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MCH PROGRAM DESCRIPTION

Uganda



Overall MCH and health sector situation

Uganda has a population of about 29.5 million, 53 percent of whom are below the age of 15 and of whom only 12 percent live in urban areas. Annual health expenditures are \$77 per capita (UNDP, 2005). Uganda has benefited from increased peace and stability with relatively high economic growth. Poverty is now at 31 percent; life expectancy has increased to 50 years; and the national primary school enrollment level is more than 90 percent. Yet, the nation still faces major development challenges. Although Uganda has universal primary and secondary education, the quality of education is still quite poor. Uganda ranked 154 out of 177 countries on the 2007–2008 United Nations Human Development Index. Adult HIV/AIDS prevalence has dropped from historical highs but remains at 6.4 percent. Food insecurity affects 60 percent of the population in northern Uganda.

While MCH funding has had limited national impact, there still have been declines in U5MR, from 162 to 137 per 1,000 in the last 5 years. The high infant mortality rate of 71/1,000 live births, out of which 27/1,000 live births are neonatal deaths, reflects the need to capitalize on primary care opportunities for children at birth and in the first year of life. Similarly, the MMR (435 per 100,000 live births) has not declined in the past decade. Exacerbating this, the TFR has remained high at 6.7 children per woman, primarily due to a variety of factors, including lack of access, cultural desire for more children, and early initiation of sexual intercourse, with the latter being the lesser of the factors, and lack of access and cultural desire for more children being the more prominent. Many of these problems are linked, at least in part, to limited service delivery in rural areas reaching the community and household levels, and to the quality of the services that do reach them.

MCH interventions at the Mission level

Priority areas of intervention include nutrition including vitamin A capsule supplementation, folate and iron supplementation during pregnancy, and local food fortification; hygiene improvement; strengthening delivery of immunization services; and community treatment of fever and diarrhea in children under 5. The new initiatives are expanding the nutrition program to include breastfeeding, complementary child feeding, and growth promotion and monitoring; management of obstetrical fistula; and systems strengthening for logistics management. All the interventions are national except the vitamin A supplementation and iron folic acid, which focus on 12 districts, representing 15 percent of the total population. Reducing maternal mortality is another priority area for the Government of Uganda, and one in which USAID wants to strengthen its programming, with a strong focus on reducing the occurrence of postpartum hemorrhage specifically. Postpartum hemorrhage is the second major killer of mothers in Uganda. Programmatic interventions include training of service delivery providers, particularly to perform AMTSL on all delivering mothers, including Misoprostol use, and health communication.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

Due to the concern that the long fight against HIV/AIDS has placed a strain on basic primary care and that improvements in mortality will not be sustained, greater attention is being directed at revitalizing and expanding basic primary health care services, such as immunizations and modern contraception methods. Village health teams, community medicine distributors, and reproductive health assistants operate within all districts. Community medicine distributors are linked to primary health facilities. Social marketing focuses on nutrition, diarrhea, and malaria. This work is being transitioned to the indigenous Uganda Health Marketing Group.

Specific actions supported as part of the MCH approach

USAID's support in MCH also focuses on strengthening health systems and quality of care, including support for Uganda's expanded program for immunization, national medical stores for pharmaceutical supply chain management, and the MOH's work to increase recruitment, retention, and quality of health personnel.

The USAID program's geographic focus

The USAID program operates at both national and district levels; there are 83 districts in Uganda. The maternal health interventions are districtwide, and will roll out in up to 20 districts, to be selected upon award of the new RH/CS RFA and expected to represent 25 percent of the population of women of childbearing age and their children under 5.

The Mission program's relationship to the country's health sector and development plans and strategies

USAID contributes to the GOU health sector through the SWAp and the 2005/06–2009/10 HSSP II. USAID programs are implemented through the SWAp coordination mechanisms for policy development, planning, and monitoring. Reduction of maternal mortality is a key national priority to which donor partners are expected to contribute.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

The USAID MCH program works closely with PEPFAR and PMI in Uganda. Uganda serves as a worldwide model for combating HIV/AIDS and has moved toward integrated health programs for FP, MCH, malaria, and HIV. Uganda receives substantial HIV/AIDS resources as a PEPFAR country. These resources have contributed to connecting PMTCT and highly active antiretroviral therapy with antenatal care and delivery. Through PMI and PEPFAR, resources are leveraged to support IPT for pregnant women through the PMTCT service points. PMI and MCH resources are used to provide ITNs for children and pregnant women, home-based management of fever for children, and the biannual child days for delivery of a package of child and women's services such as immunization, ITN distribution, vitamin A capsule supplementation, and deworming. All districts have functional village health teams and community medicine distributors, which have been strengthened by PMI, NTD, and Government of Uganda funding. They have been trained in vitamin A capsule distribution as well as home-based management of fever. There is potential for distribution of iron and folate supplementation and ORS/zinc through these health workers. The PMI primarily targets pregnant women and children under 5 with treated bednets; pregnant women receive IPT; and although all people benefit from ACT, the main focus is pregnant women and children under 5.

Investments and initiatives of other donors and international organizations

The MOH works with USG and others through the SWAp coordination mechanisms and the HSSP II. Donors coordinate through the Health Development Partners group. The Government of Uganda and donors subscribe to one coordination and monitoring mechanism. USAID leverages other global alliances, such as GAVI, The Global Fund, and Global Alliance for Improved Nutrition (GAIN), to mobilize and implement CS and MH integration.

Planned results for the Mission's MCH investments over the next 5 years

Short-term outcomes are improved coverage for immunization, vitamin A supplementation, ORS/zinc, improved management of postpartum hemorrhage, institutional deliveries, and newborn care. Long-term outcomes are reductions in maternal and U5MR rates, reduced diarrhea case fatality rates, improved assisted deliveries, improved full immunization coverage, improved nutritional status of under-5 children, and reduced rates of micronutrient malnutrition.

MCH COUNTRY SUMMARY: UGANDA	VALUE
MCH FY08 BUDGET	5,447,000 USD
Country Impact Measures	
Number of births annually*	1,404,000
Number of under-5 deaths annually	192,000
Neonatal mortality rate (per 1,000 live births)	27
Infant mortality rate (per 1,000 live births)	71
Under-5 mortality rate (per 1,000 live births)	137
Maternal mortality ratio (per 100,000 live births)	435
Percent of children underweight (moderate/severe)	23%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	95%
Percent of women with at least four antenatal care (ANC) visits	46%
Percent of women with a skilled attendant at birth	46%
Percent of women receiving postpartum visit within 3 days of birth	23%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	25%
Immunization	
Percent of children fully immunized at 1 year of age	36%
Percent of DPT3 coverage	64%
Percent of measles coverage	68%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	63%
Percent of children receiving adequate age-appropriate feeding	80%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	36%
Percent of children under 6 months exclusively breastfed	60%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	56%
Percent of children with diarrhea treated with zinc	1%
Percent of children with pneumonia taken to appropriate care	73%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	64%
Percent of population with access to improved sanitation**	33%
<small>* Census International Database ** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report (Unless otherwise noted, the data source is the 2006 Demographic and Health Survey.)</small>	