Uganda:
Strategic purchasing strategies and emerging results
**WELCOME TO UGANDA**

- Uganda is a land-locked country in East Africa with a young population (47.4% below 14 years of age) and high population growth (3.6%). Most of the population (76%) live in rural areas.

- While average annual GDP growth during the last 20 years is high for the region (6.3% in Uganda, 4.3% in Sub Saharan Africa), a large portion (41.7%) of Ugandans live in poverty.

<table>
<thead>
<tr>
<th>Indicator (2019)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (million)</td>
<td>44.3</td>
</tr>
<tr>
<td>Population growth (annual %)</td>
<td>3.6</td>
</tr>
<tr>
<td>Urban/rural divide (% of pop.)</td>
<td>24.4/75.6</td>
</tr>
<tr>
<td>Population ages 0-14 (% of total)</td>
<td>46.5</td>
</tr>
<tr>
<td>Population ages 15-64 (% of total)</td>
<td>51.5</td>
</tr>
<tr>
<td>Population ages 65 and above (% of total)</td>
<td>2.0</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>63.0</td>
</tr>
<tr>
<td>GDP growth (annual %)</td>
<td>6.8</td>
</tr>
<tr>
<td>GDP per capita (current US $)</td>
<td>794.3</td>
</tr>
<tr>
<td>Poverty headcount ratio at $1.90 day (2011 PPP) (% of population)</td>
<td>41.3 (2016)</td>
</tr>
<tr>
<td>Human Development Index (HCI) (scale 0-1)</td>
<td>0.4 (2020)</td>
</tr>
</tbody>
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MNCH CONTEXT: HIGH MATERNAL MORTALITY REMAINS A PROBLEM

- The maternal mortality rate (MMR) remains high at a rate of **336 deaths per 100,000 live births**, despite an increasing rate of births in facilities and ANC and PNC coverage nationwide.
- Evidence from the Uganda Hospital and Health Centre Census Survey point to **limited-service availability and readiness** within different health facility (HF) levels as contributors of the high MMR.
- Where the public sector is unable to meet demand for health services, a private sector of health providers has grown, particularly in Kampala.

Sources: Uganda Bureau of Statistics 2018; World Health Organization 2019
FAMILY PLANNING CONTEXT: IMPROVING TRENDS IN UPTAKE, BUT UNMET NEED IS HIGH

- Modern contraceptive prevalence (mCPR) is low (29.2%), but slightly above the regional average (24.5%)
- Large mCPR disparities across education, wealth, and residence groups
- Unmet need for FP (32.5%) and total fertility rate (5.4) remain high

<table>
<thead>
<tr>
<th>Indicator (2019)</th>
<th>Uganda</th>
<th>Africa</th>
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<tbody>
<tr>
<td>mCPR (all women) (%)</td>
<td>29.2</td>
<td>24.5</td>
</tr>
<tr>
<td>mCPR (married or in union) (%)</td>
<td>37.2</td>
<td>29.5</td>
</tr>
<tr>
<td>Percentage of women with an unmet need for modern methods of contraception (married or in union)</td>
<td>32.5</td>
<td>25.1</td>
</tr>
<tr>
<td>Percentage of women whose demand is satisfied with a modern method of contraception (married or in union)</td>
<td>53.4</td>
<td>53.6</td>
</tr>
</tbody>
</table>

Source: Track20 2020

The Ugandan health system includes both public and externally funded purchasers. Based on allocation decisions at the Ministry of Finance, Policy, and Economic Development (MOFPED), the Ministry of Health (MOH) centrally coordinates the government purchase of health services through decentralized local governments. There is consistent underfunding of public health facilities that are mandated to provide free care to all residents of Uganda, leading to poor quality and lack of availability. A large portion of facilities in the country are private, contributing to high out-of-pocket (OOP) spending.

**Government Purchasing**

- **Sources of revenue:** Government tax revenues and external financing
- **Benefits:** The Uganda National Minimum Health Care Package (UNMHCP) defines benefits for all Ugandans.
- **Facilities contracted:** Public and contracted private-not-for-profit (PNFP) facilities.
- **Provider payments methods:** Conditional wage, operating, and development grants, centrally distributed drugs and supplies, and results-based financing.

**Donors**

- **Sources of revenue:** Multi-lateral, bi-lateral, and private/foundation grants
- **Benefits:** Based on donor priorities within UNMHCP and project scope. Strong focus on HIV/AIDS, malaria, FP, MNCH, and tuberculosis.
- **Facilities contracted:** Public, PNFP, private health provider (PHP) facilities, and community-based care
- **Provider payment methods:** Varies widely from on-budget support, grants to facilities, direct project support, vouchers, results-based financing (RBF) to individual salary supplements and per diems

HEALTH FINANCING

- Government expenditures on health are below commitments to the Abuja targets of 15%. In 2020/21 Uganda’s government expenditures on health dropped to 5.9%, down from 7.4% the previous year. Due to high population growth rates, per capita spending on health has continued to drop.

- In the 2018/19 fiscal year, the GOU spent US$10.40 per capita on health, inclusive of on-budget external financing. An estimated US$3.24 of this was primary health care through local government conditional grants.

- Per capita allocations for PHC have been decreasing, however in 2018/19 PHC Grants increased with support from the Uganda Inter-Governmental Fiscal Transfers (UgIFT) project.

DECENTRALIZATION IN UGANDA

- Political decentralization was introduced in 1986 to promote participation in the democratic process by establishing a five-tiered administrative structure from the district to village levels. Following nearly a decade of progress, a new constitution was enacted in 1995 and the Local Government Act in 1997 that devolved public service delivery.

- Significant progress was made in fiscal decentralization until 2005 when the central government curtailed local government revenue by ending the graduated tax which was a major source of district revenue. In 2008 district autonomy was further reduced when Chief Administrative Officers (CAOs) became centrally, rather than locally, appointed.

- In this context, the district-managed PHC levels of the health system became dependent on conditional grants limiting their autonomy and greatly reducing the district role as a purchaser in the health system.

Over the past several decades, Uganda has implemented a range of health financing and purchasing reforms, that including broad decentralization efforts, increased use of conditional grant funding, introduction and removal of user fees, and extensive trials of both supply and demand side results-based financing mechanisms.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>Health Policy Review Commission recommends introduction of user fees which are rejected by Parliament</td>
</tr>
<tr>
<td>1989</td>
<td>National Health Plan introduced the Uganda National Minimum Healthcare Package (UNMHC Package), further emphasizing decentralization</td>
</tr>
<tr>
<td>1997</td>
<td>User fees introduced through the Local Government Act</td>
</tr>
<tr>
<td>1999</td>
<td>User fees abolished</td>
</tr>
<tr>
<td>2000</td>
<td>Uganda National Minimum Health Care Package (UNMHC) introduced</td>
</tr>
<tr>
<td>2003</td>
<td>Supply-side results-based financing introduced</td>
</tr>
<tr>
<td>2005</td>
<td>Government embezzlement scandal (point of fragmentation)</td>
</tr>
<tr>
<td>2008</td>
<td>First voucher program starts</td>
</tr>
<tr>
<td>2010</td>
<td>Purchasing reforms for UHC defined by the Health Financing Strategy</td>
</tr>
<tr>
<td>2012</td>
<td>RBF financing scaled-up nationwide</td>
</tr>
<tr>
<td>2016</td>
<td>Planning begins to integrate RBF into GOU PHC financing mechanisms</td>
</tr>
<tr>
<td>2020</td>
<td>Last voucher program ends</td>
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<tr>
<td>2021</td>
<td>National Health Insurance Scheme (NHIS) bill approved by cabinet, still awaiting full approval into law by Parliament and the President</td>
</tr>
</tbody>
</table>
KEY CONSIDERATIONS THAT HAVE INFORMED THE EVOLUTION OF OUR STRATEGIES

The GOU purchases health services through the Ministry of Health, national agencies, and local decentralized governments responsible for PHC services.

A large proportion of facilities in the health system are private providers that are largely uncoordinated by health authorities.

The public health system is underfunded, and reliant on multiple sources of donor support which cause fragmentation and inequity in resource distribution.

In Kampala, an estimated 95% of facilities are private with underfunded public facilities facing high levels of demand for free services.

Working within the Ministry of Health, ThinkWell provides technical assistance to results-based financing efforts towards integration into government systems.

Working within the Kampala Capital City Authority health department, ThinkWell is exploring opportunities to engage private providers.

ThinkWell aims to support efforts to improve the coherence in the purchase of PHC services from all types of providers through generation of evidence, technical assistance, and policy dialogue.
SP4PHC PROGRAM STRATEGIES IN UGANDA

Support MOH to harmonize and strengthen government purchasing arrangements

- Provide embedded technical support to the MOH RBF Unit to assist with the national roll-out of RBF under the GFF-World Bank supported URMCHIP mechanism.
- Provide technical assistance to efforts of the MOH to transition the RBF system to government PHC financing mechanisms under the Uganda Inter-Governmental Fiscal Transfer Project (UgIFT).
- Provide ongoing technical support to MOH efforts to establish a National Health Insurance Scheme (NHIS).

Support development of GOU purchasing of FP and MNCH services from private providers

- Joint study with the Ministry of Health of Uganda’s voucher experiences to inform future health system purchasing reforms.
- Support the Kampala Capital City Authority (KCCA) health directorate to design and implement a proof-of-concept public-private purchasing partnership for essential RMNH services.
**RMNCAH Sharpened Plan (2013 – 2017) and the RMNCAH Investment Case (2017-2020)**

With the goal to end preventable maternal and child deaths in Uganda, the plan includes a set of five strategic shifts designed to end preventable maternal and child deaths in Uganda:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Sharpened Plan 2017 Targets</th>
<th>Investment Case 2020 Targets</th>
</tr>
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<tbody>
<tr>
<td>Maternal mortality ratio (/100K)</td>
<td>438 to 211</td>
<td>336 to 219</td>
</tr>
<tr>
<td>Under 5 mortality rate (/1K)</td>
<td>90 to 53</td>
<td>64 to 47</td>
</tr>
<tr>
<td>Infant mortality rate (/1K)</td>
<td>54 to 30</td>
<td>43 to 32</td>
</tr>
<tr>
<td>Neonatal mortality rate (/1K)</td>
<td>27 to 10</td>
<td>27 to 15</td>
</tr>
<tr>
<td>Teenage pregnancy rate (%)</td>
<td>24% to 15%</td>
<td>25% to 14%</td>
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Building on the Sharpened Plan, the subsequent Investment Case updated the strategic shifts and targets, and provided cost estimations for three possible scenarios over a five-year period using 2014/15 as a baseline:

- **Scenario 1**: Current intervention coverage maintained
  - Cost: US$ 1.6 B
  - Gap: US$ 500 M
- **Scenario 2**: Rapid scale up of prioritized core services delivered countrywide
  - Cost: US$ 1.92 B
  - Gap: US$ 820 M
- **Scenario 3**: Full expanded package of services delivered countrywide
  - Cost: US$ 2.2 B
  - Gap: US$ 1.1 B

**The Uganda Reproductive, Maternal, and Child Health Improvement Project (2018-2022)**

- Financed by GFF, the World Bank, and Sida for $180M and implemented by MOH, it supports scale up of RMNCAH services based on Sharpened Plan and Investment Case.
- Implementation began in 2018 and will run through December 2022.
- Qualification and contracting of facilities took place in four cohorts to achieve nation-wide coverage:
  - Phase 1 (October 2018): 323 PHC facilities.
  - Phase 2 (March 2019): 404 PHC facilities.
  - Phase 3 (January 2020): 462 PHC facilities.
  - Hospital Phase (January 2020): 69 hospitals engaged to provide referral services.
- Key Challenge: Slow processing of facility performance invoices and payment of RBF revenues.

The current MOFPED UgIFT project, supported by the World Bank, aims to ensure PHC financing is adequate and equitable.

- The MOFPED Intergovernmental Fiscal Transfer Reform Program (IFTRP) supports the Fiscal Decentralization Strategy (FDS) with five strategic aims for service delivery funding:
  - Increase local government discretion
  - Restore adequacy and equity
  - Shift to accountability for results

- A political focus on infrastructure at the expense of social services led to the IFTRP not being effectively implemented. The FDS was given new emphasis in the second National Development Plan (15/16 – 19/20) and the initiation of the World Bank supported Uganda Intergovernmental Fiscal Transfer project (UgIFT).

- UgIFT is a Program for Results (PforR) mechanism funded for a total of $788 million (including a $200 million IDA credit), which started in 2018 and runs for 5 years. It aims to improve the adequacy and equity of fiscal transfers and improve fiscal management of resources by local governments.

Planning for a Phase II of UgIFT includes institutionalization of RBF approaches in the health sector and beyond.

- The MOFPED is currently in the process of developing a Phase II for additional funding to the UgIFT project which will begin in the 2021/22 financial year.

- Under the revised UgIFT, the RBF mechanism established by the URMCHIP project will be transitioned to become an integral part of the conditional PHC grant mechanisms in the health sector.

- Additionally, RBF mechanisms will be introduced into the education and agriculture sectors, also supported by UgIFT.

- The current RBF institutional setup and processes in the health sector will remain largely the same. Details are still emerging in this ongoing design process.

- Current plans include an expanded list of output indicators that measure facility performance that include RMNCAH, HIV, TB, NCDs, and Nutrition.

- As a key technical partner within the MOH RBF unit, ThinkWell is providing support to analyse RBF operational data, identify bottlenecks in the RBF invoice-payment cycle, develop technical documentation and facilitate policy discussions with the MOFPED and stakeholders in the design of the RBF as a GOU purchasing approach.
ENGAGING PRIVATE PROVIDERS: REPRODUCTIVE HEALTH VOUCHER SCHEMES

Voucher schemes are one approach Uganda has used for more than a decade to improve access by the poor to FP and MNCH services that contracted private providers to deliver services. The latest two voucher initiatives were the Uganda Voucher Plus Activity (UVPA) and the Uganda Reproductive Health Voucher Project (URHVP-II). Both started in 2016, covered approximately half of the country, shared many design features, and provided support to rural poor pregnant women for approximately three years.

The URHVP-II was a five-year MOH project financed by grants from the World Bank and UNFPA and was implemented by Marie Stopes Uganda. The UVPA was financed by USAID through Abt Associates. The catchment districts were chosen to avoid overlaps and contribute to national voucher coverage.

In early 2020, ThinkWell and the Uganda Ministry of Health (MOH) collaborated to study the UVPA and URHVP-II voucher experiences. The purpose of this effort was to capture what had been achieved by the voucher schemes and distill what could be taken forward to future health system purchasing reforms.

How they worked

Implementation Structures: The UVPA and URHVP-II schemes used Voucher Management Agencies (VMAs) as independent purchasers that selectively contracted public, not-for-profit, and private providers.

Benefit Package: In response to access barriers for poor women in rural areas, the voucher projects defined a benefits package of prioritized FP and MNCH services that included 4 ANC visits, safe delivery, 2 PNC visits, and postpartum FP.

Demand Creation: Voucher schemes undertook large efforts to generate demand through community mobilization. They engaged voucher distributors to conduct poverty assessments that identified rural poor pregnant women, qualifying them to purchase a voucher at the subsidized price of approximately $1.00. The voucher entitled poor women to a benefit package from a voucher service provider (VSP) near their home.

Providers: Selective contracting of VSPs was from potential BEmONC and CEmONC facilities to establish referral networks. VSPs were predominantly private and not-for-profit facilities. Private wings in high-level public facilities were also contracted.

Quality Assurance: The UVPA and URHVP-II voucher schemes used the MOH facility assessment tool, augmented by Marie Stopes International, to measure quality, but opted for an external mentorship-based approach to quality improvement.

Claims Management: As both voucher projects mainly contracted with private facilities, they established robust claims management systems that controlled for fraud.

ENGAGING PRIVATE PROVIDERS: REPRODUCTIVE HEALTH VOUCHER SCHEMES

Lessons Learned

✓ The voucher benefits package brought focus to FP and MNCH services. The voucher schemes extended access to FP and MNCH services by rural poor pregnant women by combining poverty targeting, demand creation, quality improvement efforts, and performance management of providers.

✓ The voucher projects created dynamic service delivery networks. By contracting all types of facilities, private and public, the voucher schemes established flexible networks of providers to serve poor, hard-to-reach populations. A fundamental design limitation was that voucher schemes could not work in areas with no providers.

✓ Contracted providers improved their capacity and performance while being held accountable. Being paid fair rates for the services they provided, providers had the necessary resources and autonomy to ensure the availability of services to meet demand.

✓ Provider investments drove quality improvements. With strict contract obligations and project-supported mentoring, contracted voucher service providers improved their capacity and quality of care by investing their voucher revenues back into their facilities. Facilities’ Clinical Audit Scores rose significantly from 2016-2019 under both programs.

✓ Contract-based purchase of services requires that significant levels of administrative capacity. Claim management systems are an essential part of ensuring transparency and accountability. Claim submission issues from providers or slow review processes by the purchaser can delay provider payments and interrupt service delivery, eroding trust in the system.

✓ There were concerns that voucher projects were too expensive. While the projects’ overhead costs were high, they included the investments required to startup a demand-side purchasing mechanism. Absent the investment costs, the recurring administrative costs of a government-managed demand-side purchasing mechanism would likely be lower.

Suggested Steps Forward

➢ Continue efforts to establish a government-financed demand-side purchasing mechanism.

➢ In a new demand-side scheme, plan to progressively realize a comprehensive benefits package by starting with a focus on FP and MNCH services.

➢ Explore cost-efficient modalities to purchase services from private facilities.

➢ Explore design options for claims management systems that prevent provider payment delays.

Strategy 2

Lessons Learned

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ENGAGING PRIVATE PROVIDERS: DECONGESTING RMNH SERVICES IN KAMPALA

- In close partnership with the KCCA health directorate, the Uganda team has been requested by the Director, Dr. Daniel Okello, to explore the possibility of decongesting RMNH services in Kampala’s public referral facilities through partnerships with private providers.

- The goal of this work is to develop a workable model for a public-private service delivery arrangement that can be used to advocate for the necessary funding for initial implementation.

Problem

- Services at public health facilities managed by the Kampala Capital City Authority (KCCA) are perceived as congested.

Rapid assessment

- ThinkWell conducted a rapid assessment of maternal, newborn, and child health (MNCH) and family planning (FP) services in 2 purposively selected facilities, Kawaala Health Center (HC) IV and Kisenyi HC IV, which are managed by KCCA.

Purpose

- Assess the level of congestion of MNCH and FP services
- Understand the factors that contribute to overcrowding of KCCA facilities and how these impact access, efficiency, and quality of service delivery

Levels of RMNH Service Congestion

- **Maternity Ward BOR**
  - Kisenyi: 63%
  - Kawaala: 88%
- **ANC capacity**
  - Kisenyi: 164%
  - Kawaala: 219%
- **PNC Capacity**
  - Kisenyi: 138%
  - Kawaala: 175%
- **FP Capacity**
  - Kisenyi: 138%
  - Kawaala: 169%

Rapid Assessment Findings

- Large numbers of ANC and FP clients physically congest both facilities and compromise the quality of ANC, FP, and PNC services: short consultations, exhausted midwives, long waiting times, and early discharges.
- Inefficient use of health workers, with some midwives working on non-RMNH services while with large numbers of ANC and FP clients have insufficient midwives to ensure quality service.
- The facilities are understaffed with doctors for surgical deliveries, despite being referral centers.

Key Recommendation

- KCCA to establish Kisenyi and Kawaala as referral hubs that use purchasing arrangements with private providers able to deliver ANC, FP, and PNC services. This hub-and-spoke network arrangement would decongest the public facilities and allow concentration of resources on referral deliveries.

Next Steps

- Analyze midwife work loads, referral trends, identify potential private providers and readiness, economic analysis, recruitment of stakeholders to support establishment of a public-private partnership using the recent response to COVID-19 as an example.
STRATEGIC PURCHASING LEARNING AGENDA IN UGANDA

- To support our work in both strategies #1 and #2, the Uganda team has established a learning agenda specific to Uganda and relevant to global strategic purchasing questions.

- SP4PHC is currently supporting primary research by Makerere University School of Public Health to assess district and facility levels of autonomy in Uganda’s decentralized system. The study will explore the *de jure* versus *de facto* levels of autonomy as they relate to fiscal and operational decision making, the use and accounting of resources, and the purchasing arrangements and reporting mechanisms that have been put in place for COVID-19 related activities and services.

- The following are the key learning agenda products from Uganda produced by SP4PHC.

Factsheets:
- Country Factsheet: Uganda 2020
- Family Planning Fund Flow Map: Uganda – in progress
- Health Financing in Uganda – in progress
- Maternal and Newborn Health in Uganda – in progress

Reports:
- How Primary Health Care Services are Financed in Uganda: A Review of the Purchasing Landscape
- Uganda’s Emergency Response to the COVID-19 Pandemic: A Case Study
- Reproductive Health Voucher Schemes in Uganda: How They Worked and Lessons for the Future
- Country Case Study: Decentralization in Uganda – in progress
- Overview of Health Financing Flows in Uganda – in progress
- Financial management of COVID-19 purchasing arrangements at the district and facility levels of Uganda’s health system – in progress

Blogs:
- A necessity, not a choice: the case for purchasing COVID-19 services from the private sector in Uganda
- From Ebola to COVID-19: How Uganda Can Adapt its Response to the Current Crisis
- How can decades of learning from vouchers in Uganda inform an emerging NHI? – in progress

Posters:
- Reproductive Health Voucher Schemes in Uganda: Key Lessons for the Future

Decks:
- COVID-19: Summary Update for Uganda
- Results-Based Financing in Uganda – How it Works and Key Issues – in progress
- Kampala public facility congestion landscaping and potential solutions through private sector contracting – in progress
FINAL REFLECTIONS: SP4PHC’s CONTRIBUTION

Within the efforts of the MOH to establish RBF mechanisms as an integral part of government PHC purchasing and plan for an eventual national health insurance scheme, provide analytics and technical support to improve the adequacy and equity of PHC financing.

Building on strong working relationships built during the response to COVID-19 with Kampala’s health authorities, support co-creation of purchasing approaches for private providers to decongest the city’s public facilities and provide a proof-of-concept for larger health reforms.

Build evidence, stakeholder networks, and awareness of key health purchasing issues at the national level to leverage opportunities for greater coherence across purchasing mechanisms, particularly in the financing of FP and MNCH services.
Pivoting to the Pandemic

As the COVID-19 pandemic rapidly spread around the world in 2020, the SP4PHC project pivoted to incorporate activities to respond to the crisis even as it continued to work towards its original mission.

In all five project countries, ThinkWell staff responded to government requests for support and more information on our COVID-related activities and learnings can be found here.

To stay updated on all the latest insights and events from the SP4PHC team, visit our Latest News page.
Thank you

https://thinkwell.global/projects/sp4phc/uganda/