 4.9 respectively (UNICEF 1999). Most women start bearing children early; 70.8% begin child bearing in the age of 19 and 7.7% in the age of 15 (Ministry of Gender, Labour and Social Development, 1998).

The maternal mortality has been estimated at 510 per 100,000 live births (UNICEF, 1999). Compared to neighbouring countries this figure is high and is associated with prolonged and obstructed labour, unsafe abortion, sepsis, haemorrhage, anaemia, eclampsia, malaria, and sexually transmitted diseases, especially HIV/AIDS. Cancer of the cervix is also becoming a major public health problem among women in reproductive age.

The contraceptive prevalence has improved from 5% to 15% between 1990 and 1998 (UNICEF, 1999). Ministry of Gender, Labour and Social Development has identified lack of communication between couples, cultural and social barriers, and lack of information and education as the major factors standing in the way of people's access to and use of contraception.

According to the Demographic and Health Survey of 1995 most women (92.2%) attended antenatal care, but only 35.3% of deliveries were at health facilities. Similar results were attained more recent in a household survey in Luweero district (Jitta, J. et al, 1998). Results showed that almost all mothers reported having attended antenatal care at least once during a pregnancy, but almost half (26%) of the sampled households delivered at home with untrained assistance. When looking at the women defined as poor in the sampled households, it was 39% of the households that delivered at home without trained assistance. The reasons for the high number of women delivering at home were among others lack of qualified staff at health centres, poor access to transport, and shortage of money.

With the intention to decrease morbidity and mortality among women and children (under age of five) government has in the draft health policy proposed the introduction of a Reproductive Health and Child Development Programme. Activities proposed include among others: promotion of sexual and reproductive health and rights; provision of adolescent health services; provision of counselling services on STD/AIDS; promotion of quality safe motherhood services; provision of family planning services in all health facilities; and promotion of post abortion care (Ministry of Health, 1999).

4.4 AIDS

One of the most difficult issues confronting the Ugandan society is the AIDS endemic. In 1997 about 1.5 million people in Uganda were infected with HIV and approximately one million children had become orphans due to AIDS. A cumulative total of 53,306 AIDS cases were reported; 47% were male and 53% female. Of the total reported cases 7% were children. However, there is a constant problem with under reporting of the

AIDS cases. The true number of persons who have developed AIDS is not known, but is estimated to be 6-8 times the number reported, making the actual number of AIDS cases probably over 400,000 persons (TASO, 1998). Nearly 80% of those infected with HIV are in the economically productive and reproductive ages between 15 and 45.

The HIV/AIDS endemic has also resulted in an increase in the incidence of tuberculosis (TB). In 1997, over 27,000 cases of TB were reported to the National TB/Leprosy Control Programme (Ministry of Health, 1998). About 60% of new smear positive TB patients have registered HIV positive, while HIV related bed occupancy in TB patients has reached 50% (Ministry of Health, 1999).

The Government has adopted a policy of "openness" towards HIV/AIDS. The National STD/AIDS Control Programme was established already in 1986. The strategies used by the programme aim at prevention of HIV transmission, care and support of people living with HIV/AIDS, and capacity to deal with the HIV/AIDS endemic. In order to tackle the infection in a multi-sectoral manner, AIDS Control Programme Units have been set up in quite a few ministries. HIV/AIDS control has been further strengthened and diversified by decentralising AIDS control through the Sexually Transmitted Infections Project (STIP). The project is supporting NGOs in the districts to carry out HIV/AIDS activities. One NGO carrying out prevention work is The AIDS Support Organisation, TASO. Through provision of counselling, medical care, social support and support for community initiatives, the organisation contributes in the battle against AIDS. TASO has become a role model for many other organisations, both in and outside Uganda. The Uganda National AIDS Commission has the role of co-ordinating various organisations' efforts in the fight against the infection.

During the last five years there has been a visible change in sexual behaviours in the entire country. The number of persons reporting non-regular and/or multiple sexual partners has decreased. The mean age of first sexual intercourse has increased from 15.9 in 1989 to 16.5 years in 1995. There is also an increase in usage of condoms. The changing sexual behaviour has been reflected in declining trends in the HIV prevalence. Data from HIV infection sentinel surveillance sites show that HIV prevalence in pregnant women has declined in the five last years. HIV infection among STD patients attending STD clinics in Kampala, show a decline from 44.2% in 1989 to 30.2% in 1997. Despite the declining numbers, the rates are still high and call for increased efforts to improve and sustain AIDS control initiatives. Special efforts need to target girls in the age groups 15–19 since the AIDS male to female ratio in this age group is approximately 1.6. Efforts are needed to take care of all the many orphans. Finally, since HIV/AIDS not only is a health issue, increased support to a multi-sectoral approach in the battle against the disease is called for.

4.5 Disabilities

There is lack of information regarding prevalence and distribution of various kinds of disability; both physical and mental. It is estimated by UNDP that approximately 10% of a population in a country like Uganda have some sort of physical or mental disability. Out of these is one third is estimated to be in need of rehabilitation. The impact of regional conflicts, both past conflicts in neighbouring countries having resulted in large numbers of internally displaced persons and refugees within Uganda and on-going conflicts with the Democratic Republic of Congo and Sudan, are causing mental distress and illness.

The government has realised the need to address mental health due to conflicts and disasters through community-based programmes. Increased recognition is also given to disabled people, who often become discriminated and stigmatised. Disabled children are often neglected and rarely get an opportunity to attend school. In the 1995 Constitu-

tion disability is declared as a human rights issue. The Constitution gives disabled people right to take active part in the society and to represent in local governments and the parliament. Yet many disabled children and adults are discriminated, requiring efforts at all levels in the society.

5 Health services

5.1 Policies and Reforms

Since the National Resistance Movement (NRM) assumed power in 1986, it has been involved in sustained efforts to overhaul the decadent and centralised systems of government it inherited. In the area of public administration, the government took the initiative to reform the local government through the policy of decentralisation and the civil service through multiple strategies developed under the civil service reform programme. The linkages between these and other reforms such as the constitutional reform, the economic recovery and the army demobilisation programmes are strong and ensuring their respective sustainability.

The decentralisation policy was designed to increase the powers of democratic local authorities (Government of Uganda, 1993). With the responsibility for providing public services moving closer to the beneficiaries at the local level, improved service delivery and increased transparency were expected. The administrative changes resulting from decentralisation aim to bring both decisions and funds closer to the population, fostering a sense of ownership.

As a result of the decentralisation policy, duties and responsibilities are divided between the national level represented by the Ministry of Health and the Ministry of Finance, Planning and Economic Development, and the district level, that is the Health Services Office. The Ministry of Health is presently being restructured to assume its new role of setting health policy and standards, providing technical services to districts, and monitoring and evaluation of the overall health sector performance. The roles of the districts have through decentralisation been redefined to plan, monitor and co-ordinate district health services as a whole. District health plans are providing the basis for planning, management and provision of health services in the districts.

During recent years, the government has made continuos efforts to improve the health sector and service delivery, which has resulted in a draft national health policy and draft sector strategic plan. The National Health Sector Reform Programme and the National Poverty Eradication Programme, as well as the Alma Ata Declaration of Health for All, have provided significant input into the new policy and strategy.

The policy states that "the overall goal of the health sector is the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life" and therefore the health policy has been designed to "reduce mortality, morbidity and fertility, and the disparities therein" (Ministry of Health, 1999).

The basic strategy for health development is defined to be that of Primary Health Care (PHC). To this end, the government has identified a minimum package of public health and clinical services to be provided to all its population. The Uganda National Minimum Health Care Package (UNMHCP) is intended to comprise cost-effective interventions that address the major causes of the burden of disease, which will be given the highest priority in allocation of funds and other resources.

The minimum health care package will comprise several components including: control of communicable diseases with special emphasis on malaria, STI/HIV/AIDS and tuberculosis; promotion and use of Integrated Management of Childhood Illnesses (IMCI); promotion of sexual and reproductive health and rights measures such as antenatal and obstetric care, family planning services, and adolescents reproductive health services; public health interventions regarding immunisation, environmental health, health education, school health, preparedness for epidemics and disasters, nutritious foods and eating habits, as well as interventions against diseases targeted for eradication such as guinea worms and measles; strengthening of mental health services; and finally provision of basic clinical care for injuries and non-communicable diseases, rehabilitative health services, palliative care and oral/dental care.

According to the new health policy the Minimum Health Care Package is to be provided through "a network of functional, efficient and sustainable health infrastructure". Therefore, the government has embarked on a comprehensive health infrastructure reform, aiming at dividing districts into health services zones on the basis of the 214 constituencies in the country. Each zone is to be called a Health Sub-District (HSD) headed by an existing NGO or government hospital, or an up-graded health centre with the operational responsibility. The overall responsibility for planning, supervision, co-ordination and resource mobilisation will still be with the District Health Office, in particular the District Health Team, overseen by the District Director of Health Services (formerly District Medical Officer).

Health Sub-District-concept is aimed at further decentralising the management, planning and implementation of health services. The government is not only hoping that the Health Sub-District-concept will contribute to establishment of an appropriate referral system and increase equity in access to health services, but also foster more community involvement in the planning, management and delivery of health services. Therefore health units have been encouraged to form Health Unit Management Committees (HUMC) with community representation.

The Health Sub-district-concept has raised several questions regarding its feasibility and affordability. However, both government and donors have been involved in the process of developing the draft national health policy and the draft strategic plan.

The donor approach to health development in Uganda is as in many other countries, project-focused. Insufficiently co-ordinated projects have led to fragmentation and ineffectiveness in many ways. The government and donors have realised the problems with this approach and have therefore agreed to adopt a Sector-Wide Approach (SWAp) for health development in Uganda. The main objective of the Sector-Wide Approach is therefore to enable "effective co-ordination of efforts among all partners" so that resources in the health sector can be used more efficiently and effectively for mutual priorities in nationally defined policies and strategies (Ministry of Health, 1999). This approach will drastically change the way the two parties have worked previously. However, many donors may due to requirements from their home countries not be able to adopt this approach immediately, and might therefore retain some programmes and projects over a period of time. Others might wait until some successes have been documented.

5.2 Provision and Delivery System

Health care providers in Uganda can be categorised in various ways: public or private; governmental and non-governmental; trained or untrained; modern or traditional; formal or informal. Government provided health care is an important source of care for some of the population, but it is not the primary source. Patients treat it as one among many sources of health care.

The infrastructure reform recently started by the government to implement the Health-Sub-Districts and the Minimum Health Care Package will result in a new classification of health units. Health units are to be classified according to the services they offer; Health Centre I, Health Centre II, Health Centre III and Health Centre IV in order of increasing capacity. This denomination will replace the old system of the sub-dispensaries, dispensaries, maternity units and health centres. National referral hospitals and district hospitals will also be included in the new health care delivery system.

With an aim to standardise services offered and ensuring an even distribution of health centres, major rehabilitation and even construction of health centres have been identified as needed. The Ministry of Health has committed itself to a phased infrastructure development plan. An inventory of manpower requirements will also be undertaken.

Government Health Care Facilities, 1998

Facility	Health Centre I	Health 15Centre II	Health Centre III	Health Centre IV	Hospitals	Total
Number	–	43	816	158	55	1,072

Source: Ministry of Health, 1998.

It should be noted that there is no effective referral system today. Many patients go directly to hospitals as their first level of contact. Through the infrastructure reform, the government is trying to accomplish a referral system with lower level units (Health Centre I and II) as entry points. Ultimately, there should be a Health Centre I in each village; a Health Centre II in each parish; a Health Centre III in each sub-county; and a Health Centre IV in each county. However, the interim plan is make sure that there is one Health Centre IV in each constituency. In addition to services offered by district hospitals, specialist services at ten regional referral hospitals will be available. The two national referral hospitals (Mulago and Butabika) offer country wide specialist services. In the long run the Ministry of Health will make them autonomous. No new hospitals are to be built.

NGO, mainly church-related, health facilities have a long history of providing health services and play an important role in delivering services. There are over 350 NGO units in the country, out of which 40 are hospitals (Ministry of Health, 1996). The NGO units are headed by their respective umbrella organisations; the Protestant and the Catholic Medical Bureaux and the Muslim Supreme Council.

Ministry of Health has estimated that NGOs provide approximately 40% of hospital beds and 40% of formal sector health services in the country. The rest is provided by government. They often deliver services at better standard and at lower costs than the government facilities. This has been recognised by the government, which since 1997/98 has allocated funds to NGO hospitals and one year later to lower level units.

Drug shops, private clinics and private laboratories mushroomed after the economy collapsed in the 70's and the 80's. In communities, especially rural, community health workers trained by various NGOs, trained and untrained traditional birth attendants, and traditional healers offer their services. No comprehensive inventory of the magnitude of their services has been undertaken. However, The Uganda Community Based Health Care Association (UCBHCA) has made efforts to co-ordinate work of NGOs involved in PHC and has developed training packages for community health workers.

Drugs kits have in the past been supplied to districts by the Essential Drugs Management Programme in collaboration with the National Medical Stores. Recent efforts have been made to harmonise the pharmaceutical supply system in Uganda. The national drug supply policy is dealing with issues of procurement, supply, storage, distribution and licensing of drugs. The intention is to decentralise drug management to districts through local procurement committees.

5.3 Access and Utilisation

Health units in Uganda are unevenly distributed. Available services are located mainly in urban areas, whereas the majority of the population lives in rural areas. Over 50% of the hospitals are situated in urban areas and most health centres were located near trading centres. The national average for population per health unit was in 1996 12,500 and population per bed was 800 (Ministry of Finance, Planning and Economic Development, 1999).

A considerable percentage of the population has no health care facility within walking distance. In 1996, only 49% of the Ugandans lived within five kilometres of the health units rendering both curative and preventive health services (Ministry of Health, 1996). The northern region with a rate of 27.4% was the one with lowest accessibility rate. This was mainly attributed to the political instability in the region, which hampered the establishment of basic health services.

Even if health facilities might be available in the locality it does not ensure that people have access to such services. The cost of services can be a major constraint. Costs relate not only to the actual health care but to transport and to the informal user fee practise, making it impossible for patients to estimate the final health care bill. Consequently, many poor can not afford paying. Even if an exemption policy in a health unit might be generous, the poor might not belong to the exempted categories.

A few studies have tried to explore where people seek health care and how much they actually pay. One household survey in Masaka district revealed that 56 out of 201 households reported that one member had had an illness within the past thirty days. In total these 53 patients made 93 visits to health care provides. Out of the 93 visits only 9 were to the governmental sub-dispensary. Almost half of the visits were to private clinics. Although the government unit only charged Ush 400 per visit, most people preferred to use private clinics or drug shops, the reasons being long waiting times, lack of drugs, corruption and rude staff attitude. Similar experiences have been found elsewhere in the country.

Poor groups are more likely to be ill but less likely to seek treatment in health care facilities. Recent evidence suggested that during an illness episode of 30-days, women reported more cases of sickness than men did. Reported cases of sickness were lower in rural areas, in particular those in the northern region, than for the country as a whole. About 30–40% of the reported cases were not seen by a health worker. However, it was not clear whether the illness was serious to warrant such services. About 40% of in-patient services and around 33% of out-patient services were provided by a government provider. Those in rural areas were slightly less likely to rely on home treatment and to seek private doctors and pharmacies, but more likely to seek treatment with traditional practitioners and to have in-patient services in private/NGO facilities (Ministry of Health, Health Planning Department, 1998).

5.4 Financing

The health sector relies on mainly three source of funding: central government, donor assistance and private. Individuals contribute through user fees (formal and informal), various community financing schemes and private health insurance. No social insurance exists at the moment, but efforts have been made to explore possible options. However, employers contribute often to the medical expenses of their employees.

Total spending on health for 1996/97 was estimated at USD 11.96 per capita of which nearly 90% was accounted for by recurrent expenditure and the remaining 10% by development expenditure. Government contributed 20.3% and donors 21% of health spending with the balance made up from private expenditure.

Government funding to the health sector has been diminishing in relation to the total budget. In 1972, the ratio health expenditure as a percentage of the total government spending was 5.3%, which was low compared to the neighbouring countries Kenya (7.9%) and Tanzania (7.2%) (Hiscock, J. et al, 1993). In 1993, the government was trying to run a health system slightly bigger than that of early 1970's (both in terms of infrastructure and personnel) with less than half the funding resources (ibis.). During the last years there has been a considerable increase in public spending on health care, mainly due to great increases in the level of donor funding of public expenditure programmes. In 1998/99, 6.3% of the governmental recurrent expenditure was on health, whereas education received 27.2% (Ministry of Finance Planning and Economic Development, 1999). The defence comprised about 23.2% of the recurrent expenditure but is said to be over 30% today.

Uganda has a long history of allocating funds to curative, mainly hospital-based services. In recent years – since the introduction of decentralisation in 1993 – a huge decline in spending on Primary Health Care (PHC) in districts had been observed. The Ministry of Health wanted to reverse this trend, by earmarking funds to PHC in the districts through conditional grants and lunch allowances to lower level health unit staff. Even NGO hospitals and lower level health units receive governmental support these days. In addition to conditional grants, districts receive funds for health care through block grants (unconditional grants) which are allocated to different sectors within the districts. Equalisation grants aiming at equalising differences between districts will be introduced in the near future. In addition, districts raise funds locally through graduated taxes, licenses for various purposes (market dues) and in some districts through health taxes. Finally, donors fund a considerable amount of the district health care. In some districts as much as 80% can be funded by donors (Ministry of Health, Health Planning Department, 1998).

In 1997/98, donors contributed up to about 49% of total public expenditure on health. Over 40% of donor spending was actually in recurrent costs. The major donors include Danida, USAID, DfID and the World Bank. Sweden provides about 5% of the donor support to health (Ministry of Health, Health Planning Department, 1998).

Private health expenditure accounts for some 60% of total health spending in Uganda. This represents about USD 7 per capita per year. According to the Uganda National Integrated Household Survey of 1995, 4.35% of the household's total expenditure was on health (including drugs and transport) per month. Urban households naturally spent more than rural areas on health care. Health Planning Department (1998) has estimated that almost 80% of private health expenditure was made to the private sector (NGOs and clinics). Just under 10% may be accounted for by official as well as unofficial user charges by government facilities with a similar amount for home treatment/self medication from pharmacies, and only 3% for traditional providers.

In March 1999 the Cabinet directed that the policy on cost-sharing in government health units should be thoroughly reviewed before a national policy could be launched. In reality, district and health facilities have, under the decentralisation policy, been empowered to implement user charges. The lack of a comprehensive policy has created a heterogenic structure of charging users and several different ways of using the funds raised. Most health units use revenue from charges to meet daily running costs of health units and to supplement salaries. Several health units have over-generous and poorly targeted exemption mechanisms. In order to deal with these weaknesses, and to ensure consistency across Uganda in approaches and management practise, the Ministry of Health have prepared fee-for-service implementation guidelines and started training some districts in their use.

NGO or church-based health units have a long tradition of charging patients, and often have more sophisticated and developed fee-for-service systems. Even if NGO units often charge more than government health units, they are dependent on donations, often from overseas donors. About 50–60% can usually be recovered from user fees.

Various insurance-like and non-type-insurance schemes exist. Even if these schemes are of relatively little importance to the overall funding of health service, they show that the concept of risk-sharing (insurance) is not completely unknown. These schemes might also form important basis for development of more sophisticated insurance schemes. Examples of these schemes include contribution-based sickness funds, started by rural communities to building their own health unit and/or run their own aid post, and local health plans piloted by the Ministry of Health.

Private health insurance is offered by a limited number companies. They offer different insurance packages including, hospitalisation, out-patient and ambulance services up to certain aggregated amounts per year at considerable costs.

Many private companies and parastatal organisations offer employees and sometimes dependants medical coverage. Employees of the civil service are often provided with free medical treatment. These schemes differ in type. One employer might even have a combination of schemes to cater for different cadre of employees.

Although social health insurance does not exist in Uganda, contribution based insurance does exist. The National Social Security Fund (NSSF), based on a law of 1972 (amended in 1985) provides a lump sum on retirement or as a permanent invalidity benefit. Both employers and employees contribute to the scheme.

The new health policy states that the general policy objective is "to develop and implement a sustainable, broad-based national health financing strategy that is geared towards ensuring effectiveness, efficiency and equity in the allocation and utilisation of resources in the health sector consistent with the objectives of the National Poverty Eradication Action Plan". A draft Health Financing strategy documents has been developed to provide guiding principles for health care financing. The strategy for funding of the proposed minimum health care package will include; increased allocation of the annual health budget for the provision of the package; constant spending on at central level and referral and tertiary hospitals; and an intensified search for alternative means of financing that will promote risk-pooling, protect the poor and vulnerable groups in sustainable manners.

5.5 Human Resources

The health care system employs several cadre of health staff. Some of them are trained. The table below shows the staff situation for some categories in 1996.

Government Health Staff Situation, 1996

Category	Total number	Inhabitants per category
Doctor	964	20,000
Nurse	4,059	4,800
Midwife	2,624	7,400
Medical Assistant	644	30,300

Source: Ministry of Health, 1997.

The health care system is short of staff, particularly in rural areas. About 50% of trained staff are working in hospitals. The majority of medical officers (82%) and registered nurses (79%) work in hospitals. Many Ugandan doctors, generally known as well-educated, have moved to other countries for better remunerated jobs. Many health units, in particular rural, are staffed only by non-trained nursing aides.

There are many reasons for the mal-distribution of human resources. Poor remuneration of health workers, and weak management and planning are major causes. Trained staff have good reasons for avoiding working in rural areas, as salaries generally are lower. Urban-based health staff are more likely to be considered for re-training than rural-based.

Health workers are trained in different training institutions across the country. Makerere University Medical School is recognised both within and outside the country. The school trains both medical doctors and registered nurses. Mbarara University trains doctors and other cadre of medical staff. Different governmental paramedical schools are found in for instance Mbale, where medical assistants and health inspectors are trained. NGO (church-based) hospitals often recruit trainees locally and provide them with certificates after training. Many certificate nurses have received their training in this manner. NGOs often operate through a network of community health workers and traditional birth attendants.

Several human resource development and manpower requirement studies have been commissioned by the Ministry of Health. In recent years, the government has tried to alleviate some of the mal-distribution of human resources for instance by offering medical doctors in rural hospitals and health units higher salaries. To address the major constraints of inadequate numbers and inappropriate distribution of trained health personnel, the new health policy proposes that health centres should be staffed according to national staffing standards, which are to be developed. Furthermore, a gender-responsive National Human Resources for Health Development Plan has been proposed in order to increase training of management and clinical staff as well as improve productivity of health personnel.

5.6 Research

Health research is undertaken by a number of institutes, departments and faculties attached to Makerere University. The Ministry of Health has quite often commissioned Ugandan researchers and institutes such as the Institute of Public Health, the Child Health and Development Centre and the Makerere University of Social Research to undertake operational research. The Department of Obstetric and Gynaecology has recently participated in clinical trials regarding the development of a vaccine towards

mother-to-child transmission of HIV. Research is quite often undertaken in collaboration with overseas institutes. Regional collaboration in certain areas of research exists.

Too often research is not disseminated. However, several research institutes have organised seminars on various research topics. Officials of various ministries have been invited to such functions. Operational research commissioned by the ministry has been used for planning purposes and piloting of for instance community health insurance schemes.

All research has to be granted permission by the Uganda National Council of Science and Technology, which in collaboration with various ministries has developed a list of priority research topics. The Ministry of Health has in recent years shown particular interest in socio-economic factors affecting health and ill-health. Furthermore, the ministry has in the draft health policy committed itself to provide an effective framework for research.

5.7 Planning and Monitoring

Appropriate planning tools are required for effective management of health services to take place, both at national and district levels. Since 1993, the Ministy of Health has been developing a new Health Management Information Systems (HIMS), aimed at capturing data on inputs (human resources, funds and materials), processes (training), outputs and outcomes. The data requirements for monitoring health programmes and health status were defined in collaboration with several donors.

According to the HIMS district level data is to be collected from hospitals and lower level health units, both governmental and non-governmental. Data collected is to be compiled by the district Health Services Office before it is sent to the Health Planning Department of the Ministry of Health, which in turn consolidates the same into national reports. All units are to provide data on out-patient diagnosis for different age-groups, antenatal and postnatal attendance, and in-patient data.

It has been found that all districts do not report to the HMIS. Even within districts not all health units do report. Even if districts do report, misreporting is common. This might be attributed to the lack of feed-back to districts on the use of the HMIS, lack of transport in the districts and limited management capacity of HMIS, not only at district level, but at central level as well. It is known that there is a lack of use of the data that actually is collected. There is for example little evidence that the results of the comprehensive Burden of Disease-study of 1996 has been used in district planning for health services.

During 1999, the government has embarked on efforts to strengthen data on financial resources to the health sector. It has therefore joined a combined donor initiative on National Health Accounts. Several countries are included in this programme, which comprises seminars, workshops and training programmes, aiming at each country building a national data bank.

The Statistics Department of the Ministry of Finance, Planning and Economic Development has an overall role of compiling data on all sectors of the economy. It uses the data collected by the HIMS, household surveys and others.

Since 1993, the government has through the District Health Services project supported and built capacities in districts on planning and monitoring and evaluation of health services. District health plans including funding sources are well-developed. In addition, the government has in the draft health policy set out some strong objectives regarding policy review and formulation, planning, budgeting, accountability, monitoring and evaluation.

It is committed to strengthen the capacity of the central Ministry and the districts in planning, management and monitoring and evaluation. It will also ensure support to the HMIS and establishment of a community-based health information system. Finally, it emphasises information dissemination to other stakeholders in the health sector.

6 Strategic issues and constraints for the health sector development in uganda

Various macro-economic reforms have resulted in an accelerated growth in the economy of and a relatively low inflation rate. Uganda has been able to maintain the confidence of the donor community and has attracted private investors. The favourable economic situation has been reflected in a rising Human Development Index, although the distribution of wealth is unevenly spread. Health indicators are depicting a sad situation with high infant and maternal mortality figures, falling immunisation rates, lagging adult literacy rates and a life expectancy which is among the lowest in Africa. The malaria is the predominant cause of mortality and morbidity. HIV/AIDS situation has improved but is still worse than in most other countries. In general, Uganda compares poorly to her neighbouring countries due to the low social indicators.

Uganda has embarked on co-ordinated strategies between the key sectors to not only increase the income but to increase the well-being of the poor in the country. The aims of the Poverty Eradication Programme are reflected in the National Health Policy and the Strategic Health Sector Plan. The goal of the policy is "the attainment of a good standard of health by all people of Uganda". The strategy chosen to achieve this is Primary Health Care through the introduction of the Minimum Health Care Package and the Health Sub-districts. Several donors have also decided to support the strategic plan through a Sector-Wide Approach.

When implementing this strategy, several issues need to be considered. The major prerequisite for health development must be the resources - financial and human resources – available and the distribution of them. Since Uganda is an agricultural country based on subsistence farming, the tax base is naturally low, leaving the government with relatively low revenue. As a result there is high dependence on donor support, which raises questions regarding sustainability. In addition, health services mainly rely on private expenditure. Consequently, the health financing system must ensure equitable financing policy with exemption mechanisms covering the very poor. Government expenditure on health has remained low at between 4 to 5 per cent of total recurrent budget. Scarce governmental resource must be wisely allocated on priority areas identified in the policy and plan. As of now about 80% of the non-wage resources to the health sector are allocated to the central ministry, hospitals (national, district) and training schools (1998/99). If decentralisation is to succeed resources for PHC are needed at district level. Ensuring appropriate, as well as evenly and equitably distributed, human resources at district level is another challenge. Attracting trained staff to work in rural areas with primary health care might be done with the right incentives.

As the Health Sub-district is a further decentralisation of health services to lower levels within the districts, questions have been raised regarding the capacity of the district officials to deal with further reforms. Decentralisation has not only led to resources and decisions being dealt with locally, but also donors with different reporting requirements are met in the districts. The question of over-burdened district officials needs to be taken into account when further reforms are undertaken. The same applies for the central lev-

el Ministry of Health. If decentralisation is to be effective, the central ministry need to fully take on its role in supervision and monitoring of districts, and need to have appropriate human resources to do so. The success of the Sector-wide approach will also depend on the management capacity of the Ministry of Health.

Several strategic issues for the success of health and social development in Uganda concern the health sector as a whole. The health care delivery system comprises several types of providers. All providers must be considered in discussions regarding health sector development. The government has for instance shown interest in contracting services to NGO providers mainly church-related. However, it must be recognised that most NGOs depend on overseas support that might for different reasons be interrupted. In addition, private clinics, drug shops and laboratories are mushrooming almost everywhere in the country with a weak regulatory framework ensuring standards and patients safety. Lack of laws, regulations and guidelines for the sector as a whole may counteract efforts towards health development.

Finally, as much as financial and human resources might be allocated to the underserved northern and the western parts of the country, these areas might never benefit from them as long as insecurity remains. Internal and external conflicts might continue hampering development in several sectors in the country. Thus the major strategic issue for human development in Uganda is the security situation.

References

Barton, T. and Wamai, G. (1994), *Equity and Vulnerability: A Situation Analysis of Women, Adoloscents and Children in Uganda, 1994*. GOU/UNCC/CHDC/UNICEF: Kampala.

Hiscock, J., White, J., and LaFond, A. (1993), *Sustainability in the Health Sector – Uganda Case Study*, Save the Childrens Fund:UK.

Institute of Development Studies (1998), *Creating a Framework for Reducing Poverty: Institutional and Process Issues in National Poverty Policy. Uganda Country Report:* Sussex.

International Monetary Fund (1997), *Enhanced Structural Adjustment Facility Policy Framework Paper, 1997/98-1999/2000*: Washington, D.C.

Jitta, J. and Ndidde, A. (1998), *Access to Health and Education: The Poor In Uganda*. OXFAM: Kampala.

Local Governments (Resistance Councils) Statute, No. 15 of 1993, *Uganda Gazette, No. 55, Volume LXXXVI.*

Ministry of Finance, Planning and Economic Development, *Background to the Budget 1997/98, 1998/99 and 1999/2000*: Kampala.

———(1999), *Uganda Poverty Status Report*, Kampala.

Ministry of Gender, Labour and Community Development (1998), *Women and Men in Uganda, Facts and Figures 1998*: Kampala.

Ministry of Health (1996), *Health Service Inventory*, Health Planning Department: Entebbe.

——— (1996), *District Health Planning and Management. Using the Burden of Disease/Cost Effectiveness Analytical Approach*. Epidemiology Unit, CDC Planning Unit: Kampala.

——— (1997), *Draft Five Year Health Plan Frame 1997/98-2001/2*: Entebbe.

——— (1998), *HIV/AIDS Surveillance Report*: Entebbe.

——— *(1998),* Government Statement on the Health Sector at the Pre-CG Session of the Consultative Group *Meeting, revised version of December 17: Entebbe.*

——— (1999), *Draft Health Sector Strategic Plan*: Kampala.

——— (1999), *Draft National Health Policy*: Kampala.

——— (1999), *STI-Project Supervision Mission, Sexually and Transmitted Infections Project*: Kampala.

Sida (1995), *Health Profile Uganda.* Health Division, Dept. For Democracy and Social Development: Stockholm.

Swedish Institute of International Affairs (1995), *Uganda. Länder i fickformat*: Stockholm.

TASO (1998), *Joint External Review of The AIDS Support Organisation (TASO)*, Uganda: Kampala.

UNICEF (1999), *The State of the World's Children 1999*: New York.

World Bank (1996), *Trends in Developing Economies 1996*: Washington, D.C.

Annex 1

	Uganda	Sub-Saharan Africa	Sweden	Period
Table 1: Basic Indicators				
Under 5 mortality rate	137	170	4	1997
Infant mortality rate (under 1 year of age)	86	105	4	1997
Life expectancy at birth (years)	41	51	78	1997
Table 2: Nutrition				
% with low birth weight	13	15	5	1990–97
% of children exclusively breastfed 0–3 months	70	31		1990–98
% of children still breastfed 20–23 months	40	47		1990–98
% of children underweight, moderate & severe (under age of 5)	26	31		1990–97
Table 3: Health				
% with access to safe water (total)	46	50		1990–97
% with access to adequate sanitation (total)	57	44		1990–97
% with access to health services (total)	49*			
% of 1-year-old children immunized against DPT	58	51	99	1995–97
% of 1-year-old children immunized against measles	60	52	96	1995–97
ORT use rate (%)	49	72		1990–97
Table 4: Education				
Adult literacy rate female (%)	50	47		1995
Adult literacy rate male (%)	74	66		1995
Primary school enrolement ratio (%) female (gross)	67	67	105	1990–96
Primary school enrolement ratio (%) male (gross)	79	82	104	1990–96
% school entrants reaching grade 5, primary school	55	67	98	1990–95
Table 5: Demographic Indicators				
Total population (millions)	20,8	592,4	8,8	1997
Population under 18 years of age (millions)	11,6	306,6	2,0	1996
Population annual growth rate (%)	3,2	2,9	0,5	1990–97
Total fertility rate	7,1	5,9	1,8	1997
% of population urbanized	13	33	83	1997
Table 6: Economic Indictors				
GNP per capita (US$)	300	528	25710	1996
GNP per capita annual growth rate (%)	4,0	-0,4	-0,2	1990–96
% of government expenditure to health	2**	5	0	1990–97
ODA inflow as % of recipient GNP	12	5		1996
Dept service, % of goods & services exports	13	14		1996
Table 7: Women				
Life expectancy females as a % of males	105	106	107	1997
Enrolment females as a % of males, secondary school	60	82	102	1990–96
Contraceptive prevalence (%)	15	16	78**	1990–98
% of births attended by trained health personnel	38	37	100**	1990–97
Maternal mortality rate (number reported)	510		5	1980–97

Source: UNICEF: "The State of the World's Children 1999".

* Percentage of the Ugandans lived within five kilometers of the health units rendering both curtive and preventive health services (MoH 1993).

** Data refers to years or periods other than those specified in the column, differ from the standard definition, or refer to only part of a country.

Annex 2

	Angola	Etiopien	Kenya	Period
Table 1: Basic Indicators				
Under 5 mortality rate	292	175	87	1997
Infant mortality rate (under 1 year of age)	170	111	57	1997
Life expectancy at birth (years)	47	50	54	1997
Table 2: Nutrition				
% with low birth weight	19	16	16	1990–97
% of children exclusively breastfed 0-3 months	12	74	17	1990–98
% of children still breastfed 20-23 months	49	35	54	1990–98
% of children underweight, moderate & severe (under age of 5)	42	48	23	1990–97
Table 3: Health				
% with access to safe water (total)	31	25	53	1990–97
% with access to adequate sanitation (total)	40	19	77	1990–97
% with access to health services (total)	24***	55***	58***	1985–90
% of 1-year-old children immunized against DPT	41	63	36	1995–97
% of 1-year-old children immunized against measles	78	52	32	1995–97
ORT use rate (%)		95	76	1990–97
Table 4: Education				
Adult literacy rate female (%)	29**	25	70	1995
Adult literacy rate male (%)	56**	46	86	1995
Primary school enrolement ratio (%) female (gross)	88	24	85	1990–96
Primary school enrolement ratio (%) male (gross)	95	39	85	1990–96
% school entrants reaching grade 5, primary school	34	51	68	1990–95
Table 5: Demographic Indicators				
Total population (millions)	11,6	60,2	28,4	1997
Population under 18 years of age (millions)	6,3	31,7	14,9 **	1997
Population annual growth rate (%)	3,2	3,2	2,7	1990–97
Total fertility rate	6,7	7,0	4,9	1997
% of population urbanized	32	16	31	1997
Table 6: Economic Indictors				
GNP per capita (US$)	270	100	320	1996
GNP per capita annual growth rate (%)	-5,6	2,0	-0,5	1990–96
% of government expenditure to health	6**	5	5**	1990–97
ODA inflow as % of recipient GNP	18	14	7	1996
Dept service, % of goods & services exports	12	42	25	1996
Table 7: Women				
Life expectancy females as a % of males	107	106	108	1997
Enrolment females as a % of males, secondary school		83	85	1990–96
Contraceptive prevalence (%)	8	4	33	1990-98
% of births attended by trained health personnel	15**	14**	45	1990–97
Maternal mortality rate (number reported)			370	1980–97

Source: UNICEF: "The State of the World's Children 1999".

** Data refers to years or periods other than those specified in the column, differ from the standard definition, or refer to only part of a country.
*** Source: World Bank: "Better Health in Africa"

Annex 3

	Malawi	Zambia	Bangladesh	Period
Table 1: Basic Indicators				
Under 5 mortality rate	215	202	109	1997
Infant mortality rate (under 1 year of age)	135	112	81	1997
Life expectancy at birth (years)	41	43	58	1997
Table 2: Nutrition				
% with low birth weight	20	13	50	1990–97
% of children exclusively breastfed 0-3 months	11	27	52	1990–98
% of children still breastfed 20-23 months	68	43	90	1990–98
% of children underwight, moderate & severe (under age of 5)	30	24	56	1990–97
Table 3: Health				
% with access to safe water (total)	47	38	95	1990–97
% with access to adequate sanitation (total)	3	71	43	1990–97
% with access to health services (total)	80***	75***		1985–90
% of 1-year-old children immunized against DPT	95	70	68	1995–97
% of 1-year-old children immunized against measles	87	69	62	1995–97
ORT use rate (%)	70	57	61	1990–97
Table 4: Education				
Adult literacy rate female (%)	42	71	26	1995
Adult literacy rate male (%)	72	86	49	1995
Primary school enrolement ratio (%) female (gross)	128	86	64	1990–96
Primary school enrolement ratio (%) male (gross)	142	92	74	1990–96
% school entrants reaching grade 5, primary school	94	84	47	1990–95
Table 5: Demographic Indicators				
Total population (millions)	10,1	8,5	122,0	1997
Population under 18 years of age (millions)	5,4	4,7	57,2**	1996
Population annual growth rate (%)	1,1	2,3	1,5	1990–97
Total fertility rate	6,7	5,5	3,2	1997
% of population urbanized	14	44	20	1997
Table 6: Economic Indictors				
GNP per capita (US$)	180	360	260	1996
GNP per capita annual growth rate (%)	-0,2	-4,8	2,7	1990–96
% of government expenditure to health	7**	10	5**	1990–97
ODA inflow as % of recipient GNP	27	18	4	1996
Dept service, % of goods & services exports	14	24	10	1996
Table 7: Women				
Life expectancy females as % of males	103	105	100	1997
Enrolment females as % of males secondary school	57	62	50	1990–96
Contraceptive prevalence (%)	22	26	49	1990–98
% of births attended by trained personnel	55	47	8	1990–97
Maternal mortality rate (no repoted)	620	650	440	1980-97

Source: UNICEF: "The State of the World's Children 1999".

** Data refers to years or periods other than those specified in the column.
*** Source: World Bank: "Better Health in Africa"

Annex 4

	India	Laos	Viet Nam	Period
Table 1: Basic Indicators				
Under 5 mortality rate	108	122	43	1997
Infant mortality rate (under 1 year of age)	71	99	32	1997
Life expectancy at birth (years)	62	53	67	1997
Table 2: Nutrition				
% with low birth weight	33	18	17	1990–97
% of children exclusively breastfed 0-3 months	51	36		1990–98
% of children still breastfed 20-23 months	67	31		1990–98
% of children underwight, moderate & severe (under age of 5)	53	40	41	1990–97
Table 3: Health				
% with access to safe water (total)	81	44	43	1990–97
% with access to adequate sanitation (total)	29	18	21	1990–97
% with access to health services (total)				
% of 1-year-old children immunized against DPT	90	60	95	1995–97
% of 1-year-old chuildren immunized against measles	81	67	96	1995–97
ORT use rate (%)	67	32		1990–97
Table 4: Education				
Adult literacy rate female (%)	38	44	91	1995
Adult literacy rate male (%)	66	69	97	1995
Primary school enrolement ratio (%) female (gross)	90	91	106**	1990–96
Primary school enrolement ratio (%) male (gross)	110	123	111**	1990–96
% school entrants reaching grade 5, primary school	62	53		1990–95
Table 5: Demographic Indicators				
Total population (millions)	960,2	5,2	76,6	1997
Population under 18 years of age (millions)	385,8	2,7	32,5	1996
Population annual growth rate (%)	1,7	3,0	2,0	1990–97
Total fertility rate	3,1	6.7	3,0	1997
% of population urbanized	27	22	20	1997
Table 6: Economic Indictors				
GNP per capita (US$)	380	400	290	1996
GNP per capita annual growth rate (%)	3,8	3,9	6.2	1990–96
% of government expenditure to health	1			1990–97
ODA inflow as % of recipient GNP	1	18	4	1996
Dept service, % of goods & services exports	22	5	3	1996
Table 7: Women				
Life expectancy females as % of males	100	106	106	1997
Enrolment females as % of males secondary school	64	61	93**	1990–96
Contraceptive prevalence (%)	41	19	65	1990–98
% of births attended by trained personnel	34		85	1990–97
Maternal mortality rate (no repoted)	440	650	160	1980–97

Source: UNICEF: "The State of the World's Children 1999".

** Data refers to years or periods other than those specified in the column, differ from the standard definition, or refer to only part of a country.

Annex 5

	Guatemala	Honduras	Nicaragua	Period
Table 1: Basic Indicators				
Under 5 mortality rate	55	45	57	1997
Infant mortality rate (under 1 year of age)	43	36	42	1997
Life expectancy at birth (years)	67	70	68	1997
Table 2 : Nutrition				
% with low birth weight	15	9	9	1990–97
% of children exclusively breastfed 0–3 months	50	42	11	199098
% of children still breastfed 20–23 months	43	45	17	1990–98
% of children underwight, moderate & severe (under age of 5)	27	18	12	1990–97
Table 3: Health				
% with access to safe water (total)	77	76	62	1990–97
% with access to adequate sanitation (total)	83	74	35	1990–97
% with access to health services (total)				
% of 1-year-old children immunized against DPT	83	94	94	1995–97
% of 1-year-old children immunized against measles	74	89	94	1995–97
ORT use rate (%)	22	32	54	1990–97
Table 4: Education				
Adult literacy rate female (%)	49	73	67	1995
Adult literacy rate male (%)	63	73	65	1995
Primary school enrolement ratio (%) female (gross)	78	112	112	1990–96
Primary school enrolement ratio (%) male (gross)	90	110	109	1990–96
% school entrants reaching grade 5, primary school		60	54	1990–95
Table 5: Demographic Indicators				
Total population (millions)	11,2	6,0	4,4	1997
Population under 18 years of age (millions)	5,7	3,0	2,2	1996
Population annual growth rate (%)	2,9	2,9	2,8	1990–97
Total fertility rate	4,9	4,4	3,9	1997
% of population urbanized	40	45	63	1997
Table 6: Economic Indictors				
GNP per capita (US$)	1470	660	380	1996
GNP per capita annual growth rate (%)	0,5	1,2	-0,2	1990–96
% of government expenditure to health	11	10**	13	1990–97
ODA inflow as % of recipient GNP	1	9	56	1996
Dept service, % of goods & services exports	10	26	23	1996
Table 7: Women				
Life expectancy females as % of males	109	107	106	1997
Enrolment females as % of males secondary school	92	128	116	1990–96
Contraceptive prevalence (%)	31	50	49	1990-98
% of births attended by trained personnel	35	61	61	1990–97
Maternal mortality rate (no repoted)	190	220	160	1980–97

Source: UNICEF: "The State of the World's Children 1999".

** Data refers to years or periods other than those specified in the column, differ from the standard definition, or refer to only part of a country.

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