Uganda
Health Care & Medical Program

Context of Health Care in Uganda
Uganda has a total population of 24 million people, 80% of whom live in rural areas. It is one of the least urbanized countries in Africa. In 2003, its GDP per capita was $280 (World Bank), with health expenditure per capita approximately $36 in 2001 (WHO). Health expenditure accounts for 3.9% of GDP (WHO), compared to 15% in the United States. Life expectancy in 2002 was 45 years for men, 48 years for women (World Bank). 3.8% of the population is over the age of 60, approximately 50% under 16, and the fertility rate is 7.1 (HVO documents). Adult illiteracy is approximately 31% (World Bank). HIV prevalence rates have been reported to be in decline from a high of 25-30% to 10%, and Uganda has been lauded for its progress in controlling HIV. Economic growth has been about 6% per year for the last several years, which has been encouraging, with agriculture the dominant sector and coffee the primary export good.

There are over 50 different tribes with different dialects, though the predominant tribal language spoken is Luganda, that of the Buganda people, the majority tribe in the area around the capital. Uganda gained independence in 1962 from the British, and the current president, Yoweri Museveni, has been in power since 1986. Uganda suffered greatly during the 1970’s and 1980’s due to civil strife and is still recovering. There is an active civil conflict in the north with over 1.6 million internally displaced people in one of the world’s significant current humanitarian crises.

Training
MU graduates approximately 110 physicians per year from a five-year program which follows high school. After a one-year post graduate internship covering a flexible combination of medicine, surgery, pediatrics, and obstetrics and gynecology, many of these physicians are subsequently posted to rural areas “up-country” for two years where they are general medical officers, often working independently. Those who desire further post-graduate training enroll in a master’s program with tuition. This can take an additional two to three years, first as a JHO (junior house officer), then as a senior house officer. Thereafter, one may pursue subspecialty training in the field of medicine. Positions and resources are very limited for further training, thus trainees need to go abroad if merit and finances permit. Funding is limited.

There are several well-organized weekly teaching conferences for residents presided over by demanding, knowledgeable attendings. From our perspective, generation of, and access to information were challenges to evidence-based discussion and practice in Uganda. As with other medical disciplines, much of the published medical literature is generated by northern institutions, published in northern journals, and concerns diseases affecting primarily industrialized countries. Furthermore, for many residents and faculty, accessing international journals is difficult due to delays in receiving hard copies, limited reliable internet access, and also due to the cost of subscriptions to electronic journals. Some of these equity issues in global health research have been highlighted by the 10-90 gap; 90% of the world’s biomedical research concerns 10% of the world’s population (Global Forum for Health Research).