

Demographic context

The population of Uganda progressively increased from 40 million to 47 million between 2017 to 2022. Infants less than 12 months and children under five years old accounted for less than 8% and 18% of the entire population respectively.

Economic context

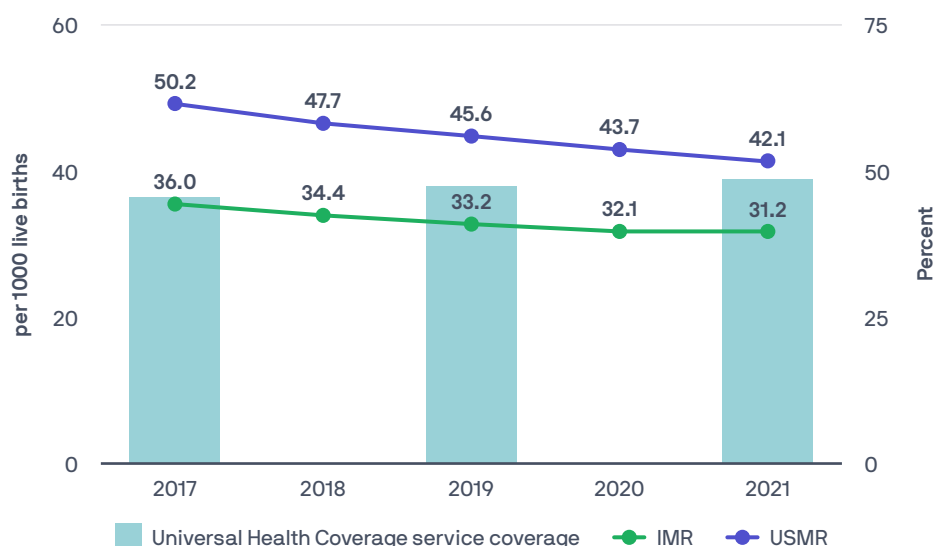
The Gross National Income per capita increased from USD 750 to USD 870 during the period of analysis. This matches the initial self-financing phase for Gavi eligibility (Gavi, 2022). The Tax to GDP ratio was between 12% and 13% between 2017 and 2022. This was below the regional 15% threshold for adequacy of financing public services.

Health system context

The top three causes of death in the general population were neonatal conditions, lower respiratory tract infections and HIV related infections. Preterm birth complications, birth asphyxia, malaria, pneumonia and diarrhea were the main causes of under-five mortalities.

There was a steady decline in both the Infant Mortality Rates (IMR) and Under-five Mortality Rates (UFMR) over the period of analysis. IMR declined from 36 to 31 deaths per 1000 live births, while UFMR declined from 50 to 42 deaths per 1000 live births as shown in figure 1.

FIGURE 1. Health system performance in Uganda



The Universal Health Coverage Service Coverage index in 2021 was 49% implying that half of the population in Uganda had access to quality essential services including reproductive, maternal, newborn and child health, infectious diseases, and non-communicable disease services.

HIGHLIGHT

The rising debt levels in Uganda beyond the regional threshold highlights potential risk of debt repayments crowding out expenditures on other essential public services including health and immunization.

This is further compounded by the low tax revenues implying the need for more efficient tax administration within Uganda.

A strengthened tax administration in Uganda would help mobilize more resources for public goods such as health and immunization.

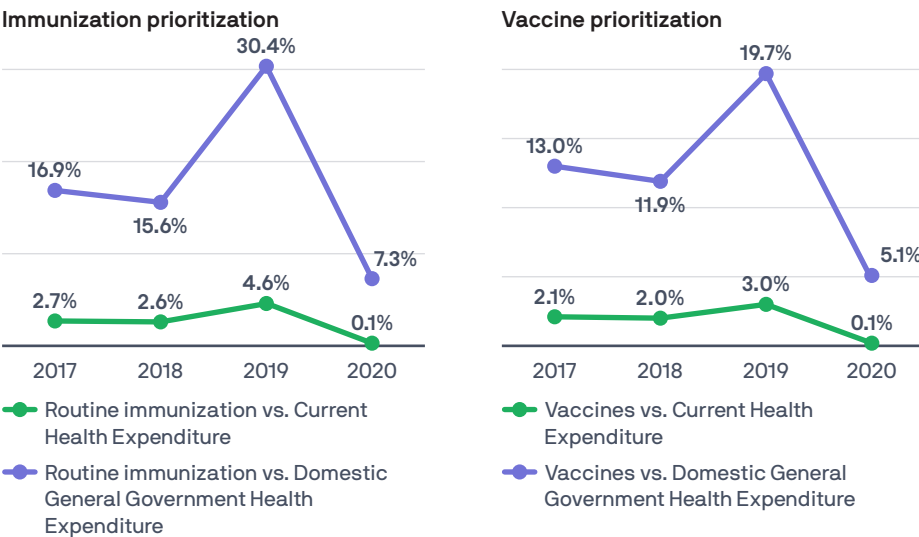
Immunization coverage

Except for the first Measles dose coverage that increased throughout the period, Bacillus Calmette-Guérin (BCG), Diphtheria, Pertussis, and Tetanus (DTP) 1, and DTP3 coverage in Uganda declined between 2017 and 2022. Measles 2 coverage remained low at 49% in 2022. There was no data available for measles 2 coverage prior to 2022.

Immunization financing

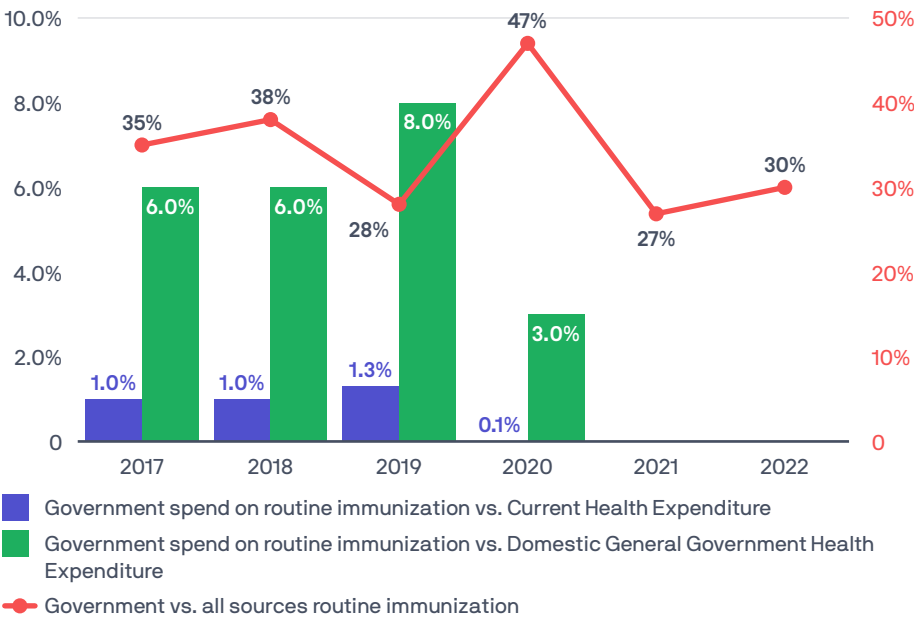
Expenditures on Routine Immunization in Uganda progressively declined during the period of study. Routine Immunization accounted for between 0.1 and 5% of the respective Current Health Expenditures (CHE); and between 7% and 30% of the Domestic General Government Health Expenditures between 2017 and 2020. Vaccine related expenditures accounted for less than 3% of the CHE, and between 5% to 20% of the Domestic General Government Expenditures (Figure 2).

FIGURE 2. Prioritization of immunization and vaccines in Uganda



Government funding as a source of immunization financing fluctuated between 27% and 47% between 2017 and 2022. This accounted for less than 2% of Current Health Expenditures and below 8% of the Domestic General Government Health Expenditure (Figure 3).

FIGURE 3. Government prioritization of immunization in Uganda



HIGHLIGHT

There is significant donor dependence for immunization financing in Uganda. This threatens sustainability of immunization services. Progressive increments in government financing of health and immunization will help mitigate against donor dependence and financial hardship among households as they seek for immunization services.

Recommendations towards improving immunization services

1. **Access and geographic barriers:** Establish mobile immunization clinics, increase the number of healthcare workers, and improve transportation infrastructure.
2. **Vaccine hesitancy:** Increase public awareness through targeted campaigns, engage with community leaders, and provide accurate information about vaccines.
3. **Inadequate government funding:** Increase government funding for immunization programs, establish a predictable funding mechanism, and reduce dependence on external donors.
4. **Health system weaknesses:** Improve healthcare infrastructure, establish efficient logistics and supply chain management, and strengthen health system governance.

Recommendations towards improving immunization financing

1. **Inadequate government funding:** Increase budget allocation for immunization programs, prioritize immunization spending, and improve budget transparency.
2. **Dependency on donor funding:** Diversify funding sources, establish predictable long-term partnerships with donors and private sector, and develop contingency plans for funding fluctuations.
3. **Financial mismanagement:** Improve financial management systems, establish accountability mechanisms, and increase transparency in financial reporting.
4. **Human resource costs:** Increase incentives for healthcare workers involved in immunization delivery, provide adequate training and supervision, and incentivize healthcare workers to work in rural areas.
5. **Healthcare infrastructure costs:** Increase budget allocation for healthcare infrastructure, prioritize infrastructure development in underserved areas, and establish public-private partnerships for infrastructure development.
6. **Health insurance coverage:** Expand health insurance programs to cover immunization costs, establish public-private partnerships for health insurance, and increase awareness of health insurance benefits.
7. **Economic challenges:** Strengthen Public Finance Management systems, establish contingency plans for economic fluctuations, prioritize immunization spending during recessions, and increase public-private partnerships for immunization financing.
8. **Advocacy and awareness:** Increase public and political awareness of the importance of immunization, engage with community leaders and stakeholders, and establish advocacy campaigns for immunization financing.
9. **Coordination and accountability:** Strengthen central and decentralized immunization coordination among government agencies, donors, and implementing partners, with stronger accountability mechanisms to ensure funds are used effectively.

References

GAVI. (2022). *Gavi Alliance Eligibility and Transition Policy Version 4*. <https://www.gavi.org/types-support/sustainability/eligibility>

McIntyre, D., Meheus, F., & Rottingen, J. A. (2017). What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Economics, Policy and Law*, 12(2), 125–137. <https://doi.org/10.1017/S1744133116000414>