THE REPUBLIC OF UGANDA

Millennium Development Goals Report for Uganda 2010

Special theme: Accelerating progress towards improving maternal health

MINISTRY OF FINANCE, PLANNING AND ECONOMIC DEVELOPMENT
SEPTEMBER 2010

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FOREWORD

This 2010 Millennium Development Goals (MDGs) progress report for Uganda comes at a critical time. The country has just launched its first National Development Plan (NDP) and the whole world is assessing progress towards the Millennium Declaration in the last five years before the 2015 deadline. As the report shows, there is good reason to celebrate the many achievements of the Ugandan government and people in recent years. Moreover, with peace in the country and the region, and the prospects afforded by newfound oil wealth, there is good reason to believe that prosperity for all is within reach. But, as the report shows, there is also cause for concern. For several MDGs, the progress has been too slow to meet the national and international targets—and, for some, there has been outright reversal. In some cases, improvements in national averages mask inequalities in progress, e.g., among the various regions of the country. We also know that the challenge of meeting the MDGs will be further compounded by the longer-term risks of climate change.

One of the key goals where there has been insufficient progress is MDG 5: Improve maternal health. However, the MDG Acceleration Framework that has been applied to MDG 5 in this report clearly spells out a series of practical solutions that, if implemented, could significantly spur progress. I hope that the report's recommendation that this analysis be followed by a joint action plan is taken forward urgently. The MDG Acceleration Framework could also be extended to other MDGs to sustain and accelerate progress and could be considered more widely in the context of the goals and targets of the NDP. The renewed emphasis in the NDP on infrastructure development is critical for economic growth and employment creation, and improved infrastructure is also crucial for the attainment of the MDGs. Investments in infrastructure and in MDGs need to go hand in hand.

Finally, I want to take this opportunity to thank all those involved in preparing this report on the side of the Government of Uganda and among my colleagues at the UN agencies, funds and programmes serving Uganda, as well as development practitioners, researchers and other stakeholders. It is my hope that the report will galvanise action and help ensure that the benefits of the development process in Uganda are shared more equally and that concerted action is taken to accelerate progress towards the MDGs as we move towards 2015 and beyond.

Theophane Nikyema
United Nations Resident Coordinator

PREFACE

The process of managing national development relies heavily on a country's ability and commitment to monitor changes in its development while using appropriate indicators. This principle is probably best captured by the old management adage, "You cannot manage what you do not measure." As a signatory to the Millennium Declaration and chief steward of the public resources of Ugandans, Government takes serious its responsibility of keeping Ugandans and other stakeholders informed of the development changes transpiring in the country as a result of its management actions. The MDG Country Report is one of the many instruments through which Government honours this responsibility.

This MDG Country report is the third in a series, the first and second having been prepared in 2005 and 2007, respectively. It is a product of a detailed consultative process involving different entities of Government and the United Nations fraternity in Uganda.

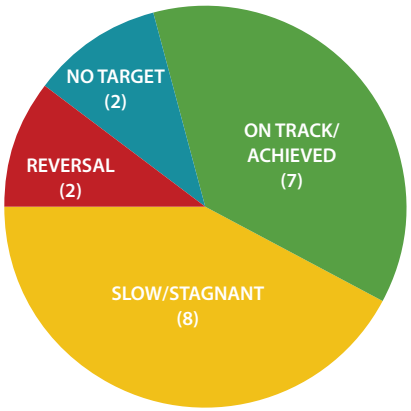
A unique feature of this report is its focus on MDG 5: Improving maternal health. The facts and figures on maternal health contained in this report highlight the challenges that our country still faces in improving the lives of women, especially during pregnancy and at childbirth. The government will continue to put in place the necessary programs and measures to ensure that maternal health services and reproductive health performance in general progressively improve.

I wish to recognize the dedicated effort of the different Government officials who prepared this report. Special recognition also goes to the UNDP Country Office in Uganda for its active and strategic role in collating the contributions of the different UN agencies, funds and programmes. I dedicate this report to the mothers of Uganda in recognition of the personal sacrifice and risk they undergo in carrying and giving birth to the people who make up the nation of Uganda that we are all proud of.

Hon. Syda N. M. Bbumba (MP)
Minister for Finance, Planning and Economic Development

STATUS AT A GLANCE: UGANDA'S PROGRESS TOWARDS THE MDGs

Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	ON TRACK
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	NO TARGET
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	ON TRACK
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	SLOW
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	ON TRACK
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	SLOW
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	SLOW
Target 5.B: Achieve, by 2015, universal access to reproductive health	SLOW
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	REVERSAL
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	ON TRACK
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	SLOW
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	SLOW
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	SLOW
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	ON TRACK
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	NO TARGET
Goal 8: Develop a global partnership for development	
Target 8.B: Address the special needs of the least developed countries	REVERSAL
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	ACHIEVED
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	STAGNANT
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	ON TRACK



EXECUTIVE SUMMARY

MDG progress and challenges

This third progress report on the Millennium Development Goals (MDGs) for Uganda shows that the country has made important progress towards many of the MDG targets. Progress has been particularly strong in reducing the share of the population that lives in poverty, and Uganda is on track to meet the MDG target of halving poverty by 2015. There has also been significant progress towards reducing the share of the population suffering from hunger. Moreover, the report shows that progress has been made in terms of gender equality and empowerment of women. The target of gender parity between boys and girls in primary education has been achieved, and the country is on track to meet the targets for access to HIV/AIDS treatment and access to safe water. There has also been progress in areas related to the global partnership for development, notably in ensuring debt relief and sustainability, as well as expanding access to information and communication technology.

In other areas however, the Government acknowledges that progress has been too slow to meet the MDGs and, in a few cases, there have been critical challenges. While access to primary education has improved especially after the introduction of universal primary education, the rates of completion of a full course of primary education have stagnated in recent years. Moreover, several of the health targets, including those related to child and maternal mortality, access to reproductive health, and the incidence of malaria and other diseases, have also progressed slowly. The same is true of environmental management and bio-diversity loss. In the area of HIV/AIDS, the data used for this report reveals significant challenges in sustaining past gains, including an increase in new infections. Population growth is adding to the absolute numbers of new infections, as is transmission of HIV between older age groups, especially those that are married/cohabitating. A dwindling of flows of overseas development assistance to Uganda is expected to continue as donors turn to fiscal tightening in the wake of the global economic and financial crisis.

The analysis presented in the report also shows that, even if there has been overall progress towards many of the MDGs, there is unevenness in how the benefits are being shared. Levels of poverty are more than twice as high in rural areas than in urban areas, and poverty levels remain higher—and have fallen less rapidly—in the northern and eastern regions of the country. Moreover, the level of inequality in Uganda has increased compared to the early 1990s. This suggests that the quality of economic growth needs to be improved in order to have a strong downward influence on poverty and to ensure that growth is inclusive. Health indicators, such as those related to child mortality, maternal mortality and malaria, also show distinct geographical patterns, with the rural least-serviced areas suffering most. Moreover, the numbers on HIV prevalence show that young women are particularly vulnerable: they are more likely to contract HIV, less likely to engage in safe sex, and have less comprehensive correct knowledge about HIV than their male counterparts.

The Government acknowledges that special efforts are needed if the MDGs are to be met not just in terms of national averages, but also in terms of real progress for all Ugandans.

Accelerating progress towards MDG 5: Improving maternal health

Every day, an estimated 16 women die from giving birth in Uganda. On average, that is one death every hour and a half and nearly 6,000 every year. Indeed, MDG 5 (Improving maternal health) is one of the key goals where progress has been too slow. Therefore, maternal health is afforded a special section in this report, which is guided by a new analytical process, the MDG Acceleration Framework (MAF). The MAF facilitates prioritization of key interventions necessary for delivering effective maternal health services. The Framework also assists in the identification of bottlenecks that impede implementation of these interventions and solutions to break open these bottlenecks and sustain or accelerate impact on the ground.

The Government has prioritized four key interventions in the area of maternal health:

1) Emergency obstetric care which addresses the major direct causes of maternal death. These are haemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour. These major causes are responsible for about 80% of maternal deaths.

2) Skilled attendance at birth helps to detect and manage complications. It also ensures appropriate referral for the further management of these complications.

3) Family planning prevents unintended pregnancies and enables women to have pregnancies neither too early, too late nor too frequently. Family planning can also promote Uganda's economic growth by reducing the economic dependency ratio and increasing the per capita private consumption value.

4) Effective antenatal care can prevent, detect, and treat problems such as malaria, anaemia, HIV/AIDS and other infections, which frequently are indirect causes of maternal deaths.

However, bottlenecks in the financing, delivery and utilisation of maternal health services impede the effective implementation of these interventions. In financing, there are pressures to increase resources for health, which also calls for sufficient prioritization of key interventions; inadequate public accountability, and incomplete harmonization and alignment of development partners' funds and programs with government priorities further aggravate this. In the delivery of services, the infrastructure and equipment for the supply of maternal health services still needs further improvement. For instance, only 5% of facilities have a vacuum extractor for assisted vaginal delivery. Insufficient supplies and commodities, as well as limitations in transport and communication for referral, are also key bottlenecks in the supply of maternal health services. In utilisation, there is high unmet need for, yet low use of the four above-mentioned priority interventions. Physical access, especially transportation for skilled attendance and emergency obstetric care, is a particular constraint here. Other bottlenecks affecting utilisation and demand for maternal health services include indirect financial costs, such as those associated with transportation and access to drugs (despite the abolition of user fees), as well as cultural norms and social influences.

Many of the solutions identified for addressing bottlenecks in the delivery of emergency obstetric care overlap with skilled attendance at birth and family planning, and antenatal care interventions. Eliminating three delays is particularly critical to reducing maternal deaths. These delays are in: (a) a woman's decision to seek care; (b) a woman's ability to reach a health care facility; and (c) a woman's ability to receive adequate care. Limited women's self-esteem and low literacy particularly in rural areas are largely responsible for the delay in a woman's decision to seek care. Community development and awareness can address this.

In response, the Government will ensure, through the Ministry of Gender, Labour and Social Affairs and the local governments, that appropriate information is communicated to the women and their families. Inexpensive transport and communications reduce the delay to reach a health facility. It also reduces delays for referral between health facilities. In addition, inexpensive alternative transportation and communications create an incentive for women to seek care promptly. The Government will therefore continue to improve roads (through the Ministry of Works and Transport) and expand information and communication technology (through the Ministry of Information and Communication Technology) to make it easier for women to access emergency obstetric care. It will build on good practices in Uganda and elsewhere.

Once a woman arrives at a health facility, everything necessary to preserve her life, including medicine and supplies, blood, and motivated staff, should be available. The Government, through the National Medical Stores, will ensure that health facilities have sufficient relevant commodities and supplies. Through the Uganda Blood Transfusion Services, it will also ensure that blood is available at health facilities. The Government will continue, through the Ministry of Education and

Sports, to train sufficient and well-qualified health professionals; to recruit, through the Ministry of Local Government, sufficient numbers of them; and to motivate them, through the Ministry of Public Service.

Two inputs which are critical in the planning for emergency obstetric care are electricity and water. Electricity is needed to provide light and operate equipment during emergency operations, and water is needed to ensure basic hygiene, and to prevent and control infections. The Government will seek to ensure that local governments and the Ministry of Water provide health facilities with reliable water sources and the Ministry of Energy will provide reliable electricity. Solutions for bottlenecks to skilled attendance at birth are similar to those for emergency obstetric care. Two aspects worth emphasising are: skilled personnel with midwifery skills and a well functioning referral system. A solution to bottlenecks to universal access to family planning is to ensure the availability of an appropriate combination of family planning methods and information to all women.

Based on the application of the MDG Acceleration Framework, the Government will develop a joint action plan for maternal health to consolidate sector commitments, and the commitments of other stakeholders such as non-governmental organisations, the private sector, bi- and multilateral donors and the UN system in Uganda, towards accelerated progress. The joint action plan will acknowledge division of labour while ensuring that sector commitments and actions converge towards accelerated progress, and will build on the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015).

TABLE OF CONTENTS

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMDD	Averting Maternal Death and Disability
ANC	Antenatal Care
ART	Anti-retroviral Treatment
Bn	Billion
°C	Celsius
CGE	Computable General Equillibrium
CPR	Contraceptive Prevalence Rate
DAC	Development Assistance Committee
DWD-MIS	Directorate of Water Development Management Information System
EAC	East African Community
EmOC	Emergency Obstetric Care
ESSAPR	Education and Sports Sector Annual Performance Report
FAO	Food and Agriculture Organisation
GDP	Gross Domestic Product
HC	Health Centre
HIPC	Highly Indebted Poor Country
HIV	Human Immunodeficiency Virus
ICT	Information and Communications Technology
IDP	Internally Displaced Person
ITN	Insecticide-treated Net
ITP	Adult Idiopathic Thrombocytopenic Purpura
MDG	Millennium Development Goal
MDRI	Multilateral Debt Relief Initiative
MMR	Maternal Mortality Ratio
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MOWT	Ministry of Works and Transport
MP	Member of Parliament
MW	Megawatt
n/a	Not applicable
NAPE	National Assessment of Proficiency in Education
NDP	National Development Plan
NEMA	National Environmental Management Authority
NER	Net Enrolment Ratio
NORAD	Norwegian Agency for Development Cooperation
NPA	National Planning Authority
NSDS	National Service Delivery Survey
ODA	Official Development Assistance
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PPP	Purchasing Power Parity
TB	Tuberculosis
UN	United Nations
UNAIDS	UN Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Organisation
UNPD	United Nations Population Division
WFP	World Food Programme
WHO	World Health Organisation

LIST OF FIGURES

LIST OF TABLES

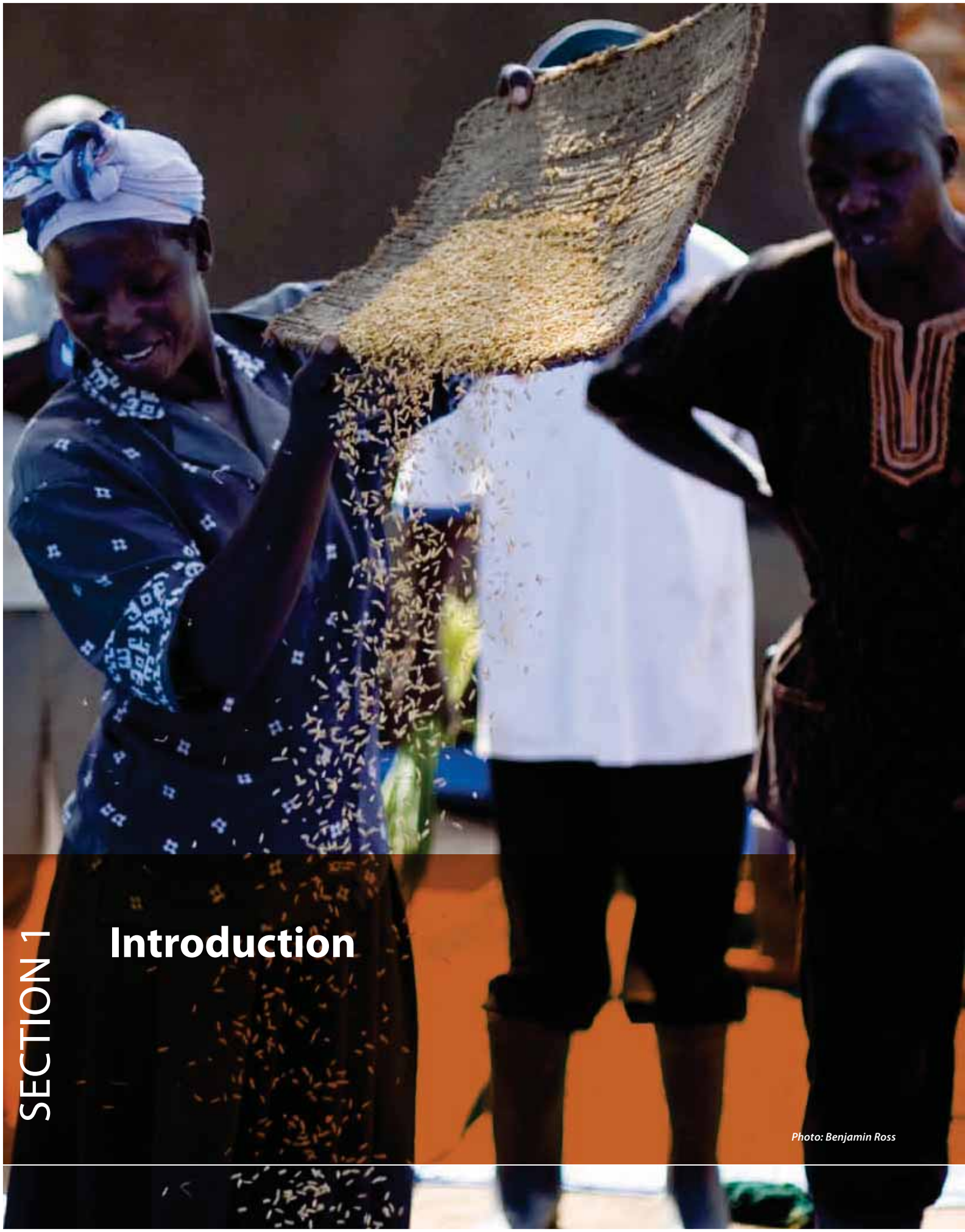
MAP OF UGANDA

Legend

International Boundary — 2009 District Boundary — 2010 District Boundary

0 50 100KM

Source: Uganda Bureau of Statistics.



SECTION 1

Introduction

Photo: Benjamin Ross

1. INTRODUCTION

The Millennium Summit held in New York in September 2000 was a landmark event that brought together an unprecedented number of countries and Heads of State to form a global consensus on the challenges facing humanity. More important, the Summit deliberated on what needs to be done to overcome these challenges. The resulting Millennium Declaration, subsequently signed by all UN member states, including Uganda, states:

> *'We will spare no effort to free our fellow men, women and children from the abject and dehumanising conditions of extreme poverty, to which more than a billion of them are currently subjected. We are committed to making the right to development a reality for everyone and to freeing the entire human race from want.'*

Emanating from the Millennium Declaration is a series of Millennium Development Goals (MDGs) that articulate in concrete terms a global vision for human and social development. The eight MDGs are:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Each of these goals is associated with a series of time-bound targets—most of which are set against a 1990 baseline and are to be achieved by 2015—and several indicators to assist the systematic monitoring of global and national progress made against the Millennium Declaration. The Declaration also defines the roles and responsibilities of key actors, namely: national governments to align their strategic frameworks and policies to achieve the goals and targets; international organisations to marshal resources and expertise in the most strategic and efficient way; and citizens, civil society organizations and the private sector to rally behind global and national campaigns towards achieving the MDGs.

1.1 Objectives of the MDG progress report

The purpose of this report is to provide an overview of where Uganda stands in terms of progress towards attaining the MDGs. Like previous MDG progress reports published in Uganda in 2005 and 2007, this report is intended to provide a credible and realistic assessment of progress with a view to stimulating change and galvanizing action in the key areas where progress has been slow and accelerated progress is necessary. The review of MDG progress is not analytical as such, but it draws heavily on qualitative and quantitative analysis done by academics, researchers and development practitioners. The report also highlights good practices in policies and programmes that have been particularly effective in ensuring progress, and it discusses cross-cutting challenges and opportunities. A special thematic chapter of the report is devoted to MDG 5 (Improving maternal health), where progress in Uganda, as in many other countries, has been particularly slow. This chapter is more analytical and uses an 'MDG Acceleration Framework' to uncover the bottlenecks that impede attainment of agreed programmatic interventions in maternal health in Uganda. On this basis, options for removing these bottlenecks are discussed with clearly defined roles and responsibilities for different arms of government and their development partners to accelerate MDG delivery.

1.2 Data and indicators

The global goals, indicators and targets that make up the MDGs were derived from the Millennium Declaration and have been updated several times. The most recent version cites eight goals, 21 targets and 60 indicators. Using the targets and indicators that are directly relevant to Uganda, this report seeks to report on progress towards all goals (See Annex A for an overview of progress on the key goals and targets for Uganda and Annex B for a complete list). In some cases, the target or indicator has been modified to fit national circumstances. With a

few exceptions, the data and indicators used in the report are from national sources, including administrative, survey and census data. The data has been sanctioned for use in the report by the country's highest authority on economic and social statistics, Uganda Bureau of Statistics, as well as the line ministries, departments or agencies responsible for generating the statistics in Uganda's decentralised system. Methods for data collection and reporting are subject to change. So, for purposes of this report, care has been taken to use comparable data only. Where comparison is a challenge, though, this will be highlighted in the presentation. Since the report relies on national data sources, some of the data is not directly usable for international comparison, where adjustments are often made to national data sets to enhance comparability across countries. Such comparisons are beyond the scope of this report, which is focused on national progress towards the MDGs.[1] Indicators based on survey data, which is subject to sampling error, are rounded to nearest whole number in order to avoid a false sense of precision. The latest nationally representative survey data used in the report is for the fiscal year 2005/2006. This time lag needs to be borne in mind when judging progress or interpreting projections reported.

1.3 Assessing progress towards global and national targets

This report uses both the global targets for progress as established in the MDG framework and the national ones that have been elaborated during the formulation of national and sectoral development strategies. In particular, the report draws on the five-year targets set in the National Development Plan, which are often linked to the MDG targets, and, in some cases, more ambitious targets, referred to as MDG+, have been set. A simple linear extrapolation of long-term trends from the most recent year and until 2015 will assess progress. Annual projections are used when available. If the projected or extrapolated progress foresees the MDG target being reached by the 2015 deadline, the overall assessment is that progress towards the target is 'On track', as indicated in green in the stop sign scheme. Green is also used if the target has already been 'Achieved'. If progress is positive but not strong enough for the goal to be attained, the overall assessment is 'Slow progress' and is so indicated in yellow colour coding. If trends are either towards only marginal improvements or even retrograde, the assessment is for 'Stagnant' (also indicated in yellow) and 'Reversal' (indicated in red), respectively.

1.4 Use of sources and references

The report draws on many data sources and analytical references. We typically refer directly to the survey data rather than to the official release document because we often use the micro-data directly, which gives a more accurate sense of timing. Thus, we reference results from the 2005/2006 Uganda National Household Survey as "UNHS (2005/2006)" rather than as "Uganda Bureau of Statistics (2006)". While we have aimed to keep the text and presentation as non-technical as possible, we have used footnotes to refer to more technical documents from which we draw findings and conclusions.

1.5 Acknowledgements

The 2010 MDG Country Report was prepared through an extensive collaboration between the Government of Uganda and United Nations agencies, funds and programmes and in consultation with a range of stakeholders among national and international development partners. The process was led by the Ministry of Finance, Planning and Economic Development (MOFPED), the National Planning Authority (NPA) and the Ministry of Health (MOH) on the side of Government, in close collaboration with UNDP and UNFPA on behalf of the UN Country Team and the Programme Management Team comprising representatives from all UN agencies, funds and programmes. Technical assistance specifically related to the application of the MDG Acceleration Framework was provided by the Economic Policy Research Centre in Kampala and the UNDP Bureau for Development Policy Poverty Group/MDG Support Team in New York. The Uganda Bureau of Statistics (UBOS) has provided extensive support by making datasets available, running special tabulations, assisting with interpretation and methodology, and, finally, sanctioning the data and sources used in the report.

1) For purposes of global and regional assessments, the UN Statistics Division maintains an extensive database of internationally comparable MDG data, which is available at http://unstats.un.org/unsd/mdg/.

SECTION 2

NATIONAL DEVELOPMENT CONTEXT

Photo: New Vision

2. NATIONAL DEVELOPMENT CONTEXT

Over the past three decades, Ugandan society has gone through a series of major transitions that have shaped almost all aspects of economic and social life. This has led to major improvements in the well-being of the Ugandan people and an increase in the capabilities and opportunities of many. Nevertheless, challenges remain in terms of: consolidating democracy; removing gender, regional and other inequalities; extending protection of basic human, social and economic rights to all Ugandans; removing barriers to sustained and sustainable economic growth, most notably strengthening the country's underdeveloped physical infrastructure; and strengthening access to and quality of social services.

2.1 Peace, stability and consolidation of democracy

Reactionary forces such as tribalism, regionalism and religious intolerance have harmed Uganda in the past. Since gaining independence in 1962, the country has emerged from decades of violence and erratic political leadership to see the introduction of multi-party democracy, the building and strengthening of institutions for good governance, and, more recently, the promise of peace as the protracted civil war in the north has ended. Under the leadership of the National Resistance Movement, the current government has been able to establish peace and stability across most parts of the country.

The government recognizes that personal safety and security of property are crucial for economic growth and development. Sustainable human development and poverty eradication are impossible amidst war and instability. Institutionalizing and consolidating democracy and good political governance will ensure durable peace and stability in the country. There has been gradual democratization and political liberalization, as evidenced by the emergence of free media and civil society in Uganda. However, despite the progress that has been made in establishing peace and stability, there is still room for improvement, particularly in the institutionalization and consolidation of democratic governance.

2.2 Population dynamics

Population dynamics is about the birth, death and migration patterns of a country's population. Uganda's population growth rate of 3.2% is one of the highest in the world. In contrast to other developing or emerging economies that Uganda often looks to for comparison, the total fertility rate (i.e., the average number of children that a women of childbearing age can expect to have) is persistently high (Figure 1). The 2006 Uganda Demographic and Health Survey estimated this rate to be 6.7 and found that levels of education and wealth have a marked effect on fertility. Uneducated mothers had about three more children on average than women with at least some secondary education (Figure 2). It is also in the group of educated mothers that the reduction in fertility has been greatest since 1995 (although there has been an increase in recent years). Similarly, women living in households in the lowest wealth quintile (i.e., the 20% poorest households) had almost twice as many children as women in the highest wealth quintile (i.e., the 20% wealthiest households) (Figure 3).

According to projections from UBOS, the population of Uganda in 2010 is 31.8 million (Figure 4). By 2050, the UN projects that the population will reach 91.3 million. The population is youthful: more than 50% of the population is below 15 years of age, and the dependency ratio in Uganda (i.e., the share of those aged 0-14 and 65+ as a share of those aged 15-64) is among the highest in the world. This means that most of the population falls into the dependant, rather than working-age, category. This dependency ratio is peaking in the middle of the MDG review period (1990-2015) and is thus likely to have contributed to the slowed progress towards many of the goals.

Figure 1 TOTAL FERTILITY RATES IN SELECTED COUNTRIES

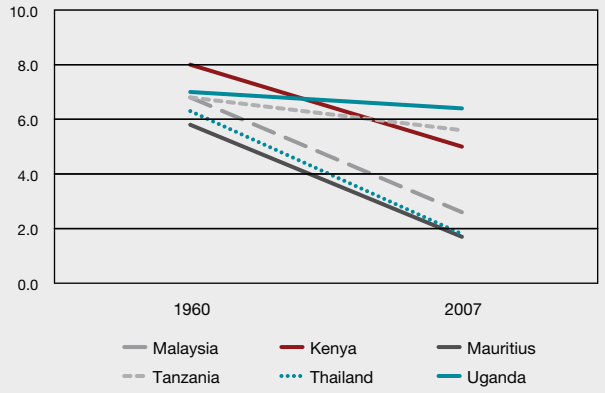


Figure 2 TOTAL FERTILITY RATE FOR UGANDA BY EDUCATIONAL STATUS OF THE MOTHER

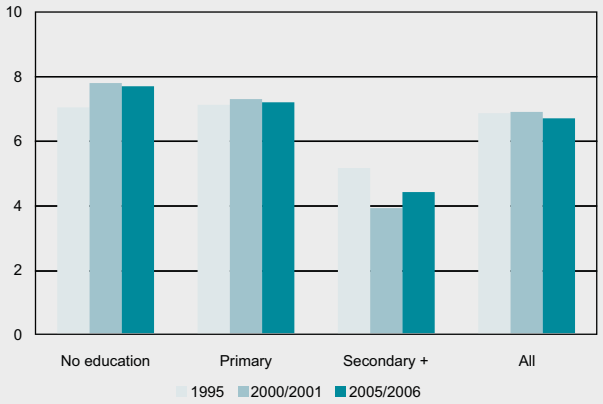


Figure 3 TOTAL FERTILITY RATES IN UGANDA BY WEALTH QUINTILE

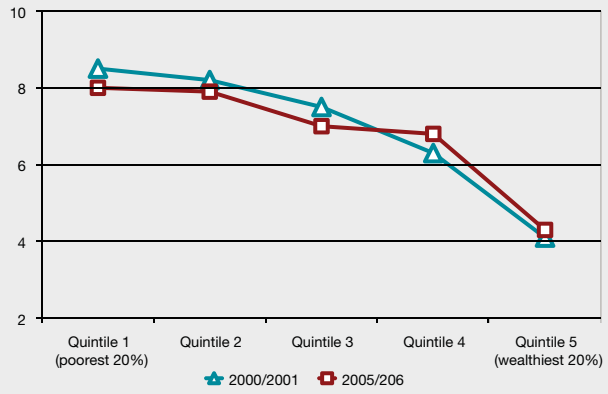
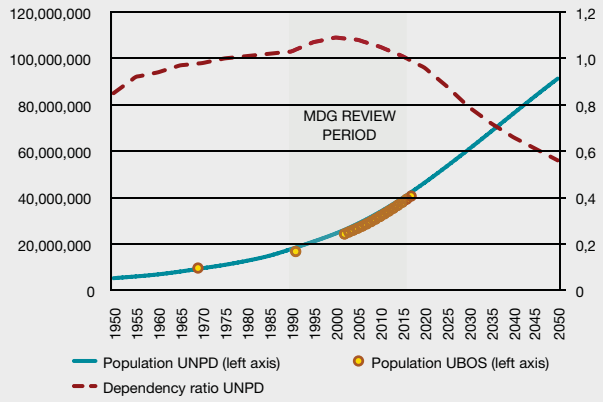


Figure 4 POPULATION PROJECTIONS FOR UGANDA



Source: UDHS (1995, 2000/2001, 2005/2006); UBOS 2002 Census and Projections data for 2003-2017; UN Population Division (UNPD); World Development Indicators (online databases accessed April 2010).
*Note: * The dependency ratio is calculated as the share of the population aged 0-14 and 65+ as a share of the total population. For UNPD, the 'medium variant' is used.*

Population projections point towards a decrease in the dependency ratio, which opens a window of opportunity for Uganda to reap a 'demographic dividend' that can be associated with a relatively larger share of the working-age population. The effect on economic growth can be significant. For instance, one study shows how a rapid increase in the working-age population relative to the rest of the population explains up to 40% of the East Asian 'miracle' of rapid economic growth between 1965 and 1990.[2] Obviously, the greater supply of labour must be productively employed and any additional savings can effectively be turned into domestic and productive investment. A changing dependency ratio also affects public expenditures, since children and the elderly typically are net beneficiaries (as recipients of public education or health care, for instance) rather than net contributors of taxes (as those of working age tend to be).

2) Bloom, D. E. and J. Williamson (1998) 'Demographic Transitions and Economic Miracles in Emerging Asia,' World Bank Economic Review, Vol. 12(3), pp. 419-455.

The 2002 Census estimated that the average life expectancy of a newborn Ugandan was 50.4 years: 48.8 years for males and 52 years for females. Projections show that the life expectancy will have increased from 50.5 for females and 45.7 for males in 1991 to 54 and 53 years, respectively, in 2017.[3] Even if urbanisation is increasing, 85% of the population still lives in rural areas, which is low by regional standards. Twenty percent of the population lives in the Northern Region, 25% in the Eastern Region, 26% in the Western Region, and 29% in the Central Region, which also includes the capital city of Kampala. The average household size is 5.2, which has remained largely stable over the past decade. While international migration is limited, about 20% of the population had migrated from one district to another according to the most recent 2005/2006 household survey. Looking for work and other income-related reasons were the major causes of migration (28%), followed by insecurity (26%), marriage and joining family (15%). Migration due to insecurity was reported by 66% of the population in Northern Uganda. With the recent return of peace in the north of the country, though, outward migration has reversed as Internally Displaced People return to resume their livelihoods in their areas of origin.

2.3 Economic performance

Uganda is classified by the UN as one of 49 Least Developed Countries, which are characterised by low per capita incomes, feeble human capital, and a high degree of economic vulnerability. Nevertheless, the Ugandan economy has transformed remarkably in recent years. According to the World Bank, GDP per capita has grown faster and at a higher average rate since the late 1980s than in most African countries. Uganda's macro-economic reform programme is generally viewed as having supported economic growth well beyond what could be expected from the recovery and reconstruction process.[4] These reforms, often considered among the most comprehensive in Africa, have reduced barriers to trade and liberalised prices and markets previously subject to state control. Improved management of monetary and fiscal policy has produced stability and has brought down the triple-digit inflation rate of the late 1980s. Against the backdrop of impressive results in macro-economic management, Uganda in 2000 became the first country to qualify for relief under the initiative for Highly Indebted Poor Countries and the country's debt remains at sustainable levels. The economic transformation has seen the share of output from the agriculture sector decline and the share from services and industry rise. Nevertheless, the vast majority of the population is still dependent on subsistence agriculture for their livelihoods and there has been limited transformation in the sectoral composition of the labour force.

Figure 5 SELECTED ECONOMIC INDICATORS

Source: NDP 2010/11-2014/15.

3) Uganda Bureau of Statistics. 'Projections of Demographic Trends in Uganda 2007-2017: Volume I,' December 2007.

4) World Bank (2007) 'Uganda Moving Beyond Recovery: Country Economic Memorandum. Poverty Reduction and Economic Management Unit,' Africa Region.

Global economic and financial crisis

Uganda has not been spared the impact of the global economic and financial crisis, which erupted in the United States in 2007 and quickly spread to the rest of the world, including the least developed countries. Nevertheless, the overall impact of the crisis on Uganda has been rather benign and, despite a slowdown in economic activity compared to earlier years, real GDP grew by 7.1% for fiscal year 2008/2009 and by 5.8% in 2009/2010 (Figure 5), which was strong by regional and international standards.

Three main factors explain the relatively limited impact of the global crisis on Uganda. First, Ugandan financial institutions are fundamentally healthy and were only somewhat directly exposed to the deleveraging in Western financial markets. Second, the country experienced a pre-crisis surge in regional-bound exports (including cereal, pulses, cement, and livestock), especially through increased demand from the neighbouring countries of Sudan, Democratic Republic of Congo and Kenya. Largely sustained through the crisis, these exports have made up for some of the falls in inflows from exports destined for international markets (notably coffee, tea, cotton, and fish), remittances, official development assistance and foreign investments, which have been the main transmission mechanisms of the global crisis onto the local economy (Figure 6). Third, fiscal space built up before the crisis allowed for the introduction of pro-growth stimulus programmes even before the onset of the crisis and was followed by monetary easing by the Bank of Uganda in the first quarter of 2009. Recent research suggests that fiscal policy has been effective in restoring economic growth and that, as a result of the crisis, the country will experience a slight slow-down in poverty reduction, but not a reversal.[5] However, this research also shows how improvements in allocation and efficiency of public expenditure would significantly speed up poverty reduction in Uganda. The immediate economic outlook for Uganda will be shaped by the projected recovery in the global economy and the effectiveness of the implementation of the Government's public investment programme. Against that background, real GDP growth is projected to rebound from the slowdown in 2009/2010 to an average GDP growth rate of 7.1% during the five-year NDP period (2010/2011 to 2014/2015). This implies a resumption of the growth rates witnessed under the implementation of PEAP 2 and 3 (also Figure 5).

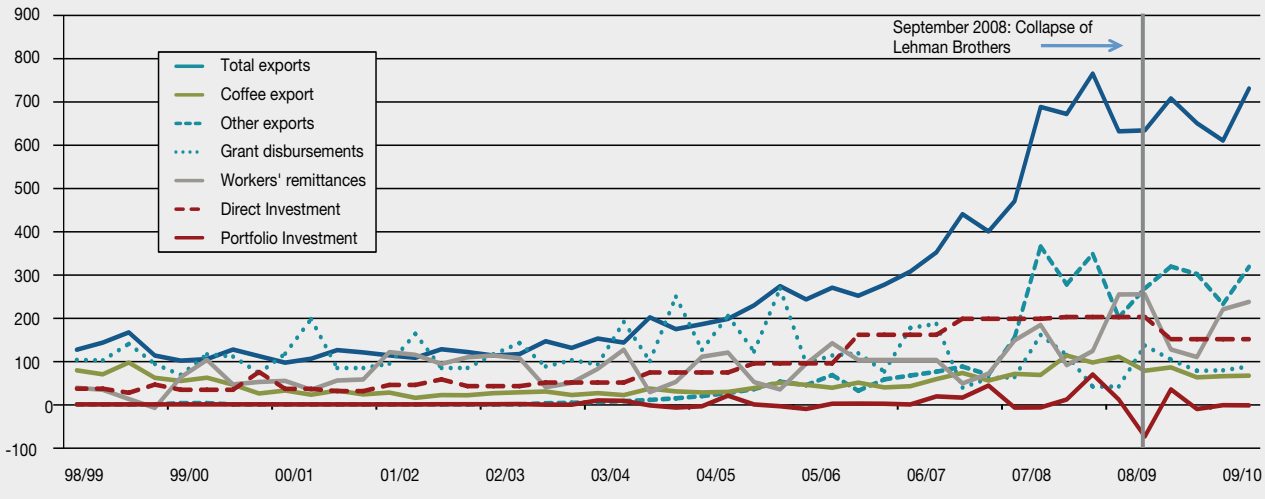
2.4 The climate change crisis

The Ugandan economy and the welfare of the population are intricately linked to the natural environment and, therefore, highly vulnerable to climate variability and change. Even if the national evidence-base is still weak and modelling the impact of the changes in climatic conditions is fraught with great uncertainty, there is little doubt that climate change could jeopardize the Government's economic and social development goals, including the MDGs. As current average temperatures in Uganda

5) Twimukye, E., Matovu, J., Levine, S. and P. Birungi (2009) 'Sectoral and Welfare Effects of the Global Economic and Financial Crisis on Uganda: A Recursive Dynamic CGE Analysis,' EPRC and UNDP. Paper presented at the international conference on Rethinking African Economic Policy in Light of the Global Economic and Financial Crisis, African Economic Research Consortium in Nairobi, 6-8 December 2009.

6) United Nations (2009) 'United Nations Joint Action Framework on Climate Change in Uganda,' zero draft, September.

Figure 6 **SELECTED COMPONENTS OF THE BALANCE OF PAYMENTS (US$ MILLION)**



Source: Bank of Uganda.

are expected to increase by up to 1.5°C by the 2020s and as rainfall patterns change, some concerns arise.[6] Natural impacts in the country include glacial melting, droughts, floods and landslides. The expected socio-economic impacts of climate change affect food security, health, and the economic development of the country. According to the 2007 National Adaptation Programmes of Action, drought is the most dominant effect of climate change in Uganda. The frequency of droughts is on the increase, with seven serious droughts experienced between 1991 and 2000. Extreme weather exposes populations to harsh living conditions and outbreaks of waterborne diseases such as diarrhoea and cholera. Prolonged dry spells have resulted in respiratory disease, and rising temperatures are changing the geographical distribution of malaria and other disease vectors.

Although the share of agriculture in total GDP has dropped to 23.9% (2009/2010), it remains an important sector in the life of Ugandans. The sector employs the majority of the labour force. Thus far, the macro-economic impacts of environmental deterioration and associated losses have been estimated to be 4-12% of GDP.[7] A temperature rise of 2°C could wipe out most of Uganda's coffee production and jeopardize 40% of export revenue. The Government of Uganda has been proactive in its response to climate change, but much still needs to be done to ensure that the country is not derailed from its current track of sustainable development.

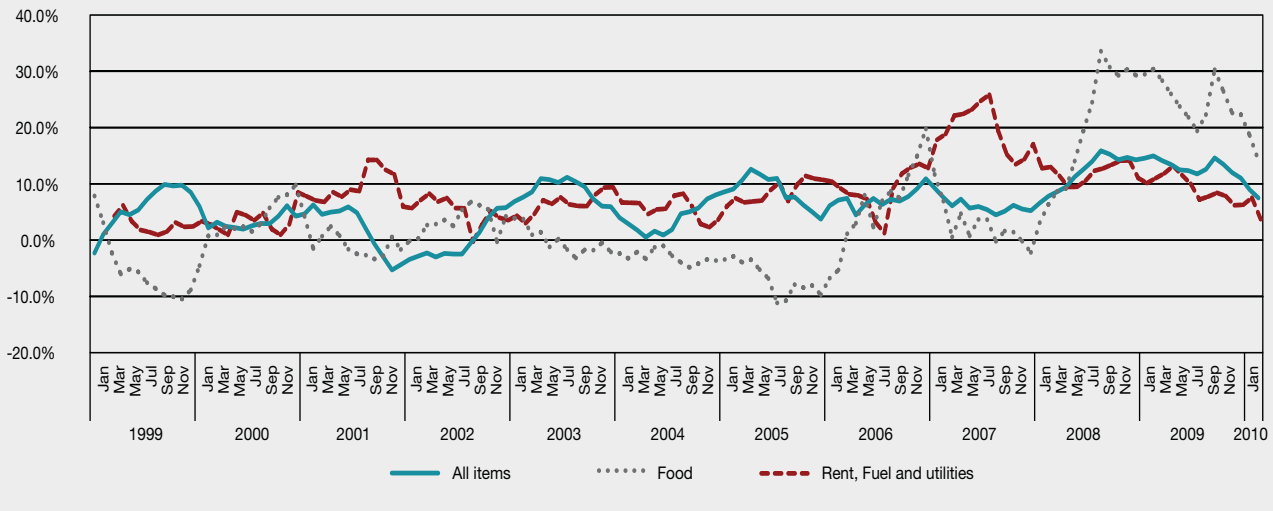
2.5 The impact of food price increases

World prices for staple foods increased between 2006 and 2008 and accelerated sharply in 2008 (Figure 7). The spike in food prices was attributed to a combination of demand and supply factors, including higher energy and fertilizer prices, diversion of food grain and oil seeds to bio-fuel production, growing demand (especially in China), and adverse policy responses to the initial price shock (i.e., minimum prices, quotas and outright export bans). At first, the adverse effects of higher food prices on poverty levels in Uganda were thought to be small because of the diversity of its staple foods, high level of food self-sufficiency, and weak links with world markets. However, one recent analysis finds that poor households in Uganda tend to be net buyers of food staples, and therefore suffer welfare losses when food prices increase.[8] While this is most pronounced in urban areas, it is also the case for rural households. The diversity of staple foods has not been an effective buffer because the prices of a range of staple foods have increased. The incidence of poverty is estimated to have increased by 2.6 percentage points in the short run as a result of higher food prices in 2008 and has been highest in the Northern region, which is already the poorest in Uganda.

7) NORAD (2009) 'Review of the Embassy's Development Assistance Portfolio: Environment and Climate Change, Greening and Climate Proofing of the Portfolio,' The Royal Norwegian Embassy, Kampala, Uganda, January 2009.

8) Simler, K (2010) 'The Short-Term Impact of Higher Food Prices on Poverty in Uganda,' World Bank Research Working Paper, No. 5210.

Figure 7 **CONSUMER PRICES (ANNUAL CHANGE IN %)**



Source: Uganda Bureau of Statistics.

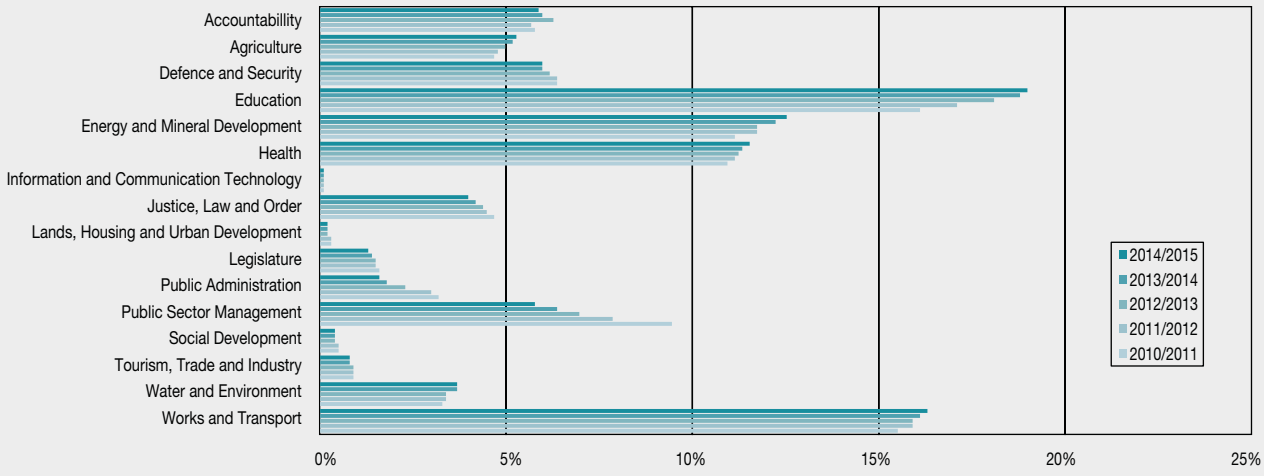
2.6 National Development Plan

With the expiration of the Poverty Eradication Action Plan (PEAP), which had guided national development policy and public expenditure since 1997, the Government of Uganda has developed a comprehensive National Development Plan (NDP) covering 2010/11-2014/15. The Plan is the first of six five-year instalments that seek to drive progress towards the long-term national vision, which sees Uganda transform from a largely peasant society to a modern and prosperous country over a 30-year period. The first NDP carries the theme of *'Growth, Employment and Socio-Economic Transformation for Prosperity'* and proposes an ambitious range of initiatives that seek to boost household incomes and the availability of jobs, significantly expand the stock and quality of the country's physical infrastructure (roads, railways, power supply), increase access to public services and enhance human capital development, strengthen governance and the rule of law, and promote sustainable population and use of the country's natural resources.

This is to be achieved by removing constraints that include:

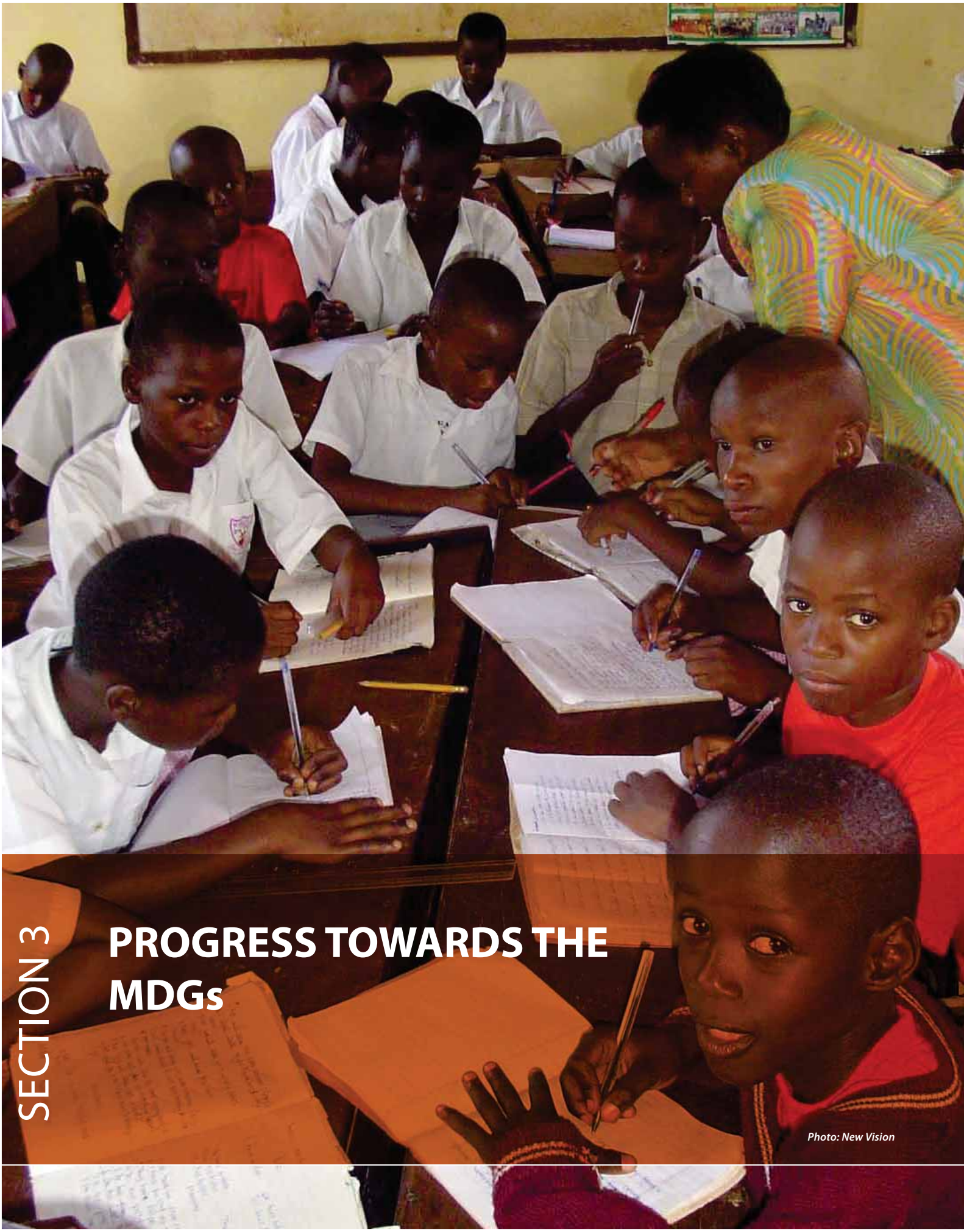
- Weak public sector management and administration
- Inadequate financing and financial services
- Inadequate quantity and quality of human resources
- Inadequate physical infrastructure
- Gender issues, negative attitudes, mind-set, cultural practices and perceptions
- Low application of science and technology
- Inadequate supply and limited access to critical production inputs

Figure 8 **SECTOR SHARES OF PUBLIC EXPENDITURE IN THE NATIONAL DEVELOPMENT PLAN**



Source: NDP 2010/11-2014/15.

The strategic reorientation of expenditure envisaged during the planning period reflects increased investments in economic infrastructure and for the exploration of vast discoveries of oil in the western part of the country alongside increased investments in health and education (Figure 8). The combined allocations to health and education will exceed 30% of the total budget by the middle of the planning period. Sectors that will receive reduced shares of the budget are related to public sector management and administration, dispensation of justice, law and order, as well as defence. Under the Plan, it is expected that the country will make sufficient progress towards the MDGs to meet—and even exceed—targets on poverty reduction and access to safe water. However, authorities acknowledge that several other key targets, notably in the areas of maternal and child health, are unlikely to be attained. The rest of this report seeks to establish the extent to which progress has been made under each goal and target and to test a methodology that seeks to facilitate the identification of interventions that can accelerate progress towards the MDGs. This type of analysis is intended to underpin implementation of the NDP.



SECTION 3

PROGRESS TOWARDS THE MDGs

Photo: New Vision

3. PROGRESS TOWARDS THE MDGs

This chapter goes goal by goal and indicator by indicator through each of the MDGs to provide an update on the status and trends towards meeting the targets. Focus is on the targets set globally following the adoption of the Millennium Declaration, but, where regional or national targets exist, progress towards these is also reported. Moreover, additional indicators that are particularly relevant for assessing progress in Uganda are also reported even if they do not form part of the global framework. The reporting of trends towards the targets is followed by a brief discussion of key factors that are either driving or hindering progress. Some of the good practices and bottlenecks are discussed further in the boxes that accompany the text.

3.1 Goal 1: Eradicate extreme poverty and hunger

Uganda has made great progress in terms of reducing the proportion of the population below the national poverty line. The poverty headcount (i.e., the share of people living in households below the poverty line) declined from 56% in 1992/1993 to 31% in 2005/2006 (Table 1). Using the former survey as the benchmark, this means that Uganda is well on its way to meeting the 2015 global target of cutting poverty in half, which would correspond to a poverty level of around 28% for that year. However, the NDP target is 25% in 2014/2015, which exceeds the global target (Figure 9). The poverty gap, a measure of how far the poor are below the poverty line, has also narrowed. This is an indication of improvements in monetary welfare even among those who have not risen above the poverty line. On the other hand, the share of the poorest 20% of the population in total household consumption has fallen, which is an indication of rising inequality (more on that below).[9]

There is great variation in both the levels of poverty and the degree of poverty reduction in the different geographical zones and regions of the country. Levels of the poverty headcount are much higher in rural areas compared to urban areas—34% and 14%, respectively—and the reduction over time has been strongest in urban areas (Figure 10). Moreover, while the share of urban poor in the most recent surveys has remained more or less constant, the absolute number of poor people in both urban and rural areas, but especially urban ones, has increased due to rapid population growth and urbanisation. The Central region of Uganda has seen levels of the poverty headcount fall from 46% to 16% from 1992/1993 to 2005/2006, compared to the Northern region, where the poverty headcount has fallen from 74% to 61%. Poverty

9) UBOS uses household consumption, rather than household income, as the main welfare measure for its analysis of poverty and inequality at the household level.

Table 1: Target 1.A Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

STATUS OF PROGRESS: ON TRACK					
Indicators	**1992/1993**	**1999/2000***	**2002/2003**	**2005/2006**	**2015 target**
1.1 Proportion of population below national poverty line (poverty headcount)	56%	34%	39%	31%	25%
1.2 Poverty gap	21	10	12	9	
1.3 Share of poorest quintile in total household consumption	6.9%	6.7%	6.3%	6.4%	

Sources: UNHS (1992/1993, 1999/2000, 2002/2003, 2005/2006), NDP 2010/11-2014/15.
*Note: * Estimates exclude the districts of Bundibugyo, Kitgum, Gulu, Pader and Kasese, which were not covered in the 1999/2000 survey due to instability.*

levels are also higher in the Eastern region, especially the sub-region of Karamoja, where the reduction in poverty has also been slower than the national average.

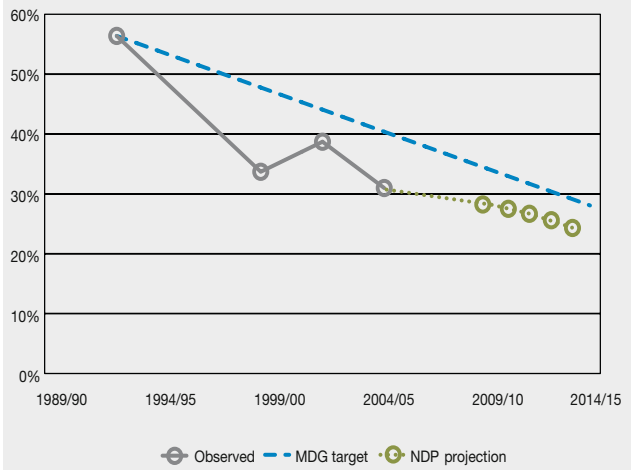
Income inequality as measured by the Gini coefficient increased from 0.365 in 1992/93 to 0.428 in 2002/3 before dropping to 0.408 in 2005/6. Despite this drop, inequality is still greater than the level of the early 1990s (Figure 11). The level of inequality is greatest in the urbanised central region and least (and falling) in the north, which is an indication of more uniformly low incomes and probably the loss of capital and assets during the years of the civil war. The country's large but decreasing number of Internally Displaced People (IDPs) has been a particularly vulnerable population group. In 2005/2006, the incidence of poverty among this group was estimated at 78%.

The results from the latest household survey conducted in 2009/2010, and for which the results were not yet available for the purposes of this report, will show whether the downward trend in poverty levels and the poverty gap have been sustained and whether the patterns of poverty and inequality have changed, especially as a consequence of the potential impacts of the global financial and economic crisis, recent spikes in food and other commodity prices, and the cessation of civil hostilities in the north (these issues are also discussed further below).

The rapid reduction of poverty in Uganda is a result of several factors. According to a 2008 evaluation of the Poverty Eradication Action Plan, overall growth in GDP per capita in the period from 1992-1997 seems to have been particularly effective in fuelling growth in per capita consumption.[10] Moreover, the PEAP prioritised expenditure since 1997 to improve personal security and access to primary education, health care and water, which, alongside continued robust economic growth, probably helped to reduce poverty. However, the evaluation also finds that the PEAP could have reduced poverty further if it had focused more on agriculture (especially research and development) and family planning.

Various policy initiatives will likely produce sustained poverty reduction throughout the NDP planning period. These include: boosting household incomes and the equality with which these are distributed; increasing agricultural production and productivity; improving access to gainful employment in high-tech and industrial production; and strengthening the country's physical and economic infrastructure.

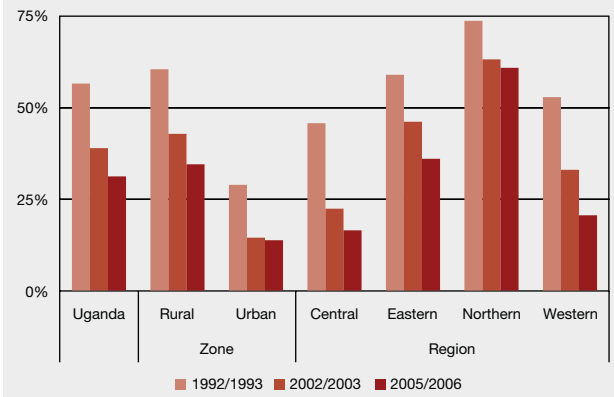
Figure 9 **POVERTY HEADCOUNT**



Sources: UNHS (2005/2006), NDP 2010/11-2014/15 and own calculations.
*Note: * Estimate for 1999/2000 excludes the districts of Bundibugyo, Kitgum, Gulu, Pader and Kasese, which were not covered in the survey due to instability.*

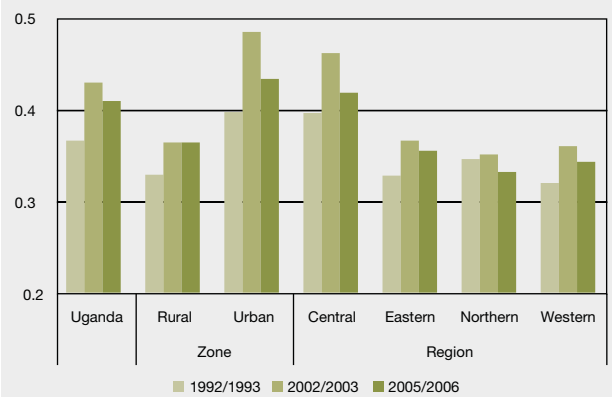
10) Oxford Policy Management (2008) 'Independent Evaluation of Uganda's Poverty Eradication Action Plan (PEAP): Final Synthesis Report, July 2008.

Figure 10 POVERTY HEADCOUNT BY REGION



Source: UNHS (1992/1993, 2002/2003, 2005/2006).

Figure 11 GINI COEFFICIENTS BY REGION



Source: UNHS (1992/1993, 2002/2003, 2005/2006).

Table 2: Target 1.B Achieve full and productive employment and decent work for all, including women and young people

STATUS OF PROGRESS: NO TARGET		
Indicators	**2002/2003**	**2005/2006**
1.4 Growth rate of GDP per person employed	n/a	n/a
1.5 Employment-to-population ratio	78%	80%
1.6 Proportion of employed people living below national poverty line	34%	18%
1.7 Proportion of own-account and contributing family workers in total employment	56%	45%

Source: UNHS (2002/2003, 2005/2006).

The creation of quality jobs is a central development challenge for Uganda; labour productivity is low and the labour market is fraught with great inequalities between men and women. The National Development Plan envisages improvements in employment levels and labour market conditions through a mix of measures that include: implementation of the national youth employment policy and other laws, policies and guidelines on labour productivity and employment; strengthening of labour market information systems; establishment of a minimum wage; provision of non-formal skills development targeted at women and youth; and enhancement of opportunities for medium-sized businesses through improved access to finance, entrepreneurship training and promotion of value chains.

However, there has already been some improvement, as the share of the employed population rose slightly from 78% to 80% between 2003/2003 and 2005/2006 (Table 2). Moreover, the conditions for those employed, as measured by the share of employed people living below the poverty line and the share of workers considered particularly vulnerable, appear to have improved over that relatively short time. The EAC Common Market Protocol that came into force on July 1, 2010, further justifies the case for intensifying skills development because labour productivity will become more important in determining the employability of workers, given the larger labour pool available to employers when labour moves freely within the Common Market. The new employment policy currently underway will be instrumental in developing targets for measuring progress towards the target.

Table 3: Target 1.C Halve, between 1990 and 2015, the proportion of people who suffer from hunger

STATUS OF PROGRESS: ON TRACK				
	1995	**2000/2001**	**2005/2006**	**2015 target**
1.8 Prevalence of underweight children under-five years of age (percentage below -2 standard deviations of weight for age)	26%	23%	16%	10%
1.9 Proportion of population below minimum level of dietary energy consumption	n/a	n/a	n/a	

Sources: UDHS (1995, 2000/2001, 2005/2006).

Indicators of nutritional status have improved somewhat in Uganda in recent years. The share of underweight children younger than five years of age declined from a national average of 26% in 1995 to 16% in 2005/2006. However, the national averages mask great inequalities between different regions of the country. The share of underweight children was 36% in Karamoja and 22% in the north of the country in 2005/2006, compared to 10% in Kampala. Other significant nutritional indicators show that Iron Deficiency Anaemia is prevalent in 73% of children under 5 and in 49% of women over 15, while vitamin A deficiency affects 20% of children and 19% of all women (UDHS 2005/2006).

3.2 Goal 2: Achieve universal primary education

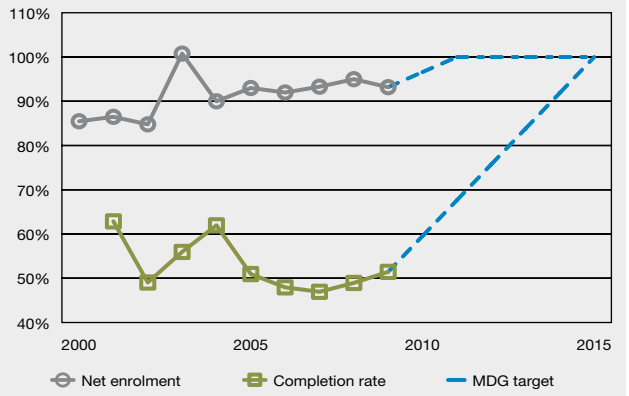
Table 4: Target 2.A Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

STATUS OF PROGRESS: SLOW					
	2000	**2003******	**2006**	**2009**	**2015 target**
2.1 Net enrolment ratio in primary education*	86%	101%	92%	93%	100%
Boys	89%	101%	94%	96%	100%
Girls	82%	100%	90%	90%	100%
2.2 Net enrolment ratio in primary education*	63%***	56%	48%	52%	100%
Boys	n/a	66%	55%	55%	100%
Girls	n/a	47%	42%	48%	100%
	2000	**2002/2003**	**2005/2006**	**2008**	
2.3 Net enrolment ratio in primary education*	n/a	81%	83%	88%	
Boys	n/a	85%	86%	90%	
Girls	n/a	77%	79%	87%	

Source: ESSAPR (2008/2009); UNHS (2002/2003, 2005/2006) and NSDS (2008).
*Notes: * Refers to the ratio of primary school children aged 6-12 years to the number of children of the same age range in the population. ** The primary completion rate is defined as the total number of pupils who registered for primary level education regardless of age, expressed as a percentage of the projected population at the official primary graduation age 12 for primary level 7. *** Year is 2001. **** Measurement errors are likely the cause of the net enrolment ratio exceeding 100% in 2003.*

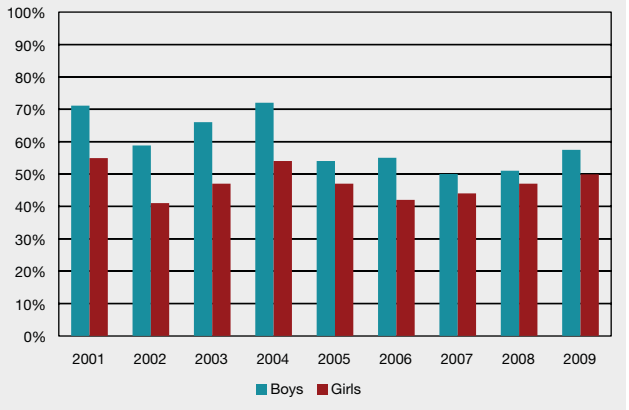
Uganda has made great strides in expanding access to primary education and thus towards the global goal of ensuring that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling. Since the introduction of Universal Primary Education (UPE) in 1997, enrolment in primary education tripled from about 2.7 million in 1996 to 8.2 million in 2009. The Net enrolment ratio (NER), which is a key MDG indicator and measures the share of children in school-going age who are actually in school, has hovered above 90% in recent years, close to the 100% needed to meet the MDG (Table 4 and Figure 12). However, the other key MDG indicator, the proportion of pupils starting grade 1 who reach the last grade of primary school, referred to as the completion rate, remains low.

Figure 12 **PRIMARY NET ENROLMENT RATIOS AND COMPLETION RATES**



Source: ESSAPR (2008/2009).

Figure 13 **PRIMARY COMPLETION RATES BY SEX**



Source: ESSAPR (2008/2009).

To address the problem of non-completion of school, the Government in recent years has adopted numerous quality initiatives, policies and curricula reform. These include a revised lower primary thematic curriculum in 2007, which focuses on literacy, numeracy and life skills and teaches through the medium of local languages, and a revised upper primary curriculum, which will be implemented in 2011. Other key initiatives include customised performance targets for head teachers and deputy head teachers to ensure compliance with set school management standards, and the introduction of basic child-friendly standards for schools through revised Basic Requirement Minimum Standards.

Since 2005, the difference in primary school NER between boys and girls has been growing and NER in 2009 was 96% for boys and 90% for girls. Conversely, the difference in the completion rate between the sexes has narrowed in recent years. The main reason for this appears to be a fall in the completion rate for boys, especially after 2004. Between 2004 and 2005, the completion rate for boys fell by a quarter, from 72% to 54%. Between 2004 and 2006, though, the completion rate for girls also fell rapidly, from 54% to 42%. The NDP (p. 210) attributes a decline in completion rate to a rise in class repetition and school drop-outs. Another key reason is that, with the introduction of UPE in 1997, the number of children enrolled increased considerably. This led to very large classes and poorer education. Consequently, a significant percentage of this cohort entering under UPE in 1997 did not complete primary school, which affected completion rates, particularly around 2004/2005.

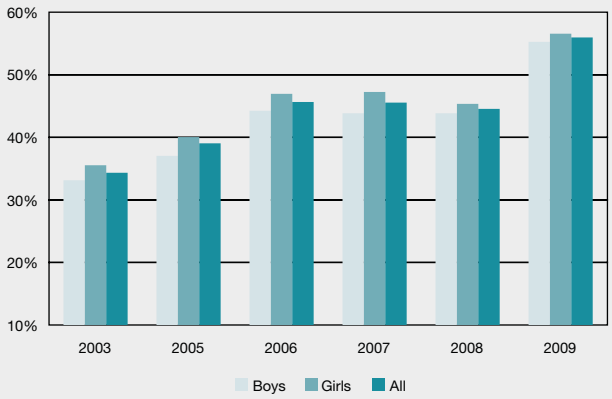
Survey data indicates that higher enrolment has increased literacy. Indeed, the literacy rate among 15 to 25-year-old children and youth increased from 81% in 2002/2003 to 88% in 2008. Although the literacy rate is slightly higher for men (90%) than for women (87%), this gap has narrowed substantially in recent years.

In 2003, the Ministry of Education and Sports began the National Assessment of Proficiency in Education (NAPE), which involved testing literacy and numeracy competences of primary three and primary six pupils nationally. These statistics, included in this report, complement the MDG indicators with information that relates more directly to the quality of the education provided to learners. The numbers highlight an improvement in general over recent years in numeracy and literacy (Figure 15 and Figure 16), with a significant improvement in literacy proficiency in primary three (P3) in 2009, which has been attributed to the implementation of the new lower primary thematic curriculum in 1997 for these learners. Literacy has also improved markedly at P6 level after 2006.

Figure 14 LITERACY RATES 15- TO 24-YEAR-OLDS BY SEX

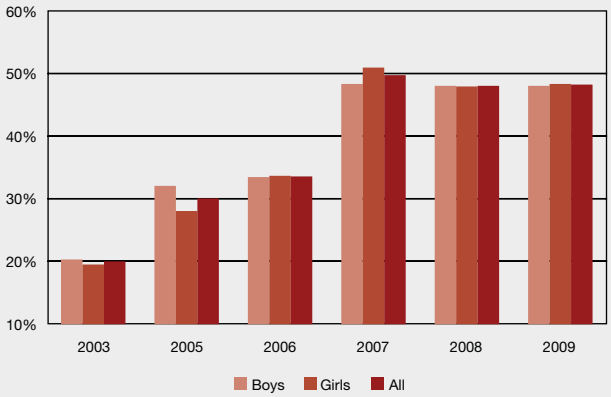
Sources: UNHS (2002/2003, 2005/2006); NAPE (2009).

Figure 15 SHARE OF P3 PUPILS RATED PROFICIENT IN LITERACY



Source: NAPE (2009).

Figure 16 SHARE OF P6 PUPILS RATED PROFICIENT IN LITERACY



Source: NAPE (2009).

3.3 Goal 3: Promote gender equality and empower women

Table 5: Target 3.A Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

STATUS OF PROGRESS: ON TRACK					
	2000	**2003**	**2006**	**2009**	**2015 target**
3.1 Ratios of girls to boys in primary/secondary/ tertiary education	0.93/0.79/0.58	0.97/0.82/0.65	0.99/0.83/0.73	1.00/0.84/0.79	1.00/1.00/1.00
3.2 Share of women in wage employment in the non-agricultural sector	n/a	39%*	28%**	n/a	
3.3 Proportion of seats held by women in national parliament	18%	25%	30%	n/a	

Sources: ESSAPR 2008/2009; UNHS (2005/2006); www.uwopa.or.ug and www.parliament.go.ug.
*Note: * Year is 2002/2003; ** Year is 2005/2006.*

The Government of Uganda is committed to gender equality and the empowerment of women to promote socio-economic transformation. Uganda is a signatory to various international commitments, including the Convention on the Elimination of All Forms of Discrimination against Women and the Beijing Platform of Action, and subscribes fully to the third MDG of promoting gender equality and empowering women. These and other commitments are domesticated through Uganda's Constitution, which guarantees equality between women and men, and includes affirmative action measures to increase women's role in decision-making and participation in the development process. Moreover, the Uganda Gender Policy provides a framework for gender-responsive development. These policies and frameworks have resulted in some modest success and the country is on track to achieve some of the key MDG 3 targets. The NDP defines "gender issues, negative attitudes, mind-set, cultural practices and perception" as a key binding constraint to socio-economic development in Uganda. Through this Plan, the challenge of women's decision-making at the household level, which is exacerbated by high levels of gender-based violence, will be addressed. It is noted that 59% of ever-married women aged 15 to 49 have experienced some form of physical and/or sexual violence. However, some progress has been made.

Notably, the ratio of girls to boys has reached 1 for primary education and recent increases in the ratio for tertiary education mean that this indicator is on track to reach parity by 2015 (Table 4). Progress has also been made at secondary levels of education, where the ratio stood at 0.84 in 2009 compared to 0.79 in 2000, although this is insufficient if this indicator is to be attained (Figure 17). The affirmative action of additional points to female applicants who wished to gain entry to university resulted in an increase in tertiary enrolment for girls, particularly in 2004.

The share of women in wage employment in the non-agricultural sector, another key indicator of women's empowerment, has declined from 39% in 2002/2003 to 28% in 2005/2006. This is an indication of continued gender disparities in the labour market and is exacerbated by other differences confronting women, such as less secure employment, lower skills levels and lower wages. Moreover, although women comprise an estimated 70% of those working in agriculture, women experience unequal access to, and control over, important productive resources, notably land, which limits their ability to raise productivity and even move out of subsistence agriculture.

Uganda's policies on affirmative action have steadily increased the share of women who take part in political decision-making at all levels of society. The share of women in the national Parliament has thus increased from 18% in 2000 to 30% in the current 8th Parliament—a remarkable increase, yet still short of fulfilling the gender parity principle established in the African Union's Solemn Declaration on Gender Equality in Africa.

Through the National Development Plan, government recognizes that critical gender inequalities remain, the outcomes of which contribute towards stalling progress on many MDGs and overall national development. Many of these gender inequalities are magnified in post-conflict areas of the north. The Plan also emphasizes that levels of sexual and gender-based violence are unacceptably high in Uganda, with 40% of women compared to 11% of men having experienced sexual violence in their lifetime (MOH 2006). Moreover, access to justice for victims of violence is considered extremely weak, as are prevention and treatment services. It is particularly worrisome that the first sexual encounter of 25% of girls is associated with the use of force (UDHS 2005/2006).

Figure 17 ENROLMENT RATIOS OF BOYS TO GIRLS AT DIFFERENT LEVELS OF EDUCATION

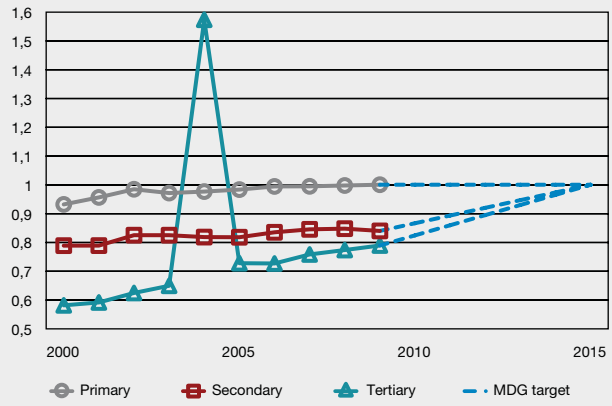
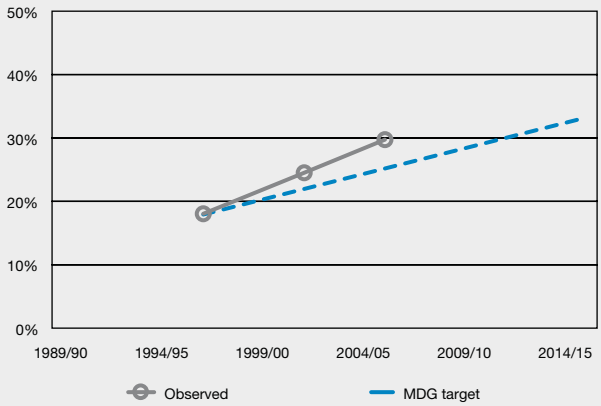


Figure 18 SHARE OF SEATS IN UGANDA'S PARLIAMENT HELD BY WOMEN



Sources: ESSAPR (2008/2009); www.uwopa.or.ug and www.parliament.go.ug.
Note: The spike in tertiary enrolment for girls in 2004 is attributed to a one-off provision of additional points to female applicants who wished to gain entry to university.

3.4 Goal 4: Reduce child mortality

Table 6: Target 4.A Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

STATUS OF PROGRESS: SLOW					
	1995	**2000/2001**	**2005/2006**	**2009**	**2015 target**
4.1 Under-five mortality rate (per 1,000 live births)	156	152	137	n/a	56
4.2 Infant mortality rate (per 1,000 live births)	81	88	76	n/a	31
4.3 Proportion of 1-year-old children immunised against measles	82%	63%*	89%**	81%	

Sources: UDHS (1995, 2000/2001, 2005/2006); immunisation data from UNEPI; NDP 2010/11-2014/15.
*Note: Data for indicators 4.1 and 4.2 are adjusted to remove districts not included in the 2000/2001 survey. * Year is 2001. ** Year is 2006.*

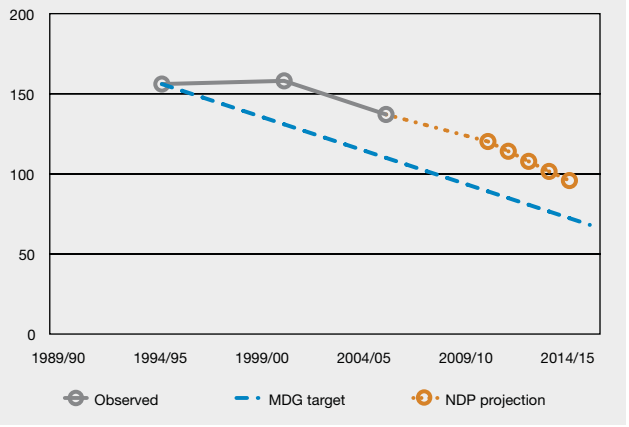
Indicators of child health and mortality show mixed progress over the past decade and, as indicated in Figure 19 and Figure 20, the rate of progress in both areas shows that acceleration is required to reach the target for reduction in child mortality. The under-five mortality rate has fallen from 156 per 1,000 live births in 1995 to 152 in 2001 and further to 137 in 2006 (Table 6). The infant mortality rate, which measures deaths among children younger than 1 year of age, rose between 1995 and 2001, from 81 to 88 per 1,000 live births, and fell again to 76 in 2006.

The Government recognises the important regional differences in under-five and infant mortality across Uganda (Figure 21), primarily because of the IDPs in the north. Also, mortality levels are much higher in rural areas than in urban areas. Kampala has the lowest level of mortality compared to the north, West Nile and southwest, which have the highest levels. Among those classified as IDPs in the 2006 survey, both under-five and infant mortality were much higher than the national average. The inequality in child health outcomes is also clear across different wealth categories. The levels of both infant and child mortality are about 40% lower in the wealthiest 20% of households in Uganda compared to the poorest 20%. However, the gap between the wealthiest and poorest households has narrowed in recent years despite the fact that the gap remains wide relative to the MDG target. Hence, it is a key priority of the Government of Uganda to sustain and accelerate attainment of MDG 4, especially among the poorest.

One analytical study[11] uses information on the direct relationship between infant mortality and household wealth, rates of immunization, basic health coverage and mothers' education, to simulate the impact of investments in these areas on infant mortality. The study shows that sustained economic growth, coupled with sizeable investments to ensure full vaccination coverage and access to basic health services for both mothers and their children, and mothers' completion of a full cycle of primary education leading to increased opportunities for secondary education, significantly reduce the infant mortality rate. While the pace of progress may not be strong enough to meet the MDG target, the study illustrates that a significant acceleration of progress is possible. Increasing vaccination rates is particularly effective in reducing infant deaths. Thus, it is particularly disconcerting that vaccination rates against childhood diseases such as measles have stagnated in recent years (Figure 23). The proportion of 1-year-old children immunized against measles declined between 1995 and 2001 from 82% to 63%. Following implementation of the 2001-2005 immunization revitalization strategic plan, measles immunization rose again in 2006 to 89%. The same pattern is evident in the provision of DPT3 vaccines, a combination of vaccines against three infectious diseases: diphtheria, pertussis (whopping cough) and tetanus. In 2009, the measles immunisation rate was 81%, which is below the 90% national target.

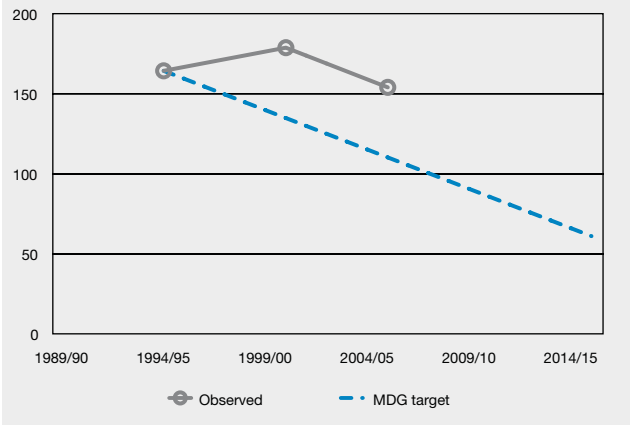
11) Ssewanyana, S. and S. Younger (2007) 'Infant Mortality in Uganda: Determinants, Trends and the Millennium Development Goals.' Journal of African Economies, 17(1):34-61.

Figure 19 UNDER-FIVE MORTALITY (PER 1,000 LIVE BIRTHS)



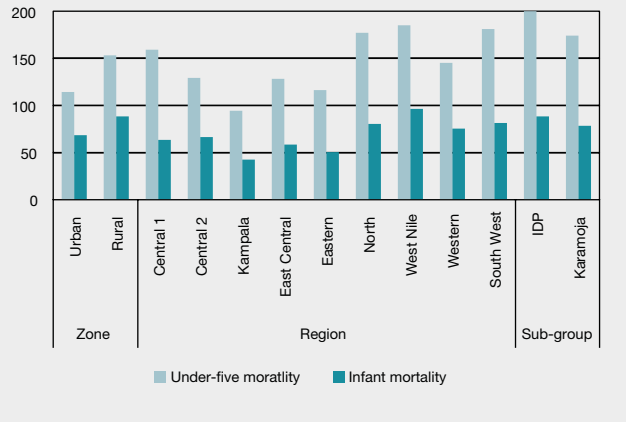
Sources: UDHS (1995, 2000/2001, 2005/2006); NDP 2010/11-2014/15.

Figure 20 INFANT MORTALITY (PER 1,000 LIVE BIRTHS)



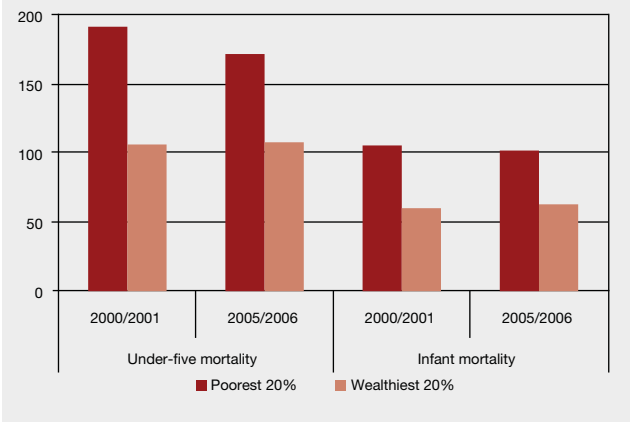
Sources: UDHS (1995, 2000/2001, 2005/2006).

Figure 21 UNDER-FIVE AND INFANT MORTALITY (PER 1,000 LIVE BIRTHS)



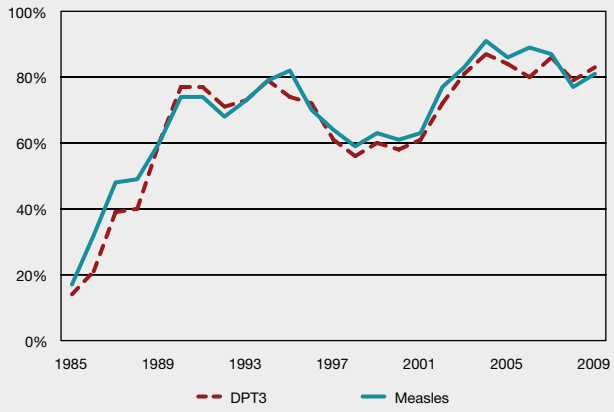
Sources: UDHS (2000/2001, 2005/2006).

Figure 22 UNDER-FIVE AND INFANT MORTALITY BY WEALTH QUINTILE



Sources: UDHS (2000/2001, 2005/2006).

Figure 23 PROPORTION OF 1-YEAR-OLD CHILDREN IMMUNISED AGAINST MEASLES AND DPT3 VACCINE



Source: UNEPI.

3.5 Goal 5: Improve maternal health

Table 7: Target 5.A Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

STATUS OF PROGRESS: SLOW				
	1995	**2000/2001**	**2005/2006**	**2015 target**
5.1 Maternal mortality ratio (per 100,000 births)	506	505	435	131
5.2 Proportion of births attended by skilled health personnel	38%	39%	42%	100%

Sources: UDHS (1995, 2000/2001, 2005/2006).

Although there was stagnation in progress in maternal health between 1995 and 2001, accelerated progress was observed in 2006. According to the data collected in the Uganda Demographic Health Survey (UDHS), the maternal mortality ratio stagnated at 506 per 100,000 births in 1995 and 505 in 2001, but has since declined to 435 in 2006 (Table 7). This suggests that the incidence of maternal mortality is declining. However, it is clear that the decline has not been fast enough to ensure that Uganda is on track to meet MDG 5 (Figure 24). These trends should be interpreted with caution, however. As highlighted by UBOS and the Ministry of Health in the 2007 UDHS report, the methodology used and the sample sizes implemented in the three surveys do not allow for precise estimates of maternal mortality. The errors that follow from the representative sample around each of the estimates are large and, consequently, the changes are not statistically significant. It is therefore not possible to say confidently that maternal mortality has declined.

Table 8: Target 5.B Achieve, by 2015, universal access to reproductive health

STATUS OF PROGRESS: SLOW			
	1995	**2000/2001**	**2005/2006**
5.3 Contraceptive prevalence rate	15%	23%	24%
5.4 Adolescent birth rate (number of births by women aged 15-19 per 1,000 women in that age group)	198	190	159
5.5 Antenatal care coverage, at least one visit/at least four visits among women aged 15-49 who had a live birth in the five years preceding the UDHS survey	91%/47%	92%/42%	94%/47%
5.6 Unmet need for family planning	29%	35%	41%

Sources: UDHS (1995, 2000/2001, 2005/2006).

A decline in the maternal mortality ratio will be accelerated by improvements in other related indicators, such as antenatal care coverage, delivery in health facilities, and medical assistance at delivery, all of which have improved only marginally over the last ten years. Most notably, the share of births that were attended by skilled health personnel merely increased from 35% to 44% in the decade after 1995. This national average masks great inequalities across the population. Among the poorest 20% of the population, the share of births attended by skilled health personnel was 29% in 2005/2006 compared to 77% among the wealthiest 20% of the population (Figure 26). There has been a slight improvement in the situation for the poorest households, though, and the Government is committed to sustaining and accelerating this progress.

Figure 24 MATERNAL MORTALITY (PER 100,000 BIRTHS)

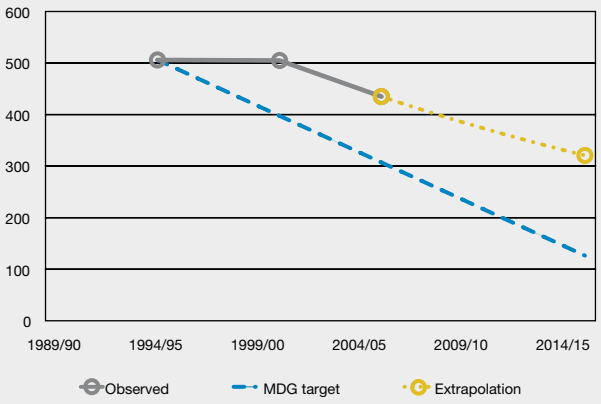
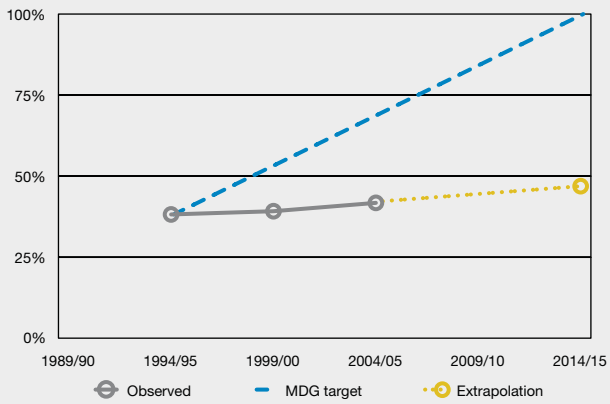


Figure 25 PROPORTION OF BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL*



Sources: UDHS (1995, 2000/2001, 2005/2006).
*Note: * Includes doctor, midwife, nurse, medical assistant, clinical officer, and nursing aide.*

Figure 26 SHARE OF DELIVERIES ATTENDED BY SKILLED PROVIDER* BY HOUSEHOLD WEALTH QUINTILE

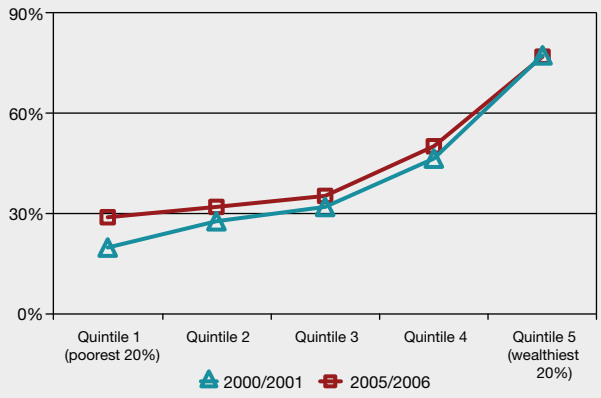
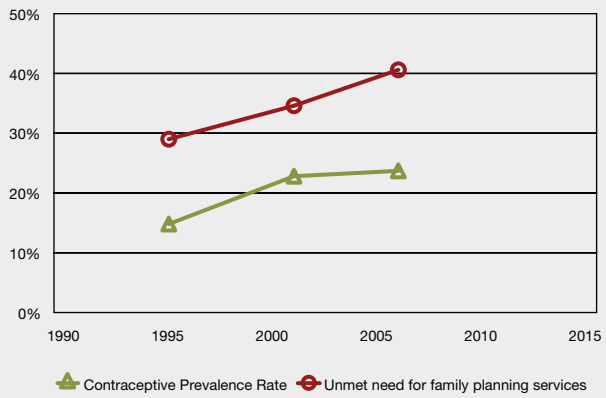


Figure 27 CONTRACEPTIVE PREVALENCE AND UNMET NEEDS FOR FAMILY PLANNING SERVICES



Sources: UDHS (1995, 2000/2001, 2005/2006).
*Note: * Includes doctor, midwife, nurse, medical assistant, clinical officer, and nursing aide.*

3.6 Goal 6: Combat HIV/AIDS, malaria and other diseases

Table 9: Target 6.A Have halted by 2015 and begun to reverse the spread of HIV/AIDS

STATUS OF PROGRESS: REVERSAL					
	2000/2001	**2004/2005**	**2005/2006**	**2012 target**	**2015 target**
6.1 HIV prevalence among population aged 15-24 years: 15-19 years, girls/boys 20-24 years girls/boys	n/a n/a n/a	n/a 2.6%/0.3% 6.3%/2.4%	n/a n/a n/a	n/a n/a n/a	n/a n/a n/a
6.2 Condom use at last high-risk sex, female/male	39%/61%	48%/53%	35%/57%	70%/73%	
6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS, female/male	27%/39%	28%/35%	31%/42%	n/a	
6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	n/a	0.90	0.96	1.00	

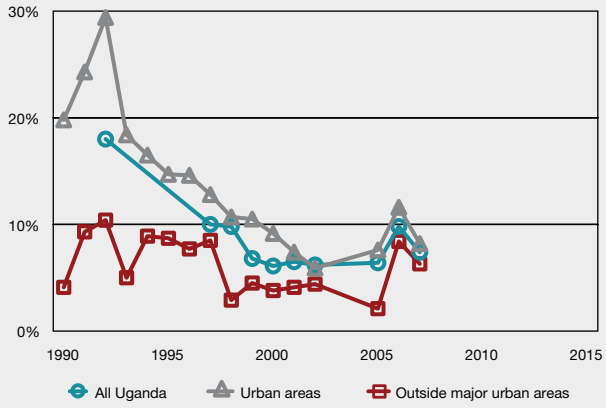
Sources: UDHS (2000/2001, 2005/2006); UAIS (2004/2005).

Uganda made commendable progress during the 1990s to reduce the spread of HIV/AIDS. The proportion of pregnant women attending antenatal care clinics who were HIV-positive fell from a high of 18% in 1992 to around 6% in 2000. The success was due to a variety of measures that enabled changes in sexual behaviour, as well as provision of care and support services. Over that period, the reduction in HIV prevalence was particularly rapid in urban areas (Figure 28) and Uganda was one of the first countries in the world to report a decline in the rate of new infections and a contracting epidemic. Prevalence among the youth is the established MDG indicator and, for Uganda, this indicator, measured in the whole population and not just among pregnant women, showed that 2.6% of girls and 0.3% of boys aged 15-19 years were HIV-positive in 2005/2006. Moreover, among those aged 20-24 years, 6.3% of girls and 2.4% of boys were HIV-positive (Table 9 and Figure 29). The vulnerability of women is most apparent in younger age groups, with young women aged 20-24 almost three times more likely to be infected than young men in the same age group. The main reason for this difference is high-risk behaviour in the sexual relationships between young women and much older male sexual partners, sexual violence and the ability of women to negotiate for safer sex.

Unfortunately, there is no comparable data for earlier or later years to provide a picture of how prevalence has been evolving. Moreover, progress towards halting and reversing the spread of HIV is regarded to be better measured when using data on new infections (incidence). In the absence of direct measures of incidence, the Ministry of Health and its partners rely on epidemiological modelling. Figure 30 presents data from one such recent modelling exercise. With more than 200,000 new infections annually, the epidemic clearly peaks in the early 1990s, falling markedly in the years thereafter. However, the data since the late 1990s show a worrying, upward trend in the number of new infections. It is estimated that more than 130,000 people have been infected with HIV so far in 2010. On this basis, the overall assessment in this report is that, while Uganda may earlier on have been well under way to reverse or halt the spread of HIV, the situation today is deteriorating. The overall assessment of progress towards Target 6.A is therefore: Reversal.

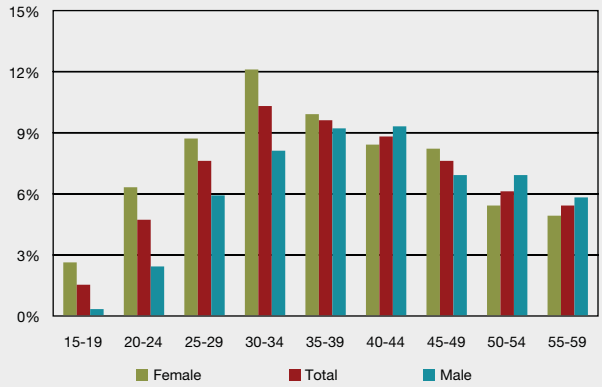
The recent epidemic expansion in the absolute number of new infections is related to high population growth, but indicators also show persistently high levels of risky behaviour (e.g., multiple partners and decreased condom use), and only 32% of young people aged 15-24 have comprehensive knowledge about HIV (Figure 31). The total number of people living with HIV in 2010 is around 1.2 million, which is higher than at the peak of the epidemic in the 1990s. Nationally, the epidemic has also evolved from a mature generalized epidemic, with transmission occurring through casual relationships largely in the 15- to 19-year-old age group, into a heterogeneous epidemic, with transmission shifting to older age groups and among the large group of people who are married or cohabitating. Recent data show that 43% of new infections occur in this group. Moreover, commercial sex work is thought to be an important bridge of the epidemic into other population groups. The President and senior officials have recognized the reversal of past gains in the fight against HIV. As a result, renewed and scaled up HIV prevention efforts are the central goals of the National Strategic Plan on HIV and are highlighted in the National Development Plan (2010).

Figure 28 HIV PREVALENCE AMONG PREGNANT WOMEN 15-49 ATTENDING ANC



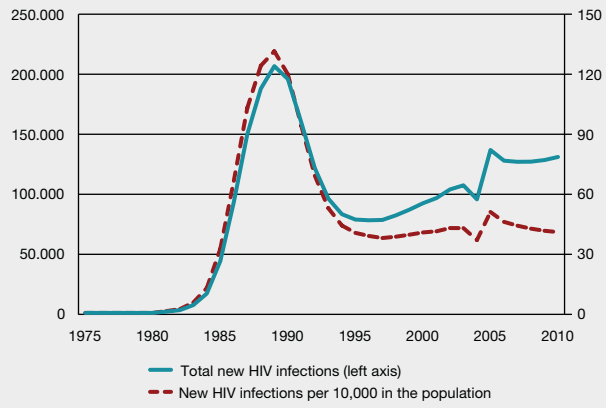
Sources: ANC data.

Figure 29 HIV PREVALENCE BY AGE GROUP, 2004/2005



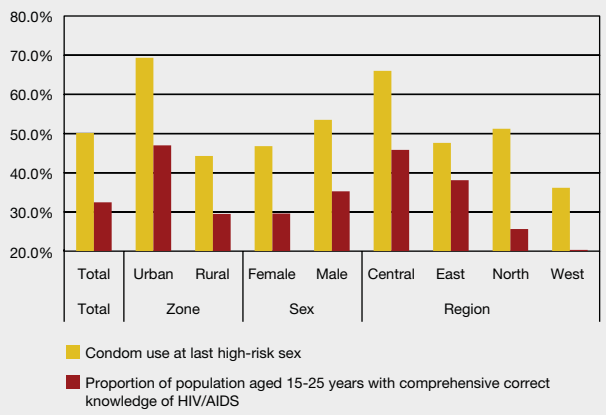
Sources: UAIS (2004/2005).

Figure 30 NEW HIV INFECTIONS



Sources: Hladik et al. (2009).

Figure 31 PREVENTION OF HIV, 2005/2006



Sources: UAIS (2004/2005).

Table 10: Target 6.B Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

STATUS OF PROGRESS: ON TRACK				
	2008	**2009**	**2012 target**	**2015 target**
6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs	44%	54%	80%	

Sources: UAC (2010).

Uganda has made commendable progress in terms of rolling out Anti-Retroviral Therapy (ART), expanding coverage from 44% in 2003 to 54% in 2009 (Table 10). As such, the country is on track to achieve the 2012 target of 80% coverage. Currently, about 200,000 of the 373,000 people who need ART have access to it (UNGASS 2010). These gains, though, are fragile, as the number of people who need ART grows each year and future financing to expand ART coverage is uncertain. In addition, newly released international guidelines recommend the much earlier initiation of ART; if adopted as government policy, this recommendation would significantly increase the number of people who need ART.

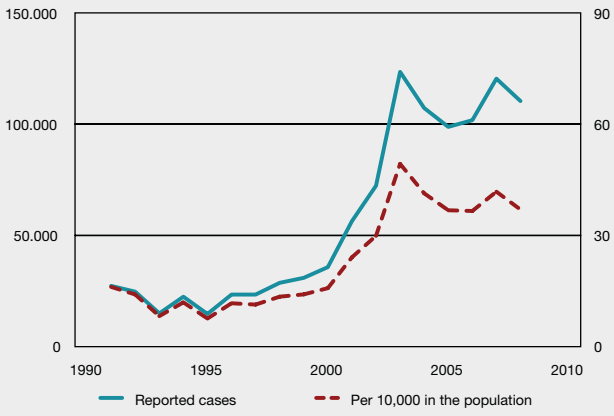
Table 11: Target 6.C Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

STATUS OF PROGRESS: SLOW						
	2003	**2006**	**2007**	**2008**	**2010**	**2015**
6.5 Reported cases of malaria (per 10,000)	49	36	42	37	n/a	n/a
6.6 Proportion of children under 5 sleeping under insecticide-treated bed nets	8%	10%	n/a	33%*	50%	n/a
6.7 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	n/a	61%	n/a	n/a	n/a	n/a
6.8 Incidence, prevalence and death rates associated with tuberculosis:						
Incidence rate/100,000	411	355	330	310	n/a	
Prevalence rate/100,000	652	561	426	350	n/a	103
Death rate/100,000	96	84	93	110	n/a	35
6.9 Proportion of tuberculosis cases detected and cured under directly observed treatment short course						
Treatment success rate	69%	70%	75%	80%	n/a	85%
New smear positive case detection rate	53%	50%	50%	57%	n/a	70%

Sources: UBOS (2003); UHDS (2005/2006); Malaria Prevalence Survey (2009); National Tuberculosis and Leprosy Programme database.
*Notes: * Year is 2009.*

Malaria is responsible for more illness and death than any other single disease in Uganda. People with low immunity, such as pregnant women, young children and people living with HIV/AIDS, are particularly vulnerable to morbidity and mortality associated with malaria. But all people living in Uganda are at risk of being infected with malaria parasites and suffering from resulting illness and potential fatality.[12] In most parts of Uganda, temperature and rainfall are sufficient to allow a stable, year-round (perennial) malaria transmission at high levels with relatively little seasonal variability. Only in the high altitude areas of the southwest, west and east is malaria transmission generally low. However, with the increasing threat from climate change, extension of malaria to these highlands could pose a serious challenge. While tremendous progress has been made in the fight against malaria through the improvement of health system performance and increased public knowledge about malaria, increasing resistance to commonly used treatments remains a serious challenge to malaria control

Figure 32 **REPORTED CASES OF MALARIA**



Sources: MOH annual health sector performance reports; UDHS (2005/2006); Malaria Prevalence Survey (2009).

12) http://www.health.go.ug/mcp/index2.html

Figure 33 IPT2+ TREATMENT AND ITN USE

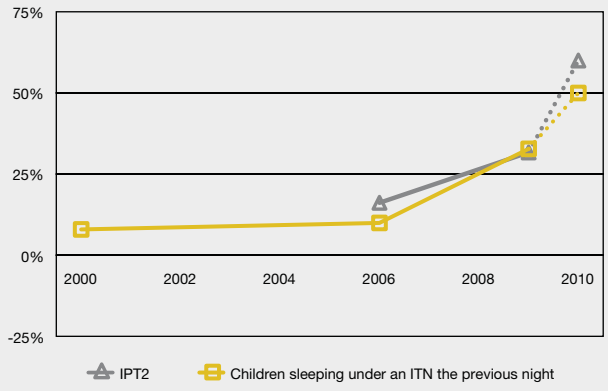
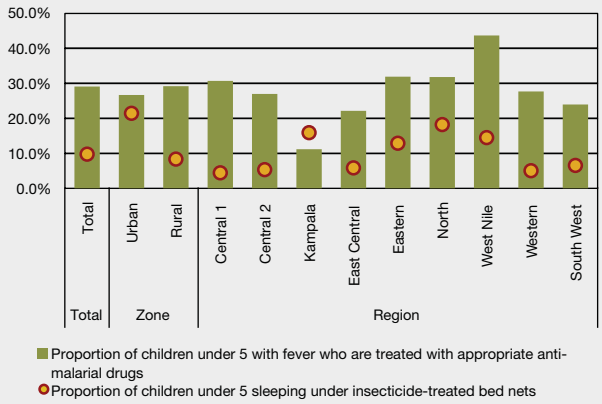


Figure 34 MALARIA TREATMENT AND PREVENTION, 2005/2006



Sources: MOH annual health sector performance reports; UDHS (2005/2006); Malaria Prevalence Survey (2009).

In 2008, over 110,000 malaria cases were reported, corresponding to 37 per 10,000 in the population. While recent trends have stabilised, rates are high, indeed, significantly higher than in the 1990s, when the number of reported cases hovered around 15,000-30,000 of the population, or 7-14 per 10,000 (Table 11 and Figure 32). The rise in the number of malaria cases since 2000 may be related to an increase in health service coverage, improved reporting, the abolition of user fees in 2001, resistance to the commonly available anti-malarial drugs and inadequate coverage of the preventive measures. In recent years, there has been some progress in the implementation of the preventive measures. The share of children under five sleeping under an Insecticide Treated Net (ITN) has increased from 8% in 2000 to 33% in 2009 and access to ITP2 treatment has doubled from 16% to 31% over the three-year period from 2006-2009. However, for both ITN and IPT2+, the achievements fell short of targets (Figure 33). Moreover, still less than 30% of children who needed treatment in 2005/2006 received treatment with appropriate anti-malarial drugs. This had great regional variation, from just over 10% in Kampala to more than 40% in West Nile (Figure 34). One key contributor to the limited access to anti-malarial drugs is the persistently high levels of stock-outs of essential medicines at the country's hospitals and clinics (see below).

Figure 35 INCIDENCE, PREVALENCE AND DEATH RATES OF TB (PER 100,000 IN POPULATION)

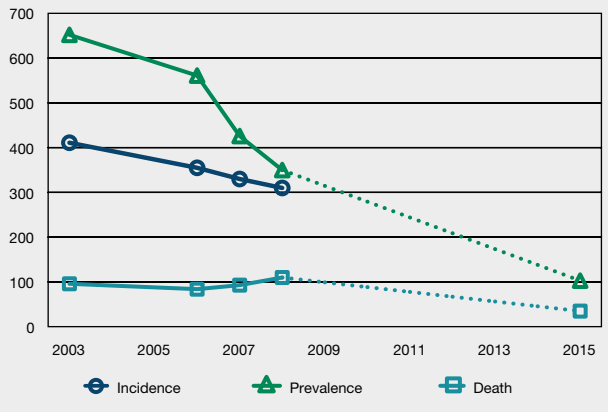
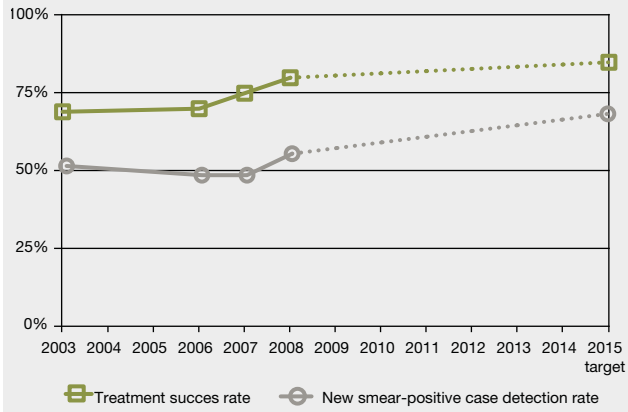


Figure 36 TB TREATMENT AND DETECTION RATES



Source: National Tuberculosis and Leprosy Programme database.

Tuberculosis is another major disease included in the MDG framework and one against which there has recently been much progress. The prevalence of TB has been reduced from 652 per 100,000 in the population in 2003 to 350 in 2008. Over the same period, incidence has also dropped from 411 per 100,000 in the population to 310. If the current speed of progress continues, Uganda will attain the 2015 goal of a prevalence of 103 per 100,000 in the population. However, TB death rates have stagnated for most of the last decade and so the one-third reduction targeted for 2015 looks unrealistic (Table 11 and Figure 35). Case detection rates have stagnated around 50% in recent years and treatment success rates have fluctuated around 70% (Figure 35 and Figure 36). For both indicators, the progress seen since 2006-2007 would have to be sustained if the 2015 targets are to be met. Key challenges in fighting TB include: inadequate financing, lack of qualified laboratory personnel, high HIV prevalence, and the emergence of drug-resistant strains of TB.

3.7 Goal 7: Ensure environmental sustainability

Table 12: Target 7.A Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources and Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss

STATUS OF PROGRESS: SLOW						
	1990	**2000**	**2004**	**2006**	**2010 target**	**2015 target**
7.1 Proportion of land area covered by forest	25%	21%	18%	18%	n/a	n/a
7.2 CO2 emissions, kg CO2 per $1 GDP (PPP)	0.0824	0.0801	0.0754	0.0944	n/a	n/a
7.3 Consumption of ozone-depleting substances (in metric tons)	15.8*	30.6	24.3	6.5**	n/a	n/a
7.4 Proportion of fish stocks within safe biological limits	n/a	n/a	n/a	n/a	n/a	n/a
7.5 Proportion of total water resources used	n/a	n/a	0.5%	n/a	n/a	n/a
7.6 Proportion of terrestrial and marine areas protected	13%*	15%***	15%	15%	16%	n/a
7.7 Proportion of species threatened with extinction	n/a	n/a	n/a	2%	n/a	n/a

Sources: Data is from State of the Environment Reports 2006/2007 and 2008/2009 by NEMA.
*Notes: * Year is 1992; ** Year is 2005; *** Year is 2002.*

Uganda's natural resource base is critical for social and economic development. Unfortunately, environmental data in Uganda, as in most developing countries, is poor and incomplete due to inadequate monitoring and reporting. National targets are also missing. This complicates an assessment of progress towards MDG targets 7.A and 7.B (and, as will be discussed below, there are similar measurement challenges related to 7.C and 7.D). But through efforts, especially by the National Environmental Management Agency (NEMA), to gather and disseminate information and data on Uganda's environment, it is possible to provide a tentative assessment. The overall assessment is that, with progress in some areas and setbacks in others, progress towards targets 7.A and 7.B is slow.

When it comes to integrating the principles of sustainable development into country policies and programmes, Uganda has made headway in recent years. The Government has established various policies, laws, institutions, regulations and standards to guide the management of natural resources. For instance, the National Environment Management Policy (1994) gave birth to the National Environment Statute (1995) and, among other things, instituted NEMA. Given that the management of environment and natural resources is decentralised in Uganda, the Ministry of Local Government has sought to mainstream environment and natural resources into the performance measures for all levels of local government. However, the implementation and level of compliance with environment and natural resource policies, laws, institutions, regulations, standards and guidelines are still considered very low, leading to the misuse and degradation of the environment.

Poverty and rapid population growth are the primary causes of biodiversity loss, threatening the existence of species, ecosystems and eco-regions throughout Uganda, and there are indications that the depletion of natural resources and the loss of biodiversity are accelerating. Indeed, the rate of biodiversity loss in Uganda was calculated in 2004 to be 10-11% per decade. The share of land covered by forest declined from 25% in 1990 to 18% in 2006. Moreover, the decline of fish species in Lake Victoria is considered to be the largest documented loss of biodiversity ever inflicted on an ecosystem by humankind,[13] where 20 species of fish have been depleted in only the last 40 years, leaving only three species. Many major mammal species, such as rhinos, cheetahs, and oryx were extirpated during Uganda's decades of internal strife in the 1970s and 1980s. Bird and fish species continue to decline in number and distribution throughout the country.

Table 13: Target 7.C Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

STATUS OF PROGRESS: ON TRACK				
	1999/2000	**2002/2003**	**2005/2006**	**2014/2015 target**
7.8 Proportion of population using an improved drinking water source (urban/rural)	57% (87%/51%)	63% (87%/58%)	68% (87%/64%)	89% (100%/70%)
7.9 Proportion of population using an improved sanitation facility (urban/rural)	n/a	n/a	(74%/62%)*	(100%/77%)

Sources: UNHS (1999/2000, 2002/2003, 2005/2006); NDP 2010/11-2014/15.
*Notes: * Year is 2007/2008.*

Sanitation and the provision of safe water have been priorities in the successive PEAPs and remain a priority within the National Development Plan. Public investments in the sub-sectors for urban and rural water supply have yielded significant results in recent decades. The share of individuals with access to safe water has increased from 57% in 1999/2000 to 68% in 2005/2006 (Table 13).[14] The Government is thus on course to meet its target of 89% access in 2014/2015, which is considered a much more ambitious target than the implied MDG target (Figure 37). Even if the share of the population in rural areas with access to safe water is lower than in urban areas, it is in the rural areas where progress has been greatest. Administrative data from the Directorate of Water Development Management Information System (DWD-MIS) shows that access to improved rural water supply has trebled, from 21% in 1991 to 63% in 2007. Assessment of progress towards access to safe sanitation facilities is complicated by differences in methodologies for measurement between various sources. In the UDHS, for instance, safe sanitation is defined to include the following sanitation technologies: flush toilet, ventilated improved pit latrine, traditional pit latrine with a slab, or composting toilet. Using this definition, the 2005/2006 UDHS found that 21% of urban residents and 9% of rural residents had access to improved sanitation. However, these estimates differ quite substantially from the figures reported by the Water and Sanitation section in the NDP, where access to improved sanitation in 2007/2008 is estimated to be 74% for urban areas and 62% for rural areas. Government departments, UBOS and UN agencies must clarify and harmonise their definitions of safe water and sanitation as they monitor MDG 7.C.

13) Witte, F. et al. (1999) 'Lake Victoria's ecological changes and their relationships with riparian societies.' In: 'Ancient Lakes' by Kawanabe, H., Coulter, G.W. and Roosevelt, A.C. (eds.). Kenobi Productions: Ghent.
14) Improved water sources such as taps, boreholes, protected and gravity flow schemes are defined as safe by UBOS.

Figure 37 SHARE OF POPULATION WITH ACCESS TO SAFE WATER

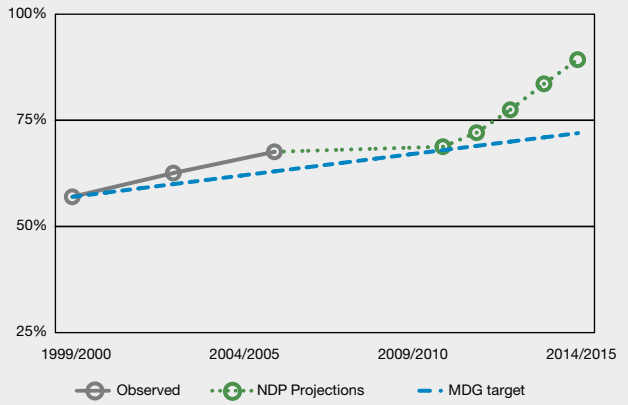
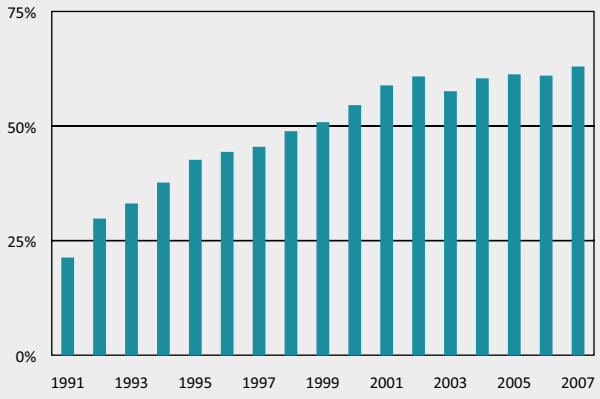


Figure 38 ACCESS TO IMPROVED RURAL WATER SUPPLY (% COVERAGE OF RURAL POPULATION)



Sources: UNHS (1999/2000, 2002/2003, 2005/2006); NDP 2010/11-2014/15; DWD-MIS data from the Ministry of Water and Environment.

Table 14: Target 7.D By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

STATUS OF PROGRESS: ON TRACK				
	2002/2003	**2005/2006**	**2008**	**2015 target**
7.10 Proportion of urban population living in slums*	34%	34%	27%	n/a

Sources: UNHS (2002/2003, 2005/2006); USDS (2008).
*Note: * The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with either walls or floors made of temporary materials, or no or uncovered pit latrine.*

Special tabulations on the household survey data by UBOS suggest that the share of the urban population living in slums is on the decline (Table 14). Slum dwellers were defined as urban population that live in dwellings made from temporary materials or without access to safe sanitation. According to this definition the share of slum dwellers has decreased from 34% in 2005/2006 to 27% in 2008. However, UBOS cautions that the survey sampling instrument in its current form is not capturing adequately the extent of slums in urban zones. With urbanisation in Uganda expected to accelerate, the capture of this and other related indicators must be improved.

3.8 Goal 8: Develop a Global Partnership for Development

Table 15: Target 8.B Address the special needs of the least developed countries*

STATUS OF PROGRESS: REVERSAL					
	2005/2006	**2006/2007**	**2007/2008**	**2008/2009**	**2009/2010**
8.1 Net ODA, total sum of off-budget and on-budget (in US$ million)	n/a	1,561.54	912.29	1,185.73	1,534.57
8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)	n/a	53.8%	61.8%	43.8%	40.2%
8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied	n/a	n/a	n/a	n/a	n/a
8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes (ODA/GDP in Uganda)	86%**	86%**	86%**	44%	52%
8.5 ODA received in small island developing States as a proportion of their gross national incomes	n/a	n/a	n/a	n/a	n/a
8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty	n/a	n/a	n/a	n/a	n/a
8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries	n/a	n/a	n/a	n/a	n/a
8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product	n/a	n/a	n/a	n/a	n/a
8.9 Proportion of ODA provided to help build trade capacity	n/a	n/a	n/a	n/a	n/a

Sources: MOFPED; NDP 2010/11-2014/15.
*Notes: * Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction. ** PEAP3 Average.*

The eighth and final MDG (Developing a global partnership for development) is designed in a way that makes monitoring progress for any one country difficult. In fact, most of the targets under MDG 8 relate more to developed countries' commitments necessary to complete the mutual responsibility for global development envisaged in the Millennium Declaration. A special set of reports is completed by the UN's MDG Gap Task Force to measure progress globally, and individual developed countries such as Sweden, Netherlands and the UK have completed MDG Country Reports that focus on their performance under MDG 8. In this section of Uganda's 2010 progress report on the MDGs, we have sought to provide data for those indicators where there is relevant information for Uganda. This way, we are interpreting the targets and indicators under MDG 8 in a national context to provide an assessment of how the global partnership for development is changing in relation to Uganda and whether it is improving. Most of the indicators relevant for national-level monitoring relate to Official Development Assistance (ODA). This also explains why data for some indicators in the tables below is not available (N/A).

While the Government of Uganda is vigorously working its way out of aid dependence, it still acknowledges the vital role that aid has to play in financing and technical assistance. With over half the population living below the poverty line in the early 1990s and many basic public services lacking, the need for large amounts of aid targeted at social sectors was very clear. The change in the profile of poverty over the last 15 years, though, demands that aid more support productive sectors.

Government is therefore keen to see more of its development partners direct large amounts of their ODA to sectors that are critical for its ability to address its strategic objectives of employment creation and socio-economic transformation.

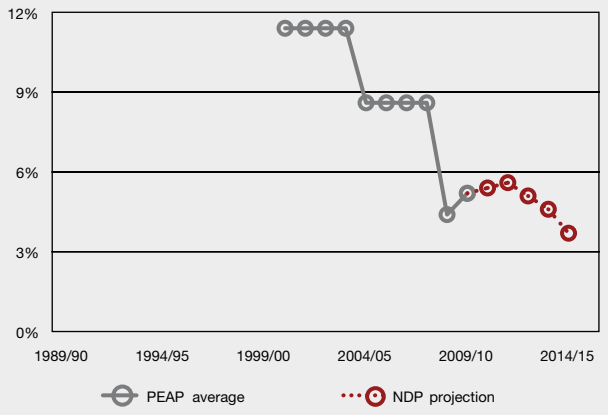
Table 16: Target 8.D Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

STATUS OF PROGRESS: ACHEIVED					
	2005/2006	**2006/2007**	**2007/2008**	**2008/2009**	**2009/2010**
8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)	n/a	n/a	n/a	n/a	n/a
8.11 Debt relief committed under HIPC and MDRI Initiatives (in US$ million)	77.7	123.4	135.1	127.6	126.7
8.12 Debt service (in US$ million)	117.4	60.9	62.2	62.6	60.8

Source: MOFPED.

While ODA as a share of GDP has declined over the past PEAP periods, ODA is expected to fall farther during the implementation of the NDP: from 5.6% in 2011/12 to 3.7% in 2014/15 (Figure 39). ODA per capita is expected to increase from just over US$ 22 in 2008/2009 to US$ 39 in 2011/2012 only to fall back to USD35 in 2014/15. This is significantly below the 12% share of ODA to GDP that the Millennium Project estimated that Uganda would need on average over the period 2005-2015 in order to finance programmes that would enable the country to meet the MDGs.[15] It is also contrary to the pledges made by the leaders of the G8 group of nations at their summit in Gleneagles in Scotland in 2005. The MDG Africa Steering Group has estimated that the global commitments to increase ODA to sub-Saharan Africa as pledged at Gleneagles would correspond to a level of ODA of USD85 per capita in each country. On this basis it is easy to compute the 'Gleneagles gap' in Uganda as the difference between projected ODA from 2010/11 and the USD85 per capita pledged at Gleneagles. This gap ranges between USD46-50 per capita over the planning period 2010/11-2014/15. The total gap is US$ 1.7 billion in the first year and US$ 1.87 billion in the final year of the NDP. The evolution and size of the 'Gleneagles gap' is also illustrated in Figure 40. The share of bilateral ODA remains significant in total ODA to Uganda. It is in steady decline, though, having fallen from 53.8% in 2006/2007 to 40.2% in 2009/2010. Considering that there has not been a significant increase in ODA disbursements to Uganda, this reflects, on the one hand, the growing preference among development partners to channel their assistance through multi-lateral institutions and arrangements and, on the other hand, their waning attachment to their own commitments.

Figure 39 **OVERSEAS DEVELOPMENT ASSISTANCE TO UGANDA (IN % OF GDP)**



Source: NDP 2010/11-2014/15.

15) Sachs J. et al. (2004) 'Millennium Development Goals Needs Assessment,' Working Paper No. 17, Millennium Project.

Figure 40 ODA IN US$ PER CAPITA

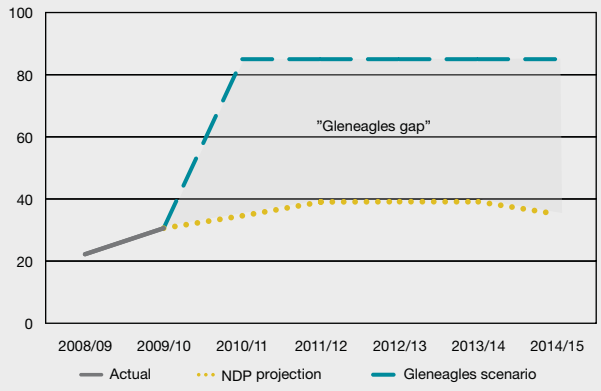
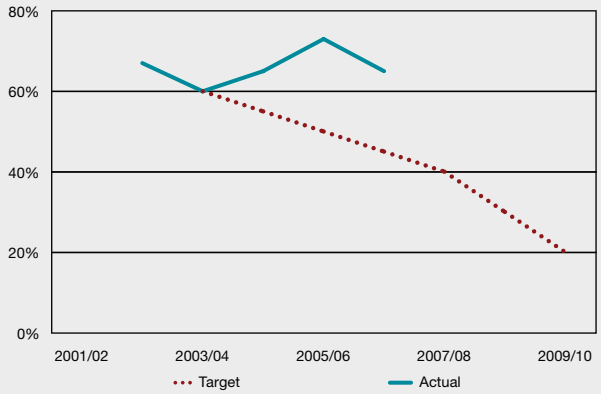


Figure 41 STOCK-OUTS OF TRACER DRUGS



Source: NDP 2010/11-2014/15; Annual Health Sector Performance Assessment.

The amount of savings Uganda has benefited from as a result of the various debt relief initiatives has generally been significant, especially given the poverty sensitivity of the programmes financed by these savings. Debt relief savings over the period 2005/2006 and 2009/2010 amounted to an annual average of US$ 118 million. With Uganda's foreign earnings from the export of goods and services now standing at US$ 2.8 billion,[16] the country's debt service payments are an increasingly smaller share of its export earnings. Hence, the Government may increase its external borrowing in order to make the strategic productive investments identified in the country's National Development Plan 2010/11–2014/15.

Nevertheless, the Government remains committed to contracting its debt under concessional terms as much as possible in order to avoid sliding back to the unsustainable debt levels experienced before the debt relief initiatives.

MDG 8 includes a target on providing access to affordable essential drugs in developing countries. In the absence of detailed data to measure access directly, progress towards this target is measured using the availability of a selection of essential medicines, or "tracer drugs," in health facilities. These drugs include selected antibiotics used for the treatment of common infections, anti-malarials, vaccines and family planning pills. The data shows that progress has been stagnant, estimated between 60 and 73% in the most recent period for which monitoring visits to health facilities have been carried out (Figure 41 and Table 17). The national short-term target is to keep levels of stock-outs at only 20% of the health facilities.

16) *MOFPED (2010) 'Background to the Budget 2010/11 Fiscal Year', Kampala: p. 49.*

Table 17: Target 8.E In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

STATUS OF PROGRESS: STAGNANT						
	2002/2003	**2003/2004**	**2004/2005**	**2005/2006**	**2006/2007**	**2009/2010 target**
8.12 Proportion of population with access to affordable essential drugs on a sustainable basis as measured by stock-outs of tracer drugs	67%	60%	65%	73%	65%	20%

Source: Annual Health Sector Performance Assessment.

Table 18: Target 8.F In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

STATUS OF PROGRESS: ON TRACK					
	2004	**2005**	**2006**	**2007**	**2008**
8.13 Telephone lines per 100 population	0.3	0.4	0.5	0.6	0.5
8.14 Cellular subscribers per 100 population	4.5	5.7	9.8	18.1	28.9
8.15 Internet users per 100 population	1.1	3.7	5.8	6.7	8.4

Source: Compiled using data from Uganda Communications Commission and UBOS.

The final set of indicators under MDG 8 relates to the availability of information and communications technology, which are considered important enablers of development and for actively participating in the global partnership. It is also an area where Uganda's liberalized economy has supported private sector development and rapid expansion of the availability of new technologies, with substantial increases in the percentage of people having cellular or fixed-line telephones and internet access. Information and communication have greatly improved, especially with the introduction of competition in the telecommunications industry. While the number of fixed-line telephones per 100 people rose from 0.3 to 0.5 between 2004 and 2008, the expansion in cell phone subscribers per 100 people increased more than six-fold, from 4.5 to 28.9 (Table 18). The increase in the number of internet users per 100 people has been even faster over the same relatively short period, rising from 1.1 in 2004 to 8.4 in 2008.

SECTION 4

SPECIAL THEME: ACCELERATING PROGRESS TOWARDS IMPROVING MATERNAL HEALTH

Photo: UNFPA

4. SPECIAL THEME: ACCELERATING PROGRESS TOWARDS IMPROVING MATERNAL HEALTH

4.1 Introduction

Government is committed to improving maternal health despite implementation challenges. As a result of the growing population, the absolute number of women that die giving birth has increased by 16% since 1995, but the maternal mortality rate has come down. Every day, an estimated 16 women die from giving birth in Uganda. On average, that is one death every hour and a half and close to 6,000 every year. In view of implementation challenges which the Government is currently addressing, MDG 5 targets are unlikely to be met by 2015. The Government acknowledges that effective interventions to improve maternal health exist, but their implementation faces significant bottlenecks.

The main objective of this thematic Chapter of the 2010 MDG Country Report for Uganda is to reflect on the country's performance on the MDG 5 targets; to determine the extent to which priority interventions have been effectively implemented; to identify and prioritise the bottlenecks that hinder or slow down the implementation of these interventions; and to set out feasible solutions on which to focus the efforts and resources of Government and its partners in order to accelerate progress. This is not intended as a new framework; it is rather intended to support implementation of the existing Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda, 2007-2015 (sometimes just referred to as the "Roadmap") and other relevant government strategies. This chapter is structured according to the MDG Acceleration Framework (MAF), which has been designed specifically to support national efforts to accelerate and sustain progress towards MDGs.

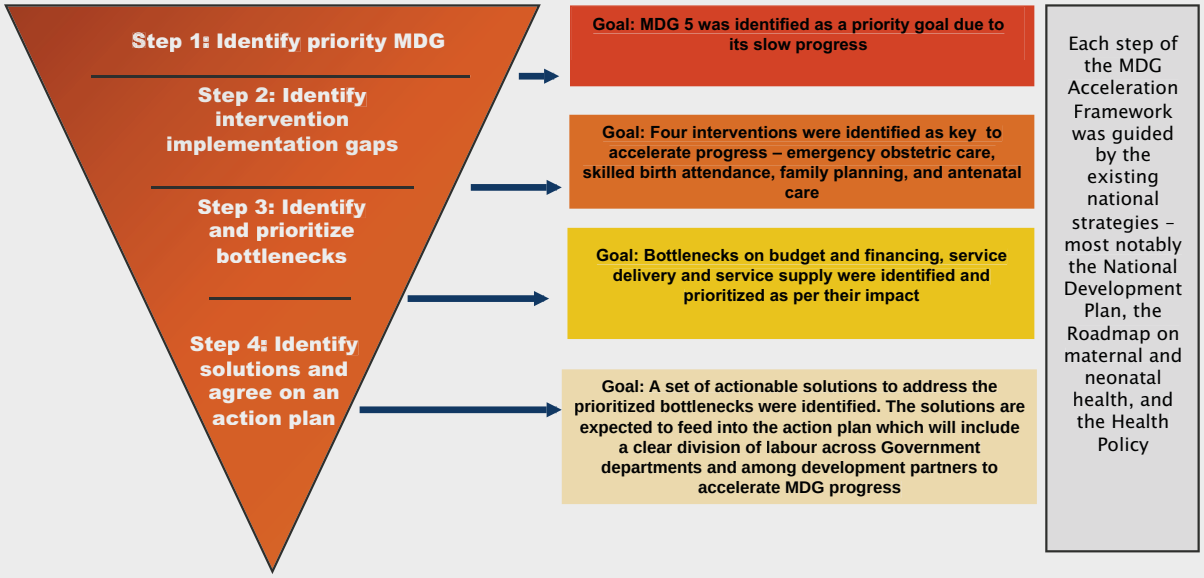
This rest of this chapter is subdivided into five sections. Section 4.2 introduces the MAF and outlines its application to MDG 5 in Uganda. Section 4.3 reflects on Uganda's performance with regard to the MDG 5 targets. Section 4.4 highlights gaps in the implementation of key maternal health interventions. Section 4.5 identifies possible bottlenecks in policy and planning, service deliver and utilisation, and financing that are considered to hinder effective implementation. Finally, Section 4.6 focuses on possible solutions and options for accelerating progress.

4.2 The MDG Acceleration Framework in Uganda

The application of the MAF involved four basic steps. In the first step, priority MDG targets were selected. The MDG 5 targets were selected specifically because progress towards them has been slow in recent years. In the second step, interventions were prioritized. In the prioritization process, key issues and questions were addressed. For example, are all relevant, evidence-based, cost-effective and country-specific interventions necessary to address maternal health being fully and effectively implemented in Uganda? If not, which ones are currently not being effectively implemented? Which ones should be urgently implemented to accelerate progress towards MDG 5 targets? In this context, *an intervention is the delivery of a package of goods, services, and/or infrastructure to achieve development goals and targets within a set timeline*. For example, is skilled attendance during birth being fully and effectively implemented? If not, is it an intervention that should be implemented fully and effectively as a matter of urgency? In the third step, bottlenecks, broadly defined as "proximate and removable constraints that impede implementation of MDG-related interventions," were identified. For the prioritized interventions, such as skilled attendance during birth, what bottlenecks impede their effective implementation? In identifying bottlenecks, we relied on analysis of nationally representative survey data, administrative records from government departments, and published and unpublished papers, articles and reports. Policies, plans and other government documents were also analyzed. Interviews with key stakeholders from government, development partners, and civil society also informed the identification of bottlenecks. The fourth and final step was the identification of solutions, whereby a solution is defined as "an action taken to resolve an intervention bottleneck in the near-term to produce quick impact on the ground." What could the Government of Uganda, in collaboration with its national and international development partners, do to address these bottlenecks?

Since a key objective of the MAF is to support implementation of existing national strategies and policies, each step was guided by key documents such the National Development Plan (2010/2011-2014/2015), the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015), the National Health Policy II (2010-2019), and Health Sector Strategic Plan III (2010-2014).

Figure 42 **MDG ACCELERATION FRAMEWORK FOR MATERNAL HEALTH IN UGANDA**



Text Box 1 **MAKING PREGNANCY SAFER – EXPERIENCES FROM SOROTI**

The multi-sectoral action to accelerate improvements in maternal health in Soroti District was part of a multi-country program to make pregnancy safer. The initiative sought to increase access to emergency obstetric care for rural women in Soroti District in eastern Uganda. It centred on providing antenatal care, emergency obstetric care, transport and communications especially for referral, through community mobilization, technical and political leadership.

The initiative had a simple rule that marshalled various sectors to improve maternal health. According to Dr Godfrey Egwau, a consultant obstetrician at Soroti Regional Referral Hospital, the simple rule was: *"For each mother, there must be a baby to go back with and, for each baby, there must be a mother to go back home with."* Under the MDG Acceleration framework, multiple sectors and partners can have a clear division of labour to attain a priority MDG target, within its own mandate. This logic was applied in Soroti to engage the multiple sectors to support the implementation of maternal health interventions.

The district local government worked on improving the road, with an emphasis on community roads to facilitate access to health units. The improved roads ensure that ambulances can now reach mothers who need emergency care much faster. It has now made it possible for the driver of the ambulance to have delight in his business. According to an ambulance driver named Kayondo, *"My business is saving lives. As long as my [ambulance] is okay, I am okay; that is all that matters."*

Communication has also been improved. Pregnant women who need emergency care can now communicate directly with health workers in health units. Communities organized themselves with community volunteers to scout cases that need urgent medical attention, educate people and facilitate their transportation. Innovative approaches have been used. For example, health units were equipped with bicycle ambulances, which are cost-effective, to transport expectant mothers in non-emergency situations. In addition, the education office in the district organized a series of public sensitisation campaigns and developed drama messages related to the potential risks of pregnancy. The results from the initiative in Soroti have been impressive. The share of deliveries in health units increased from 26% to 43%. The national average stands at 38%. In addition, the district has also recorded a 100% antenatal attendance for at least one antenatal visit.

Maternal health is more than a health issue

The Government considers the issue of maternal health to be more than a critical health issue: it is a development challenge. It is a critical health issue because it affects the health of women and their newborns. It is also a development challenge with at least three important economic implications. First, it harms families' and future generations' capacity to engage fully in production and consumption. It is estimated, for instance, that maternal and newborn mortality alone causes global productivity losses of US$ 15 billion annually[17] and hampers economic growth.[18] Second, the successful implementation of the prioritized interventions largely depends on the success of other sectors of the economy. For example, roads, electricity and water sectors are critical for the effective implementation of emergency obstetric care, which addresses about 80% of maternal deaths worldwide. Other sectors are education, gender and social development, and local governance. Third and last, the prioritized interventions are essential to accelerate the attainment of other MDGs. For example, family planning is one of the strategies to propel Uganda into a demographic window of opportunity. This window of opportunity is where the population 15-64 years is greater than that below 15 years and above 65 years or where the dependency ratio is below 100. This window of opportunity is a precondition for reaping Uganda's demographic dividend.

The successful implementation of the prioritized interventions requires a well functioning health system with appropriately equipped health units. In this regard, the Roadmap acknowledges the "three delays"—the decision to seek health care, the arrival at the point of care, and the provision of care—which occur for wide varieties of economic, social, cultural and political reasons.[19] Uganda has addressed the development challenge of maternal health by involving several sectors. One example[20] is the case of Soroti District, which, in recent years, has focused particularly on making pregnancy safer (Text Box 1). This example demonstrates how other non-health-related sectors played a critical role in enabling women in emergencies to avail themselves of life-saving interventions.

When maternal health is viewed as a development challenge, it opens up possibilities and creates synergies that would not be possible if it were seen merely as a health issue. By the same token, gains made under other MDGs also have the synergistic potential to improve the trends on maternal health in Uganda both in the near and long terms (Table 19). The promotion of education for girls (MDGs 2.A and 3.A) is associated with lower fertility rates and delayed first pregnancies. Electricity allows round-the clock care and the use of essential equipment. Clean, safe water allows basic hygiene during and after delivery and prevents infection (MDG Target 7.C). Engaging mobile telephone and transport companies to provide communication coupons to mothers and health units can be an effective intervention to reduce maternal deaths (MDG Target 8.F). Moreover, rural feeder roads are essential to providing access to health facilities. Without community engagement to create and sustain demand, efforts on the supply side may not be optimal. It is therefore the Government's priority to focus on inter-sector actions to capitalise on potential synergies.

17) USAID (2001) 'USAID Congressional Budget Justification FY2002: program, performance and prospects – the global health pillar,' United States Agency for International Development: Washington, DC.
18) Bloom DE, Canning D. 'The Health and Wealth of Nations,' Science, 2000, Vol. 287, pp. 1207-1208.
19) Thaddeus and Maine (1994) 'Too far to walk: maternal mortality in context,' Social Science and Medicine, 38(8): 1091-1110
20) MOH, WHO (Undated) 'Implementing the Making Pregnancy Safer Initiative in Soroti Uganda.'

Table 19: Linkages between Maternal Health and other MDGs

MDG	Linkages to maternal health
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	At the national level, countries with higher income per capita have more to invest in health systems, thereby enabling mothers to benefit from basic and comprehensive emergency obstetric care. In Uganda, out-of-pocket expenditure is estimated to cover more than 60% of the resources applied to health services—this greatly increases the pressure on the poorest households and especially on women, who are not economically empowered to seek health care when needed. Poverty is a huge contributor to premature first pregnancy and pregnancy-related mortality and morbidity in adolescents. It is also a huge driver of the HIV epidemic.
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Vitamin A deficiency has implications for the quick recovery for women, yet about 55% of women in Uganda have vitamin A deficiency. At the individual level, women with decent jobs and/or incomes are economically empowered to make decisions to seek medical care and to pay for transportation, thereby reducing the two main delays. Addressing under-nutrition in pregnant women and children can lead to an increase of up to 10% in an individual's lifetime earnings. By not addressing under-nutrition, a country's GDP may be lowered by as much as 2%.[21]
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	In Uganda, women who have completed primary education benefit in several ways: they delay having their first child, which reduces the risk of complications; are more likely to wait longer between pregnancies, which reduces the risk of death during childbirth; and are more likely to seek prompt health care when needed. Currently, an estimated 52% of pupils starting grade 1 reach the last grade of primary school.
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	Educated girls and women improve prospects for the whole family, thus helping to break the cycle of intergenerational poverty. In Africa, children of mothers who have received five years of education are 40% more likely to live beyond the age of 5. Men play a pivotal role in achieving gender equality, including improving women's and children's health, reducing HIV transmission, and eliminating child marriage and gender-based violence.
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	Globally, the leading cause of death among women of reproductive age is HIV/AIDS. In countries with high HIV prevalence, AIDS-related complications are among the leading causes of maternal mortality. AIDS complicates pregnancy and birth and is a key driver of maternal death. AIDS is estimated to be responsible for about 15% of indirect causes of maternal deaths in Uganda.
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	Malaria in pregnancy is also a major indirect cause of maternal death. Although the number of maternal deaths by malaria is not clear, it is estimated that over 50% of maternal deaths were linked to complications due to malaria. Effective malaria prophylaxis could help prevent maternal death.

21) Horton S, Shekar M, McDonald C, Mahal A, Brooks JK (2010) Scaling up Nutrition: What will it Cost? World Bank: Washington DC.

MDG	Linkages to maternal health
Goal 7: Ensure environmental sustainability	
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	It is estimated that access to safe water reduces maternal mortality by about 30%.
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	Women who live in slums have problems accessing basic and comprehensive emergency obstetric care, as transportation is difficult. They also lack adequate access to safe water and sanitation.
Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system	Trade, especially of agricultural products, puts more money into the hands of rural women to facilitate access to health care and other services that improve maternal health. Official development assistance will continue to play a significant role in availing resources for maternal health services and especially for family planning and HIV/AIDS prevention. Even if Uganda reaches the 15% Abuja Declaration target, the funds that are needed in the health sector to meet the existing demand may not be sufficient because its economy is small.
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	Countries with great debt have fewer resources to invest in social services, including emergency obstetric care, assisted birth delivery, family planning, and antenatal care services—all of which promote maternal health.
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	Cooperation with pharmaceutical companies to increase access to good quality contraceptives for family planning and medicines for emergency obstetric care such as iron and folic acid, pitocin, magnesium sulphate, and misoprostol supplements is essential.
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	Cooperation with mobile telephone and transport companies to provide communications and transport so that pregnant women in an emergency situation do not have to pay for these indirect costs, makes it easier for such women to reach health facilities with basic and comprehensive emergency obstetric care.

4.3 Uganda's Performance on Maternal Health

Main points worth highlighting on the status and progress towards the maternal health goal and its targets in Uganda are:

- The maternal mortality ratio declined between 1995 and 2006 from a high of 506 to 435 deaths per 100,000 live births. This maternal mortality ratio translates to about 6,000 women dying every year due to pregnancy-related causes, which remains unacceptably high. In addition, for every woman who dies, six survive with chronic and debilitating ill health, such as fistula (the leakage of urine or stool through the birth canal).

- The proportion of births attended by skilled health personnel increased between 1995 and 2006, from 38% to 42%, respectively.

- The contraceptive prevalence rate (i.e., the share of married women between 15-49 years of age who are using any method, traditional or modern, of family planning) increased substantially, from 15% in 1995 to 24% in 2006. However, the contraceptive prevalence rate (CPR) remains low, especially because the unmet need for family planning has increased over the same period.

- The adolescent birth rate in Uganda has declined. Between 1995 and 2006, it declined from 198 to 159 births per 1,000 women among women aged 15-19. The steepest decline occurred between 2001 and 2006.

- Antenatal coverage for at least one visit has remained above 90%. However, the share of pregnant women who make at least 4 visits has consistently remained below 50%. Between 2001 and 2006, the share of rural women who were informed of signs of pregnancy complications when they made antenatal care visits increased from 16% in 2001 to 33% in 2006; among urban women, the indicator increased from 38% to 50% within the same period.

- Unmet need for family planning increased in Uganda between 1995 and 2006 for all women, except those who have never married. For married women, the unmet need increased from 29% in 1995 to 41% in 2006. Unmet need for spacing is more prevalent than unmet need for limiting births. Also, inequities exist, with women in poor households and in rural areas, having the greatest unmet need for family planning.

National priorities, policies and strategies

Reducing maternal mortality has consistently been and is a Government priority. Government investments are guided by its policies, plans and implementation modalities. The most relevant policy is the National Health Policy with implementation strategies expanded in the Health Sector Strategic Plans. The Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015), together with the Reproductive Health Commodity Security Strategy, provide the implementation modalities.

In the National Health Policy I (2000-2009), the Government re-affirmed its commitment to Primary Health Care (PHC) as its basic philosophy and strategy for national health development. Within the Primary Health Care approach, interventions to reduce maternal mortality and improve maternal health were integrated in a Minimum Health Care Package, which formed the primary focus of the health care delivery. In this Package, maternal health formed one of the four clusters, with emphasis on safe motherhood, newborn care and child survival.[22] The core interventions under the cluster were: expanding emergency obstetric care; strengthening community capacity to identify and refer high-risk pregnancies; and scaling up antenatal care.

In line with the National Health Policy, the Government invested substantially in Primary Health Care during the implementation of the Health Sector Strategic Plan I (2000-2004), with demonstrable results. Figure 43 shows that capital investments increased in the 2002/2003 financial year. Indeed, capital expenditure increased more than sevenfold, from 10 billion Ugandan shillings in the previous year to 76 billion. The investments also sought to improve maternal health with the construction and rehabilitation of outpatient departments, maternity units and operating theatres. This sharp increase in capital expenditure in 2002/2003 represented a once-off, deliberate effort to expand infrastructure and to bring services closer to households.

During the 2001/2002 financial year, the amount of funds for recurrent expenditure increased more than threefold, from 18 billion Ugandan shillings in the previous year to 57 billion. The recurrent expenditure also continued to increase from the 2000/2001 financial year onwards. However, the increase in recurrent expenditure was driven mainly by the wage component. In fact, the non-wage component actually started to decline in 2003/2004 and did not recover for the duration under review. The recurrent expenditure continued to increase from that point onwards. Even though the increase in recurrent expenditure was mainly driven by the wage component and not the non-wage component, public investments paid off, as indicated in Figure 44.

22) The elements of the Uganda National Minimum Health Care Package (UNMHCP) have been regrouped in 4 clusters so as to foster increased coordination in planning, budgeting and implementation. These are: Cluster 1 – Health Promotion, Disease Prevention and Community Health Initiatives; Cluster 2 – Maternal and Child Health; Cluster 3 – Control of Communicable Diseases; and Cluster 4 – Control of Non-Communicable Diseases/Conditions (Uganda Health Sector Strategic Plan II, 2005-2010).

Figure 43 GOVERNMENT OF UGANDA INVESTMENTS IN PRIMARY HEALTH (UGANDAN SHILLINGS, BN)

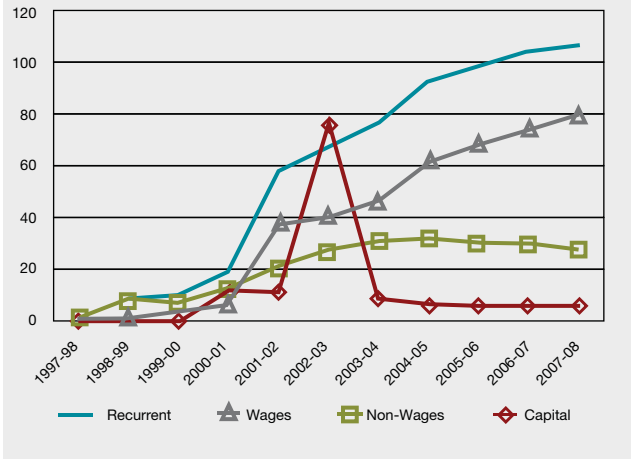
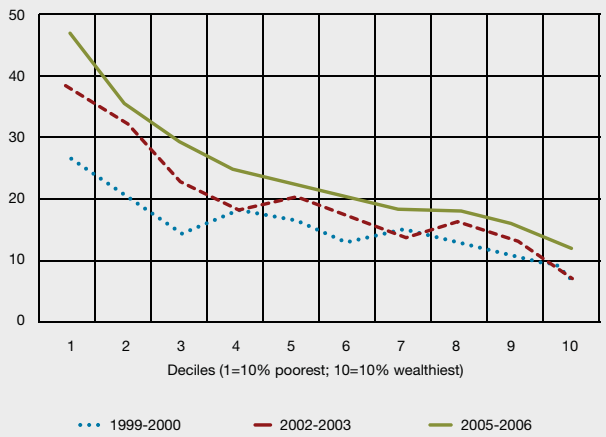


Figure 44 USE OF GOVERNMENT HEALTH CENTRES



Source: MOFPED midterm expenditure estimates, various years; UDHS (1995, 2001/2002, 2005/2006).

Figure 44, based on the Uganda National Household Survey data, shows the share of individuals that used government health centres, HCII to HCIV, between 1999 and 2006 for each of the expenditure deciles. The horizontal axis represents households divided into 10 categories from the poorest 10% to the richest 10%; the vertical axis represents the percentage of individuals from each of the 10 categories who used government health centres. Between the 1999-2000 survey and 2005-2006 survey, the poorest 10% almost doubled their use of government health centres, from 27% to 47%. The richest 10%, on the other hand, increased their use of government health centres only marginally, from 9% to 12%. Nevertheless, it is difficult to discern the extent to which the overall increase in use is attributable to an increase in use of maternal health services.

During the Health Sector Strategic Plan II (2005-2009), the Government sought to consolidate its efforts in the context of the Poverty Eradication Action Plan. Reducing maternal mortality was one of its top priorities, as it would contribute to the objectives of the plan and the MDG targets. The other priorities were to reduce child mortality, fertility rates, malnutrition, the burden of HIV/AIDS, tuberculosis and malaria, and disparities in health outcomes. In addition, the Government strengthened partnerships with the private sector, especially with faith-based health institutions, to which the Government continues to allocate and disburse funds annually.

In 2007, the Government, with support from its development partners, developed the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda as part of its effort to further consolidate and focus. In the Roadmap, the Government emphasised that improvements in maternal health cut across several sectors and attempted to highlight sector contribution. There was thus a deliberate effort to align the contribution of other existing government programs such as universal primary and secondary education, water and sanitation, nutrition and food security, transport and communication, culture and community development. The Government has now completed the National Development Plan (2010-2014), the National Health Policy II (2010-2019) and the Health Sector Strategic Plan III (2010-2014). The point of emphasis has shifted from specific programs to strengthening the organisation and management of the national health systems, including referral.

4.4 Priority Interventions to Accelerate Progress on Maternal Health

This section focuses on key interventions with documented effectiveness that are aimed at preventing the causes of maternal mortality in Uganda and highlights the extent to which they have been implemented. To put the interventions into perspective for non-medical readers, it is important to provide some explanation. First, a maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy. Second, Maternal Mortality Ratio (MMR) is the ratio of maternal deaths per 100,000 live births. The MMR is computed by estimating the number of maternal deaths, dividing this by the number of live births in a population for the same period of time, and multiplying this by 100,000.

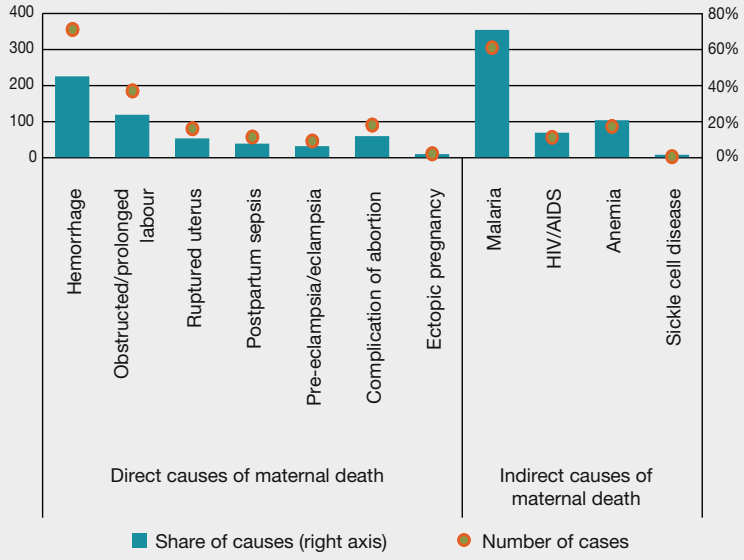
The computation brings out three important aspects: first, all pregnancies that end up in induced abortion or miscarriage increase the number of maternal deaths, but do not add to the number of live births. This means that MMR is higher when abortions or miscarriages are high. Abortions are most common when pregnancies are unintended. In Uganda, 56% of all pregnancies are unintended. Unintended pregnancies are highest in the West Nile region (64%) and lowest in the southwest.

The second aspect is pregnancy itself. Although pregnancy is a life process, it can pose a risk of death. Women should avoid early, late and frequent pregnancies. When pregnancies are too early, too late or too frequent, the risks of complications and death increase. This then increases the number of maternal deaths without increasing the number of live births, thereby increasing MMR.

Finally, because pregnancies carry a risk of complications and possible death, all deliveries must be assisted by skilled health personnel to prevent and manage any eventual complications. Figure 45 shows some of the most common complications and estimates the number of cases and the proportion of maternal complications and deaths recorded in health units in Uganda from direct and indirect causes.

It is therefore important to avoid unintended pregnancies; to avoid pregnancies that are too early, too late, or too frequent; and to ensure that deliveries are assisted to prevent and manage possible complications. *Family planning* addresses two of the three aspects: first, it prevents unintended pregnancies and, second, it enables women to avoid pregnancies that are too early, too late or too frequent. *Skilled attendance at birth* helps to detect and manage complications. It also ensures appropriate referral and further management of these complications.

Figure 45 **MATERNAL COMPLICATIONS AND DEATHS RECORDED IN HEALTH UNITS IN UGANDA**



Source: Mbonye, et al. (2007).

Emergency obstetric care manages pregnancy complications and saves women's lives. *Antenatal care* can manage the indirect causes of maternal death, such as malaria, HIV/AIDS, and anaemia, thereby reducing the risk of onset of complication and increasing a woman's chances of survival if she experiences complications.

Consequently, Uganda has prioritized four interventions that should significantly improve maternal health. These interventions, which focus on the direct and indirect causes of highest impact on maternal health, are:

1. Access to emergency obstetric care
2. Skilled attendance at birth
3. Universal access to family planning
4. Antenatal care

The four priority interventions addressing the causes of maternal deaths are shown in Table 20, which presents the extent to which the intervention has been implemented, whether the intervention is of national priority, and the likely impact of the intervention on accelerating progress towards maternal health. The key point is this: not all interventions are equal in their effect on maternal mortality. Other interventions that address the causes of maternal deaths are presented, but not discussed further, given their limited or undocumented impact on maternal health.

Table 20: Implementation status of maternal health interventions in Uganda

Intervention	Implementation	National priority	Expected impact on maternal health
1. Emergency obstetric care (EmOC)	Weak (met need only 24%)	Strong	High (main determining factor for maternal survival)
2. Skilled attendance at birth	Weak (only 44%)	Strong	High (especially considering the link to EmOC)
3. Universal access to family planning	Medium (CPR 24%, unmet need 41%)	Weak	High
4. Antenatal care (with a strong component of management of malaria and prevention of mother-to-child transmission of HIV and care for AIDS patients)	Not optimal (over 90% for 1 visit, only 47% for 4 visits)	Strong	High
5. Access to counselling, safe & post-abortion care	Weak	Weak	Lack of data, difficult to quantify
6. Combat violence against women	15.7% of women 15-49 ever experienced physical violence during pregnancy	Medium	Lack of data, difficult to quantify

Access to Emergency Obstetric Care (EmOC)

EmOC saves lives by managing pregnancy complications. The Government recognizes that the provision of EmOC addresses the major causes of maternal deaths. The majority of maternal deaths are due to preventable causes for which highly effective interventions are known. The most common causes of maternal death are hemorrhage, infection, sepsis, hypertensive disorders, unsafe abortion, eclampsia (very high blood pressure leading to seizures) and obstructed labour. These major causes are responsible for about 80% of maternal deaths worldwide.[23] Therefore, EmOC is a key intervention for drastically reducing the MMR.

EmOC covers several life-saving services ("signal functions") that are medical interventions used around the globe to treat the direct obstetric complications that cause the vast majority of maternal deaths.[24] The signal functions are indicators of the level of care being provided that define a health facility with regard to its capacity to treat obstetric and newborn emergencies. These life-saving services categorize facilities as basic or comprehensive.

The provision of basic and comprehensive EmOC services therefore requires: first, sufficient, qualified and skilled staff of various categories; second, appropriate infrastructure for obstetric surgical procedures, equipment and supplies, including drugs and blood; and, third, a functioning referral system that includes transport options.

Emergency obstetric care is available in Uganda. It is provided for in the National Health Policy and made operational at Health Centres III and IV and hospitals. The policy also provides for supporting the community to identify and refer high-risk pregnancies and complicated deliveries. In the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda, the Government calls for a scaling-up of emergency obstetric care to ensure that there will be sufficient infrastructure, equipment, human resources and medicines. The scale-up Government strategy also provides for an appropriate and effective referral system. The price for the implementation of the Roadmap recommendations is estimated at about US$ 80 million.

However, the actual provision of basic and comprehensive emergency obstetric care in Uganda is still low. For example, according to the 2004 EmOC Needs Assessment,[25] the national met need for emergency obstetric care was 24%, whereas it should be 100% if all women with complications were treated.

Skilled attendance at birth

Since complications are not predictable, all women need care from skilled health professionals,[26] especially when giving birth, when rapid treatment can make the difference between life and death.[27] In fact, history and research have shown that timely treatment of complications is critical for the survival of pregnant women and their babies.[28] A skilled attendant should have the necessary equipment and medicines and adequate referral means to be effective in reducing maternal mortality. Post-partum care of the mother, especially within the first 6 hours, up to the 6th day, and up to the 6th week after birth, is also essential, as the majority of maternal deaths and disabilities that occur due to haemorrhage, sepsis and eclampsia, occur during the postpartum period.[29]

The Government recognizes the importance of having skilled attendance at birth and has thus made it a priority in the Reproductive Health Strategic Plan and the Roadmap. The Government's Health Sector Strategic Plan III foresees an increase in the percentage of deliveries by skilled attendants from 44% to 60% by 2015. This will go far towards responding to an urgent need, especially in rural areas and among those with little or no education (Figure 46).

Increasing the share of births attended to by skilled providers among rural women and women with low education provides the greatest opportunity to increase the national average in the near term. Births attended to by trained personnel in urban areas have consistently been more than double than in rural areas. For example, about 80% of births in urban areas have consistently been attended to by trained personnel, while it has been about a third in rural areas. Significant improvements in rural areas would increase the national average, given that the majority of mothers live in rural areas. However, there is a great opportunity both in the near term and in the long term for the education sector to make significant contributions through expanding universal primary and secondary education. Educated women stay longer in school, marry at a later age and are therefore able to delay having their first child, are more likely to space births, and are more likely to seek care when need arises.

Universal access to family planning

Family planning reduces maternal mortality and morbidity by enabling women who would like to space births or stop having children to avoid pregnancy. It is worth reiterating that pregnancy and childbirth are normal life cycle events, but every woman is at risk of developing life-threatening complications. Births that are close to one other weaken a mother and therefore reduce her chances of surviving these complications. When pregnancies come too early or too late, she may

23) WHO (2008) 'Maternal Mortality: Fact Sheet.' WHO/MPS/08.12 http://www.who.int/making_pregnancy_safer/events/2008/mdg5/factsheet_maternal_mortality.pdf
24) AMDD, UNFPA, UNICEF, WHO (2009) Monitoring Emergency Obstetric Care: A Handbook (WHO, Geneva).
25) Uganda Ministry of Health and UNICEF (2004) 'Status of emergency obstetric care in Uganda, a national needs assessment of emergency obstetric care process indicators,' Kampala.
26) WHO defines a skilled attendant as "an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns."
27) WHO (2008) 'Maternal Mortality: Fact Sheet.' WHO/MPS/08.12 http://www.who.int/making_pregnancy_safer/events/2008/mdg5/factsheet_maternal_mortality.pdf
28) WHO (2008) 'Skilled Birth Attendants: Fact Sheet' WHO/MPS/08.11 h ttp://www.who.int/ making_pregnancy _safer/events/2008/mdg5/factsheet_sba.pdf
29) WHO (2006) 'Standards for Maternal and Neonatal Care' http://www.who.int/making_pregnancy_safer/ publications/standards/en/index.html

Figure 46 DELIVERIES ATTENDED TO BY A DOCTOR OR NURSE OR MIDWIFE

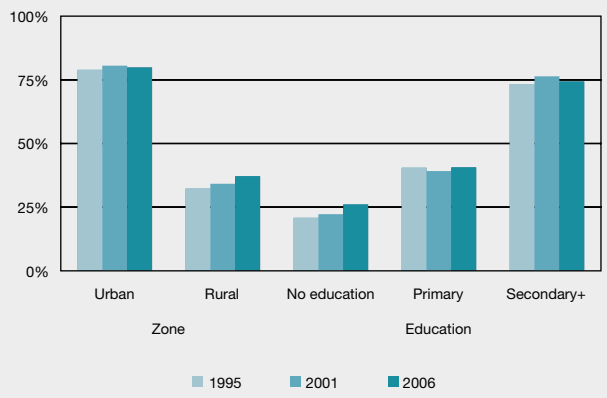
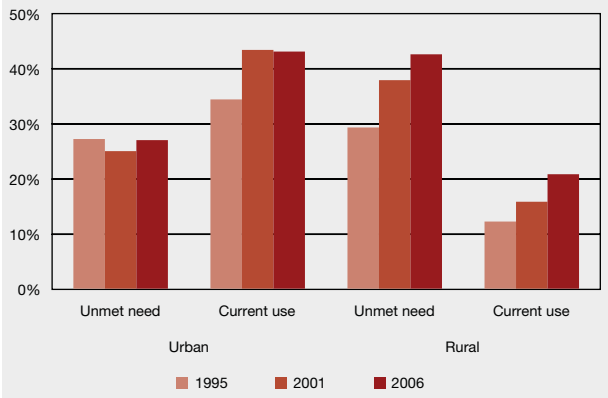


Figure 47 DEMAND FOR FAMILY PLANNING



Source: UDHS (1995, 2001/2002, 2005/2006).

not be physically able to carry the pregnancy to term. Access to an appropriate mix of family planning methods gives women a choice to create this gap between births, to delay the first pregnancy, and to avoid having pregnancies too late.

The Government recognizes that there are women in Uganda who would like to delay a pregnancy or to avoid becoming pregnant, but have no means to do so. The consequence for such women is usually unintended pregnancy. Research done in Uganda suggests that enabling women who would like to delay a pregnancy or do not want to become pregnant to have access to family planning methods would reduce maternal deaths substantially. In 2008, family planning efforts reduced the number of maternal deaths by an estimated 15%.[30] The same research suggested that making family planning accessible to women who would like to use it—those with unmet need—would potentially prevent a further 32% of maternal deaths.

Reducing unmet need for family planning provides an opportunity for the Government to accelerate progress towards MDG 5, partly because the target group is a group of women who are willing to use family planning, but are not able to access it. As with professional assistance during childbirth, the greatest potential to reduce unmet need for family planning lies among rural women. The unmet need for family planning among rural women is almost double that among their urban counterparts (Figure 47). This unmet need almost doubled between 1995 and 2006, a period of ten years, while that among urban women remained about the same. When unmet need and current use are combined, the potential demand for family planning among the rural women (63%) almost caught up with that of their urban counterparts (70%) in 2006. Yet, ten years prior to 2006, the potential demand for family planning among rural women was two thirds of that among their urban counterparts.

Family planning also has the potential to enhance Uganda's economic growth. This is mainly through accelerating the onset of the demographic window of opportunity. Uganda's current population is predominantly young. With effective family planning programs, the population structure will tilt towards having a small proportion of the population young, thereby reducing the dependence ratio.

Antenatal care

Antenatal care is a potentially important way to connect a woman with the health system, which, if it is functioning, will be critical for saving her life in the event of a complication. However, the link between receiving antenatal care during pregnancy and accessing an appropriate facility in an emergency is far from automatic. Effective antenatal care can improve outcomes for the mother and newborns. At least four ANC visits are recommended for a normal pregnancy. In the four visits, the likelihood of identifying, treating and preventing problems such as malaria, anaemia, HIV/AIDS and other infections is increased. Whereas 94% of all pregnant women make one visit to antenatal clinics, only 42% make the recommended four visits. The greatest opportunity for improvement in Uganda is to focus on encouraging expectant mothers to start antenatal care early. Expectant mothers have their first antenatal visit late in the pregnancy—a median of 5.5 months—which is too late for some to benefit and to make follow-up antenatal visits.

30) Vlassoff M et al. (2009) 'Benefits of meeting the contraceptive needs of Ugandan women,' In Brief, New York: Guttmacher Institute, No. 4.

4.5 Bottlenecks Impeding Progress

In this section, we identify and discuss bottlenecks that hinder the effective implementation of priority interventions. Overall, there is consensus in Uganda that the policies put into place are often robust and do not constitute direct bottlenecks to the implementation of the priority interventions for maternal health. The main bottlenecks are therefore in financing, service delivery, and service utilization. Table 21 summarizes the key bottlenecks in the effective implementation of priority maternal health interventions.

Table 21: Summary of bottlenecks specific to the prioritised maternal health interventions

Prioritised interventions	Financing
Improve access to Emergency Obstetric Care (EmOC)	• **Financing gap** for maternal health related services (e.g., the Maternal Roadmap and RH commodities are expected to cost US$ 78.7 million per year, which exceeds estimates for the health sector non-wage budget by 80%). • **Decentralized budget system:** Prioritization of maternal health interventions is not uniform across the 112 districts, which affects budget allocation at the local level. • **Weak Public Accountability** Inadequate public expenditure tracking systems that appropriately capture the overall budget and expenditure for the health sector across the districts.

Service delivery	Service utilization
Inadequate quantity and quality of health staff: • Insufficient number of midwives in the country. • Lack of appropriate incentives for retaining health staff, including staff housing facilities. • Poor recruitment and management of staff, including lack of monitoring and supervision of health workers. **Inadequate management of supply chain system:** • Government procurement guidelines are subject to manipulation (e.g., a vendor can stop the entire process through a complaint), which leads to procurement delays. • Delays in distribution of medicine and supplies, especially between district and health units. • Non-availability of blood at health units at the time of need, and insufficient stocks of blood, particularly for universal donors. • Mal-distribution of blood across the country, with rural and remote health units unable to obtain blood. **Deficient referral system:** • Inadequate communication system (e.g., village telephones) between villages—where women reside—and health units to allow women to communicate with health units. • Broken or inexistent telephones (e.g., intercom, including pagers, and cell phones) at health units to communicate across departments and reach available on-call staff. • Lack of communication between lower health units to referral health units in case of emergency to enable receiving units to better prepare. **Poor basic infrastructure:** • Non-existent or poor community roads, where the majority of women live, make it harder for expecting mothers to reach health units or for ambulances to reach their homes in the case of an emergency. • Inadequate maintenance of water sources and equipment, and inability to follow through long-term maintenance strategies (e.g., training of community water maintenance teams has been discontinued). • Limited electric grids reaching health units, and inadequate prioritization of health units in the rural electrification programs. • Lack of appropriate guidelines or their enforcement to ensure that health units have regular access to clean water (as in the case of schools), reliable electricity source, and adequate sanitation.	**Limited awareness and self-efficacy of service users:** • Limited awareness and misconception about blood transfusion and donation, including locations for donation. **Financial barriers prevent access to services:** • Inadequate financial protection for poor pregnant women to access health care services (e.g., health insurance coverage is limited). **Physical barriers prevent access to services:** • Non-existent or poor community roads where the majority of women live make it harder for expecting mothers to access health units or for ambulances to reach their homes in the case of an emergency.

Prioritised interventions	Financing
Provide access to skilled birth attendance (SBA) services	• **Financing gap** • **Decentralized budget system** • **Weak public accountability**
Provide universal access to family planning services	• **Financing gap (resource availability):** Family planning is not a priority within the health budget. There is limited funding for family planning commodities. Inadequate prioritization of family planning in the country's health agenda. • **Weak Public Accountability** in the allocation and use of health resources earmarked for family planning.
Improve access to Antenatal Care (ANC) services	• **Financing gap** • **Decentralized budget system** • **Weak public accountability**

Service delivery	Service utilization
Inadequate quantity and quality of health staff: • Insufficient number of midwives in the country. • Lack of appropriate incentives for retaining health staff, including staff housing facilities. • Poor recruitment and management of staff, including lack of monitoring and supervision of health workers. • Village Health Teams (VHTs) are not functional at health scale. **Deficient referral system:** • Lack of functionality of the first referral health facility as a referral unit and as a health sub-district unit, overburdening HC-IV. **Poor basic infrastructure:** • Poor quality of road network, especially of community access roads, prevents women from accessing health units in a timely manner.	**Limited awareness and self-efficacy of service users:** • Inadequate public awareness and empowerment of women (including their spouses) to communicate with health workers. **Financial barriers prevent access to services:** • Lack of appropriate incentives to stimulate the demand for health services. **Cultural beliefs and social norms:** • In some circumstances, the manner in which deliveries at health facilities are conducted are not compatible with women's cultural beliefs and are considered to be inappropriate for women (e.g., delivery in squatting position, placenta practices). • Lack of orientation of health practices concerning cultural norms and customer care (e.g., cultural norms and customer care is not part of the health curriculum).
Inadequate quantity and quality of health staff: • Insufficient number of midwives and trained nurses in the country. • Limited skills of service providers at health centres that can administer family planning services. • Regulatory barrier keeps midwives and clinical officers from expanding the range of their tasks. • Weak integration of HIV prevention services with family planning services. **Inadequate management of supply chain system:** • The limited number of centres for the distribution of supplies restricts broad access and reach to those segments of the population that need them most (e.g., rural villagers). • Inadequate storage, quantification and tracking of supplies (e.g., condoms, contraceptive pills etc.) required for family planning services to meet the current demand.	**Limited awareness and self-efficacy of service users:** • Differences in the understanding of the primary role of family planning. This includes myths and misconceptions about specific family planning methods. Lack of education about birth spacing (e.g., premature and later pregnancies harm women). • Low educational attainment of girls, which leads to early marriage, adolescent pregnancies and high-risk pregnancies. • Irresponsible parenthood—for both men and women—is not punished. **Physical barriers prevent access to services:** • Non-existent or poor community roads where the majority of women live make it harder for expecting mothers to reach health units or for ambulances to reach their homes in the case of an emergency.
Inadequate quantity and quality of Health Staff: • Inadequate integration of HIV and AIDS services into ANC services, including the prevention of mother-to-child transmission (PMCT) and voluntary counseling and testing (VCT). **Inadequate management of supply chain system:** • Inadequate supplies for malaria testing and medicines, including inadequate supply and inequitable distribution of mosquito nets. • Distribution of food supplements does not cover all HCs.	**Limited awareness and self-efficacy of service users:** • Lack of awareness about the benefits of ANC (majority of women go for only 1 visit to obtain the delivery pass). • Poor community participation in the prevention and management programs of malaria (e.g., poor sanitation, environmental management, inadequate use of indoor residual spray, ITNs, etc.). • Inadequate knowledge about nutritional content of locally available food at the community level—which could directly improve pregnant women's nutrition. **Financial barriers prevent access to services**: • Inadequate financial protection for poor pregnant women to access health care services (e.g., health insurance coverage is limited). **Cultural beliefs and social norms:** • Inadequate and unregulated traditional practices in rural villages (e.g., wrong dosages, poorly administered traditional drugs and herbs) prevent women from seeking specialized treatment for malaria.

4.5.1 Financing

Like any other country in the world, Uganda is under enormous financial pressure to increase resources for health care. The cost of health care service provision has gone up *inter alia* because of the expansion of services, increasing demand due to population growth, the adoption of new medical technologies, and changes in patients' choices and expectations. Four aspects of financing that constitute bottlenecks to the effective implementation of priority interventions have been identified:

Financing gap

The Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda alone is estimated to cost about US$ 81 million over a four-year period, and the estimated cost of reproductive health commodities is US$ 292 million, or about UGX 157 billion, per year over a five-year period. When we consider that the entire health sector budget for the Government of Uganda, excluding development partners, for the 2008/2009 financial year was UGX 313 billion, out of which UGX 123 billion was for wages, and UGX 190 billion was for non-wages, only two interventions would take up 50% of the entire health budget and over 80% of the recurrent budget. This excludes about UGX 1.3 billion in annual training costs for midwives alone, and additional wages of expanded medical staff with adequate midwifery skills. With the increasing number of women in need of services every year due to population growth, the Government acknowledges that the number of midwives trained need to increase at the same pace.

Government has made significant investments, such as in primary health care. However, there is a need to strike the optimal balance between recurrent wage and non-wage expenditure. For example, government investment in recurrent expenditure for primary health care went up from UGX 1.5 billion in 1997/97 to UGX 106 billion in 2007/2008, increasing more than 70 times in ten years. However, this increase was mainly driven by the expansion in wage expenditures due to the recruitment of additional health personnel without a corresponding increase in growth of capital expenditures. Government recognises this bottleneck to service delivery improvements in Uganda and the ongoing expenditure efficiency reforms will attempt to address this problem through incremental restructuring of the national budget.

Funds from the Government and development partners are the primary source of support to implement the priority maternal health interventions. While the Government is harnessing individual private contributions through social health insurance, private corporations and foundations have not yet been tapped for additional funds for health service provision.

Government has identified EmOC as the most critically affected as regards financial resource mobilization. Adequate financial resource allocation to equip health facilities for basic and comprehensive emergency obstetric care, to provide transport and communication for effective referral, and to have sufficient numbers of health professionals with appropriate skills at various levels requires sufficient prioritization. This prioritization of financial resource allocation will also include family planning to ensure that an appropriate mix of commodities and services are available and accessible to women when they need them. Funds are also needed to hire more professional midwives and other health workers with midwifery skills. The ability of health facilities to provide basic and comprehensive emergency obstetric care would be a good indicator of a strengthened health system.

In a decentralized budget system, maternal health needs sufficient prioritization

Government recognises that adequate prioritization in planning, budgeting and expenditure at the national and district levels of maternal health interventions, is key to sustaining progress. A number of agencies are involved in the identification and prioritization of maternal health interventions. At the national level, these include ministries responsible for: health; lands, water, and environment; agriculture, animal industry and fisheries; gender, labour and social development; works, housing and communication; education and sports; public service; and local government. Other non-ministerial Government agencies include the National Planning Authority, the Uganda Bureau of Statistics, and the Population Secretariat. Private institutions such as the media, private medical practitioners and corporations and bilateral and multilateral partners also play a complementary role.

In addition, the Government has made a deliberate effort to decentralize service provision. In the current arrangement, local governments undertake the planning, budgeting and expenditure in their areas of operation. Local governments generate their own funds and receive funds from the central government. Some of the funds received from the central government are conditional, while others are not. In both cases, there is sufficient flexibly to prioritize interventions. However, the extent to which individual local governments prioritize the four identified interventions varies widely.

Weak financial accountability

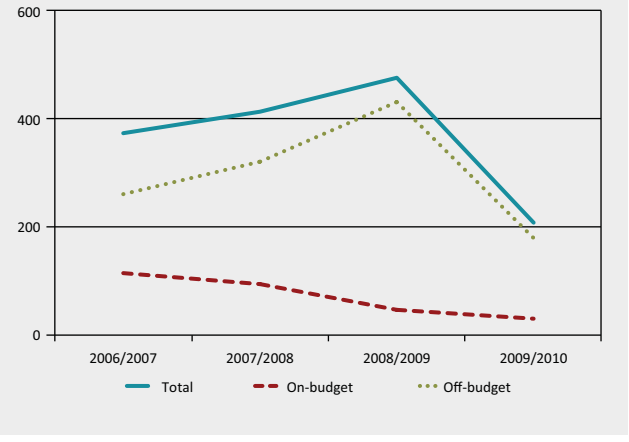
In terms of financial accountability, the Government instituted an elaborate reporting system. Local governments submit monthly and quarterly accountability reports to the Ministry of Finance and local government. Under this arrangement, 20% bonuses and penalties are applied to local governments that comply well or poorly with reporting requirements. Government has identified capacity gaps in financial management, not only in the health sector, but also in other sectors of the economy. In light of this, financial management reforms, including improving value for money which entails better targeting of budgetary resources are underway. These reforms will ensure that funds budgeted for maternal health interventions, including emergency obstetric care, family planning or assisted delivery are better prioritized

and targeted. These reforms will also improve harmonization, alignment and predictability of Government resources into maternal health.

Government interventions in the health sector have followed a sector-wide approach and have been implemented through Health Sector Strategic Plans, with donor funding going through the national budget in the form of basket funding. However, several development partners continue to offer support outside this framework—so-called off-budget support (Figure 48). In such arrangements, the extent of harmonization and alignment with government priorities is difficult to ascertain.

ODA for health sector has been rising steadily in Uganda in recent years. This has been driven in part by the off-budget component, which increased to a high of US$ 460 million in 2006 while on-budget support has declined. In terms of predictability, aid flows have remained very volatile and, in recent years, this volatility has increased. The expectation that aid would become more reliable and predictable has not been met. To add to the complexity, aid data provided by donors is largely based on financial commitments, and donors are either unwilling or unable to provide medium-term estimates of aid other than what has been committed. This creates two main problems. First, aid data provided by sectors and by donor agencies for the budget year are usually fairly comprehensive, but overly optimistic, as, in aggregate, not all donor commitments are realized. Second, aid projections for the outer years usually underestimate future levels of aid, as existing commitments tail off over the medium term.[31]

Figure 48 **OFFICIAL DEVELOPMENT ASSISTANCE FOR HEALTH TO UGANDA (MILLION, UGX)**



Source: World Bank (2008) 'Focus on Health in the Budget: Public Expenditure Review'.

4.5.2 Service Delivery

Service delivery towards improving maternal health is hampered by human capacity constraints, inadequate distribution of equipment and supplies, a dysfunctional referral system and poor basic infrastructure. These constraints are particularly pronounced in rural and hard-to-reach areas. As a result, service delivery is often deficient for all four priority interventions, leading also to low utilization of health services by pregnant women.

Human resources: inadequate quantity and quality

Adequate staffing of health units is particularly important to offering skilled attendance at births, timely referral, and reliable, quality emergency obstetric care. Health workers are also required to deliver family planning services. Government recognizes that the country faces a serious shortage of skilled and committed personal in the health sector. For example, only 55% of facilities offering deliveries have a trained provider on site 24 hours a day, while 1% have a provider on call 24 hours a day.[32] In addition, it is estimated that the country has just under 2,000 midwives,[33] which is a significant shortage.

The issue of inadequate staffing is worsened by the challenges that some districts face in recruiting staff. Remote and hard-to-reach districts, in particular, face significant obstacles in attracting and retaining health workers. Health staff often find it difficult to work in areas with inadequate water and electricity, poor housing, poor schools for their children, lack of security (especially at night, when many deliveries take place), and poor transportation and communication facilities. Absenteeism of health workers, which is a major source of waste, is also exacerbated by hard working conditions. During unannounced visits to a sample of government health facilities in 2006, 52% of health workers who were supposed to be working were absent.[34] An earlier study using a survey conducted in 2002/2003 found that, on any given day, 37% of health workers were absent from work.[35] Assuming absenteeism was on average closer to 40%, as suggested in the 2006 UDHS, health worker absenteeism alone could have cost the Government of Uganda around UGX 45 billion in 2006/2007. To address this problem, Government has developed a package of incentives for health workers in hard-to-reach and hard-to-stay areas starting with financial year 2010/11.

31) Williamson, T. (2008b) 'Putting Aid on Budget: A Case Study On Uganda', Study for the Collaborative Africa Budget Reform Initiative and the Strategic Partnership with Africa, Oxford: Mokoro.
32) Uganda Ministry of Health (2007) 'Uganda Service Provision Assessment Survey 2007: Key Findings on Family Planning, Maternal and Child Health, and Malaria.'
33) Orach et al. (2009) 'Assessment of Midwifery Training, Service and Practice in Uganda.' Makerere University School of Public Health, Kampala, Uganda.
34) Bjorkman M. and Svensson, J. (2007) 'Efficiency and Demand for Health Services: Survey Evidence on Public and Private Providers of Primary Health Care in Uganda' cited in World Bank (2008c).
35) Chaudhury, N. et al. (2006) 'Missing in Action: Teacher and Health Worker Absence in Developing Countries.' Journal of Economic Perspectives 20(1), pp. 91-116.

Inadequate management of the supply chain: distribution of equipment and supplies

Insufficient supplies and commodities, including the availability of contraceptives, prevent adequate delivery of health care services and often account for the largest share of health care costs for service users. Supplies and commodities are needed under all of the priority interventions selected. Medicine stock-outs have long been a problem, as the percentage of health facilities registering stock-outs in essential medicines has consistently been over 60% for the last 10 years. This implies that, although modern family planning services are available at 79% of the health facilities, the services may not be comprehensive. The procurement of medicines is done at the national level. The distribution system is based on the 'pull' from lower levels of government, who are supposed to submit requisitions through the district health office to the National Medical Stores.

The 'pull'-based ordering system was designed to minimize waste and improve stock control. It has helped to create a much more coherent and manageable ordering system that can better respond to integrated service delivery at the district level. However, it is dependent on the capacity of health units to order and the capacity of the district to distribute and be active in supply chain management. It also requires adequate supervision and monitoring. While capacity at the national level has improved greatly, the system is not functioning very well at health facilities and in districts where capacity is weak.

A lack of functional equipment is also a major problem at health centres. Investments in infrastructure and personnel cannot be put to optimal use if essential equipment is either missing or is not functional. It is particularly troubling if the equipment required for emergency obstetric care is either missing or broken. Evidence suggests that only 5% of facilities have a vacuum extractor (used for assisted vaginal delivery) and only 10% have a dilation and curettage kit (needed to remove a retained placenta). In some cases, equipment exists, but is incomplete. For example, while 92% of facilities offering delivery services report sterilisation of equipment for reuse, only 9% have all of the equipment and knowledge needed to sterilise or disinfect using dry heat/autoclave or boil/steam or chemical high-level disinfection. Only 5% of facilities have written guidelines for sterilisation or high-level disinfection procedures at the processing site.

Deficient referral system

Public sector health services in Uganda are provided through a seven-tier structure. It starts with Village Health Teams (VHTs). Located within the community, these Teams are expected to provide information—although in other countries, they also provide family planning services. Health centres are graded as II, III, or IV, according to the administrative zone served and by the types of services provided. Health Centres II (HC-II) serve a parish and provide outpatient care, antenatal care, immunization and outreach. Health Centres III (HC-III) serve a sub-county and provide all of the services of HC-II, plus inpatient care and basic emergency obstetric care. Health Centres IV (HC-IV) serve a health sub-district and provide all of the services of HCs III, plus surgery, supervision of the lower-level HCs II and III, collection and analysis of data on health, and planning for the health sub-district. In addition, HCs IV provide comprehensive emergency obstetric care. General, regional and national referral hospitals also provide comprehensive emergency obstetric care. According to the policy provisions, family planning services are offered from Health Centre II to the National Referral hospital, while deliveries are provided at HC III. Basic emergency obstetric care is offered starting with Health Centre III.

In Uganda, not all health facilities expected to provide certain services do so. Evidence suggests that modern family planning services are available in 79% of all health care facilities. Nearly nine in ten (89%) government facilities offer family planning, compared to only about half (49%) of private facilities. Family planning services are least likely to be available in hospitals (71%). Normal delivery services are available in about half (53%) of facilities. Furthermore, emergency services are not widely available. Only 47% of all facilities can transport a patient to a referral site for maternal emergencies. The lowest-level health centres are also least likely to have transportation support for referrals (only 33%), although these centres are also least able to treat emergencies. The inadequacy of the referral system adds pressure to higher-level health centre units, especially to HCs IV.

Poor basic infrastructure

The Government of Uganda made a deliberate effort during the implementation of National Health Policy I to construct and upgrade health facilities. However, basic infrastructure such as electricity, water, communication, means of referrals, adequate staff quarters, and security (especially at night) are the main obstacles to running 24-hour, quality emergency obstetric care services, especially in remote and rural areas. For example, only 31% have year-round water supplied in facility by tap or available within 500 metres of the facility; this bottleneck is even greater at Health Centre II level, where only 23% have regular water supply. The situation is similar with electricity. About 24% of health facilities—and only 14% of Health Centre IIs—have electricity or a backup generator with fuel routinely available during service hours. Finally, with respect to basic patient amenities, only 42% of the health facilities have a functioning client latrine, a waiting area protected from sun and rain, and basic cleanliness. Government has prioritized infrastructure development in its national budget and in the National Development Plan to address constraints to growth, which will also have a favourable outcome for the health sector.

4.5.3 Service Utilization

Along with service delivery, bottlenecks related to service utilization are major challenges to the effective implementation of maternal health interventions. Key issues related to inadequate service utilization often arise from financial barriers preventing access to services, accentuated by indirect costs; physical barriers that prevent access to health care

(such as badly maintained or non-existent roads); limited awareness and self-efficacy of pregnant women and their spouses; and inhibiting cultural beliefs and social norms.

Financial barriers prevent access to health care services

The Government abolished user fees in public health facilities in March 2001 to decouple payment from use of services. Due in part to the expansion of the private sector as service providers and to the other costs associated with seeking care (such as payment for medicines, which are often unavailable at health centres, and transportation), out-of-pocket expenditures remain a prominent source of financing for the health sector. While the use of public facilities increased substantially after the abolition of fees, the share of household expenditure on health as a percentage of total household consumption remained high. A detailed analysis of the national household survey data from 2006 indicates that, on average, almost 28% of sampled households faced health expenditures which were more than 10% of total household consumption expenditure (see Figures 50 and 51).

The Government is instituting a social health insurance system to harness the out-of-pocket expenditure so that use continues to be decoupled from payment.

Physical barriers prevent adequate access to health care services

The issue of physical access is related to financial accessibility. Due to sustained government investment in the expansion of the number of health facilities and the growth of the private sector, physical access is not considered a major bottleneck for family planning and antenatal care. By 2006, 83% of households reported living within five kilometres of a health facility or hospital. Physical access is, however, a bottleneck for assisted delivery and emergency obstetric care. Difficulties of ensuring transport for mothers from home to a health facility, and from a health facility to a referral facility, are the key manifestation of this bottleneck. The transportation challenges from home to the facility are mainly related to physical barriers such as lakes, rivers, and mountains; difficulties of travelling at night; lack of communication; lack of availability of means of transport of a standby or easily accessible vehicle; and transportation costs. In such cases, time is of the essence. Evidence shows that, as long as there is a system in place to transport women in labour within 30 minutes to a facility where there are antibiotics, blood transfusions and the capacity to perform Caesarean sections, there should be very little maternal mortality. However, it is only in Kampala where transportation time to a referral facility takes less than 30 minutes (15-20 minutes) both in the dry and rainy seasons (Figure 51). In the remaining regions, the median transportation time is above 30 minutes in both the dry and rainy seasons. The worst regions are the West Nile and the western regions, where transportation time is about 90 minutes in the rainy season.

Figure 49 HEALTH EXPENDITURE AS SHARE OF TOTAL EXPENDITURE

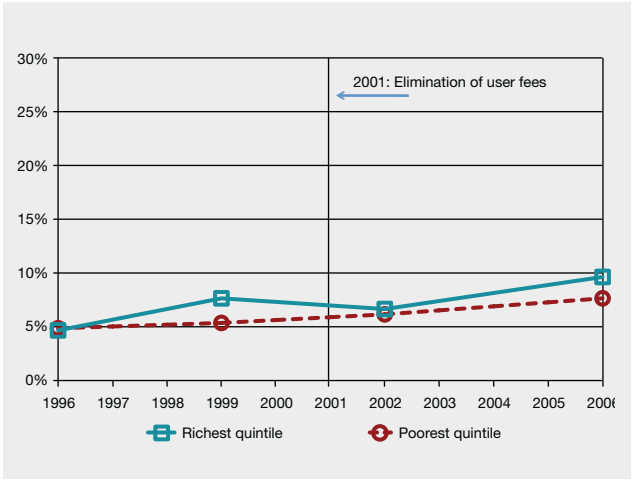
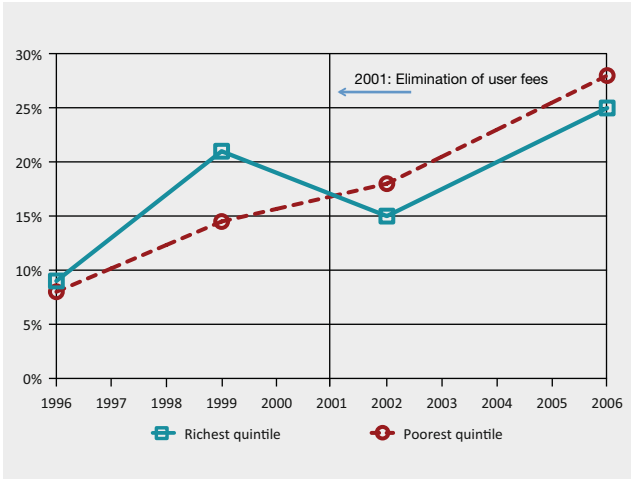
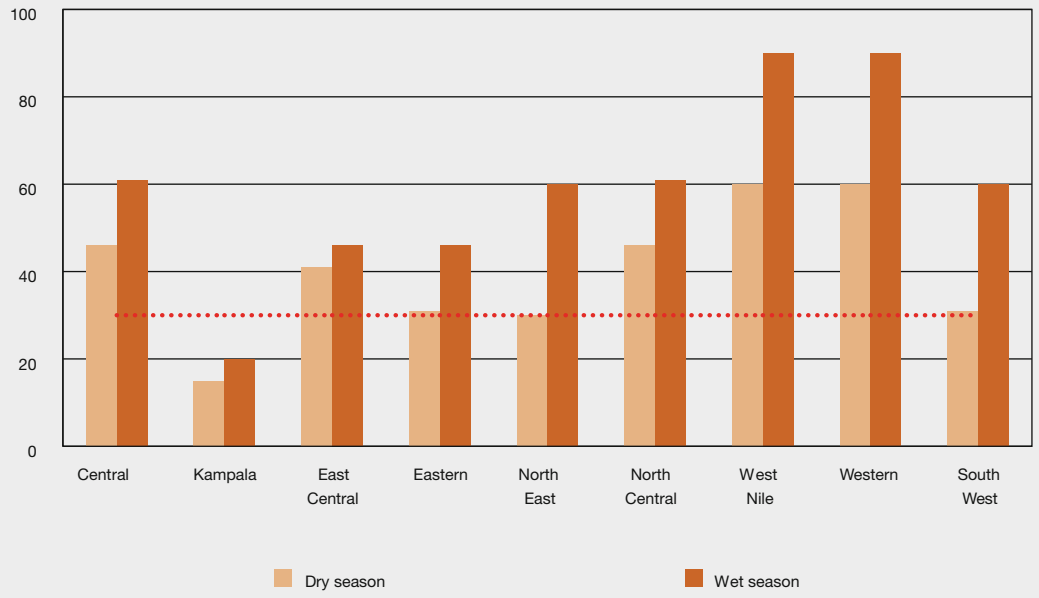


Figure 50 HOUSEHOLD HEALTH EXPENDITURE AS A SHARE OF TOTAL HEALTH EXPENDITURE



Source: World Bank (2008).

Figure 51 MEDIAN TRANSPORTATION TIME IN MINUTES TO REFERRAL FACILITY*



Source: Uganda Service Provision Assessment (2007).
*Note: * Among facilities that support transportation for obstetric emergencies. The red line indicates the critical 30-minute time frame, which, if exceeded, severely increases the risk of maternal death in case of complications.*

Limited awareness and self-efficacy of service users

Women's empowerment or self-efficacy to use available services adequately is a bottleneck for safe delivery. For instance, attendance at antenatal care visits may discourage delivery in health units if mothers are told that the pregnancy is normal. Mothers' experience of 'normal' versus 'abnormal' pregnancy affects their judgement and their decision about whether to seek skilled birth attendance. Mothers' self-efficacy beliefs therefore also constitute a bottleneck to safe delivery.

Improving care-seeking behaviours of pregnant women is clearly a critical function of the health system. Knowing when to seek care for potentially fatal childhood illnesses and knowing where to go are important. Pregnant women have a wide variety of choices once they make the decision to seek care outside the home. In addition to the marketplace, where they can purchase drugs without consulting professional advice, they can also seek first recourse from traditional healers or informal community services. In many cases, pregnant women may seek care from multiple sources. Unfortunately, women in other cases are prevented from seeking care, as husbands, relatives, or others in the community make decisions about whether to seek care.

Although the three-delays model has been an effective conceptual device for getting health planners to understand the bigger maternal mortality picture—including social, cultural, and economic determinants and factors outside facilities—it is sometimes used to assume a strictly linear decision-making process, with narrow interventions (such as information, education, and communication and community mobilization programs) focused on the decision makers themselves, in isolation from the deep systemic problems they face. Even the first delay—the decision to seek care—may be influenced by aspects of the second and third delays. For example, women and their families may choose not to seek emergency care because the nearest facilities are not functioning and they know that there is often no doctor at the more distant hospital; treatment is uncertain due to shortages of electricity, water, or supplies; or paying for transport from their village will throw them into debt. Yet, this is often regarded as the failure of the women and their families to make the right decision.[36]

36) UN Millennium Project (2005) 'Who's Got the Power? Transforming health systems for women and children,' Task Force on Child Health and Maternal Health.

Cultural beliefs and social norms inhibit access to services

Certain cultural beliefs and social norms that prevent pregnant women from availing themselves of health care services also impede the demand for maternal health services and the assurance of safe delivery. Influence of a spouse and relatives also affect the choice of delivery mode and site in Uganda. The ways in which pregnancy and childbirth are managed within families and communities and the culturally articulated ideas that surround them often differ across Uganda. Successful maternal mortality reduction strategies and health care services will put local problem solving—within facilities and within communities—at the core of implementation and be adequate to their cultural needs.

4.6 Solutions

Despite the progress that Government has made, sustained and more focused interventions are still needed to improve maternal health, and in particular reduce maternal mortality. This section presents solutions to accelerate progress towards MDG 5 in Uganda and aims to capture the contribution of various sectors (e.g., roads, energy, water, education, etc.) and programs within the health sector (e.g., blood transfusion services etc.) to unblock identified bottlenecks. The solutions reflect mandates of various government institutions in a manner that ensures accelerated progress in the next five years. Some of the solutions are common to all four priority interventions: emergency obstetric care, skilled attendance at birth, family planning, and antenatal care.

Emergency obstetric care and skilled attendance at birth have several aspects in common during their service delivery, and so do the proposed solutions. As regards skilled attendance at birth, it is important to highlight two critical elements: increasing the number of health professionals with midwifery skills and ensuring efficient transport and communication in case of complications. Assisted delivery can occur at home or in a health facility as long as it is done with the support of a trained and well qualified health professional with sufficient midwifery skills.

Overall, solutions to address identified bottlenecks have been clustered across seven main areas focusing on: the provision of adequate health financing; strengthening of the health referral system; the elimination financial barriers to pregnant women accessing maternal health services; the improvement of the supply chain system to provide equipment and supplies at adequate levels; the recruitment, training and retention of an adequate number of health staff; the improvement of basic infrastructure for maternal health service delivery and access; and the promotion of communication, education and public awareness to facilitate and improve service use.

Provide adequate health financing

The Government of Uganda acknowledges the need for increased financial resources to accelerate progress towards improving maternal health. Hence, financing of MDG 5 will be prioritized in the National Development Plan as well as in the Government's borrowing strategy. Government will also consider the possibility of establishing a financing arrangement, for example, an MDG Trust Fund to raise funds for off-track MDGs such as maternal health. To facilitate this process, an appropriate MDG-based expenditure framework along with a Public Expenditure Tracking System will be explored.

In addition to consolidating and seeking additional funding opportunities, the Government, through the National Development Plan (2010-2014), reaffirmed its commitment to eliminating wasteful spending, fighting corruption, and increasing accountability; this is in addition to improving the allocation of resources, increasing efficiency in the use of resources, and giving more attention to the effectiveness of interventions. These are opportunities to consolidate accelerated progress in maternal health with specific actions, as elaborated in Annex C.

There is also a need for integrating the identified solutions in the planning and budgeting processes across sectors and local districts. According to the National Development Plan, planning and budgeting within local governments will be strengthened in the next five years. Ensuring that the plans, budgets and actual implementation are responsive to the priority interventions would strengthen the capacity to provide better maternal health care.

Strengthen the health referral system

The Government, through the National Development Plan, has also committed itself to *"expand[ing] information and communication technology to cover major urban centres in the country"* through the ICT sector. Given the expansion of mobile telephony in Uganda, this is also an opportunity to improve communication between households and health facilities and between lower and referral health facilities, thereby strengthening the health referral system.

Communication is particularly important for the timely transfer of women between health facilities for obstetric care if a given local health centre does not have appropriate capacity. An effective referral system requires good communication systems between the different levels of facilities and readily available transport services.

There are experiences from elsewhere with regard to communication.[37] These are important experiences that Uganda could build upon. With five mobile telephone companies operating countrywide, the Government of Uganda should engage with them to provide support for accelerated improvements in maternal health.

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37) In Mali, the government invested in radio communication among referral centres and procured vehicles for patient transport. Under this system, the time required to transmit an urgent message and transport a patient was reduced from up to a day to just a few hours [Grieco Margaret and Jeff Turner (2005) 'Toolkit on gender, transport and maternal mortality in Africa.' Institute for African Development, Cornell University]. In Sierra Leone, investment in vehicles and improved communication systems led to a doubling in the use of emergency obstetric care and a 50% reduction in case fatalities [Razzak and Kellerman, (2002) 'Emergency medical care in developing countries: is it worthwhile?' Bulletin of the World Health Organization, Vol. 80 (11): 900-905]. In the Suba District of Nyanza Province in Kenya, health facilities have been provided with cell phones and solar-powered battery chargers to make communication between the health centres and the district hospital during an obstetric or neonatal emergency possible [Dr R Pendame (2007) cited as personal communication in "Improving transport and communication between facilities" http://www.eldis.org/].

Eliminate financial barriers to maternal health service access

Government is committed to expanding health care access through investments which target the inequities that prevent the most vulnerable people in society from obtaining the health care they require by, for example, removing financial barriers and providing social health protection. This is crucial for the MDG targets for maternal health to be reached. Reducing out-of-pocket payments for women's medical care will encourage access to health care while protecting poor families from financial hardship. This will allow them to provide for immediate needs and to invest more in their future, such as in housing, education, and income-generating activities. Healthy women work more productively and stand to earn more. Other options which could be explored include: reducing the cost of emergency transport to enable poor women obtain timely care; communities pooling resources in the form of insurance schemes to pay for transport, fuel costs and drivers during an emergency delivery;[38] and expanding the national coverage of the voucher scheme for maternal health to cover emergency transportation.[39]

Improve the supply chain system to provide equipment and supplies

Improving the supply chain system for equipment and medicines is critical for enhancing the capacity of health facilities to provide emergency obstetric care. This entails having in place the required skills, equipment and supplies to perform Caesarean sections and blood transfusions. Through its review of the health sector and reforms, Government aims to ensure that health facilities have capacity to provide basic emergency obstetric care, including adequate supplies of antibiotics, oxytonics, and anticonvulsants, as well as conducting manual removal of placenta, removing retained products of placenta, and assisting with vaginal delivery.[40]

The Government, through the Ministry of Health and the National Medical Stores, is also implementing a zero tolerance policy regarding stock-outs of essential medicines in public health facilities. The challenge that remains is ensuring coordination of the supply of blood to ensure availability to perform Caesarean sections. This will entail improved coordination of the Uganda Blood Transfusion Services departments and units.

In order to provide universal access to family planning, Government is committed to ensuring that an appropriate mix of family planning methods and information. This will require that government and development partners continue to review a combination of methods and align them with women's preferences to ensure choice. The Government has committed itself to reducing unmet need for family planning through the existing health strategies and plans. For effective family planning, commodity security is critical. In this respect, the Government has achieved two milestones in ensuring commodity security. First, it joined the Global Supplies Coalition and committed itself to increasing its share of funding to contraceptive commodities and, second, the Government has transferred funds for medicines directly to National Medical Stores to ease procurement processes.

The changes at the National Medical Stores—the introduction of night shifts and the commitment to zero stock-outs—are making it easy to distribute commodities to districts and hospitals. Through the National Development Plan, the Government has committed to strengthening local governments' ability to supply lower health facilities with needed commodities. It will also continue to explore possibilities, through the National Medical Stores, of distributing these to lower-level health facilities.

The Government is addressing public accountability related to leakage of medicines. Through the National Medical Stores, the Government is eliminating ghost health facilities so that medicines reach the population. This, along with other improvements at the National Medical Stores, is expected to reduce leakage of medicines.

Recruit, train and retain: health human resources

Government gives high priority to ensuring workers are in adequate quantities and have the required skills. The roles and responsibilities are clear: the Ministry of Education and Sports should train sufficient numbers with the appropriate skills, and the Ministry of Local Government, which, through decentralized governments, should recruit and retain sufficient numbers of skilled professionals. The Government's efforts to increase the number and skills of health professions through the Ministry of Education and Sports are provided for in the formal skills development institutions. They are also provided for in institutions of higher learning, such as universities. However, as part of the process, targets should be further defined and refined to enable the expansion of the number of health professionals with midwifery skills.

Government has implemented a decentralized system of service delivery which has improved the provision of health services. The Government through its National Development Plan has committed itself to filling vacant positions at the sub-county and district levels, giving priority to health workers, engineers, agriculture extension workers, community development officers and parish chiefs.

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38) In Mpongwe, Masaiti and Lufwanyama, Zambia, committees were set up in villages to collect and keep funds to be used for paying for transport during obstetric emergencies [Alwar J, Mtonga V, and Sikatoye B, (2000) 'Report of the Summative Evaluation of the Essential Obstetric Care Project in Mpongwe, Masaiti and Lufwanyama Implemented with Technical Assistance from UNICEF and Financial Assistance from Irish Aid']. In Muhororo district, Rwanda, a community set up an emergency transport scheme whereby they paid half of the cost of transportation while the health committee paid the other half [Pearson and Shoo, (2005) 'Availability and use of emergency obstetric services: Kenya, Rwanda, Southern Sudan, and Uganda.' International Journal of Gynaecology and Obstetrics. 88(2):208-15].

39) Voucher scheme being implemented by MSU on behalf of the Government of Uganda with funding from KFW.

40) UNFPA 'Emergency Obstetric Checklist for Planners,' www.unfpa.org.

Another opportunity is to explore task shifting by allowing and training low cadres to provide family planning services; this has been successful in Mozambique, Malawi and Tanzania.[41] With guidance from the Ministry of Health, appropriate task shifting opportunities will be explored.

Improve basic infrastructure to facilitate maternal health service delivery and access

In its National Development Plan, the Government has committed itself to "continu[ing] to improve the stock and quality of national roads, district roads, urban roads and community access roads" through the Ministry of Works and Transport (MOWT) and the Uganda National Roads Authority (UNRA). This is part of the Government strategy to increase and improve the quality of public physical infrastructure which is considered a biding constraint to socio-economic development. In particular, the development of district and community access roads would benefit mothers who need to travel for emergency obstetric care. Evidence in Uganda and elsewhere indicates that these efforts are essential. In Soroti District of Uganda, for example, the commitment by local government to improve access roads reduced the number of women who died of pregnancy-related causes.[42]

Reliable electricity and clean water are also critical components for the provision of emergency obstetric care.

Promising interventions that involve solar energy are being piloted and provide a potential energy source for rural health facilities that are not on the national electricity grid. The Government, through the energy sub-sector, has committed itself to enhancing rural electrification and increasing coverage to 20%. During the implementation of the National Development Plan, the Government intends to add an additional 3,430 mW of electricity. The electricity is expected to be generated from various projects: hydropower projects include Bujagali (250 mW), Karuma (700 mW), Ayago (700 mW), Isimba (130 mW), Arianga (400 mW), various mini hydropower projects (150 mW), thermal plants (700 mW), and solar thermal (150 mW), geothermal (100 mW), and co-generation from biomass (150 mW). Health facilities that provide emergency obstetric care should be included in this expansion.

The Government is committed, through the Ministry of Water and Environment, to improving access to clean water and improved sanitation, and the Ministry is focused on schools and households in urban and rural areas. However, achieving MDG 5 will require that focus be also put on water provision for health facilities. Joint sector reviews need to prioritize this intervention to ensure adequate resources allocation and monitoring of progress.

Promote communication, education and public awareness

The Government has also committed itself, through the National Development Plan, to "transform the mindset of the population through various training and practical programs" implemented through the Ministry of Gender Labour and Social Development.

Much as an appropriate mix of methods is important, so is appropriate information, which women require to make informed choices. The current channel for distributing information is mainly through health workers. With various degrees of success, countries have attempted community-based distribution of family planning methods,[43] whereby non-professional local distributors or agents provide information about family planning methods and referral for other services. Community-based distribution helped increase contraceptive prevalence in other countries such as Zimbabwe, Mali, Burkina Faso, Côte d'Ivoire, the Gambia, Ghana, Kenya, Nigeria, Rwanda, Sudan, and Tanzania.[44] Within the established Village Health Teams, there is an opportunity in Uganda to integrate the provision of family planning methods and information.

41) UNFPA, 'Finding Ways to Deliver for Women where Doctors are in Short Supply', Feature Story, 14 July 2009. http://www.unfpa.org/public/site/global/lang/en/pid/3086

42) In the Darfur region of Sudan, the construction of feeder roads providing motorized transport that connected 45 villages reportedly reduced women's travel time to health facilities (Musa, in 'Balancing the Load' 2002). In Makete District in Malawi, the rehabilitation of the road from Njombe to Makete resulted in an increase in patient numbers by around 15 % at the mission-run hospital.

43) Frontiers in Reproductive Health Program; Family Health International; Advance Africa (2002) 'Best practices in CBD programs in sub-Saharan Africa: lessons learned from research and evaluation.' Family Health International.

44) Community-based distribution helped increase contraceptive prevalence in Zimbabwe to over 50% in the late 1980s. In Mali, it increased contraceptive prevalence from 1% to 11% within a year, with a subsequent rise to 21% when delivery of pills was introduced. Successes have also been registered in Burkina Faso, Côte d'Ivoire, the Gambia, Ghana, Kenya, Nigeria, Rwanda, Sudan, and Tanzania (Chege J and Askew I (1997) 'An assessment of community based family planning programmes in Kenya.' The Population Council; Phillips et al. (1999) 'Lessons from Community-based Distribution of Family Planning in Africa.' Policy Research Division Working Paper No. 121; Chege et al. (2000) 'An Assessment of the Community Based Distribution Programs in Ghana.' Population Council, Planned Parenthood Association of Ghana; Maggwa et al. (2001) 'An Assessment of the Zimbabwe National Family Planning Council's Community Based Distribution Programme.' Population Council, Zimbabwe National Family Planning Council, Family Health International).

4.7 Towards an Action Plan for Accelerated Progress on Maternal Health

The identification of bottlenecks and the proposed solutions will provide a basis for an MDG Acceleration Action Plan to facilitate coordination and accountability among the Government, its development partners, civil society and the UN. This Action Plan will further help the Government to implement the Health Sector Strategic Plan, the Roadmap for accelerating the reduction of maternal and neonatal mortality and morbidity, and the National Development Plan. In particular, the Action Plan will focus more on the specific responsibilities of all Government departments and development partners. Most important, by strengthening synergies between government and its partners, learning from and reinforcing their respective mandates, progress towards improving maternal health will gain speed. The joint Action Plan is an integral part of the MDG report and a basis for the Plan is provided in Annex C.

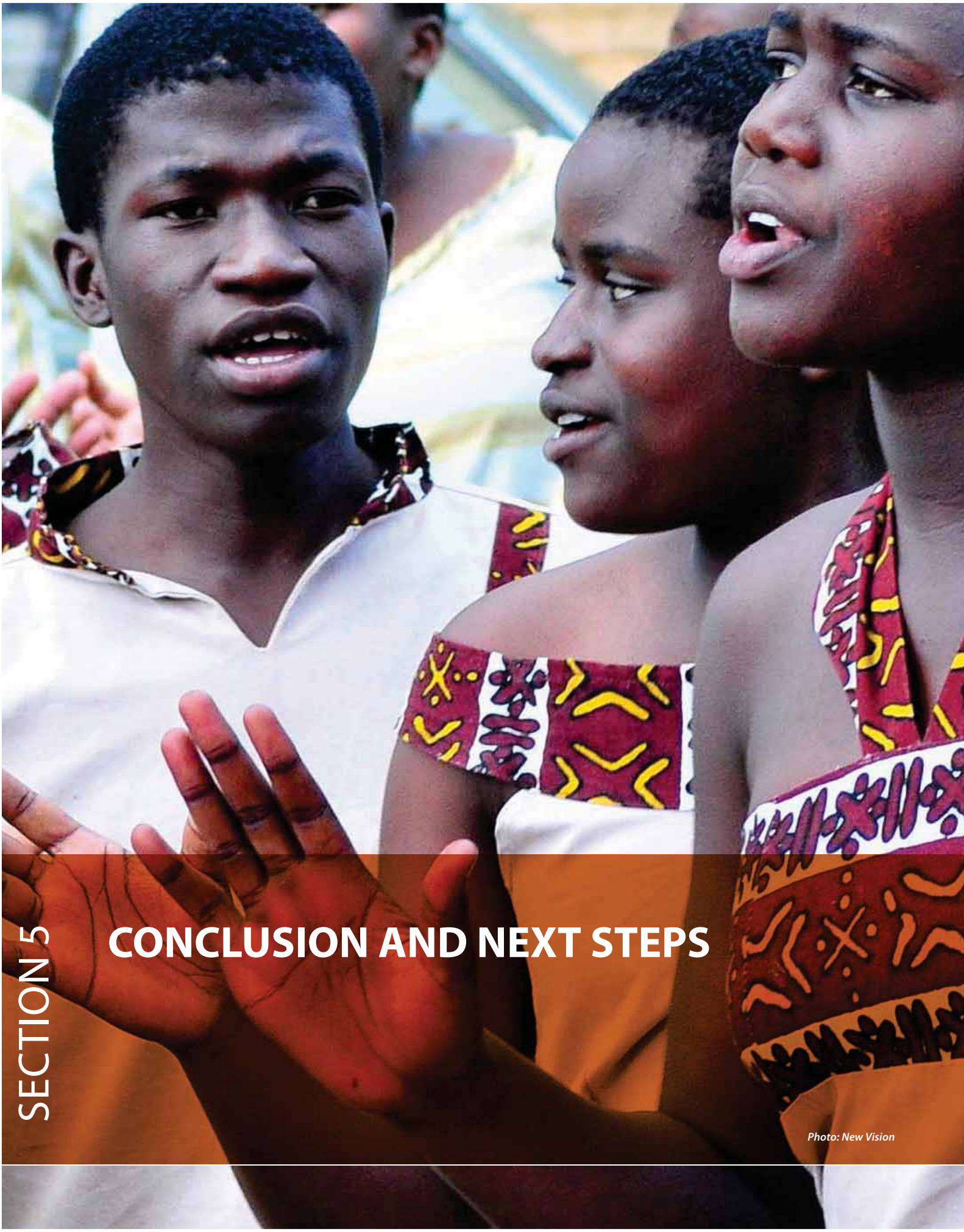
Specifically, relevant partners are expected to work on the actions proposed below, following the initial publication of this report.

1. Convene a consultation with relevant sectors and stakeholders to develop a Joint Action Plan with a clear division of labour to implement the proposed solutions to accelerate progress towards maternal health in Uganda. The expected deliverable will be a matrix accountability of commitments from relevant sectors and will identify the areas that fit best within these sectors' respective policies, plans and mandates.

2. In line with the National Development Plan, relevant sectors are expected to commit to undertake specific actions, as well as targets and timeframes, to accelerate progress towards maternal health.

3. Convene a consultation to build consensus and finalize a Joint Action Plan for accelerated progress towards maternal health in Uganda.

4. Link the implementation of the Joint Action Plan to the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015) and institute it as one of the tools to continuously assess progress towards health in the framework of the National Development Plan (2010-2014).



SECTION 5

CONCLUSION AND NEXT STEPS

Photo: New Vision

5. CONCLUSION AND NEXT STEPS

This third MDG Country Report for Uganda has shown that much progress has been made towards many of the Millennium Development Goals (MDGs) that were agreed upon at the Millennium Summit in 2000 by the leaders of the world's countries, including Uganda. Progress has been most impressive in reducing the share of the population that lives in poverty and suffers from hunger. Moreover, the target of gender parity in primary education has been achieved, and the country is on track to meet the important targets for access to HIV/AIDS treatment and access to safe water. There has also been significant progress in areas related to the global partnership for development, notably in ensuring debt relief and sustainability, as well as in expanding access to information and communication technologies.

In other areas, progress has been slow — and, in a few cases namely MDG target 6A on reversing the spread of HIV/AIDS and MDG target 8B on addressing the special needs of least developed countries — there has been a reverse trend compared to the progress made in the past. While access to primary education has improved, the rates of completion of a full course of primary education have stagnated in recent years. Several of the health targets, including those related to child mortality, maternal mortality, access to reproductive health, and the incidence of malaria and other diseases, have also progressed slowly for the national and international targets to be realised. The same is true of environmental management and biodiversity loss. In the area of HIV/AIDS, Uganda's fight against the epidemic has long been seen as one of the world's success stories. Nevertheless, the data used for this report revealed that progress has stagnated and that new infections are on the increase. A reversal was noted in the flows of overseas development assistance to Uganda. The report has also showed that, even in areas where there has been progress in the national averages, this often masks great unevenness between different population groups and between different geographical areas of the country.

These findings point to the need for Uganda to take special measures to accelerate progress towards the MDGs in the final stretch towards the 2015 deadline. In this context, a flexible analytical framework, the MDG Acceleration Framework, has been applied to assess more specifically how this could be done in the context of MDG 5 to improve maternal health. This analysis identified a series of interventions that are widely regarded as essential for reducing maternal mortality and highlighted gaps in their implementation in Uganda. On this basis, the key bottlenecks for addressing these implementation gaps were highlighted and a range of solutions was proposed. Going forward, it will be critical that these solutions are discussed and that an action plan is developed—a basis for this is presented in Annex C. This plan should draw on existing plans and strategies at the sectoral level and on non-state actors, and particularly on the private sector, non-governmental organisations and community groups. Development partners should stand ready to provide additional financial and technical assistance both efficiently and predictably. The MDG Acceleration Framework applied to MDG 5 in Uganda as part of this report could also be applied to similar analyses of other MDGs that Uganda is in danger of not meeting by 2015.

ANNEXES

ANNEX A: SUMMARY TABLE OF MDG INDICATORS FOR UGANDA

MDG	Indicator	Baseline	Current status	2015 target
1: Eradicate extreme poverty and hunger	1.1 Proportion of population below national poverty line	56% (1992/3)	31% (2005/6)	25%
	1.2 Poverty gap	21 (1992/3)	9 (2005/6)	No target
	1.8 Prevalence of underweight children under-five years of age (percentage below -2 standard deviations of weight for age)	26% (1995)	16% (2005/6)	10%
2: Achieve universal primary education	2.1 Net enrolment ratio in primary education Boys Girls	(all 2000) 86% 89% 82%	(all 2009) 93% 96% 90%	 100% 100% 100%
	2.2 Primary completion rate Boys Girls	(2001) 63% n/a n/a	(all 2009) 52% 55% 48%	 100% 100% 100%
	2.3 Literacy rate of 15-24 year-olds	(all 2002/3) 81%	(all 2008) 88%	No target
3: Promote gender equality and empower women	3.1 Ratios of girls to boys in primary/secondary/ tertiary education	(all 2000) 0.93/0.79/0.58	(all 2009) 1.00/0.84/0.79	1.00/1.00/1.00
	3.3 Proportion of seats held by women in national parliament	18% (2000)	30% (2006)	No target
4: Reduce child mortality	4.1 Under-five mortality rate (per 1,000 live births)	156 (1995)	137 (2005/6)	56
	4.2 Infant mortality rate (per 1,000 live births)	81 (1995)	76 (2005/6)	31
	4.3 Proportion of 1-year-old children immunised against measles	82%	81% (2009)	No target

MDG	Indicator	Baseline	Current status	2015 target
5: Improve maternal health	5.1 Maternal mortality ratio (per 100,000 births)	506 (1995)	435 (2005/6)	131
	5.2 Proportion of births attended by skilled health personnel	38% (1995)	42% (2005/6)	100%
	5.6 Unmet need for family planning	29%	41%	No target
Goal 6: Combat HIV/ AIDS, malaria and other diseases	6.2 Condom use at last high-risk sex, female/male	39%/61% (2000/1)	35%/57% (2005/6)	70%/73% (2012)
	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs	44% (2008)	54% (2009)	80% (2012)
	6.6 Proportion of children under 5 sleeping under insecticide-treated bed nets	8% (2003)	50% (2010)	No target
	6.8 Prevalence rates associated with tuberculosis	652 (2003)	350 (2008)	103
7: Ensure environmental sustainability	7.8 Proportion of population using an improved drinking water source, urban/rural	87%/51% (1999/2000)	87%/64% (2005/6)	100%/70% (2014/5)
	7.9 Proportion of population using an improved sanitation facility, urban/rural	n/a	74%/62% (2007/8)	100%/70% (2014/5)
Goal 8: Develop a global partnership for development	8.4 ODA to GDP ratio	8.6% (2005/6)	5.2% (2009/10)	3.7% (2014/5)
	8.12 Stock-outs of tracer drugs	67% (2002/3)	65% (2006/7)	20% (2009/10)
	8.14 Cellular subscribers per 100 population	4.5 (2004)	28.9 (2008)	No target

ANNEX B: OFFICIAL LIST OF MDG INDICATORS

(EFFECTIVE 15 JANUARY 2008)

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below $1 (PPP) per day* 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below $1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary education 2.3 Literacy rate of 15- to 24-year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1-year-old children immunised against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bed nets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, kg CO2 per $1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used 7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums**

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction—both nationally and internationally Target 8.B: Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction Target 8.C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly) Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	*Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.* <u>Official development assistance (ODA)</u> 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing States as a proportion of their gross national incomes <u>Market access</u> 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity <u>Debt sustainability</u> 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Telephone lines per 100 population 8.15 Cellular subscribers per 100 population 8.16 Internet users per 100 population

The Millennium Development Goals and targets come from the Millennium Declaration, signed by 189 countries, including 147 heads of State and Government, in September 2000 (http://www.un.org/millennium/declaration/ares552e.htm) and from further agreement by member states at the 2005 World Summit (Resolution adopted by the General Assembly—A/RES/60/1, http://www.un.org/Docs/journal/asp/ws.asp?m=A/RES/60/1). The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries 'to create an environment—at the national and global levels alike—which is conducive to development and the elimination of poverty'.

** For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.*

*** The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the four characteristics: (a) lack of access to improved water supply; (b) lack of access to improved sanitation; (c) overcrowding (3 or more persons per room); and (d) dwellings made of non-durable material.*

ANNEX C: MDG ACCELERATION FRAMEWORK FOR MDG 5

Intervention areas	Key interventions	Prioritized bottlenecks
A. Put in place basic measures to guarantee the functionality of the health system	A.1. Reduce the financing and expenditure gap for maternal health care services	A.1.1 Financing gap for maternal health related services. (e.g., the Maternal Roadmap and RH commodities are expected to cost $78.7 million per year, which is over 80 percent of the health sector non-wage budget estimates)
		A.1.2 Weak Public Expenditure Tracking Systems that appropriately capture the overall budget and expenditure for the health sector across the districts
	A.2 Ensure decentralization works in the provision of maternal health services	A.2.1 Prioritization of maternal health interventions is not uniform across the 112 districts
B. Provide universal access to family planning services	B.1. Improve the supply and distribution of family planning commodities	B.1.1 Resource availability: Family planning is not a priority within the health budget. There is limited funding for family planning commodities and inadequate prioritization of family planning in the country's health agenda
		B.1.2. Accountability in the allocation and use of health resources earmarked for family planning
		B.1.3. The limited number of centres for the distribution of supplies restricts broad access and reach to those segments of the population that need them most (e.g., rural villagers)
		B.1.4. Inadequate storage, quantification and tracking of supplies (e.g., condoms, contraceptive pills) required to provide family planning services to meet the current demand
		B.1.5. Insufficient number of midwives and trained nurses in the country

	Identified solutions (2011–2015) and component activities	Potential partners
	A. 1.1. Mobilize additional GoU funding to meet the 15 percent target set by the Abuja Declaration (2001) Leverage GoU funding to facilitate the mobilization of additional funds from development partners Mobilize additional funding from the private sector	Ministry of Finance, Planning and Economic Development
	A. 1.2 Strengthen public expenditure tracking system for the health sector	Ministry of Health
	A. 2.1 Prioritize interventions for maternal health care services across relevant sectors at district level	Ministry of Local Government
	B. 1.1. Increase GoU funding for family planning commodities as per the Reproductive Health Commodity Security Strategy Monitor trends of GoU funding of and expenditure for family planning commodities Advocate with donor partners to sustain current aid financing for family planning commodities	 Ministry of Health Ministry of Health
	B. 1.2. Earmark funds for family planning commodities Health sector to ring fence funding for family planning commodities Increase supervision of Health Centre managers by District Health Office and Ministry of Health Cost-efficient embossing of family planning commodities	 Ministry of Health Ministry of Local Government National Medical Stores
	B.1.3. Increase the number of distribution centres Integrate distribution of appropriate family planning commodities under VHT (Village Health Team) functions Increase the outreach of family planning services through mobile clinics	 Ministry of Local Government Ministry of Local Government
	B.1.4. Improve capacity for stock management Provide training to health centre managers on stock management Increase supervision of HC managers by DHOs and MoH	 Ministry of Health Ministry of Local Government
	B.1.5. Increase the number of trained midwives and nurses to meet the staffing demands Identify targeted incentives for midwives and nurses in hard to reach/stay areas District Service Commissions to improve efficiency of recruitment according to staffing norms and quotas Train more nurses and midwives to expand the human resource pool	Ministry of Public Service; Ministry of Local Government District Service Commissions Ministry of Education and Sports

Intervention areas	Key interventions	Prioritized bottlenecks
B. Provide universal access to family planning services	B.2. Improving capacity in the provision of family planning services at health facilities	B.2.1 Limited skills of service providers at Health Centres that can administer family planning services
		B.2.2. Regulatory barrier limiting midwives and clinical officers from expanding their tasks
		B.2.3. Weak integration of HIV prevention services with family planning services
	B.3. Improve public awareness and understanding for both men and women on family planning	B.3.1. Differences in the understanding of the primary role of family planning. This includes myths and misconceptions of specific family planning methods. Lack of education about birth spacing (e.g., pregnancies that are too early, too late or too close negatively affect the health of women)
		B.3.2 Low educational attainment of girls, which leads to early marriage, adolescent pregnancies and high-risk pregnancies
		B.3.3 Irresponsible parenthood — among both men and women — is not discouraged

	Identified solutions (2011–2015) and component activities	Potential partners
	B. 2.1. Expand on-the-job family planning training for midwives and clinical officers	Ministry of Health
	Conduct continued professional training (CPT)	
	B.2.2. Put in place measures to facilitate task-shifting for midwives	
	Review the legal and regulatory framework of midwife career	Ministry of Health
	Skills upgrading to match provision of surgical family planning interventions	Ministry of Health
	B.2.3. Strengthen the integration of HIV service provision with family planning	
	MoH to forge family planning service partnerships with HIV service providers	Ministry of Health
	B. 3.1. Communications strategy needs to articulate the primary role of family planning	
	Streamline family planning campaigns to the key message of 'Not too early, not too late, and not too close' for reducing the incidence of maternal deaths	Ministry of Health
	Launch IEC (information, education and communication) family planning campaigns with the key message of 'Not too early, not too late, and not too close'	Ministry of Health
	B.3.2. Provide demand-side incentives for girls' enrolment and retention in schools	
	Improve enrolment and retention in primary and secondary schooling of girls	Ministry of Education and Sports
	Design and implement national incentive programme to keep girls at school (e.g., bursary schemes, cash transfers)	Ministry of Education and Sports
	B. 3.3. Promote responsible parenthood	
	Promote responsible sexual behaviour of both men and women	Ministry of Gender, Labour and Social Development; and Ministry of Health
	Strengthen family courts to enforce legal provisions for responsible parenthood	Ministry of Justice and Constitutional Judiciary

Intervention areas	Key interventions	Prioritized bottlenecks
C. Provide access to Skilled Birth Attendants (SBA)	C.1. Train, recruit, and retain health workers with midwifery skills	C.1.1 Insufficient number of midwives in the country
		C.1.2. Lack of appropriate incentives for retaining health staff, including staff housing facilities
		C.1.3. Poor recruitment and management of staff, including lack of monitoring and supervision of health workers
	C. 2. Strengthen referral systems to address emergency cases	C.2.1. VHTs are not functional on a national scale
		C.2.3. Poor road network, especially community access roads, which prevents women from accessing health units in a timely manner

	Identified solutions (2011–2015) and component activities	Potential partners
	C. 1.1. Recruit, train and retain the required number of midwives to meet the demand gap	
	Establish a long-term strategy for boosting sciences and formal training so the pool of qualified midwives is increased	Ministry of Education and Sports
	Establish additional midwifery schools, while considering adequate distribution of technical schools and centres across districts to achieve better regional balance	Ministry of Education and Sports
	Increase partnership between national and local governments with NGOs to facilitate recruitment, retention and training	Ministry of Health
	C.1.2. Ensure the systems are in place to continuously review and improve incentive structure for health staff	
	Put in place an incentive framework for the hard to reach and hard to retain to improve staff retention	Ministry of Public Service
	C.1.3. Put in place measures to enforce results-based management systems	
	Advocate to local districts to fill their health staff quotas	Ministry of Local Government
	Introduce and enforce performance contracts accompanied by sanctions and rewards in accordance with performance	Ministry of Public Service, Ministry of Local Government
	Strengthen monitoring and evaluation systems in place at the national and local levels	Ministry of Health
	Increase public demand for accountability in delivery of services	Ministry of Gender, Labour and Social Development
	C.2.1. Implement existing policy on VHTs	
	Expand the coverage of VHTs across the country	Ministry of Health
	Devise appropriate mechanisms to motivate and sustain the VHTs (e.g., commission basis for appropriate referral similar to what was done for iganga, polio and guinea worm)	Ministry of Local Government
	Introduce an emergency number in case a mother needs help	Ministry of Information and Technology
	Introduce geographical demarcations (e.g., zip codes) and communications systems to enable locating homes for ambulance services as part of infrastructure expansion	Ministry of Information and Technology
	C.2.3. Construction and maintenance of community access roads in priority district areas	Ministry of Works, and Ministry of Local Government
	Put in place a mapping assessment of where community roads should be built or maintained as per priority district areas vis-à-vis location of HC-III	
	Implement the Community Agriculture Infrastructure Improvement Program on a national scale	
	Ensure that DUCAR, under the Ministry of Works, prioritize the construction of community roads	
	Mandate the Local Council Chairman to mobilize communities (villages) to maintain the roads through voluntary contributions and in-kind support	

Intervention areas	Key interventions	Prioritized bottlenecks
C. Provide access to Skilled Birth Attendants (SBA)	C. 2. Strengthen referral systems to address emergency cases	C.2.4. Lack of functionality of the first referral health facility HC-IV as a referral unit and as a health sub-district unit
	C.3. Strengthen public awareness and empowerment with a view to enhance dialogue among men and women in seeking care, and health workers	C.3.1. Inadequate public awareness and empowerment of women (including their spouses) to dialogue with health workers
		C.3.2. Lack of appropriate incentives to stimulate the demand for health services
	C.4. Ensure that the delivery practices respond to the needs of women (culturally sensitive interventions)	C.4.1. In some circumstances, the manner in which deliveries at health facilities are conducted are not compatible with women's cultural beliefs and are considered inadequate for women (e.g., delivery in squatting position, placenta practices)
		C.4.2. Lack of orientation of health practitioners to cultural norms and customer care (for instance, cultural norms and customer care is not part of the health curriculum)

	Identified solutions (2011–2015) and component activities	Potential partners
	C.2.4. Improve the referral system to reduce the burden of HC-IV	
	Make HC-IVs fully functional by providing sufficient human resources and equipment and ensuring adequate management	Ministry of Health
	Enhance management skills at the HC-IV	Ministry of Health
	Recruit an administrator to perform administration functions	Ministry of Health
	C.3.1. Empower women to seek adequate health care during pregnancy, including SBA services	
	Strengthen public awareness campaigns on rights (including the right to dialogue) and duties of women, and their partners, and health workers	Ministry of Gender, Labour and Social Development
	Encourage advocacy and awareness programmes that can educate men about pregnancy risks and the benefits of SBA services to ensure men are involved and supportive in the process	Ministry of Gender, Labour and Social Development
	Rethink the role of traditional birth attendants, including their training and certification	Ministry of Health
	C.3.2. Provide additional benefits for giving birth using skilled birth attendance services	
	Provide additional benefits such as birth certificates linked to baptism and school leaving exams, coupled with instant provision of birth certificates at the time of delivery at health units	Registry General of Births and Deaths, Ministry of Justice
	Include in the ongoing review processes of birth and death registration a discussion on such incentives	Registry General of Births and Deaths, Ministry of Justice
	C.4.1. Make delivery experiences culturally adequate for women	
	Review policy, standards, procedures and practices to respond to women's cultural norms, and ensuring their safety	Ministry of Health
	Enlist and develop a checklist of culturally sensitive issues related to the manner of delivery, with a focus on regions where the identified cultural practices are most prevalent (e.g., Karamoja, Buganda and Kigezi)	Ministry of Health
	Pilot test client-oriented service approaches that address cultural sensitivities and adequacy of interventions that do not put the mother at increased risk — with the aim of increasing demand for SBA services	Ministry of Health
	C.4.2. Provide proper orientation to health practitioners	
	Include cultural and customer care training curriculum of health workers especially when training is at subnational level — which has the potential to address subnational specificities	Ministry of Education and Sports
	Provide orientation packages for new health workers at different health centre levels	Ministry of Health

Intervention areas	Key interventions	Prioritized bottlenecks
D. Improve access to Emergency Obstetric Care (EmOC)	D.1. Improve the procurement and distribution of equipment to hospitals and Health Centres to perform EmOC	D.1.1. Government procurement guidelines are subject to manipulation (e.g., a vendor can stop the entire process through a complaint) which leads to procurement delays
		D.1.2. Delays in distribution of medicine and supplies, especially between district and health units
	D.2. Improve referral system, including communication systems and transportation for emergency care	D.2.1. Inadequate communication systems (e.g., telephone services) between villages and health units to allow women to communicate with health units
		D.2.2 Non-functional or non-existent telephones (e.g., intercom, including pagers and cell phones) at health units to communicate across departments and access on-call staff
		D.2.3. Lack of communication between lower health units to referral health units in case of emergency, to enable receiving units to better prepare
		D.2.4. Non-existent or poor community roads where the majority of women live, making it harder for expecting mothers to access health units or enable ambulances to reach their homes in case of an emergency
	D.3. Strengthen blood transfusion Services	D.3.1. Non-availability of blood at health units at times of need, and insufficient stocks of blood, particularly for universal donors
		D.3.2. Limited awareness and misconception about blood transfusion and donation, including locations for donation
		D.3.3. Mal-distribution of blood across the country, with no access for rural and remote health units

	Identified solutions (2011–2015) and component activities	Potential partners
	D.1.1. Improve the efficiency of procurement systems	
	Maintain a framework/database management system of contracts to ensure timely delivery	National Medical Stores
	D.1.2. Improve the distribution of medicines and supplies	
	Assess systems for nationwide distribution of exams and election ballot papers to come up with a mechanism to distribute medicine across the country in all health facilities	National Medical Stores
	D.2.1. Establish free emergency telephone numbers with accompanying support infrastructure, and create awareness and partnerships with telecommunication companies to facilitate services	Ministry of Information and Communication
	D.2.2. Installation of intercom within hospitals and Health Centre IV	Ministry of Information and Communication
	D.2.3. Encourage government to partner with private telecom companies to provide services between lower health units and referral health units	Ministry of Information and Communication
	D.2.4. Construction and maintenance of community access roads in priority district areas	
	Put in place a mapping assessment of where community roads should be build or maintained as per priority district area vis-à-vis location of HC-III	Ministry of Works and Transport
	Implement the Community Agriculture Infrastructure Improvement Program on a national scale	Ministry of Agriculture, Animal Industry and Fisheries
	Ensure that DUCAR, under the Ministry of Works, prioritizes the construction of community roads	Ministry of Works and Transport
	Mandate the Local Council Chairman to mobilize communities (villages) to maintain the roads through voluntary contributions and in-kind support	Ministry of Local Government
	Plan and regulate settlements across the country to enable community road access to heath units	Ministry of Lands and Environment
	D.3.1. Ensure the availability of blood at all times in HC-IV and hospitals	
	Provide and popularize incentive schemes for blood donation	Uganda Blood Transfusion Services
	Expand and increase the number of blood donation centres	Uganda Blood Transfusion Services
	D.3.2. Sensitize the public to dispel the misconceptions about blood donation	Uganda Blood Transfusion Services
	D.3.3. Decentralize blood transfusion services, including donation, to HC-IV (first referral unit)	Uganda Blood Transfusion Services

Intervention areas	Key interventions	Prioritized bottlenecks
D. Improve access to Emergency Obstetric Care (EmOC)	D.4. Train, recruit, and retain health workers with midwifery skills and specifically those able to provide emergency obstetric care	D.4.1. Insufficient number of midwives in the country
		D.4.2. Lack of appropriate incentives for retaining health staff, including staff housing facilities
		D.4.3. Poor recruitment and management of staff, including lack of monitoring and supervision of health workers
	D.5. Improve basic infrastructure required at health units (e.g., improve access to clean water and reliable source of electricity)	D.5.1. Lack of appropriate guidelines or their enforcement to ensure health units have regular access to: - clean water (following the model of water provision to schools) - reliable electricity source - adequate sanitation
		D.5.2. Inadequate maintenance of water sources and equipment, and inability to follow through long-term maintenance strategies (e.g., trainings of community water maintenance teams have been discontinued)
		D.5.3. Limited electric grids reaching health units, and inadequate prioritization of health units in rural electrification programmes

	Identified solutions (2011–2015) and component activities	Potential partners
	D.4.1. Recruit, train and retain the required number of midwives to meet the demand gap in the following ways:	
	Establish a long-term strategy for boosting sciences and formal training so the pool of qualified midwives is increased	Ministry of Education and Sports
	Establish additional midwifery schools, while considering adequate distribution of technical schools and centres across districts to achieve better regional balance	Ministry of Education and Sports
	Increase partnership between national and local governments with NGOs to facilitate recruitment, retention and training	Ministry of Health
	D.4.2. Ensure the systems are in place to continuously review and improve incentive structure for health staff	
	Put in place an incentive framework for the hard-to-reach and hard-to-retain, to improve staff retention	Ministry of Public Service
	Implement the 30 percent allowance for hard to reach and hard to retain	
	D.4.3. Put in place measures to enforce results-based management systems	
	Advocate to local districts to fill their health staff quotas	Ministry of Local Government
	Introduce and enforce performance contracts accompanied by sanctions and rewards in accordance with performance	Ministry of Public Service, Ministry of Local Government
	Strengthen monitoring and evaluation systems in place at the national and local levels	Ministry of Health
	Increase public demand for accountability for delivery of services	
	Establish and strengthen mechanisms that ensure health workers that have graduated with government bursaries dedicate a specified time period working at government facilities	Ministry of Gender, Labour and Social Development
	D.5.1. Develop or enforce guidelines	
	Develop and enforce guidelines (where they do not exist) to facilitate the installation and maintenance of: - access to clean water (following the model of water provision to schools) - reliable electricity source - adequate sanitation	Ministry of Local Government Ministry of Water Ministry of Energy
	D.5.2. Equip the district water department with toolkits and adequate equipment for proper maintenance of services to the district, including the training of water pump attendants	Ministry of Water
	D.5.3. Prioritize the provision of electricity to health units in the rural electrification program	Ministry of Energy

Intervention areas	Key interventions	Prioritized bottlenecks
D. Improve access to Emergency Obstetric Care (EmOC)	D.6. Ensure women access to EmOC, including emergency transport	D.6.1. Inadequate financial protection for poor pregnant women to access health care services (e.g., health insurance coverage is limited)
E. Improve access to Antenatal Care (ANC)	E.1. Provide comprehensive ANC services	E.1.1. Lack of awareness about the benefits of ANC (majority of women go for only one visit to obtain the delivery pass)
	E.2. Improve malaria prevention and management programmes and services with a focus on the needs of pregnant women	E.2.1. Inadequate and unregulated usage of traditional knowledge practices in rural villages (e.g., wrong dosages being administered) prevent women from seeking specialized health care for malaria (e.g., they instead resort to the use of traditional drugs and herbs, which are, moreover, often administered badly) and social behaviour which may downplay the negative effects of malaria on pregnant women
		E. 2.2. Inadequate supplies for malaria testing and medicines Inadequate supply and inequitable distribution of mosquito nets
		E.2.3. Inadequate financial protection for poor pregnant women to access health care services (e.g., limited health insurance coverage)
		E.2.4. Poor community participation in malaria prevention and management programmes (e.g., poor sanitation, environmental management, inadequate use of indoor residual spray, ITNs)

	Identified solutions (2011–2015) and component activities	Potential partners
	D.6.1. Ensure financial protection for expectant mothers	
	Speed up the health insurance bill and ensure that the poor receive adequate insurance coverage	Ministry of Health
	Strengthen existing financial protection systems, including community-initiated mechanisms	Ministry of Gender, Labour and Social Development
	E.1.1. Create incentives for pregnant women to access ANC services (currently, the figure for 1 ANC visit is 94 percent, but for 4 ANC or more it is less than 46 percent)	
	Develop public awareness about the benefits of additional ANC visits for pregnant women	Ministry of Health
	Support VHTs to sensitize women to the need for ANC services	Ministry of Health
	Assess the feasibility of expanding the tasks of outreach programmes (e.g., those responsible for immunization services) to integrate basic ANC services	Ministry of Health
	E.2.1. Create guidelines for use of traditional medicines and public awareness of them	
	Develop and enforce guidelines on usage of traditional medicines that affect the health of pregnant women	National Chemotherapeutics
	Sensitize the public to the use of traditional herbs during pregnancy	Ministry of Health
	E.2.2. Train logistics management and supervise the logistics management of supply chain mechanisms	Ministry of Health
	Mobilize and allocate additional funding for the procurement of malaria medical supplies and medicines, including mosquito nets	Ministry of Finance, Planning and Economic Development, and Ministry of Health
	E.2.3. Ensure financial protection for expectant mothers	
	Speed up the health insurance bill and ensure that the poor receive adequate health insurance coverage	Ministry of Health
	Strengthen existing financial protection systems, including community-initiated mechanisms	Ministry of Gender, Labour and Social Development
	E.2.4. Support VHTs in sensitizing the community to malaria prevention and the risks of malaria for pregnant women	Ministry of Health
	Mandate the Local Council Chairman to mobilize village communities to voluntarily engage in malaria prevention programmes	Ministry of Local Government
	Enforce bylaws for improvement of domestic sanitation standards that have an impact on the incidence of malaria	Ministry of Local Government

Intervention areas	Key interventions	Prioritized bottlenecks
E. Improve access to Antenatal Care (ANC)	E.3. Provide HIV/AIDS Voluntary Counselling and Testing (VCT) services	E.3.1. Inadequate integration of HIV and AIDS services into ANC services, including the prevention of mother-to-child transmission (PMCT), and voluntary counselling and testing (VCT)
	E.4. Provision of nutrition supplements to pregnant women	E.4.1. Inadequate knowledge in the community of nutritional content of locally available food which can directly improve nutrition for pregnant women
		E.4.2. Distribution of food supplements does not cover all HCs

	Identified solutions (2011–2015) and component activities	Potential partners
	E.3.1. Integrate HIV and AIDS services such as PMCT, and VCT into ANC services	Ministry of Health
	E.4.1. Enhance the knowledge of villagers about the nutritional content of local foods Establish and make public the nutritional content of locally available foods Disseminate the available knowledge about nutritional content of locally available foods, including guidance on preparation and consumption	University Faculties on Food Science & Technology, and Ministry of Agriculture, Animal Industries and Fisheries
	E.4.2. Make appropriate food supplements available Procure food supplements together with medicines and supplies to ensure availability and distribution across the country to reach pregnant women	Ministry of Health

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