

**The Eastern Africa Health Policy
and Research Organization
(EA-HPRO)
IMCHA Program**

**Uganda Situational Analysis
Report**

2017

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1. Executive summary

Introduction

This document highlights information derived from a context mapping report which indicates findings relevant to the successful implementation of Maternal, New Born and Child Health (MNCH) work in Uganda.

Below are key messages which have been identified from the report.

1. MNCH research is available and has been used to inform policy and strategy development as well as reviews.
2. The process of policy making in Uganda is evidence based and goes through different committees and stages.
3. Technical working groups are important structures in influencing policy and development of strategies.

SWOT analysis summary

To summarize the country report, a SWOT analysis structure has been used to highlight the status of MNCH issues in Tanzania. This analysis tool has also been used to outline areas the HPRO and IRTs can intervene in research, advocacy and policy influence.

I. Strengths

MNCH is considered a priority agenda in Uganda. It is evidenced by the provision of MNCH issues in various policies in the country. The policies are; Health Sector Strategic Plan III, 2010/11 – 2014/15 and Reproductive Maternal New-born and Child Health Sharpened Plan for Uganda, November, 2013.

The processes of development of these policies, strategies and guidelines have continuously been informed by research and evaluations of implemented programs and activities.

There are several platforms where researchers and policy makers meet. The following are considered to be some of the key meetings: Tanzania Public Health Annual Forum, NIMR Joint Annual Scientific Conference, Joint Health Sector Review and planned stakeholders meetings.

II. Weaknesses

Maternal and child health conditions carry the highest total burden of disease with perinatal and maternal conditions accounting for 20.4% of the total disease burden in Uganda.

III. Opportunities/Action areas

In this section, I highlight the opportunities available for intervention. They have been linked to some of the five areas of work outlined under the first approach in the revised 2015 EA-HPRO strategy.

1. Evidence synthesis

The IRTs can work with NIMR to engage stakeholders as well as research consumers in identifying which areas of IMCHA program research can inform national research priorities.

2. Networking and alliance building

The IRTs can begin engaging with the existing technical working groups and meetings in the country. The HPRO can support them by working with them to refine their presentations and key messages.

3. Support for national research uptake

The HPRO will work with the IRTs to strengthen their capacity in knowledge translation, working with various policy engagement tools such as policy briefs and understanding their impact. This will enable IRTs have a strategy of engagement whenever they are involved in various policy platforms.

IV. Threats

Existing policies need to be reviewed to include new indicators gender issues.

2. Background

2.1 Demographics and Population

According to the 2014 census, the country has a population of 34.6 million people. Females comprise 51% of the population. The Total Fertility Rate reduced to 5.8 children per woman from 7 children per woman in 1995. This is because of the increase in the use of family planning methods. Uganda also experienced a rapid migration in 2014 where 7 million people are now living in urban areas from one million people in 1980. Further, the Infant mortality rate declined from 97 to 53 deaths per 1000 live births between 1995 and 2014. The under-five mortality as well declined from 162 to 80 deaths per 1000 births over the same period. The youth between 18 and 30 years constitute 23% of the population. **(Uganda Bureau of Statistics, Statistical Abstract, 2016)**

2.2 Social-economic situation

The social – economic situation of Uganda is as follows; in 2012 the international poverty lines indicated that 34.6% of Uganda's population was living on less than \$1.90 a day. **(Poverty Headcount ration, World Bank)**. Based on the national trends of poverty, it was estimated by the 2012/2013 survey that 19.7% of Ugandans are poor which translates to 6.7 million persons. The incidence of poverty remains higher in rural areas than in urban areas. The literacy rates for population aged 18 years and above by sex in the year of 2014 was 67.6% for females and 77.4% for males. Economically, Uganda is an agro based country and the agricultural sector is dominant in Uganda. Between the years of 2011 and 2015, Uganda, exported 25% traditional products and 75% non-traditional products across the world. **(Uganda Bureau of Statistics, Formal Exports by percentage value, 2010 – 2015)**

2.3 Administrative and Political structures

The country is divided into 111 districts and one city (the capital, Kampala). The districts are spread across four administrative regions of Northern, Central, Western, and Eastern. The districts are also sub divided into 181 counties and 22 municipalities, 174 town councils which are further subdivided into 1382 sub counties, 7138 parishes and 66,036 villages. (Census report 2014). Parallel with the administration are traditional kingdoms that enjoy some degree of mainly cultural autonomy.

3. Uganda's health care delivery system

3.1 Ministry of Health (MOH)

The Ministry of Health is responsible for policy analysis, formulation and dialogue strategic planning; setting standards and resource mobilization; advising other ministries, departments, and agencies on health related matters; capacity development and technical support supervision; provision of nationally coordinated services including health emergency preparedness and response, and epidemic prevention and control; coordination of health research; and monitoring and evaluation of the overall health sector performance. **(Health Sector Strategic Plan III, 2010/11 – 2014/15)**

3.2 Health Service Delivery in Uganda

The delivery of Health services in Uganda is done by both the public and private sectors with the government being the owner of most facilities. The government owns 2,242 health centers (HCs) and 59 Hospitals. The private/not for profit organizations own 613 health facilities, 46 hospitals, 269 Health centers and eight hospitals. **(Health Sector Strategic Plan III, 2010/11 – 2014/15)**

Public health services in Uganda are delivered through HC level II, HC level III, and HC level IV, General Hospitals, Regional Referral Hospitals (RRHs) and National Referral Hospitals (NRHs). The range of health services delivered varies with the level of care. In all public health facilities, curative, preventive, rehabilitative health services are free, having abolished user fees in 2001. Other players in service provision and promotion include the media, civil society organizations and community structures such as the Village Health Teams (VHTs). **(Health Sector Strategic Plan III, 2010/11 – 2014/15)**

The private sector plays an important role in the delivery of health services in Uganda covering 50% of the reported outputs. The private health system comprises of the Private Not for Profit Organizations (PNFPs), Private Health Practitioners (PHPs) and the Traditional and Complementary Medicine Practitioners (TCMPs). **(Health Sector Strategic Plan III, 2010/11 – 2014/15)**

4. Analysis of health programs

4.1 Maternal

Uganda is a signatory to global commitments that aim at accelerating progress towards reduction of child and maternity mortality. In September 2011, the Government of Uganda made a commitment towards reinforcing the obligation of the country to improve maternal, new-born and child health as well as to ensure that Reproductive Maternal, Neonatal and Child Health stay high on the agenda. These commitments cover the whole continuum of care with a special emphasis on the human resources for health component of the health system. (Reproductive Maternal New-born and Child Health Sharpened Plan for Uganda, November, 2013).

Maternal and child health conditions carry the highest total burden of disease with perinatal and maternal conditions accounting for 20.4% of the total disease burden in Uganda. The Millennium Development Goals (MDGs) indicators show that 57.4% births were attended by skilled health personnel in a bid to reduce by three quarters between 1990 and 2015, the mortality ratio which is a step towards achieving Goal 5 of the MDGs: Improving Maternal Health.

The issue of adolescent fertility is important on both health and social grounds. Children born to very young mothers are at increased risk of sickness and death. Teenage mothers are more likely to experience serious pregnancy complications and are more constrained in their ability to pursue educational opportunities than young women who delay childbearing. The Uganda Demographic and Health Survey, 2016, indicates that 25% of adolescents of age 15 – 19 in Uganda have begun child bearing; 19% of women age 15-19 have given birth. Adolescent childbearing is more rampant in rural areas than in urban areas.

A new policy on Maternal, Neonatal Health services was developed and approved in 2016. However, the policy is yet to be disseminated by the Ministry of Health.

Uganda's policy making process

The process of policy making in Uganda is evidence based and goes through different committees and stages. The Research evidence is usually presented to the stakeholders in consultative meeting

and it is taken to the National Technical Working Group (TWG). In this case we have the National Maternal, Neonatal Child Health Cluster. The TWG presents the Policy issue to the Senior Management Committee to synthesise it before it is presented to the Health Policy Advisory Committee (HPAC) and the final decision for Policy Development or Policy Review is done at the Top Management Committee.

4.2 Neo natal and Child Health

The progress of the MDG 4: Reduce Child Mortality by two thirds in Uganda is displayed by the under-five mortality rate. The number of under five deaths fell from 167 per 1000 births in 1990 to 90 in 2011 - equivalent to a 6.3% reduction per year.

Child mortality is not evenly distributed across the country. The chances of survival for Ugandan depend on where the baby's family lives; how wealthy they are and the education level attained by the mother. For example, only 15 districts account for 36% of child deaths in the country. The highest mortality rate is reported in Karamoja, Southwest, West Nile, and the western regions which record dismal progress in the above listed indicators. It was also noted that education is critical for reducing the incidence of diarrhea.

The neo natal and child health profile in the World Health Organization data indicates that in 2013, 34% of the babies in Uganda between the ages of 0 – 28 days died. The deaths were caused by are premature birth; asphyxia and birth trauma; sepsis and other infectious conditions; congenital abnormalities; pneumonia; tetanus; and injuries. Another 66% of the babies in the age bracket of 1 – 59 months also died. The causes of these deaths were identified as pneumonia, malaria, diarrheal diseases, HIV/AIDs, injuries, non-communicable diseases; pertussis and measles. **(World Health Organization)¹**

4.3 Expanded Program on Immunization

Vaccination is a tool used to prevent a number of diseases from occurring to the mothers and children at birth and even after. Vaccination of children is universal and it is against six common vaccines for preventable diseases: tuberculosis, diphtheria, whooping cough (pertussis), tetanus, olio, and measles. This vaccination is crucial to reducing infant and child mortality. The vaccine given in Uganda against Diphtheria, Whooping Cough, and Tetanus (DPT) also protects against hepatitis B and Haemophilus Influenza Type B (Hib) and is called the DPT-HepB- Hib or pentavalent vaccine. In 2011 the Government of Uganda introduced the pneumococcal conjugate vaccine (PCV) into the national infant immunization programme. This vaccine protects against streptococcus pneumonia bacteria, which cause severe pneumonia, meningitis, and other illnesses.

Tetanus toxoid injections are given during pregnancy to prevent neo natal tetanus, a major cause of early infant death in many developing countries caused by failure to observe hygienic procedures during delivery. In Uganda 81% of women received sufficient doses of tetanus toxoid to protect their last birth against neonatal tetanus. The regional data shows some variations as to the percentage of women who received the vaccine; 71% of the women in Bunyoro received the vaccine while 94% of the women in West Nile region received the vaccine. **(Demographic and Health Survey, 2016)**

4.4 Antenatal Care

Antenatal Care (ANC) from a skilled provider is very important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, delivery, and the post-natal

¹ >www.who.int/maternal_child_adolescent/epidemiology/profiles/maternal/uga.pdf?ua=1<

period (within 42 days after delivery). The 2016 UDHS results show that 97% of women who gave birth in the five years preceding the survey received ANC from a skilled provider at least once for their last birth. Six of every ten women had four or more ANC visits an equivalent of (60%). Further, 98% of these women were from urban areas and 97% from rural areas. There was therefore a slight difference between the proportions of women that received ANC services from a skilled provider by residence. 65% of women in urban areas have had four or more ANC visits and 58% for women in rural areas. Bunyoro and Bugisu sub regions have the lowest percentage of women who have had four or more ANC visits (45% and 47% respectively). ANC visits increase amongst educated women, and with household wealth. **(Demographic and Health Survey, 2016)**

4.5 Family Planning

Contraceptive methods are classified in two categories: modern or traditional. Modern methods include female sterilisation, male sterilisation, the pill, the intrauterine contraceptive device (IUD), implants, injectable, male condoms, female condoms, emergency contraception, standard day's method (SDM) and lactation amenorrhea method (LAM). Methods such as rhythm, withdrawal, and folk methods are grouped as traditional.

The proportion of women who want to stop childbearing or who want to space their next birth is a basic measure on the need for family planning. Overall 39% of married women use contraceptives. The contraceptive prevalence rate (CPR) among women generally increases with age, peaking at 40-45 years – 47% before declining to 29% among women between 45-49 years. The educated familiarize easily with these compared to the uneducated. Among the unmarried women, 51% are currently using these. **(Demographic Health Survey, 2016)**

4.6 Essential/ Basic Equipment and supplies

In 2007, The Ministry of Health, in collaboration with Uganda Bureau of Statistics released its Service Provision Assessment Survey (USPAS), which contained collected data from a respective sample of 491 health facilities throughout Uganda. The survey addressed overall facility infrastructure and resources as well as services for child health; family planning; maternal health; and specific infectious diseases.

In support of ANC services, the survey indicated that the items that support quality counseling (Visual Aids, ANC guidelines and individual client cards) are not available in most facilities offering. These essential supplies; iron tablets, folic acid tablets; mebendazole tablets; sulfadoxine-pyrimethamine (SP); rapid plasma regain (RPR) kits; multistix for urine protein testing; TT vaccines; blood pressure machine and foetoscope are only available in one third of health facilities offering ANC services in the country. The USPA assessed the availability of five of these items: a blood pressure machine, a foetoscope, iron tablets, folic acid tablets, and TT vaccines, and it was found out that each individual item is available in between 59% and 88% of ANC facilities. **(Demographic Health Survey, 2016)**

4.7 Malaria

Malaria is one of the causes of morbidity and mortality of children and mothers. Almost all people in Uganda are at a risk of being infected with malaria but the most vulnerable groups are children under five years, pregnant women, people living with HIV/ AIDs, and travelers from areas where malaria is low or non-existent. Malaria is also attributed to the cause of anemia in children and women.

The 2016 UDHS conducted malaria testing among children age six to 59 months living in both rural and urban areas using a rapid diagnostic test (RDT), and it was detected that from the 97% of the eligible children tested, 35% of the children from rural areas tested positive compared to 12% of the children from urban areas. This means that children in rural areas are almost three times likely to

test positive than urban children. Substantial regional variations exist with malaria prevalence in children the lowest is in Kampala (1%) and the highest in Karamoja sub region (70%). Malaria prevalence declines as wealth increases, from 52% of children in the lowest wealth quintile to 5% of children in the highest wealth quintile.

Malaria in Pregnancy: in areas of high malaria transmission, by the time an individual reaches adulthood, she or he has acquired immunity that protects against the disease. However, pregnant women especially those pregnant for the first time frequently regain their susceptibility to malaria. Malaria during pregnancy can interfere with the maternal fetal exchange that occurs at the placenta, leading to the delivery of low birth weight infants. In 2016, the Uganda Demographic Health Survey, indicated that 77% of the women with a live birth in the two years preceding the survey, had malaria and had to take SP/Fansida to treat it.

4.8 Water and Sanitation

Poor sanitation and hygiene is a cross cutting health concern in rural areas. It leads to diarrheal diseases, which are responsible for 17% of all deaths of children under the age of five. Poor personal and household hygiene can lead to trachoma, increased rate of infections and a number of other diseases. **(Uganda Village Project, "Healthy Villages Program Hygiene and Sanitation Report," 2009 - 2010)**

Poor sanitation coupled with unsafe water sources has contributed significantly to the disease burden in Uganda. More than two out of five maternal deaths occur within 24 hours of birth from causes related to hemorrhage and puerperal sepsis, and many surviving mothers probably suffer longer-term effects. Sepsis (bacterial infection in the bloodstream or body tissues) is mainly caused by unhygienic practices and poor infection control in labor and delivery.

Clean hands are essential to promote safe and healthy deliveries. Hand washing reduces exposure of the mother and newborn babies to pathogens and thus helps reduce mortality. However, WASH is not well addressed at Ministry of Health, under Maternal Neonatal and Child Health services most of the policies address other components of MNCH but rarely include WASH as a component. In most cases it is recorded as an environmental issue or as a primary health care issue.

5. Health System Strengthening

5.1 Human resources

Uganda, like many developing countries is experiencing a serious human resources crisis in the health sector. HRHs are in short supply, both in numbers and in skills mix, to effectively respond to the health needs in Uganda. Nearly half of the established positions are vacant and the situation is worse in rural areas. Health workers are also unevenly distributed between the public and private sectors. The HIV/AIDS epidemic presents additional demand on the HRs because of the special skills required for HIV/AIDS prevention and treatment and the health workers themselves being affected by the disease. The present number of health staff (doctors, nurses, midwives) available in the country, including PNFP sector, amount to 59,000 with a ratio of 1 to 1818 people. This far below the recommended WHO minimum standard, which considers countries with less than 1 doctor, nurses or midwife per 439 people, in critical shortage of health workers. It is estimated that 22% of these categories of health workers in the health sector is currently contracted by the PNFP sector and 21% by the private sector. Overall almost 40% of the HRH are working for the private sector, and there is no clear policy and guidelines to coordinate and optimize their use.

In government, productivity is low due to high rates of absenteeism. A recent study of the Ministry of Health, Ministry of Finance and Economic Development and the World Bank estimates the cost of absenteeism at 26 billion Ugandan shillings annually. It is the largest waste factor in the public health sector in the country. The poor attitude of health workers to patients affects utilization of services. Health workers always do not feel accountable to clients. Leadership and management of human resources are also weak at all levels.

5.2 Human Resource and Data Management

Ministry of Health, development partners and stakeholders use the Health Management Information system (HMIS) as an integrated reporting system to collect relevant and functional information on a routine basis to monitor the health sector strategic plan (HSSP) indicators to enable planning, decision making and monitoring and evaluation of the health care delivery system. It is designed to assist managers carry out evidence based decision making at all levels of the health care delivery. At the health unit level, HMIS is used by the health unit-in charge and the health unit management committee to plan and coordinate health care services in their catchment area.

HMIS form 103 provides for staff listing, a list of all staff which is supposed to be updated every six months under the responsibility of the health facility in charge which is sometimes not used due to unqualified staff hired to do some work that unavailable required people would have done. In 2012, Uganda launched the National Human Resources for Health Information System which provides up-to-date information on the country's health workforce for evidence –based decision making. The system provides the information needed to develop and monitor strategies for health workforce issues ranging from absenteeism to credential verification to geographical or training gaps.

5.3 Shortage of drugs

Over the years, health service delivery has been affected by a number of challenges including non-availability or stock outs of medical supplies in public health facilities. In FY 2009/2020 only 21% of the health facilities reported no stock outs of tracer medicines in the previous six months. Tracer medicines include anti malaria drugs, Contrimoxazole, measles vaccines, sulphadoxine/pyramethamine, depoprovera and oral rehydration salts (ORS). Although the number increased to 57% in the FY 2013/14 as reported by the Annual Health Sector Performance Report (AHSPR, 2013/2014), the problem is still big. Patients in Public health facilities continue to die of preventable diseases due to medical stock-outs. The Budget Monitoring and Accountability Unit (BMAU) reports have continually highlighted the issue of stock outs at various levels. **(Ministry of Finance, Planning and Economic Development, "Budget Monitoring and Accountability Unit, Briefing paper 15/15)**

5.4 Health Infrastructure

Health infrastructure comprises buildings – both medical and non-medical; equipment – medical equipment, furniture, and hospital plant; Communications (ICT equipment); and ambulatory systems (ambulances, cars, pickups, vans and trucks as required for healthcare delivery at different levels). While new facilities are being constructed and equipped during the implementation of the HSDP priority will be given to consolidation of existing facilities, to provide facilities for them to function effectively (staff housing, water, and energy, theatres, equipment and stores) and required ICT and related infrastructure. The consolidation of facilities will also include the upgrading of facilities to higher level facilities specifically the sector will aim at functionalizing HC IIIs in all sub-counties and piloting the establishment of community hospitals. In addition, the sector will build capacity and mobilize resources for operation and maintenance of medical equipment and infrastructure. In the financial year 2014/2015 construction of nine hospitals which include regional referral hospital in Moroto; general hospitals: Mityana, Nakaseke, Kiryandongo, Nebbi, Anaka, Moyo, Entebbe, and

Iganga. (Ministry of Health, Health Infrastructure, Online (>health.go.ug/clinical-services-departments/health-infrastructure<))

In conclusion, Uganda's health service delivery is still facing a number of challenges which range from shortage of human resources for health to shortage on MNCH commodities, supplies and equipment. In addition, the high mortality rate of mothers and children is attributed to many causes including a lack of an integrated system conjoining nutrition, sanitation, HIV, Water and other programs. The existing policies also need to be reviewed to provide for new systems integrated in to MNCH such as the new gender indicators to be added in to the HMIS system. Lastly, the working relations between MNCH services and the CHEWs should be well explained in the policies.