

# Health Systems Reforms in Uganda: Processes and Outputs

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## Edited by

Christine Kirunga Tashobya, Freddie Ssenooba, Valeria Oliveira Cruz

## Editorial Board:

Rob Yates, Grace Murindwa, Barbara McPake

*Institute of Public Health, Makerere University, Uganda  
Health Systems Development Programme, London School of Hygiene  
& Tropical Medicine, UK  
Ministry of Health, Uganda*



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### **Taking responsibility for sustainable improvements in the health status of Ugandans**

During the 1970s and 1980s, Uganda went through a period of political and economic upheaval, resulting in the breakdown of many services. In the health sector this was characterized by general system failure. Funding was grossly insufficient, leading to problems of meagre and late salaries for health workers, permanent shortages of medicines and supplies, and dilapidated infrastructure. The National Resistance Movement, headed by President Yoweri Museveni, took power in 1986. Initial efforts by this government were focused on the restoration of law and order and on the re-establishment of public systems. However, there was minimal government funding available for social services including the health sector. Many bilateral and multilateral donors intervened to provide post-conflict support including emergency rehabilitation of the health infrastructure. These international agencies focused their support on specific aspects of the health sector (usually disease programmes) in particular parts of the country. Districts which were closer to the capital city and easily accessible attracted many donor projects, while districts which were remote and difficult to access received few or no projects at all.

Following these efforts, there were some improvements in health outputs and outcomes, which was not surprising given their initially very low levels. However, most of these gains were seen to be stagnating or reversing by the mid-1990s. There were growing concerns that the health sector was failing to deliver the expected levels of improvements in outputs and outcomes, despite what was considered an appreciable amount of funding support. In the words of one World Bank official, the health sector had become a 'bottomless pit'!

In fact, the real challenge was that due to the fragmented nature of support, there was minimal understanding of the basic features of the sector (e.g. size of the sector, significance of the different players, quantification of requirements versus what was available). Policy recommendations were often adopted from other country strategies and applied to Uganda without due consideration to the local context. Donor project activities were independent of government activities, and there were no provisions made to allocate government resources to fund the activities following completion of the individual projects. For example, in the mid-1990s, UNICEF was no longer able to maintain its level of funding for the Uganda National Expanded Programme for Immunisation. No preparations had been made for sustaining the activities using government funding and as a result, immunisation coverage plummeted again (following an increase during the 1980s and 1990s).

In the 1990s, in light of these problems, the government initiated the process of preparing a National Health Policy and a Health Sector Strategic Plan. At the same time, a number of bilateral and multilateral agencies had become disillusioned with the project-based method of delivering aid and the international community thus began to question the existing modalities of providing Overseas Development Assistance (ODA). Hence the advent of the sector-wide approach (SWAp) for health development where, instead of focusing on individual projects, donors would support and fund the implementation of a coordinated, sector-wide strategy. Since the challenges of managing ODA were a key feature of the National Health Policy and Health Sector Strategic Plan, Uganda readily embraced this new development.

The health sector stakeholders that were involved in the development of the National Health Policy and Health Sector Strategic Plan (2000/01-2004/05) under the SWAp included central (Ministries of Health, Finance, Public Service, Local Government, Education) and local government officials, representatives of multi-lateral and bilateral agencies, NGOs and private providers of health services. The then Minister of Health, Hon. Dr. Crispus Kiyonga, steered the whole process, supported by a committed technical team led by Professor Francis Omaswa (Director General Health Services), Dr. Joseph Kyabaggu (Director for Planning and Development), Dr. Sam Zaramba (Director Clinical and Community Health), and Dr. Patrick Kadama (Commissioner Planning). Particular mention is also made of Dr. Hatib Njie (WHO Country Representative), Ms. Ros Cooper (DFID Uganda Country Office), Ms. Nicola Brennan, (Ireland Aid), Dr. Phil Gowers (RIP), Ms. Mary Mulusa (World Bank Headquarters, Washington) and Dr. Daniele Giusti (Uganda Catholic Medical Bureau) for their outstanding contribution.

The details of the different interventions in the National Health Policy and the first Health Sector Strategic Plan (2000/01-2004/05) and what they have achieved are well articulated in the different chapters of this book.

In the first chapter, Yates et al. provide a useful overview of the achievements of the health sector, in terms of key outputs, since the development of the first Health Sector Strategic Plan and the launch of the SWAp in Uganda in 2000. They identify a number of demand and supply side factors that contributed to these achievements, each of which are taken up in the subsequent chapters and discussed in more detail to determine their respective contribution to the overall programme of health systems reforms in the country. Oliveira Cruz et al. outline the mechanisms and processes of the Ugandan health SWAp, discuss its major benefits, and outline challenges for the future. Kirunga Tashobya et al. investigate the implications of a major demand side policy instigated in 2001, namely, the abolition of user fees in public health facilities. They employ a range of data sources to show that this policy led to a dramatic increase in utilisation of primary health care services in the country, particularly by the rural poor. Nazerali et al. provide a detailed description of the reforms in the financing and supply of medicines, one of the three critical inputs to health care, which led to significant improvements in the availability of essential medicines in local primary health care facilities. Lochoro et al. discuss the role of partnership with the private sector, focusing in particular on progress made in partnership with the private-not-for-profit sub-sector which has contributed to greater alignment and coordination in the supply of health care services in the country. Also on the supply side, Murindwa et al. investigate the contributions of key changes in the organisation of local level primary health care services, focusing on

human resources, infrastructure (the other two critical inputs to health care in addition to medicines), and supervision and monitoring. Finally, Ssenooba et al. analyse available financial data to determine the extent to which these reforms have yielded improvements in efficiency and equity in the Ugandan health sector.

I would also like to point out a few key critical higher level factors that are common to each of the reforms discussed in this book.

Firstly, the importance of government stewardship cannot be overemphasized. The Ministry of Health (in collaboration with other institutions of government) has led the process with deliberate consultation with the different stakeholders to the sector. The majority of key decisions have been made following a consensus-building approach and in cases where this has not happened (e.g. abolition of user fees), the government has based its decisions on available information and prevailing circumstances.

Second, there has been increasing use of government mechanisms at the national, sectoral, and local government levels for purposes of planning, financing, procurement, and monitoring and evaluation, rather than using separate donor project systems. This has very important implications for developing systems that are sustainable by the government in the medium and longer term.

Third, it is crucial to build the trust and confidence of the stakeholders in order to ensure a successful partnership. However, this entails substantial transaction costs. For example, it took more than four years to agree to the Health Sector Strategic Plan 2000/01-2004/05, with innumerable meetings between stakeholders in and outside the country and several consultations between multilateral and bilateral agencies' representatives and their headquarters. Nevertheless, this process was necessary to enable the stakeholders to agree to and own a common vision and objectives.

We are very proud of what this process has achieved. Many infections have been prevented given the improved coverage of immunisation and other preventive and promotive programmes. The proportion of the population that is able to access ambulatory services almost doubled over four years (from 0.42 out-patient visits per person per year in 1999/00 to 0.79 visits in 2003/04). The last Uganda Demographic and Health Survey (UDHS) was carried out in 2000/01 at the time when these reforms were just beginning. It is expected that the UDHS of 2005/06 will show some improvements in mortality figures given these improvements in health sector outputs. This is expected despite the observed stagnation or worsening of some of the other determinants of health including the increase in poverty (in both absolute and distributional terms) and insecurity in some parts of the country.

Nevertheless, there are a number of challenges that have been, and are continuing, to emerge. The above improvements have occurred largely because of efficiency gains rather than big increases in the overall health sector resource envelope. In particular, an increasing proportion of financial support for the sector is channelled through the government budget (i.e. government funding plus donor budget support) rather than through individual donor projects, resulting in greater efficiency and equity in resource allocation. The interventions that have been articulated in the second Health Sector Strategic Plan for the period 2005/06 to 2009/10 focus more strategically on reducing child and maternal mortality and morbidity, including the provision of emergency obstetric care (basic and comprehensive) closer to rural women, and further development of prevention and treatment services for malaria and HIV/AIDS. Each of these requires efficient utilization of a bigger resource envelope for the sector.

Further increases in the health sector resource envelope are constrained by a number of factors. These include the pledge by the government to pursue conservative management of the macroeconomy, with a firm cap on the fiscal deficit, articulated in the Poverty Eradication Action Plan 2004 (the country's Poverty Reduction Strategy Paper). Therefore, future growth in the Medium and Long Term Expenditure Frameworks (MTEF & LTEF) is restricted, thereby curtailing future public spending (government and donor), including health sector expenditure. Global health initiatives (e.g. the Global Fund to Fight AIDS, TB and Malaria, and the US President's Emergency Plan for AIDS Relief) also pose a potential threat to the efficiency of the health sector resource envelope. These initiatives use traditional project-based approaches that are not consistent with the systems approach used under the SWAp. This has resulted in the re-emergence of disease-specific projects and the use of parallel systems for planning and monitoring which have implications for equity and efficiency in resource use. Moreover, funds from these less efficient funding sources are included in the health sector resource envelope outlined in the MTEF and LTEF and thus potentially displace resources allocated through the (more efficient) government budget.

As a final comment, sustaining the mutual trust established between government and development partners and other stakeholders is an ongoing challenge. This is affected by other decisions made at global, regional and national levels. The high turnover of officers in both government and other stakeholder bodies makes orientation meetings a must. There is still room for improving partnerships for health within the country, especially with the private sector, with communities, households and individuals, if these achievements are to be built on and sustained. Uganda still suffers from a high burden of preventable diseases which can only be limited by improved health literacy and involvement of the communities.

On behalf of the Government of Uganda, and in particular the Ministry of Health, we are very glad to share our experiences with other developing countries and especially those in sub-Saharan Africa. It is not often that we have success stories to share. This book has been put together by some of the Ministry of Health officials that have been involved in the implementation of these reforms, together with partners from bilateral and multilateral agencies, private healthcare providers' representatives and researchers. This collaboration has facilitated a factual and objective analysis of the experiences.

**Dr. Sam Zaramba**  
**Director General of Health Services**

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## Editors:

**Christine Kirunga Tashobya** (Mb ChB; MA Demography; MSc Health Policy, Planning and Financing) is a Public Health Advisor in the Ministry of Health (MoH) in Uganda under the auspices of the Danida-funded Uganda Health Sector Programmes Support II. She has been involved in reforms in the Uganda MoH in various capacities over the last decade, especially in areas of overall policy formulation, stakeholder coordination, health financing and public-private partnership for health. Currently, she is involved in supporting districts to provide better services in the era of decentralisation and the sector-wide approach. **Email:** [Christine@hspg-ug.org](mailto:Christine@hspg-ug.org)

**Freddie Ssengooba** (Mb ChB; MPH) is a member of the Health Systems Development Programme at the London School of Hygiene & Tropical Medicine, supported by DFID and Makerere University, Institute of Public Health. He is currently working on studies on human resources for health, hospital service quality, and response to performance contracts in the Ugandan health system. **Email:** [ssengooba@iph.ac.ug](mailto:ssengooba@iph.ac.ug)

**Valeria Oliveira Cruz** (MSc Health Policy, Planning and Financing) is a lecturer in the Health Systems Development Programme at the London School of Hygiene & Tropical Medicine. Her current work focuses on an investigation of the nature of the relationship between development partners and the Government of Uganda. **Email:** [valeira.oliveira-cruz@lshtm.ac.uk](mailto:valeira.oliveira-cruz@lshtm.ac.uk)

## Editorial Board:

**Rob Yates** (BA Economics; MBA) is seconded to the Ministry of Health in Uganda by the UK Government's Department for International Development (DFID). His work focuses on health financing mechanisms and public sector management reforms. **Email:** [yatesug@infocom.co.ug](mailto:yatesug@infocom.co.ug)

**Grace Murindwa** (Mb ChB; MA Health Policy, Planning and Management) works as Senior Health Planner in the Health Planning Department, Ministry of Health, Uganda. He has been actively involved in the formulation and implementation of health sector reforms in Uganda for over eight years. Currently, he is involved in providing technical support to districts especially with regard to planning and monitoring of health service delivery. **Email:** [murindwag@yahoo.com](mailto:murindwag@yahoo.com)

**Barbara McPake** (BA Economics; PhD Health Economics) is Professor and Director of the Institute of International Health and Development at Queen Margaret University College, Edinburgh. Her work focuses on the economics of health systems and has included studies on health financing, human resources, and hospital reform in sub-Saharan Africa. **Email:** [bmcpike@qmuc.ac.uk](mailto:bmcpike@qmuc.ac.uk)

## Contributors:

**Juliet Bataringaya** (BSc; Mb ChB; MSc Health Policy, Planning and Financing) worked as consultant for the Public-Private Partnership in Health Unit in the Health Planning Department, Ministry of Health, Uganda. She is now National Professional Officer for Health Systems Development at the WHO Country Office in Uganda. Current work involves strengthening of district and sub-district health systems, human resources for health development, collaboration with partners and NGOs, and mainstreaming community initiatives.

**Email:** [bataringayaj@ug.afro.who.int](mailto:bataringayaj@ug.afro.who.int)

**Ros Cooper** (MA Sociology of Development) worked as health adviser for the Department for International Development (DFID) in Uganda from 1999 until 2004. Since January 2005 she has worked as a policy adviser focusing on human development for DFID in the Democratic Republic of Congo. **Email:** [ra-cooper@dfid.gov.uk](mailto:ra-cooper@dfid.gov.uk)

**Joseph Herman Kyabaggu** (Mb ChB; DPH, M Med) is a long-serving Health Manager who has worked for more than three decades at various levels in the Ugandan health system. He has recently retired from the civil service post of Director of Health Services (Planning and Development) at the Ministry of Health, Uganda. His areas of interest are policy analysis, health systems development and public-private partnership for health.

**Peter Lochoro** (Mb ChB; MSc Health Service Management) is Assistant Executive Secretary at the Uganda Catholic Medical Bureau. His work focuses on improving managerial capacity and performance assessment of the Catholic health providers in Uganda and on promoting partnership with the Ministry of Health.

**Email:** [plochoro@ucmb.co.ug](mailto:plochoro@ucmb.co.ug)

**Joseph Mwoga** (B Pharm; MPS; MPH) is a public health specialist with a pharmaceutical logistics background, currently working as Senior Pharmacist in the office of the Principal Pharmacist, Ministry of Health, Uganda. He focuses on strengthening supply systems for health commodities, and has a special interest in health systems management. **Email:** [jmwoga@hsps-ug.org](mailto:jmwoga@hsps-ug.org)

**Juliet Nabyonga** (Mb ChB; MSc Health Economics) works with the WHO Uganda Country Office as a Health Economist. Her current work focuses on health system performance assessment, health financing, and health and poverty.

**Email:** [Nabyongaj@ug.afro.who.int](mailto:Nabyongaj@ug.afro.who.int)

**Hanif Nazerali** (MRPS; MPH International Health and Development) is a Danish adviser attached to the Ministry of Health, Uganda through the Danish Health Sector Programmes Support. He has been involved in formulating new systems for medicines financing and supply and making them operational in Uganda over a period of four years. **Email:** [hanif@hsps-ug.org](mailto:hanif@hsps-ug.org)

**Francis Omaswa** (Mb ChB; M Med FRCS) is the Special Advisor on Human Resources at the WHO Headquarters Geneva. Prior to this appointment he was the Director General for Health Services in Uganda. His major interests include health systems development, stakeholder coordination and quality assurance.

**Martin Olowo Oteba** (MSc Pharm; MIH) is the Principal Pharmacist, and overall coordinator and technical advisor to the Ministry of Health, Uganda on pharmaceutical policy and management. His main interests include logistics, health systems, and international health. **Email:** [orukan33@hsps-ug.org](mailto:orukan33@hsps-ug.org) or [orukan33@hotmail.com](mailto:orukan33@hotmail.com)

**Eliseus Rutebemberwa** (BSc Psychology; Mb ChB; MPH) is a lecturer at the Institute of Public Health, Makerere University, Uganda. He has worked in the Ugandan health sector for several years during which he has worked at the hospital level and as a researcher. His current areas of research are in human resources for health and hospital services. **Email:** [ellie@iph.ac.ug](mailto:ellie@iph.ac.ug)

**Sam Zaramba** (Mb ChB; DLO; M Med; FAMS) is the Director of Health Services responsible for clinical and community health services in Uganda. He is an experienced health systems manager with a special interest in medicines and health supplies management and financing. As one of the top managers of the Ugandan health system, he has been deeply involved in the health sector reforms and supervises activities related to the developments in medicines management and financing. **Email:** [zarambasam@yahoo.co.uk](mailto:zarambasam@yahoo.co.uk)

# 1

## The Ugandan health systems reforms: miracle or mirage?

Rob Yates, Christine Kirunga Tashobya, Valeria Oliveira Cruz, Barbara McPake, Freddie Ssengooba, Grace Murindwa, Peter Lochoro, Juliet Bataringaya, Hanif Nazerali and Francis Omaswa

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### Summary

Poor health indicators in the 1990s prompted the Government of Uganda and development partners to embark, at the turn of the century, on an extensive programme of health systems reforms to improve sector performance. With only a modest increase in resources, these reforms have resulted in large increases in outputs for ambulatory services. Out-patient attendances and immunisation rates have doubled. Furthermore, the growth in consumption of these services appears to be highest for the poorest socio-economic groups. However, statistics for key in-patient services, most noticeably maternity services, remain virtually unchanged. This chapter attempts to assess the significance of these changes. Is it a miracle of improved efficiency or a mirage unlikely to lead to improved health outcomes? We try to identify the key reforms within health and across government, which may be responsible for the changes in output performance. A number of supply side reforms that have increased the availability of essential inputs are highlighted. In addition, a major demand side policy (abolishing user fees) had a significant impact on the consumption of services. We conclude that increased utilisation of ambulatory services does signify improvements in consumer welfare and therefore health sector performance. However, stagnant maternity outputs indicate that key in-patient services are still not meeting the expectations of the population. Only reliable outcome data will resolve the debate about the significance of the changes in output indicators. Further research will also be required to disentangle the relative impact of the different components of the reforms.

## 1. Background – the Ugandan health sector pre-2001

For a country at the forefront of development reforms, the results from the 2001 Uganda Demographic Health Survey (UDHS) (based on 2000 data) were extremely disappointing (UBOS 2001). They showed that since 1995, infant mortality figures had deteriorated and maternal mortality figures had hardly changed. As shown in Table 1, the infant mortality rate increased from 81 to 88 (per 1,000 live births) over the period 1995-2000 and in 2000 the maternal mortality rate stood at 505 (per 100,000 live births). These statistics were significantly off track for achieving the country's own Poverty Eradication Action Plan (PEAP) and Millennium Development Goal (MDG) targets.

Whilst it is not the sole responsibility of the health sector to deliver the health related MDGs, the sector clearly has an important role to play. These health status figures must therefore reflect, to some extent, poor performance of Ugandan health services during the 1990s.

It is probable that a wide range of factors contributed to this poor performance but financing and management limitations have been particularly implicated. As well as being chronically under-funded, the sector appears to have been using its limited resources inefficiently. Using a variety of sources, an analysis of total expenditure on public and private-not-for-profit (PNFP) health services at the start of this decade shows that:

- The majority of the government budget (66 percent in 1999/00) was allocated to large hospitals (regional and national) and the central Ministry of Health (MoH), whose services tended to benefit the urban (and therefore better off) population, rather than to district level facilities providing primary health care services to the rural poor (MoH 2003a; Ssengooba et al., chapter 7 below).
- Donor projects, with high overheads, focussed on investment goods and were inefficient at providing basic health care inputs (MoH 2003b).
- User charges raised little revenue, exemption schemes did not protect vulnerable groups and user fees were a significant barrier for poor people accessing services (MoH 2002; GoU 1999; MoFPED 2000).

Due to these financing conditions, very little was spent on basic health care inputs (e.g. medicines, health workers' salaries and health centre maintenance) in rural areas. As a result, the coverage of services was limited, quality was poor and, combined with the existence of patient charges, these services represented poor value for money. Not surprisingly prospective health care consumers tended to stay away, choosing either to self-treat or to attend alternative commercial sector providers (UBOS 2000). This was reflected in low levels of utilisation for out-patient services in government and PNFP health units. In the year 1999/00, the utilisation rate for out-patient services in government and PNFP units was only 0.42 visits per person (see Figure 1). Clearly the Ugandan health system was not meeting the needs of its population.

**Table 1: Stagnating health outcome indicators in Uganda in the 1990s**

| Indicator  | 1995 | 2000 | PEAP <sup>1</sup><br>Target<br>(2005) | MDG <sup>2</sup><br>Target<br>(2015) |
|--|------|------|---------------------------------------|--------------------------------------|
| Infant Mortality Rate<br>(Deaths <1 year per 1000 live births) | 81   | 88   | 68                                    | 41                                   |
| Maternal Mortality Rate<br>(Deaths per 100,000 live births)    | 527  | 505  | 345                                   | 131                                  |

Source: MoFPED (2003).

<sup>1</sup>Poverty Eradication Action Plan.

<sup>2</sup>Millennium Development Goal.

## 2. Time for radical reform

Recognising these failings, during the late 1990s, the Government of Uganda (GoU) initiated a comprehensive programme of radical health sector reforms. This included the decision to implement a sector-wide approach (SWAp) in order to improve coordination and therefore efficiency and equity in the sector. The SWAp was officially launched in August 2000.

The blueprint for the SWAp has been the Health Sector Strategic Plan (HSSP) of 2000/01 to 2004/05. This document contains a clear statement of the health sector's mission, which is to *"reduce morbidity and mortality from major causes of ill health in Uganda and the disparities therein, as a contribution to poverty eradication and economic and social development of the people"* (MoH 2000: 3).

The focus of the HSSP is to deliver a basic package of services, the Uganda National Minimum Health Care Package (UNMHCP), as efficiently and equitably as possible. In particular, there is a strong commitment to targeting poor and disadvantaged people in line with the principles of the Poverty Eradication Action Plan. The UNMHCP consists of programmes which deliver both curative and preventive services ranging from the control of communicable diseases, integrated management of childhood illness and immunisation, to health promotion and education, and mental health services (see Annex 1 for full details).

Since 2000, it has become apparent that the health sector reform programme has evolved rapidly, beyond improving coordination mechanisms envisaged in the SWAp, into a broader programme of health systems reforms. Many of these reforms have originated in the health sector, such as improved budget allocations and medicines logistics. Others, however, have been due to the impact of public sector reforms across government. Examples here include the formulation of a nationwide Poverty Reduction Strategy Paper (the PEAP), the introduction of a Poverty Action Fund to channel resources to high priority budget areas, and processes to increase decentralisation to local governments. The net result of all these reforms has been an improvement in all four key functions of the health system as defined by the World Health Organisation (WHO),

namely stewardship, service delivery, resource generation, and financing (WHO 2000). Ministry of Health publications, notably a Mid Term Review of its HSSP and Annual Performance Reports, have attempted to document these changes (MoH 2003b; MoH 2002; MoH 2004a). However, given the breadth and simultaneous nature of the reforms, it has been difficult to disentangle the relative impact of the diverse components. Specific reforms which appear to have been most important in improving sector performance include:

- **SWAp processes** (which have encouraged development partners to align their support behind a coherent government-led strategy; see chapter 2, Oliveira Cruz et al.);
- **Abolishing user fees in GoU units** (which immediately triggered a surge in demand and catalysed a number of supply side reforms; see chapter 3, Kirunga Tashobya et al.);
- **Improved management systems** (especially in financing and supply of medicines; see chapter 4, Nazerali et al.);
- **Public-private partnership** (including US\$9 million – US\$0.40 per capita – in new grants to PNFs; see chapter 5, Lochoro et al.);
- **Decentralised service delivery** (greater resources and capacity building in district services; see chapter 6, Murindwa et al.);
- **Improved resource allocations** (with a far larger share of sector resources allocated to district primary health care services, including PNFP providers; see chapter 7, Ssenooba et al.);
- **Health financing** (notably donors switching from project to budget support and a reduction in the reliance on patient fees);
- **Political leadership** (from the President, the Minister of Health and the Ministry of Finance).

The purpose of this chapter is to stimulate debate amongst health policy makers and academics as to whether the results of the Ugandan health systems reforms to date signify a notable improvement in sector performance. Secondly, we attempt to highlight areas which may prove to be the most important factors in bringing about the results observed.

### 3. Results of the health systems reforms

As the primary function of any health system is to improve the health status of its population, the best indicators of sector performance measure changes in health outcomes. Unfortunately, demographic and health statistics are only collected every five years in Uganda so it is not possible to determine whether or not there have been any improvements in outcomes since 2000. Charting the annual progress of the HSSP has therefore required the use of intermediate measures of performance.

<sup>1</sup>In terms of absolute numbers, total new attendances increased from 9.3 million in 1999/00 to 20.2 million in 2003/04. This represents a 117 percent increase in the absolute number of new attendances over the period, with the bulk of the increase seen at government units. The percentage increase in the utilisation rate (88 percent) is lower than this due to the rising population.

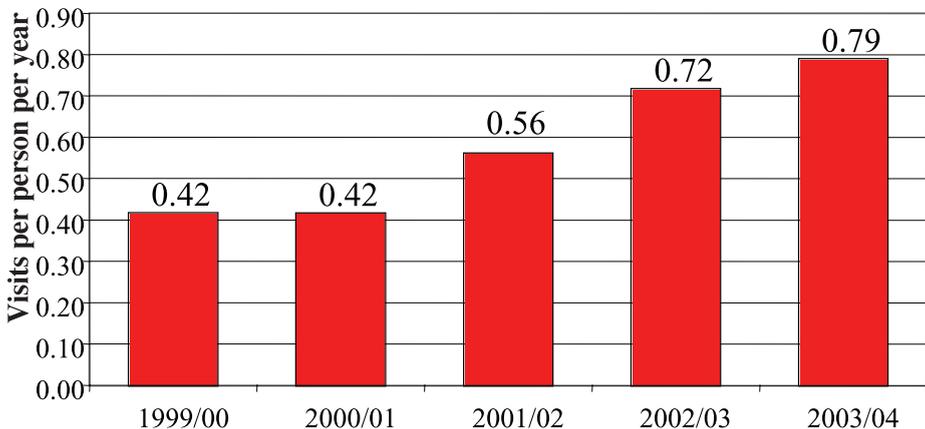
<sup>2</sup>Third dose of Diphtheria-Pertussis-Tetanus vaccine.

What was needed were output measures, where a logical case could be made that increased consumption of the services concerned would be likely to lead to improved health status. After much deliberation, in 2000, the stakeholders in the Ugandan SWAp decided to concentrate on the following key outputs: out-patient utilisation rate, immunisation rates and the proportion of babies delivered in health units. It was felt that these measures covered an appropriate range of key curative and preventive services and that measuring consumption would show whether these services were meeting the expectations of the population. For all these indicators, the statistics covered services as defined in the HSSP, which are provided by government health units and the large PNFP sector.

Figures 1-3 illustrate how these output measures have performed since the baseline year of 1999/00. In the period from 1999/00 to 2003/04, the rate of utilisation of out-patient services in GoU and PNFP units increased from 0.42 to 0.79 visits per person per year (MoH 2004a), an increase of 88 percent.<sup>1</sup> Similarly, immunisation rates for DPT3<sup>2</sup> increased from 41 percent to 83 percent (a 102 percent rise). However, for deliveries in health units the figure declined from 25 percent to 19 percent, only rising back to 24 percent in the 2003/04 financial year.

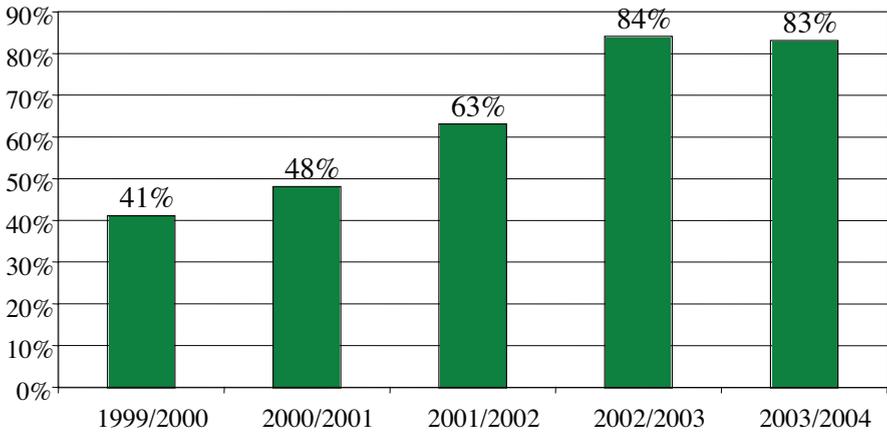
Furthermore, research by the World Bank indicates that the financial burden felt by poor households for health services fell substantially between 1999/00 and 2002/03 (Deininger and Mpuga 2004; see chapter 3, Kirunga Tashobya et al., for further discussion). While total household expenditure on health services has remained fairly constant, the expenditure by the two poorest socio-economic groups fell by 13 percent for the poorest group and 19 percent for the fourth income quintile. With 38 percent of the Ugandan population living below the poverty line, this result shows an improved distribution of the financial burden towards the non-poor population. Moreover, there are signs that poor people are falling sick less often and are less incapacitated due to illness, which could be an early indication of improving levels of health status.

**Figure 1: Utilisation Rate of New Outpatient Attendances in Government of Uganda and Private Not for Profit Health Units**



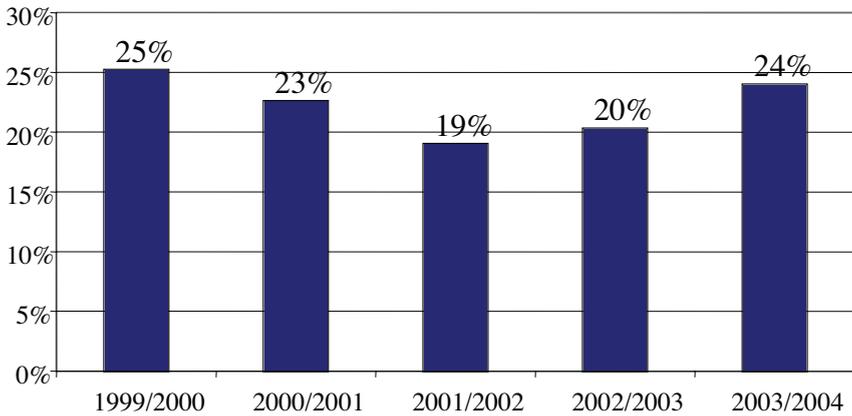
Source: Derived from MoH (2004a).

**Figure 2: DPT3 Immunisation Rates DPT3 for Children Under One Year**



Source: Derived from MoH (2004a).

**Figure 3: Proportion of Babies Delivered in Government and Private Not for Profit Health Units**



Source: Derived from MoH (2004a).

## 4. Discussion

### 4.1 What is the significance of these results?

According to Berman, *"success in the provision of ambulatory personal health services, i.e. providing individuals with treatment for acute illness and preventive health care on an ambulatory basis, is the most significant contributor to the health care system's performance in most developing countries"* (Berman 2000: 791). He also proposes three important criteria against which to measure success: level and distribution of health outcomes, level and distribution of financial burden, and population satisfaction.

Given the disease burden and resource constraints faced by Uganda, it does indeed seem appropriate to concentrate on ambulatory services when measuring health sector performance. McPake shows that by using a Paretian perspective of consumer sovereignty, an increase in the consumption of services can be taken to indicate a higher level of welfare (McPake 2002). People who have switched to public and PNFP services from alternatives (including a no service option) have benefited, since they demonstrably judge this option to be better than their previous choice. On the basis of this or Berman's criteria, a doubling in the consumption of out-patient and immunisation services would indicate a significant improvement in population satisfaction and/or welfare levels.

Overall therefore, it would appear that the population has been 'voting with its feet', choosing to increase its utilisation of public and PNFP health services, thereby expressing its preference for contemporary ambulatory health care services as opposed to the services on offer at the turn of the decade. This would suggest better performance of the services on offer. However, it should be pointed out that this happened from a very low baseline. Furthermore, it is unclear what proportion of the increase in the use of GoU/PNFP units is due to patients switching from providers in the private sector, although the indications are that utilisation of private-for-profit health clinics has not declined in recent years (UBOS 2003).

The picture for deliveries in health units is different. Here the stagnant output figures indicate the population's indifference to any changes that might have taken place in maternity services. Why there could be this differential uptake in services is discussed in the following section.

### 4.2 Interpretation of the results

Research has shown that health care users in developing countries, like other consumers, shop around for health services basing their choice of provider on their perceptions of quality and price. Studies of health seeking behaviour almost always cite quality and price as the dominant explanations of choices made and research in a variety of settings has shown that utilisation rates respond to changes in both (Mackian 2003; Litvack and Bodart 1993; Bitran 1995). People choose services which, for them, represent the best value for money. If health care providers want to increase their market share, they have two main strategies open to them: to improve quality as perceived by the user, and/or lower the price to the consumer.

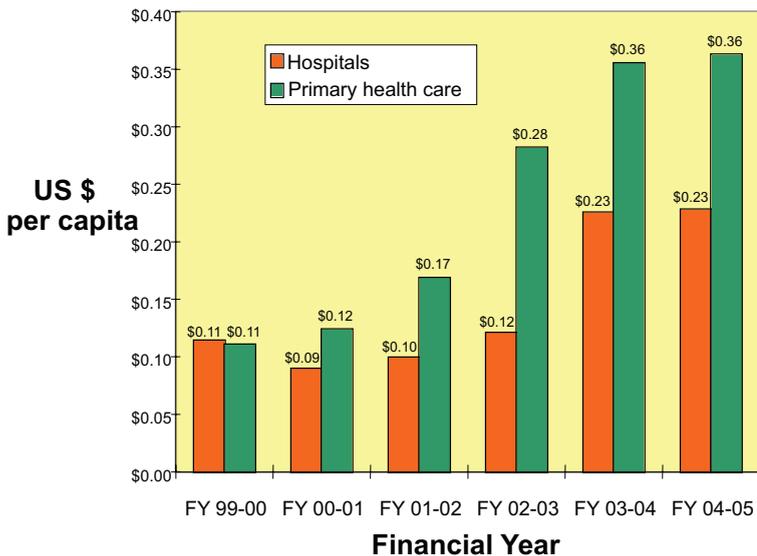
It could be argued that for ambulatory care services in Uganda, the health reforms have targeted both of these strategies, by addressing both demand and supply side

constraints simultaneously. On the demand side, the President's decision to abolish user fees in all government health units (with the exception of private wings in hospitals) clearly reduced costs for patients. This did not result in zero costs, as patients still had to incur costs associated with transport, time spent at the health facility, and possibly in paying for commodities not available at the health unit. Nonetheless, this sudden policy change stimulated a surge in demand for public services (Nabyonga et al. 2005). Similarly, in many PNFP units, increasing financial support from the government enabled these providers to reduce user fees and stimulate increases in utilisation as a result.

However, demand side reforms (abolition of fees) were not implemented in isolation. They were accompanied by a more gradual programme of supply side reforms, whose primary focus was to improve service coverage and quality. In particular, these supply side measures attempted to increase the availability and quality of health care inputs which appeared most important to rural populations, namely: medicines, human resources and accessible infrastructure. Medicines funding increased relative to other inputs, and infrastructural growth favoured primary health care services over hospitals (Figure 4). Some of these supply side measures are already demonstrating tangible improvements in technical service quality (MoH 2004a). For example, Nabyonga et al. (2005) show that despite higher demand levels, medicines availability in government health units has increased.

It is difficult to assess the effect these changes have had on the quality of services as perceived by the population, as client satisfaction data is currently limited. The second Ugandan Participatory Poverty Assessment in 2002 showed that poor people were appreciating free consultations but were still unhappy with persistent stock-outs of

**Figure 4: Budget allocations for medicines**



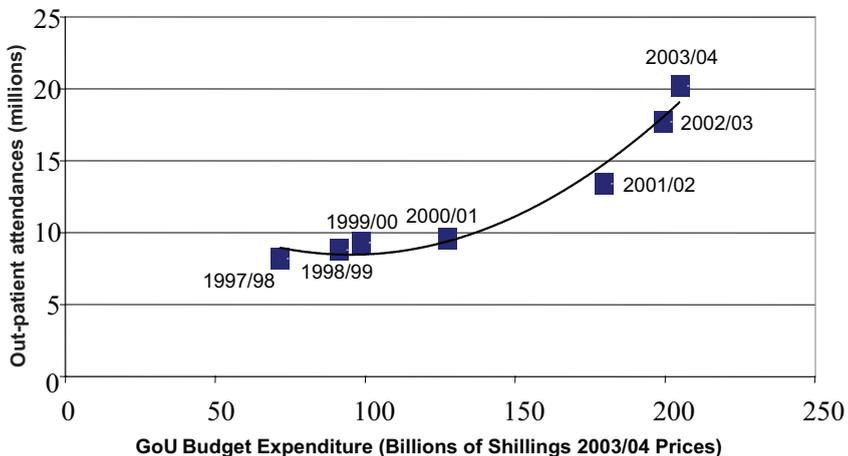
Source: Derived from MoH (2003b); MoH (2001, 2002, 2003, 2004 and 2005).

medicines (MoFPED 2002). However, despite these shortcomings in the data, overall it would appear that, for ambulatory services, the combined effect of lower patient costs and quality changes has been sufficient to make public and PNFP services more attractive in terms of value for money. This has led to the large increases in expressed demand as demonstrated by the higher output figures for these services.

Given the systems reform objective of improving efficiency, it is worth noting that these changes have not been associated with a large inflow of additional resources into the sector. In fact, since the 1999/00 financial year, it is estimated that the total government budget for the health sector as defined by the HSSP (GoU and PNFP services) has only increased by 18 percent in real terms (MoH 2004a). However, there has been a significant switch in the composition of health financing in the sector. In accordance with SWAp principles, donors are increasingly channelling their funding support through the government budget<sup>3</sup> rather than through individual projects (see chapter 2, Oliveira Cruz et al.). The GoU health budget (which includes GoU funds plus donor budget support) is now the main source of funding for the health sector, where previously the dominant source of funding was from donor project funding (see chapter 7, Ssengooba et al., for further discussion). Figure 5 illustrates how the growing GoU health budget could at least partly explain the increases in outputs and efficiency for ambulatory services. Although correlations may be wrongly ascribed when they depend on continuous time trends, the graph shows that increases in GoU budget expenditure since 1999/00 have been associated with increases in new out-patient attendances at government and PNFP health units. This could be due to the government budget mechanism demonstrating better allocative efficiency relative to donor projects, particularly in financing more health care inputs at the district level.

If the Ugandan population believes that GoU and PNFP ambulatory services in 2004 represent better value for money than they did at the turn of the decade, this begs the question as to why the same cannot be said for maternity services. This is likely to

**Figure 5: GoU Budget Expenditure and Total Outpatient Attendances**



Source: MoH (2004b).

<sup>3</sup>This includes GoU plus donor budget support. See Table 1 in chapter 7, Ssengooba et al.

be a complicated matter but if progress is to be made in improving maternal mortality figures, this question needs to be addressed and answered. On the demand side, it is possible that potential consumers do not perceive that they need medical maternity care or that for cultural reasons it is not appropriate for them to leave their homes to give birth. In addition, consuming in-patient care incurs higher costs for the household in terms of transport (especially if a referral is necessary), time away from home and health care inputs. On the supply side, it is likely that there have not been significant changes in the quality of maternity care as perceived by consumers. Access has only increased gradually and many facilities still lack qualified staff, attractive accommodation, utilities and functioning referral systems. Available evidence indicates that the population do not perceive overall value for money to have significantly changed for maternity services and thus they still tend to give birth at home. This suggests that the population view maternity services as a very different product to simple out-patient care.

In summary, it would appear that the systems reforms identified here have made sufficient changes to ambulatory services to trigger a rise in demand but that maternity services are proving more difficult to improve. Greater attention must be paid to the specific demand and supply constraints affecting these services if maternity outputs, and therefore maternal and infant health outcomes, are to improve.

It should be noted that the analysis in this chapter utilises to a large extent data from the Ministry of Health's management information systems. As with most developing country national systems, there are limitations to the accuracy and completeness of these data. Nonetheless, the output figures are consistent with those provided by other independent sources, thereby providing useful validation of the MoH data (Nabyonga et al. 2005).

## 5. Conclusions

Most commentators would agree that the Ugandan health reforms can only be deemed to be truly successful when they can demonstrate that they have contributed to improvements in health care outcomes. Given the poor 2001 UDHS figures, there is certainly considerable scope to do this. However, health outcomes are a multi-sectoral responsibility and changes in other sectors' performance will be difficult to disentangle. On the positive side, Uganda's largely successful implementation of a universal primary education system is likely to benefit health outcomes in the long-term. However, working in the opposite direction, the National Household Survey for 2002/03 has reported rising poverty levels since 2001 (UBOS 2003). Furthermore, worsening insecurity in the north of the country is likely to have a profound effect on health status figures, particularly for the one million plus Ugandans currently living in camps for internally displaced people. Given these latter constraints, it would perhaps be a successful outcome if Uganda managed to simply maintain its overall health status statistics while better performance might be looked for in districts unaffected by conflict.

Rather than waiting until the next UDHS, it is hoped that further research in the interim can shed more light on the impact of the Ugandan health system reforms. For example, have the large increases in immunisation rates reduced mortality rates from communicable diseases in children? In addition, there is clearly a need for further research into what factors are driving the demand for health services, and by poor people

in particular. This is especially needed for areas such as maternity services where consumption is inappropriately low. How can this indicator be improved? Is it a matter of improving access, service quality (if so, what aspect), or helping consumers overcome residual costs? Only good quality market research will answer these questions.

Finally, given the ongoing debate about appropriateness of user fees as a financing mechanism, how significant was their abolition to any apparent Ugandan success story? Would this policy have had a positive impact had it happened without the concurrent supply side reforms? In fact, it is likely that rather than being independent factors, these processes are mutually reinforcing. For example, it could be argued that a rising health budget and ongoing supply side reforms encouraged the government to take the bold step to abolish fees. Alternatively, the sudden abolition of patient fees and the immediate surge in demand may have promoted health up the government agenda and in effect helped catalyse the fledgling health reforms. Given growing concern about user fees in developing countries, any further research into the impact of this specific policy change which could then be applied to different contexts would be most welcome.

Despite the limitations in the data available to date, what can be said with a degree of confidence is that the Ugandan health sector has changed significantly since 2000. Firstly, the way in which the sector is being managed and financed has changed appreciably. There is now a greater reliance on government systems, especially budget financing, and a lesser role for development projects and funding from households. More importantly, and due to the above, in 2004, government and PNFP health units were a lot busier, providing twice as many ambulatory services than before. In this respect, it appears that the most important health care product launched by the Ugandan health systems reforms has been successful.

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## Annex 1: Health Sector Strategic Plan and structure of Ugandan health sector

The programmes which make up the Ugandan Minimum Health Care Package (UNMHCP) consist of curative and preventive services including the following:

1. Control of Communicable Diseases: Malaria; STD/HIV/AIDS; Tuberculosis
2. Integrated Management of Childhood Illness
3. Sexual and Reproductive Health and Rights
4. Immunisation
5. Environmental Health
6. Health Education and Promotion
7. School Health
8. Epidemic & Disaster Prevention, Preparedness and Response
9. Improving Nutrition
10. Interventions against diseases targeted for elimination or eradication
11. Strengthening Mental Health Services
12. Essential Clinical Care

The Health Sector Strategic Plan (HSSP) also formally establishes the ideal structure for the Ugandan health sector which will deliver the UNMHCP (see below). It should be noted that one of the important principles of the HSSP is that this overall structure should comprise public and private-not-for-profit (PNFP) providers working in a close partnership.

| Level    | Health Centre | Population (approx.)                    | Services Provided   |
|----------|---------------|---|---|
| District | I             | Village - 1,000                         | Community-based preventive and promotive health services. Village Health Committee or similar status.   |
|          | II            | Parish - 5,000                          | Preventive, promotive and out-patient curative health services, and outreach care.  |
|          | III           | Sub-county - 20,000                     | Preventive, promotive, out-patient curative, maternity and in-patient health services and laboratory services.  |
|          | IV            | County - 100,000                        | Preventive, promotive, out-patient curative, maternity, in-patient health services, emergency surgery, blood transfusion and laboratory services.   |
|          | V             | General Hospital – 500,000              | In addition to services offered at health centre level IV, other general services are provided including in-service training, consultation and research for community-based health care programmes.   |
| Regional | VI            | Regional Referral Hospital - 2,000,000  | In addition to services offered at the general hospital, specialist services are offered, such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical and medical services. |
| National | VII           | National Referral Hospital – 24,700,000 | These provide comprehensive specialist services and are also involved in teaching and research.   |

## 2

# Is the sector-wide approach (SWAp) improving health sector performance in Uganda?

Valeria Oliveira Cruz, Ros Cooper, Barbara McPake, Rob Yates, Freddie Ssengooba, Francis Omaswa, Christine Kirunga Tashobya and Grace Murindwa

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### Summary

International donors provide the major source of development assistance to Uganda. Until recently, for historical reasons and because of weaknesses in national policies and structures, development assistance had been largely organised through stand-alone projects. This modality of aid delivery was seen as an essential approach to allow flexibility to manoeuvre, quick response, and demonstrable results in key priority health concerns. However, project-based support has been criticised for causing fragmentation of the health system into several sub-systems with differing capacities, delivering different health interventions to different beneficiaries. Concerns for equity, efficiency, and government leadership have since led to the introduction of the sector-wide approach (SWAp) in Uganda. The main objective of the SWAp is to improve the overall performance of the health system and consequently the health status of Uganda's population. To this end, it aims to coordinate development assistance to the sector and to reduce the administrative burden for government. This chapter analyses the evolution of the SWAp as one of the key reforms undertaken in Uganda since 2000, describing the structures and processes involved. Benefits of this reform include the establishment of a platform for coalition building and policy learning among stakeholders and improved donor coordination. However, the SWAp faces important challenges, including the burden of persistent under-funding to the health sector and the renewed interest in vertical approaches to health sector funding arising from the introduction of new global health initiatives. These may adversely affect the SWAp objectives and risk destabilising the significant progress made in the health system in Uganda since 2000.

## 1. Introduction

Traditionally, in international development assistance for health, projects have been seen as the preferred approach (Peters and Chao 1998) to respond quickly, allow flexibility to manoeuvre or circumvent weak health systems, and to yield demonstrable results for selected high priority concerns (Oliveira Cruz et al. 2003). Often, projects focus on the implementation of interventions related to a particular disease or condition, such as polio or malaria (Ssenooba et al. 2004), or in a specific geographical area, and are characterised by a vertical or categorical mode of delivery.

However, provision of project-based support has been criticised for causing fragmentation of the health system into several sub-systems with differing capacities and delivering different health interventions to different beneficiaries (Cassels and Janovsky 1998). For example, the situation in Uganda during its post-conflict rehabilitation in the 1990s is described by Macrae et al. (1996) as follows: proliferation of projects rather than a coherent health policy, relative dominance of vertical programmes, unsustainable escalation of recurrent costs associated with projects, poor coordination and inequitable distribution of aid resources, skews in service provision in favour of selected interventions and urban areas, high levels of aid dependency, limited capacity building, and limited institutional development at both national and local levels. The problems associated with uncoordinated projects are also noted in other chapters in this book (chapter 1, Yates et al.; chapter 7, Ssenooba et al.; and chapter 4, Nazerali et al.).

Hence, the introduction of the sector-wide approach (SWAp) in Uganda has been motivated by concerns for government leadership, efficiency (Peters and Chao 1998; MoH 2000a), and equity (MoH 2000a), with the aim of improving sector performance by means of coordinating development assistance and thereby reducing administrative costs for government.

The SWAp is a relatively new approach, compared with decades of history of implementing projects. Therefore, stakeholders are keen to gather evidence of the impacts of this strategy on the implementation of national policies and plans. Several countries are implementing SWAps – e.g. Zambia, Ghana, Pakistan, Bangladesh (Cassels and Janovsky 1998), Mozambique, Tanzania, Cambodia, Vietnam (Foster et al. 2000) – or are considering adoption of different forms of SWAp. The Ugandan version of the SWAp has several notable features worth documenting, particularly after the extended period of its implementation (since 2000). These may help inform both national and international debates and decision-making. This chapter intends to assess and document the evolution of the SWAp in Uganda and to analyse the extent to which it is contributing to improving the performance of the sector.

## 2. Definition and objectives of the SWAp

*"The defining characteristics of a SWAp are that all significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector and progressing towards relying on government procedures to disburse and account for all funds"* (Foster et al. 2000: 1). Hence, donors' support to a SWAp is characterised by a more comprehensive approach to aid delivery with the funding of a coherent government-led plan of activities rather than managing their own discrete projects.

Essentially, a SWAp should enable governments to own and coordinate development assistance in a given sector in the following spheres: policy design, strategic and operational management, financial pooling, resource allocation and common arrangements for monitoring and evaluation (Oliveira Cruz and McPake 2004). Effective coordination of these spheres should achieve the following:

- Higher degree of government control over plans and the development agenda;
- Substantial reduction in administrative costs in dealing with different development partners' (DPs) systems and requirements;
- Flexibility in the design of strategies to accommodate local conditions and build the capacity of the overall health system;
- Greater technical and allocative efficiency of the overall resource envelope; and
- Improved management and logistics systems.

The SWAp aims to take a holistic perspective of the whole health sector. The overall goal of the health SWAp in Uganda is to improve the performance of the health system and consequently the health status of the population (MoH 2000a). A SWAp may be interpreted in narrow terms, as a financing instrument where the government benefits from a basket of funds contributed to by different DPs. This basket would represent the essence of the SWAp partnership. In Uganda however, the health SWAp involves more than just a basket approach to funding. The focus is on the sector investment plan, entitled the Health Sector Strategic Plan (HSSP) and the supporting National Health Policy (see Annex 1 in chapter 1, Yates et al.). Hence, the SWAp is a platform for adopting a comprehensive approach to implement the HSSP by harnessing all available resources (human, financial, projects etc.).

Another characteristic of the Ugandan SWAp is a strong focus on consensus building among stakeholders. Based on the consensus approach, the SWAp takes a flexible line towards channelling donor funds to the sector. Funds can be provided in the form of support to the budget, projects (at national and district level), and technical assistance.

The SWAp objectives need to be analysed critically to determine the extent to which they contribute to the improved health sector performance documented in chapter 1 by Yates et al., particularly in regard to improving the harmonisation of priorities, reducing fragmentation and duplication of efforts, increasing funding levels, and promoting sustainability of programmes.

## 3. Uganda's SWAp experience to date

### 3.1 Mechanisms and processes<sup>1</sup>

The Memorandum of Understanding (MoU) between the Government of Uganda (GoU) and DPs establishes the overall principles and mechanisms governing the SWAp partnership (MoH 2000b). The SWAp was officially launched in Uganda in August 2000. While the MoU was signed by the Ministry of Health (MoH) on behalf of the

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<sup>1</sup> Annex I provides a detailed description of these.

GoU, and by various development partner agencies, a wider range of stakeholders are actively involved in its implementation. These include the Ministry of Finance, Planning and Economic Development (MoFPED) and the Ministry of Local Government, and representatives from civil society (e.g. private-not-for-profit health organisations). This is in line with the broad definition of the SWAp in Uganda.

Policy advice, priority setting, decision-making, strategic management, monitoring and evaluation (performance monitoring) are carried out on a yearly basis, through Joint Review Missions (JRM), and followed up on a monthly basis, through the Health Policy Advisory Committee (HPAC). The JRM is an annual forum to which all stakeholders to the health sector are invited and the HPAC includes representatives from the MoH, other Ministries, DPs and other health partners (e.g. PNFP sub-sector). While the JRM and HPAC also have financing functions, these responsibilities are largely delegated to the Sector Working Group (SWG) which reviews budget priorities, agrees on broad resource allocations, and decides on the project portfolio for the sector as a whole. Discussions and decisions at the inclusive JRM and HPAC meetings are informed by the activities of individual Working Groups (WGs). These WGs streamline the operation of areas such as integrated support systems (human resources, drugs and supplies, and financing) by identifying problems, proposing action and following them up. For technical programmes within the MoH, Interagency Coordinating Committees (ICCs) perform the functions of priority setting for key programme interventions, developing work plans and coordinating projects in view of national level objectives.

These mechanisms and processes have been playing an important role in the Ugandan SWAp. For example, the HPAC is seen as a crucial forum for negotiation and policy dialogue and agreement of plans and undertakings among stakeholders in the health sector. It meets regularly, serves as an opportunity to *"discuss and resolve issues openly"*, and has contributed to building trust between the GoU and DPs (MoH 2003a: 62). ICCs are credited with facilitating programme areas to identify their core interventions according to the sector's overall priorities, as opposed to responding to project or development partners' agendas. They have also helped programme areas to streamline their functions with those of the health sector integrated support systems.

There is, however, room for improvement. For instance, the HPAC could benefit from a more strategic and policy-oriented focus and concentrate less on operational issues (MoH 2003a), and could be used more consistently as a performance monitoring mechanism (MoH 2001; MoH 2003b). In addition, the relationship between different structures, such as that between the ICCs and HPAC, needs to be streamlined and formalised (MoH 2003a). These sorts of issues and problems are discussed, together with a general assessment of the status of partnership between the MoH and DPs, at yearly review meetings (the JRM) of the SWAp.

Finally, it is worth mentioning the linkage between the SWAp and the operational level. Given the decentralised nature of service delivery in Uganda, districts are responsible for the implementation of health prevention and care activities. While district representatives participate in various SWAp-related structures (e.g. JRM and WGs), these structures remain largely under the control of the centre, and the extent to which the districts play an active role in these structures is questionable. This tension, between the increased powers held at the national level through the SWAp process and the pursuit of higher levels of devolution at district level, was highlighted at the early stages of the SWAp in Uganda by Jeppsson (2002) and more recently by Elsej et al.

(2005). For example, districts are not represented at the monthly HPAC meetings or at the meetings of the SWG where important resource allocation and budgeting decisions are taken. Nevertheless, this situation may improve over time as both the MoH and DPs continue to strive to provide better support to districts in order to improve performance at service delivery points (for further details see chapter 6, Murindwa et al.).

### 3.2 Products

Possibly the main achievements of the SWAp have been to enable the strengthening of the budget support mechanism (i.e. donor funding directed to the GoU health budget rather than to specific projects) as well as to contribute to improved allocative and technical efficiency in the sector, as demonstrated in chapter 7 by Ssengooba et al. From the outset of the first HSSP (2000/01–2004/05), the number of DPs providing budget support to the government health budget increased from five (UK, Ireland, Sweden, Belgium, and the World Bank) to eight (the previous five apart from Belgium plus EU, Norway, Netherlands, and Denmark) (MoH 2003a). These donors have gradually phased out their previous project activities and are now channelling their funds directly to the GoU health budget. While these DPs increasingly trust the efforts and commitment of the GoU, they also stress the need to improve existing accountability mechanisms. The functioning of the above-mentioned SWAp structures (e.g. HPAC and JRM) seems to be providing confidence to more DPs that their resources are being channelled efficiently according to the plans and agreed priorities.

Another product of the SWAp is the development of a comprehensive performance monitoring system which is used by all DPs (although some partners still require additional elements to the overall system for their own accountability purposes). Before the SWAp, the MoH and districts had to deal with a range of separate supervision and evaluation missions organised by DPs. For example, at one time alone, the MoH (not counting districts) had about 45 different projects running with different monitoring and evaluation requirements. This limited efforts at national and district levels to gather, consolidate, analyse and disseminate information regarding performance of the system overall. In this respect, the MoH and the DPs agreed on a monitoring framework for the HSSP (based on a selected list of performance indicators), and the strengthening of mechanisms for data collection and dissemination. Under the SWAp, emphasis was placed on the preparation of Annual Health Sector Performance Reports. Although the first reports were considered to be of poor quality, with programmes reporting from an implementation perspective (e.g. number of workshops held), the most recent one (2003/04) has been commended for providing a good synopsis of the sector's performance with regard to key outputs at the central and local levels of government.

During SWAp implementation, different undertakings<sup>2</sup> have been agreed between DPs and the MoH to improve integrated support from the national to the district level. More specifically, the Monitoring and Supervision WG analysed and identified priority actions which have resulted in the creation of area teams and district league tables (discussed by Murindwa et al. in chapter 6). These are considered valuable support structures and monitoring tools for the health sector.

<sup>2</sup>Undertakings are actions or processes in a specific area agreed during a JRM between the GoU and DPs to be given priority during the year. Progress towards the achievement of undertakings is reviewed during the subsequent JRM. For a number of donors, successful outcome of the JRM and achievement of the undertakings determines the release of funds to the budget.

A further product that has resulted from the SWAp partnership is the series of tracking studies.<sup>3</sup> These studies are agreed on during JRMs and progress relating to the studies' recommendations are followed up by the HPAC. While these studies may be seen to have a *quasi* audit function, and in fact they are part of the fiduciary requirements of some DPs, they are envisaged as a *broader* type of audit, answering questions such as 'why is it not working?' and 'where are the constraints?' Thus these studies allow an in-depth assessment of problems, formulate recommendations for action, and serve as opportunities to build consensus for these actions to be carried out, instead of functioning as *narrow* or internal types of audit. For example, disbursements of funds improved after the follow-up by MoH of recommendations from the study of financial flows from central government to districts. It was possible to decrease the average time delay for the flow of funds from the MoFPED to service delivery points in districts from 75 to less than 30 days over a two-year period (MoH 2003a).

Finally, the SWAp prompted the creation of the Health Development Partners' Group (HDPG). This forum allows for information sharing, discussion, consensus building and joint decision-making amongst DPs. This enables them to 'come with a single voice' to their negotiations with the MoH, thereby strengthening the group but also helping to focus their engagement with, and support to, government. Donor coordination also facilitates the process of alignment of project-based support to HSSP priorities and makes project delivery less disruptive to the health system as the HDPG encompasses both project and budget support donors. This is the case, for example, with the development agencies for Italy, Japan, and the USA, who are active members of the HPAC and the JRM despite being project rather than budget support donors. The USA even chaired the HDPG for a period in 2003/04.

### 3.3 Benefits

From the above, it seems that the SWAp provides an opportunity to assess the system as a whole and hence to recognise constraints which would not be feasible through other, more fragmented, ways of working. The SWAp has also facilitated the process of coalition building and joint policy learning. Illustrations of these elements of the SWAp are the agreed commitments and decisions taken during JRMs. The JRM offers a very distinctive opportunity for a wide range of stakeholders to share their performance, experiences, views and knowledge, thereby contributing to a more in-depth and open understanding of the system and the reasons why certain elements are not working well. It also facilitates decision-making regarding which problem areas need specific examination (tracking studies) and agreement on undertakings for the coming year. In addition, given the frequency with which stakeholders meet under the SWAp arrangement, a gradual learning process about the system has been enabled, helping to develop further consensus and trust among stakeholders.

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<sup>3</sup>So far four studies have been completed, one on financial flows from the central government to district health services, and a second on drug procurement and management. A third one on procurement of supplies and central activities (by the MoH on behalf of districts) was presented early in 2004 and its recommendations are being followed up. A fourth study on human resources has been completed and its results have been presented to HPAC. A fifth study on health infrastructure is underway.

When DPs provide direct district support (through projects or technical assistance for example) or at project level, the focus of attention lies on a relatively narrow range of issues. Although bigger problems, such as difficulties in financial flows from the central government to the districts and/or limited human resource capabilities at the health facilities, can still be identified in this project-specific domain, little or no action can actually be taken to address such crucial systems constraints within the project framework.

In addition, a better understanding of the problems affecting the sector in general, and an appreciation of those that lie outside the sector, helps stakeholders to improve inter-sectoral collaboration. For example, health workers not being paid on time and on a regular basis by districts prompted stakeholders in the health sector to work with the Ministry of Public Service to recentralise and computerise the payroll in 2001/02 (see chapter 6).

The nature of SWAp interactions and responses has also given its stakeholders a combined voice and stronger bargaining power. For example, during the budget negotiation process for 2004/05, health spending was expected to suffer a real per capita reduction of 11 percent relative to the previous year's budget (MoH 2004). Through combined concerted efforts, the MoH, DPs and other stakeholders successfully restored the allocations to the health sector (MoFPED 2004a).

Ssengooba et al. argue in chapter 7 that the SWAp has enabled national level decision-making, and a more equitable allocation of resources which accords with the priorities set out in the health sector plan. Sector objectives are now clearer as a result of developments such as the reporting, monitoring and evaluation system, which was enabled and improved through the SWAp.

An illustrative case study of SWAp benefits is given by the reform of the medicines financing and logistic systems leading to improved technical efficiency in this area (see chapter 5). Such reform was facilitated by the SWAp which provided a framework for the required policy consensus and coordination of efforts. First, the JRMs acknowledged that medicines financing was pivotal in improving health sector outputs, given the investment already made in the area of infrastructure and human resources (see chapter 6) and the increased demand for medicines after user charges were abolished (see chapter 3). Second, the WGs facilitated collaborative planning amongst the numerous stakeholders, and provided ownership and management of incremental change using realistic strategies and practical measures at the operational level. Third, the Drug Tracking Study played an important role in both monitoring the implementation and impact of the changes introduced and providing data on the aspects needing attention (MoH 2002; and see chapter 4).

## 4. Challenges to SWAp implementation

There are two sets of challenges to SWAp implementation in Uganda. The first refers to system-wide challenges (e.g. financing) and the second are intrinsic to this approach to aid. System-wide challenges are discussed elsewhere in the book, while this chapter focuses on this second set of challenges.

Efforts to scale up resources available from the international community for reaching the Millennium Development Goals (MDGs) are evidenced by the establishment of the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the US-sponsored President's Emergency Plan for AIDS Relief (PEPFAR). However, these new large-scale initiatives for the delivery of aid follow a project approach (in a disease-specific vertical form), with unprecedented amounts of resources channelled into the country at a fast pace with strong pressure to produce results in a short period of time. They are thus likely to put stresses on still weak health systems.

Green and Collins (2003) highlight the potentially disruptive nature of funding and accountability arrangements developed by development partners that are not in line with the values of a SWAp. Project funding is usually better resourced and more focused (on specific diseases, health system issues or geographical locations) than funding for the SWAp through the government budget. Coordination structures, delivery mechanisms and timeframes, budget cycles and objectives may be out of sync with those used by the rest of the SWAp partners. Limited resources can be diverted, such as when health workers employed by the public and private-not-for-profit sectors take better paid project posts, or when management time is required to cover separate coordination and implementation structures, as was the case when both the GFATM and PEPFAR were originally launched. In addition, policies can be undermined. For example, the delivery of anti-retrovirals (ARVs), a key element in PEPFAR and GFATM activities, was not included in the priorities of the first HSSP (2000/01–2004/05) and there is evidence of duplication and disruption as a result (MoH 2003c).

Further, the delivery of ARVs through projects implemented by non-governmental organisations is taking place to a large extent without consideration of an equitable geographical distribution. Currently, anti-retroviral therapy (ART) sites are concentrated in Kampala and Masaka, representing a disproportionate concentration compared to other parts of the country which are harder to reach and in great need, such as the conflict ridden North (ART Coordination Committee 2004).

Another problem has been that while the Ugandan government's policy is to provide co-formulated, single tablet, cheap, generic triple therapy for ARVs, US projects adopt branded multi-tablet ARVs that are much more expensive (ART Coordination Committee 2004). This could potentially create confusion for the beneficiaries of the different programmes, which in turn could impact on patient compliance with the treatment, and also means that scarce resources are not being used as efficiently as they could be.

Such international initiatives also have a strong political dimension. Decisions no longer lie at the technical level (where the emphasis is on harmonisation with the health system) but may be agreed at the highest levels of government and their agendas carried forward (e.g. preference for service delivery through faith-based organisations). These types of international initiatives often have their decisions taken outside of the country, and hence lack knowledge of local realities and are not in line with locally

agreed policies (e.g. the way the system operates, its history, the organic nature of its processes). If the objectives of harmonisation of priorities and reduction of fragmentation are to be achieved, a renewed global interest in projects represents a major threat to the SWAp.

Another dilemma for the health sector is how to align the potentially competing goals of channelling more funds through the budget, with the pressing need to augment resources for the sector in light of increasing project-based aid. In this context, high profile, externally driven project aid (such as the global health initiatives) has to be evaluated in terms of two country-level constraints to expanding health sector funding through the budget. The first is the imposition of budget ceilings on all sectors by the MoFPED, as of 2004/05. The health sector has to accommodate all project funding and budget support under its established ceiling, as an element in the ongoing efforts to ensure macroeconomic stability<sup>4</sup> of the country and improved aid efficiency.

The second constraint, of a political economy nature, concerns the general desire of the GoU to reduce the proportion of aid (budget support or project aid) to domestic revenues, which is close to 47 percent (MoFPED 2004b). The motivation for pursuing this goal is related in part to the GoU's assertion of its sovereignty. It is also related to the government's concerns regarding the (un)predictability and (un)sustainability of aid funds into the country. While agreements are signed over 3 to 5 year frameworks, the yearly flows of aid are still unstable. In this context, project aid may be difficult to incorporate into the health sector budget and is likely to displace more efficient and flexible resources channelled through the budget mechanism.

The above-mentioned constraints seem to point to the conflict of technical objectives between the health sector, to increase its budget in order to adequately fund the HSSP, and the government (in this case the MoFPED and Cabinet), to reduce the fiscal deficit and the proportionate volume of aid in Uganda (in spite of their international commitments to reach the MDGs). Although the MoH is part of Cabinet, its demands must compete with those of several other line ministries. The MoFPED clearly places its major emphasis on the achievement of a more coherent national planning and budgeting process in the context of a medium-term expenditure framework, taking into account all sectors in the budget allocations. However, an overlooked issue appears to be the need to acknowledge the specificities of the different sectors. For instance, a large proportion of health expenditure has a high import content (e.g. drugs and equipment) where increased expenditure will have a less direct adverse impact on the macroeconomy relative to other sectors.

Another significant challenge to the SWAp refers to its reliance on individual, as opposed to institutional, vision and commitment to its principles. The SWAp is a process-based approach in which individuals have an important role to play at all stages, as pointed out by Walt et al. (1999). This greater dependence on individuals has higher relevance in the context of developing countries, which lack strong institutions. It is essential that individuals, part of the system, believe and act according to SWAp principles without giving in easily to pressures and challenges. Uganda has so far

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<sup>4</sup>The rationale underpinning this refers to concerns regarding the potential negative effects of high inflows of aid. These include the potential for appreciation of the real exchange rate and decreased exports, fiscal deficits, high interest rates and reduced private investment impinging on productivity and growth (for further details see Adam and Bevan 2002; Lake 2004; and MoFPED 2004c).

benefited from a remarkable mix of individuals on the government as well as on the development partners side, who have shown strong character, leadership skills, vision, commitment and reform spirit as well as operational abilities to transform vision into practical steps. But individuals come and go. Hence the replacement of individuals in the MoH or the DP group may threaten the SWAp partnership if newcomers do not understand the essence of it, are not committed, or are too familiar and perhaps attached to the incentive structure of the project mode of funding. The project incentive structure particularly benefits the national level, emphasising project implementation units and related equipment, high salaries and foreign travel, and lacks transparency (e.g. methods of recruitment). In contrast, the incentive structure of the SWAp and budget support modes lies at the operational level (districts) with a greater element of transparency regarding how funds are used. Within the MoH, technical groups are still divided between the incentive structures of project and SWAp modes. Increased funding through projects represents another threat to the SWAp.

Related to the above is the problem of commitment in the political sphere. The pursuit of different political agendas, particularly in times of political 'stress', may not be in line with the health sector's priorities. This can represent a bottleneck in the process of moving forward agreed reforms between like-minded GoU technocrats and DPs in the absence of political support. An illustration of this issue is the current debate in Uganda on whether or not to introduce indoor residual spraying as an intervention for malaria control. At the technical level, given the type of malarial transmission in Uganda, the World Health Organisation and other experts consider this intervention not to be particularly effective (EARN 2003; Root et al. 2003). However, at the political level, this intervention is considered to have popular appeal and is believed to deliver a quick fix to a major health problem in the country.

## 5. Conclusions

Since 2000, the implementation of the SWAp by means of the mechanisms and processes presented in the previous section, guided by the general principles of the partnership as stated in the Memorandum of Understanding (MoH 2000b), and by the vision and belief of individuals committed to this approach, points to important products and benefits for the health sector. As highlighted by Yates et al. in chapter 1, it is very difficult to disentangle whether these products and benefits are directly attributable to the SWAp or to other reforms undertaken concomitantly in Uganda (discussed in the other chapters of this book in more depth).

Hutton and Tanner (2004) note the lack of standards for assessing the tangible benefits of a SWAp. They suggest there are, even if indirectly, four key areas<sup>5</sup> that if strengthened could help to understand the impact of a SWAp on population health. Within this framework, the full impact of a SWAp can be measured in terms of health outcomes, although these can only be assessed over sustained periods of implementation (5–10 years).<sup>6</sup>

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<sup>5</sup> 1) Country leadership and ownership, 2) institutional and management capacity, 3) flow of resources, and 4) monitoring and evaluation.

Clearly this begs the question as to whether the SWAp constitutes a reform in itself or if its *raison d'être* is to facilitate reforms. In the Ugandan context it seems that the SWAp plays both roles. It did represent a substantive shift from a fragmented system, where there was no coherent sector policy, strategic plan nor a consolidated planning, budgeting or capacity building approach at national and district levels. Instead there were large projects such as the Delivery of Improved Services for Health Project (DISH) funded by USAID or the District Health Services Pilot and Demonstration Project funded by the World Bank.

The way in which the SWAp is defined and implemented in Uganda, being a holistic platform for aid coordination, funding and operation of the HSSP, suggests it is also a means to an end. The main goal of the SWAp is to improve health system performance. We argue that the systems improvements demonstrated in the other chapters of this book have been facilitated by the SWAp, as it provides an opportunity to work towards identifying system-wide problems and potential solutions (within and outside the sector).

The SWAp, as shown in particular by the case of medicines supply reform (chapter 4, Nazerali et al.), has contributed to the reduction of fragmentation and duplication of efforts. It also played an important role in achieving stronger harmony of priorities and improved planning and monitoring processes at district and national levels. By bringing together all key stakeholders in the sector, building consensus on policies and processes, gathering better information, and working jointly towards agreed common goals, the SWAp has given the health sector a combined voice and stronger bargaining power.

The SWAp has also facilitated the improvements in allocative efficiency of the GoU budget, which have occurred over the period of its implementation (see chapter 7, Ssegooba et al.).

All this suggests that the SWAp has played a key role, among other reforms, in facilitating improved health sector performance. Because of this, attention to addressing the challenges outlined in this chapter is urgent. The objectives and essence of the SWAp in Uganda need to be maintained and its mechanisms and processes strengthened. However, continued achievements at sector level will not be possible if, for instance, initiatives such as the GFATM and PEPFAR are not harmonised with local policies, systems and capacities. The way in which these projects are being implemented seems to be destabilising, even in the context of a flexible and inclusive SWAp that accepts both projects and budget support.

The SWAp has represented a major change to the way in which the health system is governed, and one which it has been suggested offers the best chance of delivering improved health status to the population. However, given the challenges discussed in this chapter, the achievement of that long-term goal seems uncertain.

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<sup>6</sup>Moore (2003) compared 69 countries classified in terms of those that were implementing a SWAp and those not. Among other indicators assessed, the results showed that SWAp and non-SWAp countries did not present any significant average differences in their 1999 health outcome indicator (disability adjusted life expectancy – DALE). However, the author recognises that the result is predictable since the implementation of SWAp by these countries was at its early stages. It is also worth noting that DALE results presented in 1999 reflect the health sector situation of those countries dating back to even earlier periods than the introduction of SWAp.

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## Annex 1: Overview of SWAp-related mechanisms and processes in Uganda

The following tables intend to provide an overview of the SWAp-related mechanisms and processes currently in place in Uganda. Table A1 summarises the core mechanisms and processes with a focus at the national level. Table A2 presents the connections to the implementation level.

**Table A1: SWAp-related structures and processes in Uganda**

|  | Definition  | Purpose / Processes  | Frequency  |
|--|---|--|--|
| <b>Joint Review Mission (JRM)</b>              | A joint review of sector performance by GoU and partners (i.e. districts, Parliament, NGOs, private sector and donors).   | <ul style="list-style-type: none"> <li>• Joint visits to selected districts chosen on a rotational basis, according to performance (low and high) based on standard terms of reference with a view to assess progress on areas such as human resources, financial flows, information and management systems, and agreed technical priority areas;</li> <li>• Review of the Annual Health Sector Performance Report;</li> <li>• Use of the agreed PEAP indicators (health)<sup>7</sup> as the basis for progress assessment;</li> <li>• Discussion of proposals for the Budget Framework Paper / Medium Term Expenditure Framework priorities for the following financial year;</li> <li>• Discussion and agreement on undertakings (priorities), one or two priority programmes, and a tracking study for following year.</li> </ul> | Annual (October); used to be twice a year.                   |
| <b>Technical Review</b>                        | Substitutes the previous arrangement of two JRMs per year. This meeting among stakeholders aims to review and discuss a specific technical issue agreed during the prior JRM. The 2004 technical review meeting discussed the first draft of the second Health Sector Strategic Plan (2005/06-2009/10).   |  | Annual (around April)  |
| <b>National Health Assembly (NHA)</b>          | Involves broad participation from district and central level, and from civil society stakeholders. The purpose of the assembly is to act as a forum for building nationwide consensus and advocacy for the health development agenda in the country. It is also an opportunity to improve sector performance by highlighting differences in district performance. |  | Annual   |
| <b>Health Policy Advisory Committee (HPAC)</b> | Established as a forum to discuss and advise the Ministry of Health and development partners on the implementation of the National Health Policy and the HSSP.  |  | Monthly; started as weekly and goal is to have it quarterly. |

<sup>7</sup> These are: utilisation of out-patient services in public and private-not-for-profit units, immunisation rates for DPT3, deliveries in health units, HIV prevalence rates, proportion of posts filled by qualified staff.

|  |   |   |  |
|--|---|---|--|
| <b>Sector Working Group (SWG)</b>                | Oversees the financing of the SWAp with a particular focus on maximising efficiency and equity in the annual budget process. The SWG discusses and reviews the Budget Framework Paper <sup>8</sup> as well as proposals of new health sector projects before submission to the Development Committee of the MoFPED. It has an important role in vetting projects for compatibility with the HSSP and value for money. |   | Monthly in the run up to the budget and bi-monthly otherwise (but in practice does not happen as regularly as this).                 |
| <b>Working Groups (WGs)</b>                      | Initially created to prepare for the first HSSP and are now considered to play a key role in translating HSSP outputs into policies, plans and activities.  | There are currently 9 working groups which report to HPAC: <ul style="list-style-type: none"> <li>• Human resources for health;</li> <li>• Drug procurement and management;</li> <li>• Health infrastructure;</li> <li>• Supervision and monitoring;</li> <li>• Basic health care package;</li> <li>• Public-private partnership in health;</li> <li>• Research and development;</li> <li>• Finance and procurement;</li> <li>• Health systems</li> </ul>   | During JRMs and throughout the year as per programme of work (e.g. on a more regular basis during preparations for the second HSSP). |
| <b>Interagency Coordinating Committees (ICC)</b> | Bring together all implementing agencies and donors who support a particular programme, and other MoH departments, NGOs and districts.  | The purpose of these committees is to: <ul style="list-style-type: none"> <li>• Define core interventions, review overall progress in implementation and agree on priorities for programmes;</li> <li>• Coordinate projects and other forms of support to a specific programme;</li> <li>• Review workplans and budgets of the programme.</li> </ul> Examples of existing ICCs include: <ul style="list-style-type: none"> <li>• Reproductive health;</li> <li>• Expanded Programme of Immunisation (EPI);</li> <li>• Malaria;</li> <li>• HIV/AIDS;</li> <li>• TB;</li> <li>• Sanitation is in the process of organising an ICC.</li> </ul> | Quarterly  |
| <b>SWAp Review Meetings</b>                      | Government and development partners.  | Review the general status of the SWAp partnership and discuss specific problems.  | Annual   |
| <b>Health Development Partners Group (HDPG)</b>  | Established to coordinate development partners working in the health sector in Uganda.  | <ul style="list-style-type: none"> <li>• Provides a forum for discussion on issues in the sector;</li> <li>• Enables partners to coordinate and assemble joint responses;</li> <li>• Serves as an opportunity for members to communicate amongst themselves and with the MoH more effectively;</li> <li>• Functions as a space to discuss issues related to HPAC;</li> <li>• Allows DPs to contribute more effectively to the JRMs in the health sector.</li> </ul>   | Monthly  |

<sup>8</sup>Budget Framework Papers are prepared by each sector ministry as part of the budget process in consultation with stakeholders (to be discussed in SWG meetings) and form the basis for the Macroeconomic Plan and Indicative Budget Framework Paper, usually submitted to Parliament in April of each year (Kassami 2004).

|                                 |  |
|---------------------------------|--|
| <b>Partnership Fund Account</b> | A special bank account held by the Ministry of Health for implementation of SWAp and HSSP specific activities (e.g. the costs of the JRMs, tracking studies and technical assistance). Monitoring of the account is performed by HPAC. Contributions of funds to the account are made by DPs, which included Ireland Aid, SIDA, NORAD, DFID, Danida, and UNICEF over the period of December 1999 to July 2003. |
|---------------------------------|--|

Sources: HDPG (2002); MoH (2003a); MoH (2003b); HDPG (2001); de Loor and Hutton (2003); Kassami (2004); MoFPED (2004d).

**Table A2: SWAp and Districts**

|   | <b>Description</b>   |
|---|--|
| <b>NHA</b>  | Representatives (political and technical) from all districts are invited to take part.   |
| <b>JRM and Technical Reviews</b>                      | One 'good' and one 'bad' performing district from each geographical region (North, East, West and Central) are selected by the Health Planning Department (HPD), on a rotational basis, to host the district visits and to join the JRM. In addition, based on the key topics of the meeting, the HPD invites relevant district representatives. |
| <b>WGs</b>  | Districts participate in WG meetings generally when these take place during the JRMs but not during their regular meetings throughout the year (unless a district representative chairs the WG).   |
| <b>HPAC, SWG</b>                                      | Districts do not participate.  |
| <b>District Directors of Health Services Meetings</b> | Annual meetings organised by the MoH. These meetings are aimed at sharing key information and discussing implications (e.g. budget allocations for next financial year).   |
| <b>Planning Meetings</b>                              | Semi-annual meetings organised by the HPD. Regional meetings take place between November and February. These meetings focus on budgetary issues. Meetings at district level, between March and June, emphasise detailed planning issues.   |
| <b>Other meetings / visits / interactions</b>         | In line with the MoH function of providing support to districts, there are various other forms of interaction and meetings between the two levels such as: monitoring of the primary health care grants, area team supervision visits, HMIS, league table.   |
| <b>District and regional hospitals</b>                | The HPD meets with superintendents of all district and regional referral hospitals to discuss planning and other general matters.  |

# 3

## Health sector reforms and increasing access to health services by the poor: what role has the abolition of user fees played in Uganda?

Christine Kirunga Tashobya, Barbara McPake, Juliet Nabyonga and Rob Yates

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### Summary

User fees were introduced in Uganda in the late 1980s against a background of poorly funded health systems and strong international support for the role of user fees in encouraging community participation and ownership, and for their value in generating revenue. By the late 1990s, there were conflicting opinions about the effect of user fees on access to health services, particularly by the poor and other vulnerable groups, in Uganda and other developing countries. In March 2001, user fees were abolished in all public health units in Uganda except for private wings in hospitals. Abolition of user fees is only one of a number of reforms introduced in the health sector in Uganda since the turn of the century. To assess the impact that this policy change has had on the health sector, this chapter draws on evidence from a number of different sources including data from the Ministry of Health, the World Health Organisation, Participatory Poverty Assessment Reports and the Uganda National Household Surveys. The data point to a significant and immediate increase in utilisation of health services following the abolition of user fees, in particular by the poor. We conclude that user fees may be a bigger barrier to health service access for the poor than was previously envisaged in developing countries. Furthermore, in order to achieve sustained improvements in health service utilisation, the policy of abolition of fees should be implemented simultaneously with supply side reforms.

## 1. Background

Following years of political and economic upheaval in the 1970s and 1980s, the poor state of the public systems, including health services, led the country to be heavily dependent on foreign aid. At that time, development policy, and as a result, health policy, was heavily influenced by these donor countries and aid agencies (Okunzi and Macrae 1995).

The rationale for the introduction of user fees in the health system, as argued by the proponents of this policy, was that they had the potential to increase revenue for health services and also to increase efficiency in the delivery of health services by giving patients a stake in the system. This would lead to the use of the additional revenue for particular needs like drugs, facility improvement and staff incentives. In addition, user fees were said to have the potential to increase equity in health services by making it possible to expand coverage of services for underprivileged groups (Akin et al. 1987; Bennett and Gilson 2001; McPake et al. 1993; Shaw and Griffen 1995).

Close to two decades later, it should be possible to determine whether or not user fees have lived up to expectations. Internationally, there are mixed reports about what user fees have achieved. Some studies show that user fees have raised some revenue for health services, forming a significant proportion of non-salary recurrent expenditure at health units (Creese 1997). These resources have been used to improve service quality by improving drug availability and boosting staff morale (Soucat et al. 1997; Audibert and Mathonnat 2000; Kipp et al. 1999). There have also been some reports of increased community participation in health services management, built around user fees schemes (MoH 2001a).

Conversely, user fees have been criticised on grounds of inequity, lack of visible quality improvements, and inability to raise substantial amounts of revenue (Van Der Geest et al. 2000; McPake 1993). Rather than improving equity in health services delivery, user fees are said to have led to less equitable access to services. This is because exemption schemes appear to have failed to protect the poor and the vulnerable (Gilson et al. 1995; Weaver 1995). The revenue generated has been limited and has not led to any notable expansion of health services for improved geographical equity (Meuwissen 2002).

In Uganda, user fees were first introduced in the health sector in the late 1980s but did not spread widely until the early 1990s (Kipp et al. 1999). Initially, the fees were popular with health workers and with most local government administrative and political leaders. However, they were unpopular with many members of the community and many national level politicians (Kipp et al. 1999; MoH 1999; Hutchinson et al. 1999). By the late 1990s, a number of reports and studies indicated that exemptions for the poor were not working and that many people were being denied access to basic health services because of the fees (Kivumbi and Kintu 2000; MoFPED 2000; UBOS 2000). During the run-up to the Presidential elections of June 2001, user fees for health services became a controversial issue, with abolition of fees included in the manifestos of the major competitors to the incumbent President Yoweri Museveni. Interestingly, the President and Parliament had never officially approved a policy on user fees in the country.

With effect from March 2001, the Government of Uganda (GoU) abolished user fees in all public units with the exception of the private wings of hospitals. This has presented health policy analysts with a rare opportunity to study the effect of the removal of user fees on utilisation of health services, and in particular, utilisation by the

poor. Since 2001, several studies and reports analysing the effect this policy has had on health services utilisation in the country have been documented.

This chapter seeks to review a number of these documents, looking at the different sources of data in order to draw conclusions on whether the abolition of user fees has indeed had an effect on utilisation of health services in the country. Particular focus is given to the impact of the policy on utilisation by vulnerable groups. Furthermore, we attempt to assess the contribution that this specific policy change has had in the context of the overall health sector reform programme in Uganda. In chapter 1, Yates et al. report that there have been significant increases in key output indicators, particularly for ambulatory care, but it is not yet clear how much of this has been due to supply side reforms and what, if anything, has been the impact of the policy to abolish user fees.

## 2. Review of available data

Multiple sources of information are utilised for this review and include central level Ministry of Health (MoH) and district level data and reports; a WHO/MoH study; an analysis of the Uganda National Household Surveys for the years 1999/00 and 2002/03; and the Uganda Participatory Poverty Assessment Reports. A number of other studies covering smaller geographical areas have been carried out in the country and their findings are also considered.

### 2.1 Ministry of Health and District data

The Health Management Information System (HMIS) gives data on various input, process and output variables. Data are captured at the health facility level and submitted on a monthly basis to the district health office, where they are aggregated and sent to the MoH.<sup>a</sup> The HMIS captures data from both the public and private-not-for-profit (PNFP) health units.

Reports on the data (MoH 2001b; MoH 2002a; MoH 2003a; MoH 2003b; MoH 2004) have shown that for the whole country, the number of new out-patient (OPD) contacts in both public and PNFP health units increased significantly in absolute and per capita terms over the period 1999/00 to 2003/04.<sup>b</sup> New OPD contacts per capita did not change from 0.42 in 1999/00 to 2000/01, but rose to 0.56 in 2001/02, and further to 0.72 in 2002/03, and to 0.79 in 2003/04. The substantial increase in utilisation following the abolition of user fees in 2001 is notable. Note that the utilisation rate increased by 33 percent between 2000/01 and 2001/02 and by a further 29 percent in 2002/03 and 10 percent in 2003/04, compared with no increase between 1999/00 and 2000/01 (see Figure 1 in chapter 1, Yates et al.). This is particularly noteworthy as these rises cannot be attributed to other sudden demand factors such as an epidemic. Since the malaria epidemic in 1997/98, the country has not experienced an epidemic of national magnitude.<sup>c</sup>

<sup>a</sup>See Chapter 1, Annex 1 for an outline of the structure of the health system.

<sup>b</sup>The Ugandan financial year runs from July to June. Thus in the financial year 2000/01 no user fees applied in government units (apart from private wings in hospitals) for the period March - June 2001.

<sup>c</sup>The 2000 Ebola epidemic was localised in Northern Uganda. Similarly, some districts have experienced localised cholera and malaria epidemics which would not markedly affect national OPD figures.

Looking at data from specific districts, including hospitals (see Figures 1–5), a marked increase in utilisation following the abolition of fees in March 2001 is immediate and consistent across all four selected districts (Kisoro, Ntungamo, Rukungiri and Tororo; MoH selected years). For example, in Kisoro District, the consumption of out-patient services immediately doubled.

These district level data also bring out the monthly variation in utilisation, which is quite large in some cases.

In addition, the detailed district level data highlight the different utilisation patterns between the public and PNFP units (who maintained user fees). This is shown for Kisoro District where two hospitals, Kisoro Hospital (public) and Mutolere Hospital (PNFP), are barely 4km apart. While utilisation rose at both hospitals immediately after the abolition of user fees in the public health units, the increase in the public hospital was substantially larger than that in the PNFP. Moreover, using the benefits of growing financial support from the government (a specific PNFP grant), the PNFP hospital was able to lower its user fees by a considerable amount in 2002. This was followed by a significant increase in utilisation at the PNFP unit, and some decline at the public unit. A similar pattern is noted for Nyakibale PNFP hospital in Rukungiri District, where significant increases in utilisation were noted when the hospital revised its fees downwards and made them more uniform across diagnoses and disease conditions. In chapter 5, Lochoro et al. expand on the contribution of the PNFPs to the health sector and the impact of reforms on this sub-sector.

In addition to out-patient rates, immunisation rates also shot up following the abolition of fees, as measured by the proportion of the infant population that has received the third dose of the Diphtheria-Pertussis-Tetanus (DPT3) vaccine. This improved from 41 percent in 1999/00 to 48 percent in 2000/01 (17 percent increase), to 63 percent in 2001/02 (31 percent increase) and to 84 percent in 2002/03 (33 percent increase), and stabilising at 83 percent in 2003/04. Again the dramatic increase in coverage after 2000/01 is noted.

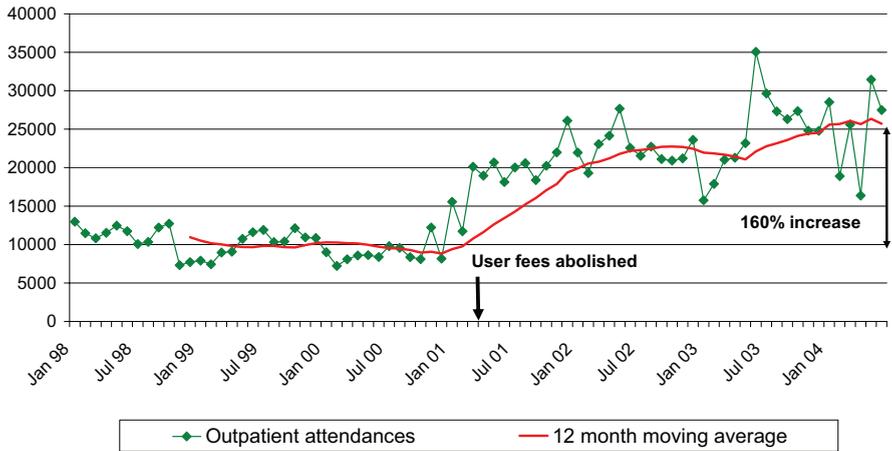
However, contrary to the above findings, the proportion of expectant mothers delivering in these health units declined from 25 percent in 1999/00 to 23 percent in 2000/01, to 19 percent in 2001/02, with just a slight recovery to 20 percent in 2002/03 and 24 percent in 2003/04.

## **2.2 WHO/MoH study on the effect of abolition of user fees**

A longitudinal study carried out under the auspices of the WHO Uganda Country Office provides both qualitative and quantitative data on the effect of the abolition of user fees (WHO 2002; WHO 2003; Nabyonga et al. 2005a; Nabyonga et al. 2005b). Of particular interest, the study links HMIS utilisation data for public and PNFP facilities with demographic (i.e. age and sex) and socio-economic variables of the health users taken from information in the community. Patients' households were classified as poorest, poor, well-off and richest on the basis of household assets.

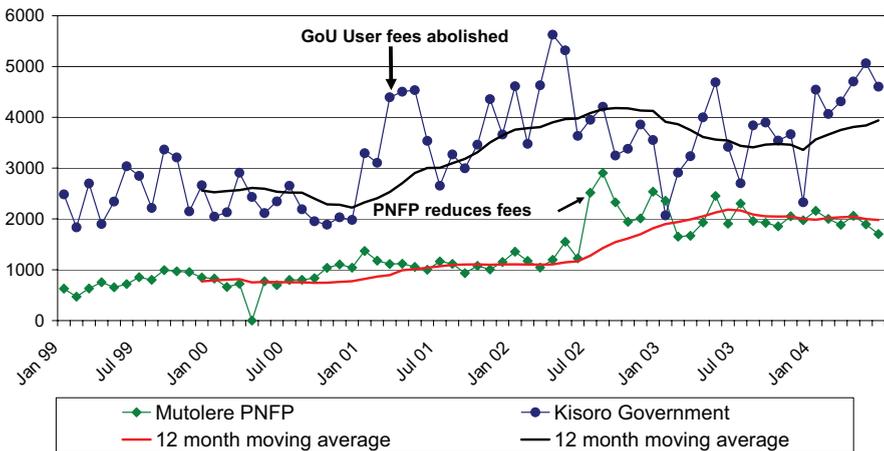
In addition to analysing OPD utilisation rates, socio-economic data were estimated for the years 2001 and 2002. Over this period, there was a strong negative socio-economic gradient in OPD utilisation – successively poorer groups had successively higher utilisation rates (Figure 6). The utilisation of the poorest group was approximately twice that of the richest group for most of the 3-year period.

**Figure 1: Monthly new out-patient attendances for all the health units (government and PNFP) in Kisoro District 1998–2004**



Source: MoH (Selected years).

**Figure 2: Monthly new out-patient attendances in 2 hospitals (one government, one PNFP) in Kisoro District 1999–2004**



Source: MoH (Selected years).

### 2.3 Uganda National Household Surveys 1999/00, 2002/03

Data on individual, household, and community characteristics are collected from a nationally representative sample in the Uganda National Household Surveys (UNHS) (UBOS 2000; UBOS 2003). Between August 1999 and September 2000, when user fees were still widespread, a sample of 10,696 households was surveyed. Between May 2002 and April 2003, after the abolition of fees, a total of 9,711 households were surveyed.

Deininger and Mpuga (2004) used these data to analyse changes in health service utilisation and to investigate the implications of these changes for the poor. Their analysis has shown that while the incidence of sickness in the population in the two surveys remained at about 28 percent, an increasing proportion of those falling sick sought health care in the period covered by the second survey relative to the first. Interestingly, the share of households reporting failure to seek care from health services due to cost declined from 50 percent in the first survey to 35 percent in the second survey. This was especially noted in Northern Uganda, the poorest region of the country.

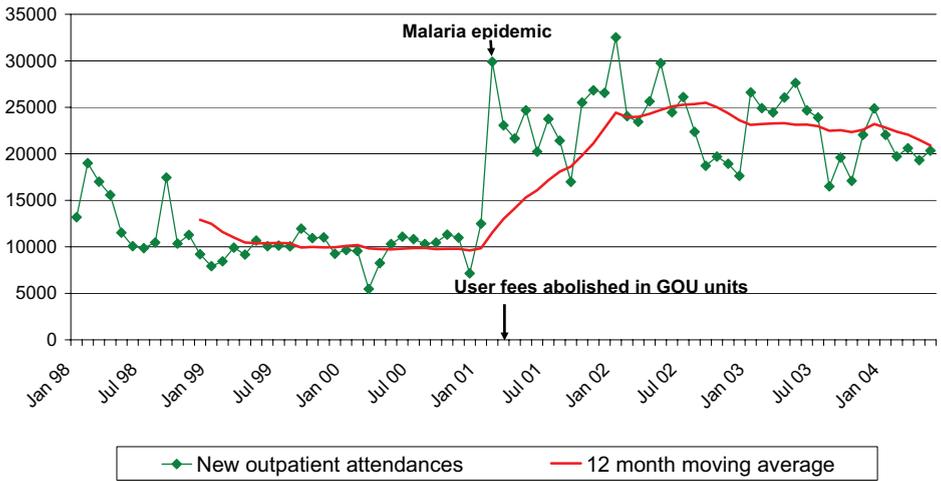
Moreover, this increase in utilisation of services by the sick was highest for those in the poorest two income quintiles. While average monthly expenditure by a household with a sick person did not show any significant change between the two surveys, there was a significant decrease in spending by the bottom two quintiles (at the 1 percent significance level). Rationing, defined as the failure to use health services because the cost is too high or the health facility too far, and not because the sickness is mild, was also found to decline. Regressions showed that the degree of rationing fell between the two surveys for both children and adults, with the decline most marked for children. In addition, wealth and urban/rural biases in rationing were eliminated for children and significantly reduced for adults.

Community level data collected in the two surveys revealed that between 1999/00 and 2002/03 there was a significant reduction in the proportions of communities that reported paying for consultation fees (from 80 percent to only 3 percent), antimalarial drugs (22 percent to 4 percent), and antibiotics (27 percent to 3.9 percent) in government health facilities.

Deininger and Mpuga (2004) also investigated whether these improvements in utilisation of health services could be having an impact on health outcomes and productivity. As noted above, the incidence of illness in the population remained at 28 percent over the period covered by the two surveys. In 1999/00, however, the burden of ill-health was more heavily felt by the poorer groups in the population. By 2002/03, the data suggest that this previous propensity for the poor to fall sick more frequently than the rich appears to have been eliminated.

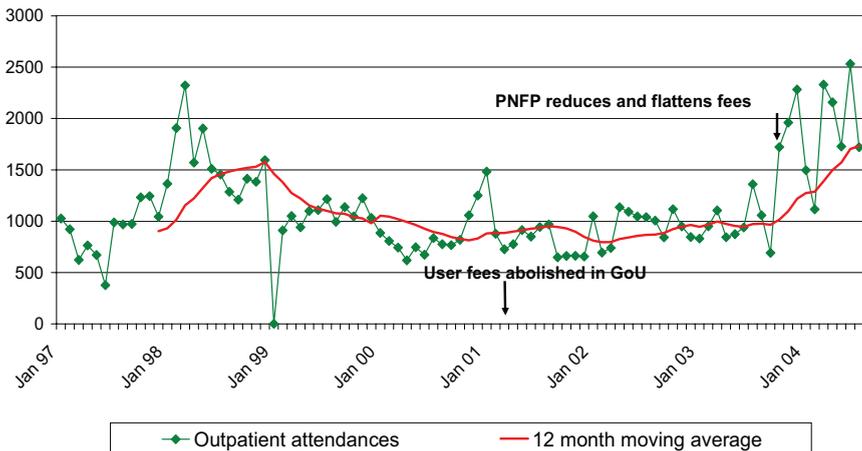
Furthermore, regarding productivity, the two surveys show that the average per capita number of workdays lost due to sickness declined from 8.3 days to 7 between 1999/00 and 2002/03. To calculate the economic cost of illness, Deininger and Mpuga used a measure which incorporated the average expected length of sickness, the average unskilled wage rate for adults (divided by four in the case of children) and the probability of falling sick. Using this measure, the economic benefit accruing from the improved utilisation and quality of health services observed in the second survey period was calculated at US\$9 million for adults, almost half of which accrued to the bottom two income quintiles in the sample.

**Figure 3: Monthly new out-patient attendances (in government and PNFP health centres) in Ntungamo District 1998–2004**



Source: MoH (Selected years).

**Figure 4: Monthly new out-patient attendances at Nyakibale PNFP hospital, Rukungiri District 1996–2004**



Source: MoH (Selected years).

## 2.4 Uganda Participatory Poverty Assessment reports

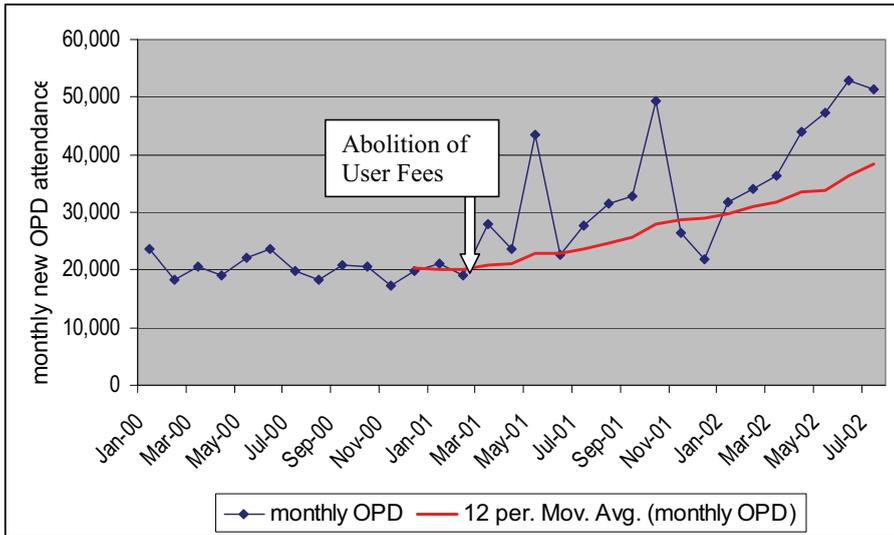
Uganda has carried out two Participatory Poverty Appraisals (PPA) to date under the auspices of the Uganda Bureau of Statistics (UBOS) in the Ministry of Finance, Planning and Economic Development (MoFPED) as part of the process of developing and updating the country's poverty reduction strategy, the Poverty Eradication Action Plan (PEAP). During these appraisals, participatory techniques are used to consult people on their understanding of the nature and causes of poverty, and on their views of the priority actions for poverty reduction by the government and/or the communities.

The first PPA (PPA1) was carried out in 1997, before the abolition of user fees (MoFPED 2000). The study covered 36 research sites in 9 districts across the country. In all 9 study districts, there was a common view that health was an important factor in poverty, both as cause and effect. Poor health and inadequate health services were cited as major causes of poverty at individual, household and community levels. The factors listed as responsible for these poor and inadequate health services included user fees, long distances to health facilities, inadequate drug and medical supplies, untrained/inadequate/poorly motivated health personnel and poor infrastructure. As a result of being unable to afford the user fees, people were reported to have resorted to no treatment, self-treatment, traditional herbalists, traditional birth attendants and witchcraft. A respondent stated *"in the 1990s you have to pay for medical care and drugs. Many die in the villages because they cannot afford to pay the user charges"* (MoFPED 2000: 62). Apart from the issue of un-affordability, it was made clear that there were other difficulties with the user fees scheme, whereby many people did not seem to have a good understanding of the nature of charges and the services to go with them (MoFPED 2000).

The second PPA (PPA2) was carried out between November 2001 and May 2002 (after abolition of user fees), and covered 60 research sites in 12 districts. Among other issues, PPA2 consulted people on their experience of the implementation of key government policies in a number of sectors, including health. As in PPA1, the most frequently cited causes of poverty were ill health and disease (MoFPED 2002). Notably, in PPA2 respondents stated that the government had been right to abolish user fees, a move that was particularly appreciated by women and the poor. Across the research sites, both community members and health service providers reported a dramatic increase in utilisation of public health facilities, but also noted problems of insufficient drugs and inadequate numbers of qualified health workers. One sub-county chief is reported to have said: *"I can confidently say that the number of patients in these units has tripled ever since cost-sharing was scrapped. The current policy of free health services should not be tampered with since it is mainly the poor who cannot afford expensive drugs in health clinics. Government should however provide more of these drugs"* (MoFPED 2002: 111). Thus it can be seen that the qualitative evidence collected through these participatory approaches supports the quantitative data presented earlier, and substantiates the negative implications of user fees for the poor in Uganda.

A number of other studies on user fees covering smaller samples have also been carried out in the country (Burnham et al. 2004). All of these point to the increase in health service utilisation following the abolition of user fees, though they provide differing estimates of the magnitude of the increase.

**Figure 5: Monthly new out-patient attendances in Tororo District (in government and PNFP health centres) 2000–2002**



Source: MoH (Selected years).

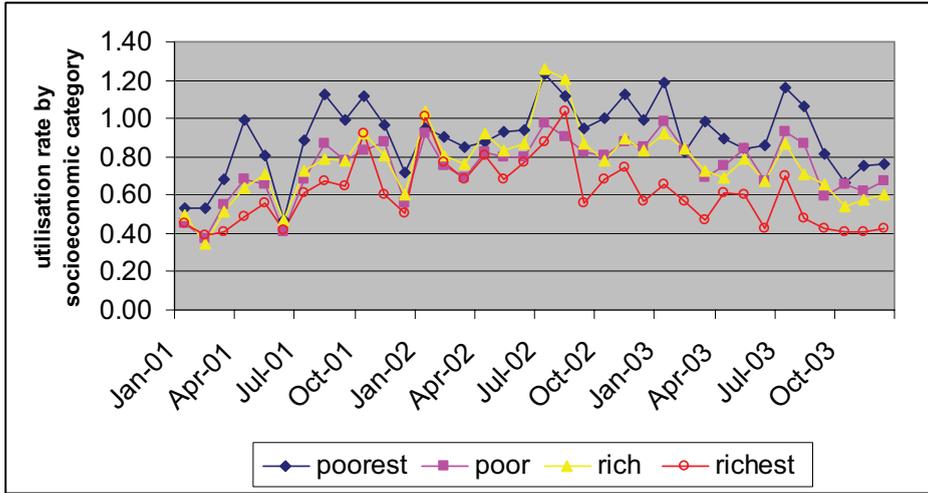
## 3. Discussion

### 3.1 Reliability of the data

A major strength of the HMIS is that it provides national data and is therefore not limited to a small geographical area or sample. Some of the possible weaknesses of the HMIS as a source of data derive from the fact that the system was introduced relatively recently (1994) and still has teething problems with poor timeliness and completeness, although both have been improving over time. Therefore, some of the improvements in utilisation of ambulatory services may be due simply to improvements in the system. However, it is unlikely that this alone could explain the extent of increases observed between 2000/01 and 2003/04.

The study carried out under the auspices of the WHO Uganda Country Office has collaborated closely with many health sector stakeholders in Uganda. The linking of HMIS and community survey data is likely to minimise the possibility of inflated health facility HMIS figures. Furthermore the UNHS provides a nationally representative household survey database. This generic database is managed by the Uganda Bureau of Statistics and is outside of the control of any one sector. The availability of data on household characteristics and on the utilisation of health services before and after the abolition of user fees makes this a very important source of information. Another perspective is provided by the PPA reports which provide the ‘voices of the poor’ themselves, rather than of their leaders or technocratic representatives.

**Figure 6: Outpatient utilisation rate at public lower level health units by socio-economic category 2001–2003**



Source: WHO (2002); WHO (2003); Nabyonga et al. (2005b).

### 3.2 How do we interpret the evidence?

These different studies/reports consistently show a marked increase in utilisation of ambulatory health services over the period 2000/01 to 2003/04. A number of factors point to the abolition of user fees as a key determinant of this increase. These include the close relationship in time between the abolition of fees and the observed increase in utilisation of services, coupled with the absence of any epidemiological reason for such an increase at this time. Another factor is the lack of a similar marked increase in PNFP outputs in the immediate aftermath of public-fee removal. Also supporting the link is the qualitative evidence that user fees were a hindrance to the population, particularly to the poor, in accessing public health services.

The correlation between fee abolition and utilisation is further borne out by the evidence from the PNFP sector. In more recent years, with increasing subsidies from the government budget, many of the PNFP units have decreased their user fees, which has also led to increased utilisation rates at these units, particularly for ambulatory services (as highlighted in Figures 2 and 4 and discussed in more detail by Lochoro et al. in chapter 5). As in the public units, the timing of these shifts in output immediately follows the reduction in fees.

The increases in utilisation documented are significantly greater than were expected by many analysts. For example, a World Bank Discussion Paper had predicted that removal of user fees could only improve utilisation by the poor by 2.3 percent, and decrease utilisation by the rich by 9 percent (Hutchinson et al. 1999). All the studies

and reports outlined here report much higher increases than this. Our data suggest an 88 percent overall increase in the rate of new OPD contacts per capita per year. This underestimation suggests a need to update the models applied by such analysts on the basis of the Ugandan experience, and that unrealistic estimates of the impact of fees may have been made in other countries where empirical tests of these estimates are not feasible.

The WHO/MoH study and the analyses of the UNHSs and the PPAs show that the more vulnerable sections of the community – the poor, children and women – have particularly benefited from this policy (MoH 2003b; WHO 2003). The data from the Uganda Household Surveys provide an early indication of the benefits of the abolition policy in terms of outcomes, with the observation that the poor now have to take fewer days off work due to illness, thereby reducing the negative impact of illness on income. This negative impact of illness on income is well known to communities. In the words of one respondent: *“as long as one is healthy, he thinks properly for his family, is able to travel to towns to do business for the well-being of the family, can cultivate land, and construct shelter and work harder”* (MoFPED 2000: 62). Clearly, as a policy, the abolition of user fees is consistent with the goals of Poverty Reduction Strategies and the internationally endorsed Millennium Development Goals (MDGs).

### 3.3 What else is involved?

One aspect of the data that requires further explanation concerns the high variation in the health service utilisation rates recorded in public health units. The annual trend of increasing utilisation of ambulatory services (especially OPD attendance) hides marked variations, which cannot be explained entirely by seasonal variation in disease factors. Immediately following the abolition of user fees as of March 1st 2001, the utilisation of public health services rose sharply, but this was soon followed by a sharp drop by May and June 2001. Subsequently utilisation rates varied from month to month and between districts. These variations appear to be more closely associated with supply factors, and in particular, with the availability of basic medicines at the health units (MoH 2003b; WHO 2003). Given the inadequacy of medicine budgets, some irregularity in release of funds, and limited capacity for medicine management in the districts, there are often medicine stock-outs at the health facilities. The length and magnitude of the stock-outs, and therefore the peaks and troughs in utilisation will vary from district to district. For example, the beginning of the financial year is likely to be a challenging period for most districts as funds from the central government may be delayed, and this same period usually shows poor utilisation of OPD services. In the PNFP health units, where there is less variation in drug availability throughout the year, much less monthly variation in utilisation is observed. In more recent years – 2002/03 and 2003/04 – improvements in medicines funding, management, and financial management appear to be reflected in decreasing utilisation variation in the public units.

Also in need of explanation is the observation that the marked increase in utilisation of ambulatory services has not been matched by an equally marked increase in the consumption of in-patient and especially maternity services. The quality of services may have played an important role in this. Specific problems in quality of care for in-patient episodes continue to be observed. A number of studies and reports,

including the PPA reports, a study on Emergency Obstetric Care in Uganda, and government monitoring reports, indicate that there continue to be problems associated with lack of access and privacy, and insufficient supplies (e.g. cotton, gauze, protectives) which are discouraging mothers from delivering at the health units (MoFPED 2000; WHO 2003; MoH 2003c; MoH 2003d). Where delivery at a health unit may require the mother to provide gloves, a plastic sheet and other supplies, it is not difficult to see how these 'hidden costs' act as a barrier to the health services in the same way as the user fees used to. This is further confirmed by the fact that the modest increase in in-patient service utilisation in public units over the period since 2000/01 is comparable to that in PNFP units (MoH 2003b).

This brings us to the question of how much of the increase in utilisation of ambulatory services can be attributed to abolition of user fees and how much to other reforms. The sudden sharp increase in the utilisation of public services that occurred following the abolition of user fees can clearly be related to increased demand due to the fall in cost for users. However, it becomes more difficult to estimate the contribution of the abolition of user fees to the sustained and continuing increase in utilisation of services observed over time since then. Consideration must be given to other reforms which have been taking place over the same period. These include the introduction of the sector-wide approach (SWAp), the increased allocation of the government budget to fund health services, enhanced partnership with the private sector (profit and non-profit), and improvements in the management and delivery of decentralised health services (e.g. infrastructure, human resources and medicines funding and management), as discussed in the other chapters in this book.

For example, a supplementary budget of one billion Uganda shillings (equivalent to US\$600,000) was provided for additional medicines immediately following the abolition of user fees. In subsequent budgets, attempts were made to compensate the health sector for the revenue lost due to the abolition of fees, and to target most of these funds at primary health care inputs (especially medicines, strategic infrastructure expansion and upgrading, and human resources). However, supply side reforms tend to take some time before they are converted into outputs. The budget for primary health care medicines at sub-district level increased almost 3-fold from 1999/00 to 2003/04 and yet, partly as a result of increasing utilisation of the health services, there continue to be stock-outs reported at the local health units (see chapter 4, Nazeri et al.).

Thus it seems reasonable to conclude that while the policy decision to abolish user fees catalysed the surge in consumption services, levels have been sustained since then by the ongoing supply side reforms.

### **3.4 What else needs to be done?**

The Ugandan case provides strong support for the argument that it is possible to increase the utilisation of health services in developing countries by improving financial access, and that the provision of free services at the point of use is a good way of targeting the poor.

Moreover, in order to achieve sustained improvements in access to health services by the poor, this chapter, together with the others in this book, underscores the point that several changes may need to take place simultaneously and that both demand and supply side issues need to be tackled.

There is, however, need for considerably more research in Uganda in this area, in particular to separate out the impacts of the user fee reforms from those of the other health service reforms. Also critical is the need for a better understanding of the costs of achieving improvements in quality, especially with regard to in-patient services, including maternity services. In all of this work it is important that the focus continues to be on the utilisation of the vulnerable groups in the population.

The impact of the abolition of user fees on the behaviour of health workers is also important to investigate. Health workers effectively suffered a loss in income following the removal of user fees, and this was coupled with a dramatic increase in workload. Though efforts were made subsequently to increase salaries, human resources are a critical input in health services and it will be important to ensure support for the reformed system is maintained.

Finally, the effect of the abolition of user fees on community participation and ownership of local health services requires attention. Through the Health Unit Management Committees, established to manage the allocation of user fee revenue, community involvement was facilitated. The loss of this key responsibility may have endangered the functioning of these committees and with it, local ownership.

## 4. Conclusions

Overall, in chapter 1, Yates et al. have discussed the effects that the many health services reforms in Uganda have had at the health output level and which are beginning to show at the outcome/poverty reduction levels. This chapter has looked at one reform in particular, that of abolishing user fees. While the other chapters in this book concentrate largely on supply side reforms, the policy of abolishing user fees focuses on the reduction of access barriers and the stimulation of demand. The evidence is convincing that user fees' removal acted as a catalyst for the initial stimulation of OPD demand. Ongoing support from supply side reforms is likely to have been important in maintaining the impetus. Further attention needs to be paid to the stimulation of in-patient and maternity demand, and the maintenance of mechanisms of local ownership that may have been undermined by the reform.

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# 4

## Medicines – driving demand for health services in Uganda?

Hanif Nazerali, Martin Olowo Oteba, Joseph Mwoga and Sam Zaramba

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### Summary

Utilisation of out-patient services at government health units in Uganda showed a significant increase following the abolition of user fees in 2001, and there is evidence that the door was opened for those who were least able to pay. Utilisation has been sustained at high levels since then. This chapter points to concurrent improvements in the medicines supply system as a key factor contributing to the continued high demand. Improved flow of medicines to the primary care level underpinned more effective delivery of Uganda's basic health care package including preventive services. The exceptional results and fast pace of reforms in the medicines supply system are attributed to good timing and an enabling environment. Chronic under-funding, fragmented financing from multiple sources, and the related problem of uncoordinated, vertical supply ('push systems') were addressed and partly resolved through the structures and mechanisms established under the sector-wide approach. At the same time, through the process of political and administrative decentralisation in Uganda, district and sub-district health managers have assumed greater responsibility and control over the medicines budget. This provided the necessary background for an accelerated transition to an integrated 'pull system' of medicines supply that is more responsive to locally determined demand and the changing requirements of a dynamic health system. Challenges still remain however, and there is need to address problems of continuing medicines stock-outs at some health units. A growing reliance on new, more expensive medicines that are often funded through global initiatives with vertical programming and parallel funding structures poses another challenge to the new systems.

## 1. Introduction<sup>a</sup>

In Uganda, health users consider medicine availability to be a key determinant of quality in health services (MoFPED 2002). It is notable therefore that there were widespread, chronic shortages of medicines at government health units throughout the era of user fees. In the context of high unmet demand, regular provision of essential medicines, without fees in government health units, or at reduced fees in private-not-for-profit (PNFP) facilities, would be expected to have a dramatic effect on health service utilisation. Following the abolition of user fees in public health units (March 2001), utilisation increased immediately. Moreover, utilisation continued to increase over several consecutive years. Public opinion was favourable towards user fee abolition, although negative about the continued poor availability of medicines at the units. This chapter focuses on the series of reforms in the public financing and supply of essential medicines (as part of the broader health systems reform programme) that were instrumental in improving access to medicines, thereby contributing to the increased and sustained demand for public out-patient services in Uganda.

## 2. Methods and sources

Figure 1 presents a conceptual framework showing pathways leading to increased utilisation of out-patient services. Access to medicines is presented as the driving factor for reforms on both 'supply side' and 'demand side'.

The situation analysis presented here is grounded in the technical reviews of the first Health Sector Strategic Plan (HSSP) 2000/01 – 2004/05, routinely conducted as part of the sector-wide approach (SWAp) during the period of health sector reforms in Uganda. The technical reviews called for systematic review and synthesis of previous consultancy reports, facility surveys and studies in the medicines sub-sector. The authors of the reviews were directly involved in the health SWAp and this facilitated consensus building on the systems issues to be addressed by the reforms. In particular, interpretation of the interaction between demand for health services and access to medicines was informed by findings from Participatory Poverty Assessments, Ugandan National Household Surveys (UNHS), and national service delivery surveys that measure satisfaction with government services in six sectors.

Health expenditure data were derived from the UNHS and National Health Accounts (UBOS 2001; UBOS 2003; MoH 2004a). Analysis of the medicines budget allocations in the public sector over a six year period pre- and post-reforms, were conducted by the authors and updated annually for the Health Sector Annual Performance Report (APR) and the annual budget planning process. Survey data on availability of medicines at the health facility level, and specifically the stock-out time for a small number of indicator medicines that are crucial for provision of out-patient

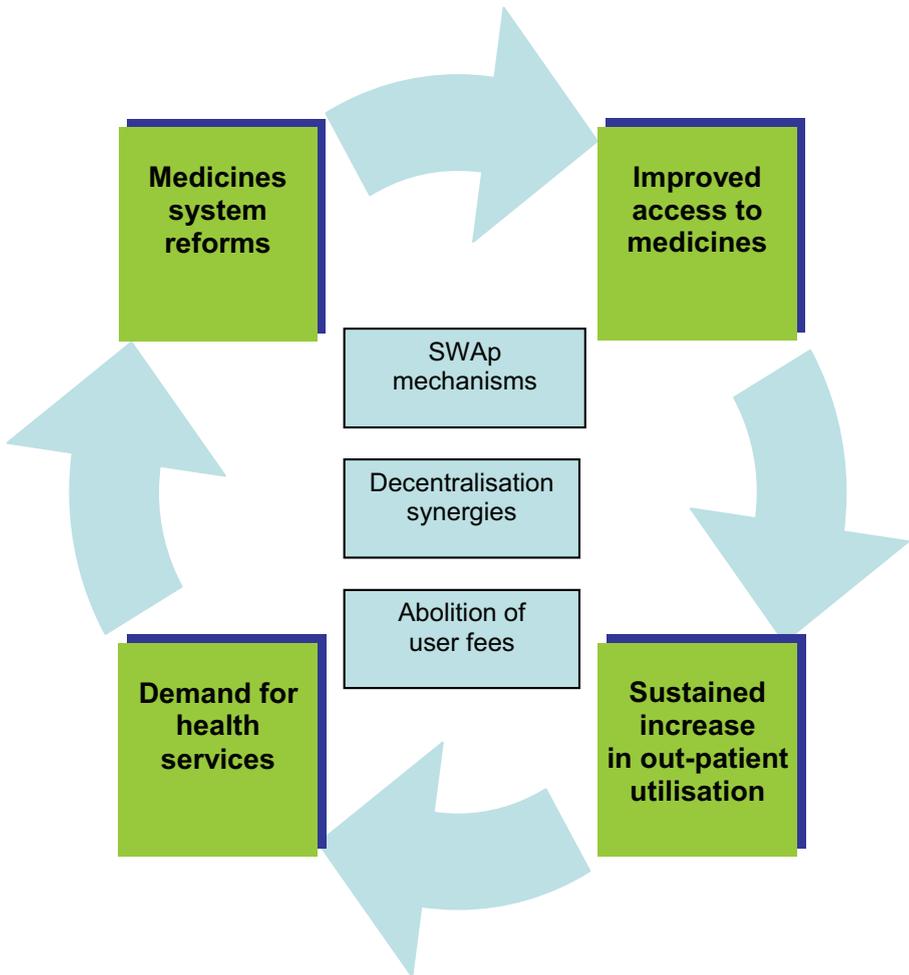
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<sup>a</sup>The authors wish to acknowledge Khalid Mohamed (consultant attached to the District Medicines Management Programme), who collected and reported much of the monitoring data used in the analysis, and are grateful for the continuing cooperation and collaboration of colleagues in the health sector, at the NMS, JMS, Uganda Catholic and Protestant Medical Bureaux, in the districts, health sub-districts, and within the Medicines Procurement and Management Working Group.

services, were used as a proxy for access to medicines. The data were collected by staff of the District Drug Management Programme of the Ministry of Health (MoH) and/or local consultants through annual surveys and a Drug Tracking Study. Findings were published in the APR and in other reports widely disseminated in the health sector.

The Ugandan experience was compared and contrasted with policies and reforms internationally through a review of the published literature, including electronic libraries and web-accessible resources.<sup>b</sup>

**Figure 1: Conceptual framework**



<sup>b</sup>Documents available through the WHO Medicines Library, development information exchanges such as Eldis id21 and the Social Sciences Development Network; abstracts and posters from the International Conference on Improved Use of Medicines (ICIUM) in 2004 and Strategies for Enhanced Access to Medicines (SEAM) in 2000.

### 3. Medicines in health care – access, cost and management issues

#### 3.1 Common factors among developing countries

Access to affordable medicines is included amongst the health-related Millennium Development Goals. Medicines are a major health expense for poor households in most developing countries where 50-90 percent of medicines are paid for by the patients themselves, while in many developed countries, 70 percent of medicines are publicly funded through reimbursement plans and other mechanisms (Quick et al. 2002).

Moreover, it is estimated that less than half of the population in the poorer parts of Africa and Asia have regular access to essential medicines. This remains a major obstacle to good health despite the many achievements in the field of essential medicines since the Declaration of Alma Ata in 1978 (Quick 2003). Social and cultural constraints disproportionately prevent women, children, ethnic minorities, and other marginalised populations from gaining access to medicines (Ruxin et al. 2005). While recognising that multi-sectoral action may be needed to address the socio-economic and political factors underlying the access gap, Quick (2003) identifies four obstacles that the health sector has yet to overcome:

- Unfair financing for health, including medicines;
- High medicines prices;
- Unreliable delivery systems;
- Irrational use of medicines.

Segall (2003) makes a strong case for increased public funding of district health care services in developing countries to reverse the overall decline in the standard of public sector health services in the 1980s and 1990s. Budget and expenditure cuts associated with implementation of macroeconomic stabilisation and adjustment programmes led to shortages of medicines and deteriorating facilities. Demoralised, poorly paid health workers charged patients under-the-table fees, diverted medicines, practised privately during working hours and became increasingly uncaring towards patients. The situation in Uganda at the end of the 1990s was perhaps worse than in other countries, following 15 years of instability that broke down what was once considered a model health system in Africa, and with the additional burden that post-conflict rehabilitation did little to alleviate the health crisis inherited in 1986 (Macrae et al. 1996).

In a costing study in primary facilities and district hospitals in Balochistan, Pakistan, Green et al. (2001) showed imbalances and inefficiencies in the allocation of public resources, with medicines often under-funded relative to salaries (and severely under-funded overall). Furthermore, the lack of a financial skills-set in decentralised settings results in poorly administered budgets having little relation to the health needs of the population. Similar constraints faced the districts in Uganda during the period when the policies of decentralisation and user fees were introduced in the latter part of the 1990s. Official user fees had little impact on efficiency at service delivery levels, and equity problems were not solved in Uganda, as elsewhere in Africa (Gilson 1997; and chapter 3, Kirunga Tashobya et al.). Not surprisingly, even the poor in Uganda had little option but to seek private care.

The following situation analysis highlights the importance of medicines access in Uganda and the barriers related to cost and limited management capacity at the outset of the health sector reforms in 2000.

### 3.2 Public perceptions and the importance of access to medicines

A Participatory Poverty Assessment early in the period of reforms gave voice to communities' concerns about limited access to medicines and the resulting deepening of poverty (MoFPED 2002). Indeed, communities in Uganda appear to be very well informed of the status of medicines supply at their local health facilities. Nabyonga et al. (2005) reported fluctuating monthly utilisation following the abolition of user fees at government health units. We believe that this volatility could be explained by irregular medicines availability. A Drug Tracking Study provided evidence for this interpretation (MoH 2002a). Comparing out-patient caseload thirty days before and after a medicines delivery, the study observed an increase of more than 50 percent on average (n=65). Anecdotal evidence indicates that volatility in out-patient attendances was even greater in the past when rural facilities relied on a quarterly supply of essential medicine kits. Uganda operated a kit system from 1987 to 2002.<sup>c</sup> Throughout that period, attendance decreased when popular medicines<sup>d</sup> were out of stock.

Moreover, health service managers in Uganda recognised that many potential users were unwilling to pay the user fee in public health units (typically a flat fee of approx. US\$0.30) in a context where non-availability of medicines was the rule rather than exception. As illustrated in chapter 3, utilisation of government health facilities remained low as users turned to private-not-for-profit (PNFP) facilities where availability was better (although utilisation here remained below capacity also), private clinics, or local drug shops<sup>e</sup> for self-medication. Notably, the average drug shop price for a course of first-line oral treatment of fever and/or malaria was usually less than the flat fee charged by the health units. However, prices of other medicines were likely to be considerably higher. Faced with non-availability at government health facilities, users may have used such monetary assessments to determine their choice of health provider in order to minimise their out-of-pocket payments, and thus medicine costs could have been a critical factor influencing access to care. These observations have led to a growing consensus of opinion that availability and affordability of medicines influence health care seeking behaviour in Uganda.

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<sup>c</sup>In a kit system, a standard package of basic medicines and health supplies is provided to health facilities for a set number of cases (e.g. 1000 out-patients). The number of kits allocated to individual facilities can be varied at each distribution round according to caseload. The composition of kits may be reviewed annually or every two years.

<sup>d</sup>Injectables, antimalarials, antibiotics, and analgesic/antipyretics.

<sup>e</sup>As noted by Ssengooba et al. in chapter 7, there are concerns about poor regulation and weaknesses in service standards and quality in many of the drug shops and private clinics in the country.

### 3.3 Cost issues

Given the importance attributed to medicines availability by households in Uganda and the ease of access to private sector drug shops, high levels of household out-of-pocket medicines expenditure are not surprising. In total, it is estimated that households spend in the region of US\$7.00-8.70 per capita on health on an annual basis (MoH 2004a; UBOS 2003; UBOS 2001). The trend has shown a modest decline in recent years, with a significant decrease in health spending by the poorest in the population, as detailed in Deininger and Mpuga (2004). More than 60 percent (US\$4.20-5.20) of this out-of-pocket spending is estimated to go on medicines (MoH 2004a). This is in contrast to the US\$0.40-0.45 per capita spent in 2000/01 on tradable medicines<sup>f</sup> through the government budget (including Government of Uganda resources and donor budget support<sup>g</sup>) for all levels of health care. However, it should be noted that government spending buys far more medicine per unit of expenditure than household spending, as the government can benefit from bulk purchasing efficiencies using the National Medical Stores (NMS) (Gabra and Green 2000; EuroHealth 2004). The NMS is a semi-autonomous medical supply agency serving the public sector. Similarly, faith-based organisations running the many PNFP health facilities can benefit from economies of scale through the Joint Medical Stores (JMS; Kawasaki 2001). Retail prices in rural drug shops are much higher, and quite variable according to a national price survey conducted by the MoH using a standard methodology established by the World Health Organisation (WHO) and Health Action International.

Even adjusting for these price efficiencies, government funding of medicines has been very low relative to out-of-pocket expenditure. In addition, the proportion of medicines funding actually reaching the primary health service delivery points has been even lower, according to the Drug Tracking Study (MoH 2002a) mentioned above. The health sector in Uganda is structured around different levels of health centre, from basic out-patient services provided in a small health centre, to national level referral hospitals. For a full description of these structures, see chapter 1, Yates et al., Annex 1. In particular, district health services are divided into small health sub-districts (HSDs) covering health centres from level IV downwards (see chapter 6, Murindwa et al.). Primary health care budgets and services are managed at the HSD level. Cash and in-kind contributions to medicines (e.g. essential drugs kits) for the health facilities at HSD level were estimated at only US\$0.16-0.20 per capita in 2000/01, and the actual utilisation of such contributions is less certain.

On the whole, user fees had negative effects. In rural districts, 25 percent of households had to work for others, sell assets, or borrow to raise money for health care during the era of user fees (Lucas and Nuwagaba 1999). While 30 percent of user fee revenue at government units was supposed to be used for medicine purchases, the reality was closer to 10 percent (EuroHealth 1999) and thus user fees appear to have had limited impact on medicines supply. At most, user fees would have added US\$0.02-0.03 per capita to funding medicines supply. In practice, medicines were usually sourced locally by the government units at private sector retail prices, and thus the actual contribution of user fees in real terms would have been negligible. Under the pilot

<sup>f</sup>Excludes vaccines, contraceptives, TB drugs and other medicines supplied without charge to providers and users on public health grounds.

<sup>g</sup>See chapter 7, Ssengooba et al., for further explanation of funding mechanisms to the health sector.

Bamako Initiative scheme,<sup>h</sup> applying full cost recovery on medicines obtained at NMS prices, medicines availability improved but with negative effects on household expenditure and equity (MoH et al. 2001). In Tanzania, user fees similarly failed to match expectations of improved medicines availability, quality of care and financial sustainability (REPOA 2004).

Overall, public financing of medicines and supplies showed a pattern of decline throughout the 1990s, eroded by currency depreciation, population growth, and an increasing burden of disease related to high HIV infection levels. At the same time, the core primary health care programmes such as treatment of childhood illnesses, malaria case management and control of sexually transmitted infections introduced a syndromic approach which increased medicines requirements. The essential medicine kits remained relatively unchanged during the last six years of their use and were phased out at the end of 2002. By this time, the kits contributed at most just one-tenth of the medicine requirements of government primary health care services in the country, and encouraged parallel supply of many items.

### 3.4 Management and logistics issues

Good managers may be able to improve the quality of health services by reducing waiting times, or extending opening hours, but are often less able to solve the problem of irregular supply and poor availability of essential medicines. Moreover, the biggest logistics challenges for ensuring adequate and regular medicines supply are present, not at urban-based hospitals, but at the health facilities at the primary care level (e.g. rural HSDs). Yet it is these facilities that are staffed by multi-purpose cadres who have limited capacity for budget and stock management. The above-mentioned Drug Tracking Study found that prolonged stock-outs were most prevalent at the lowest level of health facility (health centre IIs), where stock-out time over the one-year review period was 40 percent on average for a range of 10 key medicines, compared with 5 percent at the level of district hospital (MoH 2002a). Medicines supply management is complex, specialised, and often dependent on external factors such as resource allocation, available funds, procurement procedures, supplier performance, and distribution logistics.

Another problem in ensuring constant medicines supply in the 1990s was also one of leakage (MoH 1998). For example, a study of 10 sub-hospital facilities (i.e. HSDs) in 1995 found a median drug leakage rate of 76 percent and a high rate of informal charging, at 5-10 times the formal charge (McPake et al. 1999). However, the government health service was not well run at this time and many staff were induced to work outside the government health units and to sell government medicines in order to survive, due to non-payment or late payment of wages, low remuneration and several other system deficiencies (McPake et al. 1999; Danida 1998). Concerns about widespread leakage led to calls for more effective audit and control mechanisms, improved supervision and surveillance, and enforcement and prosecution as needed (MoH 1999). This reactive approach to problem solving may have further undermined health worker morale.

Other systemic problems affecting medicines supply were also well known, including constraints facing the NMS (Crown Agents 1999), problems of fragmented financing from multiple sources and lack of monetisation of donor-funded supplies. Other

<sup>h</sup>Only two of 56 districts had implemented the scheme before the policy change abolishing user fees in 2001.

problems included poor coordination of procurement and logistics systems, inefficient 'push systems', limited management capacity at the MoH and district health offices (EuroHealth 1999; Gabra and Green 2000) and lack of exit strategies on the part of projects procuring medicines (MoH 2002a). Further difficulties were created by MoH disease-specific programmes focusing narrowly on their own requirements and goals rather than allowing the district services to determine their own needs. Looking at the bigger picture, it can be seen that by the turn of the century, three very different modalities for medicines supply (each of which had been designed to suit a specific phase of Uganda's development, summarised in Table 1) were operating concurrently.

By 2002 the health sector had reached the conclusion that existing systems lacked transparency and accountability and suffered from huge inefficiencies with duplication of effort, misallocation of resources, wastage and expiry. This paved the way for coherent reforms in the interests of an integrated medicines supply system under the direction of the Working Group on Medicines Procurement and Management (a structure within the sector-wide approach, see chapter 2, Oliveira Cruz et al.).

**Table 1: Modalities for medicines supply in the Uganda public sector 1986-2001**

| FUNCTIONS |                           | MODALITY                            |   |  |
|-----------|---------------------------|-------------------------------------|---|--|
|           |                           | I                                   | II  | III  |
|           |                           | 1986                                | 1991  | 1996                                       |
|           |                           | Emergency response & reconstruction | Institutional development at national level | Fiscal decentralization and liberalisation |
| A         | Funding & financial flows | Donor pays for each purchase        | Donor & Gov. through MoH                    | Donor, Gov. & users through Local Gov      |
| B         | Procurement / sourcing    | Procurement agent                   | NMS and JMS                                 | Private sector                             |
| C         | Distribution              | Kit system                          | Push system                                 | Pull system                                |
| D         | Reporting & MIS           | Paper forms                         | Computerized                                | Ad hoc                                     |

Key: MIS = Management Information Systems; MoH = Ministry of Health; NMS = National Medical Stores; JMS = Joint Medical Store.

## 4. From reforms to results

### 4.1 Key reforms in medicines financing and supply systems

Two well-timed studies initiated in 2001 pointed the way towards more integrated medicines supply systems for health facilities, namely the Drug Tracking Study (MoH 2002a) and a Push-Pull Study (MoH 2002b). The Drug Tracking Study provided important feedback on the factors determining good and bad medicines supply at health facilities. In a well performing district, adherence to guidelines on procurement and

expenditure of decentralised funds at US\$0.15-0.20 per capita led to much shorter medicines stock-out periods (19 percent on average). In contrast, a poor performing district (with a percentage stock-out time of 31 percent<sup>1</sup>) was found to be spending as little as US\$0.03-0.07 per capita. Among other things, this was due to their failure to adhere to guidelines for using a specified proportion of budget funds received from the government on medicines.

The Push-Pull study found that following the decentralisation of government services (see chapter 6, Murindwa et al.), giving more autonomy to local governments in the delivery of public services, a de facto ‘pull’ system had already been introduced to some extent regardless of the readiness of individual districts. Using the results from these two studies, a task force was set up to formulate an operational strategy for a transition from a supply system that was traditionally based largely on allocations of essential medicines pushed down from the centre to the districts, to a demand-based (‘pull’) system (MoH 2002b).

It was agreed that the best way forward was to combine two financing mechanisms for medicines supply. First, the government would continue to channel government budget resources (including donor budget support) to districts for non-wage recurrent health expenditures, with the guideline that 50 percent of these funds would be spent on medicines. Second, there would be new earmarked budgets for each district for medicines purchased from the NMS (or JMS for PNFPs) in the form of ‘credit lines’ backed by centrally held funds at the MoH. Essential drug kits, and a range of other in-kind commodities previously allocated by the MoH vertical disease-specific programmes, would no longer be supplied through a top-down approach that was known to be inefficient, difficult to track, and prone to wastage through expiration. The district health services would instead order according to their requirements from a pre-printed form, within the limits of a specified budget ceiling (i.e. their individual credit line).

To consolidate all centralised sources of funding for medicines (donor and government), and to support these credit lines, a basket account was set up at the MoH. This new mechanism improved the predictability of funding flows, and helped to smooth out the irregularity of transfers associated with different financial year or project planning cycles. Some donated commodities are now monetised and converted into ‘virtual credit’, and allocated across districts along with the other resources, through a more systematic and equitable process. The NMS and JMS are provided with a guaranteed business volume (backed by a Memorandum of Understanding signed with the MoH) over a longer time horizon, aimed at improving forecasting, price stability, value for money, and performance targets (e.g. timeliness of scheduled deliveries).

In the spirit of decentralisation, the credit lines ensure that the districts and hospitals own and incorporate the central resources into their budgets and work plans. Moreover, these earmarked budgets are more accessible to the technical staff at the service delivery levels (e.g. the lower level health facilities) than the cash funds under the control of the district government. There is also now no scope for reallocation of these earmarked resources to other activities. Finally, the flow of medicines to individual health units can be easily tracked because computerised systems at NMS and JMS provide detailed supply and financial documentation and management information.

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<sup>1</sup>Stock cards for ‘tracer medicines’ were reviewed at 8 health units in each district over a 12-month period. The number of stock-out days in the review period was recorded. The percentage stock-out time represents the number of stock-out days divided by the number of days in the review period. The figures of 19 percent and 31 percent represent the average stock-out time for 10 tracer items in the well-performing district and poor performing district, respectively.

It is interesting to note that the health sector in Uganda planned for this nationwide transition from 'push to pull' with only 6 months' preparation. This was made possible by allowing the HSDs several options within the new systems, and by setting the pace of change according to local capacity. The HSD headquarters could use pre-printed forms to make a consolidated order for all the facilities in the sub-district, or it could send a batch of orders from individual facilities. An order could be for a number of (updated) pre-assembled kits, or for variable quantities by item, or a combination of the two. The new kit was empirically determined using a quantification method based primarily on prescription demand. This used actual prescribing practice rather than ideal practice, although still very much focused on a prioritised list of essential medicines for a basic package of primary health care services (Nazerali et al. 2004).

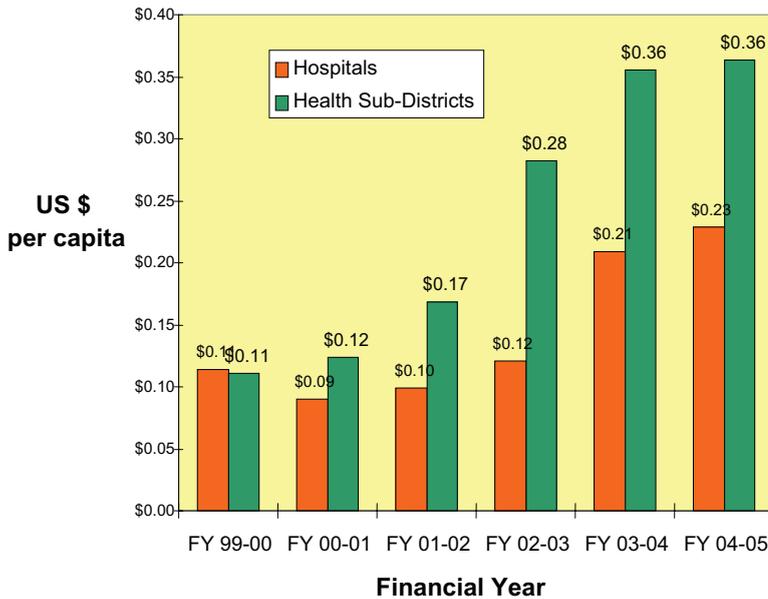
The transition was implemented, with minor delays, in early 2003, in close collaboration with the NMS and JMS. Importantly, progress made so far with this new hybrid of system modalities helped set the stage for the mobilisation of critically needed additional resources for medicines. The possibility for further integration of other project funds including those from new global initiatives, such as the Global Alliance for Vaccines and Immunisation (GAVI) and the Global Fund to Fight AIDS, TB and Malaria (GFATM), is also on the agenda.

## 4.2 Increased budget allocations

There has been a clear prioritisation in health sector resource allocations towards primary health care inputs. In real per capita terms, while the hospital medicines budget increased from US\$0.11 to US\$0.21 over the period 1999/00-2003/04, the medicines budget for the HSDs increased three-fold over the same period, from US\$0.11 to US\$0.36 (see Figure 2). In fact, the medicines budget for hospitals was stagnant for many years and only recently showed an increase when in 2003/04, the credit lines were extended to cover basic requirements in the hospital referral system. The government also provides a grant specific to the PNFP health units which is estimated to add US\$0.17 per capita to PNFP medicines expenditure (assuming usual percentage expenditure of recurrent budget on medicines). Table 2 shows that increases were even greater in nominal terms and in local currency.

The total funding available to government and PNFP health services for medicines at all levels almost doubled from US\$0.88 to US\$1.65 per capita over a four-year period (2000/01 to 2003/04). This includes centrally procured, non-tradable supplies such as vaccines, contraceptives, anti-TB drugs, HIV tests, blood products, and other commodities supplied through donor project funding for specialised disease control. Excluded from this figure are new interventions additional to the minimum health care package outlined in the HSSP, such as the pentavalent vaccine (US\$0.60 per capita) and anti-retrovirals (reaching US\$0.40 per capita by 2006) that are funded by global initiatives (i.e. GAVI and GFATM).

In summary, the medicines budget is now not only larger, it is also allocated equitably, and is utilised more efficiently. An increasing proportion of the medicines budget is now controlled by the service delivery providers themselves, who are better informed of their requirements, thereby minimising waste and duplication.

**Figure 2: Increase in the medicines budget in real terms (1999-2004)**

Sources: MoH (Selected years); Own MoH/Danida Database.

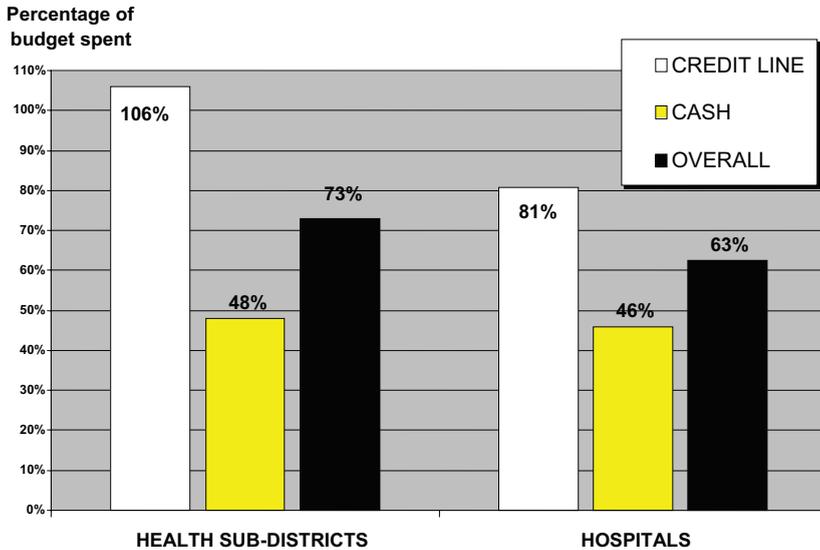
### 4.3 Increased budget expenditure and medicines consumption

It is one thing to demonstrate a growing budget for medicines and another to show that this is translated into actual expenditures on medicines. Data collected from the NMS, the JMS and surveys in a sample of districts show dramatic increases in the value of medicines purchased by mid-2004. The increase is particularly noticeable following the introduction of the credit lines in 2003 and the subsequent incorporation of some donated commodities into the credit lines (monetisation). Annual NMS sales alone increased from a baseline of US\$4.0-4.5 million prior to these reforms, to US\$9.7 million in 2003/04, with a similar trend observed at the JMS (from US\$6 million to US\$10.8 million).

Based on NMS and JMS sales data, budget performance has differed across the two different funding sources. The credit lines have performed relatively better than the government cash funds released directly to the districts, particularly at the health sub-district level (see Figure 3). Survey data indicate that in some cases, sources outside the NMS and JMS were used, or that part of the indicative cash budget for medicines was utilised for other purposes.

In part, this reflects service level limitations at NMS, where on average, only 66-75 percent of order value was served. Performance against the cash medicines budget has been used as a proxy indicator of district management capacity and a score for this is incorporated into a district league table that is now drawn up in the Health Sector Annual Performance Report (see chapter 6, Murindwa et al.). This strategy will help to

**Figure 3: Performance against the medicines budget (cash and credit lines) 2003/04 financial year**



Source: MoH (2004d)

focus support for the poor performers, and motivate improvements in utilisation of the medicines budget using the national supply agencies.

As a critical demonstration of the impact of the increased budget allocations and the improved management and allocation systems, ongoing quantification studies at the district level are beginning to show increased consumption of priority medicines per 1,000 out-patients (MoH 2004b). These data indicate a better overall match of supply and demand resulting from the new pull systems, and quality improvement at a technical level. The methodology also identifies where consumption exceeds prescription demand for a given medicine (suggestive of leakage), and so far this is occurring in less than 1 in every 10 centres.

Table 3 shows a trend of reducing stock-out time at the health centre (HC) level for several of the indicator medicines that are routinely monitored nationally.<sup>1</sup> These data are from periodic surveys because the Health Management Information System does not yet reliably capture information on medicines availability. There has been substantive improvement in availability at the lowest level of health unit (health centre II) in the health sub-district and reduced stock-outs of treatments for malaria and pneumonia, which together account for two-thirds of the disease burden. Poor availability of oral rehydration was attributable to poor delivery performance from the local manufacturer. Nevertheless, stock-outs remain surprisingly high.

<sup>1</sup>The 'percentage of health units reporting a stock-out of any of six indicator medicines' is one of 20 national indicators for the Health Sector Strategic Plan (MoH 2000). Stock-out time for each of the medicines, as presented here, is actually more useful at this point, when stock-outs are still more the rule than the exception (60 percent of health centres on average experienced a store-room stock-out each month according to survey estimates). Data are not compared for injectable contraceptives (not routinely available at health centre level II) or measles vaccine (unreliable due to missing data).

## 5. Enabling framework for medicines sector reforms

### 5.1 Role of the sector-wide approach

The HSSP recognised the importance of establishing an integrated medicines supply system and of streamlined funding (MoH 2000). However, it was the sector-wide approach (SWAp), initiated in 2000, that provided a framework for the required policy consensus among partners, coordinated reform of medicines financing and logistic systems, and the decision to re-institute a ‘public good’ role for the NMS.

In chapter 2, Oliveira Cruz et al. provide a full account of the SWAp structures and processes in Uganda. In particular, the annual stakeholder conferences - the Health Sector Joint Review Missions (JRM) - provided for continuity, joint learning and decision-making on several issues including reforms of the medicines supply system. For example, the first JRM recognised the importance of MoH stewardship for this reform and the need for an upgraded status for the MoH unit responsible for medicines and health supplies, policy and regulation (although this is yet to be realised in full). The 2001 JRM acknowledged that medicines financing was pivotal in improving health sector outputs. Consensus was reached on the budgeting requirements for medicines in the sector, estimated at US\$3.50 per capita, and realistic targets for the short to medium term were set. In health sector stakeholder discussions on the budget process, priority was given to medicines funding and there was strong support for the creation of the central basket account, the Essential Drugs Account.

The Drug Tracking Study (MoH 2002) was an undertaking by the JRM stakeholders, and unlike previous studies and consultancies in this area, there was widespread ownership of the findings and support for the recommendations, giving rise to the Push-Pull operational strategy. The new funding and logistics system was fully endorsed by a wide group of stakeholders at the National Health Assembly (NHA) in 2003, after less than one year of operation. The NHA is attended by district political and administrative leaders and parliamentarians as well as technical staff from the district health departments. The same forum recognised the challenges facing the NMS that are, in part, related to the successes of the new systems and the associated increased volume of business, and agreed on a further undertaking for a technical review of the NMS. An external team conducted the review, and the recommendations were accepted by the MoH and health development partners, including government assurance against privatisation for 5 years (EuroHealth 2004). As a result, Danida,<sup>k</sup> the lead agency in the pharmaceutical sub-sector, allocated substantial new financial and technical support for NMS. Again, much was achieved through a consensus approach, within the relatively short period of one year.

As explained in chapter 2 by Oliveira Cruz et al., Working Groups support the functioning of the SWAp and by 2003 the formal Working Group on Medicines Management had been fully established to further guide reform in this area. The mid-term review of the HSSP in 2003 encouragingly noted that *“reforms in policy and management of essential drugs to increase efficiency are already being put in place”* (MoH 2003a: 76).

<sup>k</sup>Danish International Development Assistance, part of the Danish Ministry of Foreign Affairs.

**Table 2: Medicines budget for health sub-districts and hospitals**  
(Financial Year 1999/00-2004/05)

|  | Financial Year |           |           |           |           |           |
|--|----------------|-----------|-----------|-----------|-----------|-----------|
|  | 1999-2000      | 2000-2001 | 2001-2002 | 2002-2003 | 2003-2004 | 2004-2005 |
| <b>HEALTH SUB-DISTRICT</b>                                     |                |           |           |           |           |           |
| HSD cash budget for medicines (Uganda Shillings Billions)      | 1.0            | 2.3       | 5.0       | 7.2       | 9.5       | 9.5       |
| ED kits and/or credit lines (Uganda Shillings Billions)        | 2.4            | 2.4       | 2.4       | 4.0       | 7.2       | 7.2       |
| Total HSD medicines budget (Uganda Shillings Billions)         | 3.4            | 4.7       | 7.4       | 11.2      | 16.7      | 16.7      |
| US\$ per capita drug budget                                    | \$0.11         | \$0.12    | \$0.17    | \$0.28    | \$0.36    | \$0.36    |
| <b>HOSPITAL</b>  |                |           |           |           |           |           |
| Hospital cash budget for medicines (Uganda Shillings Billions) | 3.5            | 3.4       | 4.4       | 4.8       | 5.2       | 5.2       |
| Hospital credit lines (Uganda Shillings Billions)              | 0.0            | 0.0       | 0.0       | 0.0       | 5.4       | 5.4       |
| Total Hospital medicines budget (Uganda Shillings Billions)    | 3.5            | 3.4       | 4.4       | 4.8       | 10.6      | 10.6      |
| US\$ per capita drug budget                                    | \$0.11         | \$0.09    | \$0.10    | \$0.12    | \$0.23    | \$0.23    |
| Exchange rate (1US\$:Uganda Shilling)                          | 1500           | 1800      | 2000      | 1750      | 1850      | 1750      |
| Population (millions)  | 20.47          | 21.19     | 21.93     | 22.70     | 25.40     | 26.29     |

Sources: MoH (Selected years); Own MoH/Danida Database.

## 5.2 Role of decentralisation

The decentralisation process in Uganda has moved at a much faster pace than in other countries in the region. The whole government has been decentralised, with a wide range of powers and resources transferred to the district level (Jeppsson and Okuonzi 2000). Of particular focus here, however, is how the decentralisation process posed both opportunities and threats for the medicines reforms.

One strength of the decentralisation process is the greater ownership and control over resources that has been provided to districts, thereby enabling district health managers to plan and allocate resources to match local needs. This is particularly important to focus limited resources on priority interventions and the main burden of disease, while avoiding wastage from drug supplies that have expired due to non-utilisation. This greater accountability at local level is also useful for medicines, which are tradable goods and, as was shown in the past, at risk of leakage. Moreover, the credit lines offered greater transparency and clear entitlements that did not apply in the top-down push systems.

In contrast, one known weakness has been the limited district capacity to manage and coordinate the medicines logistics cycle, resulting in variable performance between districts and even among health sub-districts. A recent human resource tracking study in Uganda (MoH and AMREF 2005) identified unfilled posts for pharmaceutical cadres in the public sector as a critical area needing improvement. Thus the push-pull transition was formulated such that users could graduate from simple ordering options to more complex ones, at their own pace.

Guidelines from the MoH require that districts procure medicines from the two national supply agencies, NMS and JMS (for PNFPs), as these agencies meet the required technical standards as well as value for money. However, procurement decisions by local government (LG) may be biased in favour of entrepreneurial private sector suppliers who offer commission or other incentives not provided by NMS and JMS. LG regulations are often cited in support of these alternative suppliers. The reliance on such private-for-profit suppliers means higher prices and mark-ups, and could undermine the performance and future viability of the NMS and JMS.

## 6. Discussion and conclusions

### 6.1 Progress

In a relatively short period of time, the health sector has taken a leap forward in the strategic area of organising medicines supply for improved quality of care and health services utilisation. There is a better balance of resource inputs and dramatic improvement in medicines funding overall. Available resources have been increasingly prioritised towards the sub-district level and more efficiently used to match the burden of disease prevented or managed at the primary care level.

This chapter presents the case that a combination of pro-poor reforms – abolishing user fees and new systems to address medicines financing and improved logistics management – promoted consumer preference for public primary health care facilities over the poorly regulated private sector retailers operating in their communities. With

respect to quality of care at public facilities, Nabyonga et al. (2005) found there were fewer medicine stock-outs in 2002 compared with 2000 and 2001. This was the first sign of improvement in the supply system. Ultimately, reduced household health spending may be better proof of improved access to medicines through primary health care facilities. While the national household survey of mid-2003 did not show a dramatic decline in out-of-pocket expenditure compared with 2001, it may have been too early to judge the effect of these changes, and there had already been significant reductions in health spending by the poor. The next survey will be more appropriately timed to assess the medicines sector reforms in relation to both access and equity, answering the question *'Did the sub-sector reforms benefit the poorest of the poor?'*

Since the 1990s, health sector reforms in a number of developing countries have been evaluated within an analytic framework presented by Walt and Gilson (1994). We have used this framework to interpret the medicines sub-sector reforms in Uganda, recounting *how* reforms were implemented, and the important roles played by both technical and political actors through the annual joint review missions and national health assemblies. This included consideration of factors of process and context such as the participatory and inclusive Ugandan health SWAp, the broad model of decentralisation, institutional reform and support for the autonomous central medicines supply agencies (NMS and JMS), constrained pharmaceutical human resources and poorly enforced regulatory systems at district and sub-district level.

**Table 3: Stock-out time for indicator medicines at health units (HU) by level**

|   |                                     | Percentage Stock-out Time |              |              |
|---|-------------------------------------|---------------------------|--------------|--------------|
|   |                                     | A                         | B            | C            |
|   |                                     | 2003-04                   | 2002-03      | 2001         |
|   |                                     | 6 districts               | 6 districts  | 4 districts  |
| <b>ALL LEVELS (HC II - HC IV)</b>   |                                     | <b>36 HU</b>              | <b>36 HU</b> | <b>32 HU</b> |
| 1   | Chloroquine tab                     | 12%                       | 6%           | 7%           |
| 2   | Sulfadoxine Pyrimethamine tab (S-P) | 9%                        | 23%          | 41%          |
| 3   | Cotrimoxazole 480mg tab             | 22%                       | 36%          | 35%          |
| 4   | Oral Rehydration Salts (sachet)     | 27%                       | 18%          | 37%          |
| <b>Average</b>  |                                     | <b>18%</b>                | <b>21%</b>   | <b>30%</b>   |
| <b>LOWEST LEVEL (HC II)</b>   |                                     | <b>10 HU</b>              | <b>10 HU</b> | <b>12 HU</b> |
| 1   | Chloroquine tab                     | 12%                       | 10%          | 6%           |
| 2   | Sulfadoxine Pyrimethamine tab (S-P) | 15%                       | 47%          | 59%          |
| 3   | Cotrimoxazole 480mg tab             | 29%                       | 47%          | 54%          |
| 4   | Oral Rehydration Salts (sachet)     | 22%                       | 25%          | 87%          |
| <b>Average</b>  |                                     | <b>20%</b>                | <b>32%</b>   | <b>52%</b>   |
| <p>NOTE: Data were missing for part of the review period due to incomplete stock records. Data completeness varied by item: &gt;90% for items 1-3 and 50-66% for items 4. Review period was 6/12 months in surveys A and B, and 12/12 months in survey C. The number of stock-out days in the review period was obtained from the item stock card. The stock card may not have been complete for the whole review period (some missing data). The percentage stock-out time was calculated based on the actual number of days reviewed.</p> <p>Sources: MoH (2003b); MoH (2004c); MoH (2002a; column C)</p> |                                     |                           |              |              |

Uganda provides a useful empirical case study of policy change and reforms with specific focus on medicines, while placed within overall health sector and government reforms. This enriches the somewhat limited literature on evaluations of health sector reforms in sub-Saharan Africa reviewed by Gilson and Mills (1995). Recent country case studies focussed on areas such as health care financing reform (South Africa and Zambia; Gilson et al. 2003) but without specific consideration of medicines financing. Much of the published country experiences examine medicines policies at the community level in the context of user charges or cost recovery and/or revolving drug funds following the Bamako Initiative, and are reviewed by Gilson (1997). The Uganda case is unusual, but perhaps illustrative of a new trend towards abolition of user fees and greater emphasis on public financing of essential medicines.

Country experience with the supply of essential medicines using ‘kit systems’ was reviewed by Haak and Hogerzeil (1995) but there is little documentation on the transition to demand driven (‘pull’) systems based on end-user budgets. We found a single study from one region of Tunisia, reporting successful order-based, cost-conscious management of the medicines budget by facility medical staff (Garraoui et al. 1999). Guidance on ‘what works’ and how to institutionalise sustainable medicines supply systems is needed from WHO and Danida based on their accumulated experience of supporting government and/or autonomous central supply agencies. WHO has an ongoing multi-country study of five alternative medicine supply systems<sup>1</sup> (WHO 1998) and a multi-country project supported by the Gates Foundation may also be expected to synthesise country experience once completed.

In general, the focus of publication appears to have moved from the local to the global, addressing issues of trade and pharmaceutical pricing in the new context of patent enforcement through the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement, the Doha declaration that aims to safeguard access to effective medicines for priority diseases (malaria, TB, HIV/AIDS), and research and development strategies that aim to address neglected diseases in developing countries.

## 6.2 Challenges

Overall, despite the considerable progress made in improving the management and funding of medicines supply, particularly for primary health care activities in Uganda, a number of challenges remain to be tackled.

Shortage of medicines remains the main complaint in the recent user satisfaction survey with regard to government health services (UBOS 2005), with less than half of respondents grading this category of service as either ‘fair’ or ‘good’ while more than 70-80 percent graded responsiveness of staff and cleanliness of the facility as fair/good. The actual flow and volumes of medicines reaching the lowest level of health facility are still less than optimal and percentage stock-out times for key primary care medicines are unacceptably high. There is need both to understand why these stock-outs persist and to formulate effective strategies and interventions to remedy them. Among other reasons for continuing stock-outs (e.g. paradoxically, increased out-patient utilisation induced by increased supply), in a setting where health workers aim to maximise client satisfaction, high patient demand for injectable medicines or antibiotics may be served

<sup>1</sup>Central medical stores, autonomous supply agency, direct delivery system, primary distributor system, and fully private supply.

at the expense of technical standards for rational medicines use (Jitta et al. 2003). Changing behaviours for more appropriate use of medicines will require long-term efforts.

The situation is complicated since, in the Ugandan context where the private sector is not well regulated, gaps in the supply at government health units will benefit local drug shops or private providers, who can at the same time be government health workers. We need to better understand vested interests and their influence on provision and consumption of health services. A future Drug Tracking Study should use qualitative research methods, and include a community component to assess the possible factors behind these stock-outs. It will be increasingly important that the regulatory framework keeps pace with the public sector reforms in Uganda, to ensure effective regulation and enforcement of the private sector in the areas of medicines use and professional practice. Strategies for coping with expansion of medicine as a business, and greater consumerism in health care, were recently identified after a mapping of the regulatory system in Thailand (Teerawattananon et al. 2003).

Resource constraints (both financial and human) may soon limit increases in outpatient utilisation. The budgets for 2004/05 and 2005/06 financial years show no growth for medicines in real terms. A study of demand for health services and quality of care in Mali suggests that structural attributes of quality, such as medicines availability, are necessary but not sufficient conditions for demand (Mariko 2003). It is important to remember that the reforms to medicines supply investigated in this chapter are only one of a series of supply and demand side reforms that are needed to achieve continued high utilisation of primary health care services in the country if health outcomes are to improve. The medicines supply reforms thus need to be seen in the context of the overall reforms outlined in this book. For example, improvements in the area of human resource development may facilitate placement of pharmaceutical personnel at the HSD level, or improve the remuneration of health workers, and these could be critical factors for improved service coverage.

Improved public expenditure and medicines supply are expected to translate into higher utilisation of health services overall. However, with increased autonomy provided in the spirit of decentralisation, differences in utilisation rates between health facilities are likely to continue. This is likely to be related to variable performance at the management level (district and/or sub-district level) and facility level, leading to differences in medicines spending, availability, access, or other quality factors affecting user satisfaction.

Finally, recent trends in health care technology, in combination with trade and intellectual property agreements, may translate into substantially higher medicines prices in developing countries. New medicines and health products, such as artemisinin-based combination therapy (ACT) for malaria, anti-retroviral medicines for HIV/AIDS, and the pentavalent vaccine for universal immunisation, are driving an exponential increase in the essential medicines and vaccines budget for a national minimum health care package (Nazerali and Oteba 2005). These products tend to come at fixed high prices. Patent protection for these new products and restrictions or royalties on domestically manufactured generics under the TRIPS came into force in 2005 in middle-income countries such as India, South Africa and Brazil. These are significant producers and exporters of generics. While enforcement in the poorest countries will not take place until 2016, importation from countries that use the TRIPS flexibilities, such as

compulsory licensing to protect public health, may be so beset by regulations that there is reasonable doubt that *"the solution can be effectively implemented"* (Messerlin 2005: 1199).

The price of these new medicines and related diagnostic tests may be dictated by agreements between global agencies and the pharmaceutical industry (e.g. WHO/Roll Back Malaria and Novartis in the case of the new ACT medicine branded "co-artem"). Such products are increasingly funded and supplied through global initiatives often with vertical programming and parallel funding structures. Unless this new funding is incorporated into existing channels, the recent efficiency gains in Uganda may be reversed, and the different strands woven together by the reforms could once again be unravelled. Undermining of the role of national agencies and integration mechanisms, and concerns about the financial sustainability of such initiatives remain unresolved issues that will need to be addressed by the health sector in Uganda and elsewhere if the gap in access to medicines is to be closed (Segall 2003; Quick 2003).

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# 5

## Public-private partnership in health: working together to improve health sector performance in Uganda

Peter Lochoro, Juliet Bataringaya, Christine Kirunga Tashobya and Joseph Herman Kyabaggu

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### Summary

One of the major reforms in the health sector of Uganda has been in the area of public-private partnership in health. Partnerships in health are increasingly seen as a valuable mechanism for moving faster towards the attainment of national and international health goals. For example, recent initiatives such as the Global Fund to Fight AIDS, TB and Malaria and the Poverty Reduction Strategy process contain an emphasis on public-private partnership. Partnership in health in Uganda is a key feature of the National Health Policy and the Health Sector Strategic Plan, and in the sector-wide approach processes and structures. Although efforts at improving public-private partnership date back to the pre-independence days, it is only in recent years that real progress has been made with the development of a specific partnership policy for the sector. In particular, partnership with the private-not-for-profit sub-sector has advanced well and its representatives are involved in a number of policies and reviews within the health sector at the national level. The government is also providing increasing financial support to this sub-sector and structures have been established to facilitate dialogue (e.g. a partnership office). There is evidence that the current partnership has brought dividends to the whole health sector in terms of increased access, quality, equity and efficiency, although as yet these rewards pertain mainly to partnership with the private-not-for-profit sector and progress is yet to be seen with the other private partners in the sector (for-profit, and the traditional and complementary medicine sub-sectors). Existing constraints will have to be overcome to sustain the rewards of the partnership.

## 1. Introduction

Since the 1990s, there has been growing international interest in promoting public-private partnerships in the delivery of health services (Cassels 1995; Green et al. 2002). Partnerships are increasingly seen as a valuable mechanism for moving faster towards the attainment of national and international health goals. Consider the emphasis on public-private partnership in new initiatives such as the Global Fund to Fight AIDS, TB and Malaria, the Poverty Reduction Strategy process (PRSP), the Global AIDS Vaccine Initiative and many others. The objectives of these various health partnerships range from developing a product (e.g. an AIDS vaccine) or distributing subsidised products, to strengthening health systems and educating the public (Widdus 2001).

In Uganda, public-private partnership in the health sector has been pursued with varying degrees of effort and success since pre-independence days.<sup>1</sup> At that time, voluntary health providers collaborated with government and received funding which continued into the post-independence period. Owing to economic collapse and the shrinking of the government budget in the 1970s and 1980s, this funding declined until it stopped altogether.

However, despite the long history of interest in public-private partnership in health in Uganda, it is only in recent years that real progress has been made, in particular since the early 2000s in tandem with the other key health systems reforms that are discussed elsewhere in this book. In chapter 1, Yates et al. describe the impact that these reforms have had on improving health sector outputs. The purpose of this chapter therefore is to identify the contribution of public-private partnership in health to the improved performance of the sector. Also, on an international level, it is useful to provide a specific country example to inform the debate on public-private partnership issues in public service delivery.

The private health sector in Uganda includes the private-not-for-profit (PNFP) or voluntary providers (mainly facility-based health providers), the for-profit private health practitioners (PHP), and the traditional and complementary medicine practitioners (TCMP) (MoH 2003a). Together, these private providers account for a sizeable proportion of the health sector in Uganda (see Table 1). In particular, 42 percent of all hospitals are PNFP hospitals. In total, the PNFP and PHP sectors account for 42.5 percent of the health facilities in the country (not including the TCMP sub-sector that is very diverse and constantly changing).

## 2. Rationale for public-private partnership in health

The rationale for entering into partnership with private health providers in Uganda is straightforward. Given the sizeable contribution made by the private providers to the delivery of health services in the country, it is argued that rather than creating duplicate government structures and thereby wasting limited resources, it makes sense to coordinate efforts and avoid competition. Moreover, the private sector has access to additional non-government sources of resources (e.g. PHP profits, PNFP donor contributions) that can be mobilised to support the common goal of improving the health services available to the population. Over time, the private sector has also

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<sup>1</sup>Uganda achieved independence in 1962.

developed capacity for health training and skills development that can be capitalised upon by government. PNFP hospitals filled a critical gap in health service provision during the 1970s and 1980s when the government health service had deteriorated considerably.

However, by the early 1990s the health sector had undergone a time of increased polarisation between public and private health providers, with little or no sharing of information and no coordination in planning or development. A significant trigger point for the recent reform occurred after the mid-1990s when the PNFP sub-sector was on the brink of collapse. An emergency situation was declared by the PNFP hospitals (MoH 1996), whereby as a result of decreased capacity to mobilise external resources, the rising cost of health services delivery, the need to keep user fees affordable, and having exhausted efficiency gains, many PNFP hospitals had reached a point where shutting down was the only option.

In response to their critical condition, and in recognition of their contribution to health service delivery in the country, the government decided to provide financial subsidies to the PNFPs, representing a major step forward in the development of public-private partnership in the sector. On the part of the PNFPs, partnership with the government was agreeable, once autonomy of management was preserved, as it provided a critical contribution to funding.

**Table 1: Health facilities by ownership**

|   | Government | PNFP | PHP | Total |
|---|------------|------|-----|-------|
| Hospitals   | 55         | 42   | 4   | 101   |
| Health Centre Level IV<br>(Higher services with doctor and theatre) | 151        | 12   | 2   | 165   |
| Health Centre Level III<br>(Providing in and out-patient service)   | 718        | 164  | 22  | 904   |
| Health Centre Level II<br>(Basic out-patient facility)              | 1,055      | 388  | 830 | 2,273 |
| Total Health Units  | 1,979      | 606  | 858 | 3,443 |

Source: MoH (2002a).

### 3. Structures of the partnership

The events that followed the re-instatement of financial subsidisation opened the way for a more structured partnership between the government and the private health sector. At the policy level, the need for public-private partnership in the delivery of health services is identified in the National Health Policy of Uganda and in the Health Sector Strategic Plan (HSSP) (see chapter 1, Yates et al., Annex 1). Since then, a specific policy laying out the principles for public-private partnership in health service delivery has been developed (MoH 2003b).

This policy defines partnership as *“The formal relationship between two or more partners who have agreed to work together in a harmonious and systematic fashion and being mutually supportive towards common goals, including agreeing to combine or share their resources and/or skills for the purpose of achieving these common goals”* (MoH 2003b: 5).

To achieve the level of partnership described in the policy, the areas in which public and private health providers are to collaborate are wide ranging. In particular they include partnership in the following areas:

- Policy development;
- Coordination and planning;
- Financial resource mobilisation and allocation;
- Human resources for health management;
- Capacity building and management;
- Community empowerment and involvement;
- Service delivery (management and implementation).

**Table 2: Structures of partnership**

| Structure of partnership  | Roles  |
|---|--|
| Central Level   |  |
| Joint Review Mission  | A joint review of sector performance by GoU and Partners (i.e. districts, Parliament, NGOs, private sector and donors) on an annual basis.   |
| Health Policy Advisory Committee (HPAC)   | A forum to discuss and advise the Ministry of Health and development partners on the implementation of the National Health Policy and the HSSP.  |
| Working Group on PPPH   | To facilitate dialogue between government and private health providers in preparation of guidelines and policy proposals, and to facilitate coordination of Ministries. The group is represented on HPAC.  |
| Ministry of Health PPPH Desk  | <ul style="list-style-type: none"> <li>- To advocate and facilitate partnership at different levels;</li> <li>- To facilitate operations research into specific PPPH issues;</li> <li>- To collect and disseminate information;</li> <li>- To liaise with private sector partners;</li> <li>- Secretariat to the PPPH Working Group and sub-working groups.</li> </ul>                           |
| Inter-ministerial Standing Coordinating Committee – Education and Health for training health workers. | To set the priorities, coordinate the stakeholders, monitor progress and refine the policy and strategic Human Resources development plan.   |
| The Umbrella Organisations  | <ul style="list-style-type: none"> <li>- To represent and coordinate the different health providers of the PNFP sub-sector;</li> <li>- To provide support services and accredit the member facilities;</li> <li>- To coordinate and promote professional development and ethics;</li> <li>- For the PHP: to represent each professional category and promote Partnership initiatives.</li> </ul> |

|  |  |
|--|--|
| Local Government Level                             |  |
| The District Health Management Team                | To prepare annual plans, provide technical assistance to the health facilities, inform, consult and coordinate with other district stakeholders, monitor and evaluate progress, and propose improvements.  |
| The District PPPH Desk Officer                     | <ul style="list-style-type: none"> <li>- To facilitate information flow between district authorities and PNFP/PHP representatives;</li> <li>- To facilitate understanding and coordination of implementation arrangements;</li> <li>- To carry out assignments given by the technical head of health services from within the existing district structure, in consultation with the PNFP/PHP coordination committees.</li> </ul>   |
| District PNFP/District PHP Coordination Committees | To represent the PNFP/PHP facilities and programmes of different ownership, to coordinate their facilities and programmes, to harmonise approaches, define common issues, propose solutions, and ensure information exchange.  |
| The Health Sub-District (HSD) Management Committee | <ul style="list-style-type: none"> <li>- To prepare plans and assist the health facilities and community groups to deliver the Uganda National Minimum Health Care Package (UNMHCP) within the HSD;</li> <li>- To inform, consult and coordinate with other sub-district stakeholders, monitor and evaluate progress, and propose improvements.</li> </ul>   |
| Hospital Board                                     | To advise and supervise hospital management on key operational issues including finance and human resources.   |
| Health Unit Management Committee                   | <ul style="list-style-type: none"> <li>- To direct and supervise implementation and quality of UNMHCP services;</li> <li>- To monitor and evaluate progress;</li> <li>- To supervise management of the health facility;</li> <li>- To liaise between management, community and stakeholders.</li> </ul>  |
| Sub-county Health Committee                        | To prepare plans, reports and budgets to be presented to the Sub-County Council (Local Sub-county council), and to the HSD management team.  |
| Parish Development Committee (PDC)                 | <ul style="list-style-type: none"> <li>- To collect and analyse data, identify the community's health needs, prioritise and implement appropriate responses;</li> <li>- Where such committees exist, the private sector partners can provide technical assistance and support to train PDC members, to assist in data analysis and generally advise the PDC during its deliberations.</li> </ul>   |
| Village Health Team                                | <ul style="list-style-type: none"> <li>- To identify the community's health needs and priorities and develop plans to make appropriate responses;</li> <li>- To mobilise additional resources and monitor use of all resources for their health programmes including performance of health centres;</li> <li>- To mobilise communities and to select and oversee Community Resource Persons;</li> <li>- To maintain registers of households and their health status, and to serve as the primary link between the community and health service providers.</li> </ul> |

Source: MoH (2003b).

While the policy refers to partnership with the whole private health sector, in practice, partnership has developed to varying degrees with the three different private sub-sectors. The PHP sub-sector has come on board recently and some progress has been made in more clearly identifying partnership activities. In contrast, minimal progress has been made with regard to the TCMP sub-sector. While the need for partnership with this group is widely acknowledged, there are difficulties in identifying all the practitioners falling into this category, whose areas of focus range from traditional herbalists to what might be classed as sorcerers and witchdoctors. A Bill is currently being drafted, the aim of which will be to facilitate definition and regulation of the TCMP and prepare the sub-sector for a better-structured partnership.

Partnership with the PNFP sub-sector has been the most successful to date. In particular, the leaders in this process have been the religious-based institutions, represented by their umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), and the Uganda Muslim Medical Bureau (UMMB). Thus the remainder of this chapter will focus on progress in partnership with the PNFP sub-sector.

In terms of partnership structures, a coordination office and partnership mechanisms have been established both at national and more gradually at district level (see Table 2). Through the sector-wide approach (SWAp) to health sector management, partnership at the national level has been facilitated. As explored in more detail in chapter 2 (Oliveira Cruz et al.), the health SWAp itself is a partnership arrangement between the Government of Uganda, development partners and other stakeholders to the sector. Within these SWAp structures, the participation of the PNFP sub-sector (through its umbrella organisations) was able to take on a formal status in national level health policy discussions. The PNFP umbrella organisations are represented on the SWAp Health Policy Advisory Committee and at the annual stakeholder review missions and the budget allocation discussions for the sector. Such involvement has also opened the way for the interaction of the PNFP umbrella organisations at policy levels even beyond the Ministry of Health (MoH), in particular with the Ministry of Finance, Planning and Economic Development (MoFPED).

#### **4. Government efforts towards the partnership**

The development of the partnership policy and the practical arrangements that have been made for planning and coordination with the PNFP sub-sector have been led by the government, with strong support from the PNFP umbrella organisations. However, the most critical contribution by government to date with regard to the partnership has been the provision of increasing financial support. A specific PNFP conditional grant is channelled to PNFP health units via the district government health office (see Annex 1 in chapter 1, Yates et al., for a description of the health service structure in Uganda). The funds are provided for recurrent expenditure and are conditional on the preparation and approval of a comprehensive work plan and budget and the signing of a Memorandum of Understanding with the local government. The decision to route the funds through the district government facilitates partnership between the PNFP health units and the district government health system. Additional

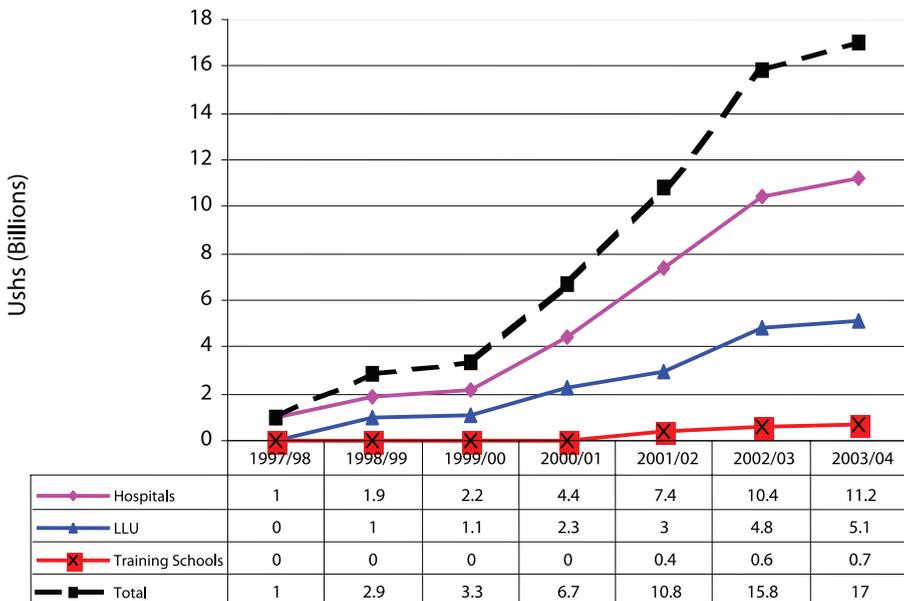
support is also provided in the form of salaries for government doctors who are posted to PNFP hospitals and in the form of a credit line for medicines from the national level pooled medicines fund (see chapter 4, Nazerali et al., for further description).

Since 1997/98, when financial support to the PNFPs was re-introduced, in the form of the conditional grant, the funding has grown significantly and has also been extended to PNFP health training institutions (see Figure 1). Total funding to the PNFP sub-sector amounted to just 0.5 percent of the total health sector budget in 1997/98, and this had grown to 7 percent by the year 2002/03 (see chapter 7, Ssengooba et al.).

This funding made a considerable contribution to the financial sustainability of the PNFP health units. For example, in the year 2001/02, government funding from the PNFP conditional grant constituted nearly 30 percent of the budgetary requirements of the PNFP health units (Bataringaya and Lochoro 2002). Thus, despite accounting for a small proportion of the total health budget, this funding is extremely valuable to the PNFP health units.

While government funding is restricted to the PNFP sub-sector at present, the way may be opened for specific publicly funded activities in the PHP sub-sector in the future, with the aim of expanding access to services in under-served areas in the country.

**Figure 1: Government funding<sup>1</sup> to PNFP health institutions**



Source: MoH (Selected Years).

<sup>1</sup>The amounts exclude a wage subvention that is approx. Ushs 0.7 billion annually (exchange rate: 1 US\$ = 1750 Ushs at July 2004).

## 5. Private sector efforts towards the partnership

In addition to the government grants, the sub-sector continues to mobilise funds from other sources including user fees, donations from abroad and other income-generating activities. Extrapolating from UCMB data, it is estimated that in the year 2002/03, user fees accounted for 45-50 percent of the PNFP budget while the other sources (mainly donations and income-generating activities) funded approximately 25 percent.

Driven by the decline in other sources of funding (in particular, foreign donations), user fee levels in PNFPs had gradually increased over time. A central element of the PNFP mission is to support the health of the population, with particular focus on the poor and most vulnerable, and yet this rising trend in user fees had led to a decline in utilisation by the poor (see chapter 3, Kirunga Tashobya et al.). Over the last two years, growing financial support from government grants and improvements in management efficiency have enabled many of the PNFP health facilities to adjust their user fees downwards. At least 81 percent of the PNFP hospitals and a number of lower level health units have been able to lower fees, leading to increases in utilisation, especially for child in-patient stays and general out-patient consultations (Odaga and Maniple 2003).

Under the guidance of the umbrella organisations, PNFP facilities were encouraged to lower their fees for selected services, focusing on those that benefit the vulnerable in particular (e.g. maternity services, child health services). In addition to fee reduction, a policy of flattening the fee structure was pursued, making the fee structures much more predictable and transparent. Training, technical assistance and planning tools for price-setting were also provided to the participating health facilities.

## 6. The rewards of the partnership

To assess the rewards of the partnership, in particular those of the partnership with the PNFP sub-sector, available analysis has looked at performance in four areas, namely access (utilisation), efficiency, quality and equity. A UCMB initiative has collected and analysed data across a range of PNFP facilities under its umbrella, both as an evaluative exercise and as a tool for facility level management (Giusti et al. 2002; Giusti et al. 2004). UCMB health facilities represent the major share of this sub-sector, accounting for 64 percent of PNFP hospitals and 46 percent of PNFP lower level units. As a general assessment, it is noted that the current partnership has enabled the PNFP sub-sector to make a substantial contribution to improvements in health sector performance (Giusti et al. 2002) and has helped services to increase access for the poor (Giusti et al. 2004).

First, in terms of access, the reversal of the decline in utilisation of health services was immediate, occurring just after the introduction of the subsidies. Figures 2 and 3 show the upward trend in utilisation of composite units of output<sup>2</sup> and this rise in utilisation has continued at an even steeper pace into the present day. This is attributed to the effect of the government subsidy in replacing user fees and allowing the charges to be gradually pushed downwards, as shown in Figure 4 (Giusti et al. 2004). Other

<sup>2</sup>A measure which adds in-patients, out-patients, deliveries, immunisations and antenatal attendances all weighted for their cost relative to the out-patient cost.

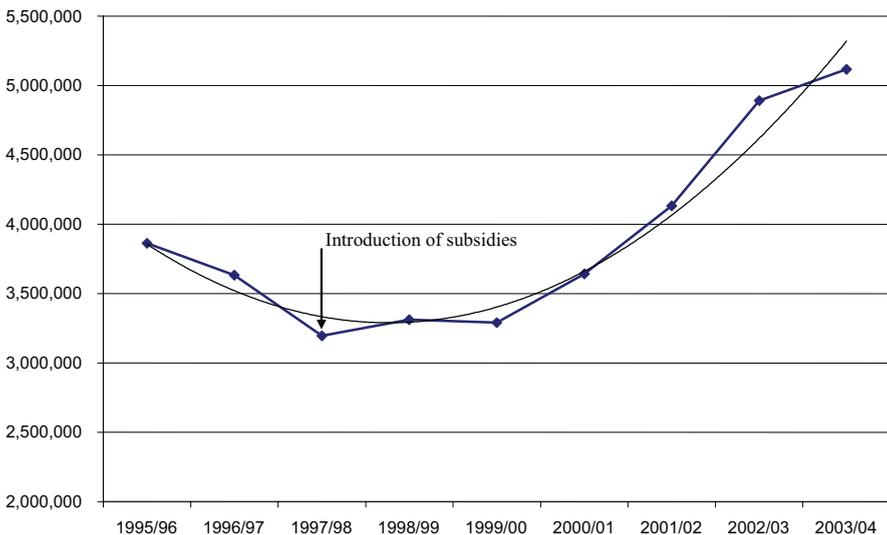
examples of this increased utilisation following the reduction in user fees at specific health facilities are presented in chapter 3, by Kirunga Tashobya et al.

Second, with regard to efficiency, the monetary cost of providing services in PNFP health units has been increasing on a yearly basis, in line with the rest of the health sector, which may indicate rising quality of care across the sector (see below). However, in 2002/03, for the first time, UCMB hospitals demonstrated a fall in the cost per unit of output compared to the previous year 2001/02. There has also been an observed increase in output per unit of staff (Giusti et al. 2004). The latter indicator in particular, given a consensus that PNFP facilities have been underutilised on the whole, suggests that efficiency improvements have been achieved by the PNFP health facilities in recent years.

Third, in terms of quality, improved performance has been found in at least one indicator of quality, the proportion of qualified staff at the health facility. This proportion has increased as a result of improved pay conditions for staff at the PNFP facilities (Giusti et al. 2002). An improvement in quality of care in PNFP facilities due to an increased proportion of qualified staff is therefore possible.

Although not explicitly demonstrated, an improvement in equity may also be suggested by the results. First, it is known that 86 percent of the PNFP health units are based in rural areas (MOH 2001a) where 85 percent of the poor reside (MoFPED 2004). Thus it is likely that the majority of the increased utilisation observed above was accounted for by the rural poor. Moreover, with regard to equity, the largest jump in utilisation was observed for child health services, especially for in-patient utilisation. These results indicate that prior to the user fee adjustments in these PNFPs, very sick children needing hospitalisation were being excluded from health care. Also, the user fee reductions were focused on services for women and children, identified as the most

**Figure 2: Total units of output 27 UCMB hospitals**

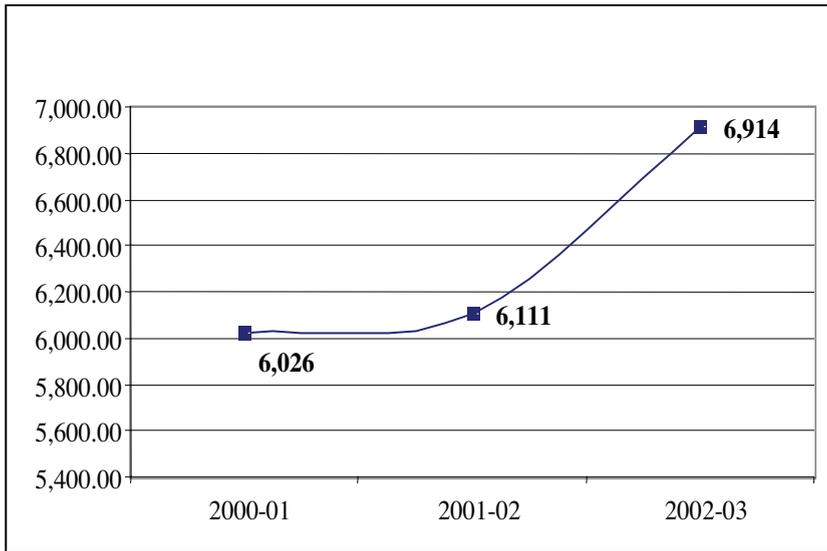


Source: UCMB (2004).

vulnerable in the population and thus another indication that the fee adjustments had a positive impact on equity.

All in all, we conclude that improved performance in the four areas of access, efficiency, quality and equity can be attributed to better funding of the health units, improved focus and capacity of the institutions (better planning, better qualified staff), and support and supervision from the umbrella organisations made possible by the growing public-private partnership in health.

**Figure 3: Total units of output in a sample of 111 UCMB lower level units**



Source: UCMB (2004).

Note: The degree of completeness and reliability of data from lower level units prior to 2000/01 were poor.

## 7. Constraints

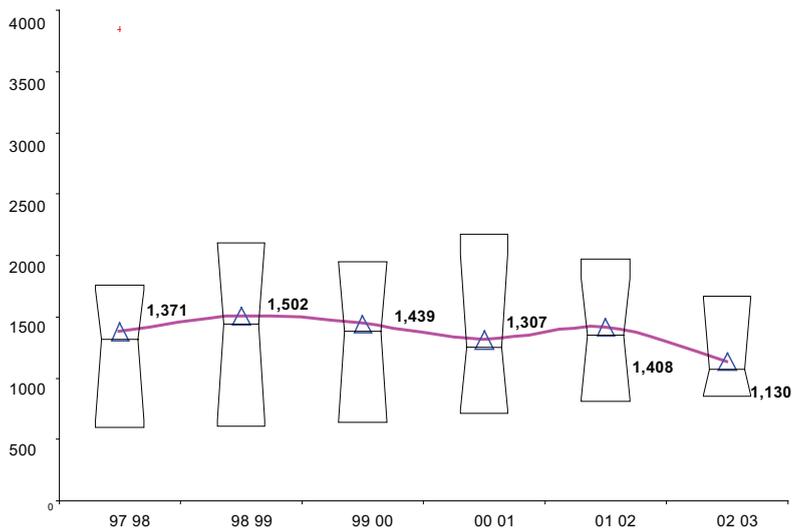
There remain a number of constraints that still need to be tackled in the area of public-private partnership (MOH 2003a). The TCMP, the PHP and the non-facility based PNFPs have poorly developed structures for adequate representation and dialogue and help is needed to improve their internal organisation.

While the partnership concept has been well received at the national level, there is much less appreciation at the district level, and both public and PNFP district partners have been slow to engage with the partnership process. The main reason behind this divergence possibly lies in the fact that the impetus for partnership originated at the national level and has only slowly been gaining the acceptance of the districts. In many cases, at district level, there remains mutual suspicion between the public and private health facilities with each complaining that the other has secret, non-disclosed sources of funding. The dominant motivation has often appeared to be one of competition (for resources) rather than of coordination (in service delivery).

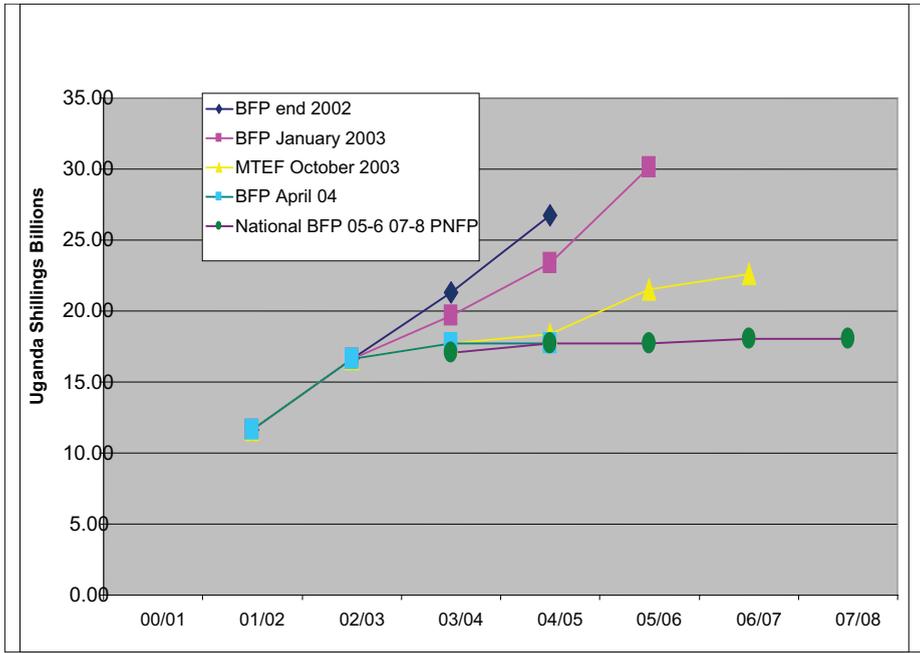
The administrative partnership arrangements, for example the government grant and the medicines credit line, have used government planning, budgeting, accounting and reporting procedures for both public and PNFP providers. This is seen by many in the PNFP sub-sector as weakening their autonomy and introducing a degree of inflexibility that may lead to loss in value for money. They consider it necessary to introduce contractual arrangements between the government and the private health providers to smooth over administrative differences and to maintain the autonomy of the private sector.

Despite improving remuneration, the PNFPs are still unable to competitively recruit and maintain health workers. Most of the losses of staff from the PNFP are to government employment posts (MoH 2005), due to both pull (higher government salaries) and push factors (e.g. more stringent management practices, fewer opportunities for professional development in the PNFP sub-sector (MoH 2001b)). The human resource constraint is probably the most difficult test for partnership currently. The PNFP units have been working to reduce the salary gap between public and PNFP staff, only to be met with further increases in public wages and increasing staff loss. This is compounded by stagnation in the size of the PNFP grant against a growing health sector budget. Furthermore, in successive government budget allocation forecasts, the size of this grant has been flattening which gives a worrying indication of a decline in emphasis on the partnership on the part of the government (UCMB 2005). For example, in the budget allocation of 2002, the PNFP grant was projected to rise quite steeply over the medium term, while in the latest medium-term budget allocations, the size of the grant is projected to grow much more slowly (see Figure 5). Maintenance of the positive achievements of the partnership will hinge on finding a solution to these constraints.

**Figure 4: Median fees charged per Standard Unit of Output OP in UCMB Hospitals (Not adjusted for time preference)**



Source: Giusti et al. (2004).

**Figure 5: Projected budget allocations to PNFPs over time**

Sources: MOH (2002b); MoH (2003c); MoH (2004); MoFPED (2003); MoFPED (2005).  
 BFP: Budget Framework Paper.  
 MTEF: Medium Term Expenditure Framework.

## 8. Conclusions

The public-private partnership in the health sector has advanced ahead of many other developing countries and international initiatives. It is clear that in promoting the partnership, the government appreciates the valuable role played by private health providers in the delivery of health services to the population. In particular, there is a clear understanding that the partnership seeks to utilise as much as possible the different capacities of all the partners from policy development through to service delivery.

The current level of partnership has been facilitated by a number of factors. The installation of the new government in 1986 paved the way for wide reforms in all sectors including health. The sector-wide approach, initiated in the year 2000 (see chapter 2), was one of the key reforms that provided an enabling environment for partnership. Due to sustained economic growth and continued financial support from donors, resources for government services have increased over time (see chapter 7), and have thus allowed some contribution towards private sector partners, in particular the PNFP health providers.

In many countries in sub-Saharan Africa, partnership with the private sector is largely understood in terms of a funding contract whereby mainly non-clinical services

are purchased from the private sector (Verhallen 2001). In contrast, the Ugandan case is seen as a more extensive partnership, with partnership areas ranging from policy development to service delivery. The overall goals and objectives of the government and private health providers, in particular the PNFP providers, overlap significantly, leaving little room for exploitation of either party, and consequently the need for legal structures is limited. Moreover, support of the private sector by the government has been shown to yield very positive results in health sector performance. Financial support to the PNFP sub-sector, equivalent to 30 percent of their budget, led to an increase in outputs of over 50 percent in a set of UCMB hospitals between the years of 1997/98 and 2002/03. Such a significant output improvement over time was achieved despite the growth in the government grant to this sub-sector to only 7 percent of the total health budget by 2002/03.

Finally, the value of the partnership with the PNFP sub-sector goes beyond that of achieving health output improvements, as it has helped this sector to refocus itself on its original mission – to assist the poor and vulnerable in the country in the hope of alleviating poverty and improving equity in the population. While much of this chapter has focused on the PNFP sub-sector, it is possible that similar benefits in terms of improved health sector performance can be achieved as greater partnership at the district level is encouraged, and that with the PHP and TCMP sub-sectors is further developed.

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# 6

## Meeting the challenges of decentralised health service delivery in Uganda as a component of broader health sector reforms

Grace Murindwa, Christine Kirunga Tashobya, Joseph Herman Kyabaggu, Eliseus Rutebemberwa and Juliet Nabyonga

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### Summary

Decentralisation in its present form was introduced in Uganda in the 1990s. Uganda has a devolved form of government where local governments have extensive political and administrative powers. The health sector has been markedly influenced by this decentralisation. In the National Health Policy and the Health Sector Strategic Plan (2000/01-2004/05), the sector has sought to decentralise health services even further by creating lower level management structures at a sub-district or county level. At the same time, the health sector undertook a number of other reforms to improve the delivery of primary health care services in the districts. These included reforms to human resource management and physical infrastructures, and the establishment of appropriate structures and institutions for support supervision and performance monitoring. This chapter investigates each of these reforms in turn, noting where progress has been made and where challenges still remain. Particular attention is paid to the impact of the reforms on efficiency, equity and community participation in the health sector. We conclude that the Ugandan health sector has performed quite well against a number of these objectives, but that performance is varied across and within districts. In particular, remote areas suffer from a number of drawbacks where, for example, staff are unwilling to be stationed in hard-to-reach unattractive locations. Thus, under the new Health Sector Strategic Plan for the period 2004/05-2008/09, a number of challenges still need to be addressed in order to further improve the decentralised delivery of health services in the country.

## 1. Introduction

Decentralisation can be defined in many ways. This chapter draws on the work of Møgedal et al. (1995), defining decentralisation as a *"dynamic process of changing relationships between the centre and the periphery with the local level taking on more and more authority and responsibility"* (p.355). Moreover, within this definition, different forms of decentralisation can be described, including deconcentration, devolution, delegation and privatisation. Using these definitions, the form of decentralisation that was introduced in Uganda is best described as devolution, where the main emphasis is on the creation or strengthening of local government. Decentralisation in its present form was introduced in Uganda in 1992 and by 1997 all districts in the country had established local governments with full administrative and political structures in place (MoLG 1994).<sup>a</sup> However, it is important to bear in mind that when these definitions are applied to real situations, a mix of different forms of decentralisation is likely to be observed within the same country/system and Uganda is no exception (Rondinelli et al. 1993; Møgedal et al. 1995).

Decentralisation in Uganda occurred as part of the broad civil service and public sector reforms which were introduced over the late 1980s and 1990s in the context of a country emerging from over a decade of civil conflict with many economic challenges. These reforms were aimed at improving the accountability of public resources and making spending more efficient.

Prior to the 1990s, management of public services, including health, was centralised and districts were responsible for carrying out functions delegated by the central government. In the health sector, districts were delegated the responsibility for the management of the smaller health units below the level of the hospitals. The Ministry of Local Government (MoLG) was responsible for supervision of the districts, while management of general and regional hospitals was under the responsibility of the Ministry of Health (MoH). Following the reforms of the 1990s, the districts became responsible for the management of all health services within their jurisdiction with the exception of regional and national referral hospitals (Hutchinson et al. 1999). After almost 10 years of decentralisation, the health sector stakeholders realised that the decentralised districts were still big both in terms of size and population. In 1999, therefore, the health sector further decentralised the delivery and management of health services to a level below the districts, thus creating a Health Sub-District level of management.

This book discusses many health sector reforms that have taken place in Uganda since 2000. The focus of this chapter is on decentralisation, looking specifically at the implications of the extended decentralisation undertaken by the health sector, and on other infrastructural, human resource and supervision reforms in the sector. Given the focus on decentralisation, and hence on district health systems where primary health care services are delivered, we mainly address primary health care services, which is in line with the central priority outlined in the Health Sector Strategic Plan (HSSP) (MoH 2000b) and the National Health Policy (NHP) (MoH 1999).

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<sup>a</sup>By 2000 Uganda had a population of 21 million, spread over 45 districts. The population is now close to 25 million and some districts have been sub-divided. For much of the period under review in this book, the total number of districts was 56; this has now increased further to 69.

## 2. Ugandan primary health care delivery system in the 1990s

Following decentralisation in the 1990s, District Health Management Teams, under the leadership of District Medical Officers (DMO), were responsible for the planning, management and provision of health services in the districts. Thus, the district teams were now expected to handle both the day-to-day issues of service delivery (e.g. managing the logistics of medicines delivery to the health units) and the more strategic functions of planning, coordination and resource mobilisation. However, these teams were seriously constrained in terms of human, financial and logistical resources. Not surprisingly, therefore, the capacity for management of the decentralised district health system was generally low (MoH 1998).

Compounding these basic capacity problems, district health services suffered from a number of other constraints in the 1990s. First, geographical access to basic health services was low, where only 49 percent of the population was estimated to be living within a 5km radius of a health facility. By 2000, this had increased to 57 percent (MoH 1991; MoH 2000a). Districts in Uganda have an average population of 500,000, although land surface area and terrain vary from district to district, affecting ease of access to services. Thus there were wide variations in access to basic health services across districts and within districts, with some of the districts reporting less than 10 percent of the population living within a 5km radius of a health facility. Looking at specific elements of basic health care, there was even wider variation in access across the country, where, for example, some districts were not able to provide emergency surgical and obstetric services.

Second, there were problems with human resources, both in terms of physical manpower and management issues. As part of the civil service reforms in the 1990s, the government imposed a ban on recruitment of civil servants, including health workers. A study carried out by the MoH in 1999 showed that only 34 percent of the established positions in health centres were filled by qualified health workers (MoH 2000b). The remaining positions were either vacant or filled by untrained nursing aides. Moreover, the distribution of the few available qualified health workers was skewed towards hospitals and urban areas. Local governments were responsible for the management of human resources for district health services and many problems were experienced, particularly with regard to payment of salaries. Local governments were provided with unconditional block grants from central government from which they were expected to pay, among other things, salaries of civil servants including health workers. Yet in many districts, salaries for health workers were not being paid on a regular basis. Some local governments continued to recruit health workers even though they could not access the formal payroll. These workers were supposed to be paid either through user fees collected at the health centre or through sub-county local revenues, but in fact many never received any salary at all (MoH 2000c).

Third, there was weak supervision and monitoring of health services at all levels. With a limited number of skilled supervisors and inadequate logistical support, neither the MoH nor the district teams were able to carry out regular and appropriate supervision and monitoring (MoH 2003a). At the district level, planning for activities such as supervision was usually undertaken without appropriate reference to available resources (financial and human), and it was often simply assumed that the required inputs would somehow materialise.

Clearly, decentralised district health services suffered considerable drawbacks in the 1990s. With the development of the NHP (MoH 1999) and the first HSSP 2000/01-2004/05 (MoH 2000b), the health sector aimed to address these problems in order to improve the delivery of primary health services in the country.

### 3. Efforts to improve decentralised health service delivery

#### 3.1 The Health Sub-District strategy

As mentioned above, the health sector extended the reach of decentralisation through the creation of a health sub-district level of management. This shift was provided for in the NHP and outlined in detail in the Health Sub-District Strategy Paper in 1998 (MoH 1998). A health sub-district (HSD) is a functional sub-division of the District Health System with the main objective of improving the management and delivery of health services at the local level. It is therefore located within a district, covers a population of approximately 100,000 and is equivalent to a county/constituency (see chapter 1, Yates et al., Annex 1).

The main objectives of further decentralisation to HSD level were to:

- improve the quality and management of routine health service delivery;
- increase equity of access to essential health services;
- foster community involvement in the planning, management and delivery of basic health care.

These three are key principles of the HSSP, and as such the HSD strategy was put in place to ensure they could be achieved.

Following the creation of the HSD, new roles and responsibilities were assigned to the district level. The district level health offices, now headed by the District Directors of Health Services<sup>b</sup> (DDHS), became responsible for overall leadership, strategic planning, supervision, monitoring and coordination of district health services. The HSD headquarters were made responsible for operational planning and management of health care delivery within their individual catchment area (i.e. health service delivery, monitoring and supervision of all the basic health services in the HSD). As part of the broader strategy to bring basic services closer to the people, each HSD was required to have a hospital or a high level health centre<sup>c</sup> (level IV) to provide emergency surgical and obstetric services. This health facility forms the headquarters of the HSD, and is referred to as the HSD Referral facility. It provides technical and management leadership for the rest of the health units (i.e. health centres at levels II and III) in the designated area. The facility is managed by a team of senior health professionals headed by a medical officer or, in his/her absence, a clinical officer or public health nurse. It is also noted that this health facility can be from either the public or private-not-for-profit

<sup>b</sup>The title of the technical head of the District Health Team was changed from District Medical Officer to District Director of Health Services in reflection of the adjustment of the post from one of direct service provision to one of health systems management.

<sup>c</sup>See Chapter 1, Annex 1, by Yates et al. for a description of the structure of the health system.

(PNFP) sector, thus demonstrating one of the ways in which partnership with the PNFP sector has developed in Uganda, as discussed in more detail by Lochoro et al. in chapter 5.

However, while the concept was introduced in the late 1990s, the HSD strategy was implemented at a varied pace across the country. This was due both to variations in human resource and infrastructural capacity across the regions and also to differing levels of interest by the political and administrative leaders in the districts. For example, in some areas, the DDHSs readily embraced the strategy, whereas in others, the change was considered to represent a loss of power and influence and was therefore not encouraged.

There have been particular problems encouraging hospital staff at HSD headquarter hospitals to consider the management of the wider HSD rather than just that of the hospital. By now, all districts have operational HSDs in place, although with continued varying levels of functionality (MoH 2004a).

It is possible, however, to assess the performance of the HSD strategy in light of the objectives outlined above. In terms of improved management of health services, progress to date has been mixed. In some districts the HSD headquarters provide effective management of resources, in particular of medicines and financial resources (and to a lesser extent, human resources). Good use is made of information available through the Health Management Information System (HMIS) and other data sources in order to prepare realistic and sensible HSD work plans and to make decisions for the improvement of services. In the districts where such HSDs are operating, the DDHS and other members of the District Health Team are released from having to deal with day-to-day operational issues and are able to concentrate on the more strategic roles of district planning, supervision, and coordination with the central government and development partners (MoH 2004a). Moreover, the results of such improvements in management at district and sub-district level can be seen in terms of service delivery performance. Districts that perform well in a league table prepared by the MoH (discussed further below) are more likely to be those that have made progress on the management side (MoH 2003c).

In contrast, in other districts progress has been much slower, with some of the roles of the HSD still being carried out by the District Health Team. Limited capacity is a major factor in this as many of the health workers at HSD level do not have the requisite skills for planning, management or supervision. To address these problems, a programme of training the HSD core management teams in planning, organisation and management was initiated by the MoH, although progress has been slow and to date about 50 percent of the HSD teams have been covered (MoH 2004d). Another major challenge has been the high turn-over of staff at the HSDs, which is disruptive to attempts to establish smooth long-term planning and management processes.

Looking at the second objective of HSD decentralisation, increased equity of access, some progress has been observed, particularly in terms of resource allocation processes. Each HSD currently receives a budget from the central government, and the formula for allocating these funds across districts and HSDs has improved over the years. The allocation has moved from being a fixed amount for each HSD, to one that is based on population and other demand side variables (e.g. poverty, morbidity), as described in more detail by Ssenooba et al. in chapter 7. Also, as a result of these changes, a far greater proportion of resources is now spent on service delivery inputs at the HSD level rather than on management functions at the district level, thereby improving the availability of basic health services for the population.

On the other hand, some inequities may have been exacerbated since the implementation of the HSD strategy. Some districts are still unable to recruit medical officers to head the HSDs, possibly because the districts are too remote and hard-to-reach or because of poor human resource management practices by the districts in question. While this inequity might not be caused by the HSD strategy per se, it does indicate that there are challenges to fully implementing the strategy universally across the country.

According to the third objective, the HSD strategy was expected to accelerate the process of community involvement in the management of health services (and in the management of their own health) by bringing health service management structures closer to the population. Local level managers have a greater understanding of local requirements and needs, and are thus better placed to take these needs into account in decision-making processes. In the health sector, such community participation is facilitated through the establishment of Health Committees and Health Unit Management Committees (HUMCs). In the HSD strategy, several tools highlight the need for community participation. For example, guidelines for the development of work plans identify the need for such participation and for the integration of community health-related priorities and activities with those of the health facilities. Another new initiative has been the development of Village Health Teams (VHT), the goals of which are to encourage communities to take responsibility for their own health and well-being, and to participate actively in the management of their local health services.

In practice, progress in encouraging community participation has been mixed. There has been some improvement in the degree to which HSDs involve communities in decision-making processes. There are also varying levels of co-operation between the political, administrative and technical leaders at this level. Often, the higher academic qualifications of the health workers at the lower levels of government intimidate the other leaders, hindering co-operation. However, in many cases, local government committees have been involved in decisions to allocate local level resources to the health sector, particularly for construction activities, whenever these have been available (e.g. general non-sector specific development funds received from central government or locally collected tax revenue). The HUMCs were much more active at the time when public facilities were collecting user fees as they participated in the management of these resources. However, since the abolition of these fees (see chapter 3, Kirunga Tashobya et al.) many of these HUMCs are no longer in place or are not functioning. The VHTs have been established in only a few districts and their operationalisation requires a considerable amount of resources for training, equipment, and logistics, and as yet these resources are not available in current budgets (MoH 2003c).

### **3.2 Improving physical access to primary health care services**

In addition to the HSD strategy and the associated efforts to improve the management of local level health services, the health sector has also focused on improving physical access to health services within the decentralised context. Over the period of the health reforms, with the support of various stakeholders (e.g. central and local governments, development partners, communities, external funding agencies), many new health facilities have been constructed and other existing ones have been

upgraded. From 2000 to 2003, over 400 new health centres (level IIs) providing basic out-patient services have been constructed and a further 180 have been upgraded to level IIIs to provide in-patient, laboratory and maternity services. In addition, a total of 150 new operating theatres and doctors' houses have been constructed at health centre level IV (MoH 2003d). A considerable amount of new equipment has also been purchased to improve the functionality of the health facilities as well as a number of vehicles to facilitate outreach services, deliveries (medicines, vaccines, gas etc.), and referrals (MoH 2004c).

As a result of these efforts, population access to health facilities has increased and the proportion of the population living within a 5km radius of a health centre had reached 72 percent by the end of 2004 (MoH 2004b).

One of the downsides of these construction activities is that the rate of expansion, particularly of the lower level health units, has been much faster than was planned due to a high level of interest by the population and political leaders and the multiplicity of financial resources earmarked for capital development (e.g. specific project funding etc.). Consequently, many of the new units lay unused for a year or more due to a lack of complementary resources such as staff and equipment (MoH 2003c; MoH 2004a).

### 3.3 Human resource management

As outlined earlier, numerous human resource problems existed in the health sector in the 1990s and concerted efforts were needed to address these problems affecting probably the most critical input to health service delivery. Health sector stakeholders successfully negotiated with appropriate institutions in government (Ministries of Finance and Public Service), which led to lifting the ban on recruitment of health workers. Thereafter, provision was made in the health sector budget for the recruitment of over 3,000 new primary health care workers, and by 2003 85 percent had been recruited. As a result, the proportion of established posts filled by qualified health workers increased from 34 percent in 1999 to 53 percent in 2003 (MoH 2003c; MoH 2003d).

To improve payment conditions, in 2001/02 the health workers' payroll was recentralised (i.e. moved back under the control of central government) in order to ensure all the properly appointed health workers were receiving their salaries regularly, and that arrears were provided for. Furthermore, particular effort has been made by the government to increase health workers' salaries, although the level of remuneration remains a thorny issue and is certainly not high enough to stem the flow of health workers to developed countries.

To further address human resource capacity constraints, over 4,000 nursing aides have undergone a 3-month in-service training programme to become nursing assistants, and similar in-service training programmes for other cadres of health workers (e.g. anaesthetic assistants, theatre attendants) have been provided. A number of other trained health workers have undertaken further training to improve their technical competence. On the management front, nearly all DDHSs have received postgraduate training in Public Health/Health Services Management, resulting in improved capacity for the management of district level health services (MoH 2003c; MoH 2003d).

Despite these improvements, there remains a critical problem of variability in human resource availability across districts. The capacity to recruit qualified health

workers varies from district to district with some districts able to attract a higher number of qualified health workers than others. Not surprisingly, health workers are attracted to urban areas, and more easily accessible and attractive districts, resulting in a skewed distribution of human resources across the country. The health sector is under increasing pressure to resolve this issue and to come up with appropriate incentives to attract staff to the more remote areas.<sup>d</sup> In addition, the public sector comes under pressure of competition from the more lucrative private-for-profit sector, particularly where supply is limited (e.g. pharmaceutical and diagnostic staff). As a further constraint, high entry requirements for nurse training programmes (set by the Professional Council for Nurses) have seriously jeopardised the selection of students into the training schools, especially in the hard-to-reach areas (which tend to be more poverty-stricken and hence less academically successful) where the need is greatest.

### 3.4 Support supervision and performance monitoring

Under the framework of decentralisation, the roles and responsibilities of the central government, in this case the MoH, change from service management and delivery to those of policy formulation, quality assurance and standard-setting, capacity development, technical support, and monitoring and evaluation of overall sector performance. As already outlined, the roles of the district health services are to plan, coordinate, supervise and monitor, while the HSD is responsible for actual service delivery. In particular, a key role for each level of management in the health system (central, district and sub-district) is to provide support and supervision to the levels that fall under their responsibility. This creates a structure of mutually reinforcing and coordinated supervision from the top right through to the lowest level health unit.

The MoH has made good progress in fulfilling some of these key roles and responsibilities. Support supervision from the centre is now better coordinated with different MoH programmes conducting integrated district visits, and annual meetings are held to help districts develop individual work plans. As a result, many districts are now able to produce credible work plans and provide appropriate health services for the populations they serve (MoH 2003c; MoH 2003e; MoH 2004a). Drawing on guidance received from the centre, the district is then expected to be able to support the HSD in the preparation of their work plans, and the HSD subsequently helps the lower level health units, although success in this continues to vary from one HSD to another.

However, the support offered to districts from the MoH is still far from optimal, with complaints that supervision visits continue to be poorly coordinated, planned and even implemented. Thus a recent initiative has been to implement an Area Team Strategy, whereby groups of officers from technical programmes within the MoH (e.g. health planning, child health, reproductive health, quality assurance etc.) are designated to provide continuous support to a small number of districts each (i.e. 3-8 districts per group). This set-up is envisaged to initiate a continuous, effective and sustainable mentoring relationship, and to provide appropriate follow-up to problems raised.

In addition to providing support supervision, more formal monitoring of performance also takes place. The HSSP includes a comprehensive monitoring framework for the sector, with indicators for assessing performance at national and district levels. As outlined in chapter 1, considerable progress has been achieved in the

<sup>d</sup>An incentive scheme has been proposed but is yet to be approved by the Ministry of Public Service.

monitoring of key output performance indicators of out-patient utilisation and immunisation since 2000. A new innovation since 2002/03 has been to rank districts in terms of performance against a selection of 12 indicators (input, process and output indicators) to create a District League Table. The major objective of this league table is to compare performance among districts, recognise good performers in order to learn from their success, and to identify the poor performers and develop ways in which to support them (MoH 2003c). As mentioned earlier, the league table helped to identify management factors as important contributors to good performance in district health services. However, while collection and monitoring of performance data has improved over time, utilisation of these data to inform planning and decision-making at district level continues to be poor.

Finally, it is important to note that decentralisation both supports and challenges the new roles and responsibilities of the different levels of the health sector. With the continued progress in the decentralisation of public services in Uganda, local governments have a high level of autonomy in political, administrative, and increasingly, financial management. This poses a particular challenge to the MoH in fulfilling its roles and responsibilities, as in this context, the MoH may struggle to ensure that nationally agreed policies and standards are adhered to, and that resources are used in the most efficient and equitable manner.

## 4. Discussion

The focus of the reforms outlined above has been to improve the delivery of decentralised primary health care services in Uganda. Since the turn of the century, particular efforts have been made to improve management at the lower levels of the health system and to support the provision of the key health inputs of human resources, health infrastructure and medicines (the latter are addressed by Nazerali et al. in chapter 4). This is in recognition of the fact that in addition to demand side reforms such as the abolition of user fees and supply side reforms such as improved allocation of public resources, management reforms are equally important. Management issues at the health service delivery level are often not given due consideration, and instead health sector reforms are equated with high-profile policies such as the abolition of user fees or high-level organisation management in terms of restructuring of Ministries of Health (Frenk 1994; Cassels 1995; Møgedal et al. 1995). It is important therefore to consider the impact that these local level management reforms have had on the delivery of primary health care services in the country in the context of the other demand and supply side reforms that have taken place concurrently and are discussed elsewhere in this book.

As already highlighted by Yates et al. in chapter 1, in combination, the health sector reforms have yielded observable improvements in key health outputs. While it is difficult to isolate the contributions of the different reforms to these outputs, it is possible to assess the individual reforms against useful criteria of efficiency, quality, acceptability, relevance and equity, as suggested by Møgedal et al. (1995).

As already noted, the specific reforms investigated in this chapter have shown variable performance. The efforts made to further decentralise the management of health services have already yielded positive results in some districts, in terms of increased capacity for planning and management of the lower level health units and

more equitable distribution of health resources across the country. This would suggest improvements in quality and equity. However, the implementation of the HSD strategy has not yet delivered any significant improvements in community participation, which would suggest a more modest score on the criteria of acceptability and relevance.

Similarly mixed performance has been achieved on the part of the human resource, health infrastructure, supervision and monitoring reforms. For example, the increase in the numbers of filled qualified staff positions, the continued on-the-job training, and the efforts to improve staff motivation (e.g. payroll improvements) all point to improved quality and efficiency in service delivery. Clearly however, serious gaps in efficiency and quality still exist given the proportion of health worker positions that remain unfilled.

In addition, while there have been marked improvements in physical access to health services with clear attempts to redress equity concerns, the mismatch between infrastructure development and availability of complementary inputs implies considerable room for improvement in resource-use efficiency. Similarly, the criteria of quality and acceptability are not being fully met either. Finally, the supervision and monitoring framework still faces a number of challenges. In particular, all levels of the health sector need to internalise the importance of appropriate performance assessment in order to guide decision-making and achieve more efficient use of resources to improve service delivery.

Thus, rather than seeking to isolate out the specific impact that these reforms to decentralised primary health care services have had on the improvements in overall health output indicators, this discussion has shown where these reforms have succeeded and where further progress is needed. Certainly, it is possible to see how these reforms have contributed to the improved health sector performance. As argued by Cassels (1995), health sector reform is not a sequential process but rather that improvements in organisation management will often occur both in parallel and sometimes in response to other aspects of reform (Cassels 1995; Møgedal et al. 1995). Thus it is important to remember that the reforms in Uganda were undertaken in parallel and that some of the improvement is due not to the individual incremental changes, but to the way in which these reforms interacted and responded to each other.

## 5. Conclusions – lessons for the future

Overall, as shown in this chapter, the reforms that focused on improving the decentralised system of health service delivery have led to improvements in efficiency, quality, acceptability, relevance, and equity in the primary health care sector. These can in turn be assumed to have made a significant contribution to the notable improvements in health sector outputs in the country since 2000.

However, as also noted here, a number of challenges still remain and progress on some of these reforms has been variable, particularly across districts and sub-districts. The next phase of reforms will take place under the guidance of the second HSSP for the period 2005/06 to 2009/10. In preparing the second HSSP, a crucial part of the process was to incorporate into the plan strategies and actions to address these challenges. It will be equally important to ensure that the new HSSP operates in an environment that is as supportive as the one in which the first HSSP was implemented.

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As discussed in more detail by Oliveira Cruz et al. in chapter 2, there are some emerging factors that threaten to destabilise this supportive environment, such as the resurgence of disease-specific global initiatives which tend to be dominated by central level vertical programmes and are not as conducive to a decentralised context.

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# 7

## Have systems reforms resulted in a more efficient and equitable allocation of resources in the Ugandan health sector?

Freddie Ssengooba, Rob Yates, Valeria Oliveira Cruz and Christine Kirunga Tashobya

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### Summary

One of the claims of the sector-wide approach in the health sector is that improved coordination mechanisms should lead to a better allocation of resources within the sector. In particular, it is argued that the pooling of financial resources, in order to fund a coherent sector-wide plan, should lead to improved efficiency. This chapter explores whether or not there is any evidence to support this assertion in the case of the Ugandan health systems reforms since 2000. It also asks if the reforms are addressing another vital performance measure, that of improving the equitable allocation of health care resources. Due to the complex nature of health sector financial flows, providing an accurate analysis of the breakdown of expenditure is problematic. However, an assessment of the largest financing mechanisms, the government budget and donor projects, seems to indicate that overall, allocative and operational efficiency have improved. This has largely been driven by improvements in the performance of the government budget, which increased allocations to district primary health care services by a considerable proportion in only four years. This in turn led to an increase in the provision of services available for the rural population and for addressing the major causes of ill health. Donor projects appear to be less efficient at allocating resources to these services, so it may be appropriate that this mechanism has been overtaken by the budget as the largest contributor to sector funding. Increased funding for rural services also indicates a more equitable allocation of resources towards high need groups. However, the battle has not yet been won and a number of issues still need to be addressed, in particular the overall shortage of resources for the sector.

## 1. Introduction

The health sector in Uganda is under-funded to such an extent that current available resources are estimated to fund just 32 percent of the amount required to fully implement the country's Health Sector Strategic Plan (HSSP)<sup>1</sup> (MoH 2000). Nevertheless, there are indications that efforts to increase allocative efficiency within existing resources could result in appreciable improvements in health system performance. One of the claims of the sector-wide approach (SWAp) is that improved coordination mechanisms should lead to a better allocation of resources within the sector (see chapter 2, Oliveira Cruz et al.). In particular, it is argued that the pooling of financial resources, in order to fund a coherent sector-wide plan, should lead to improved efficiency. This chapter explores whether or not there is any evidence to support this assertion in the case of the Ugandan health systems reforms since 2000. It also asks if the reforms are addressing another vital performance measure, that of improving the equitable allocation of health care resources.

In order to assess whether or not there have been significant changes in efficiency and equity in the Ugandan health sector, it is necessary to determine and monitor indicators for these performance measures. Economic and political theory suggests that both allocative and operational efficiency (McPake et al. 2002), and equity (McIntyre and Gilson 2002) are important social goals for resource allocation.

## 2. Efficiency and equity issues

### 2.1 Efficiency

Health resources can be allocated across a number of different uses including disease control programmes, reproductive health, mental health and curative care. Allocative efficiency is concerned with allocating resources across these different uses in such a way as to maximise health benefits. In this regard, allocative efficiency would pursue the financing of health programmes whose benefits exceed their costs or seek to expand/contract programmes up to the point where marginal benefits equal marginal costs. On the other hand, the goal of operational efficiency is to minimise costs for any given health output using an optimal mix of inputs within a particular health programme (Donaldson and Gerard 1993).

If health systems reforms are to improve allocative efficiency, resources for health care interventions need to be directed towards the health programmes that tackle the major contributors to a country's burden of disease, thereby providing opportunity for maximum health benefits. In the Ugandan context, stakeholders preparing the first HSSP (for the period 2000/01 to 2004/05) recognised that this meant increasing funding for a minimum health care package that would tackle over 60 percent of the preventable disease burden (MoH 2003a). This package focused on providing preventive and basic curative services, with a particular emphasis on the major causes of the disease burden such as communicable diseases and child and maternal health problems (see Annex 1 of chapter 1, Yates et al.). Furthermore, in order to maximise uptake of these services, it was realised that they should be provided from health centres close to the population,

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<sup>1</sup>See Annex 1, Yates et al. (this book) for a description of the HSSP.

rather than the more dispersed and distant hospitals. As a result, the health plan sought to increase the proportion of funds allocated to primary care services as opposed to secondary and tertiary care in hospitals – where health benefits per shilling were likely to be lower. Allocative efficiency in this context meant that the proportion of resources allocated to district health services (primary care) should have increased in comparison with hospital services (MoH 2003a).

In terms of operational efficiency, at the beginning of Uganda's SWAp in 2000, stakeholders perceived that there was an inappropriate concentration of resources in relatively large hospitals and in centralised services, in particular project administration activities (Macrae et al. 1996; Matthauer 2001; Hanson et al. 2002). As a result, there was a relative under-investment in basic inputs such as drugs and staffing in health centres, and yet such inputs are central to the goal of stimulating demand for services from the population (MoFPED 2002). In this context, operational efficiency (outputs per resource input), needed to improve by investing in inputs with better 'value for money', as and when more funding became available. For example, the large-scale but short-term orientation training of nursing assistants (on-the-job apprentices) was given priority as an interim strategy to expand access to many critical elements of the minimum package (see chapter 6, Murindwa et al.). Training more comprehensive nurses and other medical cadres to fill the personnel gaps continues as a longer-term strategy. In addition, better management of the medicines supply system ensures greater availability of essential drugs through pooling of previously uncoordinated sources of funding (chapter 4, Nazerali et al.), and expansion of cheaper health centre infrastructure, rather than building and equipping new hospitals, brings health services closer to the rural poor (chapter 6, Murindwa et al.). These were explicit policies set out in the first HSSP to address operational efficiency in resource allocation (MoH 2000).

## 2.2 Equity

The concept of equity in relation to the distribution of health care benefits is more complicated and controversial than that of efficiency. This is because assessment of whether resources are distributed fairly or justly is a concept based on normative value judgements (Peter and Evans 2001). In addition, when setting an equity objective, there is not always consensus as to whether the health system is trying to secure equal health care for people with equal needs (horizontal equity) or providing more health care for people with greater needs (vertical equity), or indeed trying to achieve equity in access, utilisation or outcome. Monitoring performance in equity objectives is therefore complex. Diderichsen (1995) proposes that one should "*look at equity both in terms of equal access to health care and in terms of its contribution to equality in health and the social consequences of illness*" (p.144). The value judgements implicit in the social consequences of illness assign a high premium to context-specific equity measures. Therefore, an equity measure that may be agreed in Uganda may not be appropriate elsewhere, even in a neighbouring country.

In producing the Ugandan HSSP, the stakeholders did not clearly define equity indicators. However, the goal of vertical equity is implied in the central objective of the health sector, which seeks "*to reduce morbidity and mortality from major causes of ill health in Uganda and the disparities therein*" (MoH 2000: 14). From the perspective of vertical equity, the HSSP does refer to preferential access for those with 'high needs', for example

those afflicted by the major causes of ill health such as malaria and childhood illnesses. Information on access to health services in Uganda indicated poor service coverage in rural communities, and thus improvements in equity implied the need to incorporate pro-rural targeting of services into health sector allocations so as to achieve disproportionately higher consumption of services by rural populations relative to urban ones in order to redress the imbalance (UBOS 2001).

Therefore, when assessing the performance of the system in improving efficiency and equity in the Ugandan policy context, we looked for the following as evidence:

|            |                        |  |
|------------|------------------------|--|
| Efficiency | Allocative Efficiency  | A greater proportion of resources allocated to district primary health care services relative to hospital services.                                  |
|            | Operational Efficiency | Relatively more expenditure on inputs that represent good value for money in generating additional health sector outputs (e.g. drugs and personnel). |
| Equity     |                        | The extent of access or coverage of rural populations with primary health care services.   |

### 3. Resource allocations

Before one can determine the impact of the reforms since 2000 on efficiency and equity in the Ugandan health sector it is necessary to obtain a picture of how the sector was performing against these measures in the late 1990s. Given the paucity of financial data for this period, this is not an easy task, but an analysis of the main financing mechanisms provides some insight.

In 1999/00, the financial year preceding the official launch of the first HSSP, the total resource envelope available for the health sector was estimated at 310 billion Uganda Shillings<sup>2</sup> (MoH 2000). There are two main sources of funding to the health sector in Uganda. The first, channelled through the government budget, includes both Government of Uganda (GoU) domestic resources and donor budget support (general or earmarked to the health sector). The second includes all donor project funding which may be directed to projects handled by the central Ministry of Health (MoH), by individual districts or by non-governmental organisations (NGOs). In terms of allocating resources in line with efficiency and equity objectives, the first channel provides the greatest scope as activities for donor project resources are often pre-determined. The performance of these modalities against efficiency and equity criteria is addressed below.

Added to this resource envelope is out-of-pocket household expenditure. Although out-of-pocket household payment is estimated to contribute about 45 percent of total health expenditure (UBOS 2001), a large proportion of which is spent in the private-for-profit and private-not-for-profit sectors, there is limited scope for policy influence on how these funds are allocated by households.

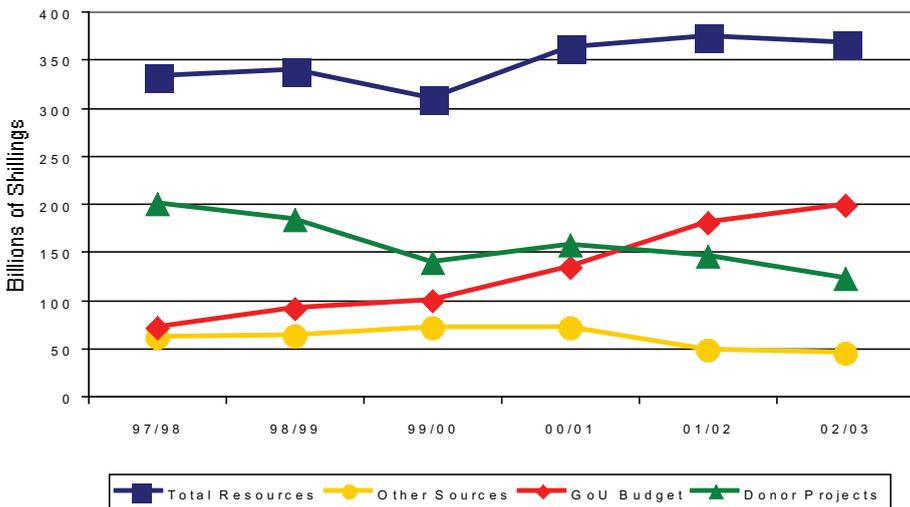
<sup>2</sup>In 2003/04 prices. Exchange rate US\$ 1 = Uganda Shillings 1850.

### 3.1 Donor projects

According to the Ministry of Finance, Planning and Economic Development (MoFPED), donor projects made the largest (45 percent) contribution towards the health sector resource envelope<sup>3</sup> in 1999/00 (see Figure 1). However, due to the large numbers of projects, it is extremely difficult to determine whether or not they were being allocated to inputs necessary for implementation of HSSP priority activities. What is certain is that there were concerns at the time that uncoordinated projects were not allocating resources efficiently (Macrae et al. 1996). In terms of operational efficiency, donor projects concentrated expenditures on areas such as capital development, training and capacity building (training workshops), and spent less on recurrent inputs such as drugs and supplies, and human resources. Large proportions of resources channelled via projects were spent on project administrative costs where project headquarters tended to be located in large urban towns, especially in the capital city of Kampala.

Trying to analyse the beneficiaries of project expenditure for equity purposes is also problematic but there is no evidence to suggest that projects at the time were allocating resources equitably. On the contrary, project managers wanting to demonstrate a tangible impact often focused on districts with higher absorptive capacity and these tended to be the more affluent ones (Matthauer 2001). In addition, some project donors who were concerned about the safety of their staff set restrictions on operating in conflict areas where displaced persons face acute health care needs.

**Figure 1: Trends in funding sources contributing to the Health Sector Strategic Plan 1997/98 to 2002/03**



Source: Derived from MoH (2003b).

<sup>3</sup>i.e. Government and donor resources only, excluding out-of-pocket household expenditure.

### 3.2 Government of Uganda budget

Better data are available on the breakdown of the GoU budget in 1999/00 and show baseline performance of the HSSP against the efficiency and equity measures. Table 1 outlines the trends in resource allocation of the GoU budget from 1999/00 to 2002/03. Although these trends are set in a context of overall resource insufficiency for health care, an increase of 18 percent (inclusive of donor budget support) occurred in the period under review (MoH 2002; MoH 2003a).

The baseline allocation level in 1999/00 shows that secondary and tertiary hospital care (mostly located in affluent urban centres) captured the largest share of the budget (44 percent), whereas the primary care level accounted for less than 25 percent of the budget. Given the high proportion of tertiary services provided by large hospitals, their high cost structures and their location in urban areas, the allocation in 1999/00 does not score well against either efficiency or equity measures for targeting high-need client groups. However, by 2002/03 about 43 percent of the health sector budget was allocated to the primary care level. This reallocation, combined with an increase of 18 percent in real terms in the health budget, has meant that the level of financing for district health services has increased approximately 3.8 times. Evidence that this change in allocation has resulted in increased levels of cost-efficient inputs for district health activities (i.e.

**Table 1: Percentage allocation of GoU budget by health sector level  
1999/00 – 2002/03**

|   |                    | Level of Care | 1999/00 | 2000/01 | 2001/02 | 2002/03 | Variance 1999-2003 |
|---|--------------------|---------------|---------|---------|---------|---------|--------------------|
| Health Sector Budget <sup>1</sup><br>(Billions of Uganda Shillings) |                    |               | 79.9    | 114.2   | 170.1   | 196.0   | 116.1 <sup>5</sup> |
| District Services   | PHC <sup>2</sup>   | Primary       | 19%     | 33%     | 36%     | 36%     | 17                 |
|   | PNFP <sup>3</sup>  |               | 4%      | 6%      | 8%      | 7%      | 3                  |
|   | District Hospitals | Secondary     | 8%      | 6%      | 4%      | 5%      | -3                 |
| Regional Hospitals  |                    |               | 14%     | 10%     | 11%     | 8%      | -6                 |
| Central Hospitals   |                    | Tertiary      | 22%     | 13%     | 14%     | 12%     | -10                |
| MoH Headquarter <sup>4</sup>  |                    | Sector-Wide   | 30%     | 30%     | 26%     | 28%     | -2                 |
| Other MoH Agencies  |                    |               | 2%      | 2%      | 2%      | 2%      | 0                  |
| Total   |                    |               | 100%    | 100%    | 100%    | 100%    |                    |

Source: Muhwezi (2003).

<sup>1</sup>Includes GoU funding and donor budget support.

<sup>2</sup>This item also included salaries of all district services and operational funds for primary health care (PHC).

<sup>3</sup> Private-not-for-profit.

<sup>4</sup> Includes national service delivery programmes, in particular bulk procurement, 40 percent of which is attributable to district services in 2002/03.

<sup>5</sup> Increase in resources over the period is 18 percent in real terms.

improved operational efficiency) is illustrated in chapter 4 by Nazerali et al., in terms of medicines supply, and in chapter 6 by Murindwa et al., in terms of decentralised delivery of primary health services. The former shows significant improvements in the availability of essential drugs for primary health care activities, and the latter, higher investment in human resources and infrastructure inputs.

With regard to equity concerns in allocation, some progress was made in increasing resource allocations to rural populations, as reflected above, but more was needed to target particularly under-privileged districts. Since 2002/03, adjustments to the allocation criteria have tried to address this problem. For example, conditional grants to districts for primary level care are now allocated across districts by the MoH according to a weighted capitation formula, taking into account need factors such as: poverty, morbidity, prevalence of refugees and internally displaced people, and health facility coverage. Thus, as an example, in the 2003/04 budget, the district with the highest need (i.e. in the conflict ridden northern Uganda) received 25 percent more primary health care funding per capita than the relatively privileged district capital, Kampala (MoH 2003b). In the same vein, the government grant to support private-not-for-profit (PNFP) health facilities (mostly located in high need areas) was significantly increased (see chapter 5, Lochoro et al.).

If the GoU health budget (GoU funds plus donor budget support) performs better in terms of efficiency and equity than the project-channelled mechanism, an increase in the former vis-à-vis the latter should result in improvements in overall sector performance as measured by sector outputs, particularly for targeted high-need groups or rural populations. There have in fact been big changes in the composition of financing such that the GoU budget now makes up the largest contribution, discussed further below.

Table 2 indicates the type of medical attention sought by representative populations in national surveys for the years 1999/00 and 2002/03. Although the survey definition of provider types may mis-classify some public dispensaries and overestimate the

**Table 2: Source of medical care four weeks before National Survey, 1999/00 and 2002/03 (percentage)**

| Level of Care                     | Source of Care if Sick Last Month | 1999/00 |       |       | 2002/03 |       |       |
|-----------------------------------|-----------------------------------|---------|-------|-------|---------|-------|-------|
|                                   |                                   | Rural   | Urban | Total | Rural   | Urban | Total |
| Household Level                   | None                              | 8       | 4     | 8     | 7       | 6     | 7     |
|                                   | Home Self Medication              | 23      | 20    | 23    | 12      | 10    | 11    |
| Primary Care Level                | Traditional Healers               | 1       | 1     | 1     | 1       | 1     | 1     |
|                                   | Drug Shops                        | 10      | 9     | 10    | 14      | 8     | 13    |
|                                   | Pharmacy                          | 0       | 1     | 0     | 0       | 4     | 1     |
|                                   | Private Clinic                    | 27      | 44    | 29    | 34      | 52    | 36    |
|                                   | Dispensary                        | 8       | 2     | 7     | 7       | 2     | 6     |
|                                   | Health Centre <sup>1</sup>        | 3       | 1     | 3     | 12      | 4     | 11    |
| Secondary and Tertiary Care Level | Out-patient in Hospital           | 18      | 17    | 18    | 9       | 11    | 9     |
|                                   | In-patient Hospital               | 2       | 1     | 2     | 2       | 3     | 2     |

Source: UBOS (2003).

<sup>1</sup>Includes government health units and private-not-for-profit units

contribution of private clinics, it is a useful source for establishing baseline figures and trends in service utilisation across the rural and urban settings and across alternative providers (see also Figure 5 in chapter 1, Yates et al.).

The survey indicates that the proportion of people in the rural areas utilising curative services at the primary care level increased from 49 percent to 68 percent between 1999/00 and 2002/03. There has been a fourfold increase in the utilisation by rural populations of services at public and PNFP health centres, while the proportion of those that do not seek any care when sick has declined from 31 percent to 18 percent. This represents a promising trend in moving the delivery of the minimum package of primary health services to lower levels of care that are closer to the groups perceived to be most in need of health services.

Of concern, however, is the increase in the percentage of the population using the private clinics. The percentage increase in the use of the private clinics and drug shops in the survey period was higher for rural (poor) populations compared to their urban counterparts. This indicates that there is still a gap in coverage and/or quality of care provided through the public and PNFP sectors for which the private sector is a preferred substitute. Drug shops and the majority of private clinics are poorly regulated and have weaknesses in service standards and quality (Birungi 1998).

#### 4. Trends in health sector funding composition

The rise in the health budget in recent years has partly been due to the government allocating additional domestic revenues to health (courtesy of the HIPC<sup>4</sup> Debt Relief initiative), but is mostly due to the fact that many development partners have switched their assistance from project funding to direct GoU budget support (see chapter 2, Oliveira Cruz et al.).

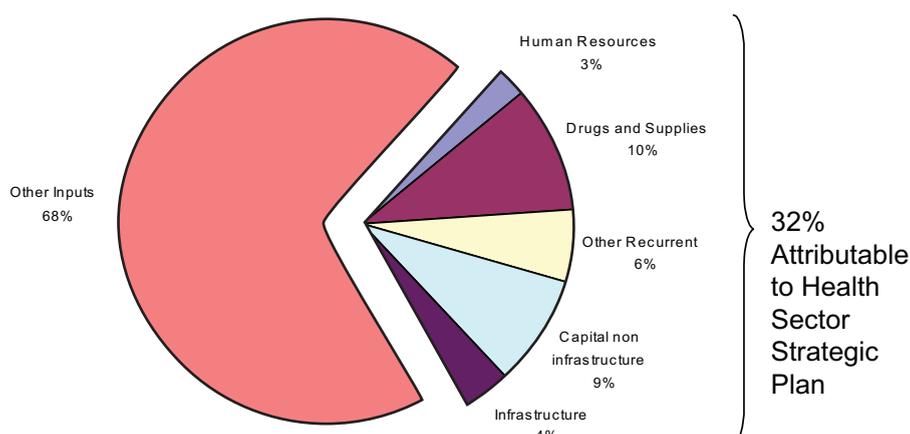
With a number of key development partners (DPs) switching to channel their support through the GoU budget in line with the principle of the SWAp, the proportion of expenditure directly disbursed by DPs for health projects now stands at just 34 percent of the total resource envelope, down from 45 percent in 1999/00. An analysis of this residual project portfolio undertaken by the MoH in 2003 shows that this shift in resource flows has been potentially beneficial (MoH 2003b). However, this is bound to change as more funds from the Global Fund to Fight AIDS, TB and Malaria and the US President's Emergency Plan for AIDS Relief are earmarked for the project support mode.

Figure 2 shows the resource allocation pattern for a representative sample of five health projects under the donor-disbursed, project support mode (in contrast to GoU budget support). Only 32 percent of donor project expenditure in 2003 can be attributed to inputs envisaged to contribute directly to the objectives of the health sector plan. Instead, allocation to technical assistance, project administration costs, and other complementary inputs were preferred areas of expenditure. Particularly noticeable in this analysis was the observation that projects had allocated very little (just 3 percent) to Ugandan health workers employed in local health facilities.

<sup>4</sup>Heavily Indebted Poor Countries Initiative.

**Figure 2: Sample of project funding to the health sector, 2003**

**Sample of Project Funding 2003, Total 63.3 Bn Shillings**  
**Donors: USAID, SIDA, GTZ, DFID, DANIDA**



Source: Derived from MoH (2003b).

Note: "Other Inputs" refer to project overheads, technical assistance, and investment goods not envisaged in the Health Sector Strategic Plan

## 5. Conclusions

Due to the complexity of health sector financing, it is difficult to obtain an accurate picture of the level and distribution of health expenditures in any country. This is particularly true in developing countries where large proportions of supposed health expenditure are not channelled through the public budget or through social insurance systems. In turn, the poor quality of health expenditure data, especially on out-of-pocket expenditures, makes it difficult to monitor related performance indicators such as efficiency and equity.

The evidence presented here seems to suggest that the government budget is being allocated more efficiently at present than at the beginning of the reform period in 2000. The increase in service uptake at primary care levels and health centres in particular seems to suggest that the shift in the allocation of resources from hospitals towards primary health care services at district level has improved the overall efficiency of the health system. Furthermore, the ring-fencing of resources for essential drugs and personnel recruitment suggests improved operational efficiency in the sector (see chapter 4, Nazerali et al.; chapter 6, Murindwa et al.). However, one emerging problem

for resource allocation is the poor uptake of services such as maternity services, where utilisation levels have stagnated for the last 15 years (UBOS 2001; Ssengooba et al. 2003).

As illustrated in this book, the Ugandan health sector has been undertaking a range of comprehensive reforms since the turn of the century. The radical approach taken was facilitated by a number of factors both technical and political. Health sector reforms were clearly on the international agenda, and different experiences had been documented from which Uganda could learn. Politically, the country was recovering from a prolonged period of civil and economic unrest, and thus the government was able to capitalise on the positive attitude of the population to spearhead fundamental changes to the public sector. Similar experiences have been witnessed in other countries. For example, Mozambique (following a long period of civil war) and Zambia (following a change of leadership and type of democracy) have implemented fairly radical reforms since the 1990s, whereas changes have been much more incremental in the more politically stable systems of Botswana and Tanzania (Frenk 1994; Møgedal et al. 1995).

The chapters in this book describe a series of policy measures and progress towards health sector goals that have taken place within an overall setting of resource insufficiency for the health sector. In spite of the resource problems, we suggest that as the reforms have progressed, there has been an improvement in both allocative and operational efficiency, and also in equity.

There is, however, still a long way to go and it would be dangerous to become complacent. The poor uptake of maternity services needs to be urgently addressed if we are to see an improvement in maternity health outcomes. More research is needed to understand what is driving demand for services in both the public and private health sectors and how these services are perceived in terms of quality. It is hoped that the anticipated increase in project expenditure by new global health initiatives will be more transparent, aligned with the needs of the health sector plan, and channelled through the government budget system (see chapter 2, Oliveira Cruz et al.). More research is required to track and assess the performance of recent resource flows from new global health initiatives in terms of efficiency, equity, coordination with overall system development, and sustainability. Finally, there are upper limits to the levels of efficiency and equity gains attainable without enlarging the resource envelope for the health sector. The current resource envelope amounts to approximately US\$7-11<sup>5</sup> per capita compared with the target of US\$28 required to afford every Ugandan a minimum package of health services.

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<sup>5</sup>GoU plus donor resources.

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