UGANDA

COUNTRY CONSULTATION REPORT

Key Findings

DRAFT FOR REVIEW

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This report was prepared as a part of a five-country consultation for the African Collaborative for Health Financing Solutions project. The report was jointly contributed to by a team of writers, analysts and ACS team members who travelled to Uganda for one- on- one interviews. Juliana Hagembe, Ben Mbaya and Kathleen Axelrod provided background and writing support; Danielle Bloom and Katie Van Es coded interviews; Danielle Bloom provided an initial analysis of the data.

Executive Summary

Uganda is located in East Africa and lies about 800 kilometers inland from the Indian Ocean. According to the 2014 census, the country has a population of 34.6 million people comprised of 51% females, with 55% of the population under 18 years. The Total Fertility Rate (TFR) is 5.8 children per woman and the Maternal Mortality Rate (MMR) is 438 per 1000. The Infant Mortality Rate (IMR) is 53 infant deaths per 1000 live births. Nearly 75% of the population live in rural areas.

The Ugandan health sector is a mixed delivery health system including government, development partners and their implementing agencies, private-not-for-profit, private-for-profit, civil society, and the informal health sector including traditional and complementary medicine practitioners and unlicensed private practitioners. Llike many countries throughout the world, Uganda has joined the global movement towards UHC. While the concept is relatively new in Uganda, the government of Uganda (GoU) has put many policies in place for years that contain various elements of UHC including the creation of a *National Health Insurance (NHI)* scheme and other community health insurance programs (CBHI). However, there is no consensus on the NHI bill's content. For the last two decades, health officials and political leaders have pondered the introduction of a NHI scheme. In 2006, the MoH drafted a Bill and re-introduced it in 2014, but the Cabinet has yet to approve it upon submission of a Regulatory Impact Assessment Report.

The African Collaborative for Health Financing Solutions project (ACS) conducted a detailed consultation phase as a way to hone in on core challenges faced by countries in moving forward UHC, elucidate potential solutions, and ultimately inform framing of the ACS implementation approach. Uganda was one of five countries of the consultation process as well as a number of regional and global actors who were also consulted.[1] Consultation countries included: Burkina Faso, Nigeria, Senegal, Tanzania, and Uganda. A team of six ACS staff and consultants conducted approximately 29 interviews during October 10-18, 2017, meeting with a broad array of stakeholders from across sectors and levels of implementation (see Annex 5 for interview profiles).

Key findings from the consultation include the following:

- There is no common understanding or definition of UHC among stakeholders in Uganda. They used a variety of phrases to define UHC in their country context. The most common terms used included: *"health for all"*, "*access", "healthcare", "coverage",* and "*without financial barriers/risk."*.
- Respondents generally believed that the pace of progress towards UHC is slow and identified several barriers to moving towards UHC. These include low levels of funding, lack of political leadership and effective governance, lack of learning and knowledge sharing around UHC, lack of a common understanding of UHC and the difference between it and health insurance, a lack of an operational plan to implement UHC, lack of community involvement, and both poor coordination and low ability to hold stakeholders accountable to UHC.

[1] Consultation countries include: Burkina Faso, Nigeria, Senegal, Tanzania, and Uganda.

- There is no single UHC strategy in Uganda. Respondents stated that elements of UHC are embedded in many government policies without an over-arching framework and operational plan for its implementation.
- Lack of coordination or synergy among different initiatives, thus, resources are not aligned across GoU agencies and health stakeholders.
- On collaboration, it was found that not all actors relevant to UHC are involved in the policy dialogue or the UHC process. Those mostly involved are implementing partners, MoH, and CSOs, while the private sector is not fully involved in the dialogue.
- All stakeholders agreed there is no single forum that brings together all the relevant stakeholders supporting UHC and recommended the establishment of such platform.
- Respondents listed a number of barriers to stakeholder engagement on UHC including: old mindset on stakeholder engagement fostering mistrust between public and private sectors, general perception that health is the sole responsibility of the MOH, lack of common understanding of UHC and inadequate collaboration skills
- Overall, stakeholders ranked accountability activities as the largest barrier, with supporting platforms for exchange as the second-highest ahead of learning.

Based on these findings, the USAID Uganda Mission ACS to provide support to establish a collaborative and inclusive process to develop an action-oriented roadmap for implementing UHC-related strategies in Uganda

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Acronyms

ACS	African Collaborative for Health Financing Solutions		
AHSPR	Annual Health Sector Performance Reports	PHC	Primary Health Care
CBHI	Community Based Health Insurance	PNFP	Private-not-for-Profit
CCI	Composite Coverage Index	R B F	Results Based Financing
CGS	Coverage Gap Scores	RHV	Reproductive Health Vouchers
CSO	Civil Society Organization	SPEED	Supporting Policy Engagement for Evidence-based Decisions
DP	Development Partners	SSA	Sub-Saharan Africa
FBOs	Faith-based Organizations	TCMP	Traditional and Complementary Medicine
GoU	Government of Uganda	THE	Total Health Expenditures
		TWG	Technical Working Group
HFS	Health Financing Strategy	UBOS	Uganda Bureau of Statistics
HRH	Human Resources for Health	UDHS	Uganda Demographic Health Survey
HSDP	Health Sector Development Plan	UHC	Universal Health Coverage
HPAC	Health Policy Advisory Committee		
MCH	Maternal and Child Health	UGX	Ugandan Shilling
MOH	Ministry of Health		
M/RH	Maternal and Reproductive Health	UCMB	Uganda Catholic Medical Bureau
NHA	National Health Accounts	UNMHCP	Uganda National Minimum Health Care Package
NHI	National health Insurance		
NHP	National Health Policy	USAID	United States Agency for International Development
OOP	Out-of-Pocket	WHO	World Health Organization
PFP	Private-for-Profit	WB	World Bank

1. BACKGROUND

The Ugandan health sector is ***a mixed delivery health system*** of various stakeholders including government, development partners (DPs) and their implementing agencies, private-not-for-profit (PNFP), private-for-profit (PFP), civil society, and the informal health sector including Traditional and Complementary Medicine (TCM) practitioners and unlicensed private practitioners (See Annex 1 for overview). There is a complexity of challenges that the Ministry of Health (MoH) confronts in its lead role as steward of Universal Health Coverage (UHC) initiatives, including diverse and somewhat fragmented private health sectors and Civil Society Organizations and non-Governmental Organizations [CSO/NGO] sectors, the considerable number of informal health providers. There is a push to decentralize health decision making to district levels (O'Hanlon et al. 2016).

The total Current Health Expenditure (CHE) in Uganda in 2012/13 was Shs. 4,866 billion that translates to a per capita spending of Shs. 144,374 ($55). This increased in nominal terms by 1.7% and in real terms by Shs. 86 billion to 4,952 billion in 2013/14 that translates to a per capita spending of 146,941 ($56). The CHE for both years in a row is much lower than the Minimum $84 per capita recommended by WHO(CME) if quality care is to be provided by any country in sub-Sahara African Countries. Over the same period, PPP(GDP) grew in nominal terms by 4.7% on average and in real terms from Ushs. 58,865 Billion in 2012/13 to Ushs 68,400 Billion after rebasing in 2013/14. Current health spending as a ratio of GDP was at 8.2% for 2012/13 and 7.2% (after rebasing) for 2013/14

According to the Uganda's 2012-2014 NHA Report, total out of pocket expenditure by services paid for in Billions is as follows:

Services	2010/11	2011/12	2012/13	Percent for the 3 years
	Amount	Amount	Amount	
Consultation fees	35.3	40.8	47.3	2.3
Medicines	904.8	1047.6	1,212.50	59
Hospital/clinic charges	173.3	200.6	233	11.3
Traditional doctors' fees/medicines	47.5	55.0	63.3	3.1
Other expenses/transport	372.6	431.5	500.1	24.3
TOTAL	1,533.50	1,775.60	2,056.30	100

As the health indicators in Annex 2 show, there has been a marked improvement in many health areas in the Uganda National Minimum Health Care Package [UNMHCP.] The Supporting Policy Engagement for Evidence-based Decisions (SPEED) project also analyzed Uganda's

Box 1. UNMHCP Main Categories

- ✓ Health promotion, environmental health, disease prevention, and community health initiatives, epidemic and disaster preparedness and response
- ✓ Maternal and child health
- ✓ Prevention, management, and control of communicable diseases
- ✓ Prevention, management, and control of noncommunicable diseases

progress towards achieving UHC.[2] The analysis focuses on availability, affordability, and acceptability of health services to develop a Composite Coverage Index (CCI) and Coverage Gap Scores (CGS) using data from the Uganda Demographic Health Survey (UDHS). Table 1 also confirms these positive trends: the CCI shows an overall improvement (the higher the score the better) in healthcare coverage between 2006 and 2011 at the national level as well as across rural/urban areas and all wealth quintiles. The index shows that there remains a considerable gap in attaining 100% coverage with CGS scores (the lower score, the better) demonstrate inequitable access to coverage between rural and urban and across income groups (see also Annex 3 for socioeconomic statistics).

Policy Frameworks Supporting UHC

Uganda, like many countries throughout the world, has joined the global movement towards UHC. While the concept is relatively new in Uganda, the government of Uganda (GoU) has put many policies in place for years that contain various elements of UHC (see Annex 4). The first step on the journey towards UHC was the introduction of the UNMHCP in 1999/2000 (see box 1). The Ugandan MoH continues to renew its commitment to the key principles outlined in UHC. Uganda's Health Sector Development Plan (HSDP) 2016-2020 emphasizes *"the need to accelerate movement towards UHC."* The second National Health Policy's (NHP II) objectives are aligned with those of UHC: increase access to a basic package of healthcare, shield consumers from catastrophic health spending; and ensure equity in access to health services (MoH, 2010). The GoU has launched several initiatives to address equity and efficiency such as subsidies of public health and essential clinical services (NHP I), abolishing user fees (HSSP I) in 2001, and near-universal access to the UMNHCP (HSSIP I and II).

Box 2. Health Finance Strategy

Goal: To facilitate the attainment of UHC through enabling effective/efficient delivery of and access to the essential package of health services while reducing exposure to financial risk, by 2025.

Objectives: Key HFS strategies related to UHC framework include:

- ✓ Mobilize resources to finance UNMHCP
- ✓ Implement a Social Health Insurance scheme that covers 30% of the population
- ✓ Strengthen strategic purchasing to ensure equitable/efficient allocation of resources

In 2016, the MoH published a Health Financing Strategy (HFS) that closely links HFS to UHC. As Box 2 shows, the HFS is focused on addressing the economic and financial barriers to achieving UHC. Below is a discussion of the MoH's progress in implementing the HFS strategies related to UHC.

Health Insurance. A key element of the HFS is the creation of a *National Health Insurance (NHI)* scheme and other community health insurance programs (CBHI). However, there is no consensus on the NHI bill's content. For the last two decades, health officials and political leaders have pondered the introduction of a NHI scheme. In 2006, the MoH drafted a Bill and re-introduced it in 2014, but the Cabinet has yet to approve it upon submission of a Regulatory Impact Assessment Report. The public is also not fully supportive of the NHI proposal for a variety of reasons including poor publicity and limited efforts to sensitize the public, and perception that is an additional tax on the public (O'Hanlon et al., 2016).

There is also *private health insurance* in Uganda. Corporate employers offer health benefits to their employees and the employees' dependents (HFS, 2016). The benefits covered are largely curative, including some inpatient services. There are over 20 licensed commercial insurance firms in the country, of which five provide private health insurance. Penetration of private health insurance remains less than 1%.

Community Based Health Insurance (CBHI) has been in practice for over three decades in Uganda, but has not policy framework guiding it. Most of the CBHI schemes are hospital-based (primarily with PNFP facilities) and managed by the respective communities. A 2015 inventory shows that there are 23 CBHI schemes in 17 districts. Their sizes vary from as few as 180 to 36,000 members. The CBHI benefits mostly

[2] Okokonyero, T. et al. 2016.

cover inpatient care, outpatient care, minor surgeries, and diagnostics. CBHIs have struggled to become a viable insurance mechanism: their premiums are too low to ensure financial sustainability; the benefit packages are limited in scope and do not attract a sufficient number of beneficiaries; and, they are not professionally managed. The MoH acknowledged the importance of CBHIs, as demonstrated by their inclusion in the 2016 HFS and proposed NHI Bill. But there are no provisions in either of these policies to fund CBHIs despite their focus on the poor. (O'Hanlon et al., 2016).

Strategic Purchasing Despite the MoH's mandate to focus more on stewardship and governance, the MoH has not operationalized a purchaser-provider split and still functions as both the provider and purchaser of services in the public sector (HFS, 2016). However, the MoH is experimenting with purchasing arrangements, such as vouchers, service level agreements and performance-based financing. They show great promise in moving towards a purchaser-provider split and helping address economic barriers to health services (See Annex 4).

2. ACS CONSULTATION FINDINGS

The African Collaborative for Health Financing Solutions project (ACS) conducted a detailed consultation phase as a way to hone in on core challenges faced by countries in moving forward UHC, elucidate potential solutions, and ultimately inform framing of the ACS implementation approach. Uganda was one of five countries of the consultation process as well as a number of regional and global actors who were also consulted.[3] Consultation countries included: Burkina Faso, Nigeria, Senegal, Tanzania, and Uganda. A team of six ACS staff and consultants conducted approximately 29 interviews during October 10-18, 2017, meeting with a broad array of stakeholders from across sectors and levels of implementation (see Annex 5 for interview profiles). The following results were elucidated:

- Understanding of UHC as a concept, and perception of GoU level of support for and progress in implementing UHC related policies;
- Attitudes towards the inclusiveness of and mechanisms for dialogue on UHC policies and plans;
- Barriers to advancing UHC and innovative solutions to accelerate implementation of UHC related policies and programs; and
- Potential areas and technical priorities for ACS project support.

2.1. Background on UHC

Universal Health Coverage Definition

The Uganda stakeholders used a variety of phrases to define UHC in their country context. The most common terms used included: *"health for all"*, "*access", "healthcare", "coverage",* and "*without financial*

Box 3. UHC Definitions

"Healthcare provided to every individual, family, community irrespective of gender, social status, and means." Public Implementer

"Ensure the entire population has access to services without experiencing financial hardship and services are of quality." Technician

"There are many aspects to UHC. You need systems to support all these components. Another aspect is whether clients understand their rights to UHC and demand it." Technician

"Let me put it in a simple way - health for everybody of all ages…leaving no one behind…. but it should also be about consumers being responsible and taking care of their own health." Private Implementer

[3] Consultation countries include: Burkina Faso, Nigeria, Senegal, Tanzania, and Uganda.

barriers/risk." However, few interviewees explicitly used the term "*Universal*" (n=1) or used the terms "*minimum or basic package*" (n=2). Technicians, public implementers, and Development Partners (DPs) mentioned quality more often in their definitions.

In examining the different stakeholder definitions of UHC more closely, a total of three researchers and technicians referenced "*the WHO definition*" explicitly in their response, while other actors, including public and private sector representatives, used various other elements of the WHO definition (as above), potentially indicating an entry point for dialogue. Non-state actors, private sector representatives and private implementers as well as researchers and CSOs stressed financial protection more than the government stakeholders.

Government Commitment to UHC

Most respondents felt the country commitment to UHC is slightly above average (average score of 5.8 out of 10). However, the most common reasons stated for why there is not progress towards UHC is that the commitment does not result in action. Reasons include lack of GoU funding directed to the health sector to support implementation, and that the MoH has not been able "to make the case" using data or evidence effectively to move the UHC agenda forward.

One individual summarized both public and private stakeholders' perspectives on GoU commitment to UHC as "*Commitment is in words and not action*s." Additional reasons for why the GoU is not implementing policies and programs supporting UHC included UHC is a donor-driven concept; and that policies are not aligned with operational plans.

Box 4. Government Commitment to UHC

"I have not seen commitment from high levels of government…like the President, Prime Minister or Parliament…but there is opportunity to move forward." Public Implementer

The government is not driving the UHC agenda… it is donor-driven." Private Implementer

"The MoH readily and wholly embraces international goals like SDG and UHC. But they have yet to translate these commitments into action. Commitments have to be coupled with resources." Researcher

"There is not real clear commitment [to UHC], especially financially by the government. The [donors] commit funds, but the government commits less. So, you ask yourself, is the government really interested? Why don't they commit more funds?" Private Implementer

Barriers to moving towards UHC

All stakeholders interviewed – public, private, CSO and DPs alike – generally agreed that the pace of progress toward UHC is slow: they all gave implementation progress a below-average score (4 on a scale of 10). Three top reasons cited for slow progress noted across stakeholder groups were:

Low levels of funding are misaligned to policy priorities: Although many stated that the MoH does not have enough funds to implement its policies, others offered more nuanced interpretations on funding. For example, some technicians cited that MoH budgets do not reflect UHC priorities, and funds are not appropriately or efficiently allocated towards its implementation. Other private and public-sector implementers and researchers also stated that budget inputs (e.g., drugs, medical supplies, and infrastructure) are not aligned with UHC priorities.

Lack of political leadership and effective governance: The private sector made up more than half of respondents who indicated political leadership as an issue. One technician who identified this issue cited that lack of supportive supervision of private providers contributes to ineffective governance. While few referred directly to corruption, one public provider also referred to political interference in recruitment as a cross-cutting factor that impacts the hiring of high-quality staff.

Other top non-technical barriers to progress included barriers to learning and knowledge sharing around UHC, lack of a common understanding of UHC and the difference between it and health insurance by the MPs, a lack of an operational plan to implement UHC, poor skills to move forward policies and plans, lack of community involvement, and both poor coordination and low ability to hold stakeholders accountable to UHC. Importantly, respondents acknowledged that there is no cohesive plan to drive implementation of UHC. Respondents stated that elements of UHC are embedded in many government and MoH policies. But many also shared that no over-arching framework and operational plan is outlining how to achieve UHC by pulling together all the pieces. As a result, there is no coordination or synergy among different initiatives, and resources are not aligned across GoU agencies and health stakeholders. DPs' projects, implemented in silos and in some instances duplicating even one another's efforts (for instance, in the case of voucher programs), further hamper and fragment implementation of UHC-related policies and strategies.

Stakeholder priorities, activities and innovations

Stakeholders reported on their priorities and activities around UHC. Of their own organizations, seven stakeholders reported their organizations are committed to moving UHC forward as a priority with six signed on to commitments. However, only one organization reported being held accountable for those commitments. Organizations report supporting UHC in a variety of ways, with the top reported activities including conducting advocacy, championing policy development and conducting research. One civil society representative specifically mentioned holding government accountable for honoring commitments. Civil society and DP stakeholders most frequently referenced supporting work with a group at community levels.

Stakeholders also identified innovations at the country level. Many innovations were cited, but voucher programs were the most consistently referenced. Issues were flagged by some respondents as to the sustainability, coverage and access of these schemes.

Box 5. Pace of UHC Implementation

"We do not have a common understanding of UHC. Without this understanding how can it be achievable? Also, there are no credible champions advocating for UHC and no unifying platform that brings all the stakeholders together to focus on UHC." Technician

"The MoH has no 'big hammer' strategies towards UHC. Instead, policies are fragmented into pieces." Technician

"There is no one in the MoH with a degree in health economics. There is only one person who has experience in health policy. If there is no one with a policy or health economics background at the MoH, how can we design and implement UHC policies?" Technician

"There are other overarching barriers like human resources (HR). The level of training and technical competency varies. The competency of HR outside of Kampala is low." Private Implementer

"Without a 'roadmap,' it makes it difficult for Uganda to advance towards achieving UHC goals." CSO

2.2. Perceptions of UHC Dialogue

Collaboration on UHC

Not all actors relevant to UHC are involved in the policy dialogue or the UHC process. Implementing partners, the MoH, and CSOs are those most involved in platforms, while the private sector is not fully involved in the dialogue. Also, almost all the respondents noted a gap created by the absence of CSOs who represent the community perspective. Although CSOs are involved in some policy dialogue, CSO respondents stated their participation is mostly confined to specific health interventions.

Finally, DPs and private sector stakeholders agreed that there is a need for other government agencies to participate in UHC deliberations and platforms. Other stakeholders that were commonly cited as left out of the UHC dialogue were the community, politicians, local decision-makers, and Faith Based Organizations (FBO). Overall, public, private, and CSO stakeholders seem to engage with each other on some level. Most engagements of the private sector by MoH do not segregate the PHP and PNFP. For example, the Professional councils license the PFPs and PNFPs, SQIS is implemented in both. CSOs are involved in many health technical working groups (e.g., HIV/AIDs, MCH, TB, etc.) with the MoH but PFPs are not systematically included. Finally, DPs work with a range of stakeholder groups including training private providers in health insurance and financial management, training CSOs in statistical analysis and advocacy, and training MoH on community engagement to name a few. Because stakeholders work in silos on different aspects of UHC, they are not fully aware of what each other is doing to contribute to advancing UHC, thus making accountability to each other difficult.

Mechanisms for Collaboration

UHC is discussed in fragments. All stakeholders agreed there is no single forum that brings together all the relevant stakeholders supporting UHC. The respondents listed several policy platforms (see Table 4), with the SPEED platform being listed most consistently. They also offered insight into the challenges of existing platforms as a coordination mechanism for UHC (listed in order of priority and by stakeholder groups): i) platforms and forums are fragmented and operate in silos (technicians, public and private implementers, CSOs); ii) While most forums are chaired by the MoH or DPs, there MoH leadership of the health sector is perceived to be weak (technicians, public and private implementers, CSOs); iii) there are no policy forums that focus on UHC (all stakeholder groups); iv) there is poor coordination within and across stakeholder groups (technicians, private implementers, and CSOs,); and vi) there is an absence of champions for UHC – a recurring theme throughout the interviews.

Table 4. Policy Forums and Coordinating Mechanisms

Disease-specific Coordinating Bodies	DPs also fund and support entities (e.g., HIV/AID Coordinating Mechanism, Stop TB, RMNCH Initiative, etc.) to coordinate implementing partners' activities and reduce duplication of efforts. These mechanisms are primarily donor-driven. Not all stakeholders, particularly PFPs, are active in these coordinating mechanisms.
Health Policy Advisory Committee (HPAC)	HPAC is the principle policy forum for health, chaired by the Permanent Secretary of Ministry of Health with participation of most stakeholders active in health.. HPAC meets only monthly. Agenda priorities are generated monthly based on submissions from the Technical Working Groups and emerging policy issues. Monitoring implementation of the HSDP where UHC is featured in the goal is a priority in the HPAC annual workplan.
Supporting Policy Engagement for Evidence-based Decisions for Universal Health Coverage (SPEED Project)	SPEED Project partners are Makerere University School of Public Health, Economic Policy Research Centre, National Planning Authority and Uganda National Health Consumers' Organization. Although SPEED centers on UHC, it was criticized in some cases as not having broad involvement beyond MOH.
Technical Working Groups (TWG)	Most of HPAC's work is conducted through TWGs. Guidelines for the TWGs exist and require representation of the key partners on all TWGs however, in practice not all stakeholders (Academia, PFP, PNFP, and CSOs) are present on all TWGs. TWGs focus on health system issues (e.g., budget, NHI, HRH) or disease-specific

	topics (HIV/AIDS, MCH, TB, etc.).. Some TWGs, for example, Budget, MCH and PPPH, are more active than others primarily due to DP funding support.
Uganda National NGO Forum (UNNGOF)	UNNGOF is an inclusive national platform bringing together international and national NGOs, Voluntary Development Organizations, Farmer's Cooperatives and other citizen groups covering a diverse range of thematic areas. Health is one of the topic areas. It is very representative of NGOs but not other stakeholders in health. Also, the MoH does not participate in this Forum.

Barriers to Collaboration

The respondents revealed multiple barriers contributing to limited stakeholder engagement on UHC:

- "Old mindset" on stakeholder engagement persists, fostering *mistrust between the public and private sectors*. Poor communication among stakeholders also has contributed to suspicion among public, private and CSO stakeholders. Also, the MoH's approach to interacting with the private sector has aggravated mistrust.
- Another barrier is the general perception that *health is the sole responsibility of the MoH*, limiting other government ministries from being included in UHC dialogue and implementation of UHC policies. DPs and private implementers agreed that more ministries should be involved in policy forums and UHC discussions.
- Private, particularly PFP stakeholders, shared they would get more involved when they see *more MoH leadership on UHC*. The private sector respondents do not see the government and/or MoH spearheading the UHC agenda but instead perceive it as a donor-driven initiative. A private sector interviewee stated, *"Partners are pushing more [for UHC] than the MOH."* Moreover, the non-state stakeholders (private sector, CSO, researchers) state that "*there are no credible champions in the MoH or government advocating for UHC."*
- Technicians, private implementers, researchers cited the *lack of a common understanding of UHC* as a collaboration barrier. As a respondent shared, *"Without this understanding how can it be achievable?"* The lack of understanding reinforces a prior finding on the absence of a shared definition for UHC.
- Several cited a shortage of skills and capacity. MoH, private sector and CSOs expressed *inadequate collaboration skills*, such as consensus-driven decision-making, facilitation, and conflict resolution, to name a few. Technicians and public implementers named a *lack of technical skills* to prioritize and/ or expertise needed to implement strategic areas of UHC.

Despite the barriers to collaboration, there is a strong desire by all - public, private and CSO alike - to come together to discuss UHC and to make the investments (time, resources) to ensure that all stakeholder groups are involved. When discussing current platforms to raise the visibility of UHC, some

Box 6. Barriers to Collaboration on UHC

"The MoH convenes meetings with CSOs, community representatives, and religious leaders but PFP and PNFP are left out of those meetings. There is an NGO Forum led by the Community Development office, not the MoH." CSO

"A big barrier is the mistrust between private and public sectors. Many in the government do not believe in the private sector and don't think anyone should make money when delivering health services. Many in the private sector that believe the government is out to prevent them from making money." Technician

"We would get more involved when we see the MOH more engaged…when they take a front role on [UHC] with more follow-through. I am tired of pushing, then the MOH stalling." Private Implementer

"UHC is too big – we need to have some prioritization to get started." Public Implementer

"There is no unifying platform that brings all the stakeholders together to focus on UHC." Technician

public and private implementers and technicians agreed that UHC dialogues need to occur at two levels - political (possibly through Office of the Prime Minister (Inter-Ministerial Committee)) and HPAC (has representation of MoH, MoFPED, MoES, MoLG, CSOs, PNFP, PHP, and DPs). A few respondents proposed creating a new forum. They explained that a new forum could start with inclusion as a core principle involving all the relevant stakeholders.

2.3. Priority Areas for ACS Support

ACS aims to advance UHC by convening regional and country level practitioners to support accountability, foster learning, and knowledge sharing, and build space for collaboration around health financing policies and processes. Through these focus areas, ACS hopes to further inform decision-making based on evidence, raise the voice of those typically left out of UHC and health financing process, and support greater capacity to hold actors accountable to commitments to accelerate shared implementation of UHC policies and programs.

Stakeholders were asked about accountability, learning and knowledge sharing, and collaboration during the consultation period to ground truth in this approach, and identify challenges, solutions, and priorities related to these proposed ACS focus areas. Stakeholders were also asked to identify a set of technical priority areas where they felt ACS may be able to support (See box 7.)

Overall, stakeholders ranked accountability activities as the largest barrier, with supporting platforms for exchange as the second-highest ahead of learning. Accountability was similarly ranked as the focus area of highest importance, with learning emerging as slightly higher than support to platforms (non-significant difference).

Collaboration

In line with the barriers to collaboration included above (ie., weak platforms; lack of action post meeting), stakeholders pointed to several areas around collaboration where the ACS project could support engagement:

Identify an appropriate platform, and foster an inclusive and collaborative process: As noted earlier, stakeholders either proposed building on existing HPAC and TWGs or possibly creating a new one. Based on stakeholder responses, ACS's facilitative role could be to help stakeholder groups ensure whatever route they choose, that the platform has inclusive representation and balanced leadership. This can include bringing together the "right" partners by building linkages between levels of government and other sectors; help build early consensus for a multi-stakeholder platform(s) as well as a terms-of-reference for stakeholder interactions. Other proposed ideas included working with platform members to outline the consultative process and fostering improved community involvement as a way to support both enhanced accountability and collaboration. This last point was cited as a high priority by both civil society and private implementers.

A few respondents suggested this new forum have smaller committees to carry out the analysis and advocacy needed to implement UHC policies and plans while other cautiously recommended the MoH should share leadership of this initiative to address the concern with limited action due to MoH/ government bureaucracy.

Strengthen collaboration skills: Some representatives from different stakeholder groups – private implementers, technicians, CSOs, and researchers – cited the need to build stakeholder engagement and collaboration skills. ACS can support a cadre of regional experts and/or regional organizations to

strengthen public, private and CSO skills in process facilitation, effective listening, and conflict resolution skills and to coach platform leadership and working group chairs.

Accountability

Accountability was a reoccurring theme throughout the interviews. The largest issue that emerged was governance at the national level. Other barriers that emerged included a perception of corruption, a weak culture of accountability in the health sector; unequal skills in advocacy and accountability among public, private and CSO stakeholder groups; and a shortage of systems, tools and lack of data to foster a culture of accountability. Some of the stakeholders acknowledged that this would not be an easy task, but *"if we work together, we can do it."* Possible areas of support include:

Creating a culture of accountability: Public and private stakeholders agreed that fostering a productive working relationship between the MoH and non-state actors is the first step in building trust – a necessary condition for dialogue and accountability. As trust grows, CSOs and private implementers then proposed partnering with the MoH to create a culture of accountability for all stakeholders. Private implementers also proposed opening the dialogue on UHC to involve as many stakeholders as possible – *"having more stakeholders around the table gives you more accountability."*

Establish accountability mechanisms, including an accountability framework: A number of stakeholders suggested the need to include a jointly-owned accountability framework as a part of supporting progress towards UHC. This framework should include for all stakeholders (including the CSOs and communities) as they all have a role to play. "*There should be a framework for accountability. The discussion should not be government-led, but from outside in order to hold them accountable"*. Some CSOs proposed innovative solutions to enable communities to hold public and private providers accountable, including developing a community scorecard to involve communities in analyzing health services, drafting patient charters to incorporate their voices, and using radio program and mobile communications to disseminate information on their rights and responsibilities supporting UHC. A private implementer suggested creating a "dashboard" that captures agreed upon indicators of performance so that *"we are pinned to that and are not just 'rubber stamping' a MoH report."*

Build stakeholder skills in monitoring, advocacy and accountability skills: ACS can support regional experts and/or regional organizations to strengthen key stakeholder groups' advocacy and accountability skills, focusing on the groups responsible for leading the UHC consultative process. Several suggested topics for advocacy, including organizing non-state actors like private providers and CSOs to lobby the GoU for more funding to be directed to MoH and health; promoting a focus on determinants of health for UHC policies and plans to encourage the MoH to link to urban and other government sectors; and, pressuring the MoH to better target health resources to meet community needs.

Stakeholders also suggested a number of ways that the ACS project itself can be held accountable. The top three included: Creating a clear ToR, work plan and deliverables that are shared with stakeholders, to share results of the work directly, and to hold review meetings that are inclusive of the stakeholders and beneficiaries of the project.

Learning

The respondents also identified several issues that fell under the category of learning. When examining responses, it was clear that more respondents said that opportunities for learning themselves were not a barrier but rather that information or knowledge sharing itself posed more of an issue. They provided specific areas for learning and knowledge sharing but with several caveats to ensure the learning and evidence gathered is maximized and applied:

- Focus on the *operations and mechanics of implementing* UHC policies and programs. Although policies exist and knowledge sharing related to UHC occurs, there is little application of new learnings or action on implementation of policies and programs.
- Establish comprehensive learning mechanisms to ensure learning is systematic rather than ad hoc, and to overcome the training/learning silos created by DP project-driven learning.
- Extend training and other learning opportunities to all relevant stakeholders. Training on M&E, accountability, and financing mechanisms were mentioned by various stakeholders.
- Follow-up with individuals who received the training to ensure they have applied it and who participated in a study tour/overseas training to ensure they have shared their new insights with others.

The most frequently cited learning areas were (in order of priority) i) clinic skills in priority health services; ii) health financing and economics; iii) health policy analysis, design and implementation; iv) health services management and administration.

To facilitate implementation, respondents requested:

- Opportunities to learn about other country experiences in voucher programs and performance-based financing (public and private implementers);
- Study tours to observe how other countries structure, deliver and manage PHC services (public and private implementers);
- Assistance to strengthen government capacity to collect data on non-state actors' activities and analyze their performance/contribution to the health sector (private implementers); and
- Assistance to define UHC and prioritize interventions to *"get the process started"* (public implementers, technicians, private implementers and CSOs).

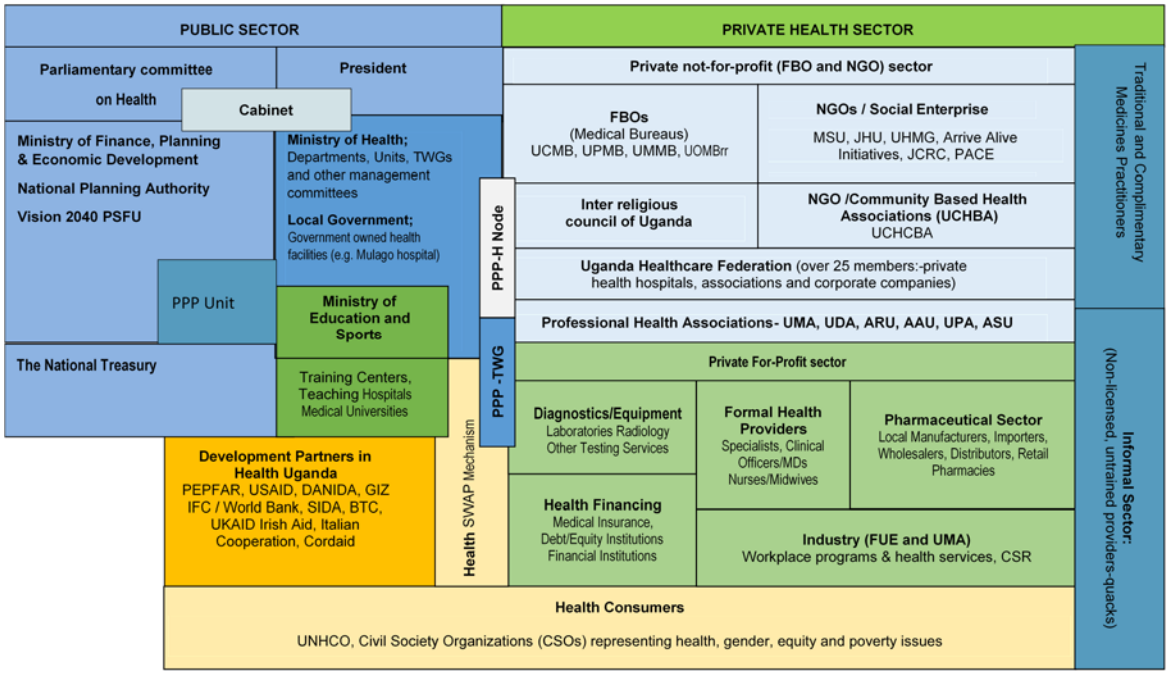
Box 7. Technical Priorities for ACS Support

Besides non-technical priorities related to the three modalities of ACS support, respondents also identified a set of technical priorities that may provide direct entry points for intervention. The top six technical priority areas identified, in descending order of priority, included:

- Human resource for health (general training, retention etc.)
- Domestic resource mobilization (including making the case for more funds)
- Resource allocation/Efficiency
- Health insurance
- Service delivery
- Private sector inclusion

Annex 1.
Overview of Uganda health sector

Landscape of Uganda Health Sector



Source: 2016 Private Health Sector Assessment

Annex 2. Uganda Health and Health Financing Statistics

General Health Statistics

Uganda General Health Statistics

Indicator	Statistics	Year
Infant Mortality Rate (death per 1,000 live births)	43.0	2016 (2)
Under Five Mortality Rate (death per 1,000 live births)	64.0	2016 (2)
Maternal Mortality Rate (deaths per 100,000 live births)	336	2016 (2)
Infant Mortality Rate (death per 1,000 live births)	43.0	2016 (2)
Total Fertility Rate	5.4	2016 (2)
Modern Contraceptive Prevalence Rate among MWRA	35	2016 (2)
Demand for Family Planning (%of MWRA)	67	2016 (2)
Prevalence of HIV, female (% ages 15-24)	3.8	2016 (4)
Prevalence of HIV, male (% ages 15-24)	1.9	2016 (4)
Prevalence of HIV, total (% of population ages 15-49)	6.5	2016 (4)

Sources: (1) Uganda Office of Statistics Bureau, (2) Key Uganda Demographic Health Survey Indicators, (3) WHO Country Statistics, (4) World Bank Development Indicators

Health Finance Statistics

Selected Health Financing Indicators for Uganda and SSA

Selected Indicator	Uganda	SSA	Year	Source
Total health expenditure on health (THE) as % of GDP	7.2	5.5	2014	WDI, 2016
Per capita expenditure on health in current US $	52	99	2014	WDI, 2016
Government expenditure on health as % of THE	25	43	2014	WDI, 2016
Donor expenditure on health as % of THE	46.3*	10.3	2013	NHA 2011-12/ WDI, 2016
OOP expenditure on health as % of THE	41	35	2014	WDI, 2016
OOP on health as % total private health expenditure	55/96*	60	2014	WDI, 2016/ NHA 2011/12

Source: World Development Indicators (WDI) Database and *Uganda NHA 2010/11 and 2011/12

Annex 3. Uganda Socio-Economic Statistics

Socio-Economic Statistics

Economic Indicators		**Period**
GDP at current market prices	72,765 bill. Shs	2014/15
Per capita GDP at current market prices	2,103,035 Shs	2014/15
GDP growth rate at constant (2009) market prices	5.0 Percent	2014/15
Per capita GDP growth rate at constant (2009) market prices	1.9 percent	2014/15
Contribution of agriculture to GDP at current market prices	24.0 percent	2014/15

Reserves	202.4 million US$	2014/15
Inflation rate	4.3 percent	2014/15
Budget deficit excluding grants as a percentage of GDP (2014/15)	-8.5 percent	2014/15

Socio-economic indicators		
Poor	19.7 percent	2012/13 UNHS
Unemployment Rate	9.4 percent	2012/13 UNHS
Pupil Teacher ratio (Primary 2014)	46	2014 Statistical Abstract
Pupil Classroom ratio (Primary 2014)	58	2014 Statistical Abstract
Student Teacher ratio (Secondary 2014)	22	2014 Statistical Abstract
Student Classroom ratio (Secondary 2014)	53	2014 Statistical Abstract

Health Indicators		**Period**
Maternal Mortality Rate	438/100 K	2011 UDHS
Contraceptive Prevalence Rate	30 Percent	2012 UDHS
Children less than 5 Years who are Stunted	33 Percent	2013 UDHS
Children less than 5 Years who are severely Anaemic	15 Percent	2014 UDHS

Annex 4. Analysis of Health Policies Linkages to UHC

#	Policy/Program	Description	Contribution to UHC
1	Liberalization Policy (1987)	This policy allows for the private sector to partner with the public sector to provide health services.	A diverse range of health service providers helps increase access.
2	Constitution (1995) Decentralization Policy (1987)	The 1995 constitution and 1997 Local Government Act allow local authorities to deliver health services, recruit and manage health personnel, pass bylaws, mobilize and allocate resources to health.	Fosters greater responsiveness to consumers by delegating authority districts; but Introduces user fees creating access barriers for the poor.
3	1st National Health Policy (1999/00 – 2009/10)	Policy's goal is to reduce mortality, morbidity, and fertility. Also introduces UNMHCP as a strategy to reduce disparities in services.	Subsidizes designated public health and clinical services offering UNMHCP.
4	2nd National Health Policy (2010/11 – 2019/20)	Policy aims to mobilize financial resources to fund health sector programs while ensuring equity, efficiency, transparency and mutual accountability.	Call for the establishment of a National Health Insurance scheme and other community-based financing mechanisms.
5	Health Sector Strategic Plan I (2000/1 – 2004/5)	Proposes key health system objectives including i) effective, efficient and equitable use of health resources; ii) removal of cost barriers to essential care; iii) recruit 75% of staff needed at each level of district health system.	Abolishes user-fees in 2001. Commits to increasing government funds to the health sector. Ensures adequate staffing for MOH facilities.
6	Health Sector Strategic Plan II (2005/06 – 2009/10)	Objective is to ensure a network of functional, efficient and sustainable health infrastructure for effective health services closer to communities.	Focuses on reducing morbidity and mortality through universal access to UNMHCP.
7	Health Sector Strategic & Investment Plan	Defines benefit package – Uganda National Minimum Health Care Package (UNMHCP) – to operationalize health sector policy.	Continues to support UNMHCP and to guarantee free access.
8	Health Sector Development Plan (HSDP) (2015/16 – 2019/20)	The plan's objectives include to: contribute to production of a healthy population; increase financial protection of households against impoverishment due to health expenditures; address key determinant of health through inter-sector collaboration; and, enhance health competitiveness regionally and globally.	The plan emphasizes accelerating Uganda's movement towards UHC.
9	National Health Insurance Bill (current)	Plans initially enroll public employees; three years later will enroll formal private employees. Strives to achieve 100% enrollment in 15 years. Employees and employers contribute 4% each to NHIS. Government and/or donor funds pay the premium for the poor until the NHIS is up and running. NHIS purchases services from MoH, PNFP and, PHPs.	Proposal has potential to improve risk-pooing, to increase access to health services, and reduce financial risk.

Source: Okokonyero, T. et al. 2016. Appendix 4

Summary of Health Financing Mechanisms

Mechanism	Pros	Cons
Primary Health Care (PHC) Conditional Grant: Government, through local governments, subsidies all PNFP hospitals and lower level health centers and medical training institutions.	• Gov't acknowledges Medical Bureaus' (FBOs) important contribution to health, particularly in serving the poor and rural populations • Bureaus' service statistics regularly included in all MOH policies and plans • PHC Grants helped create long-standing and collaborative working relationships between to MOH and Bureaus • Bureaus regularly participate in policy design and implementation • Grants help address gaps in reaching underserved population groups	• Steady decline in last ten years in PHC Grants allocated to individual facilities due to stagnated GoU contributions combined with growing # of FBO facilities • Grants cover approximately 9% of a PNFP health facility's costs • Shortfall has forced Bureaus to charge fees for goods and services running contrary to Bureaus' mission and values • Bureaus want to move to more effective funding mechanisms, e.g., performance-based service contracts

Maternal/Reproductive Health (M/RH) Voucher	• Two donor-supported (WB and USAID) M/RH voucher programs implemented through partner organizations • Programs focus on rural areas and underserved groups • Cover different geographic regions to avoid duplication (WB-Western and East Central regions while USAID- East and Northern Regions) • WB assessment showed impact: increased uptake of maternal health services by 9% and improved the quality of care delivered.	• M/RH voucher program does not cover KCCA region which experiences similarly high rates of maternal mortality • Pressing need to harmonize donor M/RH programs to ensure they cover same M/RH benefits to avoid consumer confusion; do not duplicate resources; offer consistent provider reimbursement rates for comparable services; and reduce management /administrative costs • Not sustainable in long-term without MoH funding and transfer to Uganda institution(s)
Performance-based Financing (PBF) Cordaid three-year pilot incentivizes health workers for outpatient consultations, range of M/RH and child health interventions to meet quality standards. Sixteen PNFP and four public facilities participated the PBF pilot.	• Nascent experience in PBF with the Uganda Catholic Medical Bureau (UCMB) in Eastern Uganda • PBF pilot demonstrated improvements in outpatient consultations, antenatal care visits, and facility deliveries • PBF is a cornerstone of the 2016 HFS • WB loan supports growth of PBF	• WB providing technical assistance but MoH struggling to institutionalize and scale-up Jinja experience • MoH process to design PBF Unit has not been inclusive; PFP have been excluded from deliberations • Initial PBF does not include PFP providers

Source: Summarized from 2016 Private Sector Assessment

Following all the performance based pilots in Uganda, the MoH has embraced Results Based Financing (RBF) as a catalyst for health systems reform to address some of the health sector challenges. The RBF approach is currently implemented in West Nile and Rwenzori region in both PNFP and Public health facilities with support from the Belgian Technical Cooperation and this has informed the scale up of the program to other districts in the country.

The MoH has developed a National RBF Framework to support scale up and institutionalization of the RBF approach in the health sector as a way of promoting quality service delivery, more efficient use of resources and equity. This is to be rolled out in 74 districts with focus on primary health care facilities from the public and PNFP subsector in the country with support from the WB, Global Financing Facility (GFF) for every woman and every child, and Swedish International Development Aid (SIDA).

Annex 5. Respondent Profiles

Interview Profile

Stakeholder Category	Total #	Gender	
		Male	Female
Civil Society Organizations	10	3	7
Development Partner	13	7	5
Politician	1	1	0
Private Implementer	6	3	
Public Implementer	7	5	1
Researcher	2	2	0
Technician	12	8	3

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