REPUBLIC OF UGANDA

Uganda National Health Compact (2025-2030)

ADOPTED DECEMBER 2025

#InvestinHealth

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ABBREVIATIONS

CatHE	Catastrophic Health Expenditure
CHE	Current Health Expenditure
CHEWs	Community Health Extension Workers
CPD	Continuous Professional Development
CSO	Civil Society Organization
DP	Development Partner
GoU	Government of Uganda
HC	Health Center
HCDP	Human Capital Development Programme
HRH	Human Resource for Health
HTA	Health technology Assessment
ICT	Information Communication Technology
IHR	International Health Regulations
ITN	Insecticide Treated Net
JEE	Joint External Evaluation
LG	Local Government
M&E	Monitoring and Evaluation
MoES	Ministry of Education and Sports
MoFPED	Ministry of Financing Planning and Economic Development
MoGLSD	Ministry of Gender Labor and Social Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service
MoWE	Ministry of Water and Energy
NCD	Non-Communicable Disease
NDP	National Development Plan
OOP	Out of Pocket
OPM	Office of the Prime Minister
PHC	Primary Health Care
PPP	Public Private Partnership
RBF	Results Based Financing
RMNCH	Reproductive Maternal Newborn and Child Health
RRH	Regional Referral Hospital
SDG	Sustainable Development Goals
TWG	Technical Working Group
UgIFT	Uganda Intergovernment Fiscal Transfer
UDHS	Uganda Demographic Health Survey
UHC	Universal Health Coverage
URMCHIP	Uganda Reproductive and Child Health Improvement Project
VHT	Village Health Team
WASH	Water Sanitation and Hygiene

FOREWORD

The National Health Compact for Uganda is both a testament to our nation's resolve and a strategic blueprint for transforming the health and wellbeing of every Ugandan. As leaders entrusted with the stewardship of our country's health and financial resources, we recognize that the prosperity, peace, and resilience of Uganda are inseparable from the health of our people.

Uganda stands at a pivotal moment in its journey towards Universal Health Coverage (UHC). This Compact is the product of extensive consultation, rigorous analysis, and the collective wisdom of government, development partners, civil society, and private sector. It builds on the foundation laid by Uganda Vision 2040, the National Development Plan IV, and our commitment to the Sustainable Development Goals—especially SDG 3, which calls for ensuring healthy lives and promoting wellbeing for all at all ages.

We acknowledge the significant progress Uganda has made in recent years in increasing life expectancy from 63.7 years in 2014 to 68.2 years in 2024, HIV treatment coverage, reducing maternal and child mortality, and the expansion of infrastructure and primary health care services to previously underserved regions. These achievements demonstrate what is possible when bold policy, strategic investment, and community engagement converge. Yet, we remain aware of the persistent challenges. Disparities in health outcomes, the burden of preventable diseases, and financial hardship continue to affect many Ugandans. The COVID-19 pandemic and other shocks underscore the importance of building equitable and resilient health systems.

The National Health Compact sets forth a clear vision: to build a resilient, equitable, and people-centered health system that leaves no one behind. It articulates high-level targets and strategic pillars that address the full spectrum of health needs—health promotion and disease prevention, to strengthening service capacity, workforce development, sustainable financing, multi-sectoral collaboration, and governance.

The Government of Uganda through the Ministry of Health and the Ministry of Finance, Planning and Economic Development affirms that achieving these ambitions requires a whole-of-government and whole-of-society approach. Health is not created in clinics alone; it is shaped in homes, schools, workplaces, and communities. Every sector—public and private—has a role to play in advancing health and wellbeing.

We are committed to mobilizing the necessary resources, aligning investments with priorities, and ensuring that every shilling spent delivers value for the people of Uganda. We will work together to close funding gaps, strengthen accountability, and foster innovation. Through transparent monitoring, regular reporting, and participatory review, we will hold ourselves accountable for results. Let this Compact be our collective pledge: to translate vision into action, to protect the most vulnerable, and to secure a healthier, more prosperous future for the people of Uganda.

We invite all stakeholders—development partners, philanthropies, private sector actors, academia, research institutions, civil society, and communities—to join us in this transformative journey.

Hon. Dr. Aceng Jane Ruth Ocero
Minister of Health

Hon. Matia Kasaija
Minister of Finance, Planning, and Economic Development

1. DECLARATION OF COMMITMENT

The Government of Uganda hereby affirms its national commitment to achieving Universal Health Coverage (UHC) by ensuring that all people, especially the most vulnerable, have access to high-quality, affordable, and people-centered health services in line with the Uganda Essential Health Care Package. To this end, the Government aims to achieve seven high-level targets:

High-level targets of the Compact

- *Increase UHC Service Coverage Index from 49 percent to 58 percent by 2030*
- *Increase the health share of the Government budget from 5.6 percent by 2024/25 to 9 percent by 2030.*
- *Decrease the number of people exposed to financial hardship as they seek health care services from 13.6% of the population to below 10 percent by 2030.*
- *Expand access to essential health services by increasing coverage of sub-counties with Health Centre IIIs from 74 percent to 85 percent by 2030, prioritizing hard-to-reach and underserved populations.*
- *Expand domestic production of essential medicines and health commodities from 20 percent to 30 percent of national demand by 2030.*
- *Increase availability of 41 tracer commodities for essential medicines and health supplies from 64 percent to >90 percent.*
- *Increase the density of health workers (doctors, nurses, and midwives) from 27 to 37 per 10,000 population.*

Alignment of Compact with national and global initiatives

Uganda aligns its health sector transformation with the National Development Plan 2025/26 – 2029/30 (NDP IV) by expanding access to quality care, investing in a skilled workforce, and unlocking private sector potential. The compact's focus on UHC supports the country's vision 2040 of "A transformed Ugandan society from a peasant to a modern and prosperous country within 30 years". It also aligns with Sustainable Development Goal 3 (SDG3) of Health and Well-being by promoting access to quality essential health services without financial hardship to individuals, and other health and well-being related SDGs 1, 2, 4, & 6, the World Health Assembly's 78th session resolution on strengthening health financing, Political Declaration of the High-Level Plenary Meeting on UHC (2023), the World's Bank's goal of reaching 1.5 billion people with quality affordable health services by 2030 and the UHC2030 Global Compact: Operationalizing commitments to equitable, resilient, people-centered health systems. Furthermore, the compact reinforces the African Union Agenda 2063 by strengthening Primary Health Care (PHC), local manufacturing of health products, and digital innovation, and the East Africa Health Sector Strategic Plan. These investments position Uganda as a regional leader in building resilient, equitable, and future-ready health systems.

Key policy commitments by Pillar

To achieve the targets outlined in the National Health Compact, the Government of Uganda commits to addressing critical bottlenecks across the health value chain as outlined in the Compact's action plan, with commitments to implementing bold reforms and coordinated action across six strategic pillars:

I: STRENGTHEN HEALTH PROMOTION AND DISEASE PREVENTION THROUGH COMMUNITY HEALTH SYSTEMS AND OTHER PLATFORMS.

To close equity gaps in access and behavioural change, Uganda is transforming health service delivery by strengthening PHC service delivery through operationalizing the Community Health Strategy using various community and social structures like households, institutions, schools, cultural and religious leaders, and workplaces. The Government is scaling up delivery of an Integrated Essential Community Health Care Package using the community platform and deploying

two trained Community Health Extension Workers (CHEWs) in every parish in Uganda. The Community Health Strategy is to be implemented in line with the Parish Development Model approach to enable active community engagement. In addition, the sector will continue leveraging religious, cultural institutions and social groups which are trusted and powerful channels for disseminating accurate information, combating misinformation, and mobilizing community participation. To this end, the Government commits to the following policy actions:

- ***Roll out the integrated essential community health care package with a focus on life-course approach*** *to prevention and health promotion, targeting pregnant women, newborns, children, adolescents, older persons, refugees, and other vulnerable population.*
- ***Increase investment in the PHC system, with focus on the community health system for health promotion and diseases prevention*** *to address behavioural barriers to seeking health care, promote lifelong healthy behaviors, create demand, and shift social norms and perceptions.*
- ***Strengthen capacity and adequately remunerate frontline community health workforce*** *(CHEWs & Village Health Teams (VHTs)) for effective delivery of health promotion and disease prevention services, including empowerment and tooling for community digital health roll out.*
- ***Promote self-care and mobile (tele) health service roll-out*** *at community level to enhance access, reduce patient travel, and strengthen continuity of care.*
- ***Build capacity and equip emergency first responders*** *for road safety and disaster response.*
- ***Revitalize public health inspection and National Cleaning Days in institutions, public places, and communities*** *to enhance compliance to the Public Health Act.*
- ***Establish and enforce integrated, environmentally sound waste management systems across communities, public institutions, and health facilities*** *to mitigate public health risks, environmental pollution, and disease outbreaks.*
- ***Disseminate and monitor implementation of the National School Health and Nutrition guidelines,*** *defining roles for school nurses, screening protocols, surveillance, deworming, nutrition, and referral programmes.*
- ***Implement the National Framework on Health Education and Life Skills for In-School and Out-of-School Adolescents and Youth*** *to protect girls from child marriage and harmful traditional practices.*
- ***Strengthen community engagement, ownership, and feedback mechanisms in health planning, delivery of public health interventions, and accountability*** *by Parish Development Model structures, cultural, religious, and social institutions, Information Communication Technology (ICT) systems, and Community Health Action groups (Barazas) as platforms for multi-disciplinary appraisal and action planning for health.*

II: STRENGTHEN HEALTH SERVICE CAPACITY TO INCREASE ACCESS TO QUALITY PEOPLE-CENTERED SERVICES

The Government of Uganda is committed to strengthening the country's health service capacity as a critical foundation to access to quality care. To address long-standing disparities in service availability and quality, the Government will strengthen the health system's capacity to deliver the National Essential Health Care Package by functionalizing existing health facilities, construction of new health facilities in marginalized regions, ensure digital connectivity, service-readiness and resilience, with access to reliable power and internet connectivity, clean water and sanitation, modern diagnostics and laboratories, essential medicines and vaccines at the last mile, electronic health records and interoperable data systems, and the strengthening of core capacities for surveillance and emergency response. To this end, the Government will:

- ***Develop a National Health Infrastructure Master Plan (2025–2035)*** *with explicit targets and financing strategies for the*

construction, rehabilitation, expansion, equipping, and maintenance of referral hospitals, general hospitals, community hospitals, Health Centers (HC) IIIs, laboratories, ambulance call centers, blood banks, and incinerators, prioritizing underserved regions and districts, while ensuring incorporation of climate smart technologies in the designs, and mobilizing private sector investment in health infrastructure.

- ***Construct, rehabilitate /upgrade and equip HC IIIs and IVs in line with the MoH policy of establishing HC IIIs in every subcounty and HC IVs*** *in every constituency to increase access to PHC services.*
- ***Earmark Operation and Maintenance in health budgets****, maintain comprehensive infrastructure and equipment registries, and institutionalize preventive maintenance systems to ensure sustainable financing, regular upkeep, and functionality of biomedical and digital technologies.*
- ***Provide reliable and sustainable clean energy,*** *informed by a comprehensive health–energy needs assessment, to ensure reliable and sustainable power for all public health facilities — prioritizing off-grid and rural areas, integrating renewable and hybrid energy solutions like solar panels, and establishing maintenance and financing mechanisms for long-term functionality.*
- ***Provide safely managed supply of clean water for health facilities and schools,*** *to improve infection prevention and control as well as WASH.*
- ***Strengthen Health Supply Chain management system,*** *and ensure availability, physical access, affordability, digitization for improved accountability and appropriate use of quality-assured essential medicines, health commodities, and pharmaceutical services.*
- ***Revise, adopt, and roll out national standards for medical laboratory, imaging, and radiology services*** *across public and private sectors to ensure reliable, safe, and high-quality diagnostic services for all levels of care.*
- ***Roll out and maintain an integrated digital health data system*** *including early warning systems for health service disruption (utilization and quality) that crowd sources data from the administrative sources (DHIS2), Electronic Medical Records System (EMRS), other existing systems, and social platforms etc). This will include streamlining pathways for* ***piloting and scaling digital health innovations*** *without compromising safety, interoperability, data privacy or creating a chaotic, unregulated market.*
- ***Construction, rehabilitation /upgrading and equipping HC IIIs, and IVs*** *to increase access to quality PHC services in line with the government policy of having a functional HC III in every subcounty and a HC IV in every constituency.*
- ***Expand internet connectivity,*** *especially in rural and underserved areas.*
- ***Enforce national service-readiness standards, quality improvement initiatives for all public and private facilities to enhance quality, people centred care*** *by conducting inspections and audits to verify compliance with quality standards, publish results and enforce corrective actions.*
- ***Update and implement the National Action Plan for Health Security*** *to strengthen capacity for preparation for, detection early and rapid response to public health emergencies and disasters.*
- ***Roll out implementation of the Climate Change Health National Adaption Plan*** *to create a resilient health system and reduce Climate change induced shocks to the health system.*

III: IMPROVE ADEQUACY OF A SKILLED, COMPETENT AND ETHICAL HEALTH WORKFORCE

Uganda's health workforce transformation centers on scaling training, recruitment, upskilling, retention, enhancing digital readiness, and productivity to deliver quality primary, secondary, tertiary, and quaternary care across the life course. The Government will reform performance management, professional standards, distribution, and productivity, as follows:

- ***Develop a Human Resources for Health Investment (HRH)*** *Plan and Compact, including needs-based training, recruitment, equitable deployment policies and incentives for underserved and hard-to-reach areas, and retention based on labor market analysis.*
- ***Strengthen performance management of HRH*** *through digitization - workforce registry and information system integrated with payroll and licensing.*
- ***Develop service standards for health workers*** *to define roles and responsibilities for interdisciplinary care teams (e.g. doctors, nurses, midwives, pharmacists, nutritionists, and social workers).*
- ***Safeguard the health, safety, and well-being of all health workers*** *by establishing a comprehensive and enforceable national framework for Occupational Health and Safety (OHS) to reduce workplace injuries, infections, and burnout, thereby protecting the frontline of Uganda's health system.*
- ***Accredit and quality-assure public and private training institutions*** *using competency-based standards.*
- ***Institutionalize continuing professional development*** *and competency-based recertification through digital platforms.*
- *Develop and implement* ***one national in-service HRH training plan.***
- ***Systematically scale up the production, retention, and continuous skill development of specialist health workforce cadres*** *to ensure equitable access to quality tertiary healthcare services for all Ugandans*
- ***Functionalize the HRH in-service training Institute*** *in Mbale.*

IV: STRENGTHEN THE HEALTH FINANCING SYSTEM TO IMPROVE ADEQUACY, EFFICIENCY, EQUITY, AND FINANCIAL RISK PROTECTION.

The Government remains committed to addressing the funding gaps and inefficiencies that result in low quality health services, stock-outs, low utilization of public health services, and an increased disease burden by removing cost barriers to care, especially for the vulnerable groups, reducing reliance on out-of-pocket (OOP) payments and addressing inefficiencies. The Government of Uganda recognizes that true financial protection requires shielding households not only from Catastrophic Health Expenditure (CatHE), but also from impoverishing health expenditure and foregone care due to cost. We commit to tracking and reducing the number of individuals and households pushed into, or deeper into, poverty because of OOP payments for health care, and addressing the barrier of cost that prevents individuals from seeking needed healthcare, which leads to worse health outcomes and increased long-term economic burdens.

This will be through increased domestic financing for health prioritizing the critical gaps like medicines and health supplies and human resource for health, alignment of donor support, equitable resource allocation, and strategic purchasing to improve quality and outputs. In addition, the Government will harness the role of the private sector in domestic health financing. To this end, the Government will:

- ***Develop the 10-year Uganda Health Financing Strategy 2025 – 2035 (aligned to the National Integrated Financing Framework)*** *to provide a framework through which Uganda will finance its health sector to achieve UHC.*
- ***Fast track the approval and operationalization of a mandatory NHIS*** *for all people in Uganda, with equity and financial protection considerations for the informal sector, elderly, and vulnerable populations.*
- ***Ensure adequate and equitable fiscal transfers*** *to PHC facilities and referral hospitals.*
- ***Convene high level financing dialogues*** *between Ministry of Health (MoH), Ministry of Finance Planning and Economic Development (MoFPED), Parliament on a regular basis to track progress.*
- ***Implement public investment management reforms*** *in the health sector to improve value for money.*

V: ENHANCE MULTI-SECTORAL COLLABORATION AND PRIVATE SECTOR ACTION

The Government is committed to improving the environment for multi-sectoral collaboration to address the gaps in other sectors that are undermining the investments and progress made in the health sector. To this end, the Government commits to the following actions:

- ***Strengthen the multi-sectoral coordination structures** at all levels of the system, from national to Local Government (LG) level to achieve UHC.*
- ***Establish an integrated human capital development program performance management system,** encompassing performance measurement, evidence generation, Monitoring and Evaluation (M&E) frameworks, performance standards setting, and regular performance reviews across all sectors including progress on UHC.*
- ***Strengthen Health in All Policies and programs** by developing a multisectoral collaboration framework with clear accountability mechanisms for priority cross sectoral health and development challenges like teenage pregnancy, road traffic accidents, nutrition, and high impact non communicable diseases.*
- ***Jointly implement cross-sectoral projects,** prioritizing areas requiring integrated approaches.*
- ***Strengthen Public Private Partnerships for Health** to increase the efficiency and leverage scarce public resources*
- ***Promote local manufacturing of essential vaccines, Active Pharmaceutical Ingredients, and diagnostics,** including fiscal incentives and procurement guarantees for priority products.*
- ***Institutionalize private sector participation in health facility construction, rehabilitation, and equipment maintenance through well-structured Public Private Partnerships (PPPs),** standardized performance-based contracts, and simplified permitting processes, supported by a joint MoH–MoFPED PPP framework, risk-sharing mechanisms, and capacity-building for project preparation and contract management.*
- ***Strengthen partnerships with academia and research institutions** for evidence generation, monitoring, and innovation in service delivery.*

VI: IMPROVE GOVERNANCE, OPERATIONAL EFFICIENCY AND ACCOUNTABILITY

The Government is committed to ensuring that the health system is strategically oriented, efficient, person-centred, and free from corruption. To this end Government commits to the following actions:

- ***Improve operational efficiency** by ensuring joint planning, budgeting, implementation and monitoring and evaluation- "One Plan, One Budget, One M&E".*
- ***Strengthen integrated person-centered care, technical support, mentorship and hands-on coaching** to LGs for continuous quality improvement.*
- ***Institutionalize health technology assessment (HTA)** to support regular revision of service packages and interventions based on value-for-money.*
- ***Fast-track the establishment of the Uganda Health Professionals Authority** to regulate public and private healthcare providers and ensure competence and quality.*
- ***Enforce all the UHC relevant Acts regulations and** policies from MoH and other MDAs to ensure compliance.*
- ***Strengthen the national regulatory & quality assurance capacity of the National Drug Authority (NDA)** to ensure safety, efficacy and quality of medicines and health products.*
- ***Institutionalize and digitize resource mapping and expenditure tracking systems** and routinely measure progress.*
- ***Empower Parish-level committees, Health Unit Management Committees and Hospital Boards** to monitor services, manage drug stocks, and hold providers accountable. Facilitate participatory spaces and social audits where citizens can directly question local leaders and health managers.*

- ***Institutionalize multi-stakeholder engagement platforms*** *(e.g. civil society forums) to align priorities and address bottlenecks.*

Commitment to Monitoring Compact

The Government of Uganda, in collaboration with key stakeholders, is unequivocally committed to the transparent and accountable monitoring of the National Health Compact. This commitment will be operationalized through a robust, multi-level M&E framework designed to track progress, ensure learning, and drive evidence-based action towards achieving UHC. To this end the Government commits to:

- ***Establish and maintain a comprehensive National Health Compact M&E framework, led by the MoH. This framework*** *will define clear indicators, baselines, and targets aligned with the Compact's strategic objectives.*
- ***Regular and Transparent Reporting:*** *Integrated within the Human Capital Development Programme (HCDP) M&E system, the HCDP M&E Technical Working Group (TWG) will be responsible for producing and disseminating quarterly progress reports. These reports will be formally presented and discussed in performance review meetings to foster accountability.*
- ***Conducting a comprehensive mid-term review of the Compact's implementation for strategic learning.*** *The findings and recommendations from this review will be publicly shared and will directly inform necessary strategic adjustments and resource allocation.*
- ***Strengthen existing data collection and feedback mechanisms*** *to ensure that real-time information and community insights continuously guide policy refinement and programmatic decisions.*

Call for Partnerships

The Government of Uganda is fully committed to transforming the country's health system to ensure every individual has a fair and just opportunity to achieve their highest level of health, regardless of who they are or where they live. *It is a recognition that health is created in our homes, schools, workplaces, and communities, and therefore, its improvement requires the commitment of every sector of society. Through this National Health Compact, the government invites development partners, philanthropies, private sector stakeholders, and civil society to support Uganda's journey toward UHC. These efforts will strengthen the health system, improve health outcomes, and contribute to the country's broader social and economic development goals.*

2. COMPACT PREPARATORY PROCESS

The compact development process involved rigorous endeavour that started with the formation of an inter-ministerial Core Technical Working Group and engagement of a consultant to assist with the development of the Compact.

The preparatory process involved the development of an inception report, conduct of a stakeholders' validation workshop, and finally endorsement of the Compact by the Senior Management of the Ministries of Finance, Planning and Economic Development, and the Ministry of Health. The compact will be further presented to the inter-ministerial human capital development programme working group in accordance with programme approach to budgeting.

3. FUNDING NEEDS

The success of this Compact relies on a collaborative financing model shared between the Government of Uganda, the Private Sector, and Development Partners.

The below table provides an estimate of the funding needs for implementation of the National Health Compact for Uganda by 2030. These figures are high-level estimates intended to signal the scale of investment required from all sources. Total Health Expenditure was estimated at The NHA survey findings revealed that Uganda's total health expenditure was Uganda Shillings 7.79 trillion and 8.71 trillion for the FYs 2019/20 and 2020/21 respectively therefore the funding proposals here are towards enhancement for the critical areas like health promotion and diseases prevention, human resources for health, medicines and other health systems strengthening components. Actual costs will be determined through detailed micro-costing studies and annual budget processes.

TABLE 1: FIVE YEARS FUNDING NEEDS 2025 - 2030 (US$ MILLIONS) (EXCHANGE RATE 1 UUD 3,600 UGX)

Strategic Pillar	Government	Private Sector	Development Partners	Total
1. Strengthen Health Promotion and Disease Prevention	450	50	300	800
2. Strengthen Health Service Capacity	1,200	400	800	2,400
3. Improve Adequacy of the Health Workforce	900	100	200	1,200
4. Strengthen the Health Financing System	150	50	100	300
5. Enhance Multi-Sectoral Collaboration and Private Sector Action	100	200	150	450
6. Improve Governance & Accountability	200	50	150	400
GRAND TOTAL	**3,000**	**850**	**1,700**	**5,550**
Percentage contribution	**54%**	**15%**	**31%**	**100%**

3.1 BREAKDOWN OF COST ESTIMATES BY PILLAR

Pillar 1: Strengthen Health Promotion and Disease Prevention Through Community Health Systems and Other Platforms ($800 Million)

- **Focus:** Community-based health promotion and disease prevention.
- **Major Cost Drivers:** Recruitment, training, and stipends for CHEWs and VHTs; integrated health package delivery; digital literacy and telehealth roll-out; school health programs; community engagement platforms (Barazas).

Pillar 2: Strengthen Health Service Capacity ($2,400 Million)

- **Focus:** Physical infrastructure, equipment, and essential supplies.
- **Major Cost Drivers:** Construction, renovation, and equipping of health facilities (HC IIIs, IVs, Hospitals) as per the National Master Plan; national electrification and internet connectivity for facilities; strengthening the health supply chain to reduce stock-outs; procurement of essential medicines and health commodities.

Pillar 3: Improve Adequacy of the Health Workforce ($1,200 Million)

- **Focus:** Addressing the human resources crisis.
- **Major Cost Drivers:** Salaries and incentives to fill vacant posts (increasing from 34% to 55%); pre-service and in-service training; scaling up CPD and digital recertification; operationalizing the HRH training institute in Mbale.

Pillar 4: Strengthen the Health Financing System ($300 Million)

- **Focus:** Systemic reforms for sustainable health financing.
- **Major Cost Drivers:** Technical assistance for developing the 10-year financing strategy; setup costs and initial capital for the National Health Insurance Scheme (NHIS); capacity building for public investment management.

Pillar 5: Enhance Multi-Sectoral Collaboration and Private Sector Action ($450 Million)

- **Focus:** Cross-sectoral action on health determinants.
- **Major Cost Drivers:** Joint projects in WASH, nutrition, and road safety; fiscal incentives and guarantees to promote local pharmaceutical manufacturing; establishing PPP frameworks and hosting investment forums; research partnerships with academia.

Pillar 6: Improve Governance & Accountability ($400 Million)

- **Focus:** Systems for efficiency, transparency, and oversight.
- **Major Cost Drivers:** Digitizing and integrating planning, budgeting, and M&E systems ("One Plan, One Budget, One M&E"); establishing the Uganda Health Professionals Authority (UHPA); institutionalizing Health Technology Assessment (HTA); digital resource tracking and national health accounts.

4. COMPACT TARGETS AND ACTION PLAN

Table 2: Outlines the indicators for the high-level commitment actions with targets by 2030. These indicators and targets have been extracted from existing health programme plans like the NDP IV and UHC Roadmap for Uganda and aligns with the National Health strategy.

TABLE 2: INDICATOR MATRIX FOR THE HIGH-LEVEL COMMITMENTS AND TARGETS BY 2030.

High level commitment Actions	Indicator	Baseline	Target by 2030	Source of Data
1. Strengthen Health Promotion and Disease Prevention Through Community Health Systems and Other Platforms	Households visited by a VHT member in the last 12 months (%)	45 (2022)	>80	eCHIS
	Children aged 12 – 23 months fully immunized (%)	54 (2022)	>90	UDHS
2. Strengthen health service capacity to increase access to people-centered services	Subcounties with functional HC IIIs (%)	74 (1,670/2,207) (2024/25)	>90	MoH Reports
	Deliveries in health facilities	65 (2023/24)	>90	HMIS
	Average availability of the 41 tracer medicines and health supplies (%)	64 (2023/24)	>90	HMIS
	Client satisfaction level (%)	73% (2021)	>90	NSDS
3. Improve adequacy of a skilled, competent, and ethical health workforce	Density of doctors, nurses, and midwives per 10,000 population	27 (2023/24)	32	Registries
	Approved posts filled in public health facilities (%)	34 (2023/24)	55	HCMS
4. Strengthen the health financing system	Government health expenditure as a % of total government expenditure (%)	6.3 (2024/25)	9	MTEF
	Catastrophic Health Expenditure at 10%	13.6%	<10%	NHA
	Population covered with health insurance	1.1% (2024)	10%	Reports
	Health development aid channelled through Government systems (%)	48 (2023/24)	>80	MTEF

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5. Enhance multi-sectoral collaboration and private sector action	Joint operational plans developed and funded with key sectors (Number)	2 (WASH, Nutrition)	9	MTEF
	Basic sanitation- Improved toilets (%)	43	<10%	NHA
	Reduction in stunting prevalence among children under 5 years (%) disaggregated by wealth quantile and region	26 (2022)	10%	Reports
	Teenage pregnancy rate (%)	44	>80	MTEF
5. Improve governance, operational efficiency, and accountability	Partner plans incorporated in the annual sector plans and budgets (Joint Planning) (%)	50	100	Reports
	Annual health sector performance reports publicly available and reviewed (%)	100	100	MoH Website

4.1 ACTION PLAN

The action plan matrix below outlines the policy commitments, actions to operationalize, indicators to track progress, timelines and targets, and responsibility for accelerating progress towards UHC.

TABLE 3: NATIONAL HEALTH COMPACT ACTION PLAN FOR UGANDA 2025 – 2030

Policy Commitment	Actions to Operationalize	Indicators	Timelines and Targets	Responsible Entity
PILLAR 1: STRENGTHEN HEALTH PROMOTION AND DISEASE PREVENTION THROUGH COMMUNITY HEALTH SYSTEMS AND OTHER PLATFORMS				
1.1 Roll out the integrated essential community health care package with a focus on life-course approach.	Disseminate the integrated package; train VHTs and CHEWs on its delivery; integrate it into the national supply chain.	Parishes with functional VHTs/CHEWs delivering the full package (%).	Package disseminated to all LGs by Q4 2025/26; 80% of parishes per district /city covered by 2028	MoH; LGs, DPs
1.2 Increase investments in PHC systems, with focus on the community health system for health promotion and diseases prevention.	Conduct investment case for community health; advocate for PHC budget increase.	PHC budget allocation increase (%)	Increase PHC budget allocation from 27% to 35% of the total health subprogramme budget by 2030	MoH, MoFPED, LGs

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1.3 Strengthen capacity and adequately remunerate and the frontline community health workforce (CHEWs & VHTs) for health promotion and disease prevention, including empowerment and tooling for community digital health roll out.	Develop a standardized remuneration policy; conduct regular competency-based training; provide tools and equipment (e.g., smartphones, kits).	CHEWs trained and receiving regular stipends/ incentives (%).	Package disseminated to all LGs by Q4 2025/26; 80% of parishes per district /city covered by 2028	MoH; LGs, DPs
1.4 Promote self-care and mobile (tele) health service roll out at community level to enhance access, reduce patient travel, and strengthen continuity of care.	Community-Based Digital Literacy and Awareness Campaigns	CHEWs trained and receiving regular stipends/ incentives (%).	Package disseminated to all LGs by Q4 2025/26; 80% of parishes per district /city covered by 2028	MoH; LGs, DPs
1.5 Build capacity and equip emergency first responders for road safety and disaster response.	Finalize and disseminate the First Aid training manual, provide trauma kits, identify, train, and facilitate key first responders	Proportion of highway hot spots with trained and equipped first responders	90% of highway hot spots have active first responders	MoH, MoWT & LGs
1.6 Revitalize public health inspection and National Cleaning Days in institutions, public places, and communities to enhance compliance to the Public Health Act.	Equip (motorcycles, etc) of Health Assistants / Inspectors for strengthened disease / event surveillance	Proportion of highway hot spots with trained and equipped first responders	90% of highway hot spots have active first responders	MoH, MoWT & LGs

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1.7 Establish and enforce integrated, environmentally sound waste management systems across communities, public institutions, and health facilities.	Develop and Disseminate National Waste Management Standards and Regulations; Scale Up Functional Solid Waste Collection Systems in Urban and Peri-Urban Areas; Ensure Safe and Complete Management of Healthcare Waste; Promote Community-Led Total Sanitation (CLTS) and Safe Faecal Sludge Management	Existence of officially gazetted waste management regulations. Existence of officially gazetted waste management regulations. District Environmental Officers trained on and equipped with the new standards and enforcement tools (%). Urban households with access to regular solid waste collection services (%). Number of functional, regulated sanitary landfills in operation. Tonnage of waste diverted from landfills through recycling/ composting Health facilities (HC III and above) fully compliant with national healthcare waste management standards (%). Healthcare waste that is safely treated and disposed of (%) Number of sub-counties certified as Open Defecation Free (ODF). Faecal sludge that is safely emptied, transported, and treated (%). Number of licensed and compliant faecal sludge emptying companies.	Q4,2026/27 Waste management regulations gazetted. Q2, 2027/28 100% of District Environmental Officers trained. 2027/28: 50% of urban households have access to collection services (from a low baseline). 2029/30: All 15 City/ Municipal Councils have a functional, regulated landfill or transfer station. 2027/28: 70% of RRHs and General Hospitals are compliant. 2029/30: 100% of HC IVs and 80% of HC IIIs are compliant. 2028/29: Reduce the proportion of untreated healthcare waste from >30% to <10%. 2028/29: 40% of sub-counties achieve ODF status. 2029/30: 60% of faecal sludge is safely managed (from a very low baseline).	MoWE, NEMA, MoH, MoLG, Municipal and City Councils, Private Sector, Health Facilities, CSOs, DPs
1.8 Develop and monitor implementation of the National School Health and Nutrition guidelines.	Finalize and disseminate guidelines; train school nurses and teachers; integrate school health into LG work plans.	Schools implementing the national school health & nutrition guidelines	90% of highway hot spots have active first responders	MoH, MoWT & LGs

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1.9 Implement the National Framework on Health Education and Life Skills for In-School and Out-of-School Adolescents and Youth	Revise the national school and secondary primary school curriculum include the revised comprehensive curriculum on health education and life skills Train teachers on delivery Train youth peers and community facilitators Set up safe spaces (youth centers) for sessions	% of secondary primary schools using the revised comprehensive curriculum on health education and life skills Number of teachers trained pre- and in-service. Number of youth peers and community facilitators trained Number of safe spaces (youth centers) operational	100% of secondary primary schools using the revised curriculum by Q4 2028/29 5,000 teachers trained by Q4 2027/28 500 youth peers trained per district by 2028 Establish 2 safe spaces (youth centres) per district by Q4 2028	MoH, MoES, LGs, Secondary Schools, Primary Schools, MoGLSD, CSOs
1.10 Strengthen community engagement, ownership, and feedback mechanisms in health planning, delivery of public health interventions, and accountability by leveraging PDM structures, cultural, religious, men and boys, youth and social institutions, ICT systems, and Community Health Action groups (Barazas) as platforms	Establish PDM Pillar 4 Committees Mandate each health facility and LG to establish and maintain active community action groups (CAGs) that integrate PDM Pillar 4 leaders and meet quarterly Train cultural and religious leaders, youth groups, men, and boys as health champions on key health messages and feedback mechanisms Integrate health messages into major religious and cultural events Institutionalize biannual barazas at every health facility co-chaired by facility in-charge and CAG chairperson Develop and install Public Accountability and Performance Dashboards at Regional Referral and General Hospital levels showing availability of medicines, maternal deaths, budget execution, etc Institutionalize the Routine client satisfaction feedback Initiative Empower communities on their rights and responsibilities as well as health care workers on their obligations	Functional PDM Pillar 4 Committees (%) Health facilities with functional CAGs and updated action plans (%) Number of community priorities integrated into health plans and budgets Number of religious and cultural leaders, youth groups, men, and boys actively disseminating health messages and mobilizing for barazas per quarter % of planned barazas conducted annually Number of action points from barazas resolved and publicly communicated back to the community Dashboards installed at all Regional Referral and General Hospitals and updated quarterly Routine client satisfaction feedback rolled out nationally Number of feedback reports received and resolved Number of health facilities with client charters	50% Pillar 4 Parish Committees functional by 2027, 75% by 2030 100% Health facilities with functional CAGs and updated action plans by end of 2026 80% of community generated actions reflected in LG annual health plans by 2027/28 Train religious and cultural leaders in 50% of districts by 2027/28 and 100% by 2030 Train youth groups, men, and boys in 30% of districts by 2027/28 and 75% by 2030 100% of health facilities conduct biannual barazas by end of 2027 90% of action points from barazas resolved and communicated back to the community within 3 months Dashboards in 100% Regional Referral and General Hospitals by end of 2026. 50% health facilities implementing the client feedback initiative by Q4 2026/27, and 85% by 2030. % of feedback reports resolved and feedback provided to the community within 3 months 100% of health facilities have client charters displayed by Q4 2026/27	OPM, MoH, MoLG, LGs, Implementing Partners, CSOs, Religious Institutions, Cultural Institutions, Referral Hospitals

Policy Commitment	Actions to Operationalize	Indicators	Timelines and Targets	Responsible Entity
PILLAR 2: STRENGTHEN HEALTH SERVICE CAPACITY TO INCREASE ACCESS TO QUALITY PEOPLE-CENTERED SERVICES				
2.1 Develop and Implement the National Health Infrastructure Master Plan 2025 – 2035.	Conduct a comprehensive mapping and needs assessment for health infrastructure including ambulances; Develop and cost the master plan; Review health infrastructure designs to include climate safe technologies	National health infrastructure gap assessment report published; Costed Masterplan finalised; Health infrastructure designs revised to include climate safe technologies Ambulance procured	Report published Q1 2026/27; Master Plan launched by Q3 2026/27; 30% of construction targets met by 2030; 100% BOQs include appropriate climate safe technologies 100% constituencies have functional ambulances by 2030	MoH, National Level Health Institutions, MoFPED, LGs, DPs
2.2 Construct, rehabilitate /upgrade and equip HC IIIs and IVs	Secure funding; initiate construction/renovation or upgrading and modernizing of prioritized facilities with necessary amenities (power, WASH and internet connectivity, access for people with disabilities), procurement of equipment	New facilities constructed (Number); Facilities upgraded or renovated as per master plan (Number) % of facilities physically accessible for people with disabilities	500 HC IIIs established and equipped by 2030; 50 HC IV established and equipped by 2030 100% new / rehabilitated facilities physically accessible for people with disabilities	MoH, MoFPED, LGs
2.3 Earmark Operation and Maintenance funds in health budgets.	Issue a Treasury Directive mandating O&M earmarking; build capacity of LGs to plan and utilize O&M funds.	Health facility budgets at national and LG level allocated to O&M (%)	100% of health facility budgets include a dedicated O&M line by 2026	MoFPED, MoH, NRHs, RRHs, LGs
2.4 Provide reliable and sustainable clean energy.	Conduct energy audits; connect health facilities to the power grid; scale up solar power solutions for off-grid facilities.	Health facilities with reliable electricity (24/7) (%)	Increase from baseline to 80% of all facilities by 2030	MoH, Ministry of Energy and Mineral Development (MoEMD), Private Sector

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2.5 Provide safely managed supply of clean water for health facilities and schools	Conduct a national audit of water access in all health facilities (HC III and above), primary and secondary schools; Integrate and fund "Water Security Plans" as a mandatory component of the National Health Infrastructure Master Plan and school construction plans; Install and maintain appropriate water systems (e.g., motorized systems with storage tanks, rainwater harvesting) at all targeted institutions.	Health facilities (HC III and above) with access to a reliable, on-site improved water source (%) Primary schools with access to a basic drinking water service on premises (%). Secondary schools with access to a basic drinking water service on premises (%).	2027/28: 90% of health facilities have reliable water. 2029/30: 95% of health facilities and 90% of primary and secondary schools have a basic water service on premises	MoWE, MoH, MoES, MoFPED, LGs, Private Sector, Medical Bureaus
2.6 Establish and enforce integrated, environmentally sound waste management systems across communities, public institutions, and health facilities.				
2.7 Strengthen the health supply chain management system and ensure availability, physical access, affordability, and appropriate use of quality-assured essential medicines, health commodities, and pharmaceutical services.	Consolidate and accelerate the 10-Year Roadmap for Health Supply Chain Self-Reliance (2021/22–2031/32) by strengthening governance, financing, digital systems and last-mile delivery improvements. Strengthen National Warehouses (National Medical Stores (NMS) & Joint Medical Stores (JMS) capacity for local procurement and warehousing; scale up the use of electronic Logistics Management Information System	Essential medicines and health commodities available at health facilities (%) Essential medicines and health commodities available at at the warehouses (%)	Reduce stock-out rate at health facilities from 36% to less than 10% by 2030	OPM, MoH NMS, JMS, LGs, DPs

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2.8 Revise, adopt, and roll out national standards for medical laboratory, imaging, and radiology services across public and private sectors to ensure reliable, safe, and high-quality diagnostic services for all levels of care.	Finalize and disseminate standards, quality assurance, and biosafety frameworks; accredit facilities; train personnel.	Public and private laboratories/ imaging centers accredited (%)	Standards disseminated by Q4 2025/26; 60% of facilities accredited by 2030	MoH, Private Health Providers, LGs
2.9 Roll out an integrated national digital health data system including early warning systems for health service disruption, and streamlining pathways for piloting and scaling, digital health innovations without compromising safety, interoperability, data privacy or creating a chaotic, unregulated market.	Scale up the use of EMRS and DHIS2 to all facilities; ensure interoperability with other systems (e.g., eLMIS, mTRAC, eCHIS, Health Registries). Establish a digital health innovation sandbox at MoH; create a clear pipeline for scaling successful pilots.	Public and private health facilities reporting data electronically into the national system (%) Digital health innovations piloted and scaled nationally (%)	100% of hospitals and 80% of HC IVs & IIIs reporting in real-time by 2028 At least 5 innovations scaled nationally by 2030	MoH, LGs, DPs, Private Sector, Academia
2.10 Expand internet connectivity, especially in rural and underserved areas.	IT connectivity infrastructure mapping and Public-Private Partnership (PPP); Conduct a detailed geospatial mapping of internet connectivity gaps at all public health facilities (HC IIIs, IVs, Hospitals). Subsidize Connectivity and Energy Solutions	Underserved sub-counties mapped for connectivity gaps (Number); MoUs signed with private telecom companies for infrastructure rollout (Number); Targeted health facilities with functional, high-speed internet (>10 Mbps). (%) Health facilities receiving a subsidized data/connectivity package (%).	Comprehensive mapping and investment prospectus completed by Q4 2025/26 50% of targeted HC IIIs and above connected by 2027 90% of HC IIIs and above have reliable, high-speed internet by 2030 Subsidy mechanism and standards operational by Q2 2026/27 70% of targeted facilities benefiting from subsidized connectivity by 2028	UCC, MoH, NITA-U, MoFPED, MoEMD, Private Sector

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2.11 Enforce national service-readiness standards, and quality improvement initiatives for all public and private health facilities to enhance quality, people centered care.	Train inspectors and conduct annual audits / assessments Publish results Enforce corrective action Conduct national client satisfaction surveys	PHC facilities meeting readiness and quality standards (%) Client satisfaction disaggregated by type of user (e.g., youth, PLHIV, postnatal women). (%)	Standards adopted by Q4 2025/26; 70% compliance by 2027; 95% compliance by 2030 75% satisfaction by 2027, 80% by 2030 Biennial National Client Surveys conducted	MoH, LGs, Private Health Providers, Implementing Partners, UBOS
2.12 Update and implement the National Action Plan for Health Security (NAPHS) with a One Health approach to strengthen preparedness, early detection, and rapid response to epidemics and public health emergencies at national and subnational levels.	Conduct Joint External Evaluation (JEE); cost and re-source the NAPHS; simulate responses through drills.	Annual progress score on NAPHS implementation (JEE scores)	NAPHS fully costed; 50% implemented by 2028	OPM, Office of the President, MoH, UVRI, UNIPH, LGs, MAAIF, MoWE, MoGLSD, MoDVA, UWA, MoIA, Uganda Atomic Energy Council, UBOS, Uganda Civil Aviation Authority, DPs, CSOs
2.13 Roll out implementation of the Climate Change Health National Adaption Plan	Train health workers on climate sensitive diseases and risks Establish integrated early warning and alert system	Number of health workers in sentinel districts trained on CCH Number of modules on CCH adapted in the pre-service training curriculum Number of alerts triggered by climate data	50% of LGs have trained health workers by end of 2026; 90% by 2030 National wide alerts by 2030	MoH, LGs, DPs, MoWE, Uganda Meteorological Department

Policy Commitment	Actions to Operationalize	Indicators	Timelines and Targets	Responsible Entity
PILLAR 3: IMPROVE ADEQUACY OF A SKILLED, COMPETENT, AND ETHICAL HEALTH WORKFORCE				
3.1 Develop a HRH Investment Plan and compact.	Finalize, cost, and disseminate the HRH Investment Plan and compact; establish a multi-sectoral steering committee for oversight.	HRH Investment Plan and Compact developed; Multi-sectoral steering committee established	HRH Investment Plan and Compact launched by Q1 2026/27; % of quarterly Multi-sectoral steering committee meeting held; Staffing level increased from 34% to 55% by 2029/30	MoH, Ministry of Public Service (MoPS), HSC, MoFPED, MoES, MoLGs, NPA
3.2 Strengthen performance management for HRH through digitization.	Roll out the revised Integrated Human Resource Information System (iHRIS) to all LGs and hospitals. Linkage of iHRIS with workforce registry and integrated with payroll and licensing.	Functional HRH performance management system Health workers registered on iHRIS with complete data (%)	100% of public health workers on iHRIS by end of 2026; Workforce registry updated and published annually by 2026; timely staff appraisal; rewards and sanctions applied based on performance. Absenteeism of health workers reduced by 98%	MoH, MoPS, DPs Ministry of ICT, MoLG
3.3 Develop service standards for health workers to define roles and responsibilities for interdisciplinary care teams.	Define and disseminate clear standards for productivity, ethics, and client care.	Existence of disseminated and adopted service standards	Service standards developed and disseminated by Q2 2026/27	HSC, MoH, Professional Councils, MoPS, MoLG, MoES
3.4 Safeguard the health, safety, and well-being of all health workers by establishing a comprehensive and enforceable national framework for Occupational Health and Safety	Ensure Universal Access to Essential Safety Supplies and Infrastructure	% of health facilities with no stock-out of critical PPE in the last 6 months. % of health facilities with 24/7 access to running water, soap, and alcohol-based hand rub. % of facilities with immediately accessible PEP kits.	2027/28: 80% of facilities report no critical PPE stock-out. 2028/29: 90% of hospitals and 70% of lower-level facilities have 24/7 WASH services. 2026/27: 100% of hospitals and HC IVs have accessible PEP kits.	MoH, National Medical Stores, JMS, MoGLSD, LGs, Health Facility In-Charges, HUMCs

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3.5 Accredit and quality-assure public and private training institutions using competency-based standards.	Conduct institutional audits; support under-performing institutions; publish accreditation status.	Health training institutions fully accredited (%)	Increase from baseline to 80% of institutions by 2030	MoES, Health Professionals Councils, MoH, National Council for Higher Education
3.6 Institutionalize Continuous Professional Development (CPD) and competency-based recertification through digital platforms.	Develop and implement a national Clinical Mentorship Framework Develop online CPD modules; Operationalize the training database, Link CPD completion to annual licensing by Professional Councils.	Clinical Mentorship Framework developed Health workers completing mandatory CPD hours annually (%)	Clinical Mentorship Framework developed by Q1 2026/27 70% of health workers compliant with CPD requirements by 2028	Professional Councils, LGs, Health Service Commission (HSC), MoLG
3.7 Develop and implement one national in-service HRH training plan.	Conduct a national training needs assessment; Develop a Standardized, Competency-Based Curriculum; Strengthen Training Management, Mentorship & funding. Decentralize Training Delivery & Leverage e-Learning	A finalized and validated national needs assessment report Number of cadres approved with competence-based curricula % of training institutions using standardized packages Existence of a training management system (database and tracking system) Number of trainings conducted at regional hubs Number of health workers completing training via e-platform	Assessment completed by June 2026 Core curricula for 5 priority cadres developed in one year; 100% in-service trainings aligned with curriculum by 2030. Training management system (database and tracking system) operational by Q2 2027/28; Four regional hubs operational by 2028, 50% trainings available via e-platform by 2030	MoH, MoES, Professional Councils, LGs
3.8 Systematically scale up the production, retention, and continuous skill development of specialist health workforce cadres.	Expand Physical and Technological Training Capacity Increase Specialist Training Intake and Diversify Specialties Implement a Bonded Retention and Deployment Scheme Establish a dedicated Tertiary Health Training Fund to support infrastructure, scholarships, and research.	Number of functional regional simulation labs operational. % of tertiary training institutions reporting adequate teaching equipment and infrastructure. Existence of a national digital learning platform for specialists. Annual intake of postgraduate medical and surgical students.	Q4 2027/28: 3 regional simulation labs operational. Q4 2028/29: 80% of core tertiary institutions report adequate infrastructure. Q4, 2026/27 National digital learning platform launched. Increase postgraduate student intake by 30% by 2028/29	MoES, MoH, MoICT & NG, MoPS, HSC DPs, Parliament (Health and Education Committees)

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		Number of scholarships awarded for priority specialties annually. Number of RRHs accredited as specialist training centers. % of government-funded specialist graduates fulfilling their service obligation. Specialist vacancy rate in RRHs and General Hospitals. Amount of domestic funding (UGX) allocated to the Tertiary Health Training Fund annually.	Beginning 2027/28: Award at least 50 new scholarships for priority specialties annually. 2030/31: Accredit 5 additional RRHs for specialist training. 2028/29: 90% compliance with the service obligation scheme. 2030/31: Reduce the specialist vacancy rate in RRHs from >60% to <30%. FY 2028/29 Establish the Fund with initial capital.	
3.9 Functionalize the HRH in-service training Institute in Mbale	Refurbish and operationalize functionality of the HRH training institute in Mbale	Functional HRH training institute	Fully functional HRH training institute; 3,000 people trained by 2023.	MoH, MoES, Partners

Policy Commitment	Actions to Operationalize	Indicators	Timelines and Targets	Responsible Entity
PILLAR 4: STRENGTHEN THE HEALTH FINANCING SYSTEM TO IMPROVE ADEQUACY, EFFICIENCY, EQUITY, AND FINANCIAL RISK PROTECTION.				
4.1 Develop the 10-year Uganda Health Financing Strategy 2025 – 2035 (aligned to the National Integrated Financing Framework)	Conduct a comprehensive health financing situation analysis; convene stakeholders to draft and validate the strategy.	10-year Health Financing Strategy launched and disseminated Level of financing for wage Level of financing for essential drugs, commodities and supplies Revenue generated from health taxes; % of revenue allocated to PHC Health projects funded through climate finance; value of funds leveraged (Number). % of donor funding channelled through the government system (on-budget)	Strategy launched by Q1 2026/27 Increase level of financing for wage by 66% by 2030 Increase level of financing by 66% by 2030 At least one major health project funded via climate finance by 2028 % of donor funding channelled through government system increased from 26% to 50% by 2030.	MoH, MoFPED, NPA, DPs, Academia

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4.2 Fast track the approval and operationalization of a mandatory NHIS with equity and financial protection considerations for the informal sector, elderly, and vulnerable populations.	Secure Parliamentary passage and Presidential assent to the NHIS Bill; establish the NHIS institutional structures; Develop & Test Modalities for Key Populations, Establish Provider Networks & IT Systems, Launch National Enrolment and Public Awareness	NHIS Bill passed by Parliament; Act gazetted and published in the Uganda gazette NHIS Board and CEO inaugurated Develop and test modalities for key populations Health providers accredited National digital system operational Individuals enrolled in the scheme (Number).	NHIS Bill passed by Q2 2026/27; Act gazetted by Q3 2026/27; Board and CEO appointed by Q4 2026/27; NHIS head-quarters operational by Q1 2027/28; Enrolment strategy approved by Q3 2027/28; Pilot registration of initial 10,000 mem-bers in two LGs by Q4 2027/28; Health providers accredited and digital system operational by Q1 2028/29; enrol 1.5 million formal sector employees and dependents by Q4 2028/29 and 2 million informal sector members by Q4 2029/30.	MoH, Parliament, MoFPED, Private Sector, CSOs, Academia, DPs, NHIS Authority, IRA, URA
4.3 Ensure adequate and equitable fiscal transfers to PHC facilities and referral hospitals.	Conduct an equity analysis of health access and outcomes; map resources;	NHIS Bill passed by Parliament; Act gazetted and published in the Uganda gazette NHIS Board and CEO inaugurated Develop and test modalities for key populations Health providers accredited National digital system operational Individuals enrolled in the scheme (Number).	Resource map developed by Q4 2025/26; Resource allocation formulae developed by Q2 2026/27 and piloted in 5 hospitals by 2027/28	MoFPED, MoH, UBOS, LG Finance Commission, Academia
4.4 Convene high level financing dialogues between MoH, MoFPED, Parliament on a regular basis.	Evidence synthesis on health financing, tracking progress against commitments Advocate for increased allocation	Number of high-level policy dialogues Government health expenditure as % of total government budget (%)	High level dialogues convened biennially Increase to 9% by 2030 from 5.6% in 2023/24	MoH, Parliament, MoFPED, DPs, Office of the President, Academia, CSOs, Private Sector
4.5 Implement public investment management reforms in the health sector to improve value for money.	Capacity building of health sub-program actors on national public investment management framework	Budget Execution rate	Increase to budget execution from 74% to >90% by 2030	MoH, MoFPED, LGs, DPs

Policy Commitment	Actions to Operationalize	Indicators	Timelines and Targets	Responsible Entity
PILLAR 5: ENHANCE MULTI-SECTORAL COLLABORATION AND PRIVATE SECTOR ACTION				
5.1 Strengthen the multi-sectoral coordination structures at all levels to achieve UHC.	Strengthen and resource the Inter-Ministerial Steering Committee (HCDP WG) and TWGs at national and LG levels.	Quarterly meetings held with attendance from all key sectors (Number).	Committees functional by Q4 2025/26; meets quarterly with >80% attendance	OPM, MoES, MoH, MoWE, MoGLSD, MoFPED, Key MDAs
5.2 Establish an integrated human capital development program performance management system for UHC.	Develop a joint National UHC Compact results framework with OPM, MoES, MoGLSD, MoWE, MoLG, MoFPED and MoH Commemoration of the UHC Day, including progress review on implementation of the UHC Compact	Existence of a joint UHC results framework and annual review UHC Day commemorated annually	Framework developed and adopted by Q4 2025/26 Annually, December	OPM, MoES, MoGLSD, MoWE, MoLG, MAAIF, MoFPED, MoH, LGs
5.3 Strengthen the "Health in All Policies and programs by developing a multi-sectoral collaboration framework with clear accountability mechanisms for priority cross sectoral health and development challenges.	Establish a National HiAP Steering Committee chaired by the OPM with representation from all key ministries (Health, Education, Gender, Works, Agriculture, Water, Finance). Develop and officially launch a HiAP Operational Manual with standardized protocols for joint planning and budgeting. Integrate specific, measurable health-outcome indicators (e.g., stunting rates, adolescent pregnancy rate, road traffic fatalities) into the performance agreements of relevant non-health sector Permanent Secretaries and Chief Administrative Officers. Establish a public, annual "Cross-Sectoral Health Impact Review" presented to the SDG Secretariat.	Existence of a formally constituted and actively meeting HiAP Steering Committee. HiAP Operational Manual officially approved and disseminated. Number of key non-health ministries with health-impact indicators in their annual performance contracts. Annual Cross-Sectoral Health Impact Report published and presented to Cabinet. Non-health sector policies that have undergone a Health Impact Assessment (Number).	Q4 2025/26: HiAP Steering Committee inaugurated and holds its first meeting. Q2 2026/27: HiAP Operational Manual finalized and launched. FY 2027/28: 3 key ministries (e.g., Education, Agriculture, Works) have health indicators in performance contracts. Q4 2027/28 (and annually): First annual report presented and discussed in SDG progress review. 100% of relevant major new policies/projects undergo a HIA. from 2027	Cabinet Secretariat, OPM, NPA, MoH, Key Line Ministries (MoES, MAAIF, MoGLSD, MoWT, MoWE, MoFPED)

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	Mandate that all new major policies, legislation, and infrastructure projects in non-health sectors undergo a rapid HIA before approval.			
5.4 Jointly implement cross-sectoral projects prioritizing areas requiring integrated approaches.	Launch joint projects on nutrition (MAAIF, MoH), WASH (MoWE, MoH), and road safety (MoWT, MoIA, MoH), Community Health (MoH, MoGLSD), School health, Adolescent health, Training (MoH, MoES) electrification (MoEMD, MoH), Digitization (MoICT, MoH).	Joint cross-sectoral projects funded and implemented (Number). Population with access to improved sanitation (%), Households using clean energy for cooking (%) Stunting among children under 5 years (%) Teenage pregnancy rate (%) Scholarships awarded for training specialists (Number) Mortality due to road traffic injuries (per 100,000 population) Internet access at subcounty level Interministerial Top management meetings between MoH and MoLG (Number)	At least 2 major cross-sectoral projects operational per year from 2027; Access to improved sanitation increased from 43% to 50% by 2030, Population with access to safe water increased from 81% to 90% by 2030, Use of clean energy for cooking increased from 25.3% to 40% by 2030 Surgeons per 100,000 population increased from 0.7 to 1/100,000 by 2030 Psychiatrists per 100,000 population increased from 0.14 to 1/100,000 by 2030 Mortality due to Road traffic injuries <10/100,000 by 2030 Quarterly Interministerial Top Meetings held	MoH, MAAIF, MoWE, MoWT, MoGLSD, MoES, MoEMD, MoICT, MoLG
5.5 Strengthen Public Private Partnerships for Health	Develop PPPH Strategy and operational guidelines for the PPPs; strengthen the functionality of the PPPH Division at national and Nodes at LG level	PPPH Strategy developed Memorandum of Understanding Signed with CSOs and Implementing Partners Engagement meetings / fora held with CSOs	Strategy and operational guidelines developed by Q4 2025/26 At least 10 MoUs signed or renewed annually Annual CSO forum held	Hospitals, LGs, CSOs, Private Sector
5.6 Promote local manufacturing of essential vaccines, pharmaceutical products and medical consumables, Active Pharmaceutical Ingredients, and diagnostics, including fiscal incentives and procurement guarantees for priority products.	Establish an industrial park for pharmaceuticals; provide procurement guarantees to local manufacturers.	% of essential medicines and supplies procured from local manufacturers	Increase local procurement from local manufacturers 20% to 30% by 2030	UIA, MoTI, MoH, NDA, Private Sector

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5.7 Institutionalize private sector participation in health facility construction, rehabilitation, and equipment maintenance through well-structured PPPs	Pilot and scale up standardized health service delivery PPP models e.g. laboratory & imaging equipment placement & maintenance Develop PPP Framework for standardized equipment placement Implement Standardized Performance-Based Contracts Develop a robust M&E system for PPP health projects Establish annual Private Sector Health Roundtables and Bi-annual Health Investment Forums. Provide fiscal incentives or de-risking mechanisms (e.g. blended finance, guarantees) for private investments in underserved areas or strategic products / services.	Framework for standardized equipment placement developed PPPs contracts signed (Number) Value of private investment leveraged for health infrastructure PPPs fully operational or contracts completed Functional web-based M&E platform for PPP projects established Statutory instruments for blended finance and guarantees developed and signed New private health facilities established in underserved regions (Number).	3 PPP signed or renewed annually % of PPPs fully operational or contracts completed Web-based M&E platform established by Q2 2027/28 % of PPP projects meeting agreed-upon performance indicators At least 10 new facilities established in underserved regions by 2030	MoFPED, MoH, Private Sector, DPs
5.8 Develop and publish a national health sector investment roadmap signalling priority opportunities for private participation.	Map and cost priority investment areas; package them into bankable projects; host an annual health investment forum; leverage corporate social responsibility projects	Private investment deals signed in priority areas (Number).	Roadmap published by Q3 2026/27; at least 3 major deals signed by 2028	MoH, MoFPED, UIA, Private Sector Foundation Uganda
5.9 Strengthen partnerships with academia and research institutions for evidence generation, monitoring, and innovation in service delivery.	Sign memoranda of understanding between MoH and key universities or research institutes Create joint technical working groups for priority health themes Establish a competitive dedicated research fund for implementation research Launch annual call for proposals on MoH priorities Expand the “researcher in residence” or “fellowship” programs within MoH, relevant MDAs and LGs	Number of functional research collaboratives established by Q4 2026/27 Annual research agenda published and implemented % of annual health research budget allocated to priority-based research Number of joint research projects funded Number of researchers embedded in MoH, relevant MDAs and LGs Number of co-designed innovations tested in service delivery settings	At least 5 MoUs with x universities or research institutes by 2027 At least 5 joint research papers published annually 5% of national health budget allocated to research fund by 2027/28 At least 10 joint implementation research projects funded every year 10 researchers embedded in MoH, relevant MDAs and LGs by 2027 At least 2 innovations piloted and scaled up every year.	MoH, MoFPED, UNHRO, Universities / Research Institutes, LGs, DPs

Policy Commitment	Actions to Operationalize	Indicators	Timelines and Targets	Responsible Entity
PILLAR 6: IMPROVE GOVERNANCE, OPERATIONAL EFFICIENCY, AND ACCOUNTABILITY				
6.1 Improve operational efficiency by Joint Planning, Budgeting & M&E for "One Plan, One Budget and One M&E."	Disseminate the harmonized planning and budgeting framework at national and LG levels; Recruitment of health managers in LGs (DHTs, Facility Managers) capacity building of LG Health Teams; Hands on training of LGs and health facility managers on joint planning, budgeting, and performance monitoring. Conduct regional planning and performance reviews	Health programs using the joint planning, budgeting, and M&E framework (%) DHT structures filled (%) Health facility managers recruited Joint planning and performance review meetings held at all levels	100% of programs using the joint framework by end of 2026 100% DHT structures filled by Q4 FY 2027/28 100% Health facility manager positions filled by Q4 FY 2027/28 Annual joint planning and performance review meetings held at all levels	MoH, MoFPED, MoLG, LGs
6.2 Strengthen integrated person-centered care and technical support, mentorship, and hands-on coaching to LG health facilities for continuous quality improvement.	Implement the Health Services and Systems Integration Roadmap and relevant guidelines; Roll out the MoH Guide for Integrated Health Service Delivery for District and Urban Authorities to provide continuous, hands-on coaching and mentorship.	Staff trained in multi-disciplinary or integrated care models (%) Standardized care pathways adopted Technical specialists led supervision to General Hospitals conducted quarterly	80% of staff trained in integrated care models 100% technical supervision conducted quarterly	MoH, RRHs
6.3 Institutionalize health technology assessment to support regular revision of service packages and interventions based on value-for-money.	Establish a National HTA Committee; develop HTA guidelines; pilot assessments for new technologies and medicines.	Health technologies assessed using HTA guidelines before adoption (Number).	HTA Committee operational by 2026; 5 technologies assessed annually from 2027	MoH, NDA
6.4 Fast-track the establishment of the Uganda Health Professionals Authority (UHPA).	Enact the UHPA Bill; establish the Authority's board and secretariat; develop initial regulations.	UHPA Bill enacted and operational	UHPA Bill enacted by Parliament by end of 2025; UHPA operational by 2026	MoH, Parliament, MoJCA, Professional Councils, MoFPED, Partners

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6.5 Enforce all the UHC relevant Acts regulations and policies from MoH and other MDAs to ensure compliance	Develop, amend, and enact relevant laws, regulations, and policies Develop standardized training modules; train LGs for enforcement, equip LGs with enforcement tools (e.g., testing kits, PPE). Conduct a nationwide crackdown on unlicensed drug shops; scale up the accredited drug shop program	Relevant laws, regulations and policies developed or amended, enacted & disseminated (Number). LG staff trained and certified in enforcement (Number); Compliance inspections conducted (Number) % of drug shops fully licensed and staff trained 100% of drug shops licensed and 80% of proprietors trained by 2028	Relevant laws, regulations and policies developed or amended, enacted & disseminated (Number). LG staff trained and certified in enforcement (Number); Compliance inspections conducted (Number) % of drug shops fully licensed and staff trained 100% of drug shops licensed and 80% of proprietors trained by 2028	MoH, MoJCA, Parliament MoLG, MoH, UNBS NDA, LGs
6.6 Strengthen the national regulatory & quality assurance capacity of the National Drug Authority to ensure safety, efficacy and quality of medicines and health products.	Implement the Institutional Development Plan as a precursor to achievement of the WHO Maturity Level 3.	% of planned activities implemented	WHO Maturity Level 3 achieved by 2027	NDA
6.7 Institutionalize & digitalize resource mapping and expenditure tracking systems	Roll out the integrated resource mapping tool (Digitalized off budget tracking tool – Virtual pool) Conduct National Health Accounts (NHA)	Resource mapping report generated Number of NHAs conducted	Resource mapping report generated annually Every two years	MoFPED, MoH
6.8 Empower Parish-level committees, HUMCs and Hospital Boards for social accountability	Provide standardized orientation and tools for these structures	HUMCs/ Hospital Boards demonstrating active oversight (e.g., reviewing reports, overseeing drug management) (%)	80% of committees are functional and active by 2028	MoH, LGs, CSOs
6.8 Institutionalize multi-stakeholder engagement platforms (e.g. CSO and DP forums) to align priorities and address bottlenecks.	Hold accountability forums	Actionable recommendations from forums implemented (Number).	Annual roundtables held from 2025; 60% of actionable recommendations implemented	MoH, LGs, CSOs, DPs

5. COUNTRY AND SECTOR OVERVIEW INCLUDING CURRENT STATUS AND OPPORTUNITIES

Uganda like several other countries in the world, committed to achieve Universal Health Coverage (UHC) by 2030, as indicated in the Sustainable Development Goals (SDGs). SDG goal 3 target 3.8. spells out the need to achieve UHC, including protection from financial risk, access to quality health services, and quality and affordable essential medicines and vaccines for all.

According to the mid-term review of the Uganda UHC Roadmap 2020 – 2025, the country has made significant but uneven progress towards UHC. The UHC Service Coverage Index for Uganda increased from 40 percent in 2010 to 49 percent in 2019, and since then, there have been remarkable strides in specific high-priority health programs like Reproductive Maternal Newborn and Child Health (RMNCH) and infectious disease control.

The most outstanding achievements are the near-universal coverage for HIV treatment which increased from 60 percent in Financial Year (FY) 2019/20 to 96.8 percent in 2023/24, and TB effective treatment increasing from 40 percent to 91.3 percent during the same period. (MoH AHSPR 2023/24) The achievements in HIV and TB are attributed to a combination of bold policy change, strategic use of technology, patient-centered service delivery models, robust partnerships and donor alignment, and strong leadership. The country has effectively coordinated support from major donors like The Global Fund, PEPFAR, and US Government. Instead of working in silos, these partners aligned their strategies with the government's national health plan, creating a unified and scaled-up effort.

Specific interventions for HIV treatment coverage are adoption of "Test and Start" / Universal Treatment of anyone diagnosed with HIV was immediately eligible for treatment, regardless of their CD4 count. This removed a major barrier and simplified the process. Differentiated Service Delivery Models to make treatment more patient-friendly; and Scale-Up of Viral Load Testing as the standard to monitor treatment success. The TB response focused on finding "missing" TB cases and ensuring they completed treatment through active case finding, introduction of rapid molecular Diagnostics (GeneXpert (Xpert MTB/RIF), Patient-Centered Support and Adherence Monitoring, and improved Drug-Resistant TB (DR-TB) Management.

The significant concern under the infectious diseases cluster, is the use of insecticide-treated net (ITN) for malaria prevention which has declined by 4 points from 66 percent in 2016 to 62 percent in 2022 despite a 90 percent household ownership of ITNs. (UDHS 2022) This is a serious setback for malaria control and needs immediate attention.

The country has achieved sustained high (>90 percent) DPT^3 vaccination coverage since 2019/20. There is almost no improvement in care-seeking for pneumonia (79 percent to 80 percent), indicating a specific barrier that needs addressing.

Antenatal Care (4+ visits) had a 20-point increased from 48 percent in 2016 to 68 percent in 2022, with progress halfway (48 percent) to the ideal target. There was steady progress in family planning with the proportion of women satisfied with modern methods improve by 12 points from 46 percent in 2016 to 58 percent in 2022, though still has a long way to go (27 percent) progress. (UDHS 2022). The low satisfaction with modern family planning methods is a complex issue rooted in a combination of socio-cultural, service delivery, and method-related factors.

The achievements in RMNCH services are a result of consolidation of the earlier gains and a push towards reaching more marginalised populations. This has been through accelerated high-impact interventions in line with the RMNCAH roadmap and Sharpened Plans I & II, which have been pivotal in galvanising action and resources. Nation-wide projects like the Uganda Reproductive Maternal Neonatal and Child Health Improvement Project (URMCHIP), Uganda Covid-19 Response and Preparedness Project (UCREPP) and the Uganda Intergovernmental Fiscal Transfer (UgIFT) Reform Program that focused on consolidation of system strengthening (more health facilities, training and deployment of more health workers, procurement of medical supplies, results based financing, increased PHC grants) for increasing access, quality and efficiency of PHC services, have had great impact on the RMNCH outcomes. Specific approaches like Results Based Financing (RBF) with focus on RMNCH were scaled up in all LGs and to sustain the achievements from the URMCHIP, the GoU mainstreamed the RBF mechanism into the PHC grant mechanisms in July 2023 through the UgIFT program. A quasi-experimental impact evaluation of the URMCHIP (Thinkwell, 2024) found that adopting RBF had significantly improved most of the incentivized performance indicators including antenatal care, facility deliveries, family planning, and outpatient and inpatient visits.

The continued community mobilization and referral of pregnant women by VHTs played a crucial role in driving women to facilities for delivery. The sustained high (90 percent) DPT^3 vaccination coverage since FY2019/20 was achieved through routine immunization strengthening and supplementary immunization activities with support from global initiatives like GAVI, GFATM, PEPFAR and other partners.

The progress in basic sanitation also stands out as a major gain, despite starting from a very low baseline of 19 percent in 2019/20 to 43 percent in 2024/25 (UBOS, UNHPC 2024), highlighting a fundamental infrastructure gap. The progress realised so far, is because of the sanitation programs implemented in Uganda, as part of the broader Water, Sanitation and Hygiene (WASH) initiatives, involving government efforts and partnerships with CSOs and international organizations like UNICEF, USAID, World Vision, and the Red Cross. These programs have focused on increasing access to clean water and sanitation, ending open defecation, and promoting hygiene practices through projects like building latrines, handwashing stations, and implementing faecal sludge management solutions. Efforts also include community-led initiatives e.g. Community Led Total Sanitation and the use of innovative technologies.

Performance of the Non-Communicable Diseases (NCDs) cluster has mixed but promising early trends in progress and in management of the growing burden of NCDs. The proportion of the population with normal blood pressure improved slightly from 73 percent to 76.5 percent with 21 percent progress towards the UHC target of 90 percent. This suggest NCD prevention efforts e.g. routine medical screening for hypertension are having a slow but positive effect. Mean fasting plasma glucose (a diabetes indicator) is within the ideal range (<5.6 mmol/L), and tobacco non-smoking rates improved from 90 percent to 91.7 percent, exceeding the 90 percent target. The progress in tobacco non-smoking is the result of a sustained, decades-long effort involving policy and legislation (high tobacco taxes, smoke free laws & marketing restrictions), public education and changing social norms, and rise of alternatives (e-cigarettes). Reaching the final segments of the population to achieve "ideal" targets will require even more targeted, equitable, and nuanced approaches to address the deep-rooted socioeconomic and health disparities that remain.

The Service Capacity & Access cluster is the weakest area and represents the greatest systemic challenge to achieving UHC. There are resource deficits in both HRH and infrastructure. The number of physicians doubled from 1 to 2.1 per 10,000 but the ideal is 23 per 10,000. Progress is only 5 percent. This is because of increase in the number doctors graduating from

the Medical Schools in Uganda. The scarcity of surgeons (0.7 per 100,000) and psychiatrists (0.14 per 100,000) against the desired level of 1 per 100,000, means specialized care is inaccessible for most. Only 34 percent of approved health worker positions are filled as per the new human resource structure of 2024, which is a fundamental constraint on service delivery at all levels. Remote and rural areas suffer the most from workforce shortages. Hospital beds capacity increased from 5 to 6 per 10,000, against the ideal 30 for developing countries. Progress is only 4 percent towards the target.

The International Health Regulations (IHR) score has not been computed since 2017 when the score was 73 percent. A Joint External Evaluation (JEE) of the IHR core capacities of Uganda conducted in 2023 shows impressive progress in strengthening its capacity to prepare for, detect early and rapidly respond to public health emergencies and disasters since the previous IHR JEE in 2017.

Despite notable gains, Uganda has not fully established all capacities required for the implementation of IHR (2005). Overall, funding to IHR implementation is inadequate to address needs, with the animal health and environment sectors mostly affected. There is a need for continued advocacy support for all sectors to fully embrace the IHR concept and increase ring-fenced funding for interventions. Finalization of the amendment of Animal Diseases Act and development of the food safety legal instruments will also play a critical role in enabling the respective sectors to comply with the IHR. In an environment of technological advancement and public health threats, the country has not updated the legal framework to cover biosecurity concerns. The national laboratory diagnostic system is still largely funded by development partners, posing a threat to system sustainability. The limited systematized collaboration between sectors impedes surveillance and laboratory data sharing and information exchange and results in lost opportunities for widening sources of information for public health interventions.

The country is required to update and implement the National Action Plan for Health Security using the priority actions identified through the JEE consensus process.

The incidence of catastrophic health spending (CatHE) at the 10 percent threshold declined from 22.4 percent in FY05/06 to 11.9 percent in FY19/20 (WB, UPER 2023), which is the baseline year for the Uganda UHC Roadmap. There is no current data to determine progress since 2019/20.

The incidence of CatHE varies across the sub-regions of Uganda, with the highest incidence in Teso and West Nile sub-regions and the lowest incidence in Kigezi and Acholi sub-regions. The main factors associated with CatHE were gender and age (having children below the age of five and households headed by old people (>60yrs). (WB, UPER 2023).

The incidence of CatHE is higher among the non-poor than the poor households. Lower incidence of CatHE among the poor may not be because there is a protection mechanism for them, but likely because they are too poor to seek care when they need it.

The other two critical dimensions of financial hardship are impoverishing health expenditure because of OOP for health care, and foregone care due to cost which leads to worse health outcomes and increased long-term economic burdens. Lack of money or funds for consultation was noted as a reason for not seeking medical attention for illnesses or injuries suffered by 10 percent of respondents compared to others. This has reduced from 22 percent in 2021. (UNHS 2023/24).

Using the international poverty line, the percentage of households that have been impoverished due to healthcare expenditures reduced from 5.2 percent in FY05/06 to 2.6 percent in FY19/20, which translates into about 233,328 households (1.1 million people). Although there has been a decline in impoverishment due to healthcare expenditures, households in rural areas remain more prone to impoverishment. The incidence of

impoverishment among households in rural areas declined from 5.6 percent in FY05/06 to 2.9 percent in FY19/20, which is 181,374 households compared to urban areas which declined from 2.9 percent in FY05/06 to 1.9 percent in FY19/20 (WB, UPER 2023). Protecting households from catastrophic health spending and building a healthier, more productive workforce, will lay the foundation for sustainable economic growth, resilience, and competitiveness.

Under the SDGs there are a number of non-health sector UHC indicators related to the social determinants of health. The UHC Roadmap MTR report shows significant progress in several health and safety indicators, but major challenges remain in core areas of WASH, nutrition, and living standards. Most indicators are still far from their ideal targets, highlighting the need for continued and intensified efforts.

Child wasting rate reduced from 4 percent to 2.9 percent (28 percent progress towards the UHC target of 90), bringing this indicator of acute malnutrition close to the ideal target. This suggests that interventions for managing acute malnutrition are effective. Wider availability and use of Ready-to-Use Therapeutic Food has revolutionized the treatment of severe wasting. Community-based management of acute malnutrition has made treatment more accessible than requiring hospitalization. There is also improved healthcare access for treatment of common childhood illnesses like diarrhoea, pneumonia, and malaria prevents the rapid nutrient loss and weight loss associated with these diseases.

Improved source of drinking water has increased to 81 percent (UNPHC 2024) from 78 percent in 2016. The 25 percent progress is good, but the pace needs to accelerate to reach the >90 percent target. The 81 percent figure masks disparities in water quality, reliability, and distance to source. The country needs a final push to reach the universal target - The “Last Mile” Problem: Reaching the Most Difficult Populations. The remaining 19 percent of the population is the hardest to reach. They live in remote rural areas, poorest of the poor, indigenous communities, small, scattered communities, difficult terrain (e.g., mountains, islands), or urban informal settlements where laying pipes is physically challenging and economically unviable. Climate change is another concern whereby increasing droughts deplete water sources, while floods can damage water infrastructure. Climate variability makes it harder to ensure a reliable year-round supply, undermining previous gains and making new projects riskier. Achieving universal coverage for improved source of drinking water will requires targeted, context-specific solutions and a well-funded approach.

Hand washing with soap and water improved from 34 percent to 47 percent (NSDS 2021). This is positive but indicates that over half the population still lacks this critical hygiene practice. There is a critical disconnect between providing WASH infrastructure (water sources, toilets) and ensuring its correct and consistent use (water treatment, handwashing). The system is building hardware but failing on the critical “software” of behaviour change and maintenance.

Mortality rates due to injuries attributed to road traffic accidents declined from 29 per 100,000 population in 2018 to 16 per 100,000, (WHO, 2021) achieving 90% progress towards the ideal target for Uganda of <14.5 per 100,000 population by 2030 i.e., SDG target of reducing mortality due to road traffic accidents by 50 percent by 2030. This is a major public health success in comparison to the global fatality rate of 15 per 100,000 (a decline from 18 per 100,000 in 2018). The African Region has the highest fatality rate at 19 deaths per 100,000 population while the European Region has the lowest fatality rate at 7 deaths per 100,000 population (Global Status on Road Safety, 2023). Road traffic injuries (RTIs) rank sixth among causes of death and fourth for disability in Uganda, while at global level RTIs rank twelveth in cause of deaths. Males were more affected by all RTIs (224/100,000) compared to females (144/100,000). There was a decline in all RTIs from 411 to 357/100,000 population between 2012 - 2023. However, admissions due to RTIs increased from 77 to 116/100,000. While there

was a decline in the overall incidence of RTIs due to RTIs, the rise in severe injuries requiring hospitalization highlights ongoing challenges

This is a result of a multi-pronged approach combining stronger legislation, establishment of a National Co-ordinational Mechanism of Road Safety Activities, establishment of a strong coalition of CSOs in road safety, review and update of laws and regulations on road traffic and safety, adoption of a standard driver licensing card, enhanced law enforcement, stricter penalties for traffic offences, public awareness campaigns, and incremental improvements in emergency care, road infrastructure and society and behavioural shifts to newer and safer cars as the economy grows. Efforts, though still limited, have been made to improve ambulance services and emergency response times, particularly along major highways. Training for healthcare workers in managing trauma cases and some improvements in emergency facilities in RRHs have helped save lives that would have been lost. Some initiatives have focused on training motorcycle taxi (boda boda) riders in first aid (First Responders), as they are often the first on the scene of an accident and can provide critical initial assistance.

Road traffic accident victims account for approximately 45 percent of all hospital admissions in Uganda, resulting in significant costs for treating injured individuals. Currently, road traffic accident victims in Uganda do not often receive compensation for their treatment from insurance companies, resulting in lifelong incapacitation or death. A significant number of road traffic accident deaths occur because victims do not receive timely medical care. Motorcycles are a leading cause of accidents and fatalities.

Despite progress in reducing mortality rates, particularly at emergency departments, continued investment in comprehensive road safety strategies, emergency medical services, and public health interventions is imperative further to mitigate the burden of RTIs. The Country will adopt the Safe systems approach to Road Safety to further reduce case fatality.

Anaemia Prevalence in women has reduced from 32 percent to 26 percent (Nutrition Situation Report 2020), showing a good downward trend for women though is still very far from the ideal (<5 percent). Data for anaemia prevalence in males is not available. For adult women, a rate of 26 percent contributes to maternal mortality and low energy levels. Anaemia is a complex interplay of direct nutritional deficiencies, widespread diseases, and underlying socioeconomic factors. Addressing anaemia in Uganda requires a multi-sectoral approach:

- Health Sector: Strengthening malaria prevention (bed nets, prophylaxis), deworming programs, and antenatal care (including iron-folate supplementation).
- Nutrition Sector: Promoting dietary diversification, food fortification (e.g., iron-fortified flour).
- WASH Sector: Improving access to clean water, sanitation, and promoting hygiene to break the transmission of parasites.
- Agriculture: Promoting the production and consumption of diverse, nutrient-rich foods, including animal-source foods.
- Education and Empowerment: Empowering women and girls, delaying marriage and first pregnancy, and improving nutrition knowledge.

Anaemia prevalence in children reduced from 53 percent to 44 percent (Nutrition Situation Report 2020). This is a positive trend, but the prevalence is still devastatingly high with over 50 percent of children under five anaemic. Addressing it requires a multi-sectoral approach that goes beyond simply distributing iron supplements. It necessitates:

- Strengthening nutrition-specific interventions: Promoting exclusive breastfeeding, diverse complementary feeding, and micronutrient supplementation.
- Scaling up nutrition-sensitive programs: Improving WASH to reduce infections, enhancing food security, and empowering women.
- Fortifying the health system: Ensuring reliable access to deworming, malaria prevention, and antenatal care.

Without a concerted effort, the high burden of childhood anaemia will continue to undermine progress in education, economic growth, and overall societal well-being.

Child stunting has reduced slightly from 29 percent to 26 percent (UDHS 2022). Although there is 13 percent progress towards the target, it is critically high and far from the <5 percent ideal. A stunting rate of 26 percent means over a quarter of Ugandan children are chronically malnourished. This causes irreversible cognitive and physical impairment, undermining the country's future human capital. A slow decline indicates that while some progress is being made, the fundamental drivers are not being addressed quickly or comprehensively enough. The immediate causes are poor infant and young child feeding practices and high burden of infectious diseases. Household level challenges include food insecurity, poor WASH, poverty and lack of resources, high adolescent pregnancy, and poor maternal nutrition.

The slow reduction in stunting in Uganda is a symptom of the country's ongoing struggle with multidimensional poverty, food insecurity, and poor sanitation. Accelerating progress will require a much more integrated and well-funded approach that simultaneously tackles the quality of children's diets, the safety of their environment, and the health and empowerment of their mothers.

Child underweight rate: A slight improvement (11 percent to 10 percent, 10 percent progress), but the change is minimal, and the ideal target of 1 percent is very distant. Like stunting, this indicates that the underlying causes of chronic undernutrition are not being adequately addressed. It stems from a combination of immediate, underlying, and systemic causes which include; inadequate dietary intake, household food insecurity, frequent infections, and illnesses (dairrhoea, acute respiratory infections, intestinal worms, malaria), maternal malnutrition, poor WASH, gender inequality, climate change and environmental shocks. Addressing child underweight in Uganda requires a multi-sectoral approach that goes beyond just giving food. Effective strategies must integrate:

- Health: Strengthening systems for immunization, disease treatment, and prenatal care.
- Agriculture: Promoting diverse, nutrient-rich crops and sustainable farming.
- WASH: Expanding access to clean water and sanitation and promoting hygiene.
- Social Protection: Implementing safety nets like cash transfers for the most vulnerable.
- Education: Empowering women and girls and promoting nutrition education.
- Gender Equality: Ensuring women have control over resources and decision-making.

Vitamin A Deficiency in Children: No new data since 2016 makes it impossible to assess current progress. This is a critical data gap for child nutrition. The prevalence of 9 percent in 2016 is high compared to the UHC target of 1 percent by 2030. The national response has been multi-pronged, combining high-impact, short-term strategies with longer-term sustainable solutions. Vitamin A Supplementation is conducted biannually targeting all children aged 6 to 59 months. This is primarily done through mass campaigns and routine outreach at health centers. Uganda has consistently achieved high coverage rates for biannual Vitamin A supplementation, often exceeding 80 percent in campaign years.

Postpartum women are also often given a high-dose capsule immediately after delivery to boost their levels and improve the Vitamin A content of their breastmilk. Vitamin A supplementation is also integrated into routine health services at health facilities during immunization visits, growth monitoring sessions, and when children are treated for illnesses like measles or diarrhoea. The country is also promoting Bio-fortified Crops (orange-fleshed sweet potato) and high-iron beans. Dietary Diversification and Nutrition Education is undertaken through public campaigns educate communities on the importance of consuming Vitamin A-rich foods. The government has created an enabling environment to support these interventions e.g. the National Food Fortification Program

and Integration into National Plans. Uganda has a policy mandating the fortification of specific commercially produced staple foods (cooking oil & margarine, wheat and maize flour, sugar). The fight against vitamin A deficiency is embedded in key national documents like the Uganda Nutrition Action Plan and health sector strategies, ensuring it receives budgetary and political attention.

Undernourishment of the population decreased from 40 percent to 36.9 percent (Global Hunger Index Report 2024). The current level represents a severe challenge. Adult undernutrition is often a continuation of childhood malnutrition and a driver of it in the next generation. The data reveals a "syndemic" of malnutrition—the coexistence of undernutrition (stunting, underweight) and dietary deficiencies (anaemia). This represents a profound failure that will limit the cognitive and physical potential of an entire generation, constraining Uganda's long-term development. The high rate of undernourishment confirms that this is primarily an issue of food systems, affordability, and access, not just a health sector problem.

Childhood obesity is a growing concern in Uganda, fuelled by factors like increased access to fast and processed foods, reduced physical activity, and more screen time. Recent surveys show that 6% of urban children aged 5-17 are overweight or obese, and a 2022 survey found that more than 5 percent of children under five were overweight (Global Nutrition Report 2020).

Addressing nutrition in Uganda requires a multi-sectoral approach.

Households appropriately treating water has regressed, falling from 52 percent to 42 percent (-26 percent progress), UDHS 2022. The decline in households treating water following improvements in the source of drinking water, can be attributed to a combination of behavioural, economic, and perceptual factors. When a household gains access to an improved water source, they perceive the water as inherently safe. The infrastructure (a tap, a pump) signals "modern" and "safe." Therefore, the perceived need and motivation to invest the extra time, money, and effort into treating this already "improved" water drops dramatically. The critical technical point is that an "improved" source is not necessarily a "safe" source. Many "improved" sources can still be contaminated due to cracks in borehole seals or spring protection, contamination entering broken pipes, runoff entering a protected spring during heavy rains, and unsanitary collection practices and dirty storage containers at home.

Use of clean energy has declined from 29 percent to 25.3 percent (UNPHC 2024). Moving in the wrong direction, which has implications for respiratory health and environmental sustainability. Solid biomass (firewood and charcoal) is the dominant energy source for cooking, especially in rural areas, leading to deforestation, indoor air pollution, and associated health problems. The national electrification rate is 60 percent (22 percent on grid and 38 percent off grid), but this masks a huge urban-rural divide. Urban Access is over 70 percent, and rural access below 40 percent, with many relying on off-grid solutions. Uganda has made significant strides in building a clean electricity generation base. The challenge now is to translate this generation into affordable, reliable, and accessible energy for all its citizens, while simultaneously addressing the massive and more complex issue of clean cooking. Recognizing the continued reliance on biomass, there is a major push for "improved" or "clean" cookstoves. These are more efficient, reducing fuel consumption and smoke emissions.

Reduction in Solid Fuel (firewood and charcoal) for Cooking: Has reduced slightly from 95 percent to 89 percent. Any progress in absolute numbers of people gaining access to clean energy may be offset by population growth, leading to a lower percentage of users. The "progress" of +7 percent is minimal given the vast distance to the <10 percent target. This represents widespread indoor air pollution, a leading risk factor for pneumonia in children and chronic respiratory and cardiovascular diseases in adults, especially women. In respect to the environment, deforestation and forest degradation are severe, with Uganda having one of the highest deforestation rates in the

world. This leads to soil erosion, loss of biodiversity, and climate change impacts. Economically, collecting firewood is time-consuming (primarily for women and children), taking time away from income-generating activities and education. Health costs from smoke-related illnesses also burden families.

While the reduction of solid fuels for cooking in Uganda is a monumental challenge, it is not insurmountable. The path involves a pragmatic mix of promoting a transition to modern fuels like liquified petroleum gas and electricity where possible, while simultaneously drastically improving the efficiency of solid fuel use where a transition is not immediately feasible. Success hinges on making clean cooking solutions affordable, accessible, and desirable for the average Ugandan household.

Housing floors made of cement screed: A slight decline from 34 percent to 31 percent (-5 percent progress). This suggests a potential backslide in housing quality and a key poverty indicator. The explanation is a combination of rapid population growth, urbanization and a stagnant or struggling economy for the poor. The total number of houses with cement floors may be increasing, but it is not keeping pace with the construction of new, informal housing.

Alcohol abuse: Showing regress (42 percent) from 3.4 percent to 4.4 percent, moving in the wrong direction from the <1 percent ideal.

Health Impact Indicators

At the "real-world" health outcomes (impact) level as life expectancy at birth increased from 63.7 years in 2014 to 68.2 years in 2024 (UNHPC 2024), barely short of the NDP III target for the year of 68.7 years. Maternal mortality ratio reduced by 44 percent from 336/100,000 live births in 2016 to 189/100,000 live births in 2022 against the NDP III target of 236/100,000 by 2023/24. Achieved target due to targeted investments in increasing access to maternal and child services by upgrading / construction of HC IIIs, RBF for PHC and strengthened maternal perinatal death surveillance response and action.

Under-five mortality rate reduced by 18.5 percent from 64 per 1,000 in 2016 to 52 per 1,000 live births in 2022 though still far from the target of 33 per 1,000 by 2023/24; and infant mortality rate reduced by 16.3 percent from 43 per 1,000 live births in 2016 to 36 per 1,000 live births in 2022 achieving the NDP III target of 35.6 percent by 2023/24. Neonatal mortality rate reduced by 18.5 percent from 27 per 1,000 live births to 22 per 1,000 short of the NDP III target of 20 per 1,000 live births by 2023/24. The Total Fertility Rate has declined slightly from 5.4 to 5.2 (UDHS, 2022). Neonatal deaths due to prematurity and sepsis.

The distance to a health facility is one of the measures of accessibility to healthcare. Limited access to healthcare contributes to the poor performance in some health sector performance indicators. Access to a health facility has increased from 86 percent to 90.4 percent of the population living within 5 kilometre radius from a health facility, although in some regions people must travel longer distances (UNHS 2023/24).

The health sector faces substantial challenges in service capacity, and access, and these include under-financing characterized by low domestic investment and high OOP spending, exacerbated by donor transitioning, critical shortage of health workers, weak service capacity & access like inadequate hospital beds, frequent medicine stock-outs, and geographic disparities. Other challenges are inequitable service delivery with gaps based on geography, socioeconomic status, gender, and other vulnerabilities, poor multi-sectoral coordination leading to failures in WASH, nutrition, and clean energy undermine health gains. There are systemic operational gaps for example, lack of health facility accreditation system, fragmented digital systems, and weak regulation. On the demand side, there are behavioural and perception shifts leading to low preventive health uptake like for ITN for prevention of malaria use despite high ownership, and preference for care providers where 16 percent of the sick prefer pharmacies or drug shops, often due to perceived better quality or accessibility.

In summary, the country is making commendable progress on specific health outcomes but is held back by a weak foundational health system. Priority actions should focus on strengthening the health workforce and infrastructure (Service Capacity) while reversing declines in key preventive measures (like ITN use) to ensure that all gains are sustainable and equitable.

5.1 PILLAR I: STRENGTHEN HEALTH PROMOTION AND DISEASE PREVENTION THROUGH COMMUNITY HEALTH SYSTEMS AND OTHER PLATFORMS

Overall, Uganda has made significant progress in establishing a robust policy and strategic framework for community health promotion and disease prevention, but the operationalization and full implementation are severely hampered by chronic underfunding. A comprehensive Community Health Strategy 2021–2025, with corresponding implementation guidelines are in place providing a clear roadmap for all stakeholders. Training and deployment of a new cadre, CHEWs, is ongoing with full coverage of 28 percent (38 out of 136) LGs by October 2025.

There is an extensive network of VHTs, with approximately 179,175 members across Uganda (2-3 per village), about 70 percent of whom have received basic training. Successful social mobilization has been achieved through campaigns like National Sanitation Days, Supplementary Immunization Days, Integrated Child Health Days, Community Awareness, Screening, and testing for TB and, Bold Adolescent Health, Menstruation with Dignity, Protect the Girl, Save the Nation, among others. An Integrated Communication Strategy and various educational materials (handbooks, calendars, IEC materials) have been developed and disseminated. The Integrated Essential Community Health Care Package has been developed to guide community-led actions on family planning, malaria prevention, RMNCH, and more.

Several positive drivers and opportunities can be leveraged to accelerate progress:

- Established Policy and Strategic Framework: The existence of a clear strategy and guidelines reduce ambiguity and provides a solid foundation for all partners to align their support.
- Proven Model with CHEWs: The ongoing, phased scale-up of CHEWs demonstrates a workable model for a professionalized community health workforce. Support from partners like US Government, The Global Fund, the World Bank and MasterCard Foundation, among others provides a blueprint for expansion.
- Strong Partner Engagement: Significant technical and financial support from development partners has been crucial in training, tooling, and deploying CHEWs and supporting health promotion campaigns. This creates opportunities for further collaboration and blended financing.
- Integration with National Structures: The deliberate effort to integrate Community Health into broader systems, such as the Parish Development Model and the Facility Catchment Area Planning (F-CAPA) approach, offers a pathway for sustainability and mainstreaming.
- High-Level Government Initiative: The recent Cabinet's approval of the National Cleaning Days Initiative signals high-level political will and provides a platform for a "whole of government" approach to health promotion.

The country is facing several challenges that are preventing the Community Health system from becoming fully functional and effective.

Severe Underfunding: This is the single greatest barrier. It prevents the full deployment of CHEWs to all districts, limits the operationalization of community structures as outlined in the strategy, VHTs, the backbone of the system, lack sustainable incentives and remuneration, affecting their motivation and performance, the formal community health workforce (Health Assistants, Inspectors, Educators,

etc.) is understaffed due to lack of funding for recruitment, despite a revised structure that expanded these roles, and the slow pace of CHEW rollout (only 17 percent of LGs covered) means most of the country lacks this critical cadre. While the private sector is involved through the Public-Private Partnership for Health policy, there is no system to monitor their contributions to health promotion and education at the community level. There is a need for more capacity building and support for Local Governments to implement approaches like Community-Led Monitoring and F-CAPA effectively. Client feedback indicates persistent issues with drug stock-outs and staff levels, showing a gap between community participation and tangible system improvements.

Uganda has successfully designed the system for community health promotion and prevention but is struggling to resource and operationalize it at scale. The "software" (plans, strategies, guidelines) is advanced, but the "hardware" (trained and paid workforce, consistent funding, supplies) is lagging far behind. The potential of Community Health to drive health gains and create demand for services is widely recognized, but without a decisive increase in domestic financing and a sustainable model for the community health workforce, this potential will remain untapped.

5.2 PILLAR II: STRENGTHEN HEALTH SERVICE CAPACITY TO INCREASE ACCESS TO PEOPLE-CENTERED SERVICES

Overall, Uganda has made notable progress in expanding health infrastructure and defining service packages, but the system's capacity to deliver equitable, people-centered services is severely constrained by critical gaps in human resources, financing, and supply chains. The "hardware" (buildings, equipment) is outpacing the "software" (staff, medicines, systems).

There has been significant infrastructure development, leading to improved geographical access. The proportion of sub-counties with a HC III has increased from 52 percent in 2020 to 78 percent by June 2025. A total of 433 HC IIIs were upgraded/constructed, equipped, and staffed. There is an increase in the number of HC IVs providing advanced services like blood transfusion (from 46 percent to 66.4 percent) and C-sections (from 68.2 percent to 83.8 percent). Significant investments have been made in specialized care (Uganda Heart Institute, Uganda Cancer Institute, Children's Surgical Hospital, International Specialized Hospital in Uganda (under construction)) and equipping of the Regional Referral Hospitals with Intensive Care Units and oxygen plants.

The Essential Health Care Package for Uganda was revised and expanded, including the introduction of a quaternary level of care and specialized referral service packages. There are six heath care delivery clusters including Health Promotion, Disease Prevention and Community Health Initiatives, Management and Control of Communicable Diseases, Management, and control of NCDs, RMNCAH, Surgical and Aneasthesia care, and Emergency, High Dependency and Critical care. Specific program strategies, service standards, and guidelines were developed to support implementation of the package.

The country has achieved high coverage in targeted programs. Immunization coverage for most antigens is high (>90 percent). Over 90 percent of the population is within a 5-kilometre radius of a public or private health facility.

Major concerns regarding access to health care services at public health facilities, are the unavailability of medicines/supplies (78 percent), followed by long distances (60 percent) and long waiting times (39 percent). Conversely, for private facilities, the main concern is the expensive or unaffordable health services, also at 78 percent, along with long distances and a limited range of services, each at 35 percent, respectively (UNHHS 2023)

Significant investments have been made in digital health, including operationalisation of the District Health Information System (DHIS 2) for routine reporting from health facilities, a Digital Health Platform established to

create a "health information exchange" that allows different systems to talk to each other seamlessly and share data, mTrac an SMS-based system for reporting on health commodity stocks (logistics) and disease surveillance, mHealth and telemedicine, the Electronic Medical Record System is being rolled in several hospitals, the electronic Community Health Information System for community health workers reporting and the National Health Data Warehouse. RBF has been mainstreamed into PHC funding for HC IIIs and IVs to incentivize quality and performance. The direction in digital health in Uganda is guided by National Digital Health Strategy 2020 – 2025, Uganda Health Information Security and Data Protection Policy, Uganda Health Interoperability Framework and the MoH Health Information, Innovation and Research TWG, which plays a key role in coordinating digital health initiatives and approving new pilots to prevent fragmentation.

Several opportunities exist to build on the current foundation. The massive expansion of HC IIIs and functionalization of IVs provides a physical platform to which services, staff, and supplies can be deployed. The focus can now shift from building to making these facilities fully functional.

Major opportunities for digitisation are, improved real-time data-driven decision making, enhanced patient care, tracking and continuity of care, increased efficiency, empowered patients and communities, and accountability and transparency.

The revised EHCP and service standards provide a clear benchmark for what services should be available and at what quality, which is essential for accountability and quality improvement initiatives.

The successful scale-up and mainstreaming of RBF demonstrate a viable mechanism to incentivize and reward improvements in service quality and access.

Investment plans for specialized institutes (Heart, Cancer) show a commitment to expanding the breadth of services beyond basic care.

The health system faces profound challenges that directly limit its capacity to provide people-centered services.

The health supply chain is fragile and about 30 percent of health facilities experienced stock-outs of essential medicines and supplies in FY2023/24. Although government funding for essential medicines and health supplies increased from UGX 446 billion in FY 2020/21 to UGX 683.5 billion in FY 2024/25 this is not in tandem with the population growth and needs. Financing for HIV/AIDS and TB medicines and supplies is by donors. Per capita government spending on medicines is critically low (USD 3.86 in FY2023/24) vs. the recommended USD 12 for low-income countries). There is inadequate funding for medicines and health supplies, with funding gaps of USD 37.5 million, 45.8 million, 47.1 million over the three FYs of the review period (MTR MoH SP). This forces patients to pay OOP for medicine and health commodities even in public facilities, undermining "people-centered" care.

Domestic pharmaceutical production in Uganda currently meets an estimated 20-30 percent of the country's total need for essential medicines and health commodities. The remaining 70-80 percent is imported, making the country vulnerable to global supply chain disruptions.

The heavy reliance on imports is due to several interconnected challenges like importation of 100 percent of its Active Pharmaceutical Ingredients (APIs) which is single biggest constraint and cost driver, limited local market & procurement, regulatory hurdles, infrastructure and costs, and limited technical capacity.

The Ugandan government recognizes this vulnerability and is actively working to increase the domestic production percentage through several key initiatives:

- The Pharmaceutical Manufacturing Plan for Uganda: This is a strategic government plan aimed at making Uganda a regional pharmaceutical hub.
- Import Substitution: Policies are being developed to prioritize the purchase of

locally manufactured products where they are available and meet quality standards.
- Promotion of Local Content: The "Buy Uganda, Build Uganda" (BUBU) policy encourages both government and private entities to source locally made goods, including medicines.
- Investment in Science and Innovation: Supporting institutions like the Pharmaceutical Society of Uganda and academic programs to build local capacity.

The Hospital bed density increased from 5 per 10,000 in FY2019/20 to 6 per 10,000 people by June 2025, (ideal is 30), indicating very limited inpatient capacity. The lack of a National Master Plan for Health Infrastructure leads to uncoordinated development and poor maintenance of existing assets.

Systemic Operational Gaps Undermining Quality: There is no mandatory national system to accredit health facilities against quality standards, hindering continuous quality improvement. Delays in establishing the Uganda Health Professionals Authority and gaps in enforcing regulations (e.g., for drug shops) undermine quality and accountability.

Digital health systems are often developed in silos and lack interoperability, preventing a seamless patient journey and a comprehensive view of system performance. Poor internet connectivity, especially in rural areas, and unstable electricity undermine the reliability of digital systems. Many digital health initiatives are project-funded by donors, raising concerns about long-term sustainability for maintenance, upgrades, and scale-up. There is a shortage of digital literacy among some health workers and a critical lack of specialized in-country IT staff (developers, system administrators, data scientists) to manage and maintain these complex systems. Under data privacy and security, robust legal and technical frameworks are needed to protect sensitive patient data. Enforcing the "no pilot without HIIRE TWG approval" rule remains a challenge, and the pace of policy development can lag technological innovation.

Inequitable Access and a Two-Tiered System: Geographical Disparities exist with sub-regions like Kigezi (64 percent) and Karamoja (76 percent) having significantly lower care-seeking rates than the national average (82 percent) indicating localized systemic failures (UNHHS 2023/24).

A significant portion (64.2 percent) of OOP spending goes to private healthcare, suggesting issues with the availability, quality, or perceived quality of public services (Draft NHA Report 2021-23). This creates a two-tiered system where quality of care is linked to the ability to pay.

Uganda's health system is at a crossroads. It has successfully built an extensive network of health facilities, bringing physical access closer to many. However, the system's capacity to provide true people-centered services—defined by quality, equity, and financial protection—is critically weak.

The core challenge is a "hardware-software" mismatch: the infrastructure is being built, but it lacks the essential "software" of a motivated health workforce, reliable medicines, and efficient, integrated systems to make it functional. Without urgent action to address the HRH crisis, stabilize supply chains, and strengthen underlying operational systems, the newly built infrastructure will not translate into meaningful, people-centered care for most Ugandans. The goal must shift from simply increasing physical access to ensuring effective, equitable, and dignified access to quality care.

5.3 PILLAR III: IMPROVE ADEQUACY OF A SKILLED, COMPETENT AND ETHICAL HEALTH WORKFORCE

Based on the Uganda UHC Roadmap mid-term evaluation report, the status of HRH in Uganda is best described as a severe crisis that represents the single biggest systemic bottleneck to achieving UHC. While there are some positive developments, the overall situation is critical and undermines all other health gains.

The HRH Strategic Plan 2020-2030 and operational plan 20/21-24/25 was developed, a Health Labor Market Analysis, and National Health Workers Accounts were conducted. All salaries, gratuity and pension for public health workers were paid on time.

There are only 2.1 physicians per 10,000 people (less than 10 percent of the ideal 23). Specialists like surgeons (0.7 per 100,000) and psychiatrists (0.14 per 100,000) are extremely scarce. Access to surgery, mental health, and NCD management is severely constrained for most of the population due to lack of specialists. Only 34 percent of approved health worker positions are filled under the new structure (74 percent based on the old structure). This is a fundamental constraint on service delivery at all levels. The Health Labor Market Analysis for Uganda highlighted significant disparities in the distribution of health workers, with rural and hard-to-reach areas facing severe shortages, crippling access to even basic services.

In FY2022/23, MoPS approved a new human resource structure for the National and Regional Referral Hospitals, and LG health facilities, to improve numbers and skills mix, and in the same year, the government enhanced salaries for health workers. This is a crucial step for motivation and retention. The Integrated Human Resources Information System is now operational in 100 percent of districts, with 75 percent of these fully functional. This system allows for better tracking of staff attendance, vacancies, and payroll, contributing to improved workforce management. The MoH has introduced Continuous Professional Development programs aimed at improving the skills and competencies of health workers, particularly in emergency care and maternal health.

Despite the crisis, MTR report points to several opportunities that can be leveraged to address the HRH challenge. The approval of a new HRH structure demonstrates high-level recognition of the problem and provides a formal framework for expanding and re-profiling the workforce. The recent salary enhancement shows a willingness to invest in the existing workforce, which can improve morale and reduce attrition. This sets a precedent for further investment.

The severity of the crisis and the availability of precise data (e.g., density figures, vacancy rates, distribution) create a compelling and clear evidence base to advocate for a dedicated, multi-year HRH implementation plan and budget.

The ongoing process to establish the Uganda Health Professionals Authority presents an opportunity to strengthen regulation, ensure competence, and enforce ethical standards across the profession.

The health system faces profound HRH challenges that directly limit its capacity to provide people-centered services. The challenges are deep-rooted and systemic, requiring more than incremental solutions.

Under-financing of the wage Bill is the core challenge. The government's budget allocation is insufficient to fill even the approved positions. The stark 66 percent vacancy rate is primarily a result of the lack of a dedicated, multi-year budget to recruit and retain staff.

The extremely low density of doctors and specialists means that even basic medical and surgical care is inaccessible to a large majority of the population. This is a fundamental constraint on improving health outcomes.

The concentration of the few available health workers in urban centers leaves rural and remote populations with minimal access to qualified care, directly contravening the equity principle of UHC. Addressing these imbalances requires targeted incentives, more robust deployment strategies, and provision of staff accommodation.

The delay in establishing the Uganda Health Professionals Authority means there is a gap in ensuring the competence, quality, and ethical conduct of health workers, which can impact patient safety and trust. While training programs have increased the number of health workers, the quality and relevance of training, especially in specialized areas, require more alignment with emerging health sector needs. CPD and improved curricula for health professionals are critical for maintaining quality care.

Government commitment has been crucial in health workforce development, but enhanced coordination among different sectors, such as education and finance, is necessary to fully realize the health workforce goals. Stronger accountability mechanisms are needed to ensure timely implementation of HRH-related policies.

With only a third of positions filled, the existing health workforce is overstretched and facing burnout, which can affect the quality of care and further drive attrition, creating a vicious cycle. This is exacerbated by the high staff absenteeism, especially in hard-to-reach areas.

5.4 PILLAR IV: STRENGTHEN THE HEALTH FINANCING SYSTEM TO IMPROVE ADEQUACY, EFFICIENCY, EQUITY, AND FINANCIAL RISK PROTECTION.

The healthcare financing system in Uganda is in transition, but one where the resources available are not adequate to meet the UHC targets by 2030. It is characterized by inadequate government allocation where the share of the total government budget allocated to health has declined from 8.9 percent in 2010/11 to 5.6 percent in 2024/25. This is far below the 15 percent target committed to in the Abuja Declaration (2001), indicating that health is not a primary fiscal priority.

Household OOP spending and private corporation payments constitute a significant and growing share (31.6 percent in 2022/23) of Current Health Expenditure (CHE). This high level of OOP spending leads to catastrophic health expenditure for 11.9 per cent of households (at the 10 percent threshold), pushing families into poverty (WB, UPER 2023). 64.2 percent of OOP spending goes to private healthcare, indicating a lack of trust, availability, or quality in the public "free" services, forcing people to pay privately.

There is heavy reliance on volatile external funding. Direct Foreign Transfers (donor funds managed outside government systems) are the single largest source of health funding, peaking at 45.4 percent during COVID-19 and stabilizing at 37.2 percent in 2022/23. This makes the health system's financial stability highly vulnerable to shifts in donor priorities and global economic conditions.

The country has a critically underdeveloped health insurance. Voluntary prepayment mechanisms (insurance) are minimal, contributing only ~1.7 percent of the CHE (MoH, NHA 2023). If well regulated, voluntary insurance can play a vital supplementary or complementary role to publicly funded services. Overall, Uganda's health insurance coverage is low, at one percent (1.1 percent) of the household population. The health insurance coverage in urban (1.6 percent) was more than two times that of rural areas (0.7 percent) (UBOS, UPHC 2024). The establishment of a National Health Insurance Scheme has been delayed for years, with the draft bill from 2023 still awaiting approval. A well-designed insurance scheme with mandatory pre-payment mechanisms and a substantial subsidization by the government for the marginalized and informal proportion of the population has the potential to improve equity and financial protection.

There is a positive but insufficient growth in domestic revenue. Transfers from Government Domestic Revenue (GGHE-D) have consistently grown, both in amount and share of CHE (from 22.7 percent in 2019/20 to 24.9 percent in 2022/23). However, the GGHE-D per capita remains critically low at USD 13.2, far below the UHC roadmap target of USD 60 and the recommended USD 86 for low-income countries.

Overall, there is low health expenditure in Uganda. The Total Health Expenditure (THE) as a percentage of Gross Domestic Product (GDP) has declined from 5.58 percent to 5.14 percent, indicating that health spending is not keeping pace with economic growth. Total CHE per capita is USD 53.1, which is below the average of peer countries in the region (USD 75.6).

Despite the challenges, the MTR report identified several opportunities for improvement. The consistent upward trend in government

domestic health spending is a strong foundation to build upon. It demonstrates a commitment that can be leveraged for further increases. The existence of a drafted NHIS Bill provides a clear opportunity for a transformative shift towards pre-pooled funding and financial risk protection. Its passage and implementation would be a game-changer.

The report recommends exploring innovative options such as increased "sin taxes" on tobacco and alcohol, oil levies, debt2health swaps, and climate financing, which represent untapped revenue streams. There is an opportunity to better coordinate and harmonize donor funding through a "virtual pooled fund" to reduce fragmentation and align resources with national priorities. Opportunities exist to use funds more efficiently through strategic purchasing of services from both public and private providers and creating incentives for private sector investment.

The challenges are fundamental and require systemic reform. The consistently low share of the national budget allocated to health is the root cause of the financing crisis. Without a political decision to prioritize health, other reforms will have limited impact.

The absence of a pre-payment national insurance scheme has negatively contributed to the high catastrophic health expenditure, leaving a significant proportion of the population without financial protection and the system reliant on inefficient and inequitable OOP payments.

The heavy reliance on external funding creates a system that is not self-reliant and is vulnerable to external shocks. This unpredictability makes long-term health planning extremely difficult. The high level of OOP spending is both a cause and consequence of a weak system. It makes healthcare a luxury good for the poor, directly contravening the UHC principle of financial protection and trapping families in poverty. Even the available funding may not be used optimally due to systemic inefficiencies, stock-outs, and a lack of focus on strategic purchasing.

Uganda's health financing system is structurally unsound for achieving UHC. It is built on a fragile foundation of volatile foreign aid and high, catastrophic household spending, with a promising but still insufficient increase in direct government funding.

The path forward requires a dual strategy. Significantly increase domestic investment in health through higher budget allocation and innovative taxes and fundamentally reform the financing model by urgently passing the NHIS to pool funds and provide financial protection. Without these decisive reforms, the health system will continue to be under-resourced, inequitable, and unable to deliver on its promise of health for all.

5.5 PILLAR 5: ENHANCE MULTI-SECTORAL COLLABORATION AND PRIVATE SECTOR ACTION

The status of multi-sectoral collaboration in Uganda is characterized by existing institutional structures and notable successes in specific areas, but overall coordination remains ad-hoc, unintegrated, and weak in enforcement, limiting its impact on health outcomes. The NDP III and the Uganda UHC Roadmap itself explicitly recognize the need for collaboration beyond the health sector, providing a strong mandate and strategic entry point.

At national level, a HCDP Working Group was established during the NDP III (2020/21 – 2024/25) period, with the introduction of the Programme-Based Planning approach, which is inherently multi-sectoral.

The HCDP is composed of four sub-programmes, Health, Education and Sports (Chair of the group), Gender, Labor and Social Development, and Water and Environment. All Working Groups are coordinated by the OPM. The Working Group is responsible for preparation of Programme Implementation Plans, preparation of Programme Budget Framework Papers, Quarterly, Semi-Annual and Annual Programme performance reports and the medium-term budget strategy documents.

The MoH has a Department of Multi-Sectoral Coordination and Health Partnerships, and a Public-Private Partnership for Health TWG is in place. LGs were supported to establish PPPH Nodes to facilitate collaboration at the district level.

Uganda's key achievements in social determinants are significant gains in sanitation infrastructure, a dramatic improvement in road safety, and positive trends in reducing acute malnutrition. These were primarily driven by scaling up high-impact interventions (like RUTF, community-based management and sanitation hardware), implementing comprehensive multi-sectoral strategies (especially for nutrition), and enforcing strong legislation and public awareness campaigns (for road safety).

Significant progress has been made, with basic sanitation access more than doubling from 19 percent to 43 percent. While still far from the ideal (>90 percent), the 34 percent progress is significant and is attributed to coordinated efforts and projects involving multiple ministries and partners (e.g., Water Supply & Sanitation Project, USAID Uganda Sanitation for Health Activity).

A major public health success, with mortality rates from road accidents dramatically improving from 29 to 16 per 100,000, close to achieving the SDG target. This was achieved through a multi-pronged approach combining stronger legislation, law enforcement, public awareness, and road infrastructure improvements.

Despite infrastructure improvements, only 42 percent of households treat water, and access to clean energy for cooking has declined to 25.3 percent. 26 percent of children are stunted, and 44 percent are anaemic, reflecting failures in food security and WASH.

The dramatic successes in road safety and sanitation provide powerful evidence that multi-sectoral challenges can be overcome in Uganda with coordinated action. These can be used as blueprints for other areas.

Despite the opportunities, significant bottlenecks prevent effective collaboration. Collaboration is often project-based and ad-hoc, rather than being fully integrated into routine LG planning and budgeting cycles, which makes it unsustainable. Enforcement of the Public Health Act remains weak, particularly in areas like food safety, environmental sanitation, and road safety, undermining the potential impact of laws and policies. There is a critical gap in addressing major health determinants like road safety, child marriage, mental health, and substance abuse through a consistent multi-sectoral lens. Efforts are fragmented or lacking. Despite the programme-based approach to planning, non-health ministries are not held accountable for their contribution to health outcomes. There is no mechanism to make the achievement of specific health-outcome indicators (e.g., stunting rates, adolescent pregnancy) a performance metric for sectors like Agriculture, Water, or Education. Even where there is willingness, sectors and LGs often lack the dedicated funding and technical capacity to plan and implement integrated programs effectively.

Uganda has laid the initial groundwork for multi-sectoral collaboration but has not yet operationalized it into a systematic, accountable, and fully funded approach. The country is effectively "mopping the floor while the tap is still running"—making health sector investments that are then undermined by failures in other sectors like WASH, energy, and food security.

The path forward requires a shift from ad-hoc meetings to institutionalized accountability. This involves:

- Formalizing the "Health in All Policies" approach.
- Strengthening accountability mechanisms so that sectors are measured on their health-impacting outcomes.
- Accelerating the development of subsidiary regulations for the Public Health Act and building LG capacity for enforcement.
- Developing integrated cross-sectoral projects with joint funding and planning.
- Strengthen partnerships with universities and research institutions for data use and evidence generation, monitoring and innovation.

Without this decisive shift, the full potential of multi-sectoral action to drive health gains will remain untapped.

5.6 PILLAR VI: IMPROVE GOVERNANCE, OPERATIONAL EFFICIENCY AND ACCOUNTABILITY

The country has a clear strategic direction provided by the UHC Roadmap, NDP III/IV), and various health sub-programme strategies. LGs) are legally empowered and receive conditional grants with clear guidelines, promoting a form of decentralized governance. Citizen participation structures like Health Unit Management Committees and Hospital Boards are in place to promote citizen participation in planning and accountability.

Enforcement of the Public Health Act and other regulations remains weak. There are also significant delays in establishing the Uganda Health Professionals Authority, creating a regulatory vacuum for health workers' competence and conduct. There is no mandatory national accreditation system for public and private health facilities, meaning there is no mechanism to drive continuous quality improvement or inform the public about the quality of care.

Efficiency is hampered by systemic leaks and fragmentation. Digital health systems especially donor supported programs are developed in siloes and lack interoperability. This creates data inefficiencies, prevents a seamless patient journey, and leads to duplication of effort.

The chronic stock-outs of essential medicines (>30 percent of facilities) represent a massive efficiency failure, wasting the time of health workers and patients and leading to poor health outcomes. Eight in every ten communities (81 percent) suggested the necessity of increasing drug stock levels as a major health concern to be addressed.

The infrastructure expansion has outpaced the human resources and supply chains needed to make them functional. This is a fundamental inefficiency; billions are invested in buildings that cannot deliver services to their potential due to a lack of staff and medicines. The lack of a National Master Plan for Health Infrastructure leads to uncoordinated, ad-hoc development and poor maintenance of existing assets, which is highly inefficient.

Accountability is limited by data gaps and weak feedback Loops. The government has developed tools like the Harmonized Resource Mobilization and Expenditure Tracking framework to track financial flows and improve transparency. A major accountability gap exists in the private health sector, where reporting to the national health management information system is poor. This means a significant portion of the health system is invisible to planners and policymakers.

There are weak citizen feedback mechanisms. While Health Unit Management Committees exist, their effectiveness is limited. Client satisfaction data is collected, but the link between this feedback and tangible system improvements appears weak. The Uganda National Household Survey 2023 shows 54 percent of individuals who fell ill sought care from private hospitals or clinics, in contrast to 27 per cent who utilised government health facilities. Major concerns regarding access to health care services at public health facilities, are the unavailability of medicines/supplies (78 percent), followed by long distances (60 percent) and long waiting times (39 percent). Conversely, for private facilities, the main concern is the expensive or unaffordable health services, also at 78 percent, along with long distances and a limited range of services, each at 35 percent, respectively. More than half of the communities recommended enhancing local access to government health services/maternal care (64 percent) and increasing staff levels at local facilities (39 percent). (UNHHS 2023).

Mechanism to hold non-health ministries accountable for health outcomes are weak (e.g., holding the Ministry of Education accountable for WASH in schools or the Ministry of Agriculture for nutrition outcomes).

Several opportunities exist to build on existing foundations:

- The existing digital health investments (EMRS, NHDW) provide a platform to mandate interoperability and create an integrated data ecosystem, which would dramatically improve efficiency and oversight.
- The ongoing process to amend Health Professional Councils laws and establish the Uganda Health Professionals Authority is a clear opportunity to finally close the regulatory gap and improve quality and accountability.
- Approaches like RBF and the Facility Catchment Area Planning (F-CAPA) provide proven models for linking resources to performance and community input, which can be scaled and strengthened.
- Client feedback from surveys shows clear demands from citizens (e.g., for more drugs and staff). This public pressure can be leveraged to demand greater accountability from leaders and service providers.
- The government's PDM offers a new structural opportunity to integrate health planning and accountability at the very lowest administrative level, potentially strengthening community-led monitoring.

The challenges under governance, efficiency are accountability in the health sector in Uganda are deeply embedded in the system's operations. The lack of accreditation, infrastructure master planning, and interoperable systems are not minor issues; they are fundamental weaknesses that perpetuate inefficiency and block accountability. The consistent mention of weak enforcement of laws and regulations points to a systemic governance challenge that goes beyond the health sector, undermining the rule of law and citizen trust.

The fragmentation of digital systems and the ad-hoc nature of multi-sectoral action reflect a deeper cultural and institutional challenge where sectors and programs operate in siloes, preventing integrated and efficient action.

Inadequate means there is no money not just for medicines and staff, but also for the critical "software" of governance—training for Health Unit Management Committees, maintenance budgets, robust regulatory inspections, and data system integration.

Uganda has created a robust architecture for governance (policies, strategies, decentralized structures), but the engine of efficiency and accountability is sputtering. The system is plagued by leakages, fragmentation, and a lack of consequences for poor performance. The government knows what to do but struggles with the how—the operational discipline required to translate plans into effective, accountable, and efficient action.

The priority must shift from writing plans to building systems that enforce them. This means:

- Mandating interoperability for all digital health systems.
- Finalizing and empowering regulatory bodies like the Health Professionals Authority.
- Institutionalizing a national quality and accreditation system.
- Linking funding and performance more aggressively at all levels.

Without this focus on the underlying systems of execution, governance will remain a theoretical concept rather than a driver of health and well-being at population level.

6. ANNEX

FIVE YEARS FUNDING NEEDS 2025 - 2030 (UGANDA SHILLINGS IN MILLIONS)

Strategic Pillar	Government	Private Sector	Development Partners	Total
1. Strengthen Health Promotion and Disease Preven-tion Through Com-munity Health Systems and Other Platforms	1,620,000	180,000	1,080,000	2,880,000
2. Strengthen Health Service Capacity	4,320,000	1,440,000	2,880,000	8,640,000
3. Improve Ade-quacy of the Health Workforce	3,240,000	360,000	720,000	4,320,000
4. Strengthen the Health Financing System	540,000	180,000	360,000	1,080,000
5. Enhance Multi-Sectoral Collabora-tion and Private Sector Action	360,000	720,000	540,000	1,620,000
6. Improve Governance & Accountability	720,000	180,000	540,000	1,440,000
GRAND TOTAL	**10,800,000**	**3,060,000**	**6,120,000**	**19,980,000**
Percentage contri-bution	**54%**	**15%**	**31%**	**100%**