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Maternal and Child Survival Program

Strengths, Challenges, and Opportunities for RMNCH Financing in Uganda

Report on RMNCH Financing Assessment

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The Maternal and Child Survival Program (MCSP) is a global, $560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries,* as well as other countries. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

* USAID's 25 high-priority countries are Afghanistan, Bangladesh, Burma, Democratic Republic of Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen and Zambia.

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Abbreviations

ANC	antenatal care
BTC	Belgian Technical Cooperation
CFI	Certificate of Financial Implication
CHE	current health expenditure
DHMT	district health management team
DHO	District Health Officer
FP	family planning
FY	fiscal year
GFF	Global Financing Facility
GGHE	general government health expenditure
GOU	Government of Uganda
HC[II]	Health center [II]
LG	local government [district or municipality]
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MSU	Marie Stopes Uganda
NHI	national health insurance
NHIS	National Health Insurance Scheme
NMS	National Medical Stores
OOPE	out-of-pocket expenditure
PBB	program-based budgeting
PFP	private, for-profit
PHC	primary health care
PNFP	private, not-for-profit
RBF	results-based financing
RMNCAH Investment Case	*Investment Case for the Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda*
RMNCH	reproductive, maternal, newborn, and child health
SWAp	sector-wide approach
UHC	universal health coverage
URHV	Uganda Reproductive Health Voucher
VHT	village health team

Executive Summary

Motivation and Methods

New financing mechanisms (e.g., universal health coverage [UHC], national health insurance [NHI], results-based financing [RBF], revised resource allocation formulas) have potential to ensure regular and increased funding for reproductive, maternal, newborn, and child health (RMNCH) or could shift financing in ways that negatively affect the delivery of RMNCH services. This report presents the results of an assessment on the context of national health financing in Uganda—including current financing policies and practices, as well as health financing reforms proposed and in development—to understand the implications that such mechanisms may have on RMNCH services. The assessment employed a combination of desk review, key informant interviews, and secondary data review to gather data on challenges and opportunities related to RMNCH financing. The assessment team met with key informants at national level, and with district health management teams (DHMTs) and facility staff in two districts, Kaliro in East-Central region and Mbarara in Southwest region.

Major Findings

Health is not a national budget priority, which contributes to high household spending and donor reliance for RMNCH services

The fiscal year (FY) 2015/16 National Health Accounts showed that 21% of current health expenditure (CHE) was for reproductive and maternal health, with the majority of that category spent on maternal (12%) and perinatal (6%) conditions. Households fund the majority of reproductive health–related expenses through private sources, primarily out-of-pocket expenditures (OOPEs). Between FY2014/15 and FY2015/16 there was a 5% increase in total spending on reproductive health, with the majority of the increase in maternal and perinatal conditions (Government of Uganda Ministry of Health [GOU MOH] 2018). However, for both maternal and perinatal expenditures, the proportion of expenditures from public sources increased 6%–7% for each condition category; private (e.g., OOPE) sources increased marginally at 2% each. The larger proportional increase from public sources compared to private sources suggests that the GOU has mobilized additional public resources for reproductive health services. Family planning (FP) and other or unspecified reproductive health expenditures made up a small portion of reproductive health expenditures, each at 1%. The majority of funding for FP comes from donors, followed by public sources. For child health, households finance 62% of expenditures, with public and nongovernmental sources financing 23% and 12%, respectively; the remaining 3% of child health expenditures originated from other private sources (GOU MOH 2016b).

Subnational funding levels limit ability to provide high-quality RMNCH services

Of the three main types of district-level health grants—wage, nonwage, and discretionary development—the average FY2017/18 wage grant composed 81% of total grant funding, leaving 11% to the nonwage portion and 8% to discretionary development (though less than half of districts received this grant). Decomposition of the nonwage grant shows that 39% and 61% of the nonwage grants go to district hospitals and primary health care (PHC) service delivery, respectively, meaning that a district had on average UGX 155 million (USD 41,867) for direct PHC service delivery—a large component of which is RMNCH services—in FY2017/18. Between the two most recent FYs (2016/17 and 2017/18), the average district health grant decreased by approximately 10% and fewer districts received development grants. While the health sector nationally spent 96% of its budget in FY2017/18, the sampled districts fully spent the nonwage and wage portions of their health grants. At the facility level, the nonwage grant functions as the primary source of cash funding to facilities. Much of this direct service facility-level funding for health center (HC)IIIs and HCIIs was for immunization and integrated outreaches—typically immunization with FP and/or HIV testing—in collaboration with village health teams (VHTs). The assessment team also found that sampled facilities

reported continuing planned activities even with funding delays from the districts. For public facilities, the assessment team found that nonwage allocations to the type of health facility (e.g., HCIV versus HCIII) were consistent across facilities within the district, but that the amount to different types of facilities varied across districts. The National Medical Stores (NMS) supplies commodities based on a standard line of credit per facility level; sampled lower-level PHC facilities reported irregular stock of key RMNCH commodities, as the supply chain functions as a push system. Collectively, the size of nonwage subnational funding appears to limit the ability to provide comprehensive RMNCH services.

RBF appears to improve RMNCH funding at facility level

RBF has been used to finance and improve RMNCH services in Uganda for over a decade. Uganda's experience to date has focused on private, not-for-profit providers (PNFP), with less experience with payments to public sector facilities. RBF has been used as a component of demand-side vouchers (including promotion through community health teams) and as an exclusively supply-side incentive to motivate provider performance. Both experiences in Uganda have improved service coverage rates and adherence to clinical guidelines As a result, the GOU considers RBF an important component of its RMNCH strategy and plans to scale up RBF as a primary mechanism for discretionary funding to districts and facilities. The MOH is planning to scale up RBF to public facilities in 70 prioritized high-burden districts as a core component of its strategy for improving RMNCH services. The MOH finalized its guidance document, *Results Based Financing Framework for the Health Sector,* in 2016. Funding for this effort has been secured at USD 85 million over 5 years, mobilized through the Global Financing Facility (GFF). Several non-MOH informants expressed concern about the lack of a detailed plan for implementation, even in the prioritized districts.

UHC vision is ambitious and requires further implementation planning

The GOU is committed to the global goal of UHC and has identified NHI as a key strategy for achieving UHC. Referenced in the Second National Health Policy, NHI has been in development since 2010. The national *Health Financing Strategy* identifies implementation of a "Social Health Protection system [that reaches] 30% of the people of Uganda by 2025" as one of six specific objectives (GOU MOH 2016a). There were some areas where the MOH may benefit from additional support for NHI introduction:

- Few details related to institutional design for NHI management and governance: The MOH and other stakeholders will need to continue advocating for an NHI design that can deliver on the goal of financial protection and is financially sustainable.
- Lack of discussion regarding options related to institutional responsibilities for health insurance, and the respective advantages and disadvantages of various alternatives.
- Potential reaction from civil servants and private sector employees is unclear, as are their expectations regarding individual benefits from the scheme.

Recommendations

- The MOH and health sector stakeholders should develop and implement a coordinated and sustained advocacy effort to mobilize additional government resources for RMNCH—such as to improve commodity security and fill PHC-level health worker vacancies—while improving national- and district-level expenditure of the recurrent GOU national health budget, especially PHC funding.
- Funding to districts and facilities for RMNCH services should be increased to provide resources to conduct health promotion, community mobilization, and regular supervision outside of those activities covered by donors. To achieve greater efficiency and coverage of community-based RMNCH services with available funding, outreach activities should deliver integrated services.
- Targeted technical assistance is needed to improve the financing and supply chain system for RMNCH commodities to HCIIIs and HCIIs (a push system), with focus on addressing national challenges in forecasting, quantification, procurement, and distribution for RMNCH commodities.

- The process for discretionary development grants to local governments (LGs) should be revisited so every LG has sufficient funds to make needed physical improvements and repairs to PHC infrastructure annually.
- The MOH should convene a broad stakeholder group to gather inputs, generate additional support, and synthesize lessons learned in implementing RBF scale-up. Although the MOH intends to prioritize public providers in RBF expansion, strategic engagement of the private sector should be considered to maximize access and reduce OOPEs.
- NHI planning will require a detailed road map and external support; implementing partners should consider providing direct support to this process, including inputs on how the reforms can best use strategic financing to address RMNCH service delivery challenges.

Introduction and Objectives

Many countries in which the Maternal and Child Survival Program operates are planning or introducing various financing reforms and initiatives (e.g., universal health coverage [UHC], national health insurance [NHI], results-based financing [RBF], revised resource allocation formulas) aimed to improve health system performance. These national initiatives often change policies that affect financial flows to subnational administrative levels and health facilities. New financing mechanisms have potential to ensure regular and increased funding for reproductive, maternal, newborn, and child health (RMNCH) or could shift financing in ways that negatively affect the delivery of RMNCH services. This report assesses the national health financing context in Uganda—including current financing policies and practices, as well as health financing reforms proposed and in development—to understand the implications that such initiatives may have on RMNCH services.

This assessment focuses on understanding how funding for RMNCH services and providers is affected by financing structures and processes in Uganda, and how proposed reforms can be leveraged to address challenges in financing for RMNCH. Its specific objectives are to:

- Document and analyze current health financing policies, as well as new health financing reforms, and how they affect financing for RMNCH from the national to facility level
- Recommend ways to influence financing policies and implementation to increase quality and access to RMNCH services

Methods

The assessment employed a combination of desk review, key informant interviews, and secondary data review to gather data on the larger status of health financing in Uganda and those challenges and opportunities related to RMNCH financing. The methods of the assessment were designed to gather key information from a variety of actors (e.g., government, private sector, implementing partners, multilateral organizations) working across all levels of the health system.

Desk Review and Development of Interview Tool

The assessment team began with a comprehensive document review on the status of health financing and financing polices in Uganda. The review documents included national development plans, national health sector policies and strategies, budget framework papers, public financial management guidelines, and past assessments of the health system, health financing, and RMNCH services conducted by Ugandan government agencies, international organizations, research institutions, and implementing partners. Focus areas for the desk review included: 1) RMNCH service delivery and utilization, 2) health policy environment, 3) health financing environment, and 4) public financial management and subnational financing flows. To home in on RMNCH-related financing challenges, the assessment team examined three RMNCH "tracer" services to identify specific financing challenges: facility-based delivery, family planning (FP), and immunization.

Findings from the desk review informed the identification of interview subjects and the development of interview guides. The assessment team developed separate interview guides for national-, district-, and facility-level informants. The guides were organized thematically and could be easily tailored for individual informants; themes included policy context, new financing initiatives, funding flows, donor funding, resource allocation, district-level planning and budgeting, intragovernmental coordination, drug and commodity financing, maternal health financing, immunization financing, FP financing, subnational health sector management and financing, and facility-level financing. The guides aimed to confirm and fill gaps in the desk review findings.

Data Collection

A team of three researchers completed the primary interviewing over a 2-week period in September–October 2017. The team met with key informants at national level, and with district health management teams (DHMT) and facility staff in two districts, Kaliro in East-Central region and Mbarara in Southwest region. The assessment team sampled facilities in consultation with District Health Officers (DHOs) to ensure an adequate variety of facilities by health system level, type of ownership, physical accessibility, and support from donor programs; details of the institutions are included in Table 1 and Table 2. In total, the team interviewed 46 individuals. Detailed informant lists are in the Appendix.

Table 1: National-level informants

Institution	Department/program (number of informants)
Ministry of Health	• Department of Planning and Policy (3) • Expanded Program on Immunization (1) • Child Health (1) • Public-Private Partnership (1) • Maternal and Child Health Services Improvement Project (1)
Ministry of Finance, Planning and Economic Development	Health Desk (1)
Ministry of Local Government	Office of Principal Inspector (2)
World Health Organization	Child, Adolescent Health, and Nutrition (1)

Institution	Department/program (number of informants)
US Agency for International Development	• Health Systems Strengthening (1) • Maternal and Child Health (2)
Marie Stopes Uganda	Uganda Reproductive Health Voucher Project (1)
Belgian Technical Cooperation (BTC)	BTC Private Not-For-Profit Project (2)
Maternal and Child Survival Program	Child Health Technical Lead (1)

Table 2: District-level informants

District	District management team	Facilities/community (number of informants)
Kaliro	• Elected District Chairperson (Local Council V) • Chief Administrative Officer • DHO • Cold Chain Technician	• Bumanya HCIV (4) • Namugongo HCIII (3) • Buyinda HCII (1) • Dr. Ambrosoli Memorial HC (private, for-profit) (1) • Village Health Team (1)
Mbarara	• Chief Financial Officer • Principal Assistant Secretary • District Planner • DHO • Health Management Information System Focal Person • Expanded Program on Immunization Focal Person • Logistics and Pharmaceuticals Focal Person	• Kinoni HCIV (2) • Kakoba HCIII (1) • Kakigani HCII (2) • Ruharo Mission Hospital (private, not-for-profit) (2)

Abbreviations: DHO, District Health Officer; HC, health center.

Synthesis of Findings

Detailed notes on interviews were taken by the assessment team and combined. Following the compilation of notes, each researcher independently coded findings to a preassigned code, structured around the key themes identified in the interview guides. In some interviews, the informants provided the assessment team with quantitative data, which the assessment team subsequently analyzed; in some cases, the assessment team conducted additional desk research based on data revealed during the interviews. Following the synthesis and triangulation of data, the assessment team identified multiple themes by which to organize the key findings.

Health Financing Context

Uganda's current health expenditure (CHE), as a share of the country's annual gross domestic product, has consistently declined from 11% in 2010 to 6% in 2016. Distributed across the country's population, CHE per capita has correspondingly declined from USD 63 per capita in 2010 to USD 38 per capita in 2016; CHE per capita remains above East African Community, though below sub-Saharan Africa, averages of per capita health spending. Disaggregated by source, donors and private sources contribute the largest proportion of Uganda's health expenditures: each contributes approximately 42%–43% of Uganda's CHE, with public sources accounting for approximately 16% of CHE. In this context, "private" is defined to include all money spent on health by households (e.g., out-of-pocket expenditures [OOPEs]), private firms, or private organizations; it excludes all financing from donors and the government. The majority of private funding comes from OOPEs (Government of Uganda Ministry of Health [GOU MOH] 2018).

Health has not been regularly prioritized in the GOU's budgetary decisions, and GOU has yet to meet the Abuja Declaration target of 15% of government expenditures spent on health. Although the nominal value of GOU general government health expenditure (GGHE) has increased since fiscal year (FY) 2011/12, the percentage of GGHE has been around 7% since FY2009/10 and has been relatively stagnant since FY2013/14. Domestic GGHE per capita is also relatively low at approximately USD 6 per capita in FY2015/16 and has decreased in constant terms since 2010.

Financing schemes are defined as the "financing arrangements through which health services are paid for and obtained by people" (OECD et al. 2014). Household OOPE composed 41% of CHE in FY2015/16, a small increase from past years and representing the largest share of CHE by scheme. Voluntary prepaid schemes through employer-based insurance, nonprofit institutions servicing households, and enterprise financing schemes composed about 42% of CHE in FY2015/16. Despite the existence of prepaid voluntary financing schemes (which cover a small proportion of the population), OOPEs constitute the largest proportion of overall health spending in Uganda. OOPEs are a regressive form of health financing because the poor spend disproportionately more on health services as percentage of household earnings than do the rich. In 2010, approximately 23% of Ugandan households faced catastrophic OOPEs when using a threshold of 10% of household income; even at lower spending thresholds, a large proportion of households faced catastrophic health expenditures (Kwesiga et al. 2015).

Disaggregating FY2015/16 CHE by disease categories, infectious and parasitic diseases took up the largest proportion of CHE at 37% of the total share; within this disease group, spending related to HIV/AIDS and other sexually transmitted infections accounted for 18% of CHE, while malaria accounted for 12%. Reproductive and maternal health made up the third-largest category of health expenditures: approximately 21% of CHE. Maternal and perinatal conditions represent 12% and 6% of CHE, respectively. The following summarizes key issues across core health financing functions:

Revenue Generation

- Uganda has no earmarked taxes for health and its overall tax contribution relative to gross domestic product is lowest among regional neighbors, leading to limited revenue collection from a narrow tax base (Ladu 2016).
- Uganda Revenue Authority (URA) has proposed improved sensitization and collection strategies within the informal sector to try to increase tax revenues (Ladu 2016).
- Local government (LG)—district or municipality—revenue contributions (e.g., local taxes) are low, representing less than 4% of LG revenues in 2014 (OECD 2014).

Pooling

- Uganda lacks any clearly defined pooled funds for health; rigid earmarks from conditional grants and donor projects have contributed to overall fragmentation in financing.
    - Attempts to harmonize development assistance have experienced brief success in the past through the sector-wide approach (SWAp)—wherein several donors pooled funding into one basket and MOH allocated the funds toward sector priorities. Corruption scandals, however, caused partners to turn away from the SWAp in favor of parallel donor funding (GOU MOH 2016a).
- As of 2014, more than 30 community-based health insurance schemes were operational in Uganda, with a total of 140,000 people enrolled (less than 1% of the population) (East African Community 2014); these schemes target the rural poor who can afford the payment (20% of fee to provider) while subsidizing those unable to contribute to the fund (Mathew 2017).
    - There is a low enrollment in voluntary health insurance schemes in Uganda. There is low insurance scheme market penetration, and those that do exist have low membership numbers and high dropout rates (GOU MOH 2016a).

Purchasing

- Purchasing in Uganda occurs through passive means; passive purchasing of services includes the public sector through the MOH and LGs (24% of total purchasing), nongovernmental organizations (28%), individual purchasing by households through direct OOPEs (42%), and private health insurance (1%) (GOU MOH 2016a).
- Public sector purchasing in Uganda relies primarily on the input-based approach, where funds are disbursed quarterly to LGs to support service provision at publicly owned facilities and central-level government institutions. GOU also purchases health services from private, not-for-profit (PNFP) health facilities through grants for specific services (GOU MOH 2016a).
- In the private sector, payment of services by households occurs primarily on a fee-for-service basis, which has contributed to cost escalation, particularly in PNFP and private, for-profit (PFP) facilities.

Public Financial Management

- Under the decentralization policy framework, LGs are mandated to provide most health services (GOU MOH 2016a). Government resources are allocated to decentralized subunits (e.g., DHMTs, health subdistricts, and hospitals) using a resource allocation formula.[1]
- *Primary Health Care Grants Guidelines* establish the expenses and budget ceilings for LGs and health facilities, including qualifying PNFPs (GOU MOH 2016c, 2017). As the main source of subnational health sector funding, grants include wage and nonwage portions, with some sectors receiving development grants for larger investments, such as health infrastructure development.
- The flow of health funding from national to subnational levels is obstructed by delayed release to facilities and misalignment between amounts scheduled for release and amounts received in district accounts (Lukwago 2016).

In February 2016, the GOU developed a national health financing strategy aimed at "enabling the effective/efficient delivery of and access to the essential package of health services while reducing exposure to financial risk by 2025" (GOU MOH 2016a). The specific objectives include creating a social protection system covering 30% of the population by 2025, increasing pooling and strategic purchasing, and improving institutional arrangements for more accountable and transparent resource use (GOU MOH 2016a).

[1] Incorporates variables such as population, child mortality as a proxy for health need, district topography as a proxy for cost of service delivery, and poverty index of the district as a proxy for deprivation (Orem and Zikusooka 2010).

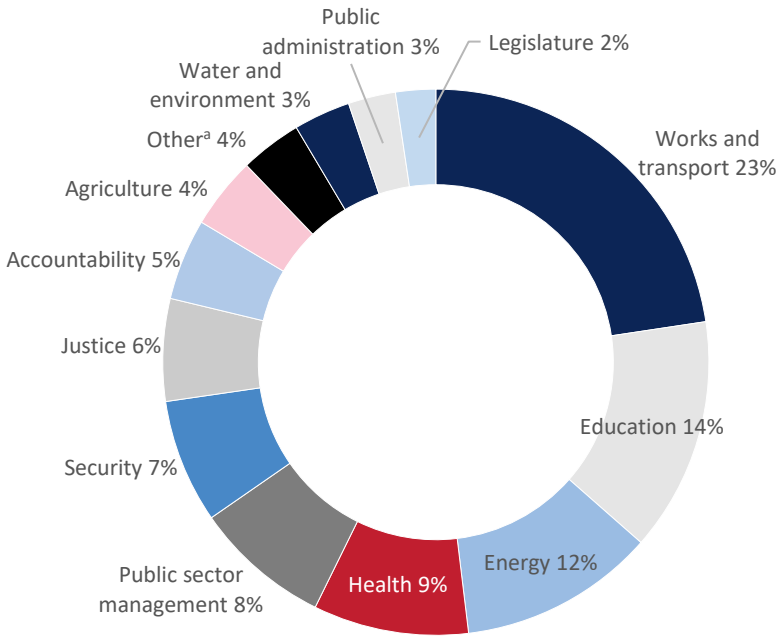
Major Findings

1. Health is not a national budget priority, which contributes to high household spending and donor reliance for RMNCH services

Health Sector Budget Performance

Government spending on health in Uganda has remained relative stagnant since FY2011/12—at approximately 7% of the total government budget despite increases in the overall budget envelope (GOU MOH 2018). Investment within the health sector has not been the priority of the government; infrastructure and energy sectors have been major priorities. In the FY2017/18 budget, works and transport, education, and energy sectors composed nearly one-half of the entire government budget with health only making up 9% (Figure 1). However, the projected health sector budget is anticipated to increase through FY2022/23 per the Medium-Term Expenditure Framework.

Figure 1: Fiscal year 2017/18 budget by sector



Source: Government of Uganda Ministry of Finance, Planning and Economic Development. 2016. *National Budget Framework Paper FY 2017/18 – FY 2021/22.* http://budget.go.ug/budget/sites/default/files/ National%20Budget%20docs/Final%20BFP%20FY%202017_18.pdf.

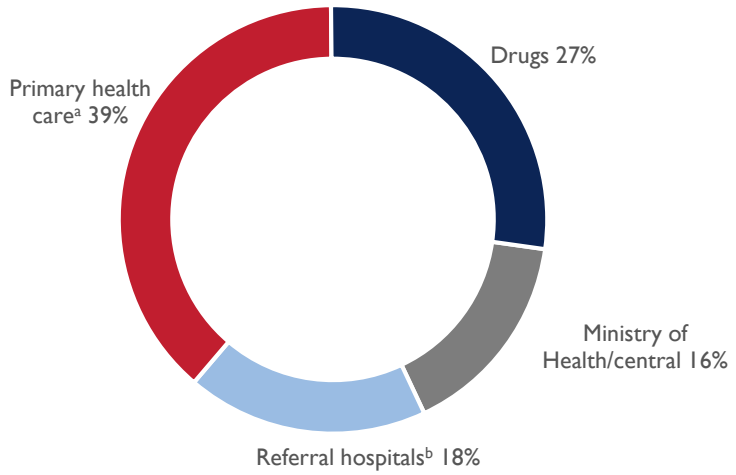
a. "Other" comprises tourism, social development, land, information and communication technology, and science and technology, each at 1% of the total budget.

While budget projections have shown higher allocations to health, the health sector has experienced challenges in fully expending its annual budget. For example, in FY2017/18, the Ministry of Finance, Planning and Economic Development (MOFPED) released 91% and 92% of the recurrent wage and nonwage health sector budget, respectively, while the sector spent 79% and 90% of the released wage and nonwage budget. For the development budget, the health sector received 129% of the GOU-financed development budget and 31% of the externally financed development budget and spent 110% and 24% of the budgets, respectively. Collectively, the GOU released 103% of the health sector budget, with the sector spending 92% of these releases and 96% of the overall budget in FY2017/18 (GOU MOFPED 2017, 2018a, 2018d). Strikingly, the largest underspent category was the recurrent wage budget. The FY2017/18 *Budget Monitoring Report* stated that a mismatch between staff recruitment and budget cycles, as well as shifting of funds from the wage budget to the nonwage budget, led to the underspending in this budget category.

Assessment informants shared that below-budget expenditure has contributed to stagnation in allocations because the budgeting process utilizes past FY expenditures as a reference for the following year. Led by the MOFPED, the GOU has worked to reform public expenditure management over the past decade, developing new institutional arrangements for budgeting including SWAp, the Medium-Term Expenditure Framework, Output Budgeting Tool, and fiscal decentralization process (GOU MOH 2016a). In its consultation with national-level informants, the assessment team repeatedly heard that the health sector has not been successful in presenting a compelling case to the MOFPED on the macroeconomic returns on investments in health. The MOH reported that efforts are underway to provide convincing evidence to the MOFPED to advocate for additional funding to health.

The total FY2017/18 health sector budget was current UGX 1.4 trillion (USD 379 million), with UGX 926 billion (USD 250 million) from domestic resources and UGX 440 billion (USD 119 million) from external assistance. Across different programmatic areas, when accounting for only domestic resources, 39% of the budget was for primary health care (PHC; including district hospitals), 27% to drugs, 18% to national and regional referral hospitals, and 16% to the MOH and other central health institutions (e.g., Uganda Blood Transfusion Service) (Figure 2).

Figure 2: Fiscal year 2017/18 health budget, domestic resources



Source: Author analysis of Government of Uganda Ministry of Finance, Planning and Economic Development. 2016. *National Budget Framework Paper FY 2017/18 – FY 2021/22.* http://budget.go.ug/budget/sites/default/files/ National%20Budget%20docs/Final%20BFP%20FY%202017_18.pdf.

Note: Estimated Government of Uganda budget equal to current USD 250 million.

a. Includes budget for district hospitals.

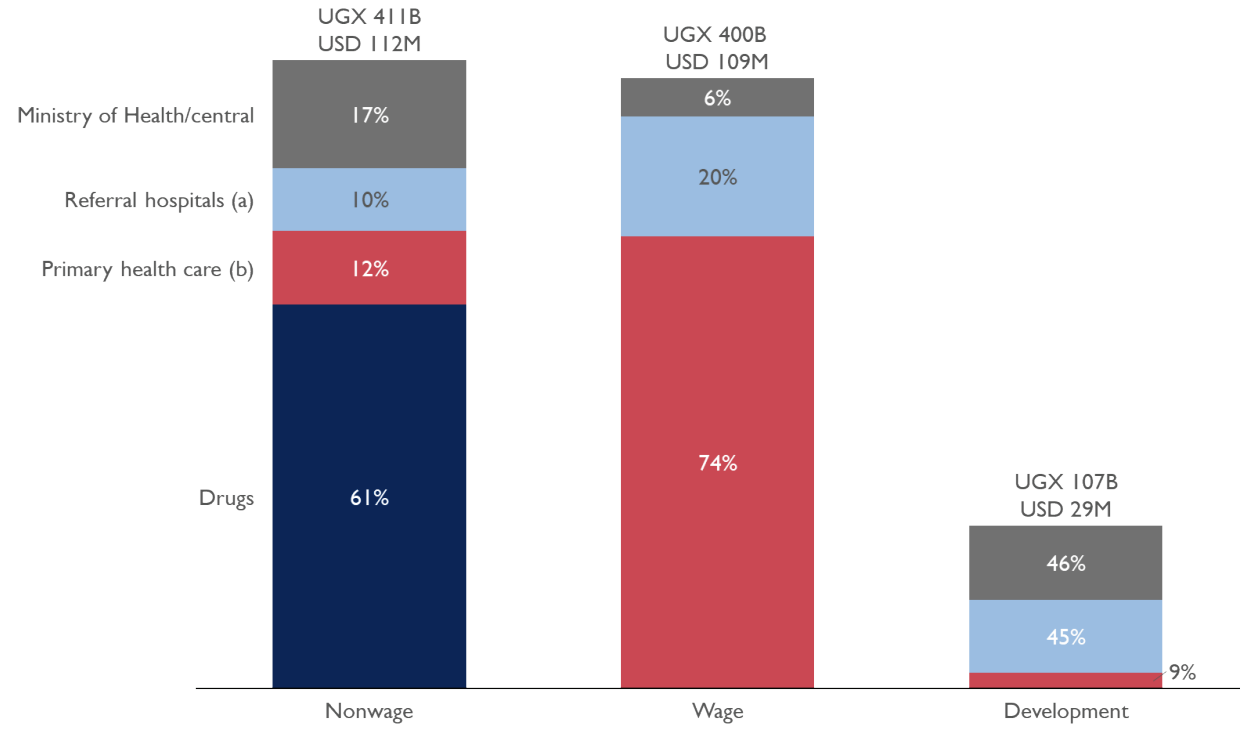
b. National and regional.

Across wage, nonwage, and discretionary development categories, when excluding all on-budget external assistance, 44% of the budget was for wages, 45% for nonwage expenditures, and 12% for discretionary development (e.g., health infrastructure development) (GOU MOFPED 2016b). Further disaggregation of the wage, nonwage, and discretionary budget categories against the respective allocations to MOH and central institutions, referral hospitals, PHC, and drugs revealed further information on the health sector budget composition.

For the nonwage proportion of the health budget, 61% was for drugs, 17% for MOH and central health institutions, 12% for PHC (including funding for district hospitals), and 10% for national and regional referral hospitals (Figure 3). While PHC received a relatively small proportion of the nonwage budget, it received 74% of the total wage budget, reflecting the staffing levels at health centers (HCs) and district hospitals (Figure 3). Of the development budget, however, PHC received only 9% of the budget (approximately UGX 9.6 billion or USD 2.6 million), while MOH/central level and referral hospitals received 46% and 45% of the

budget, respectively. With the nonwage and discretionary development portions of the budget being the predominant source for RMNCH funding at HCs, the relatively small allocations of these portions underscore findings from informant interviews on the small size of nonwage LG grants and the limited availability of discretionary development grants in the health sector, both of which impede the provision of some RMNCH services.

Figure 3: Allocation of wage, nonwage, and development budgets, fiscal year 2017/18



Source: Author analysis of Government of Uganda Ministry of Finance, Planning and Economic Development. 2016. *National Budget Framework Paper FY 2017/18 – FY 2021/22*. http://budget.go.ug/budget/sites/default/files/ National%20Budget%20docs/Final%20BFP%20FY%202017_18.pdf.

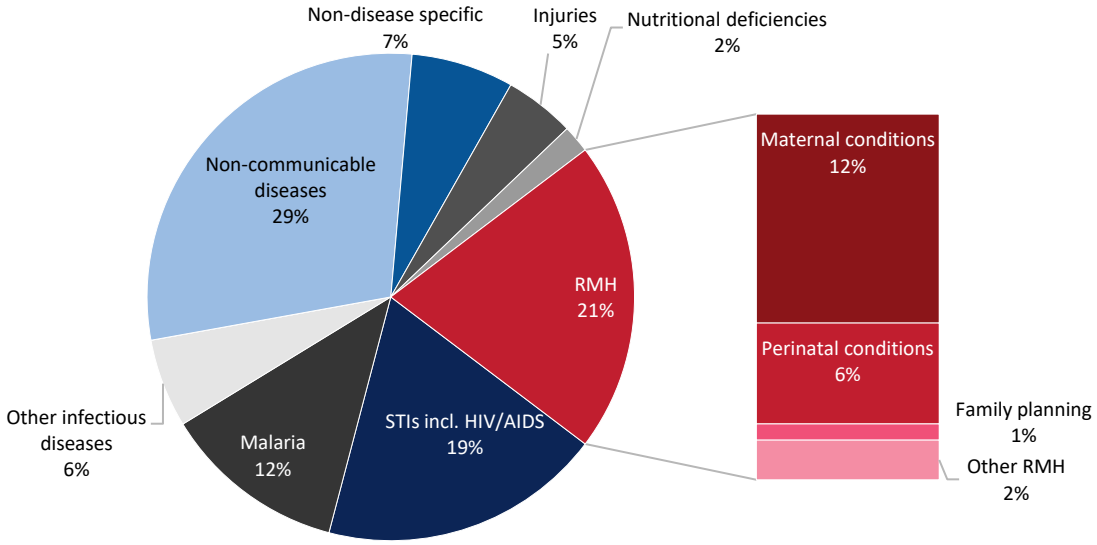
a. National and regional.

b. Includes budget for district hospitals.

RMNCH Expenditures

The FY2015/16 National Health Accounts showed that 21% of CHE was spent on reproductive and maternal health, with the majority of that category spent on maternal (12%) and perinatal (6%) conditions (Figure 4).

Figure 4: Health expenditure by major disease category, fiscal year 2015/16

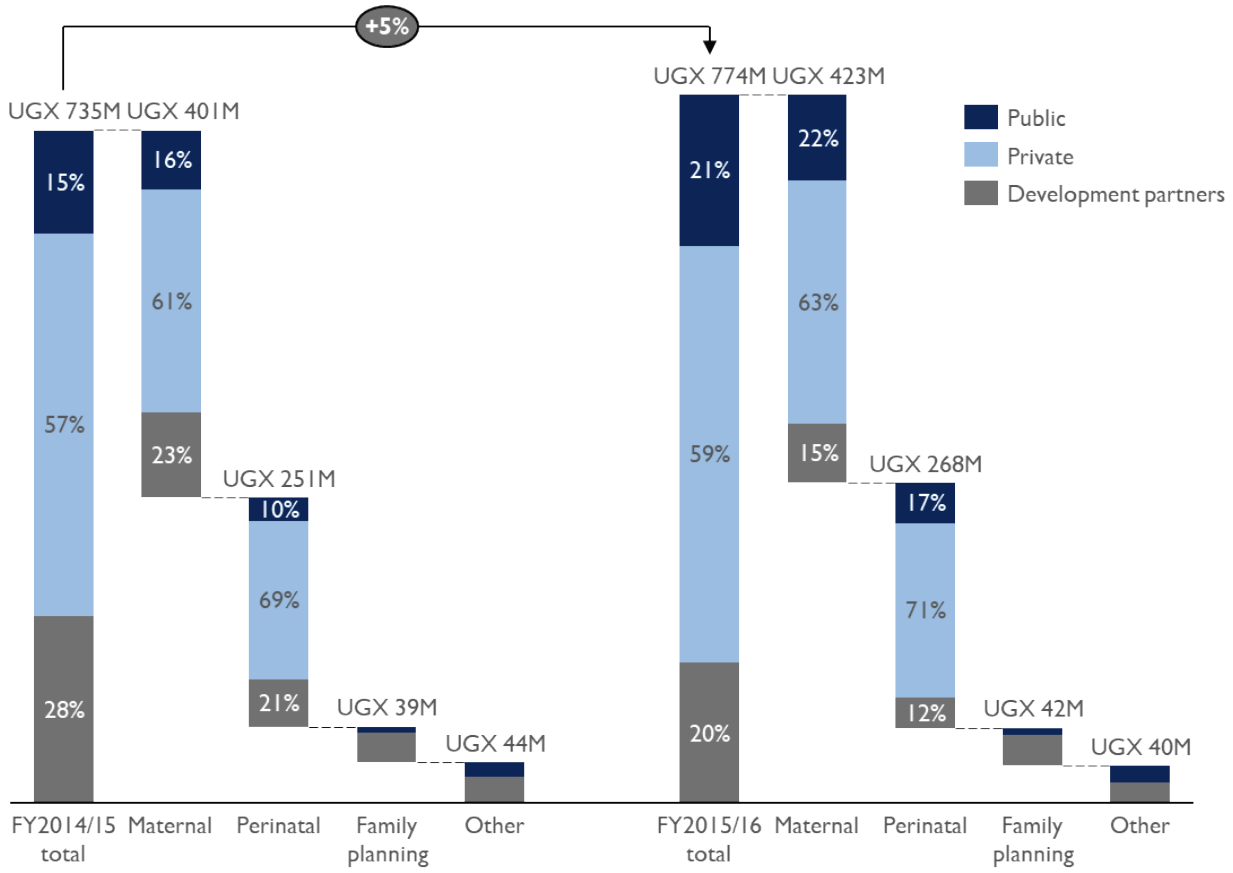


Source: Government of Uganda Ministry of Health. 2018. *Uganda Health Accounts: National Health Expenditure Financial Years 2014/15 and 2015/16*. http://library.health.go.ug/publications/health-insurance/national-health-accounts-fy-201415-201516.

Abbreviations: RMH, reproductive and maternal health; STI, sexually transmitted infection.

Households fund the majority of reproductive health–related expenses through private sources, primarily OOPE (Figure 5). Between FY2014/15 and FY2015/16 there was a 5% increase in total spending on reproductive health, with the majority of the increase in maternal and perinatal conditions. However, for both maternal and perinatal expenditures, the proportion of expenditures from public sources increased 6%–7% for each condition category; private (e.g., OOPE) sources increased marginally at 2% each. The proportion from donors decreased overall. The larger proportional increase from public sources compared to private sources suggests that the GOU has mobilized additional public resources for reproductive health services.

Figure 5: Expenditures on reproductive health, by fiscal year (FY) and financing source



Source: Author analysis of Government of Uganda Ministry of Health. 2018. *Uganda Health Accounts: National Health Expenditure Financial Years 2014/15 and 2015/16*. http://library.health.go.ug/publications/health-insurance/national-health-accounts-fy-201415-201516.

FP and other or unspecified reproductive health expenditures made up a small portion of reproductive health expenditures, each at 1%. The majority of funding for FP come from donors, followed by public sources (Figure 5). Funding at the national level for FP commodities has increased steadily from FY2009/10; however, challenges remain in advocating that sufficient funding be provided to lower levels of the system and improving the stewardship of these funds (GOU MOH 2014a). To achieve Uganda's Family Planning 2020 commitments of reducing unmet need for FP by 10% and increasing the modern contraceptive prevalence rate among women married and women in union to 50%, additional financing is necessary (GOU MOH 2014a).

For child health conditions, households finance 62% of expenditures, with public and nongovernmental sources financing 23% and 12%, respectively; the remaining 3% of child health expenditures originated from other non-OOPE private sources (GOU MOH 2016b).

Aligning External Financing for RMNCH

Acknowledging slow progress on reducing maternal and under-5 mortality and resource gaps to do so, the GOU and Global Financing Facility (GFF) developed the 2016 *Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda* ("RMNCAH Investment Case") to identify bottlenecks to increase effective coverage and estimate resource needs for implementing the 2013 RMNCH *Sharpened Plan*. The RMNCAH Investment Case also allowed the GOU to access funding from the GFF through an agreed-upon loan of USD 110 million and grant of USD 30 million. Collectively, 49% of the GFF funding is for expansion of RBF for PHC, 39% for health system inputs such as facility construction, 7% for scale-up of birth and death registration services, and 5% for project management capacity-building (World Bank 2016).

During the assessment, the team found that the GOU has intermittently implemented mapping of external health resources for RMNCH; there is no existing system through which the MOH can easily track all external resources. There have been examples of disease-specific resource tracking, such as the Country Multi-Year Plan for immunization investments and the 2016 RMNCAH Investment Case. The latter showed that in FY2016/17, 8% of RMNCH commitments came from the GOU with the remaining commitments coming from external donors (GOU MOH 2016b).

Outside of the RMNCAH Investment Case, there has not been meaningful coordination and alignment of funding against Ministry of Health (MOH) RMNCH priorities. As outlined in the *Health Financing Strategy 2015/16 – 2024/25*, the health sector aspires to revive a pooled donor basket fund (GOU MOH 2016a). However, key informants expressed that—given concerns over insufficient accountability structures in past basket funds—the MOH remains interested in a virtual pooling structure, in which donor funds better align with government health priorities through more efficient on-budget funding. To date, there has been no concrete plan for reinvigorating discussion on pooled donor resources.

Coupled with infrequent resource mapping, high levels of donor funding directly influenced provision of RMNCH services at subnational levels, the assessment team found. In both sampled districts, subnational managers commented that supplementary support—most commonly for immunization through Gavi, the Vaccine Alliance—aided in implementing regular activities. This support was in-kind through donations of equipment, such as solar refrigerators for the immunization cold chain. While district managers and facility staff recognized this funding provides needed inputs into the health system, the assessment team found that the source and purpose of funding—combined with low government funding to facilities—could skew the focus of facility activities to certain donor-funded services, such as community outreaches. The sampled district informants also expressed that donor funding channeled through implementing partners provided essential supportive functions that could otherwise not happen; for example, the DHMT informants stated that the US Agency for International Development Regional Health Integration to Enhance Services programs provided regular supervision visits to HCIVs and HCIIIs, which the districts did not have sufficient funding to complete on a regular basis.

While donor support allows the Uganda health system to provide essential services it otherwise could not, the predictability and sustainability of external assistance is a concern of the government. Within the RMNCH space, external funding is often for specific subareas, such as immunization or FP, creating challenges in implementation and the verticalization of funding. Similar to a Parliament-endorsed though not-yet-operational HIV/AIDS trust fund for antiretroviral therapies, the assessment team found that the GOU continues to discuss the creation of an immunization trust fund to secure dedicated funding for immunization, mainly to finance the procurement of vaccines. Although the trust fund proposal could help secure more funding for the sector as donor funding tapers with increasing economic development, the GOU should consider taking measures to limit disease-specific verticalization of funding to ensure that the health system has resources to provide a wide range of essential services.

2. Subnational funding levels limit ability of districts and facilities to provide comprehensive high-quality RMNCH services

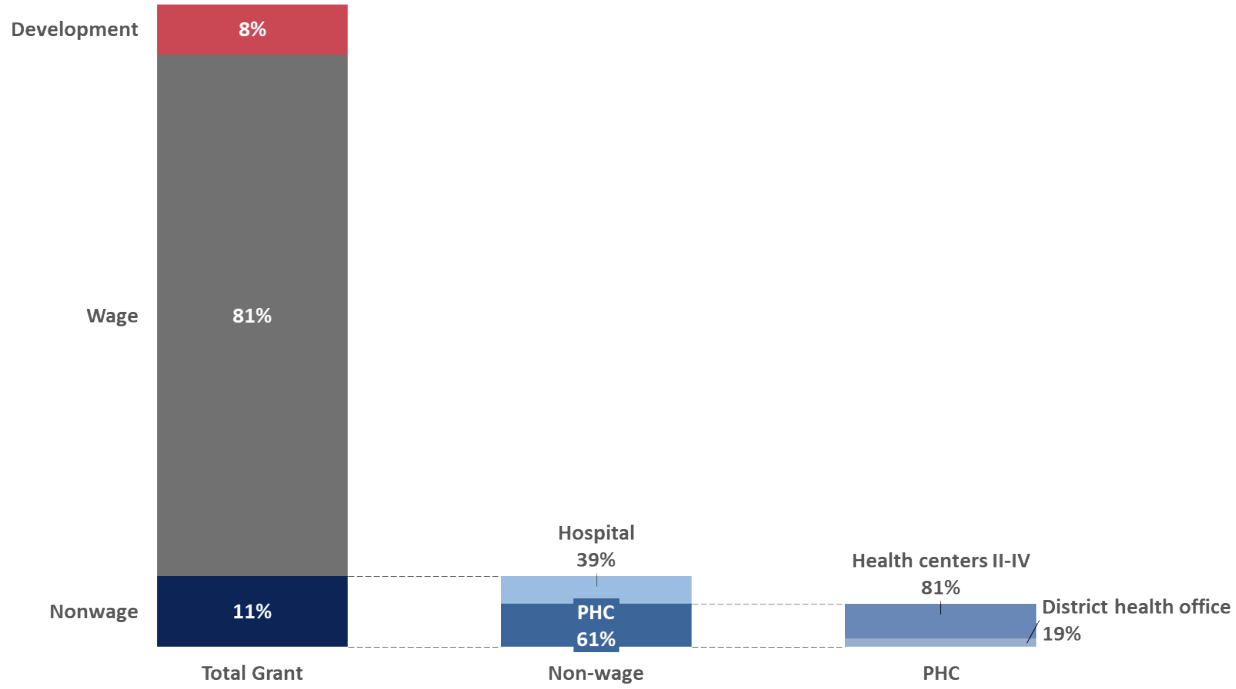
Sources of Subnational Funding

Funding to LGs—districts and municipalities—comes from a series of grants jointly managed by the MOH, MOFPED, and Ministry of Local Government. The assessment team heard from multiple key informants that the creation of new districts in recent years has led to overall decreasing allocations to each district and challenges in creating strong administrative structures in newly formed districts.

Of the three main types of LG health grants (wage, nonwage, and discretionary development), the FY2017/18 wage grant for all districts—excluding municipalities—made up 81% of total grant spending, leaving 11% to the nonwage portion and 8% to discretionary development grants (Figure 6). Further

decomposition of the nonwage grant shows that 39% and 61% of the nonwage grant are for district hospitals and PHC service delivery, respectively (Figure 6). Of the 61% allocated to PHC delivery, 81% is for funding to HCIV–HCIIs and 19% to the DHO office (Figure 6). Of the few health facility budgets the assessment team reviewed, more than half the budget was allocated for basic administration (photocopying, office supplies) and costs associated with meetings (with village health teams [VHTs], health management committees, and other committees).

Figure 6: Breakdown of total health grants to districts fiscal year 2017/18, by category



Source: Author analysis of Government of Uganda Ministry of Health. 2017. *Primary Health Care Grants Guidelines Financial Year 2017/18*. http://health.go.ug/sites/default/files/PHC%20Guidelines%20FY201718%20-%20Final%20%20%20Edition151217.pdf.

Note: Analysis excludes grants to municipalities.

Abbreviation: PHC, primary health care.

Analyzing the total amount of health sector funds allocated to district and municipality grants in FY2017/18, districts on average received UGX 2.23 billion (USD 603,486) for wages, UGX 192 million (USD 52,021) for PHC, UGX 121 million (USD 32,570) for district hospitals (if any), and UGX 94 million (USD 25,463) for development, though only 50 districts received these grants in FY2017/18 (Table 3). Assuming that 81% of the PHC nonwage grant is for direct service delivery (Figure 6), a district had on average UGX 155 million (USD 41,867) for direct PHC service delivery in FY2017/18; districts with district-level hospitals would have up to UGX 275 million (USD 67,330) for PHC- and hospital-level service delivery in FY2017/18, depending on the proportion of the hospital grant spent on direct services.

Table 3: Average district and municipality health grant totals, fiscal year 2017/18

	District (121)	Municipality (41)
Wage	**UGX 2.23B USD 603,486**	**UGX 518M USD 139,776**
Nonwage—hospital	**UGX 121M (70)a USD 32,570 (70)**	**—**
Nonwage—primary health care	**UGX 192M USD 52,021**	**UGX 53M USD 14,381**

	District (121)	Municipality (41)
District Health Officer	UGX 38M USD 10,154	UGX 11M USD 2,927
Health centers II–IV	UGX 154M USD 41,867	UGX 42M USD 11,305
Development	**UGX 94M (50)** **USD 25,463 (50)**	**UGX 500M (1)** **USD 134,952**

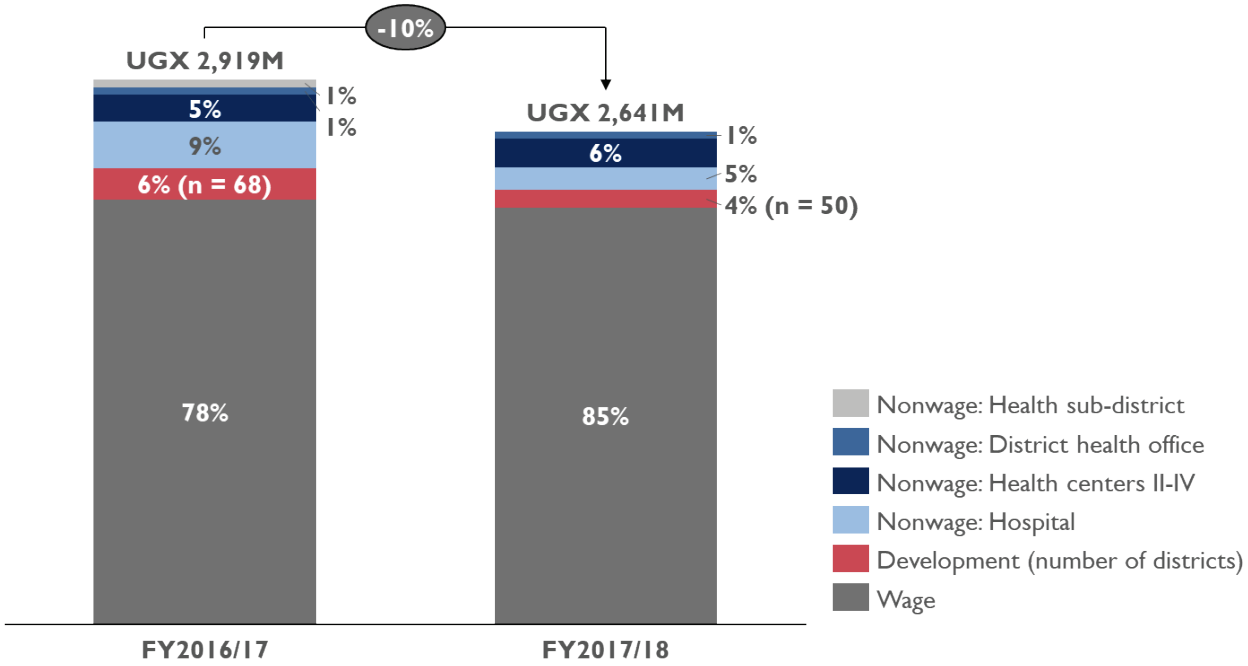
Source: Author analysis of Government of Uganda Ministry of Health. 2017. *Primary Health Care Grants Guidelines Financial Year 2017/18*. http://health.go.ug/sites/default/files/PHC%20Guidelines%20FY201718%20-%20Final%20%20%20Edition151217.pdf.

Note: Figures in current USD.

a. Values in parentheses represent number of districts or municipalities receiving grant if different from total.

Between the two most recent FYs, the average district health grant totals decreased by approximately 10% (Figure 7). The relative portion of the wage grant increased between the two FYs, but the average proportion of the hospital grant to qualifying districts decreased in value. Furthermore, fewer districts received development grants in FY2017/18 compared to FY2016/17.

Figure 7: Average district health grant totals between fiscal years (FYs) 2016/17 and 2017/18, by subcategories



Source: Author analysis of Government of Uganda Ministry of Health. 2016. *Primary Health Care Grants Guidelines Financial Year 2016/17*. http://health.go.ug/sites/default/files/PHC%20GUIDELINES%20%20%20FY2016-17_Final.pdf and Government of Uganda Ministry of Health. 2017. *Primary Health Care Grants Guidelines Financial Year 2017/18*. http://health.go.ug/sites/default/files/PHC%20Guidelines%20FY201718%20-%20Final%20%20%20Edition151217.pdf.

In the sampled districts in FY2017/18, Kaliro received a total grant of UGX 1.6 billion (USD 420,782) with a UGX 159 million (USD 42,914) nonwage grant; Mbarara District and Municipality received a total grant of UGX 3.8 billion (USD 1,021,862) with a UGX 724 million (USD 195,411) nonwage grant (Table 4). Between FY2016/17 and FY2017/18, the total grant increased for both Kaliro and Mbarara; however, the nonwage grant portion decreased for Kaliro and increased for Mbarara.

Table 4: Health grant totals for Kaliro District and Mbarara District and Municipality, fiscal years (FYs) 2016/17 and 2017/18

	Kaliro		Mbarara	
2014 population	**236,199**		**472,629**	
FY	**2016/17**	**2017/18**	**2016/17**	**2017/18**
No. of facilities	**17**	**16**	**54**	**52**
Wage total	**UGX 1,330M USD 381,719**	**UGX 1,400M USD 377,867**	**UGX 2,600M USD 749,427**	**UGX 3,000M USD 809,716**
Nonwage total	**UGX 178M USD 51,047**	**UGX 159M USD 42,914**	**UGX 657M USD 188,445**	**UGX 724M USD 195,411**
Hospital	—	—	UGX 270M USD 77,326	UGX 220M USD 59,379
Primary health care	UGX 178M USD 51,047	UGX 159M USD 42,914	UGX 388M USD 111,119	UGX 504M USD 136,032
District Health Officer	UGX 35M USD 10,241	UGX 32M USD 8,636	UGX 72M USD 20,674	UGX 71M USD 19,163
Health subdistrict	UGX 26M USD 7,584	N/A	UGX 106M USD 30,308	N/A
Health centers II–IV	UGX 116M USD 33,222	UGX 127M USD 34,278	UGX 210M USD 60,136	UGX 433M USD 116,869
Development total	**—**	**—**	**—**	**UGX 62M USD 16,734**
Grand total	**UGX 1,508M USD 432,766**	**UGX 1,559M USD 420,782**	**UGX 3,257M USD 937,872**	**UGX 3,786M USD 1,021,862**
Expenditure per capita	**UGX 6,385 USD 1.83**	**UGX 6,600 USD 1.78**	**UGX 6,908 USD 1.98**	**UGX 8,010 USD 2.16**

Source: Author analysis of Government of Uganda Ministry of Health. 2016. *Primary Health Care Grants Guidelines Financial Year 2016/17*. http://health.go.ug/sites/default/files/PHC%20GUIDELINES%20%20%20FY2016-17_Final.pdf; Government of Uganda Ministry of Health. 2017. *Primary Health Care Grants Guidelines Financial Year 2017/18*. http://health.go.ug/sites/default/files/PHC%20Guidelines%20FY201718%20-%20Final%20%20%20Edition151217.pdf; and Uganda Bureau of Statistics. 2014. *Uganda National Household Survey 2012/13*. http://www.ubos.org/onlinefiles/uploads/ubos/UNHS_12_13/2012_13%20UNHS%20Final%20Report.pdf.

Note: Average current exchange rates for respective FYs.

Abbreviation: N/A, not applicable.

The difference in the total grant amount between the two districts can be attributed to Mbarara's larger population and the higher number of PHC grant-supported facilities (Table 4); furthermore, Kaliro lacks a district-level hospital while Mbarara has two faith-based hospitals that receive PHC grant funds (Table 5). However, in per capita terms, Mbarara had a per capita health grant allocation of UGX 8,010 (USD 2.16) in FY2017/18 compared to Kaliro's at UGX 6,600 (USD 1.78) per capita, approximately 17% less than that of Mbarara's; furthermore, Mbarara's per capita allocation increased across the two FYs while Kaliro's decreased (Table 4).

Table 5: Facilities receiving primary health care grants fiscal year 2017/18, by location, ownership, and facility level

	Kaliro District			Mbarara District			Mbarara Municipality
Ownership	**Public**	**PNFP**	**FB**	**Public**	**PNFP**	**FB**	**Public**
HCII	7	—	3	25	1	3	4
HCIII	4	—	1	9	—	2	2
HCIV	1	—	—	3	—	—	1
Hospital	—	—	—	—	—	2	—

Source: Government of Uganda Ministry of Health. 2017. *Primary Health Care Grants Guidelines Financial Year 2017/18*. http://health.go.ug/sites/default/files/PHC%20Guidelines%20FY201718%20-%20Final%20%20%20Edition151217.pdf.

Abbreviations: FB, faith-based; HC, health center; PNFP, private, not-for-profit.

In FY2017/18, Kaliro District spent 91% of its overall PHC grant budget, though only 70% of its overall health budget. Within the PHC portion of the budget, Kaliro spent 100% of wage and nonwage budgets. The budget performance report stated that the overall underperformance of the health sector occurred because of two main factors: 1) reduced allocations from LGs to the health sector, and 2) a 20% reduction in the budget due to unmet commitment by donors (GOU MOFPED 2018b).

Mbarara District spent 90% of its overall health budget, including 90% of the overall PHC grant budget. Within the PHC portion of the budget, Mbarara spent 100% of its nonwage portion but only 91% of its wage portion. The underspending in the wage category occurred because of delays in reconciling staff numbers between employee master data records at the district and records at the MOFPED (GOU MOFPED 2018c).

In interviews with DHOs, the assessment team found that PHC wage grants are based on existing staff numbers at the end of the preceding FY; therefore, districts with higher vacancy rates of health workers have difficulty recruiting new staff. While DHMTs reported mass national recruitment events that filled many vacancies in 2015, some districts did not take advantage of these events, leading to persistent vacancies. Requesting approval for new recruitments through the PHC wage grant requires additional budget and approval from the Ministry of Public Service; some interviewed DHMTs reported that they were not successful in gaining additional budget, leaving many positions vacant.

At the facility level, the nonwage grant functions as the primary source of cash funding to facilities because the National Medical Stores (NMS) centrally distributes drugs and supplies based on a standard line of credit per facility level. For public health facilities, the assessment team found that nonwage allocations per level (e.g., HCIV versus HCIII) were consistent within each district, but not across districts (Table 6).

Table 6: Primary health care nonwage grant per health center (HC) level, Mbarara and Kaliro Districts, fiscal year 2017/18

	Kaliro District		Mbarara District	
	Total annual budget	**Number of facilities**	**Total annual budget**	**Number of facilities**
HCIV	UGX 50M USD 13,690	1	UGX 31M USD 8,456	3
HCIII	UGX 6M USD 1,725	4	UGX 14M USD 3,905	9
HCII	UGX 3M USD 913	7	UGX 5M USD 1,429	25

Source: Government of Uganda Ministry of Health. 2017. *Primary Health Care Grants Guidelines Financial Year 2017/18*. http://health.go.ug/sites/default/files/PHC%20Guidelines%20FY201718%20-%20Final%20%20%20Edition151217.pdf.

Note: USD figures in current USD.

For development grants, the assessment team found that the GOU had suspended regular health sector development grants to LGs in recent years due to concerns over the choice and quality of development projects. For FY2017/18, the MOH had requested for districts to submit annual proposals on unfinished development projects within their districts. In one sampled district, the district received a health sector development grant to finish a facility renovation that had been incomplete since the suspension of earlier development grants. Furthermore, the value of the grant was sufficient to complete only one project, though the DHMT expressed that multiple earlier infrastructure development projects remained incomplete. The MOH also reported that it completes a needs assessment—which informs the proposal process for health sector infrastructure development grants—every 3 years. However, the assessment team found there was not a clear or regular process for DHMTs to submit proposals, and that decisions to fund certain development grants were ad hoc. DHMT informants reported that they had to make significant noise to receive one of the grants, while one informant at central level reported that political considerations influence the allocation of development grants.

While such flaws in the development granting process stymie efforts for major capital development at LG level, the assessment team found that the MOH had provided equipment to all districts, in this case new beds, in FY2016/17. Although DHMTs and facility staff appreciated the new beds, the assessment team heard these inputs were sent to the DHMTs without adequate consultation beforehand. DHMT and facility staff also reported to the assessment team that the nonwage grants were insufficient to cover any large capital investments, but only covered basic expenses, such as transport for outreaches, meetings, and basic nonmedical supplies.

Among the sampled districts, the assessment team confirmed that local revenue generation (e.g., taxes) for health service delivery is limited. However, interviewed DHMTs and facility staff noted that donor funds through implementing partners provided inputs in-kind (e.g., cold chain equipment or supervision visits). Districts and facilities with an operational RMNCH voucher scheme also reported that voucher incentives were an additional source of funding for both DHMTs and facility staff (see "Current Implementation of URHV" for more detail). Interviewed staff in public facilities confirmed that they do not charge user fees for services per the national policy; however, should an HCIV have a dedicated private wing, fees from services within it could provide additional funding to the facility.

Subnational RMNCH Drug Funding

Funding for drugs exists outside of the wage, nonwage, and discretionary development framework, though the *Primary Health Care Grants Guidelines*—in collaboration with the NMS—articulate the parameters for LG- and facility-level drug funding (GOU MOH 2016c, 2017). Each LG and facility receives a line of credit with the NMS; all public facilities regardless of location receive the same line of credit dependent on facility level. In FY2017/18, the NMS credit lines were UGX 324 million (USD 87,395) for district hospitals, UGX 53 million (USD 14,310) for HCIVs, UGX 22 million (USD 6,036) for HCIIIs, and UGX 7 million (USD 2,004) for HCIIs (GOU MOH 2017). For HCIVs and HCIIIs participating in the Uganda Reproductive Health Voucher (URHV) Project, a portion of facility bonuses can fund the purchase of relatively inexpensive drugs or consumables; however, the program is shifting to a policy that would require all participating facilities to procure drugs through the Joint Medical Stores.

While conceived as a pull system for all facility levels, the system effectively functions as a push system at HCIIs and HCIIIs. Although HCIIs and HCIIIs are supposed to receive a standard drug kit every 2 months, facility in-charges are supposed to create an annual plan for drugs and NMS-provided supplies within the line of credit. In practice, the assessment team found that the frequency, regularity, and composition of RMNCH commodity deliveries to HCIIs and HCIIIs varied widely. HCIV facilities can directly order drugs and supplies from NMS. However, HCIV staff reported to the assessment team that the level of funding is insufficient to order necessary supplies.

Facilities report challenges with district- and facility-level stock-outs of essential RMNCH drugs and supplies as significant barriers to effective RMNCH service delivery. Multiple interviewed facilities reported persistent

stock-outs of antibiotics, pain medicines, and contraceptives—in some cases oral contraceptives were out of stock for close to 2 years.

Many facilities also lacked sufficient supplies to provide safe institutional delivery. Facilities are supposed to distribute the GOU-procured Mamma Kits to all pregnant women during antenatal care (ANC), though many facilities reported only distributing kits to women once they came to a facility for labor. However, facility staff reported that the number of kits received from NMS was chronically insufficient for deliveries. The assessment team also heard from the MOH that the quantification for Mamma Kits was only 60% of anticipated annual demand for them. HCIIIs—the first facility level at which a woman can deliver—do not have the ability to order a specific number of Mamma Kits and rely on the amount that they receive from NMS. The assessment team also found variation between the two sampled districts on the availability and sufficiency of NMS-delivered Mamma Kits; fewer Mbarara facilities cited challenges compared to facilities in Kaliro.

For vaccines, the assessment team did not hear of regular stock-outs of antigens, though some DHOs and facility staff cited recent stock-outs of bacille Calmette-Guérin (TB) vaccine.

At the district level, many facility staff reported that they would notify the DHO of stock-outs. Some facilities reported receiving additional stock from other facilities through the DHO, who may collect unused medicines and redistribute within the district. Along with the small size of nonwage PHC grants and challenges with stock-outs of RMNCH commodities, the assessment team found that there were no additional funds with which to procure additional drugs or supplies for any RMNCH-related service, thereby impeding the delivery of high-quality services.

Planning, Budgeting, and Disbursement Processes

LG health sector planning aligns with central MOH priorities and policies. LG-level administrators stated that indicative planning figures shared by the central government serve as the basis for sector-specific planning. Within the health sector, DHMTs reported taking a bottom-up approach to planning, including taking into account needs and priorities from health subdistricts, parishes, and VHTs. Once DHMTs collect these data, they combine their findings and determine whether identified needs are addressable within the expected budget envelope and at which corresponding system level (e.g., health subdistrict, facility). Multiple LG-level informants reported that donor planning cycles do not align with those of LGs; DHMTs stated they often did not have details of donor or implementing partner activities with which to align their own plans.

At all facilities, guidance for planning and budgeting for their nonwage PHC grants comes directly from DHMTs. Generally, facility in-charges reported that the standard guidance is to spend 40% on direct service delivery and the remaining 60% on general administration. The assessment team found that much of the direct service facility-level funding for HCIIIs and HCIIs was spent on immunization and integrated outreaches—typically immunization with FP and/or HIV testing—in collaboration with VHTs. Most reported conducting weekly outreaches and semiregular child health days, although it was unclear whether the outreach conducted was sufficient to meet community needs. Costs associated with these activities included transport, airtime, allowances, and mobilization incentives to VHTs. Other activities included regular reporting, such as costs associated with collecting data on reportable epidemic diseases. Planned administrative costs included maintenance, cleaning, tea, stationery, transport to health subdistrict and bank, and small costs related to meetings. Based on the assessment team's review of a small sample of facility budgets, there was little PHC grant funding to complete non-outreach activities—including supervision at HCIV level—or do any substantial physical improvements to facilities.

Disbursements from the central level to the LG and from the LG to facility level occur on a quarterly basis. Each facility has its own bank account through which the LG authorizes disbursement from the funds it receives from the Central Bank of Uganda. LGs and DHMTs reported that delays in funding from the Central Bank of Uganda do occur, though typically in the first quarter of the FY and less frequently throughout the remainder; facility staff also reported a similar pattern of more noticeable delays in the first

quarter. The assessment team found that the interviewed facilities received the amount that they anticipated based on their annual budget. However, facility in-charges commonly reported that the travel time and distance to access the appropriate bank from which to withdraw their nonwage PHC grant impeded timely receipt of funds.

The assessment team also found that all sampled facilities reported continuing planned activities even with funding delays. Multiple facility staff reported that they trusted that the funding would eventually arrive based on experience. Facility staff stated they would pay out of pocket and then obtain reimbursements for small expenses, such as travel for outreaches or stationery. DHMTs reported similar views, implementing activities when facing delays and noting that there had been shorter delays in recent years.

Collectively, the size of subnational funding flows appears to limit the ability of facilities to provide comprehensive RMNCH services. For example, facility staff reported conducting regular immunization outreaches; however, the assessment team found there was less direct funding to facilities to provide FP counseling.

Reforms to Budgeting Processes

While the assessment team found that there are regular planning and budgeting processes institutionalized at the LG and facility levels, efforts are underway to reform the budgeting process to program-based budgeting (PBB). The stated goal of PBB is to improve the efficiency and effectiveness of public funding by clearly articulating the intended outputs of a given program, thereby increasing accountability. The GOU's goal is to roll out the PBB system across all government levels. In FY2017/18, the MOFPED reported rolling out the new PBB system to central ministries. While the FY2017/18 *Budget Framework Paper* reports a set of indicators and targets, the assessment team found that the Office of the Prime Minister had not yet approved the final set of output/outcome indicators for each sector (GOU MOFPED 2016b).

The assessment team found that some key informants expressed concern over the potential verticalization of funding that could result from PBB. As the health sector intends to move away from vertical programs and funding, the goals of the PBB reform will need to align with other health financing goals. Similarly, LG and DHMT informants expressed some concerns over the lack of clarity on how this new PBB process will function at subnational levels. Given the small amounts of funding available through the PHC grants, alignment with disease-specific programs could create greater inefficiencies.

3. RBF appears to improve RMNCH service utilization, quality, and funding

Background of RBF in Uganda

Uganda has used RBF to finance and improve RMNCH services for over a decade. Uganda's experience to date has focused on PNFP providers, with less experience with payments to public sector facilities. RBF is part of demand-side vouchers that include promotion through community health teams and has also been a supply-side incentive to motivate provider performance. Generally, external partners have funded and/or administered the programs, and although each generation of programs increases in size, there has been no experience with national implementation yet. Table 7 provides a summary of recent RBF programs targeting RMNCH.

Table 7: Synthesis of recent results-based financing programs targeting reproductive, maternal, newborn, and child health services

Name (timeline)	No. of districts (regions)	Approx. no. of facilities	Type of providers	Administrator	Demand side promotion	Target services
PNFP project (2014–2018)	15 (West Nile and Rwenzori)	45	PNFP initially, expanded to include public facilities	Belgian Technical Cooperation	No	Minimum Health Care Package
Uganda Reproductive Health Voucher (2015–2019)	25 (Southwest and Eastern)	240	Approximately 65% PNFP and PFP; 35% public facilities	Marie Stopes	Target poor women	• ANC • Delivery • PNC • FP • Transport
Uganda Voucher Plus (2016–2021)	31 (East and Northern)	136	PNFP and PFP facilities	Abt Associates (US Agency for International Development implementing partner)	Target poor women	• ANC • Treatment of common illnesses • Delivery • Prevention of mother-to-child transmission of HIV • PNC (2 visits) • Postpartum FP
Healthy Baby Voucher/ Saving Mothers Giving Life (2012–2017)	10 (West and Northern)	117	PNFP, PFP, and public facilities	Baylor, Infectious Disease Institute, Marie Stopes, STRIDES for Health	All mothers	• ANC • Delivery • PNC • Transport

Abbreviations: ANC, antenatal care; FP, family planning; PFP, private, for-profit; PNC, postnatal care; PNFP, private, not-for-profit.

Experiences with RBF (whether embedded in a demand-side voucher or solely targeting provider payments) in Uganda have shown to improve service coverage rates and adherence to clinical guidelines. As a result, the GOU considers RBF an important component of its RMNCH strategy and plans to scale up RBF as a primary mechanism for discretionary funding to districts and facilities.

Current Implementation of URHV

The URHV is a program that sells vouchers at modest cost (UGX 4,000) to lower-income women that entitle them to a package of ANC, delivery, postnatal care, and FP services, including emergency transport for referral if necessary. VHTs sell the vouchers within their community, with a small commission provided to the VHT. PNFP and public HCIIIs, HCIVs, and hospitals provide the services. HCIIs are not eligible for this program as they are unable to provide the full package of services: most importantly, delivery. Facilities must be prequalified as providers, based on meeting minimum quality standards. Participating PNFP and PFP facilities agree to limit user fees for clients without vouchers to levels set by the program. Facilities then submit claims for reimbursement based on services provided to voucher holders. Independent reviewers validate claims to ensure delivery of services and adherence to clinical guidelines; providers do not receive reimbursement for cases that did not follow clinical guidelines.

The assessment team visited public and PNFP health facilities that were accredited providers under the URHV, implemented in both Kaliro and Mbarara Districts. The team visited one PNFP hospital, one PFP HCIII, and three public HCIIIs in the two districts. In all facilities, informants reported approximately 50% increases in the number of deliveries since the introduction of the voucher, which the Mbarara DHMT validated. Additionally, Mbarara District reported 40%–50% increases in numbers of women receiving four ANC visits, as well as generally improved timeliness and quality of reporting from facilities.

Informants reported that 30%–50% of URHV RBF payments are allocated for staff incentives, which staff within a facility share. Facilities reported that the bulk of funding for staff incentives goes to staff in the maternity and laboratory units, as the majority of the workload associated with higher utilization falls on those units. Facilities used RBF funds for a range of critical needs, including replacing a window, fixing the water system, repairing an ambulance, and buying blood pressure machines, gloves, fuel, and drugs.

Funding received from the voucher program represents a significant source of discretionary funds at public health facilities. Marie Stopes Uganda (MSU)—the implementer of the URHV program—reported that approximately 30% of providers receive UGX 3–4 million (USD 800–1,080) per month in reimbursements, with approximately 40% receiving over UGX 4 million (USD 1,080), and 30% receiving less than UGX 3 million (USD 800). The guidance to facilities is that 30% of funds are for medical consumables and drugs, 20% for facility maintenance, 10% for the DHMT, and the remainder for staff incentives. Assuming these rates, a facility that receives UGX 9 million (USD 2,400) in reimbursements per quarter would have available approximately UGX 4.5 million (50% of 9 million; USD 1,200) available for use within the facility. By comparison, the average PHC grant for an HCIII is UGX 1.8 million (USD 485) per quarter.

There were some implementation challenges noted across the two districts. Although the staff incentives and facility improvements motivated informants in the facility, a few noted the increased paperwork burden associated with processing claims. Although informants did not voice any complaints about claims processing, the assessment team noted the burden for claims submission in Kaliro District. One facility reported that traveling to submit claims in Tororo required approximately 5 hours by bus. Another health facility, luckily, has a staff member who lives in Tororo and travels there regularly, so she has transported their claims for them. During the time of the assessment, MSU was preparing to institute a new requirement that facilities using voucher reimbursements to purchase drugs must do so through Joint Medical Stores and may not use private pharmacies. One informant had learned of this and expressed concern about the time needed for delivery and potential drugs shortages. Lastly, the assessment team learned that only two VHTs distribute the vouchers in each community. It seemed that additional VHTs could be involved in distribution, particularly in facilities and communities where uptake was lower than expected.

MOH Plans for Scale-Up of RBF

The MOH is planning to scale up RBF to 70 districts as a core component of its strategy for improving RMNCH services. The MOH finalized its guidance document, *Results Based Financing Framework for the Health Sector,* in 2016, incorporating lessons from programs administered by Belgian Technical Cooperation (BTC) and MSU. Funding for this effort is USD 85 million over 5 years, mobilized through the GFF. Informants expected initial implementation to begin in 15–20 districts as early as December 2017. The assessment team was not able to find a detailed implementation plan, with several informants referring the team to the *Results Based Financing Framework* as the foundational document guiding implementation.

Based on the *Results Based Financing Framework* and informant responses, there are two key differences between the MOH-planned RBF program and previous programs that included RBF components. First, the MOH is proposing to administer the payment mechanism internally, led by an RBF unit within the Directorate of Planning and Development level and relying on DHMTs for prequalification and supervision of facilities and verification of quality and quantity of services delivered. There were no details on who would be responsible for processing payments to facilities. The MOH is pursuing self-administration to minimize costs, estimated at approximately 20% of funding, based on previous experiences. Secondly, the MOH wants to prioritize public facilities for inclusion in the RBF program. Both MSU and BTC informants conveyed that there were additional challenges in working with public providers, mostly related to ensuring minimum quality standards. Both these differences will require additional monitoring mechanisms. Several non-MOH informants expressed concern about the lack of a detailed plan for implementation, even in the initial districts. The assessment team was not able to confirm district selections for the first phase of implementation. Informants also expressed concern regarding MOH self-administration of the program, given its limited experience with RBF.

4. UHC vision is ambitious and requires further implementation planning to address RMNCH

To reduce OOPEs and improve insurance coverage across the population, the GOU proposed the National Health Insurance Bill in 2007, which set out to establish the National Health Insurance Scheme (NHIS) through the National Health Insurance Fund. The bill, however, was tabled in March 2009 due to resistance from employers, trade unions, and worker representatives who were skeptical about the government's ability to provide efficient service delivery, given the poor state of health facilities in the country (Center for Health Market Innovations 2017). The MOH renewed efforts to establish the NHIS in 2014, and is preparing to launch an initial version of the NHIS that will cover the formally employed (Mathew 2017). Once the scheme is in place, members will not incur cost-sharing at point of service. The MOH, however, is facing challenges in designing such a scheme while improving the quality of care in private and public facilities (East African Community 2014). In 2017, the National Health Insurance Bill reached a milestone by receiving a Certificate of Financial Implication (CFI) from the MOFPED, which authorized a preliminary revenue source plan. Furthermore, the National Planning Authority developed a UHC policy action paper in 2018. This document outlines key challenges in overall health financing, as well as supply-side health system challenges, to overcome to achieve UHC in the long term. Related to RMNCH service provision, the recommended policy actions include fast-tracking of the community health education worker program, scale-up of RBF, and stronger coordination of financing for service delivery priorities.

Legal and Financial Framework

The GOU is committed to the global goal of UHC and has identified NHI as a key strategy for achieving UHC. Referenced in the Second National Health Policy, NHI has been in development since 2010. The national *Health Financing Strategy* identifies implementation of a "Social Health Protection system [that reaches] 30% of the people of Uganda by 2025" as one of six specific objectives (GOU MOH 2016a). Despite slow progress, there was increased momentum in 2017 toward achieving this goal. The MOFPED issued a CFI in April for the NHI Bill 2012, which initially targets the formally employed for insurance coverage, allowing the bill's presentation to Parliament for discussion. While this is a major milestone, the CFI limited the amount of

government contribution to 1% of salary for civil servants and stipulated contributions by the indigent (with no specification of who qualifies as indigent or the contribution amount.) Other sources of revenue for NHI include public and private sector employees contributing 4% of salary, private sector employers contributing 1% of employees' salaries, and pensioners contributing 1% of pensions. The bill requires revision based on the CFI, and discussions between the Parliamentary Council, the MOFPED, and the MOH continue. Nonetheless, the CFI represents an important milestone on the path to NHI. Informants within the MOH hoped that the bill could appear before Parliament within 1 year, or by the end of June 2019 at the latest.

Preparations for NHI

The MOH is building capacity internally related to NHI, while the US Agency for International Development is supporting costing of the health benefits package, and BTC is supporting a study of diagnostic-related groups for insurance payment. These efforts will inform decisions on NHI design. Several respondents also mentioned previous experiences with RBF as a critical input to understanding how to structure provider payments under NHI. To the extent that NHI maintains the priorities of the current programs—on the Minimum Health Care Package (BTC) and RMNCH (URHV, Healthy Baby Voucher, and Voucher Plus)—as it defines its benefits package, it can contribute to improving RMNCH services. Current experiences related to provider accreditation may also prove useful in guiding design and implementation of NHI. There were some areas where the MOH may benefit from additional support for NHI introduction. There seem to be few details related to the institutional design for health insurance management and governance. There has not been discussion of the options related to institutional responsibilities for health insurance and the respective advantages and disadvantages of various alternatives. It is unclear how civil servants and private sector employees will react and what their expectations will be regarding individual benefits from the scheme. Now that the NHI Bill has achieved the first milestone with the CFI issued by the MOFPED, continued advocacy by the MOH and other stakeholders will ensure that NHI design can deliver on the goal of financial protection and is financially sustainable.

Strengths, Weaknesses, Opportunities, and Threats Analysis

Strengths	Weaknesses
• The 2013 RMNCH *Sharpened Plan* and 2016 *Investment Case for the Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan* present clear priorities for RMNCH financing, including the scale-up of RBF (GOU MOH 2013, 2016b). • Pilot demand-side RMNCH voucher programs and RBF appear to show increased demand for some RMNCH services, such as facility-based delivery, and improve some dimensions of quality. The voucher programs also provide participating facilities with supplemental funds for staff incentives, supplies, physical improvements, and DHOs. • Immunization activities, such as outreaches, are a priority at subnational levels and integrate other RMNCH services into them. • Delays in funding to local governments and facilities have improved; though some disbursement delays exist, they do not appear to interfere with key RMNCH facility-level activities.	• Real per capita government health budgets are declining, with little advocacy to prioritize health and reverse the trends. • Level of nonwage subnational funding to PHC facilities is inadequate to provide essential RMNCH services and conduct essential system functions, such as health promotion and supervision of PHC facilities. • Push system to HCIIIs and HCIIs for NMS drugs limits ability of lower-level facilities to request drugs, leading to unmet need for drugs and stock-outs; insufficient credit lines for HCIVs at NMS contribute to facility-level stock-outs of RMNCH commodities. • Allocation of PHC grants by facility level appears inequitable across districts; although total per capita health grant allocation to districts is more equitable, funding per facility level is at discretion of DHO. • Donor funding is needed to supplement essential subnational system functions, such as supervision and outreach, given the low level of nonwage subnational health grants.
Opportunities	**Threats**
• Lessons from the RMNCH voucher programs and RBF pilots should be carefully incorporated into the RBF scale-up implementation planning. • The RMNCH voucher programs could streamline claims-processing systems to reduce facility staff time spent on claims and administration; the voucher programs could better address funding for referral transport in emergencies. • Detailed implementation planning for creation of NHI creates opportunity to directly address financing for PHC and RMNCH in design of benefits package and purchasing mechanisms. • Private sector engagement for PHC and RMNCH service delivery should be leveraged in planning for RBF scale-up and NHI implementation. • Willingness of population to make OOPEs can serve as steppingstone for contributions into prepaid financing schemes, such as NHI.	• Implementation of the RBF scale-up requires further planning to ensure the program can effectively and sustainably meet its objectives. • Verticalization of funding for RMNCH, such as through immunization trust fund, must be carefully managed to avoid challenges associated with vertical funding; rollout of program-based budgeting must carefully consider how to mitigate verticalizing funding for health sector areas. • Recentralization, politicization, and small size of discretionary development grants make it difficult for districts and municipalities to make needed physical improvements to facilities. • OOPEs consistently comprise a high proportion of total health expenditures; while user fees have been abolished, the lack of financial risk protection continues to put the population at risk for impoverishing health expenditures.

Abbreviations: DHO, District Health Officer; HC, health center; NHI, national health insurance; NMS, National Medical Stores; OOPE, out-of-pocket expenditure; PHC, primary health care; RBF, results-based financing; RMNCH, reproductive, maternal, newborn, and child health.

Recommendations

The lack of government budgetary commitment to the health sector severely limits health system quality and performance, especially for RMNCH. While there have been improvements in financial management and disbursement processes at subnational levels, the impact is limited due to overall funding levels. Planned investments in RMNCH financed through the GFF (USD 140 million) represent an opportunity to make substantial progress. The MOH plans to allocate half that funding to LGs and facilities through an RBF mechanism, which will represent a significant new source of funding at subnational levels. Successful RBF implementation could provide the foundation to support advocacy for additional government budget and the design of a payment system for NHI. The assessment team offers the following recommendations:

National and Subnational RMNCH Funding

- The MOH and health sector stakeholders should develop and implement a coordinated and sustained advocacy effort to mobilize additional government resources for RMNCH, such as to improve commodity security or fill PHC-level health worker vacancies.
- In tandem with resource mobilization efforts, the MOH should work to improve budget execution efficiency at national and district levels, including PHC wage and nonwage spending.
- The MOH has prioritized HCIIIs because they are the first level PHC facility able to provide a complete package of essential services, including RMNCH. Nonetheless, HCIIs provide needed services close to the community and require additional funding and supervisory support through GOU and donors to deliver needed services to their communities.
- Funding to districts and facilities to support high coverage and quality of RMNCH services should be increased to provide resources to conduct health promotion, community mobilization, and regular supervision outside of those activities covered by donors. To achieve greater efficiency and coverage of community-based RMNCH services with available funding, outreach activities should deliver multiple services, such as immunization, FP, and other appropriate services.
- Targeted technical assistance is needed to improve the financing and supply chain system for RMNCH commodities to HCIIIs and HCIIs (a push system), with focus on addressing national challenges in forecasting, quantification, procurement, and distribution for RMNCH commodities.
- The process for discretionary development grants to LGs should be revisited so every LG has sufficient funds to make needed physical improvements and repairs to health infrastructure annually. Transparent criteria and guidelines for grant allocation are needed to ensure equity, while support to LGs to prepare and execute development plans is needed to address infrastructure deficiencies.
- Reforms to budgeting processes and resource mobilization strategies should mitigate the effects of verticalizing funding by programs, specifically for RMNCH.

RBF Scale-Up

- The MOH should convene a broad stakeholder group to gather inputs, generate additional support, and synthesize lessons learned to develop a detailed plan for RBF scale-up.
- Health sector partners should support the MOH to establish appropriate monitoring and evaluation processes to ensure that RBF achieves its intended objectives.
- RBF implementers should consider streamlining claims processing to improve efficiency.
- Although the MOH intends to prioritize public providers in RBF expansion, strategic engagement of the private sector should be considered to maximize access and reduce OOPEs.

NHI Planning

- NHI planning will require a detailed road map and external support; implementing partners should consider providing direct support to this process, including inputs on how the reforms can best use strategic financing to address RMNCH service delivery challenges.

Appendix: List of Key Informants

Informant	Title, affiliation
National	
Immaculate Ampaire	Medical Officer, EPI, MOH
Dr. Jesca Nsungwa Sabiiti	Assistant Commissioner Child Health, MOH
Phiona Atuhaire	Senior Policy Analyst, MOH
John Ssengendo	Uganda Reproductive Maternal and Child Health Services Improvement Plan, Project Coordinator, MOH
Owen Abidrabo	Principal Inspector, MOLG
Ishmael Ahmed	Acting Principal Inspector, MOLG
William Nyombi	Program Manager, MSU
Dr. Musila Timothy	Senior Health Policy Planner, Private Sector, MOH
Galbert Fedjo	PNFP Project Co-Manager, BTC, MOH
Peter Asiimwe	National Technical Assistant – MOH, PNFP Project, BTC
Bodo Bongomin	Child, Adolescent Health, Nutrition National Professional, World Health Organization
Dr. Sarah Naikoba	Child Health Technical Lead, Maternal and Child Survival Program
Thomas Aliti	Assistant Commissioner, Planning and Policy; Lead NHA and Insurance, MOH
Ezra Trevor Rwakinanga	Technical Assistant – Health Financing (NHA), MOH
Juliet Kyoheire	Senior Health Desk Officer, Ministry of Finance, Planning and Economic Development
Christine Mugasha	Senior Health Advisor, USAID
Alfred Boyo	Senior Health Advisor, USAID
Garoma Kena	Senior Health System Strengthening Advisor, USAID
Kaliro District	
Wycliff Ibanda	Elected District Chairperson, Local Council V
Fred Kizito Mukasa	Chief Administrative Officer
Dr. Sara Kasewa	DHO
Andrew Kisame	Cold Chain Technician
Robert Kikomeko	In-Charge, Namugongo HCIII
Eface Nakigudde	Senior Midwife, Namugongo HCIII
Jennifer	Nursing Assistant, Namugongo HCIII
Margaret Onyet	Owner, Nursing Officer, Dr. Ambrosoli Memorial HC (Private Health Facility)
Nicholas Engwu	Regional Coordinator East, MSU Voucher Project
Paul Kibirige	In-Charge, Bumanya HCIV
Christine Mwogeza	Head, Nursing Department, Bumanya HCIV
Elliot Wambuzi	Village Health Team, Bumanya HCIV
Mary Goretti Baseke	Senior Midwife, Bumanya HCIV
Felister Drijaru	In-Charge, Buyinda HCII

Informant	Title, affiliation
Mbarara District	
Peter Ssebutinde	DHO, Mbarara District
Justine Tumusiime	Health Management Information System Focal Person, Mbarara District
Agatha	Assistant DHO, Mbarara District
Emma Kente	Surveillance, EPI Focal Person, Mbarara District
Annette Agaba	Chief Financial Officer, Mbarara District
Alfred Byamukama	Principal Assistant Secretary, Mbarara District
Johnson Twijuke	District Planner, Mbarara District
Celestine	Logistics/Pharmaceuticals Focal Person, Mbarara District
Priscilla Natukunda	In-Charge, Kakoba HCIII
Oscar Tweheyo	Medical Officer, Ruharo Mission Hospital (PNFP)
Sylvia Ngabirano	Midwife, Ruharo Mission Hospital (PNFP)
Agnes Nyabweso	In-Charge, Kakigani HCII
Alan Twesigomwe	In-Charge, Senior Medical Officer, Kinoni HCIV
Allen Kiwanuka	Senior Midwife, Kinoni HCIV

Abbreviations: BTC, Belgian Technical Cooperation; DHO, District Health Officer; EPI, Expanded Program on Immunization; HC, health center; MOH, Ministry of Health; MOLG, Ministry of Local Government; MSU, Marie Stopes Uganda; NHA, National Health Accounts; PNFP, private, not-for-profit; USAID, US Agency for International Development.

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