



POLICY BRIEF

Health Sector

Background

HIV/AIDS was first reported in the country in 1982 but to-date, its prevalence has reached a national average of about 6.4% with variation across gender and regions.

The government's response has included the adoption of a multi-sectoral approach in 1992 which has been implemented through (a) the National Operational Plan (NOP) for period 1993/4-1996/7 (b) the National Strategic Framework (NSF) for period 1998-2002 (c) the Revised NSF for period 2000/01-2005/6 and (d) the most recent National Strategic Plan (NSP) for HIV/AIDS 2007/8-2011/12. The NSP is focusing on three thematic priority service areas namely: prevention, care and treatment and social support that are to be supported by a strengthened service delivery system and structure in order to ensure quality, equity and timely service provision. Taking cognizance of availability of relatively cheap and effective anti-retroviral treatment (ART) and aiming at providing universal access to ART to those who need it, provision of ART in the NSP is projected to account for over 90% of the resources required for care and treatment programmes. However to-date, only 170,000 people out of an estimated 350,000 persons that are eligible to receive ART are on the treatment, and there are approximately 130,000 new infections every year.

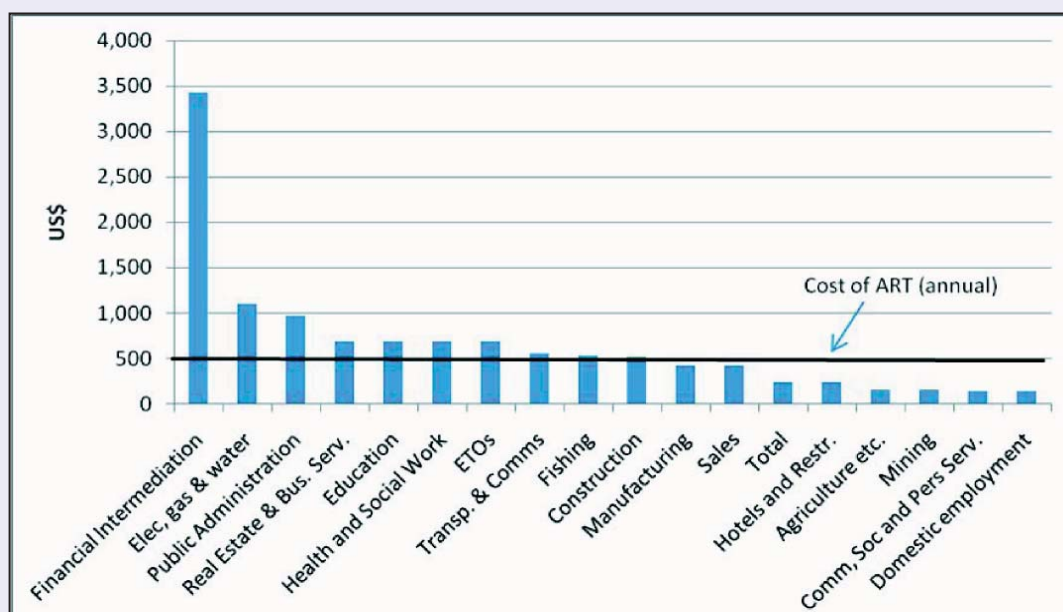
The provision of ART was found to be associated with considerable increase in foreign currency inflows which was thought to threaten and destabilize the macro-economy of the country. Hence, in 2007, "Assessing the Macroeconomic Impact of HIV/AIDS in Uganda" study was commissioned to study, among others, the impact HIV/AIDS in Uganda on national and sectoral economy, the extent to which the provision of ART would have in reversing the negative impacts of HIV/AIDS and the likely impact of ART provision on the macro-economy of the country.

Major Findings from the Macro-economic Impact Study of HIV/AIDS in Uganda

- Health & Social Work sector as well as Education, Finance and Public Administration are the most vulnerable sectors because of their high dependence upon skilled workers than other sectors
- The prevalence of HIV among working adults in health sector was 8% compared to Public Administration which was at 16%
- Between 2008/09 and 2009/10, there were reductions in the percentage allocations to eight sectors including health which had a reduction from 10.7% in 2008/9 to 10.2% in 2009/10. In medium term expenditure framework, it is projected that government will invest Uganda Shillings (UGX) 853.9 billion, which is about 10.9% of the national expenditure outlay of UGX 7,836.2 billion.
- Currently the threshold for CD4 cell counts that makes an HIV infected person eligible to ART drugs in Uganda is at 250 cells/mm³ which is far lower than the 350 cells/mm³ recommended by WHO due to scarce resources; the lower a patient's CD4 count is, the lower his/her immunity and more likely he/she will succumb to opportunistic infections thus requiring more expensive drugs for treatment.
- Government facilities are more likely to report ART stock outs than private facilities; indeed, more

than 80% of facilities providing ART had stock outs of first-line drugs in the 6 months that preceded the Uganda Service Provision Assessment survey of 2007.

- In Uganda, per capita expenditure on health is only US \$25 which is far less than cost of (\$500) of providing ART to a patient in a year; the average wage for most people employed in different sectors is less than \$500 while over 34% of population live on less than a dollar per day.



Average wage by Sector (US\$/Year)

- Annual cost of providing ART to the 170,000 PHAs is about US\$ 85 million which is (a) over 23% of the health sector allocation of UGX 737.7 billion for FY 2009/10 (b) far greater than the Government's projected contribution of US\$ 75 million to national response under NSP in FY2011/12.
- Quality Chemicals factory is not yet accredited by WHO as a registered source of ART and hence it cannot currently compete regionally and globally thus making it unable to produce the drugs on a larger and more economically feasible scale

Policy Implications

- Prevention interventions need to be re-designed and targeted according to the different target beneficiaries in order to avert new cases of infection.
- Laws and bye-laws that can curb deliberate spread of HIV infection (e.g. sexual and gender based violence, deliberate infection of sexual partners, domestic relations bill, etc.) need to be put in place as deterrents and to address complacency that has come in due to availability of drugs rendering AIDS as a treatable disease.
- Promotion of proven approaches (e.g. condoms) and technologies (e.g. male circumcisions) to prevention need to be advocated for.
- There should be substantive positions for counselors in the health sector facilities, to-date, which do not exist in all public health facilities.
- Support needs to be given in enhancing commercially viable production of ARTs whose qualities meet international standards; this will address issues of external aid inflows, unit costs and drug stock out.
- Provision of health services need to be rationalized with donors urged to invest in holistic strengthening of government health systems and religious private-not-for-profit health facilities while strengthening civil society capacity in advocacy, health rights campaigns, community empowerment and demanding for transparency and accountability from health service providers.