



THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

NATIONAL HEALTH ACCOUNTS

2021/22 – 2022/23



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ACRONYMS

BoU	Bank of Uganda
CHE	Current Health Expenditure
FY	Financial Year
GDP	Gross Domestic Product
GGHE	General Government Health Expenditure
GGHE-D	General Government Health Expenditure Domestic
GGHE-E	General Government Health Expenditure External
HAPT	Health Accounts Production Tool
HDP	Health Development Partners
HK	Capital Expenditure on Health
ICT	Information Communication and Technology
IFMS	Integrated Financial Management System
MDAs	Ministries, Departments, and Agencies
MoH	Ministry of Health
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NHA	National Health Accounts
NPISH	Not-For-Profit Institutions Serving Households
NRH	National Referral Hospital
OOP	Out of Pocket
PHC	Primary Health Care
RH	Reproductive Health
RRH	Regional Referral Hospital
SHA-2011	System of Health Accounts for 2011
THE	Total Health Expenditure
UBOS	Uganda Bureau of Statistics
UHC	Universal Health Coverage
WHO	World Health Organization

GLOSSARY OF KEY TERMS

1. **Ancillary services:** a variety of services, mainly performed by paramedical or medical technical personnel, with or without the direct supervision of a medical doctor. There are three sub-categories for ancillary services: laboratory services, imaging services, and patient transportation.
2. **Capital formation (HK):** the types of the assets that health providers have acquired during the accounting period and that are used repeatedly or continuously for more than one year in the production of health services, i.e., infrastructure, machinery and equipment, and intellectual property products.
3. **Current Health Expenditure:** the sum of health care goods and services for final consumption of resident units. It represents the value of that part of the output of the health providers consumed by households, non-profit institutions serving households, and General Government, valued at market prices.
4. **Financing schemes (HF):** components of a country's health financial system that channel revenues received and use those funds to pay for, or purchase, the activities inside the Health Accounts boundary.
5. **Financing sources (FS):** the revenues of the health financing schemes received or collected through specific contribution mechanisms. It consists of the institutional units that provide revenues to financing schemes. There are five categories: government, corporations, households, NPISH, and rest of the world.
6. **General Government Health Expenditure:** represents the amount of resources that the government has mobilized and spent through the budget allocations for health.
7. **Health care functions (HC):** the types of goods and services provided and activities performed within the health accounts boundary, e.g., preventive, curative, and administration.
8. **Health care providers (HP):** organizations and actors that deliver health care goods and services as their primary activity, as well as those for which health care provision is only one among several activities, e.g., hospitals, health centres, ambulatory, pharmacies, long-term care facilities, and ancillary service providers.
9. **Health care:** all activities with the primary purpose of improving, maintaining, and preventing the deterioration of the health status of persons and mitigating the consequences of ill-health through the application of qualified health knowledge (medical, paramedical, and nursing knowledge, including technology and traditional, complementary, and alternative medicine (TCAM)).
10. **Not for profit institutions serving households (NPISH):** a special type of non-profit organization that consist of non-profit institutions that provide financial assistance, goods, or services to households free of charge or at prices that are not economically significant. Their operation is not controlled by the government.
11. **System of Health Accounts:** tracks all health spending in a given country over a defined period of time, regardless of the entity or institution that financed and

managed that spending. It generates consistent and comprehensive data on health spending in a country, which contributes to evidence-based policy-making.

12. Total Health Expenditure: the sum of all public and private spending on health goods and services within the country. It includes government budgets, external aid, social insurance funds, private insurance, and out-of-pocket spending. It is equivalent to the sum of current health expenditure and capital formation

PREFACE

Sustainable health financing remains a central priority within health systems development. The focus extends beyond the sheer volume of health expenditures to encompass equity, effectiveness, and efficiency. Of particular importance is the distribution of financial resources across various levels of healthcare delivery, priority interventions, and the socio-economic groups that ultimately benefit from these allocations.

Emerging technologies, shifting demographics, evolving patterns of disease and mortality, and recurrent public health emergencies, such as COVID-19, Ebola, and Marburg, underscore the need for both prudent resource utilization and, often, increased funding. In Uganda, healthcare is delivered through a multifaceted system comprising public institutions and private entities, both for-profit and not-for-profit. Within this complex landscape, policymakers require accurate, comprehensive, and comparable data on health financing sources and expenditures to enhance the performance of the national health system.

Reliable health expenditure data is essential for strategic decision-making, effective planning, and optimal resource allocation. It also plays a vital role in tracking progress toward key policy objectives, including Universal Health Coverage, equity, efficiency, and long-term sustainability. When conducted routinely, National Health Accounts offer a standardized and thorough approach to monitoring financial flows within the health sector.

It is therefore imperative to foster collaboration among all stakeholders, including development partners, to support this resource-tracking initiative. Such efforts serve as evidence of sound, data-driven management of health sector resources.

This tenth edition of the Uganda National Health Accounts provides a comprehensive overview of financial commitments, disbursements, and actual expenditures, and examines their alignment with stated policy goals. Stakeholders across the health sector are encouraged to engage with and apply the insights contained herein.

For God and My Country.



Dr. Diana Atwine

PERMANENT SECRETARY

FOREWORD

This tenth edition of the Uganda National Health Accounts (NHA) has been developed in alignment with the globally endorsed System of Health Accounts (2011). The NHA framework provides critical insights into the movement of health expenditures, from their original financing sources to the final beneficiaries. Designed as a strategic tool, the NHA supports health policy formulation, including dialogue, planning, implementation, and the monitoring and evaluation of health interventions.

This report presents a detailed analysis of health expenditure data for the fiscal years 2021/22 and 2022/23. It includes breakdowns by financing source, service provider, health activity, input type, disease category, and beneficiary group. Additionally, it offers focused sub-analyses on reproductive health and non-communicable diseases. The financial data contained herein will inform the development of sector strategic plans, guide resource mobilization efforts, and support evidence-based recommendations for health financing policies and efficient resource reallocation.

We extend our sincere appreciation to the development and implementing partners who provided both technical and financial support, working in close collaboration with the Ministry of Health's Planning, Financing, and Policy Department under the leadership of the Commissioner. The successful completion of this NHA round was made possible through the generous contributions of data from various governmental and non-governmental organizations.

It is our earnest expectation that stakeholders across the health sector will leverage the findings of this report to prioritize cost-effective interventions and accelerate progress toward achieving the Sustainable Development Goals.



Prof. Charles Olaro

DIRECTOR GENERAL HEALTH SERVICES

EXECUTIVE SUMMARY

Background

Uganda's tenth round of National Health Accounts (NHA) provides a comprehensive analysis of health financing flows for FY 2021/22 and FY 2022/23, using the internationally recognized System of Health Accounts (SHA-2011) methodology. The report tracks financial resources from their origin, government, households, corporations, and development partners, through financing schemes and agents, to health service providers and functions. It also includes targeted sub-analyses for priority disease areas such as HIV/AIDS, malaria, TB, reproductive health (RH), and noncommunicable diseases (NCDs).

The NHA is a critical tool for evidence-based policy-making, enabling Uganda to assess progress toward Universal Health Coverage (UHC), equity, and efficiency. This round aligns with the National Development Plan III (NDP III), the Program implementation plan for Human Capital Development, the strategic plans for the different MDAs under the Uganda's UHC roadmap.

Key Findings

Health Financing Trends

- Total Health Expenditure (THE) rose from UGX 9.29 trillion in FY 2021/22 to UGX 9.50 trillion in FY 2022/23, representing 5.14% of GDP. Translating into a per capita health expenditure of UGX 212,601 (USD 59.5) in FY 2021/22 and UGX 208,487 (USD 55.5) in FY 2022/23.
- Current Health Expenditure (CHE) increased by 4.9% year-on-year, from UGX 8.66 trillion FY 21/22 reaching UGX 9.09 trillion in FY 2022/23.
- CHE per capita was UGX 198,218 (USD 55.0) in FY 2021/22 and UGX 199,401 (USD 53.1) for FY 2022/23, still below WHO's recommended USD 86 for low-income countries.
- Capital expenditure declined by 24.6%, from UGX 628.5 billion in FY 2021/22 to UGX 413.9 billion in FY 2022/23.

Financing Sources and Schemes

- Donor funding (HDPs) remained dominant, contributing 43.4% of CHE in FY 2021/22, which reduced to 42.4% of CHE and FY 2022/23.
- Government funding (domestic on-budget) as a share of CHE decreased from 27.4% to 25.9%, indicating a slight reduction in domestic public investment in health financing. Translating into a per capita health expenditure of UGX 47,582 (USD 13.3) in FY 2021/22 and UGX 49,610 (USD 13.2) in FY 2022/23.
- Government schemes (merged domestic on-budget and external on-budget), though decreased nominally, remained the second-largest contributory mechanism of pooling resources for health, with UGX 2.89 trillion in FY 2021/22 to UGX 2.75 trillion in FY 2022/23.

- Households contributed 94% of private sector health expenditure, with OOP rising to 31.7% of CHE in 2022/23 from 29.2% of CHE in 2021/22.
- Voluntary insurance schemes remain marginal, though employer-based insurance doubled in value but remained the least source of financing in the health sector.

Financing Agents and Providers

- NPISH (mainly NGOs) managed 36.5% (2022/23) of pooled resources which was a reduction from 35.4% the previous year. This was followed by government entities which managed 30.3% in 2022/23 which was a reduction from 33.3% in 2021/22
- Households managed resources equivalent to 30.3% of CHE (2022/23) which was an increase from 29.2% in the previous year.
- Hospitals absorbed 48.6% of CHE in 2022/23 (an increase from 47.9% in 2021/22), with private-for-profit hospitals receiving the largest share (26.2% and 26.3%) of CHE in the respective years under study.

Health Care Functions and Inputs

- Curative care dominated CHE at 59.3% in 2022/23 which was an increase from 58.1% in 2021/22, while preventive care dropped to 24.6% in 2022/23 from 25.8% in the previous year.
- Compensation of employees accounted for 30.9% of CHE in 2022/23 which was an increase from 26.1% in 2021/22, overshadowing spending on health care / medical goods (21.8% and 24.7% for respective years).
- Pharmaceuticals remain a major driver of household OOP spending.

Disease-Specific Expenditure

- As a share of CHE, different key conditions accounted as follows; Malaria (22.8%), NCDs (23.9%), and HIV/AIDS (13.5%) were the top-funded conditions in 2022/23. In the previous year, these expenditure shares were; Malaria (25.5%), NCDs (22.0%), and HIV/AIDS (14.4%).
- Reproductive health rose to 12.6% of CHE in 2022/23 from 11.7% in 2021/22.
- Donors focused heavily on infectious diseases (66.1% of their funding), while government prioritized both infectious diseases (40.2%) and NCDs (38.0%) for the FY2022/23.

Capital Formation

- Buildings accounted for 42.9% of capital expenditure in FY 2022/23 which was an increase from 26.0% in 2021/22.
- Medical equipment rose to 17.3% in 2022/23 (an increase from 9.2% in 2021/22), while machinery and transport equipment declined.
- In 2022/23, Donors overtook government as the leading source of capital investment (49.4% and 48.1% respectively). In the previous year, government's contribution was 74.7% while it was only 23.8% for the donors.

Key Policy Implications and Recommendations

Strengthen Domestic Health Financing: Uganda's GGHE-D remains low compared to regional peers. This under-investment increases reliance on donors and households and risks the sustainability of health gains achieved over the past two decades.

Recommendations:

- Increase GGHE-D toward the Abuja target (15% of national budget).
- Prioritize PHC, essential medicines, and preventive services.
- Assess if the alignment medium-term expenditure frameworks with sector priorities is effective.

Expand Financial Risk Protection: High OOP spending exposes households to financial hardship, especially for pharmaceuticals and curative care.

Recommendations:

- Accelerate rollout of the National Health Insurance Scheme (NHIS), with subsidies for vulnerable groups.
- Integrate health cooperatives and community-based insurance models and digital platforms.
- Expand social protection schemes targeting catastrophic health expenditure.

Rebalance Toward Preventive and PHC Services: Preventive care declined to 18.6% of CHE, despite its cost-effectiveness and alignment with UHC goals.

Recommendations:

- Introduce PHC earmarks in government and donor budgets.
- Incentivize preventive services through performance-based financing.
- Mobilize private sector and HDPs to co-invest in preventive services

Reduce Donor Dependency and Align Off-Budget Support: Nearly half of donor funding remains off-budget, complicating coordination and accountability.

Recommendations:

- Develop a donor coordination framework under a Sector-Wide Approach (SWAp).
- Introduce co-financing transition plans for vertical programs.
- Institutionalize annual donor mapping and alignment reviews.

1 BACKGROUND

1.1 Concept of National Health Accounts

National Health Accounts (NHA) serve as a crucial policy instrument for systematically tracking the flow of financial resources within a country's health sector (Poullier et al., 2002). This structured approach provides a comprehensive depiction of financial transactions, enabling ministries of health to monitor health financing over time from various perspectives. Globally, NHA has become the main instrument for tracking resource flows within the health sector (Bui et al., 2015) and Uganda's NHA exercises, including the 10th cycle covering Financial Years 2021/22 and 2022/23, are conducted in accordance with the internationally recognized System of Health Accounts (SHA 2011) methodology.

The SHA 2011 framework establishes an integrated and comprehensive methodology for tracking health expenditure through a uniform set of accounts, facilitating comparability across countries (Eurostat & WHO, 2017). This framework categorizes every expenditure within the health system according to three major classifications: Health Care Functions (what services are provided), Health Care Providers (who provides the services), and Health Care Financing Schemes (how services are financed).

The World Health Organization (WHO) plays a pivotal role in coordinating global efforts to produce these estimates, emphasizing the importance of standardized methodology for robust policy formulation. The adoption of the SHA 2011 by Uganda is fundamental to the credibility and utility of its NHA reports. This standardization enables international benchmarking, allowing Uganda to assess its progress towards Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs) against regional and global peers.

1.2 Uganda's Socio-Economic and Health Context

Uganda's health financing landscape is closely linked to its broader socio-economic and demographic realities. During the review period, the nation experienced a fluctuating economic trajectory. Real Gross Domestic Product (GDP) (at 2010 US\$ Billions) demonstrated growth, increasing from \$42 billion in 2021 to 47 billion in 2023 (World Economics, 2024). Concurrently, real GDP per capita (at 2010 US\$) also saw an increase, rising from \$919 in 2021 to \$956 in 2023. The annual GDP growth rate was recorded at 3.5% in 2021, accelerating to 4.6% in 2022, and 5.3% in 2023 (World Economics, 2024). However, the onset of the COVID-19 pandemic significantly impacted the economy (Nabukeera, 2022), with real GDP growth in 2019/20 registering at 2.9%, less than half of the 6.8% recorded in 2018/19. This downturn

was largely attributed to a sharp contraction in public investment and private consumption, severely affecting the industrial and service sectors (World Bank, 2020).

Demographically, Uganda continues to experience rapid population expansion. The total population was estimated at approximately 45.85 million in 2021, with projections indicating 45.6 million by mid-2023, maintaining a high growth rate of 2.9% (UBOS, 2024). A notable characteristic of Uganda's demographic profile is its youthful population, with 48.21% of the populace aged 0-14 years in 2020. This demographic structure exerts considerable pressure on the health system. The high population growth rate and the large proportion of young individuals imply a sustained and intensive demand for essential health services, particularly maternal and child health, and immunization programs.

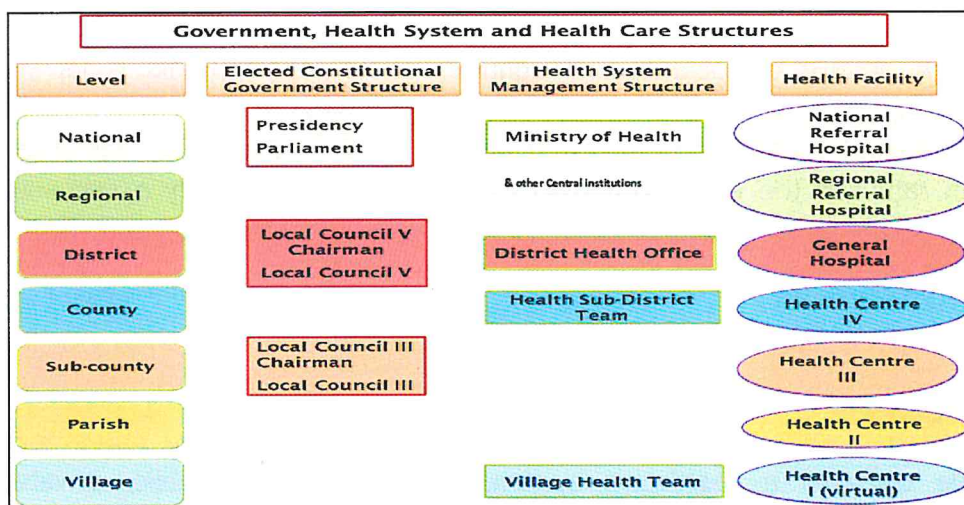
1.3 Health System in Uganda

1.3.1 Context

Uganda operates a healthcare system, which integrates public, private, and traditional/complementary medicine providers. The system delivers services through a six-tiered structure, where at the apex are five National Referral Hospitals (NRHs) alongside semi-autonomous institutions such as the National Medical Stores (NMS) and the Uganda Blood Transfusion Services (UBTS), followed by 17 Regional Referral Hospitals (RRHs) and 153 General Hospitals (GHs), largely at the district level. Progressing downwards, 215 Health Centre IVs serve as referral points for 1,510 Health Centre IIIs and 4,208 Health Centre IIs, which provide essential primary healthcare. The foundational layer of community-level care is delivered by approximately 72,000 Village Health Teams (VHTs), who offer crucial life-saving interventions. All tiers below the national and regional levels constitute the district health system, forming the fundamental unit of the national healthcare infrastructure.

The private healthcare sector in Uganda encompasses both private not-for-profit (PNFP) organizations and private health practitioners, with their facilities categorized similarly to their public counterparts. Beyond facility-based services, the healthcare system receives substantial support from numerous non-governmental organizations (NGOs) and community-based organizations (CBOs). Additionally, volunteer community health workers, often members of VHTs, play a vital role in service delivery.

Figure 1: The health system and health care structure by level in Uganda



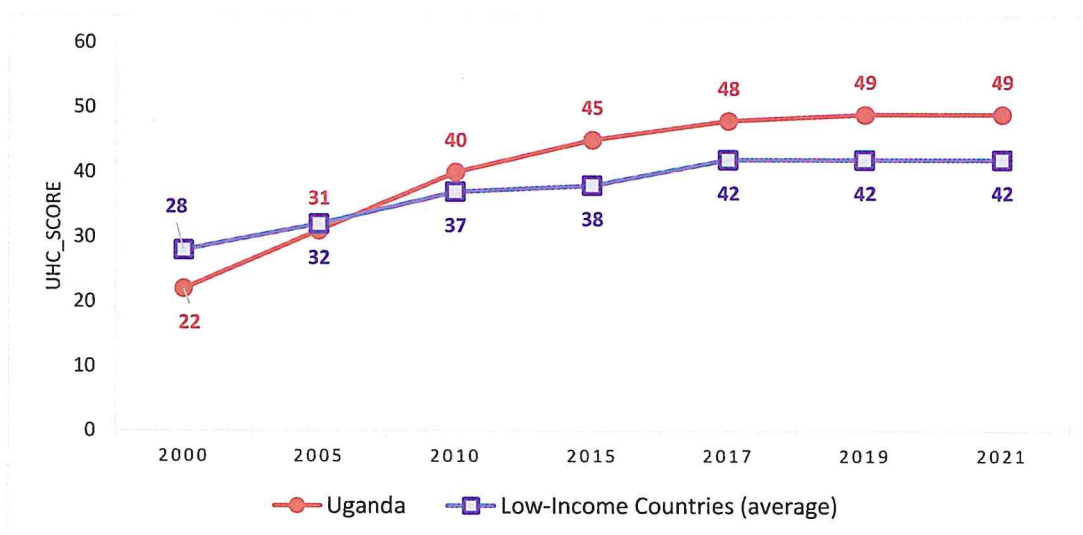
Notably, a Community Health Extension Workers (CHEWs) strategy is currently undergoing pilot implementation to further enhance community health initiatives which is premised to play a critical role in advancing Universal Health Coverage (UHC) and achievement of the relevant Sustainable Development Goals (SDGs) and the recent 2018 Astana Declaration (WHO and UNICEF, 2018; Limb, 2016). Governance of the health sector rests with the Ministry of Health (MoH), which is responsible for planning, budgeting, policy formulation, and regulation, guided by the Health Sector Strategic and Investment Plan (HSSIP) (MOH, 2010).

1.3.2 Health system performance

The Universal Health Coverage (UHC) service coverage index, the average coverage of essential services based on tracer interventions¹, for Uganda has doubled since 2000 from 22 to 49.

¹ Includes reproductive, maternal, newborn, and child health; infectious diseases; NCDs; and service capacity and access.

Figure 2: Service coverage index trend in Uganda 2000-2019



Source: Global Health Observatory 2021

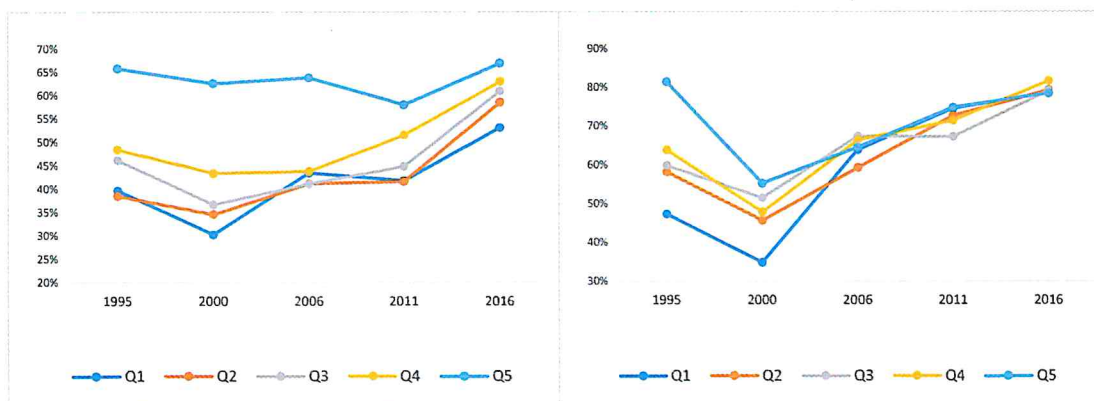
(<https://www.who.int/data/gho/data/themes/topics/service-coverage>)

For some of the service coverage components of the index, there are marked inequalities. For fourth antenatal care visits, the national average in 2016 was 60%, with the coverage being 67% among the richest quintile and 53% among the poorest quintiles. For DTP3 coverage, the national average is 79%, with the coverage varying from 79% in the poorest quintile to 82% among the rich.

The density of doctors, nurses, and midwives per 10,000 population in Uganda stands at 9.6 in 2018, which is an increase from 7.8 in 2005, both of which are much lower than the 22.8 per 10,000 targets in the Millennium Development Goals era and the current 44.5 per 10,000 Sustainable Development Goals index density threshold. This marked shortage is further compounded by geographical inequities in distribution, low stock of specialists, and attraction and retention challenges.

Figure 3: Antenatal care and DTP3 coverage by quintile in 2016

Antenatal care +4 visits					DTP3 coverage 1-year olds				
National average (2016): 60.2%					National average (2016): 79.3%				
Value by quintile – 2016					Value by quintile – 2016				
Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)	Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
53.1%	58.4%	60.9%	62.9%	66.9%	78.6%	79.2%	79.0%	81.6%	78.4%



Source: <https://apps.who.int/gho/data/node.imr>

1.3.3 Health financing landscape in Uganda

In Uganda, the health system is generally financed through two main modalities public and private with the public financing being further sub divided into on-budget and off-budget. The financing to these modalities comes through a variety of stakeholders who include the Government of Uganda, private sector, households, and HDPs.

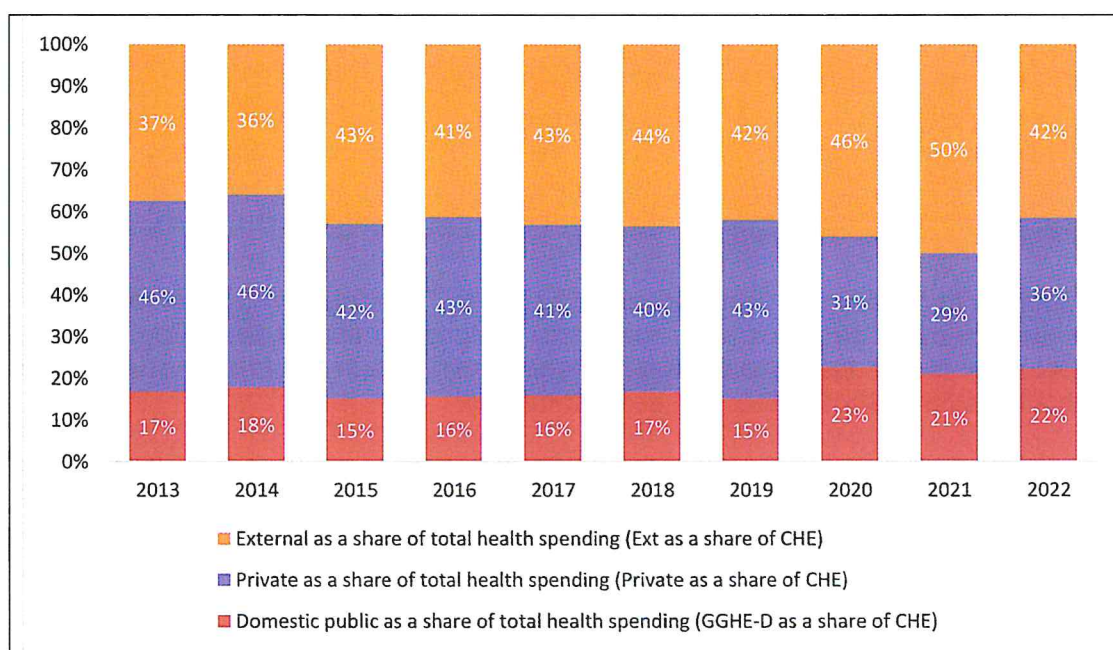
On-budget financing modality represents what government budgets for in a given FY and is contributed to by the domestic revenue as well as the external revenue (coming from HDPs to the national budget). In FY 2021/22, the health sector budget as a share of the national budget was 7.4% which increased to 7.6% in FY 2022/23 which matched with the increase in the nominal terms from UGX 3,331 billion in FY 2021/22 to UGX 3,685 billion in FY 2023/24.

According to the Annual Health Sector Performance Report for 2022/23, both the growth rate and growth per capita of health budget continued to increase in the period under review reflecting government's continued commitment to improving the health needs of the population. The per capita allocation to health in the last seven years has risen by over 62% from UGX 49,910 in 2016/17 to UGX 80,879 in 2022/23.

All the resources mentioned in the budget and other health financing sources like households, private companies and health development partners, support either recurrent activities or capital investment for the health sector. A sum of recurrent spending and capital spending form THE. Uganda's THE per capita was USD 52.1 in 2019/20 which increased to USD 57.2 in 2020/21, amounts which are much lower than the USD 86 recommended by the World Health Organization as a minimum per capita spending required in low-income countries if quality of health is to improve in the country.

The government budget allocation for the health sector as a percentage of the total government budget in the last five years has averaged around 7.5%. Additionally, there remains an increasing dependence in external funding in the health sector as shown in trends (Figure 4) where domestic public financing as a share of current health expenditure (CHE) remains the lowest for all the years representing a low share of government domestic resources being allocated to the health sector in comparison to what is spent by households and private companies as well as the external resources.

Figure 4: Trend in health financing in Uganda 2013–2022



Source: The Global Health Observatory, 2022
<https://apps.who.int/nha/database/Home/Index/en>

In the context of Uganda, government health expenditure as a percentage of GDP saw a decline from 1.68% in 2019/20 to 1.43% in 2020/21. This level of investment is considerably below the recommended 5% for low- and middle-income nations. Consequently, Uganda's health service delivery system, at all levels, is likely to be significantly hindered by persistent financial constraints across various operational domains.

1.4 Rationale, objectives, and policy questions of the NHA

NHA is an invaluable tool for policymakers and managers of the health system that helps them in their efforts to improve system performance by making evidence-based decisions. This it achieves by providing a reliable source of useful information on the use of financial

resources which facilitates decisions linked to the allocation of resources to better meet the objectives of the health system in this complex and ever-changing mix of public, private not-for-profit and private provision and financing of health services.

Uganda has been conducting NHA for the past two decade since 1998 when the first NHA was conducted. This was followed by a series of other rounds where reports have been produced for FY 2008/09, FY 2009/10, FY 2010/11, FY 2011/12, FY 2012/13, FY 2013/14, FY 2014/15, FY 2016/17, FY 2017/18, FY 2018/19, FY 2019/20 and FY 2020/21.

The overall objective of the tenth round of the NHA was to quantify health funding in Uganda for FY 2021/22 and FY 2022/23 and to describe its financial flows, including a sub-analysis on HIV/AIDS, TB, Malaria, RH NCDs and other infectious diseases. Furthermore, this round has also continued the process for institutionalizing resource-tracking initiatives in the country.

In addition to providing a clear picture of the health financing environment in Uganda, this tenth round of NHA was more specifically designed to answer the policy questions below so as to give insight to the health management system and provide stakeholders with a basis for policy direction and decision-making:

- (a) What was the overall level of funding for the health sector during FY 2021/22 and FY 2022/23?
- (b) How does the health funding of Uganda compare with that of other countries in the region?
- (c) What were the major sources funding for the health sector?
- (d) How were the funds managed and channelled within the health care system?
- (e) How were resources allocated to the different levels of health care?
- (f) How are resources allocated to the different health functions?
- (g) How were the resources allocated to the different factors of provision?
- (h) Which disease conditions are being financed?

HIV/AIDS, TB, Malaria, RH and NCDs remain key priority areas for the health system in Uganda and given that the country operates an integrated service delivery system, the NHA provided an opportunity to determine the resource envelope allocated to HIV/AIDS, TB, Malaria, RH, NCDs and other infectious diseases as well as their respective functions. A sub-analysis of these components was therefore conducted to answer the following policy questions:

- (a) How much did Uganda spend on each component during FY 2021/22 and FY 2022/23?
- (b) What is the percentage share of each component out of CHE?
- (c) Who are the main financiers of each component in Uganda?
- (d) How much is spent on different functions under each component?
- (e) Which financing sources are funding the different functions under each?

2 NHA METHODOLOGY AND DATA SOURCES

2.1 Overview

These NHA have been compiled using the framework of the System of Health Accounts 2011 (SHA-2011) as well as applying Health Accounts Production Tool (HAPT) Version 4.0.0.6 in order to expand the scope of analysis and provide a more comprehensive look at health expenditure flows in the country. This has enabled the capturing of a full range of information contained in these resource flows and to reflect the main functions of health care financing: resource mobilization and allocation, pooling and insurance, purchasing of care, and the distribution of benefits. It tracks health expenditures covering FY 2021/22 and FY 2022/23.

2.2 Data Sources for Uganda

2.2.1 Primary data sources

Government:

The estimates of government expenditure presented in this NHA report are based on statistics obtained from respondents including the government Ministries, Departments, and Agencies (MDAs). The Integrated Financial Management System (IFMS) is the main expenditure data source for government transactions and this study utilized the actual expenditure captured in its final accounts for the FY 2021/22 and FY 2022/23. This was supplemented by health facility surveys to inform on the health care functions.

Non-Government:

The non-government sources of data included donors (HDPs), NGOs, private employers, insurance companies, private not-for-profit and private health practitioner health facilities. Expenditure data from the private sector for the financial years under study were obtained through the data collection tools. All survey questionnaires were vetted by the NHA technical team to reflect the needs of SHA-2011 reporting.

2.2.2 Secondary data sources

The team obtained data of secondary nature which included national and macro-economic data such as population and official GDP figures for the financial years under study were obtained from the UBOS and BoU. There were secondary sources of NHA information that included published and non-published documents in different formats (see Annex 2). It is important to highlight that all data obtained, either directly from respondents or through their implementing partners, were treated with the highest level of confidentiality.

Household data was obtained from both the household survey data of 2019/20 and 2023/24 report and using relevant methodologies was extrapolated to represent the respective financial years based on national income and expenditure statistics by UBOS. A sample of questionnaires which were used in data collection has also been attached in Annex 3. A list of all primary sources of data has been added as Annex 4.

2.2.3 Data collection, cleaning, and entry

The number of targeted institutions for data collection was 543, of which 465 have positively responded while 78 they were not willing or able to answer the questionnaires. This report is therefore based on an 85.6% positive response rate and the biggest reason for non-responses was that contact persons were either not available or had been affected by the financing interruptions due to executive order of the USA government to close USAID. The MoH Technical Team is confident that having obtained data from key HDPs, government MDAs, and private sector, the final analysis will have a meaningful impact on policymaking.

In some instances, special meetings (physical and virtual) were arranged to have respondent's queries answered especially where the research assistants needed support from the technical team. The focal unit for these meetings/engagements was the Division of Sector Planning and Policy at the MoH. Supervisors were responsible for confirming if data was obtained from right sources through emails and random calls to respondents as a way of ensuring quality of data collected and cleaning was made where inconsistencies were found and reconciled. The IFMS is based on input-based accounting system whereas NHA reporting focuses on expenditure leading to the delivery of outputs. Therefore, the NHA technical team used the IFMS chart of accounts and mapped the IFMS expenditures directly to the new SHA-2011 classification.

2.2.4 Data analysis and mapping

After cleaning and categorizing data by major funding sources (donors, NGOs, employers, and insurance providers), it was uploaded into the HAPT for mapping. The mapping process involved allocating each expenditure item to specific classifications within the SHA-2011 framework which was done by the technical team with guidance from the consultant. The HAPT software automatically generated tables from the mapped data. These tables were meticulously cross-examined to identify and correct any inconsistencies. Following this, the refined data was exported to Microsoft Excel for the creation of final graphs and tables, with a focus on key aspects of health financing. These final visualizations were subsequently integrated into the report, which was drafted using Microsoft Word.

Household expenditure data was sourced from the Uganda National Household Survey for the fiscal years 2019/20 and 2023/24, provided by the Uganda Bureau of Statistics (UBOS). The survey variables included household identifiers and expenditures on various health items, such as outpatient and inpatient services, pharmaceuticals, and the gender of the household head. Stata 18 was utilized to extract the final data from the main database, which was then managed in Microsoft Excel to produce the necessary graphics for the report. The analysed information was subsequently converted into the SHA-2011 dimensions using Microsoft Excel and then imported into the HAPT for mapping.

As a foundational step in the national RMET harmonization roadmap, and to align with the requirements of specific sub-accounts (e.g., Reproductive Health, HIV/AIDS, Tuberculosis, Malaria, and Non-communicable diseases), the general NHA tables were further disaggregated within the HAPT. This enhancement is designed to further establish the NHA as the primary source for health expenditure data, eliminating the need for separate program-specific surveys. Final graphics related to all sub-accounts (including financing sources, financing schemes, and beneficiary categories) were generated using Microsoft Excel.

3 FINDINGS OF THE NHA STUDY

3.1 Financing the Health System in Uganda

3.1.1 Key health financing indicators

Health financing constitutes a critical element of the health accounts, typically reflected through a country's Total Health Expenditure (THE). Conceptually, THE comprises both recurrent and capital components, that is, Current Health Expenditure (CHE) and Capital Expenditure on Health (HK), respectively. Uganda's THE was recorded at UGX 9.290 trillion in FY 2021/22 and UGX 9.499 trillion in FY 2022/23. On a per capita basis, this translated to UGX 212,601 (approximately **USD 59.5**) and UGX 208,487 (**USD 55.5**) spent on health per individual in FY 2021/22 and FY 2022/23, respectively.

As a proportion of Gross Domestic Product (GDP), THE accounted for approximately 5.71% in FY 2021/22, reducing to 5.14% in FY 2022/23, as illustrated in Table 1. Notably, capital expenditure declined from UGX 628.5 billion in FY 2021/22 to UGX 413.9 billion in FY 2022/23 representing a 24.60% reduction over the reporting period, as shown in Table 1.

Table 1: General health financing, 2019/20 – 2022/23

	FY2019/2020	FY2020/2021	FY2021/2022	FY2022/2023
CHE (UGX Millions)	7,394,624	8,404,668	8,662,119	9,085,124
HK (UGX Millions)	402,961	303,800	628,532	413,979
THE (UGX Millions)	7,797,584	8,708,468	9,290,651	9,499,103
GGHE (UGX Millions)	2,351,289	2,109,882	2,893,964	2,767,620
GGHE-D (UGX Millions)	1,680,293	1,761,576	2,079,330	2,260,326
GDP (UGX Millions)	139,689,000	147,962,000	162,750,000	184,895,000
THE % GDP	5.58%	5.89%	5.71%	5.14%
GGHE % GDP	1.68%	1.43%	1.78%	1.50%
GGHE-D % GDP	1.20%	1.19%	1.28%	1.22%
POPULATION	40,308,000	41,583,600	43,700,000	45,562,000
THE Per Capita (UGX)	193,450	209,421	212,601	208,487
CHE Per Capita (UGX)	183,453	202,115	198,218	199,401
GGHE-D Per Capita (UGX)	41,686	42,362	47,582	49,610
Exch. Rate	3,715	3,661	3,572	3,754
THE Per Capita (USD)	52.1	57.2	59.5	55.5
CHE Per Capita (USD)	49.4	55.2	55.0	53.1
GGHE-D Per Capita (USD)	11.2	11.6	13.3	13.2

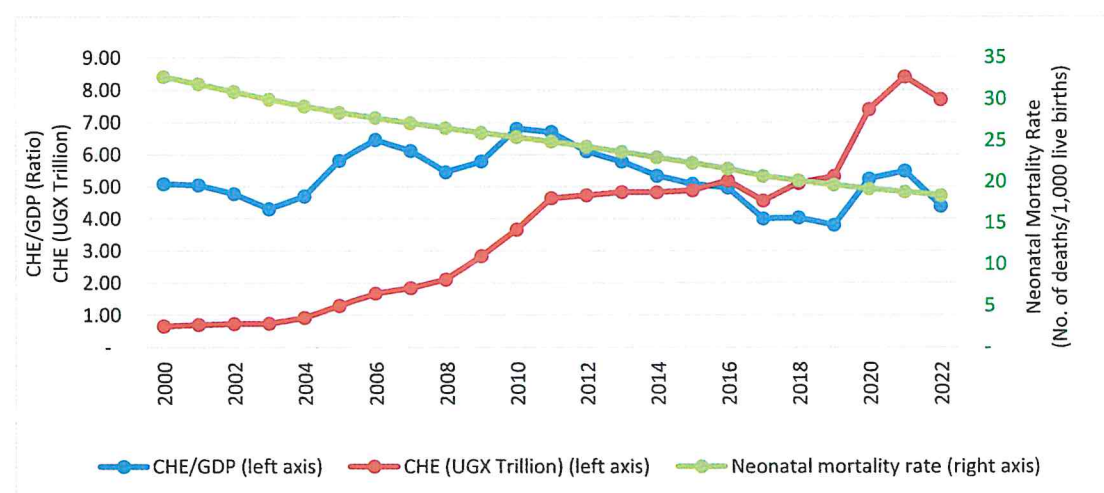
Note: GGHE = General Government Health Expenditure

GGHE-D = General Government Health Expenditure Domestic

Current Health Expenditure (CHE) increased from UGX 8.66 trillion in FY 2021/22 to UGX 9.09 trillion in FY 2022/23, reflecting an annual growth of 4.9%. Looking at the trend, CHE has generally risen over time, although growth has been uneven. Between FY 2019/20 and FY 2020/21, CHE rose significantly from UGX 7.39 trillion to UGX 8.40 trillion (13.7%), before moderating in FY 2021/22. When expressed as a share of GDP, CHE had declined from 5.6% in FY 2019/20 to 5.1% in FY 2022/23, despite overall increases in nominal expenditure and this suggests that while health spending is growing in absolute terms, it is not keeping pace with the growth in the economy.

On a per capita basis, CHE rose from UGX 183,453 (USD 49.4) in FY 2019/20 to UGX 199,401 (USD 53.1) in FY 2022/23. The trend indicates a modest increase in health spending per person, although the rate of increase slowed in recent years. These findings highlight a gradual but constrained growth in Uganda's health financing. While nominal allocations are rising, the declining share of CHE relative to GDP underscores sustainability challenges in ensuring that health expenditure keeps pace with both economic expansion and population growth (see Figure 5).

Figure 5: Current health expenditure and related indicators, 2001–2022

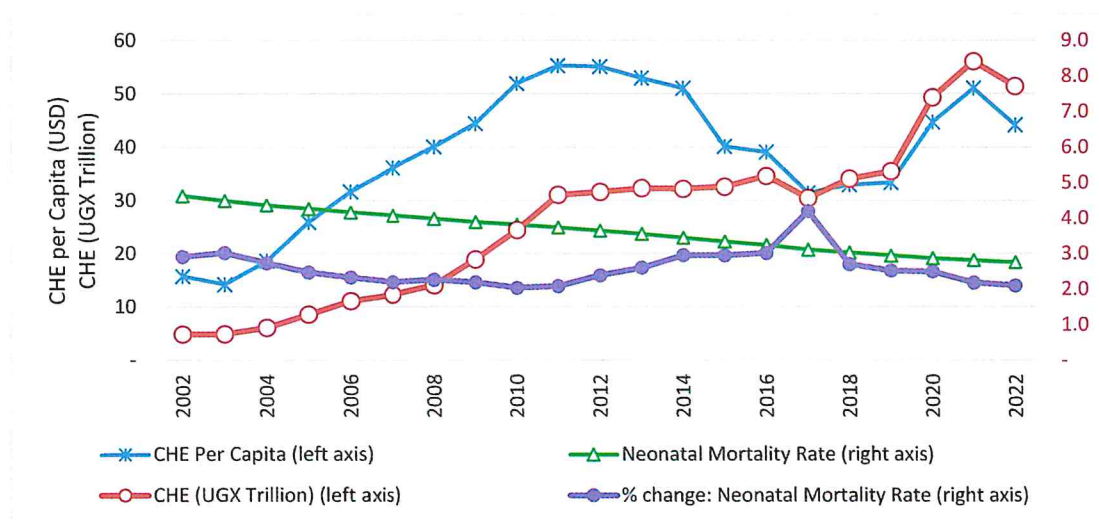


Resource allocation analysis indicates that Uganda's total health expenditure (THE) per capita rose from UGX 193,450 (USD 52.1) in FY 2019/20 to a peak of UGX 212,601 (USD 59.5) in FY 2021/22, before slightly declining to UGX 208,487 (USD 55.5) in FY 2022/23 (Table 1). A similar trend is observed in current health expenditure (CHE) per capita, which grew from UGX 183,453 (USD 49.4) in FY 2019/20 to UGX 202,115 (USD 55.2) in FY 2020/21, then fluctuated modestly, reaching UGX 199,401 (USD 56.1) in FY 2022/23.

An analysis of historical trends in Uganda reveals that CHE per capita showed consistent growth from 2003 to 2011, plateaued until 2014, and subsequently

experienced a slower, more inconsistent growth. When compared with health outcomes, the data suggest a link between periods of rising CHE per capita and a more rapid decline in neonatal mortality rates. This decline was more pronounced from 2003 to 2011 compared to the slower progress seen between 2012 and 2020, when CHE growth slowed (see Figure 6). While other factors may also be at play, these observations are consistent with existing research. Studies by Maruthappu et al. (2015) and Sultana et al. (2023), for instance, have similarly found a strong correlation between increased government health spending, higher per capita health expenditure, and enhanced health infrastructure, all of which are associated with reduced mortality rates among neonates, infants, and children under-five mortality.

Figure 6: Current health expenditure per capita, annual real growth, 2002–2022



For example, per capita Current Health Expenditure (CHE) rose from USD 14.2 in 2003 to a peak of USD 55.3 in 2011, before declining to USD 35.4 by 2017, as illustrated in Figure 6. This downward trend indicates that the growth in population over the past decade has not been matched by a proportional increase in CHE, which poses significant challenges to the health and well-being of the population. Supporting this concern, the World Health Organization (2009) emphasizes that adequate health financing is essential for health systems to sustain and enhance human welfare. Without sufficient funding, it becomes impossible to recruit qualified health professionals, procure necessary medical equipment, or implement effective health promotion and disease prevention initiatives.

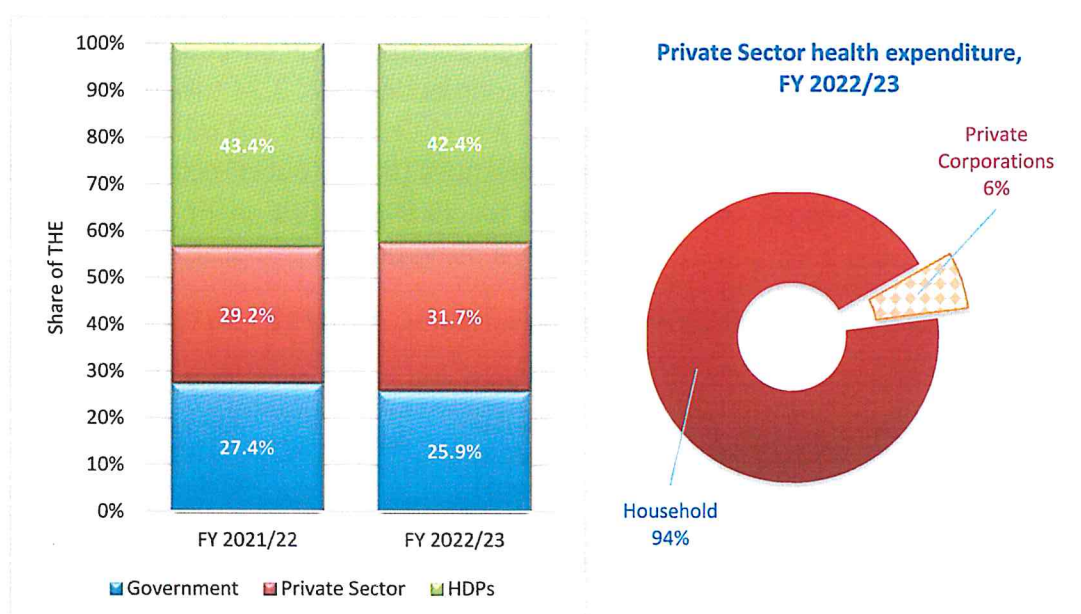
3.1.2 Financing sources: where do resources come from?

Uganda applies the SHA-2011 framework to classify health financing according to sources, schemes, and agents. Analysis of revenue streams indicates the following as

illustrated in Figure 7 (Left side). The share of government financing decreased from 27.4% in FY 21/22 to 25.9% in FY 22/23, indicating a slight reduction in domestic public investment in health. This may reflect fiscal constraints or shifting priorities in budget allocations.

The private sector's share rose from 29.2% in FY 21/22 to 31.7% in FY 22/23, suggesting increased reliance on private financing mechanisms, possibly through out-of-pocket payments (Figure 7 Right side), private insurance, or corporate health spending. Although still the largest contributor, HDPs' share declined marginally from 43.4% in FY 21/22 to 42.4% in FY 22/23. This could signal that donor support is getting to its maximum especially in the post-COVID period.

Figure 7: Financing sources for THE 2021/22 - 2022/23



Breakdown of Private Sector (FY 2022/23) reveals the following: Households accounted for approximately 93.7% of private sector health expenditure, underscoring the heavy burden of out-of-pocket payments on individuals. While private corporations contributed around 6.3%, reflecting limited corporate engagement in direct health financing.

The dominance of donor funding and household contributions raises concerns about sustainability and equity. Heavy reliance on out-of-pocket payments can lead to financial hardship and limit access to care. The declining government share may necessitate policy review to ensure alignment with national health priorities and reduce dependency on external sources. Strengthening domestic resource mobilization and

expanding risk-pooling mechanisms (e.g., national health insurance) could improve financial protection and system resilience.

3.1.3 Revenues of health financing schemes

In line with the SHA-2011 framework, resources within the health care financing system are mobilized through distinct contribution mechanisms. These include government on-budget allocations (both domestic and external), voluntary prepayment mechanisms, off-budget foreign transfers, and household or private contributions.

The findings in Table 2, show that direct foreign transfers (HDP off-budget) remained the leading source of health sector revenue, contributing UGX 3.34 trillion (38.5% of CHE) in FY 2021/22 and UGX 3.38 trillion (37.2% of CHE) in FY 2022/23. The second largest revenue stream was other domestic revenues (mainly out-of-pocket payments and private corporations), which accounted for 29.9% of CHE in FY 2021/22 and increased to 31.6% in FY 2022/23, indicating a rising burden on households.

Table 2: Revenues of health care financing schemes, 2021/22 - 2022/23

Revenue Sources	FY 2021/22		FY 2022/23	
	Amount (UGX, Millions)	Share (%)	Amount (UGX, Millions)	Share (%)
Transfers from government domestic revenue (allocated to health purposes) _ GGHE-D	2,079,330.2	24.0%	2,260,326.0	24.9%
Transfers distributed by government from foreign origin _GGHE-EXT	814,633.5	9.4%	507,294.2	5.6%
Voluntary prepayment (Insurance revenues/payments)	106,896.4	1.2%	150,220.1	1.7%
Other domestic revenues (OOP and Private Corporation)	2,593,089.4	29.9%	2,868,567.8	31.6%
Direct foreign transfers (HDP off-budget)	3,068,169.0	35.4%	3,298,715.8	36.3%
TOTAL	8,662,118.6	100.0%	9,085,123.9	100.0%

Government domestic revenues allocated to health (GGHE-D) ranked third, amounting to UGX 2.08 trillion (24.0%) in FY 2021/22 and UGX 2.26 trillion (24.9%) in FY 2022/23, reflecting steady growth in domestic fiscal commitments. By contrast, transfers from external sources channelled through government systems (GGHE-EXT) declined both in absolute and proportional terms, from UGX 814.6 billion (9.4%) in FY 2021/22 to UGX 507.3 billion (5.6%) in FY 2022/23. Voluntary prepayment schemes,

though still marginal, showed slight growth from 1.2% in FY 2021/22 to 1.7% in FY 2022/23, signalling gradual but limited uptake of health insurance in Uganda.

Overall, these results confirm that Uganda's health financing landscape remains dominated by off-budget donor flows and household resources, while on-budget external funding is shrinking. Such patterns raise critical concerns about the sustainability and coordination of health financing especially on key disease conditions that are largely supported by donors such as HIV/AIDS, Tuberculosis and Malaria. Without stronger alignment between government priorities and the prevailing reliance on off-budget donor support, the system risks fragmentation, duplication of services, and inefficiencies in resource allocation.

3.1.4 Financing schemes: How are resources pooled?

According to the SHA-2011 methodology, health financing schemes represent the structures through which health care funds are mobilized and managed, illustrating the extent of pooling across different financing agents. In FY 2022/23, the largest share of health care financing was managed by NPISH (NGO/CBO) schemes, amounting to UGX 3.40 trillion (37.4% of CHE), a slight nominal increase from UGX 3.34 trillion (38.5% of CHE) in FY 2021/22. These schemes consistently accounted for the largest pool of resources, demonstrating their central role in the health financing landscape.

Table 3: Health financing schemes (detailed), 2021/22 - 2022/23

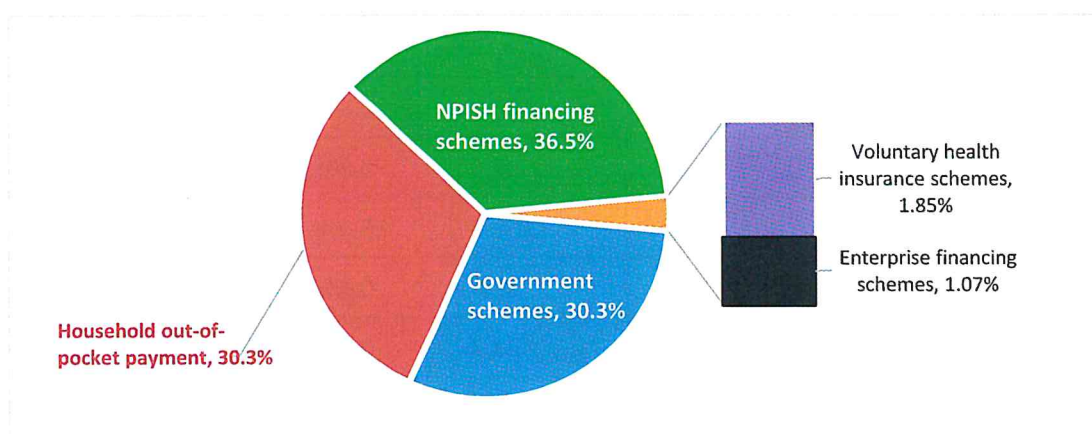
Financing Schemes	FY 2021/22		FY 2022/23	
	Amount (UGX, Billions)	Share (%)	Amount (UGX, Billions)	Share (%)
Government schemes	2,886.2	33.3%	2,749.6	30.3%
Voluntary health care payment schemes				
- Employer-based insurance (Other than enterprises schemes)	66.9	0.8%	140.7	1.5%
- Complementary/supplementary insurance schemes	47.8	0.6%	27.5	0.3%
- NPISH financing schemes (excluding HF.2.2.2)	3,068.4	35.4%	3,317.8	36.5%
- Enterprises (except health care providers) financing schemes	33.6	0.4%	48.8	0.5%
- Health care providers financing schemes	33.3	0.4%	48.5	0.5%
Household out-of-pocket payment	2,526.0	29.2%	2,752.2	30.3%
TOTAL	8,662.1	100.0%	9,085.1	100.0%

Government schemes, though decreased nominally, remained the second-largest contributor, with UGX 2.89 trillion in FY 2021/22 to UGX 2.75 trillion in FY 2022/23. Despite the decrease in absolute terms, the relative share of government financing in the overall current health expenditure appears to be stabilizing compared to earlier years when its share had dropped notably.

Household Out-of-Pocket (OOP) payments continued to represent a significant portion of health care financing. These payments rose from UGX 2.53 trillion (29.2% of CHE) in FY 2021/22 to UGX 2.75 trillion (30.3% of CHE) in FY 2022/23. In the period under review, the OOP expenditure is increasing in nominal terms while Table 3 shows a gradual increase in the share of OOP to CHE, which might indicate that the burden on households may be increasing slightly due to reduced support from pooled schemes like NPISH and government programs.

Among voluntary health care payment schemes, employer-based insurance more than doubled, from UGX 66.90 billion in FY 2021/22 to UGX 140.73 billion in FY 2022/23. Conversely, complementary/supplementary insurance schemes declined from UGX 47.77 billion to UGX 27.49 billion over the same period, suggesting potential shifts in preference or coverage. Financing from enterprises and health care providers also grew moderately, reflecting a slow but steady expansion of alternative financing sources outside government and household contributions. Figure 8 shows that, in general, voluntary health insurance schemes accounted for approximately 2 percent which was not different from 2020/21 value (2.1%).

Figure 8: Financing schemes (summarized), FY 2022/23

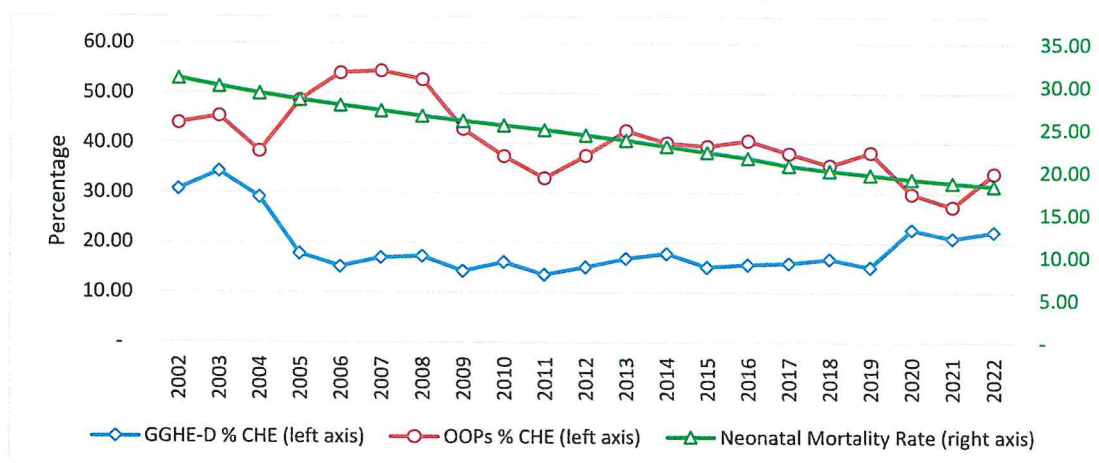


Overall, Figure 8 illustrates a more diversified financing structure in FY 2022/23, with improved pooling mechanisms, particularly through NPISH schemes, playing a pivotal role in reducing household vulnerability to health care costs. It is important to note

that the share of NPISH schemes (majorly off-budget donor support) has declined due to reduced donor funding.

Figure 9 below illustrates the long-term trends in General Government Health Expenditure from domestic sources (GGHE-D) and Out-of-Pocket Spending (OOP) as proportions of Current Health Expenditure (CHE), alongside neonatal mortality rates from 2002 to 2022. In 2022, GGHE-D accounted for 22.26% of CHE, showing a modest recovery from the 2021 figure of 20.96%. This marks a continuation of the post-2020 upward trend, though still below the early 2000s peak of 34.28% in 2003. Over the past decade, GGHE-D has hovered around an average of 16%, indicating limited fiscal prioritization of health from domestic sources.

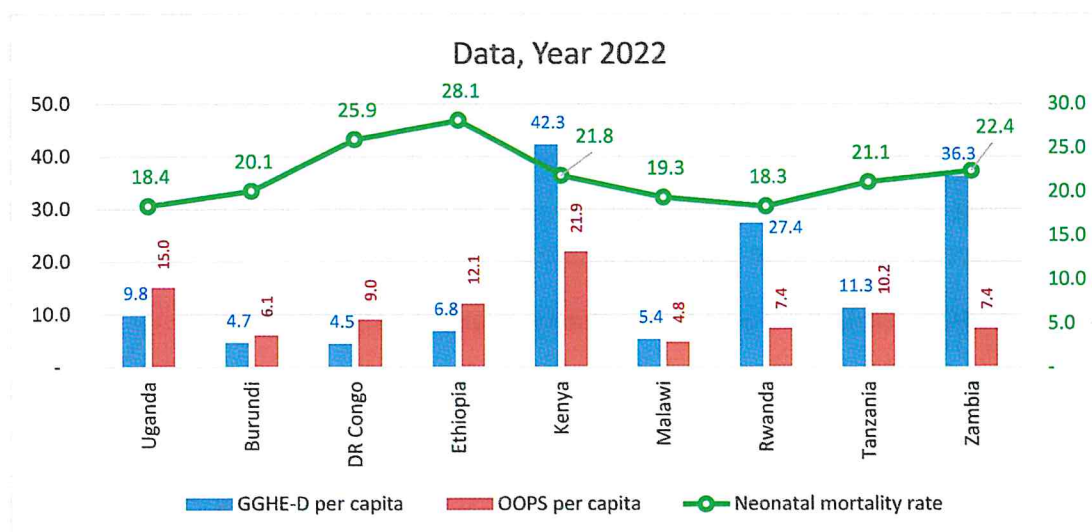
Figure 9: Household OOP and GGHE-D as a share of CHE, 2002–2022



Conversely, OOP spending in 2022 stood at 34.09% of CHE, a notable increase from 27.36% in 2021. This reversal suggests a growing financial burden on households, potentially undermining progress toward universal health coverage. The neonatal mortality rate continued its steady decline, reaching 18.35 deaths per 1,000 live births in 2022—down from 30.9 in 2002—highlighting gradual improvements in maternal and child health outcomes despite fiscal constraints.

Figure 10 provides a comparative snapshot of GGHE-D and OOP per capita across selected countries in 2022. Uganda's GGHE-D per capita was USD 9.83, placing it among the lowest in the region, ahead only of Burundi (USD 4.67), DR Congo (USD 4.48), and Ethiopia (USD 6.84). In contrast, Kenya (USD 42.27), Zambia (USD 36.28), and Rwanda (USD 27.40) demonstrated significantly higher domestic health investments.

Figure 10: GGHE-D per capita and OOP per capita for selected countries, 2022



Source: Global Health Expenditure Database

Uganda's OOP per capita in 2022 was USD 15.05, which, while lower than Kenya's USD 21.89, still reflects substantial household expenditure. Interestingly, despite lower public health spending, Uganda's neonatal mortality rate (18.4) compares favorably with regional peers such as Kenya (21.8), Tanzania (21.1), and Zambia (22.4), suggesting relative efficiency in health service delivery. This correlation suggests that inadequate public investment in health infrastructure, essential medicines, and skilled health workers directly contributes to poor health outcomes, especially for vulnerable populations such as newborns. The high out-of-pocket payments can also deter families from seeking timely and necessary maternal and newborn care, further exacerbating the mortality rate.

The current financing structure creates a major barrier to UHC, as it fails to provide the essential financial protection that UHC seeks to guarantee. For Uganda to make significant progress, it must fundamentally reform its health financing system. This requires not only a substantial increase in the national budget allocated to health to meet and exceed the Abuja Declaration target of 15%, but also a strategic shift away from a system heavily reliant on out-of-pocket payments. Implementing a national health insurance scheme, as has been proposed, could be a critical step. Such a scheme would pool funds and spread the financial risk of illness across the entire population, thereby ensuring that access to healthcare is based on need rather than the ability to pay. Without such reforms, the burden of illness will continue to push Ugandans into poverty, making the promise of UHC an elusive goal.

3.1.5 Financing agents: who manages the pooled resources?

Table 4 below presents the distribution of pooled health resources across key financing agents in Uganda over two consecutive fiscal years. In FY 2022/23, the total pooled health expenditure rose to UGX 9.09 trillion, up from UGX 8.66 trillion in FY 2021/22. That was a 4.9% nominal increase. The largest share of pooled resources continued to be managed by Non-Profit Institutions Serving Households (NPISH), which accounted for 37.4% in FY 2022/23. Although this represents a slight decline from 38.5% in the previous year, NPISH remain the dominant financing agent, underscoring the central role of NGOs and development partners in Uganda's health sector.

Table 4: Financing agents, 2021/22 - 2022/23

Financing Agents	FY 2021/22		FY 2022/23	
	Amount (UGX, Millions)	Share (%)	Amount (UGX, Millions)	Share (%)
General government	2,886,189	33.3%	2,749,615	30.3%
Insurance corporations	93,828	1.1%	125,297	1.4%
Non-Insurance Corporations	87,755	1.0%	140,181	1.5%
NPISH	3,068,397	35.4%	3,317,787	36.5%
Households	2,525,950	29.2%	2,752,244	30.3%
TOTAL	8,662,119	100.0%	9,085,124	100.0%

The largest share of pooled resources continued to be managed by Non-Profit Institutions Serving Households (NPISH), which accounted for 36.5% in FY 2022/23. Although this represents a minimal increase from 35.4% in the previous year, NPISH remain the dominant financing agent, underscoring the central role of NGOs and development partners in Uganda's health sector. Households emerged as the third-largest financing agent, increasing their share from 29.2% to 30.3%. This upward shift suggests a growing reliance on household contributions to health financing, which may reflect either increased service utilization or persistent gaps in public funding.

General government entities managed 30.3% of pooled resources in FY 2022/23, a decline from 33.3% the previous year. While the government management of resources for health is improving, this trend highlights the need for stronger public sector stewardship and alignment of domestic resources with national health priorities until this share exceeds the NPISH share. Insurance corporations and non-insurance corporations, though still managing the smallest shares, showed notable growth. Insurance corporations increased their share from 1.1% to 1.4%, and non-insurance corporations from 1.0% to 1.5%. These shifts may signal early signs of diversification in health financing mechanisms, potentially paving the way for broader private sector engagement.

3.2 Provision of Health Services in Uganda

3.2.1 Health providers: who receives the money?

The second dimension of SHA-2011 methodology is provision of health services which accounts for providers, services/functions, and factor inputs. Health care providers are the recipients of resources from financing agents — in Uganda, these are hospitals, ambulatory care providers, providers of preventive care, providers of ancillary services (e.g., laboratory), and health administration, among others.

Table 5 below presents the distribution of current health expenditure across various health service providers in Uganda. In FY 2022/23, total CHE rose to UGX 9.09 trillion, up from UGX 8.66 trillion in FY 2021/22. That was a 4.9% increase.

Table 5: Health service providers, 2021/22 - 2022/23

	FY 2021/22		FY 2022/23	
	Amount (UGX, Millions)	Share (%)	Amount (UGX, Millions)	Share (%)
HOSPITALS	4,146,098	47.9%	4,418,055	48.6%
Government Hospitals				
NRHs	567,662	6.6%	623,786	6.9%
RRHs	668,359	7.7%	728,356	8.0%
General hospitals	348,376	4.0%	391,451	4.3%
Specialised hospitals	285,646	3.3%	293,827	3.2%
Private Hospitals				
- Private Not-For-Profit Hospitals	571,525	6.6%	654,038	7.2%
- Private-For-Profit Hospitals	1,704,530	19.7%	1,726,596	19.0%
AMBULATORY FACILITIES	1,087,492	12.6%	1,091,021	12.0%
- Government Owned Health Centers	853,031	9.8%	851,534	9.4%
- Non-Government Health Centers	234,461	2.7%	239,487	2.6%
Providers of ancillary services (Non-facility)	67,219	0.8%	51,080	0.6%
Providers of medical goods (Non-facility)	165,376	1.9%	192,597	2.1%
Providers of preventive care (Non-facility)	1,969,244	22.7%	2,060,535	22.8%
Providers of health care system administration and financing	1,168,050	13.5%	1,208,504	13.2%
Rest of economy (Community Health Workers)	10,816	0.1%	11,681	0.1%
Unspecified health care providers (TCAM)	47,825	0.6%	51,651	0.6%
TOTAL	8,662,119	100.0%	9,085,124	100.0%

Hospitals remained the dominant recipients of health financing, absorbing 48.6% of CHE in FY 2022/23, up from 47.9% the previous year. This growth was driven by increases across both public and private hospital categories. Notably for 2022/23:

- Private-for-Profit Hospitals received UGX 1.73 trillion (19.0%), maintaining their position as the single largest hospital sub-category.
- Private Not-for-Profit Hospitals saw a rise to UGX 654 billion (7.2%), reflecting continued reliance on faith-based and charitable institutions.
- Government hospitals collectively accounted for 22.4% of hospital spending, with Regional Referral Hospitals and National Referral Hospitals receiving UGX 728 billion (8.0%) and UGX 623 billion (6.9%) respectively.

Ambulatory facilities experienced a slight decrease in their share of CHE, falling from 12.6% to 12.0%. Government-owned health centres were the primary drivers of this growth, receiving UGX 851 billion (9.4%) in FY 2022/23, from UGX 853 billion the previous year. Providers of preventive care had stability in their share, increasing from 22.7% to 22.8%. This steadiness might reflect the state of these providers where their nature does not change over time as shown in their definition.

Health system administration and financing remained relatively stable, accounting for 13.3% of CHE in FY 2022/23, consistent with historical averages. This includes central-level institutions such as the Ministry of Health, National Medical Stores, and regulatory bodies, as well as district-level health offices. Other provider categories, including ancillary services, medical goods suppliers, traditional and complementary medicine providers, and community health workers, collectively accounted for less than 5% of CHE, with minimal year-on-year variation.

3.2.2 Health care functions: what is the purpose of health care spending?

The population seeks health care functions which are diverse in nature depending on their needs. According to SHA-2011, these functions refer to groups of health care goods and services consumed by final users or the population with a specific health purpose. Table 6 presents the distribution of Current Health Expenditure (CHE) by health care function, while Figure 11 highlights the share of government financing across these functions in FY 2022/23.

In FY 2022/23, curative care remained the dominant health care function, absorbing UGX 5.39 trillion, equivalent to 59.3% of total CHE. This marks a slight increase from 58.1% in FY 2021/22, indicating a growing emphasis on treatment services across both inpatient and outpatient settings. Preventive care, which had previously accounted for 25.8% of CHE in FY 2021/22, declined slightly to 24.6% in FY 2022/23.

This reduction is also reflected in government allocations, where preventive services represented just 20.1% of government domestic health spending. The shift suggests a potential deprioritization of preventive interventions, which may have long-term implications for population health outcomes.

Governance and health system administration maintained a stable share, rising slightly from 13.1% to 13.2% of CHE. Government contributions to this category were proportionally higher, at 19.7%, underscoring the continued investment in oversight, coordination, and regulatory functions.

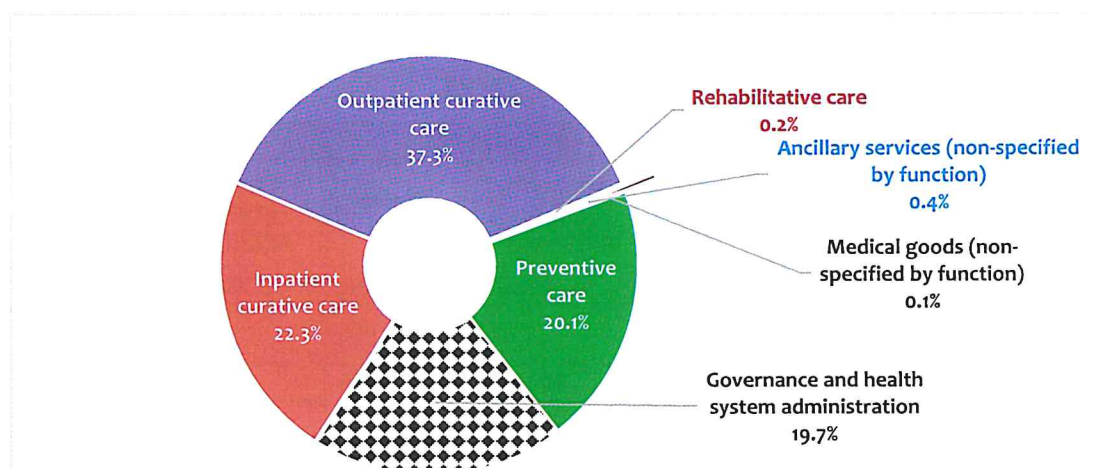
Ancillary services and medical goods, both not specified by function, remained minor components of CHE. In FY 2022/23, ancillary services accounted for 0.6% and medical goods for 2.1%. Government financing for these categories was even lower, at 0.4% and 0.09% respectively, suggesting limited public investment in diagnostic support and non-prescription pharmaceuticals. Rehabilitative and long-term care services continued to receive minimal funding, together constituting less than 0.3% of CHE. Their negligible share in government financing (less than 0.2%) reflects persistent gaps in coverage for chronic and post-acute care needs.

Table 6: Health care services, 2021/22 - 2022/23

Health Functions	FY 2021/22		FY 2022/23	
	Amount (UGX, Millions)	Share (%)	Amount (UGX, Millions)	Share (%)
Curative care	5,031,538	58.1%	5,386,078	59.3%
Rehabilitative care	22,830	0.3%	21,170	0.2%
Long-term care (health)	18	0.0%	18	0.0%
Ancillary services (non-specified by function)	67,219	0.8%	51,080	0.6%
Medical goods (non-specified by function)	165,376	1.9%	192,597	2.1%
Preventive care	2,237,582	25.8%	2,233,831	24.6%
Governance, and health system and financing administration	1,137,556	13.1%	1,200,350	13.2%
TOTAL	8,662,119	100.0%	9,085,124	100.0%

Government financing mirrored this trend (Figure 11) that a significant majority of the government's budget is directed towards curative services, with outpatient curative care and inpatient curative care accounting for 37.3% and 22.3% of spending, respectively. Combined, these two categories constitute a staggering 59.5% of the CHE.

Figure 11: Health care services by government financing, 2022/23



A further 19.7% is allocated to Governance and health system administration, which, while essential for managing the health sector, is a substantial proportion. In stark contrast to curative care, a smaller fraction of the budget is dedicated to preventative health measures. Preventive care receives a mere 20.1%, while other crucial services like rehabilitative care (0.4%), ancillary services (0.2%), and medical goods (0.1%) are virtually negligible in their budgetary allocation.

3.2.3 Factors: which inputs are purchased to provide health services?

In the context of health accounts, factors of provision represent all the inputs used by healthcare providers to produce goods and services within a country. As defined by SHA-2011, these factors illustrate the shares of the total health spending, which includes, but is not limited to, compensation for employees and health goods (like pharmaceuticals) and non-health goods and services (like cleaning and security).

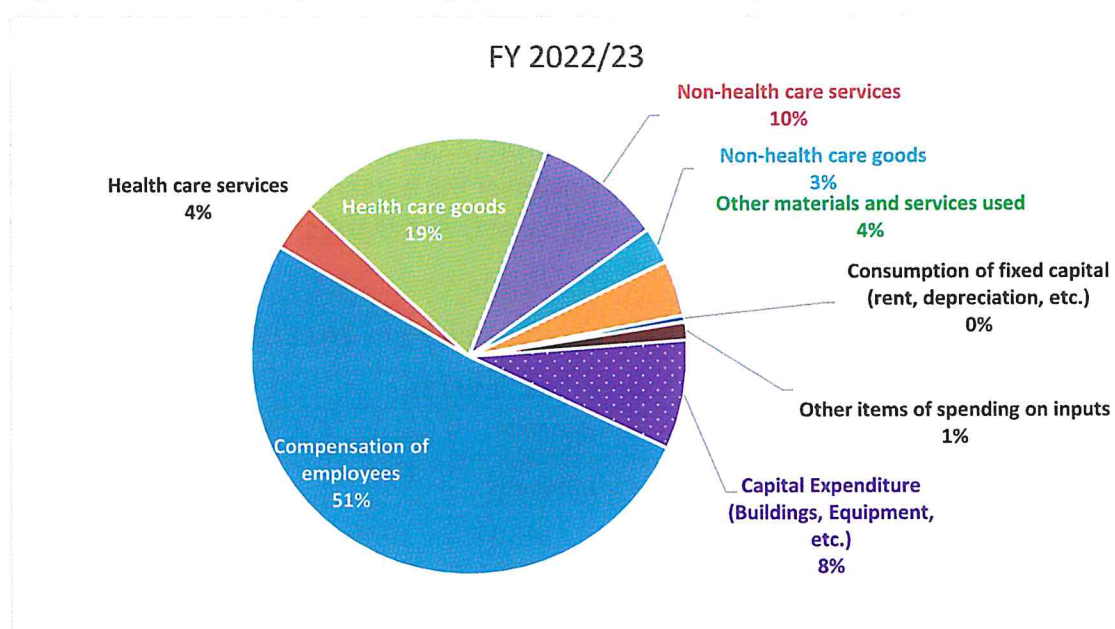
Table 7 details the allocation of health expenditure by factors of provision in Uganda for the fiscal years 2021/22 and 2022/23. In both years, the largest share of spending was allocated to Compensation of employees, which saw a notable increase from UGX 2.42 trillion (26.1%) to UGX 2.93 trillion (30.9%). Health care goods represented the second largest share, although its allocation decreased from UGX 2.29 trillion (24.7%) to UGX 2.07 trillion (21.8%). Other significant categories included non-health care services (incl. EMHS) and other materials and services used (n.e.c.), which maintained relatively stable shares. Capital Expenditure (Buildings, Equipment, etc.) decreased from UGX 0.63 trillion (6.8%) to UGX 0.41 trillion (4.4%), while Consumption of fixed capital saw a significant jump from UGX 1.66 billion (0.0%) to UGX 11.56 billion (0.1%).

Table 7: Factors of provision, 2021/22 - 2022/23

Factors of Provision	FY 2021/22		FY 2022/23	
	Amount (UGX, Millions)	Share (%)	Amount (UGX, Millions)	Share (%)
Compensation of employees	2,422,221	26.1%	2,930,660	30.9%
Self-employed professional remuneration	1,919	0.0%	2,072	0.0%
Health care services	281,238	3.0%	341,670	3.6%
Health care goods	2,294,039	24.7%	2,068,573	21.8%
Non-health care services (incl. EMHS)	1,778,767	19.1%	1,787,561	18.8%
Non-health care goods	402,338	4.3%	401,882	4.2%
Other materials and services used (n.e.c.)	942,074	10.1%	967,793	10.2%
Consumption of fixed capital	1,663	0.0%	11,558	0.1%
Other items of spending on inputs	490,033	5.3%	521,702	5.5%
Unspecified factors of health care provision (n.e.c.)	47,825	0.5%	51,651	0.5%
Capital Expenditure (Buildings, Equipment, etc.)	628,532	6.8%	413,979	4.4%
TOTAL	9,290,651	100.0%	9,499,103	100.0%

The shifts in spending shown in Table 7, especially, the increased share for compensation of employees suggests a growing investment in the health workforce, which is crucial for improving the quality and accessibility of services. However, a simultaneous decrease in the share for Health care goods, including pharmaceuticals, could indicate a potential challenge in ensuring a consistent supply of essential medicines, which is a key component of UHC.

Figure 12: Factors of provision by government financing, 2022/23



NHA findings in Figure 12 highlights the share of government financing across these functions in FY 2022/23. The largest share of the budget, 51%, was allocated to compensation of employees. The next largest share, 19%, went to Health care goods, which includes items like pharmaceuticals. Other significant allocations were to Non-health care services (10%), capital expenditure (8%), Health care services (4%), and Other materials and services used (4%). The remaining categories like non-health care goods, consumption of fixed capital, and other items of spending on inputs, accounted for 3%, 0%, and 1% of the total, respectively.

3.3 Consumption of Health Services in Uganda

Which disease/conditions are being spent on?

The SHA-2021 methodology helps in analysis of consumption patterns by looking at different aspects of population characteristics and these include disease/conditions that the population either are suffering from or whose expenditure aims at preventing their occurrence. Table 8 below presents the distribution of CHE across major disease categories and health conditions in Uganda. In FY 2022/23, total CHE rose to UGX 9.09 trillion, reflecting a continued commitment to addressing both communicable and noncommunicable disease burdens.

Malaria remained the single largest expenditure category, absorbing UGX 2.07 trillion or 22.8% of CHE. Although this represents a slight decline from 25.5% in FY 2021/22, malaria continues to command a significant share of health resources, underscoring

its persistent public health impact. Noncommunicable diseases (NCDs) saw a notable increase in funding, rising from UGX 1.91 trillion (22.0%) to UGX 2.17 trillion (23.9%). This upward trend reflects growing recognition of the burden posed by conditions such as cardiovascular disease, diabetes, and cancer, and signals a shift toward chronic disease management.

Table 8: Disease conditions as share of CHE, 2021/22 - 2022/23

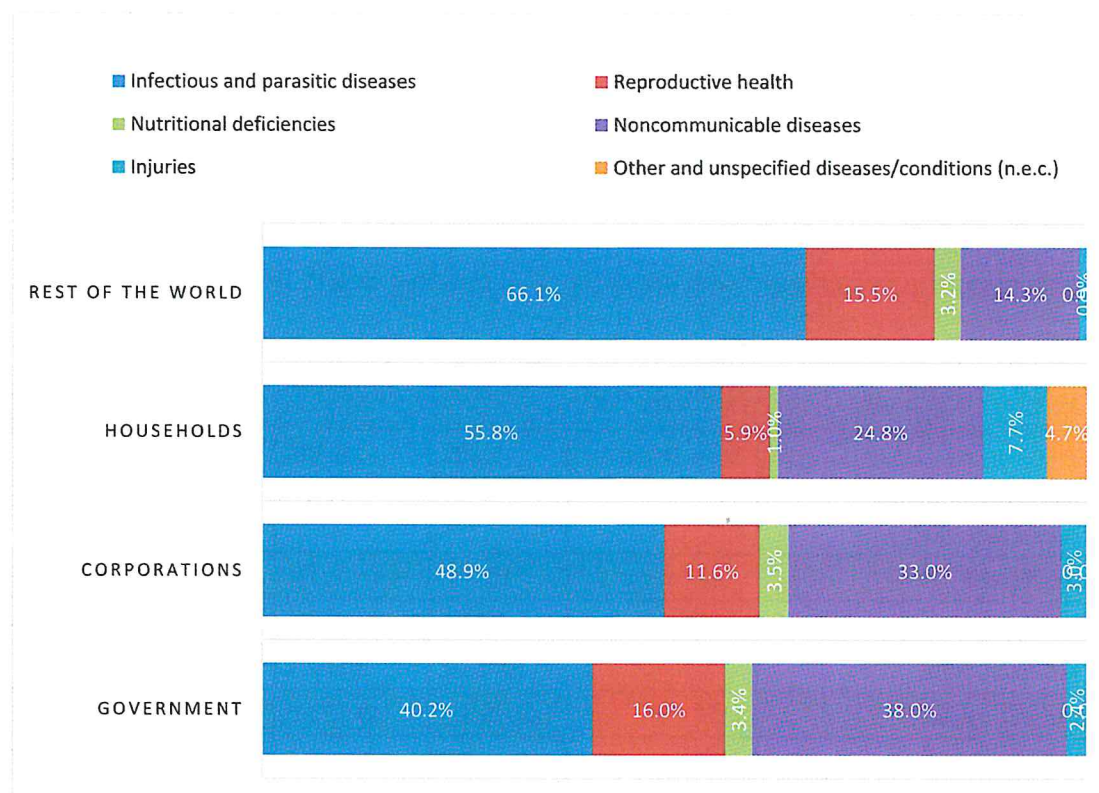
	FY 2021/22		FY 2022/23	
	Amount (UGX, Millions)	Share (%)	Amount (UGX, Millions)	Share (%)
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	1,247,047	14.5%	1,229,239	13.5%
Tuberculosis (TB)	148,667	1.7%	144,606	1.6%
Malaria	2,207,684	25.5%	2,074,275	22.8%
Respiratory infections	419,415	4.8%	412,991	4.5%
Diarrheal diseases	197,472	2.3%	313,497	3.5%
Neglected tropical diseases	22,092	0.3%	34,254	0.4%
Vaccine preventable diseases	153,136	1.8%	212,983	2.3%
Hepatitis	1,092	0.0%	1,405	0.0%
Public Health Emergencies of International Concern (PHEICs)	51,762	0.6%	10,359	0.1%
Other and unspecified infectious and parasitic diseases (n.e.c.)	669,046	7.7%	637,881	7.3%
Reproductive health	1,014,206	11.7%	1,142,965	12.6%
Nutritional deficiencies	220,636	2.5%	232,648	2.6%
Noncommunicable diseases	1,908,789	22.0%	2,166,840	23.9%
Injuries	307,744	3.6%	310,654	3.4%
Other and unspecified diseases/conditions (n.e.c.)	93,329	1.1%	133,813	1.5%
TOTAL	8,662,119	100.0%	9,085,124	100.0%

HIV/AIDS and other sexually transmitted infections accounted for UGX 1.23 trillion (13.5%), maintaining a stable share compared to the previous year. Despite a slight decline, this category remains a key focus of health financing, particularly through donor-supported programs. Reproductive health expenditures rose to UGX 1.14 trillion (12.6%), up from 11.7% in FY 2021/22. This increase aligns with efforts to improve maternal and neonatal outcomes and expand access to family planning services.

Diarrheal diseases experienced a significant rise in funding, increasing from UGX 197 billion (2.3%) to UGX 313 billion (3.5%). This may reflect intensified interventions in water, sanitation, and hygiene (WASH) and child health programs. Vaccine-preventable diseases also saw a marked increase, with expenditures rising from UGX 153 billion (1.8%) to UGX 213 billion (2.3%), likely driven by expanded immunization efforts and catch-up campaigns post-COVID-19 disruptions.

Conversely, Public Health Emergencies of International Concern (PHEICs), which had surged during the pandemic, dropped sharply from UGX 51.8 billion (0.6%) to just UGX 10.4 billion (0.1%), reflecting the waning fiscal footprint of COVID-19-related interventions. Figure 13 provides a comparative breakdown of how different financing sources like Government, Corporations, Households, and the Rest of the World (primarily Health Development Partners, or HDPs), allocated resources across major disease categories in FY 2022/23.

Figure 13: Disease/condition shares for each financing source, 2022/23



Upon reviewing different financing sources, Figure 13 reveals that in the fiscal year 2022/23, the government primarily allocated its current resources to infectious and parasitic diseases (40.2%). This was followed by non-communicable diseases (NCDs) at 38.0%, reproductive health (RH) at 16.0%, and nutritional deficiencies at 3.4%. Similarly, households spent a significant portion of their resources (55.8%) on infectious and parasitic diseases. A unique aspect of household expenditure was the 4.7% spent on unspecified conditions, which often includes traditional, complementary, and alternative medicine services. Health Development Partners (HDPs) predominantly financed infectious and parasitic diseases (66.1%), which is expected as this category covers major diseases like HIV/AIDS, malaria, and Tuberculosis.

This analysis shows the continued dominance of infectious disease spending, especially among external donors and households. Concurrently, it indicates a gradual shift in domestic financing towards NCDs and reproductive health. The data emphasizes the need for a strategic realignment of health financing to reduce the financial vulnerability of households and broaden support for other health priorities.

Reproductive Health Sub-analysis

Total CHE increased from UGX 7.4 trillion in 2019/20 to UGX 9.1 trillion in 2022/23, while RH expenditure rose faster, from UGX 738 billion to UGX 1.14 trillion during the same period. This translated into RH's share of CHE rising from 10.0% to 12.6%, highlighting the sector's growing importance in national health financing.

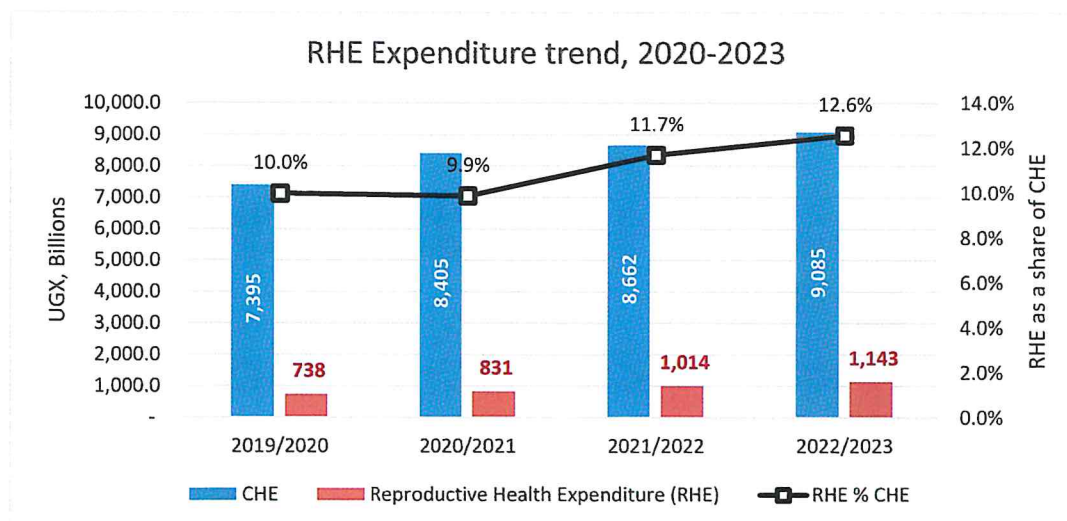
Table 9. Trends of expenditure on RH in Uganda, FY 2019/20-2022/23

VARIABLES	UNITS	2019/20	2020/21	2021/22	2022/23
CHE	UGX, Billion	7,395	8,405	8,662	9,085
Reproductive Health Expenditure (RHE)	UGX, Billion	738	831	1,014	1,143
RHE % CHE	Percentage	10.0%	9.9%	11.7%	12.6%
Population	Million	40.31	41.58	43.70	45.56
USD Exch. Rate		3,715.1	3,661.1	3,571.6	3,754.1
RHE per capita	UGX	18,315.5	19,972.0	23,208.4	25,085.9
RHE per capita	USD	4.9	5.5	6.5	6.7

In per capita terms, RH spending increased from UGX 18,315 (USD4.9) in 2019/20 to UGX 25,086 (USD6.7) in 2022/23, reflecting both higher investments and population growth. Despite these gains, RH spending remains modest relative to needs, especially considering Uganda's persistent maternal mortality, adolescent pregnancy, and unmet family planning demand. Sustained increases will be critical to meeting RMNCAH Sharpened Plan II and SDG 2030 targets.

Figure 14 illustrates Uganda's RHE and its share of the CHE (RHE%CHE) from 2020/21 to 2022/23. The data shows that while RHE has increased in nominal terms, rising from approximately UGX 1.05 trillion to UGX 1.2 trillion, its proportion of total health spending has shown some volatility. In 2020/21, the RHE%CHE stood at 18.7%, but it decreased to 17.8% in 2021/22 before recovering to 18.9% in 2022/23.

Figure 14. Trends in expenditure on reproductive health in Uganda

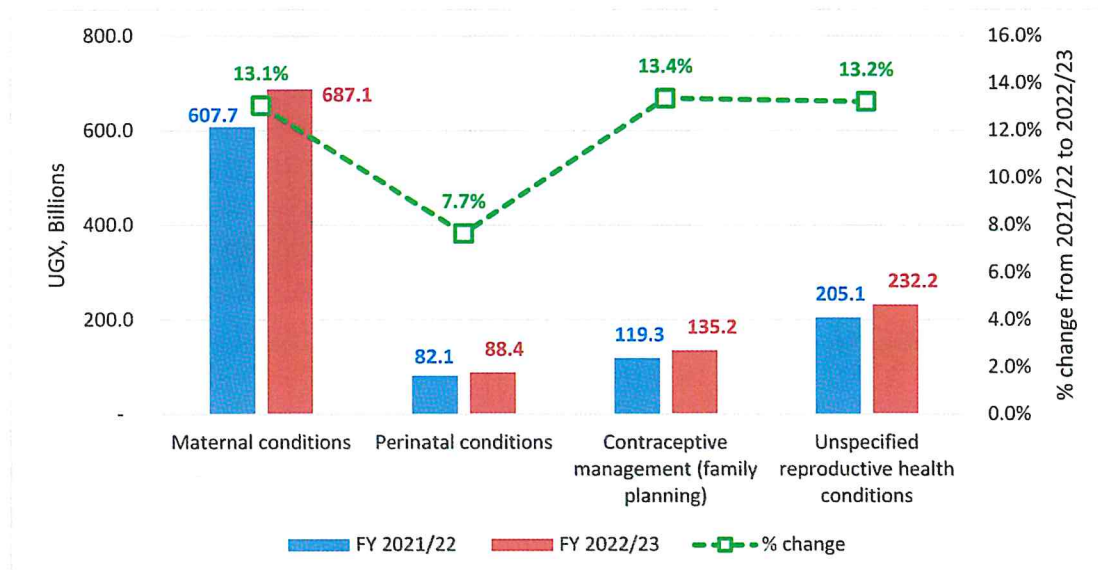


The findings suggest that while Uganda is increasing its investment in reproductive health, the growth is not consistently outpacing the overall increase in total health expenditure. The drop in RHE as a percentage of CHE in 2021/22 could indicate a period of resource reallocation, perhaps in response to other public health priorities like COVID-19.

The subsequent rebound in 2022/23 demonstrates renewed prioritization of reproductive health, but the overall trend highlights the sector's financial vulnerability. This reliance on a fluctuating share of total health spending means that progress toward key RMNCAH targets, such as reducing maternal and neonatal mortality, may be susceptible to shifts in national health budgeting.

Figure 15 presents a breakdown of Uganda's RH expenditure across four major components: maternal conditions, perinatal conditions, contraceptive management, and unspecified RH conditions. The data reflects both absolute growth and proportional shifts in spending priorities over the two fiscal years.

Figure 15. Expenditure on reproductive health components in Uganda, 2020-2023



Maternal conditions remained the largest expenditure category, increasing from UGX 607.73 billion in FY 2021/22 to UGX 687.14 billion in FY 2022/23—an approximate 13.1% rise. This growth likely reflects expanded coverage of antenatal, delivery, and postnatal services, as well as increased investment in maternal health infrastructure and personnel. Perinatal conditions saw a more modest increase of 7.7%, rising from UGX 82.15 billion to UGX 88.44 billion. While still a relatively small share of total RH spending, this uptick may indicate improved neonatal care and targeted interventions for newborn survival. Contraceptive management (family planning) experienced a significant increase of 13.4%, from UGX 119.27 billion to UGX 135.21 billion. This suggests growing emphasis on fertility regulation and access to modern contraceptive methods, in line with Uganda’s commitments to universal access and demographic transition goals. Unspecified RH conditions rose by 13.2%, from UGX 205.06 billion to UGX 232.18 billion. This category likely includes cross-cutting RH services, administrative costs, and interventions not explicitly classified under the other components.

Non-Communicable Diseases Sub-analysis

Non-Communicable Diseases Health Expenditure (NCDE) grew from UGX 1,489 billion to UGX 2,167 billion over the period FY 2019/20 to FY 2022/23, marking a 45.5% increase. (See table 10). This outpaced the growth in CHE, signalling a rising prioritization of NCDs. The share of NCDE within CHE fluctuated, dipping to 15.5% in

FY 2020/21 before rebounding to 23.9% in FY 2022/23. This suggests a temporary contraction, possibly due to COVID-19 disruptions, followed by renewed investment in chronic disease management.

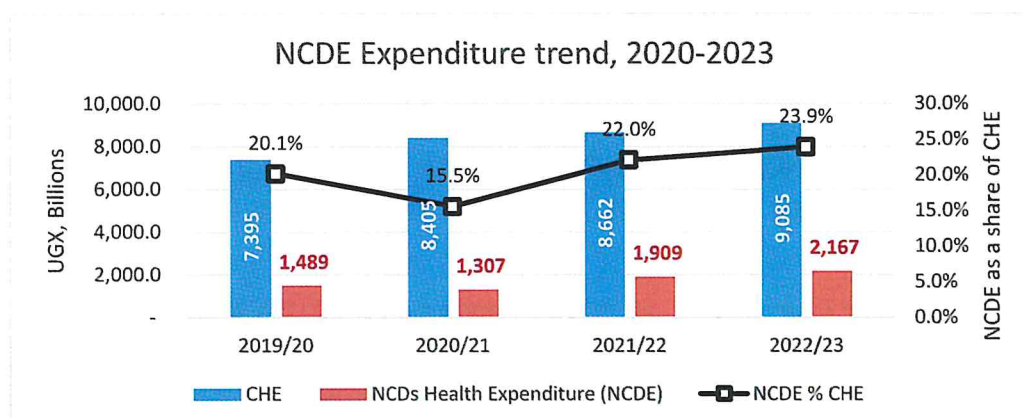
Per capita NCDE spending increased from UGX 36,928 (USD 9.9) in FY 2019/20 to UGX 47,558 (USD 12.7) in FY 2022/23. This reflects both inflationary effects and real growth in service utilization. The population grew from 40.31 million to 45.56 million, reinforcing the need for scalable NCD interventions. The data underscores a growing fiscal commitment to NCDs but also highlights the need for efficiency gains and strategic targeting, especially as per capita spending remains modest by global standards.

Table 10. Trends of expenditure on NCDE in Uganda, FY 2019/20-2022/23

VARIABLES	UNITS	2019/20	2020/21	2021/22	2022/23
CHE	<i>UGX, Billion</i>	7,395	8,405	8,662	9,085
NCDs Health Expenditure (NCDE)	<i>UGX, Billion</i>	1,489	1,307	1,909	2,167
NCDE % CHE	<i>Percentage</i>	20.1%	15.5%	22.0%	23.9%
Population	<i>Million</i>	40.31	41.58	43.70	45.56
USD Exch. Rate		3,715.1	3,661.1	3,571.6	3,754.1
NCDE per capita	<i>UGX</i>	36,928.3	31,419.5	43,679.4	47,558.0
NCDE per capita	<i>USD</i>	9.9	8.6	12.2	12.7

The National Health Accounts further reveal that CHE showed a consistent upward slope, rising from UGX 7,395 billion in FY 2019/20 to UGX 9,085 billion in FY 2022/23. This reflects macro-level health system expansion. (See figure 16).

Figure 16. Trends in expenditure on NCD health in Uganda



NCDE, while more volatile, demonstrates a sharper incline, from UGX 1,489 billion to UGX 2,167 billion. The dip in FY 2020/21 (UGX 1,307 billion) likely corresponds to pandemic-related service disruptions and reallocation of resources. The percentage of CHE allocated to NCDE dropped from 20.1% in FY 2019/20 to 15.5% in FY 2020/21, before climbing to 23.9% in FY 2022/23. This rebound suggests a policy shift toward rebalancing health priorities post-COVID. The visual contrast between CHE and NCDE lines highlights the relative acceleration of NCD spending in recent years, though the gap remains substantial.

Table 11 presents the government's recurrent health expenditure (RHE) on specific NCD components, comparing both the absolute amounts and proportional shares across two fiscal years.

Table 11. Expenditure on NCD components in Uganda, 2021-2023

	FY 2021/22		FY 2022/23	
	Amount (Billion, UGX)	Share (%)	Amount (Billion, UGX)	Share (%)
Neoplasms	207.4	10.9%	224.2	10.3%
Endocrine and metabolic disorders	168.2	8.8%	224.1	10.3%
Cardiovascular diseases	248.6	13.0%	317.1	14.6%
Mental & behavioural disorders, and Neurological conditions	282.9	14.8%	325.4	15.0%
Respiratory diseases	227.1	11.9%	216.2	10.0%
Diseases of the digestive	198.5	10.4%	231.7	10.7%
Diseases of the genito-urinary system	155.6	8.2%	169.3	7.8%
Sense organ disorders	153.8	8.1%	166.0	7.7%
Oral diseases	123.2	6.5%	92.4	4.3%
Other and unspecified noncommunicable diseases	143.5	7.5%	200.3	9.2%
NCDE	1,908.8	100.0%	2,166.8	100.0%

Mental & Behavioural Disorders, and Neurological Conditions: This category received the highest allocation in both years—UGX 282.9 billion (14.8%) in FY 2021/22 and UGX 325.4 billion (15.0%) in FY 2022/23. The consistent prioritization reflects growing awareness of mental health and neurological conditions, though the share increase is modest. It suggests a steady but cautious expansion of services, possibly concentrated in urban and tertiary settings.

Cardiovascular Diseases: Spending rose from UGX 248.6 billion (13.0%) to UGX 317.1 billion (14.6%), marking one of the most significant increases. This aligns with the rising burden of hypertension, stroke, and heart disease in Uganda, and may reflect expanded access to diagnostics and chronic care medications.

Endocrine and Metabolic Disorders: Expenditure jumped from UGX 168.2 billion (8.8%) to UGX 224.1 billion (10.3%), indicating increased investment in diabetes and related conditions. The rise suggests improved integration of these services into primary care and possibly better commodity availability.

Neoplasms (Cancers): Although the absolute amount increased from UGX 207.4 billion to UGX 224.2 billion, the share declined slightly from 10.9% to 10.3%. This may reflect slower growth in cancer programming relative to other NCDs, despite its high treatment costs and mortality rates.

Diseases of the Digestive System: Spending rose from UGX 198.5 billion (10.4%) to UGX 231.7 billion (10.7%), suggesting moderate expansion of services, possibly linked to gastrointestinal diagnostics and treatment. **Respiratory Diseases:** Interestingly, this category saw a decline in both amount and share, from UGX 227.1 billion (11.9%) to UGX 216.2 billion (10.0%). This could indicate reduced prioritization or improved control measures, though it warrants closer scrutiny.

Oral Diseases: Funding dropped sharply from UGX 123.2 billion (6.5%) to UGX 92.4 billion (4.3%), suggesting de-prioritization of dental and oral health services. This may reflect limited integration into broader NCD programming. **Other and Unspecified NCDs:** This category rose significantly from UGX 143.5 billion (7.5%) to UGX 200.3 billion (9.2%), possibly due to improved classification or increased cross-cutting programmatic costs.

HIV/AIDS Sub-Analysis

HIV/AIDS expenditure (HIVHE) dropped from UGX 1,917 billion to UGX 1,256 billion over the same period—a 34.5% reduction. This is illustrated in Table 12 below.

Table 12. Trends of expenditure on HIV/AIDS in Uganda, FYS 2019/20-2022/23

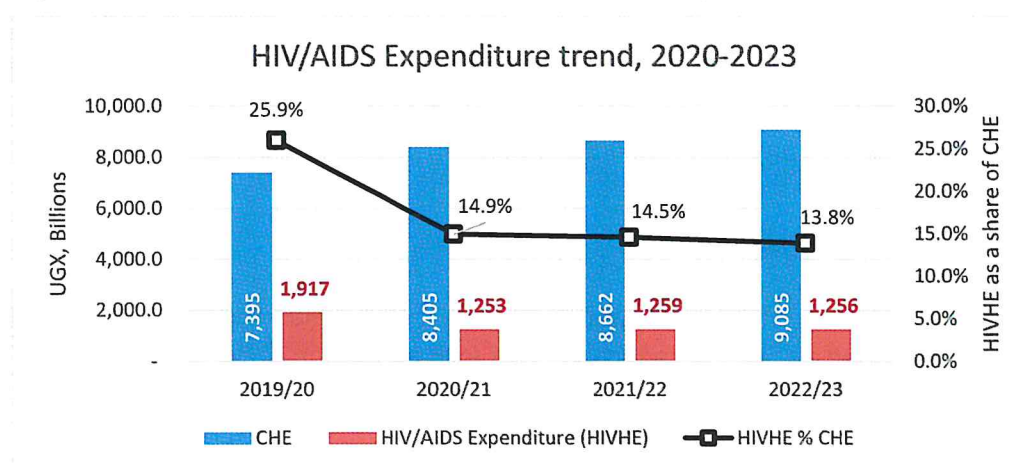
VARIABLES	UNITS	2019/20	2020/21	2021/22	2022/23
CHE	UGX, Billion	7,395	8,405	8,662	9,085
HIV/AIDS Expenditure (HIVHE)	UGX, Billion	1,917	1,253	1,259	1,256
HIVHE % CHE	Percentage	25.9%	14.9%	14.5%	13.8%
Population	Million	40.31	41.58	43.70	45.56
USD Exch. Rate		3,715.1	3,661.1	3,571.6	3,754.1
HIVHE per capita	UGX	47,548.4	30,140.5	28,810.2	27,565.8
HIVHE per capita	USD	12.8	8.2	8.1	7.3

HIVHE as a share of CHE fell sharply from 25.9% to 13.8%, nearly halving in four years. The data reveals a declining trend in the proportion of HIV/AIDS expenditure relative to CHE. This downward trajectory is further illustrated by figure 17 below. While CHE shows a consistent upward slope year-on-year, HIV/AIDS expenditure plateaus and slightly declines after 2020/21. The divergence between the two curves illustrates a relative deprioritization of HIV/AIDS funding within the broader health budget.

Despite population growth from 40.31 million to 45.56 million, per capita HIVHE declined by 42% in UGX and 43% in USD. This suggests that the reduction in HIV/AIDS funding was not offset by population scaling, potentially impacting service coverage or intensity.

The drop from 25.9% to 13.8% of CHE may reflect shifting health priorities, donor transitions, or efficiency gains. This also raises questions about sustainability and equity in HIV response financing.

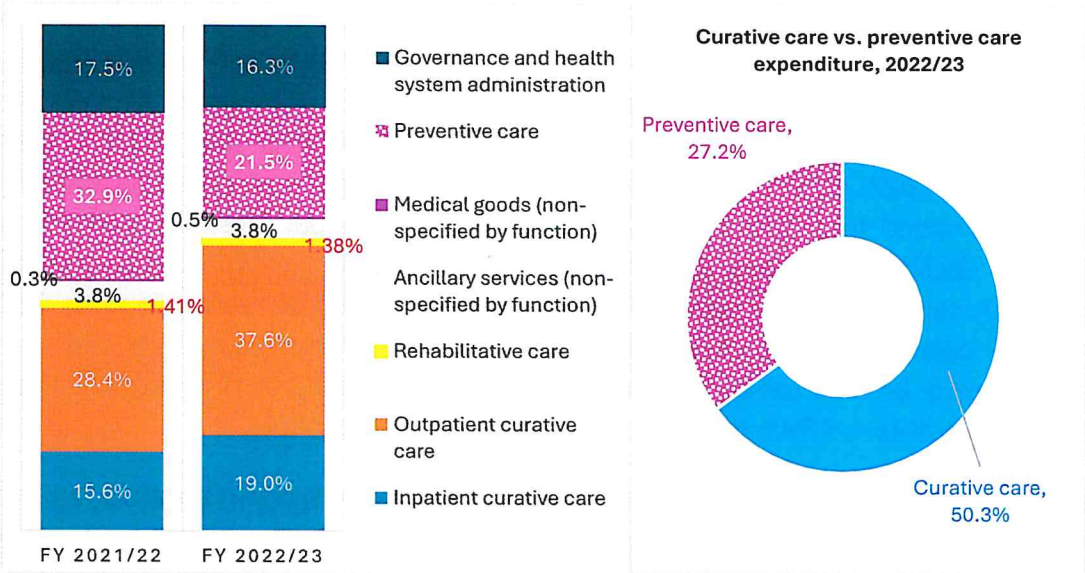
Figure 17. Trends in expenditure on HIV/AIDS in Uganda



Outpatient curative care saw the most significant increase, rising from 28.4% to 37.6% of total HIV-related health expenditure, indicating a strategic push toward accessible, community-level treatment. Inpatient curative care also grew from 15.6% to 18.9% suggesting increased demand for facility-based interventions, possibly due to more advanced cases or improved hospitalization capacity.

Expenditure on HIV healthcare services across FY 2021/22 and FY 2022/23 was structured as illustrated in Figure 18 below.

Figure 18. HIV/AIDS Services provided in Uganda, 2020-2023



Preventive care, however, experienced a marked decline, dropping from 32.9% to 21.5%, which may reflect a reallocation of resources toward treatment or a plateau in prevention programming. Governance and health system administration expenditures slightly decreased from 17.5% to 16.3%, hinting at modest efficiency gains or reduced overhead costs. Ancillary services and rehabilitative care remained relatively stable, with only minor fluctuations, suggesting consistent support functions without major expansion.

Medical goods (non-specified by function) saw a small uptick, from 0.31% to 0.48%, possibly due to increased procurement of HIV-related commodities. When comparing curative versus preventive care in FY 2022/23, curative services accounted for over half of the expenditure (50.3%), while preventive care dropped to 27.2%, underscoring a clear prioritization of treatment over prevention. This evolving allocation pattern reflects Uganda’s shifting HIV response strategy—balancing immediate clinical needs with long-term public health goals. The data invites further

exploration into whether this trend aligns with epidemiological outcomes and national targets.

Malaria Sub-Analysis

Malaria-specific health expenditure (MALHE) peaked in 2020/21 at UGX 2,286 billion, then declined slightly in subsequent years. (See table 1 below). The proportion of CHE allocated to malaria rose sharply in 2020/21 to 27.2%, before tapering to 22.8% by 2022/23. Population growth was consistent, rising from 40.31 million to 45.56 million, which influenced per capita metrics. MALHE per capita in UGX terms mirrored the overall expenditure trend, peaking in 2020/21 at UGX 54,969.8 and falling to UGX 45,526.4 by 2022/23. When adjusted for exchange rates, per capita malaria spending in USD dropped from \$15.0 to \$12.1 over the same period. The data suggests a relative decline in malaria prioritization despite overall health budget growth. Exchange rate fluctuations also impacted the USD valuation of health spending. The table 13 below provides a clear snapshot of fiscal commitment to malaria control in the context of broader health financing. It highlights a need to assess whether reduced malaria allocations reflect improved outcomes or shifting priorities.

Table 13. Trends of expenditure on Malaria in Uganda, FYS 2019/20-2022/23

VARIABLES	UNITS	2019/20	2020/21	2021/22	2022/23
CHE	UGX, Billion	7,395	8,405	8,662	9,085
Malaria Health Expenditure (MALHE)	UGX, Billion	1,466	2,286	2,208	2,074
MALHE % CHE	Percentage	19.8%	27.2%	25.5%	22.8%
Population	Million	40.31	41.58	43.70	45.56
USD Exch. Rate		3,715.1	3,661.1	3,571.6	3,754.1
MALHE per capita	UGX	36,376.2	54,969.8	50,519.1	45,526.4
MALHE per capita	USD	9.8	15.0	14.1	12.1

The consistent population growth underscores the importance of maintaining or increasing per capita investments. The declining MALHE % CHE may warrant policy review, especially if malaria burden remains high. Overall, the table is a useful tool for tracking fiscal trends and guiding strategic health planning.

Figure 19. Trends in expenditure on Malaria in Uganda

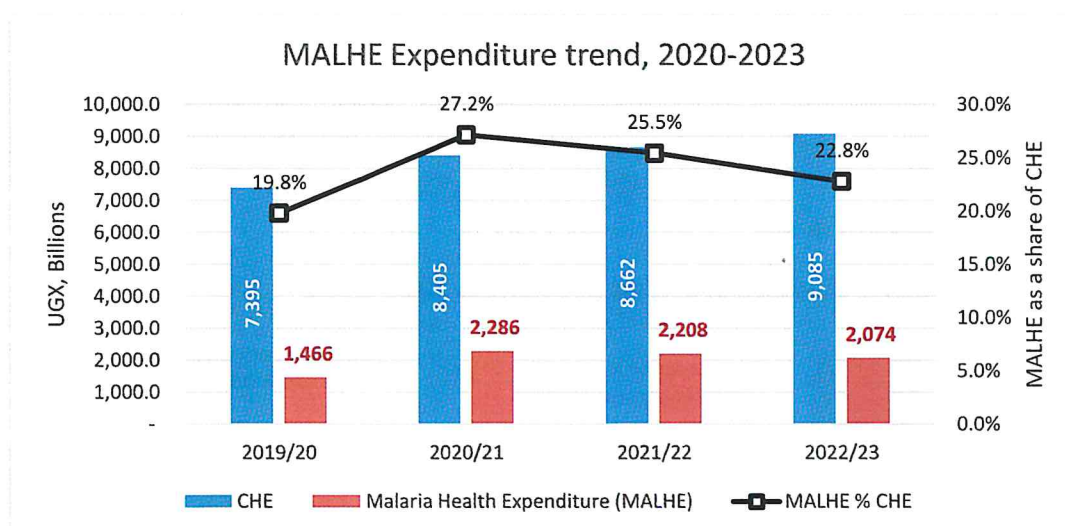
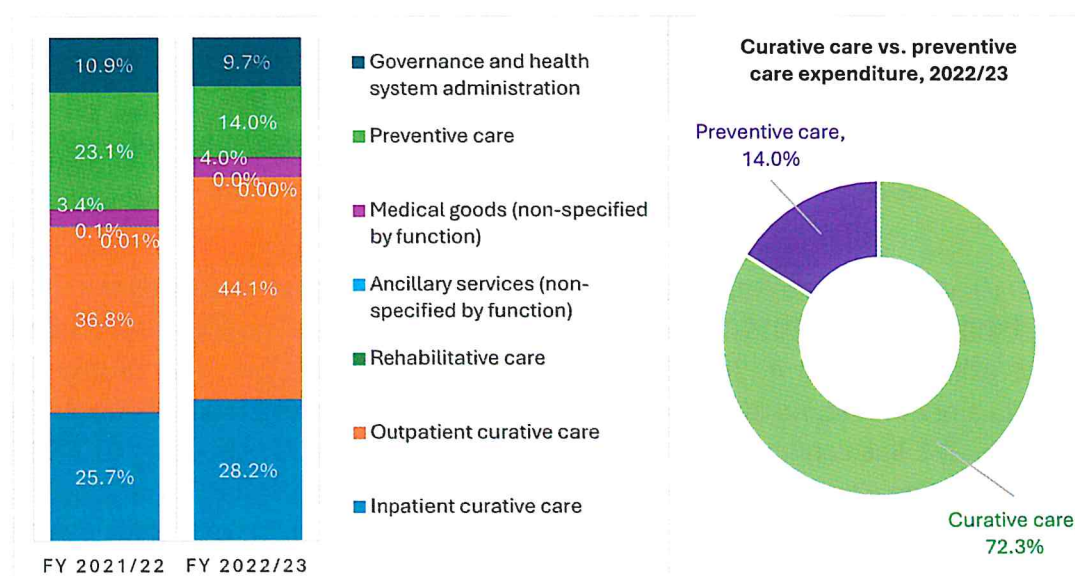


Figure 19 visually illustrates the trajectory of malaria-related health expenditure against total CHE from 2019/20 to 2022/23. While CHE shows a steady upward trend, MALHE exhibits a peak in 2020/21 followed by a gradual decline. This divergence suggests a relative deprioritization of malaria within the expanding health budget. The MALHE % CHE line confirms this, with a high of 27.2% in 2020/21 dropping to 22.8% by 2022/23. The visual contrast between rising CHE and falling MALHE is striking and policy-relevant. It implies that although Uganda is spending more on health overall, malaria is receiving a shrinking share. The figure effectively communicates this shift, making it easier to grasp than raw numbers alone. The declining MALHE trend may reflect reduced malaria incidence, donor transitions, or reallocation to other health priorities. However, without outcome data, the rationale remains speculative. The figure is a compelling prompt for further investigation into malaria program performance. It also raises questions about sustainability and equity in health financing. The visual format supports quick interpretation for stakeholders and policymakers. Overall, the figure complements the table by emphasizing proportional changes and temporal dynamics.

Figure 20 below categorizes malaria services by function, highlighting a dominant shift toward curative care. Outpatient curative services rose from 36.8% to 44.1%, while inpatient curative care increased from 25.7% to 28.2%. Preventive care dropped significantly from 23.1% to 14.0%, mirroring trends seen in provider distribution. Ancillary and rehabilitative services remained minimal, with rehabilitative care disappearing entirely in FY 2022/23. Governance and administration expenditures slightly declined, suggesting stable overhead costs. Medical goods maintained a consistent share, supporting both curative and preventive efforts. The overall curative

care share reached 72.3% in FY 2022/23, dwarfing preventive care at just 14.0%. This imbalance may reflect reactive spending patterns rather than proactive disease control. The data underscores the need to rebalance investments toward prevention to sustain long-term gains.

Figure 20. Malaria Services provided in Uganda, 2020-2023



Tuberculosis and Leprosy Sub-analysis

Uganda's tuberculosis health expenditure (TBHE) shows a gradual decline in both absolute and relative terms. TBHE dropped from UGX 168 billion in 2019/20 to UGX 145 billion in 2022/23, despite rising overall health expenditure (CHE). As a percentage of CHE, TBHE fell from 2.3% to 1.6%, indicating reduced prioritization. Per capita TBHE in UGX terms declined from UGX 4,179.6 to UGX 3,173.8, while the USD equivalent dropped from \$1.1 to \$0.8. See table 14 below.

Table 14. Trends of expenditure on TB in Uganda, FYS 2019/20-2022/23

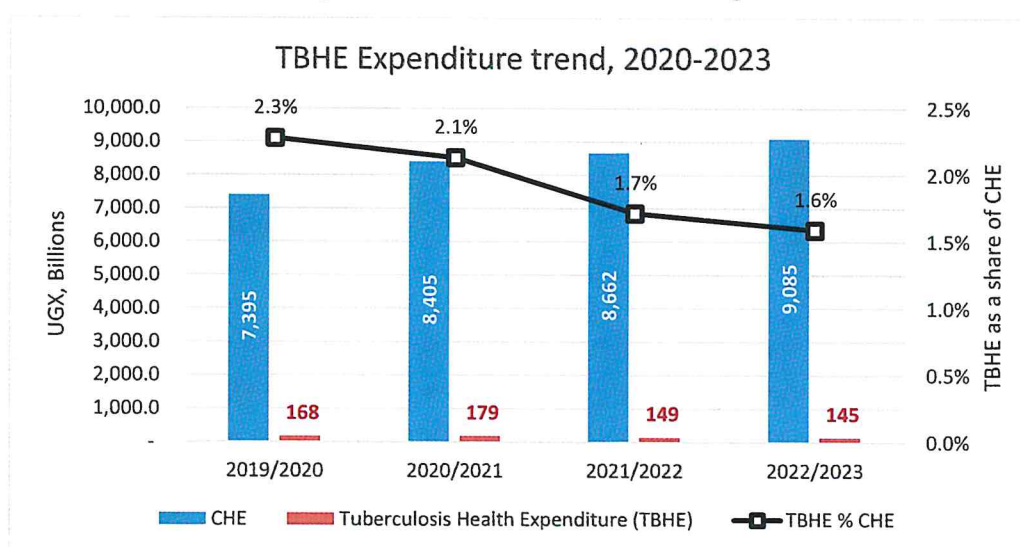
VARIABLES	UNITS	2019/20	2020/21	2021/22	2022/23
CHE	UGX, Billion	7,395	8,405	8,662	9,085
Tuberculosis Health Expenditure (TBHE)	UGX, Billion	168	179	149	145
TBHE % CHE	Percentage	2.3%	2.1%	1.7%	1.6%
Population	Million	40.31	41.58	43.70	45.56
USD Exch. Rate		3,715.1	3,661.1	3,571.6	3,754.1
TBHE per capita	UGX	4,179.6	4,310.7	3,402.0	3,173.8

TBHE per capita	USD	1.1	1.2	1.0	0.8
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This downward trend may reflect shifting health priorities or perceived reductions in TB burden. However, it raises concerns about underinvestment in TB control amid persistent transmission risks. Population growth further diluted per capita spending, underscoring the need for scaled investment. The table highlights a potential gap between disease burden and resource allocation.

This declining trajectory of tuberculosis health expenditure relative to Uganda's growing CHE is further illustrated by figure 21 below.

Figure 21. Trends in expenditure on Tuberculosis in Uganda

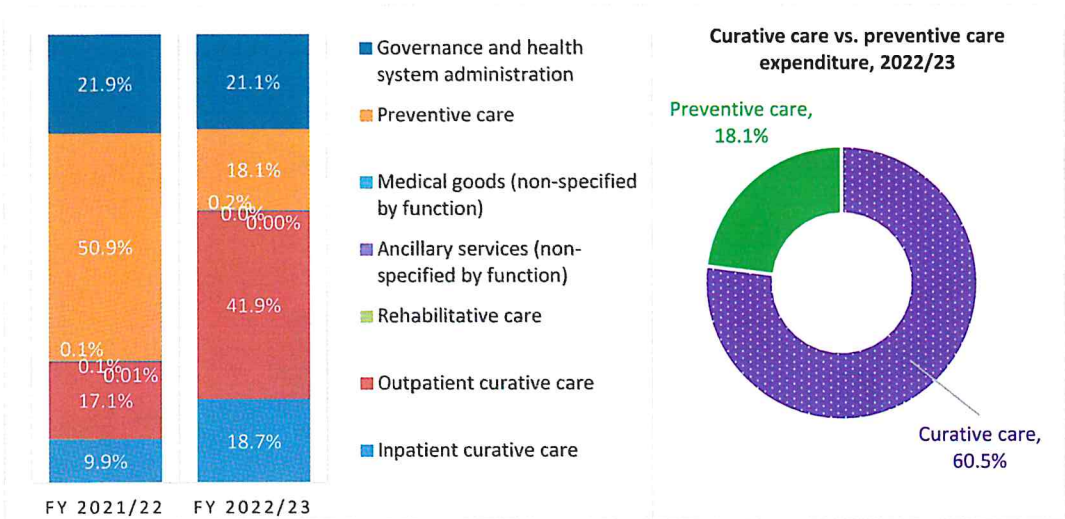


While CHE steadily increased from UGX 7,395 billion to UGX 9,085 billion, TBHE fell from UGX 168 billion to UGX 145 billion. The TBHE % CHE line shows a consistent drop, reinforcing the narrative of reduced fiscal attention to TB. This divergence suggests tuberculosis is receiving a shrinking share of the health budget. The figure effectively communicates this imbalance, making the trend immediately apparent. It prompts questions about whether reduced TBHE reflects improved outcomes or budgetary reallocation. The visual contrast between rising CHE and falling TBHE is policy-relevant. It may signal a need to reassess TB program funding in light of ongoing public health risks. Overall, the figure complements the table by emphasizing proportional shifts and funding dynamics.

The composition of TB services in Uganda shifted markedly between FY 2021/22 and FY 2022/23. Outpatient curative care surged from 17.1% to 41.9%, becoming the

dominant service modality. Inpatient curative care nearly doubled, rising from 9.9% to 18.7%, reinforcing the trend toward treatment-focused interventions.

Figure 22. Tuberculosis services provided in Uganda, 2020-2023



Preventive care, once the largest category at 50.9%, fell to just 18.1%, echoing the decline seen in provider roles. Governance and system administration remained steady at around 21%, indicating consistent overhead investment. Ancillary and rehabilitative services were minimal, with rehabilitative care disappearing entirely. Medical goods provision increased slightly, though still marginal. The overall expenditure pattern reveals a strong shift toward curative care, which now accounts for over 60% of TB-related spending. This reallocation may reflect rising caseloads, diagnostic improvements, or changing donor strategies. However, the decline in preventive services raises concerns about long-term TB control and sustainability.

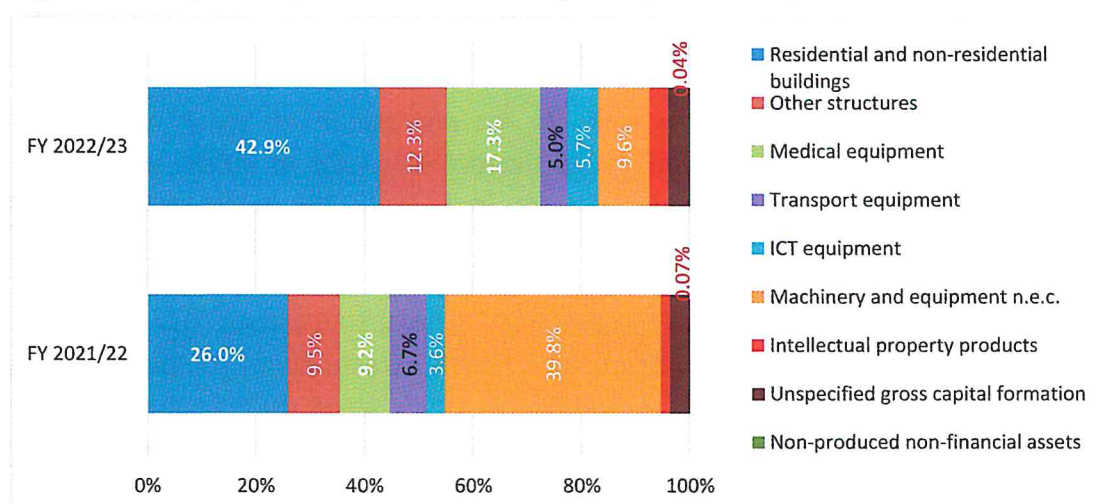
3.4 Capital Expenditures on Health

3.4.1 Which capital items were spent on?

HK is an important health expenditure component due to its contribution in the production of health services. Examples of capital expenditure include construction of new health facilities or expansion/upgrading of existing ones and investment into new medical equipment or Information Communication and Technology (ICT) equipment. Figure 14 below presents the distribution of capital expenditure across key asset categories in the health sector for 2021/22 and 2022/23. The data reveals a notable shift in investment priorities between the two years.

In 2022/23, Uganda's capital expenditure for health was significantly dominated by residential and non-residential buildings, which constituted 42.9% of HK. This represents a substantial increase from the 26.0% allocated in 2021/22, a trend that likely reflects a renewed sector focus on developing healthcare infrastructure, including the construction and rehabilitation of new facilities. Concurrently, there was a shift in the procurement of general-purpose assets. Spending on machinery and equipment experienced a sharp decline, plummeting from 39.8% in 2021/22 to just 9.6% in 2022/23, suggesting either a temporary contraction in purchasing or the conclusion of major investment projects from the previous fiscal year.

Figure 23: Capital expenditure for health, 2021/22 - 2022/23



Despite the overall reduction in general equipment procurement, targeted investments in key areas saw notable increases. Expenditure on medical equipment nearly doubled, rising from 9.2% to 17.3%, indicating a heightened priority on acquiring advanced diagnostic and treatment technologies to enhance service delivery. Similarly, investments in other structures, such as water and sanitation systems, grew from 9.5% to 12.3%, reflecting continued efforts to build and improve supportive infrastructure. Furthermore, a modest but steady increase was observed in spending on ICT equipment, which rose from 3.6% to 5.7%, suggesting ongoing investment in digital health systems and connectivity to modernize the sector.

The allocation for transport equipment saw a slight decrease from 6.7% to 5.0%, which could be attributed to reduced needs for fleet expansion or lower maintenance costs. A notable growth area was intellectual property products, which more than doubled from 1.4% to 3.2%, a change that may indicate increased investment in crucial software, licenses, and health information systems. Other categories remained

relatively stable, with unspecified gross capital formation at 4.0% and non-produced non-financial assets remaining a negligible component of the total capital expenditure.

This evolving expenditure profile highlights a strategic pivot toward infrastructure and specialized medical equipment, while general machinery and transport saw reduced allocations. The data suggests a deliberate effort to strengthen facility readiness and technological capacity, potentially in response to post-pandemic recovery needs and long-term service delivery goals.

3.4.2 Who financed these capital items?

Findings in table Table 9 below presents the distribution of health care capital formation by funding source, highlighting the evolving roles of public, private, and donor contributions over the two fiscal years. In 2021/22, the public sector was the dominant contributor, accounting for 74.7% of total capital formation (UGX 469.2 billion). Health Development Partners (HDPs) provided 23.8% (UGX 149.3 billion), while the private sector contributed a modest 1.6% (UGX 10.0 billion). This distribution reflects strong government-led investment in health infrastructure, complemented by substantial donor support. By 2022/23, the funding landscape shifted markedly. HDPs emerged as the leading source, contributing 49.4% of total capital formation (UGX 204.5 billion), slightly surpassing the public sector, which accounted for 48.2% (UGX 199.5 billion). The private sector maintained a small but stable share at 2.4% (UGX 10.0 billion).

Table 15: Health care capital formation by source of funds, 2021/22–2022/23

Financial Year	PUBLIC		PRIVATE		HDPs		TOTAL	
	Amount (UGX, Millions)	Share (%)	Amount (UGX, Millions)	Share (%)	Amount (UGX, Millions)	Share (%)	Amount (UGX, Millions)	Share (%)
FY 2021/22	469,236	74.7%	10,003.1	1.6%	149,293	23.8%	628,532	100%
FY 2022/23	199,522	48.2%	10,003.5	2.4%	204,453	49.4%	413,979	100%

This shift underscores the increasing reliance on donor financing for capital investments in the health sector, particularly in the context of fiscal constraints and competing public priorities. While government contributions remain substantial, the growing share of HDP funding highlights the importance of sustained external partnerships in achieving infrastructure and service delivery goals. The consistently low private sector contribution suggests limited formal investment in health capital formation, pointing to a need for improved data capture and targeted research, particularly through costing studies, to better understand private sector dynamics and inform strategic planning.

4 CHALLENGES, POLICY IMPLICATIONS, CONCLUSION, AND RECOMMENDATIONS

4.1 Challenges Encountered

NHA in Uganda is on an improving trend, and this ninth round was a success considering most of the intended institutions were available for interviews, even when some could not provide data to the level of detail required by the team. Mainly, the challenges for this round included the following:

- Management of some private institutions was reluctant to share their financial data to the level of detail required for NHA.
- Financial resources for tracking activities were not adequate, which made it difficult to cover each and every part of the country.
- The integrated nature of service delivery in Uganda makes some analyses more tedious; hence, the NHA require more time compile.
- Different accounting periods, methods, and reporting in different organizations make consolidation more tedious.
- While government data are easily available from the Integrated Financial Management System, there is no reporting format for HDPs, NGOs, and private institutions with the level of detail required for the purposes of NHA.

4.2 Key Policy Implications and Recommendations

The NHA report for FY 2021/22 and FY 2022/23 provides a comprehensive overview of health sector expenditure patterns in Uganda and lays a foundation upon which policymakers can design strategies to improve the sector. This section, therefore, provides key insights for health care management and policymakers.

I: Strengthen Domestic Health Financing to Reduce Fiscal Vulnerability

Implication: Uganda's General Government Health Expenditure from domestic sources (GGHE-D) remains among the lowest in the region, USD 13.2 per capita in FY 2022/23, far below Kenya (USD 42.3), Rwanda (USD 27.4), and Zambia (USD 36.3). This underinvestment places disproportionate pressure on households and donors, risking sustainability and equity.

Recommendation:

- Commit to progressive increases in GGHE-D toward the Abuja target of 15% of the national budget.
- Prioritize ring-fenced allocations for Primary Health Care (PHC), essential medicines, and preventive services.
- Institutionalize medium-term expenditure frameworks that align health sector priorities with fiscal planning.

II: Expand Financial Risk Protection Through National Health Insurance

Implication: Out-of-pocket (OOP) payments accounted for 30.3% of pooled health expenditure in FY 2022/23, with households contributing 93.7% of private sector health financing. This exposes millions to catastrophic health spending, particularly for pharmaceuticals and curative care.

Recommendation:

- Accelerate implementation of the National Health Insurance Scheme (NHIS), with subsidies for vulnerable populations.
- Integrate community-based health insurance models, drawing lessons from Rwanda's CBHI success.
- Establish a phased rollout strategy with clear benefit packages and interoperable digital platforms.

III: Rebalance Resource Allocation Toward Preventive and PHC Services

Implication: Curative care absorbed 65.3% of Current Health Expenditure (CHE) in FY 2022/23, while preventive care declined to 18.6%. PHC interventions received less than half of total CHE, despite their cost-effectiveness and alignment with Universal Health Coverage (UHC) goals.

Recommendation:

- Introduce a PHC earmark within the national health budget and donor frameworks.
- Develop performance-based financing models that reward preventive and promotive service delivery.
- Mobilize private sector and HDPs to co-invest in community health, immunization, and NCD prevention.

IV: Improve Efficiency and Absorption of Health Sector Funds

Implication: Despite nominal increases in health allocations, Uganda faces persistent challenges in budget absorption and execution. Capital expenditure

declined by 24.6% between FY 2021/22 and FY 2022/23, and machinery/equipment spending dropped sharply.

Recommendation:

- Strengthen Public Financial Management (PFM) systems, including timely releases and procurement reforms.
- Link budget execution to measurable health outcomes through output-based budgeting.
- Establish a health sector expenditure tracking dashboard to monitor disbursement, absorption, and impact.

V: Reduce Donor Dependency and Align Off-Budget Support

Implication: Health Development Partners (HDPs) contributed 49.4% of capital expenditure in FY 2022/23, surpassing government contributions. However, 45.4% of donor funds remain off-budget, complicating alignment and accountability.

Recommendation:

- Develop a donor coordination framework under a Sector-Wide Approach (SWAp), with joint planning and pooled funding.
- Introduce co-financing transition plans for vertical programs (e.g., HIV, malaria) as Uganda approaches middle-income status.
- Institutionalize annual donor mapping and alignment reviews led by the Ministry of Health.

VI: Unify Expenditure Tracking to Enhance Data Integrity and Efficiency

Implication: The current fragmented approach to expenditure tracking, with parallel surveys running alongside the NHA, creates significant systemic challenges. This results in data overlaps, a high reporting burden on stakeholders, and increased operational costs to maintain duplicative systems. Critically, these parallel exercises often produce conflicting data on similar indicators due to varying methodologies, creating uncertainty for decision-makers and undermining evidence-based resource allocation.

Recommendation:

- Establish the NHA as the single, institutional source for all retrospective health expenditure under the national RMET Harmonization Roadmap, and mandate the phasing out of all duplicative, program-specific expenditure surveys.

- Prioritize investment in the progressive digitization of the NHA data collection process to reduce turnaround time, ease respondent burden, and ensure a single, cost-effective system for generating trusted health financial data for all stakeholders.

Conclusion

Uganda's health financing system demonstrates resilience in achieving outcomes with limited resources, but faces structural vulnerabilities. The seven policy shifts outlined above, grounded in NHA evidence and regional best practices, offer a roadmap to strengthen financial protection, improve equity, and accelerate progress toward UHC and the Sustainable Development Goals.

ANNEX

Annex 1: National Health Accounts Technical Team

	Name	Title	Professional Background	Role
1	Dr. Sarah Byakika	Commissioner Health Services - PFP	Medicine/Health Management	Chair
2	Mr. Chris Mugarura	Assistant Commissioner Health Services – SP&P	Economics/Planning	Member
3	Mr. Richard Kabagambe	Assistant Commissioner – B&F	Economics	Member
4	Mr. Paul Mbaka	Assistant Commissioner Health Services - HID	Statistics	Member
5	Ms. Susan Najjuko	Principal Economist	Economics	Secretariat
6	Dr. Sam B. Kamba	Senior Health Planner	Medicine/Management	Secretariat
7	Mr. Sylvester Mubiru	Senior Economist	Economics	Member
8	Dr. Dan Murokora	Senior Consultant	Gynaecology/Obstetrics	Member
9	Dr. Elizabeth Namagala	Consultant	Paediatrics	Secretariat
10	Dr. Andrew Kimera	Medical Officer Special Grade	Paediatrics	Member
11	Ms. Daphine Kanshabe	Economist	Accounts	Member
12	Mr. Ezra Rwakinanga	Economist	Health Economist	Member
13	Mr. Isaac Mubanza	Economist	Economics	Member
14	Mr. Hilary Arinaitwe	Economist	Economics	Member
15	Ms. Harriet Basirika	Economist	Economics	Member
16	Mr. Fahad Mawanda	Senior Health Planner	Demography	Member
17	Mr. Aliyi Walimbwa	Principal Health Planner	Administration/ Economics	Member
18	Dr. Peter Wambi	Senior Health Planner	Medicine/Management	Member
19	Dr. John Lukwago	Consultant	Public Health	Member
20	Mr. Musooka Derrick	M&E Officer	Statistics	Secretariat
21	Ms. Shamirah Nakyanzi	BCC	Administration	Secretariat
22	Mr. Ronald Kimuli	M&E Officer	Statistics	Secretariat
23	Dr. Darmian Rutazana	M&E Officer	Public Health	Secretariat
24	Mr. Bruno Serumaga	M&E Officer	Statistics	Secretariat
25	Mr. Rogers Gusoomba	M&E Officer	Statistics	Secretariat
26	Mr. Jimmy Ogwal	Sen. Biostatistician	Statistics	Member
27	Mr. Martin Lukwago	Senior M&E Officer	Statistics	Secretariat
28	Mr. Emmanuel Oluka	Biostatistician	Statistics	Member
29	Ms. Christabel Abewe	Programme Officer WHO	Health Economics	Member
30	Ms. Grace Ssali	ED Uganda Health Care Federation	Management	Member

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Annex 3: Sample of Questionnaires for NGO and Private Employers

DONOR QUESTIONNAIRE SAMPLE



Microsoft Excel
97-2003 Worksheet

NGO QUESTIONNAIRE SAMPLE



Microsoft Excel
97-2003 Worksheet

PRIVATE EMPLOYER QUESTIONNAIRE SAMPLE



Microsoft Excel
97-2003 Worksheet

INSURANCE QUESTIONNAIRE SAMPLE



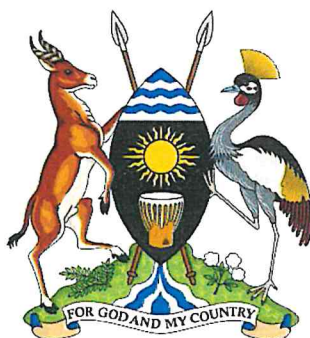
Microsoft Excel
97-2003 Worksheet

Annex 4: List of Primary Data Sources

S/N	NAME OF INSTITUTION	TYPE OF QUESTIONAIRE	S/N	NAME OF INSTITUTION	TYPE OF QUESTIONAIRE
1	BUJUBULI HC II	PROVIDER	31	BUTEZA HC III	PROVIDER
2	ST.THEREZA WEKOMIRE HC III	PROVIDER	32	MBALE CITY	PROVIDER
3	KYELEGWA DISTRICT LOCAL GOVERNMENT	LOCAL GOVERNMENT	33	MBALE DISTRICT LOCAL GOVERNMENT	PROVIDER
4	ACCESS PHARMACY	PROVIDER	34	NABUMALI TOWN COUNCIL	PROVIDER
5	ACCESS CLINIC	PROVIDER	35	BUSIU SUBCOUNTY	PROVIDER
6	KASULE SUBCOUNTY LOCAL GOVERNMENT	LOCAL GOVERNMENT	36	MBALE REGIONAL REFERRAL HOSPITAL	PROVIDER
7	KYELEGWA GENERAL HOSPITAL	PROVIDER	37	CURE CHILDREN'S HOSPITAL OF UGANDA	PROVIDER
8	BENSON KYAKA DRUG SHOP	PROVIDER	38	KOLONYI HC IV MBALE	PROVIDER
9	KAKABARA TOWN COUNCIL	LOCAL GOVERNMENT	39	ST AUSTIN HC III MBALE	PROVIDER
10	MIGONGWE HC II	PROVIDER	40	MAYO CLINIC SIRONKO	PROVIDER
11	ST.THEREZA RWIBARE HC IV	PROVIDER	41	PARENT'S DRUG SHOP MBALE	PROVIDER
12	KYENJONJO DISTRICT LOCAL GOVERNMENT	LOCAL GOVERNMENT	42	MODERN CLINIC MBALE CITY	PROVIDER
13	KYARUSOZI HC IV	PROVIDER	43	BUDADIRI NGO HC II	PROVIDER
14	KYENJONJO GENERAL HOSPITAL	PROVIDER	44	ZAI DRUG SHOP SIRONKO	PROVIDER
15	LAIKA PHARMACY	PROVIDER	45	PACODEF	NGO
16	VILA MARIA KAIHURA HC II	PROVIDER	46	MARIE STOPES MBALE	NGO
17	DATWINS PRIMARY SCHOOL	EMPLOYER	47	MBALE SS B15B14:B17B13:B17	EMPLOYER
18	JEWA HC III	PROVIDER	48	KABERAMAIDO CATHOLIC MISSION HC III	PROVIDER
19	HENRICO PHARMACY	PROVIDER	49	MIDLAND HIGH SCHOOL	EMPLOYER
20	OUR LADY OF FATIMA AND ST. JUDE HC II	PROVIDER	50	KABERAMAIDO GENERAL HOSPITAL	PROVIDER
21	BUNYABA SUBCOUNTY	PROVIDER	51	ABIRABIRA HC II	PROVIDER
22	SKY PHARMACY	PROVIDER	52	HOSSANA DRUG SHOP	PROVIDER
23	BUDADIRI TOWN COUNCIL	PROVIDER	53	EMMANUEL MEDICAL SERVICES	PROVIDER
24	SIRONKO DISTRICT	PROVIDER	54	KABERAMAIDO PRIMARY SCHOOL	EMPLOYER
25	PROGRESSIVE SS SIRONKO	EMPLOYER	55	AILWA HC III	PROVIDER
26	SIRONKO HIGH SCHOOL	EMPLOYER	56	KABERAMAIDO SECONDARY SCHOOL	EMPLOYER
27	BUMBOBI PRIMARY SCHOOL	EMPLOYER	57	ASONE PRIMARY SCHOOL	EMPLOYER
28	BUDADIRI BOYS PRIMARY SCHOOL	EMPLOYER	58	KABERAMAIDO TECHNICAL INSTITUTE	EMPLOYER
29	ELGON JUNIOR SCHOOL	EMPLOYER	59	PRINCE OF PEACE ORPHANS AND WIDOWS	NGO
30	ST.THOMAS COMPREHENSIVE COLLEGE	EMPLOYER	60	TIRIRI HC IV	PROVIDER
61	KATINE MISSION HC II	PROVIDER	91	DODOI HC II	PROVIDER
62	SOROTI DISTRICT LOCAL GOVERNMENT	PROVIDER	92	KIBUKU DISTRICT	PROVIDER
63	GOOD NEWS DRUG SHOP	PROVIDER	93	PALLISA DISTRICT	PROVIDER
64	TESO COLLEGE ALOET	EMPLOYER	94	KWEEN DHO'S OFFICE	PROVIDER
65	ST KIZITO TECHNICAL INSTITUTE	EMPLOYER	95	CHEMINT CHRISTIAN DAY AND BOARDING	EMPLOYER
66	SOROTI DEMONSTRATION PRIMARY SCHC	EMPLOYER	96	KAPRONON HC IV	PROVIDER
67	MANDERA PHARMACY	PROVIDER	97	KAPTOYOY	PROVIDER
68	ARAPAI HC II	PROVIDER	98	CAO'S OFFICE	PROVIDER
69	VOCATIONAL TRAINING INSTITUTE	EMPLOYER	99	TRUST CARE DRUG SHOP	PROVIDER
70	SOROTI CITY	PROVIDER	100	TRUST CARE DRUG SHOP	PROVIDER
71	PALLISA TOWN COUNCIL	PROVIDER	101	BINYINY TOWN COUNCIL	PROVIDER
72	LIMOTO HC II	PROVIDER	102	KAPTERON HC II	PROVIDER
73	JOHNSON PHARMACY	PROVIDER	103	BIYINY HC III	PROVIDER
74	ADAGANI DRUG SHOP	PROVIDER	104	KWEEN HOME CARE	PROVIDER
75	KIBUKU HC IV	PROVIDER	105	NEBBI DISTRICT	PROVIDER
76	LIFE SPRINGS SCHOOL OF NURSING	EMPLOYER	106	ACRESOI HOPE SCHOOL	EMPLOYER
77	KASODO SUBCOUNTY	PROVIDER	107	NEBBI PRIMARY SCHOOL	EMPLOYER
78	PALLISA HIGH	EMPLOYER	108	NEBBI PROVIDENCE VOCATIONAL	EMPLOYER
79	MULTICARE CLINIC	PROVIDER	109	AVENUE MEDICAL CLINIC	PROVIDER
80	COMMUNITY HC III PNFP	PROVIDER	110	GOLI HC IV	PROVIDER
81	BUSETA HC III	PROVIDER	111	PAMINYA HC IV	PROVIDER
82	BUSETA SS	EMPLOYER	112	KOCH HC II	PROVIDER
83	EBENEZER PRIMARY SCHOOL	EMPLOYER	113	GIKOA PHARMACY	PROVIDER
84	TIRINYI PRIMARY SCHOOL	EMPLOYER	114	NEBBI GENERAL HOSPITAL	PROVIDER
85	PALLISA GENERAL HOSPITAL	PROVIDER	115	CARITAS NEBBI	PROVIDER
86	PALLISA TOWN COUNCIL HC III	PROVIDER	116	INFECTIOUS DISEASE INSTITUTE	NGO
87	MOTHER KEVIN PRIMARY SCHOOL	EMPLOYER	117	PAKWACH GIRLS PRIMARY SCHOOL	EMPLOYER
88	PALLISSA MISSION HC III PNFP	PROVIDER	118	EXCEL COLLEGE PAKWACH	EMPLOYER
89	ALLAINE SS	EMPLOYER	119	CARITAS PAKWACH	NGO
90	KARCHO PRIMARY SCHOOL	EMPLOYER	120	MEDI POINT PHARMACY	PROVIDER

121 INFECTIOUS DISEASE INSTITUTE	NGO	181 KISORO TECHNICAL INSTITUTE	EMPLOYER
122 PAKWACH DISTRICT LOCAL GOVERNMENT	PROVIDER	182 GISORO PRIMARY SCHOOL	EMPLOYER
123 PAKWACH MISSION HOSPITAL III	PROVIDER	183 RUSHERE COMMUNITY HOSPITAL	PROVIDER
124 PAKWACH HC IV	PROVIDER	184 BETTER LIVING DRUG SHOP	PROVIDER
125 ALWI HC III	PROVIDER	185 KIRUHURA HC IV	PROVIDER
126 AMIR HC III	PROVIDER	186 NYAKASHARARA HC II	PROVIDER
127 LIRA DISTRICT LOCAL GOVERNMENT	PROVIDER	187 SANGA TOWN COUNCIL	PROVIDER
128 OBER PRIMARY SCHOOL	EMPLOYER	188 KANGE MEDICAL CENTRE	PROVIDER
129 AGALI HC III	PROVIDER	189 RWABIGYEMANO HC III	PROVIDER
130 AMACH HC IV	PROVIDER	190 KIRUHURA DISTRICT	PROVIDER
131 OBER HC IV	PROVIDER	191 SHEEMA DISTRICT	PROVIDER
132 MARIE STOPES INTERNATIONAL LTD	NGO	192 SHEEMA MUNICIPALITY	PROVIDER
133 MARIE STOPES FY 21/22	NGO	193 KABWOHE DIVISION	PROVIDER
134 KIGOROBIA HC IV	PROVIDER	194 KITAGATA GENERAL HOSPITAL	PROVIDER
135 MEETING POINT HOIMA	NGO	195 BUGONGI HC III	PROVIDER
136 2 SONS DRUG SHOP	PROVIDER	196 TROPICAL MEDICAL DOCTOR'S KABWOHE	PROVIDER
137 KIKUUBE HC IV	PROVIDER	197 MUSHANGA HC III PNFP	PROVIDER
138 AFRICAN RF PHARMACY	PROVIDER	198 KABWOHE PHARMACY	PROVIDER
139 HOIMA CHILD RIGHTS NETWORK CLUB	PROVIDER	199 KYABANDARA HC II	PROVIDER
140 MPAGARANSI HC III	PROVIDER	200 PK DRUG SHOP	PROVIDER
141 ST LODOVISCO'S KITANA PRIMARY SCHOOL	EMPLOYER	201 KABWOHE H C IV	PROVIDER
142 MUNTEME JUNIOR SCHOOL	EMPLOYER	202 NTUNGAMO DISTRICT	PROVIDER
143 HOIMA DISTRICT LOCAL GOVERNMENT	PROVIDER	203 MBARARA REGIONAL REFERRAL	PROVIDER
144 BUHIMBA TECHNICAL INSTITUTE	EMPLOYER	204 BWIZIBWERA HC IV	PROVIDER
145 MUNTEME COLLEGE SS	EMPLOYER	205 MBARARA DISTRICT LOCAL GOVERNMENT	PROVIDER
146 ST THOMAS MOSE SS	EMPLOYER	206 HOLY INNOCENTS PNFP	PROVIDER
147 SIR TITO WINYI PRIMARY SCHOOL	EMPLOYER	207 NYAMITYOBORA HC II	PROVIDER
148 BUGAMBE SS	EMPLOYER	208 RUHAMA HC III	PROVIDER
149 ST JOSEPH'S VOCATIONAL TRAINING INSTITUTE	EMPLOYER	209 ITOJO HOSPITAL	PROVIDER
150 BUJALYA HC III	PROVIDER	210 RUBARE HC IV	PROVIDER
151 KIKUUBE DISTRICT LOCAL GOVERNMENT	PROVIDER	211 NTUNGAMO MUNICIPALITY	PROVIDER
152 KASOMORO HC III	PROVIDER	212 KARWESANGA HC II	PROVIDER
153 BUGAMBE TEA HC III	PROVIDER	213 KASHARE HC III	PROVIDER
154 UNITY DRUG SHOP	PROVIDER	214 MMC	PROVIDER
155 KISIIHA HC II	PROVIDER	215 KAKOBA HC II	PROVIDER
156 HIBAH PHARMACY	PROVIDER	216 DHO'S OFFICE MOROTO	PROVIDER
157 OYAM DLG	PROVIDER	217 CALVARY HEALTH CARE KOTIDO	PROVIDER
158 OYAM TOWN COUNCIL	PROVIDER	218 MOROTO POLICE HC II	PROVIDER
159 OYAM MEDICARE	PROVIDER	219 MOROTO REGIONAL REFERRAL HOSPITAL	PROVIDER
160 DOGAPIO PRIMARY SCHOOL	EMPLOYER	220 MOROTO MUNICIPAL NORTH DIVISION	PROVIDER
161 ANGELICA SS	EMPLOYER	221 KOTIDO DISTRICT LOCAL GOVERNMENT	PROVIDER
162 KISORO GENERAL HOSPITAL	PROVIDER	222 LOSILANG HC II	PROVIDER
163 MUGANZA HC II	PROVIDER	223 KOTIDO MUNICIPAL COUNCIL	PROVIDER
164 POTTERS VILLAGE MEDICAL CENTRE	PROVIDER	224 MOROTO MUNICIPAL COUNCIL	PROVIDER
165 MUHABURA VOCATIONAL INSTITUTE	EMPLOYER	225 LOPUTUR HC III	PROVIDER
166 NYABIHUNIKO HC III	PROVIDER	226 KANAWAT HC III	PROVIDER
167 REAL QUALITY PRIMARY SCHOOL	EMPLOYER	227 KOTIDO CENTRAL DIVISION	PROVIDER
168 KISORO PROGRESSIVE SS	EMPLOYER	228 KOTIDO GENERAL HOSPITAL	PROVIDER
169 KISORO TECHNICAL INSTITUTE	EMPLOYER	229 PADIBE HC IV	PROVIDER
170 GISORO PRIMARY SCHOOL	EMPLOYER	230 KITGUM MUNICIPAL COUNCIL	PROVIDER
171 CHAI SUBCOUNTY	PROVIDER	231 KITGUM GENERAL HOSPITAL	PROVIDER
172 CHAHAFI HC IV	PROVIDER	232 LAMWO DISTRICT LOCAL GOVERNMENT	PROVIDER
173 FRIENDS OF KISORO	NGO	233 KITGUM DISTRICT LOCAL GOVERNMENT	PROVIDER
174 KISORO DISTRICT LOCAL GOVERNMENT	PROVIDER	234 MASINDI DISTRICT LOCAL GOVERNMENT	PROVIDER
175 SESEME GIRLS	EMPLOYER	235 MASINDI MUNICIPALITY	PROVIDER
176 DAHAYA PHARMACY	PROVIDER	236 MASINDI GENERAL HOSPITAL	PROVIDER
177 TRINITY DRUG SHOP	PROVIDER	237 BWIJAGA HC IV	PROVIDER
178 DOCTOR'S CLINIC KISORO	PROVIDER	238 KIRASA HC II	PROVIDER
179 CHYANIKA TOWN COUNCIL	PROVIDER	239 MASINDI SS	EMPLOYER
180 KISORO PROGRESSIVE SS	EMPLOYER	240 JORDAN PRIDE SEC SCHOOL	EMPLOYER

241 KIRYANDONGO GENERAL HOSPITAL	PROVIDER
242 NYAKADOT HC III	PROVIDER
243 PANYADORI HC IV	PROVIDER
244 KATALITARE HC III	PROVIDER
245 BLESSED MOTHER THEREZA COLLEGE	EMPLOYER
246 UGANDA PETROLEUM INSTITUTE	EMPLOYER
247 ZION PRIMARY SCHOOL	EMPLOYER
248 KISUBI HOSPITAL	PROVIDER
249 CEHURD	NGO
250 OXFARM NOVIB UGANDA	NGO
251 LOKOLIA HC III	PROVIDER
252 KAABONG GENERAL HOSPITAL	PROVIDER
253 BUYENDE HC III	PROVIDER
254 KAABONG LOCAL GOVERNMENT	PROVIDER
255 ST DAUDI DRUG SHOP	PROVIDER
256 KAABONG EAST SUBCOUNTY	PROVIDER
257 KAABONG SS	EMPLOYER
258 ARISE AND SHINE	EMPLOYER
259 KAABONG MISSION HC III	PROVIDER



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