

Forum for Women in Democracy

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UGANDA HEALTH SECTOR GENDER BUDGET ANALYSIS 2001/2002

What is the health situation in Uganda?

According to the Uganda Demographic and Health Surveys (UDHS) by Macro International and Uganda Bureau of Statistics (UBOS) conducted in 1989, 1995 and 2000 respectively the trends in the health situation of Uganda population generally indicate an improvement in health indicators between 1989 and 1995. But between 1995 and 2000, the same indicators had stagnated or declined. See Table 1. What is paradoxical, is that this decline is occurring in the era of economic growth, poverty reduction and health sector reforms.

Most of the health indicators especially in the rural areas where the funds are channeled have either stagnated or declined outright since implementation of the Health Sector Strategic Plan (HSSP) started three years ago, poverty reduction interventions and other health sector reforms.

In other words, the HSSP priority interventions are not equitably utilized i.e. those people with acute health needs (mostly women, children and the poor), have not increased consumption of the health services. Worthwhile noting is the steady decline in the proportion of mothers delivering in public and PNFP health facilities.

These poor health outcomes are a problem that extends throughout Ugandan society, and the major challenge is not only to extend basic healthcare services to the entire population, but also to address the disparities in health status between better off and the most vulnerable segments of the population (women and children). This constitutes the main objective of the National Health Policy (NHP) and the HSSP.

Performance of the Health Sector

To assess the performance of the health sector, reference will be made to the HSSP, which defines a minimum healthcare package and a healthcare delivery mechanism for reducing ill health in the country.

Table 1 Key Health indicators, Uganda 1998-2000

	1989	1995	2000	GoUTarget
Infant Mortality	119	97	101	68 (2005)
Under five Mortality	180	147	151.5	103 (2005)
Infant Immunisation Rate	31%	47%	38%	-
Maternal Mortality	523	506	496	354 (2000)
Births supervised by skilled Health workers	38%	38%	38%	50% (2000)

Source: GoU targets): UNDP (2000), MFPED (2001 a)



Five indicators will be used viz OPD attendance, immunization, proportion of approved posts filled with trained staff, deliveries in health units and HIV/AIDS prevalence.

The results indicate improvements in OPD attendance and (immunization), even beyond the revised Poverty Eradication Action Plan (PEAP) targets.

The number of health workers recruited since 1990/00 stands at 2,786, and by December 2002, 4349 Nursing Aides (65% of all Nursing Aides in the country) had been trained and upgraded to nursing assistants. The objective is to improve quality of services at a lower level units (LLUs). Gender disaggregated data on staff establishment and new recruitment is not available.

Health Services Utilization

The UDHS (2000/01) findings indicate disparities in utilization of health services, with rich, urban and more educated people more likely to use health services than the poor less educated rural residents. This trend was attributed to better economic and physical access to services among the former but also to attitudes influenced by religion, culture and limited understanding of disease causation among the latter.

Cost of services was cited as the most common barrier in recent studies before abolition of user fees. This has to some extent been supported by increased utilization since abolition of user fees in government health units and reduction of fees in NGO units. Such patterns are however more evident in public (LLUs).



Quality of Services

Analysis of post user fees abolition utilization patterns show that removal or reduction of access barriers (e.g. user fees) greatly affects quality of services. The offering of free OPD services has led not only to acute drug shortages and other medical supplies in health units. This scarcity of drugs is reported as the cause of severe morbidity, especially among the poor and vulnerable who cannot afford to purchase drugs from private outlets. Such outcomes to a well-meaning policy are justifiably viewed as unacceptable and urgent need has been expressed to address the issues of quality of services provided.

Other important factors seen as hampering access to and use of health facilities include:

- Inadequacy of health workers, a problem aggravated by lack of staff housing. The few available staff travel long distances between home and health facilities. They report for work late and leave early. This leaves many health units with no staff at night and weekends.
- Gender issues at household level, especially women's lack of control over cash which limits their consumption of health services especially those requiring cash payments. This problem is mainly faced by the poor, cash strapped and time constrained women.
- Negative media campaigns which have undermined some services like immunization.
- Lack of specialized facilities for people with disabilities

Table 2: Achievements of the HIV/AIDS Programme

	2000/01	2001/02
HIV sero prevalence (National Average)	6.1%	6.5%
Knowledge on preventive practices	85%	90%
PMCT Centres	12	24
VCT Centres		
Centres providing ARVs	6	20

Source: Uganda Health Bulletin Vol. 9 No. 1 Jan – March 2003

HIV/AIDS

The HIV/AIDS surveillance Report of Ministry of Health MoH of June 2002 shows that a total of 1,050,555 people lived with HIV/AIDS in Uganda, (51% women; 39% men and 10% children below 15 years). The overall male: female ratio among HIV infected persons is approximately 1:1.2. For girls aged 15-19 years, the rate is as high as 1:6. This means that girls in this age cohort are six times more prone to HIV-infection than their male counterparts. HIV infection prevalence rates from ante-natal sentinel surveillance sites that have been declining over the last decade have stabilized. The overall ante-natal prevalence rate in 2001 was 6.5% compared with 6.1 % in 2000.

Knowledge on preventive practices has also risen from 85% to 90% in the 1st and 2nd HSSP years respectively. Condom use and age at first sexual intercourse are both rising. There is progressive improvement in accessibility to services like PMCT, voluntary counselling and testing (VCT) and antiretrovirals (ARV) (see table 2). Most Health Centres are equipped to manage STIs and common opportunistic infections. Patient follow-up is assured at the district hospitals.

The current status of HIV/AIDS in the country shows that the prevalence rates, though declining or stabilizing, are still unacceptably high. Females, urban residents and those aged below 35 years are the most affected. The epidemic still poses a severe health burden, a potential security concern, and a grave development crisis (UHDR 2002).

The major constraint is that the strategy to increase the availability of ARVs is constrained by the budget. Due to the high cost of the drugs only a very limited number of people are accessing these drugs. Now the costs for treatment of one patient per month range from US\$214 to US\$740. In addition there is no national policy or guideline on antiretroviral treatment (ART).

Health Staffing

Staffing levels are still insufficient. The population per doctor and nurse is 18,000 and 4,000 respectively. Overall, (74%) of the top decision makers are men, compared to (26%) women. There are more females at the lower nursing assistants levels.

What does the health policy say?

The 2001 President Museveni Election Manifesto, the National Health Policy NHP 1999 and the HSSP 2000/01 provide the guiding principles of the health sector development in Uganda up to FY 2004/05. As in all government sectors, gender-blind planning has been the norm in the health sector. Women and gender issues are occasionally mentioned in the documents with no specific or concrete measures proposed.

Though the policy framework for 2001/02 focuses on further decentralization and spells out technical programme priorities for the fiscal year i.e. malaria, immunization, education – information – communication (IEC), HIV/AIDS, sexual and reproductive health rights and establishment of a stronger public health care presence at the community level, it is evident that it (the framework) does not explore the immediate underlying and structural factors which cause health problems, and their different effects on the specific categories of people including women.

In the policy statement, there is no reference or clear recognition of distinctions between the sexes or vulnerable groups. This is contrary to the issues of equity emphasized in the PEAP and the HSSP. The health policy statement is thus prone to incorporating biases in favour of existing gender relations. The policy statement does not recognize that in striving to access resources in the health system, women and men as a result of having differing and often conflicting needs, interests and priorities, are constrained in different ways. This may result in women not benefiting even from those interventions specifically meant for them.

Among the technical programme priorities in the 2001/02 health policy statement, is sexual and reproductive health rights. From a gender perspective this is positive since provision of reproductive health services, offering women choice over child bearing, is one of the interventions, which address women's practical gender needs. Such interventions should target both men and women or only one group and aim to address women's practical and strategic gender interests, in ways that have transformatory potential. The interventions should create supportive conditions for women to empower themselves and have greater access to resources in the health system.

This calls for clear multisectoral policy planning aimed at addressing the interplay between women's specific reproductive health needs and socio-cultural needs. Focusing on the health sector alone appears the case, is clearly detrimental to women i.e. can not meet their specific health needs.

The way forward thus is to move towards a gender aware health policy which recognizes men and women respectively as equally important actors, constrained in different and often unequal ways in access to and utilization of health services. Policy interventions should put into consideration men and women's often conflicting needs, interests and priorities.

Recommendations for the Health Sector

The Health Sector Strategic Plan (HSSP) launched three years ago with the aim of developing the health sector through delivery of the minimum healthcare package intended to provide primary health care to many vulnerable people especially women in the rural areas, is yet to realize its objectives. This is so in spite of increased funding and improved performance of the health sector budget. The health and well being of the poor and vulnerable especially women and children is thus still at stake as reflected by the persistently high burden of communicable and other diseases, and the subsequent stagnating or declining health indicators. To address this situation, the following are thus recommended: -

- Policy statements should be developed taking into account gender needs, problem and context of women and men as they affect accessibility, utilization and planning for health services.
- The instrument of interest should be the MTEF, which focuses on mainstream macro-economic assumptions and targets, and in the process fails to recognize the different roles and needs of women and men as they strive to access resources in the health system. Including gender concerns in the MTEF has capacity to offer opportunities for addressing prevalent gender inequalities/inequities in access to and utilization of health services especially in the rural areas.
- The gender specific content of HSSP and related Health Policy statement should be assessed to establish or ensure more effective gender orientation of these policies/plans in future. This calls for generation of sex disaggregated data/information as an initial step.
- There is urgent need for raising gender awareness, demystifying the budget and building up initial budget literacy as well as advocacy skills among various cadres of health sector staff, politicians, and other stakeholders. This calls for frequent organization of workshops, training and short presentations on gender budget initiatives targeting all stakeholders, even in the rural areas.
- Since the targets and indicators are well spelt out in the HSSP, ways should be devised to evaluate the gendered impact of the policies and estimate the required financial resources to implement the priority interventions within a given time framework.

Urgent measures (not excluding affirmative action) should be taken to address the poor representation of women in positions of decision-making in the health sector.

Health gender budget analysis

Sectoral Allocations of the National Budget FY 2000/01 – 2002/03 show that the Health Budget although small compared to sectors like Security, Public Administration, Education, and Roads and Works, has been rising steadily over the years from 7.6% of total budgetary allocation in FY 2000/01 to 8.9% in FY 2001/02 and a projected 9.6% in FY 2002/03. The growth over the period is 71.6%. Unfortunately this is not at sufficient rates to meet the HSSP requirements.

For example, if the 2002/03 Health Sector Share of 9.6% is maintained, and if growth is also maintained at rates envisaged in the current MTEF, it will take 36 years to attain the agreed target of 15%!

A summary of the 2001/02 MoH Budget as shown in the Medium Term Expenditure Framework, is shown in table 3 which shows the various priority areas that are competing for scarce financial resources. Optimal allocations of funds have to be decided between central programmes, the districts, hospitals and health centers, government units and private not for profit (PNFP) providers, and wage, non-wage and development budgets. In addition careful allocation has to be made to the different central programmes e.g. malaria control, drugs, human resources and services provided at HC IVs and HC IIIs.

Performance of the Health Sector Budget

In order to make a critical analysis of primary health care (PHC) delivery, medical staff within Kiboga District (120 km away from Kampala), one of the areas where PHC is implemented were interviewed. The data gathered provided insight on the performance of PHC programmes, budgetary allocations and the impact to its targeted beneficiaries.

Table 3: Summary of the 2001/02 MoH Budget

All amounts in Billions of shillings 2001/2002							
Vote	Budget Heading	Government of Uganda (GoU)			Donor projects	GoU	Resource Envelope
		Wage	Non-wage	Development			
14	Ministry of Health	3.50	29.64	10.23	122.72	43.37	166.09
19	Butabika Hospital	1.00	1.51	1.12	16.92	3.63	20.55
23	Mulago Hospital	7.76	9.64	2.09	4.44	19.49	23.93
32	Health Service Comm.	0.35	0.69	0.04		1.08	1.08
301	Uganda AIDS Comm	0.52	0.63	1.08		2.23	2.23
50	NGO Health Units		11.59		11.59	11.59	
50	Primary Health Care	35.04	14.87	10.98		60.89	60.89
50	General Hospitals		8.87			8.87	8.87
50	Referral Hospitals	13.20	5.42			18.62	18.62
	TOTAL	61.37	82.86	25.54	144.08	169.77	313.85

Source: Compiled from MTEF 2001 – 2002



The research showed that core PHC activities are under budgeted for. The bulk of the PHC funds are for development programs (construction commitments) where Shs. 350,000,000 million was budgeted for and 315,100,268 (90%) spent. Health centers were contracted but four of them are not operational due to lack of staffing and absence of basic equipment.

Only 2,940,300 (43% spent) was budgeted for service delivery activities which included environment health, oral health, health education and promotion, TB and Leprosy control. The report also reflects that 8,149,448 were returned to the center while some vital PHC activities received no funding at all. These facts show that the objective of taking services closer to the people is yet to be achieved.

The constraints faced in implementing PHC in the district cited from the District Health Performance Report of August 2002 include: insufficient funds to deliver minimum health care package for every one in the district; shortage of health workers; poor morale; and poor relationships between health workers and the community.

Donor Funding

The MoH budget has also received substantial donor support. Most donor funding goes direct to support the delivery of healthcare at the district level. The Kiboga case study has shown that many programs have halted with the closure of some donor funded programmes.

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