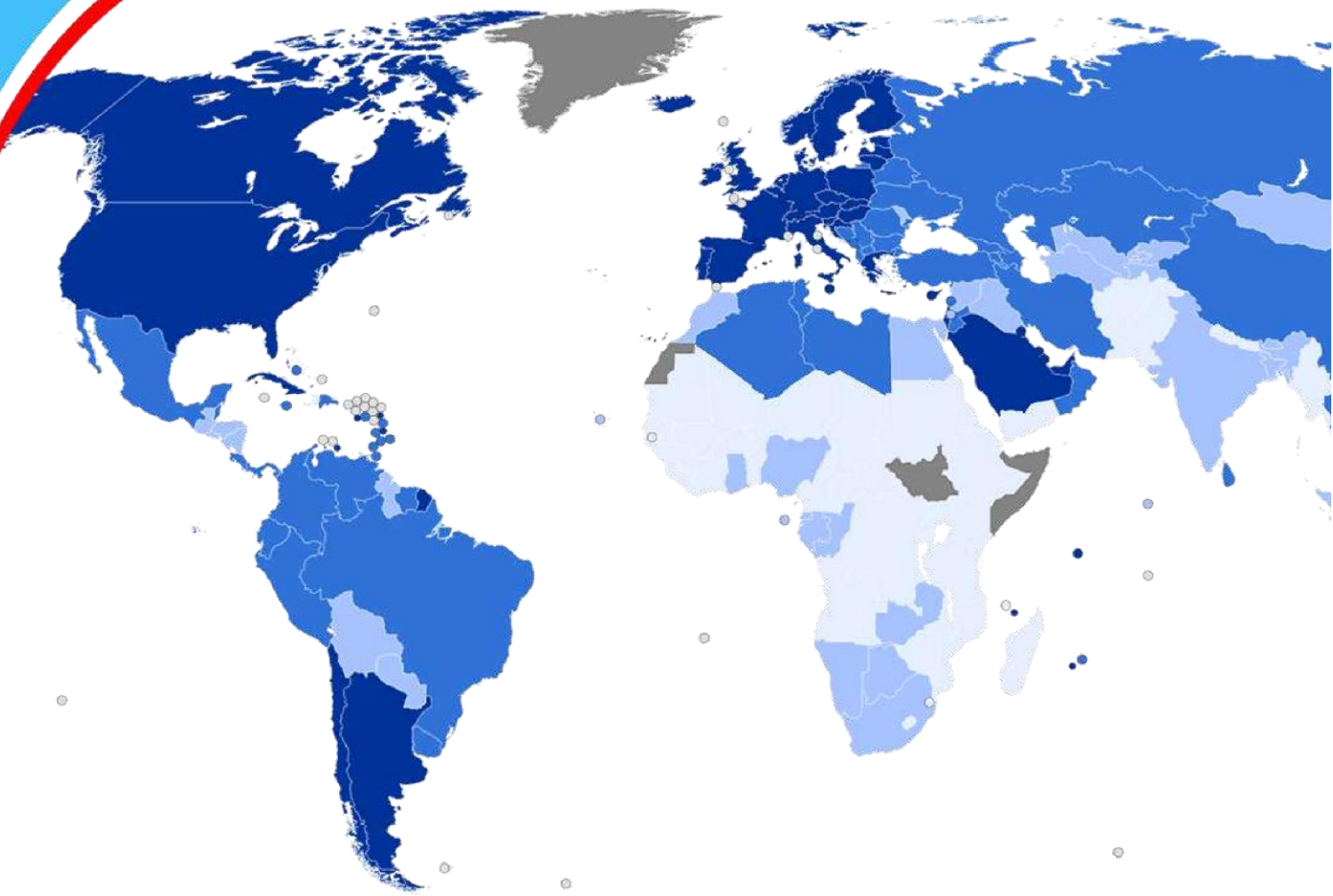


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DONOR POWER AND PRIORITIZATION IN DEVELOPMENT ASSISTANCE FOR HEALTH POLICIES: THE CASE OF UGANDA

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ABSTRACT

This research study was conducted to explore Development Assistance for Health policies in Uganda, the programs that donors took interest in, as well the country's health priorities from 2002 to 2015.

Purpose: The study sought to fill the knowledge gap by examining whether there were changes in Health Financing policies for Uganda's health care system from 2002 to 2015 and their impact.

Methodology: Literature on aid for health in low and middle-income countries was reviewed, while data on major donors to Uganda's health care system obtained from their websites, as well as the Creditor Reporting System. Walt and Gilson's health policy triangle framework was used to examine how different donors operated in Uganda's health financing space. Vertical, horizontal, earmarked and budget support, as well as disease-specific fund allocation modes were also explored.

Findings: Overall, donors influenced decisions on the selection of priority areas as well as fund allocation, despite efforts to involve the government in health policy formulation. The results were intended as an overarching guide for both donors and health policymakers in future health financing decision making processes.

Unique contribution to theory, practice and policy: Country engagement and policy ownership are critical to ensure harmonization of donor interests and country health needs. Increased aid for Health Systems Strengthening, Primary Health Care and NonCommunicable Diseases would also go a long way in improving population outcomes. Further studies on the sustainability of Development Assistance for health for middle and low-income countries are recommended.

Key words: *Development, Aid, Health, Interests, Priorities.*

1.0 INTRODUCTION

1.1 Background

Health financing is a key pillar of Health Systems and countries use various methods to acquire resources for health care. According to the World Health Organisation (WHO) in 2009, low-income countries like Uganda accounted for nearly 75% of the world's mortality rate, while Africa contributed 90% to the global Malaria burden. Such countries however have insufficient resources for health care so they greatly depend on Development Assistance for Health (DAH) (WHO, 2008).

DAH comes from bilateral and multilateral agencies, International Development Partners (IDPs) and Global Health Initiatives (GHIs). High-income countries like the U.S.A, UK and Japan, were Uganda's top DAH providers in 2002, contributing 39.5%, 11.1% and 10.7% respectively (Michaud, 2003). Like most low-income countries, Uganda's health sector took up the majority of Official Development Assistance (ODA), at 39% of the US\$ 3.98 billion received in 2014 (OECD, 2016).

Situated in East Africa with a fast-growing population of about 40 million, Uganda is classified as a low-income country (World Bank, 2016a). It faces several health issues like HIV/AIDS, Malaria, Tuberculosis, maternal and infant mortality, as well as chronic diseases (WHO, 2014). Furthermore, Uganda's health care system needs improvement in order to efficiently utilise resources to provide adequate and quality health care. These undertakings require enormous financial resources over extended periods of time, amidst ever-changing political, economic, environmental, social, and technological conditions (Ministry of Health, 2010).

Uganda's health care system is funded through the national budget, DAH, Out-of-Pocket payments and health insurance especially through employer schemes (Stierman, Sengooba, and Bennet, 2013). In 2010, DAH was the second largest source of Uganda's health financing at 35%, after households and private sources at 55.4%, while the Government of Uganda (GoU) covered the remaining portion, according to the Health Sector Strategic and Investment Plan (HSSIP, 2010).

In 2014, 11% of the national budget was assigned to Uganda's health expenditure, while provisions from 2010 to 2015 were less than 10% (World Bank, 2016b). These allocations were below the 15% target of the Abuja declaration and Uganda remained on Africa's top ten DAH recipients list (WHO, 2016). In 2006, DAH in the form of General Budget Support (GBS) to Uganda was US\$ 194 million, surpassing GoU financing by US\$ 10 million (Okwero, Tandon, Sparkes, McLaughlin and Hoogeveen, 2010). DAH also came in the form of Off-Budget Support (OBS), amounting to US\$ 1.8 million in the 2008/2009 financial year.

At the core of DAH are the debates on prioritization of health issues, choice between vertical and horizontal fund allocation, earmarked and non-earmarked funding, as well as disease-specific and primary health care (PHC) funding (Mills, 1983). Bilateral donors such as the United States Agency for International Development (USAID) and the UK government's Department for International Development (DFID), historically provided

GBS. In this case, selection of priority areas was done by GoU in line with country needs (MOFPED, 2016). After 2000, funds were allocated more to OBS than GBS due to evolving donor interests (The Global Fund, 2016a).

More recently however, the International Health Partnership plus (IHP+) sought to improve fund allocation and increase country engagement. IHP+ fostered dialogue to identify Uganda's health priorities and align them with the global agenda. Consequently, IHP+ used diagonal fund disbursement, which focused on strengthening the health care system to tackle Uganda's various health issues (Ooms, Van Damme, Baker, Zeitz, and Schrecker, 2008).

Development Assistance for Health is essential to Uganda's health care system due to insufficient national funds to address the country's health issues. Donor priorities are crucial as aid availability depends on their own budget constraints, political, economic and other factors. Although research on aid for health in Uganda had been done, studies examining the extent of sustained donor influence in prioritization of health issues and fund allocation were limited. Furthermore, research on the power dynamics in prioritization of health areas and fund disbursement was limited. This study thereby sought to fill this gap, so as to advise future health policy decisions in Uganda and other low-income countries.

2.0 PURPOSE

To investigate if there has been changes in DAH policy in Uganda, by examining the extent of donor influence in prioritisation of health issues and fund disbursement.

2.1 Objectives

1. To investigate who determined the prioritisation of health issues for DAH and their motivation.
2. To establish how much of DAH was allocated to the selected health issues.
3. To explore whether donor interests matched Uganda's needs and the effect on health care.
4. To ascertain whether there had been a power shift in DAH policies in Uganda from 2002 to 2015.

3.0 METHODOLOGY

The study used a qualitative assessment approach and content analysis of the DAH policies of GoU and nine donors. Literature was extensively reviewed on health financing and DAH in middle and low-income countries, to set the background for donor operations in Uganda. Sources included published authors and grey literature from WHO bulletins, papers and reports online.

The search terms used were; development assistance for health in middle and low-income countries, health financing in middle and low-income countries, aid for health in Uganda, official development assistance, donor influence in health, DAH policy, vertical and horizontal funding, Uganda health budget and global health initiatives.

3.1 Analysis

Walt and Gilson's 1994 health policy triangle framework was utilised to assess DAH policy in Uganda. The extent of donor power in the prioritisation of health issues and fund allocation was examined. Walt and Gilson emphasised the need to consider the actors, context, process and content and the researchers used this conceptual method for the study.

The actors were GoU and nine bilateral and multilateral donors, IDPs, as well as GHIs. The variety in donor types gave a balanced picture of Uganda's DAH scene. The researchers selected donors who consistently supported Uganda's health sector from 2002 to 2015, as per ODA statistics. The researchers acknowledged that recipient organisations implemented DAH policy, while individuals were affected by the policy decisions but did not include them as actors.

The context was the DAH scene in Uganda and its implications for national health care from 2002 to 2015. The contents were the criteria used to select health issues and how much funding to allocate. The process involved identifying all Uganda's health issues and the procedure for aid acquisition.

3.2 Data sources

Data on Uganda's health expenditure was obtained from the Ministry of Finance, Planning and Economic Development (MoFPED) website. Information on DAH was retrieved from Ministry of Health (MoH) documents, the National Health Accounts, the Joint Assessment of National Strategies (JANS) report, the Joint Assessment of Uganda's Health Sector Development Plan (HSDP) report, as well as the Health Sector Strategic and Investment Plan (HSSIP).

The Creditor Reporting System (CRS) and the Africa-Development-Aid-at-a-glance charts of the Organisation for Economic Co-operation and Development –Development Assistance Committee (OECD-DAC), were vital sources of DAH commitments and ODA statistics.

The funding activities of the nine selected donors from 2002 to 2015, were examined from the USAID, DFID, Unitaids, the Global Alliance for Vaccines and Immunisation (GAVI), Bill and Melinda Gates Foundation (BMGF), Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM), United States President's Emergency Fund for AIDS Relief (PEPFAR), Clinton Health Access Initiative Inc. (CHAI) and IHP+ websites.

In this study, Non-Governmental Organisations (NGOs) were identified as Not-For-Profit entities, such as faith and non-faith-based groups, as well as Civil Society Organisations (CSOs).

4.0 FINDINGS

The activities of each actor, changes in DAH landscape, donor power, as well as debates on prioritisation and fund disbursement were presented in this section, highlighting the events that possibly led to a power shift in Uganda's DAH policies.

4.1 Government of Uganda

Health financing in Uganda is managed by GoU through MoFPED, which mobilises funds and releases them to MoH for allocation (Uganda Budget Information, 2016) (Ministry of Health, 2016). Uganda receives GBS, as well as OBS which includes earmarked funds given to the GoU, private sector and NGOs (Zikusooka, Kyomuhang, Orem and Tumwine, 2009a).

In 2013, GoU contributed 15% to disease and condition-specific costs leaving the 85% to donors. In this category, infectious and parasitic conditions expenditure was the biggest at 66%, while Reproductive health followed at 12%. HIV/AIDS received the bulk of infectious diseases funding at 55%, while Malaria and Tuberculosis got 32% and 2% respectively (Ministry of Health, 2016a) (The Global Fund, 2017).

In 2014, U.S.A and UK donated the most to Uganda's health sector at 73.1% and 11.4% respectively, while France and Sweden gave the least at 0.02% each, of the US\$ 504.77 million (OECD-DAC, 2016). Uganda's health sector was guided by the first National Health Policy (NHP I) from 1999 to 2010 and the second Health Sector Strategic Plan from 2005 to 2010.

GoU used the JANS to develop the HSSIP and HSDP to ensure well-balanced outcomes. MoH formulated the second NHP and the HSSIP (2010-2015), to define Uganda's health plans and guide the selection of priority areas (Ministry of Health, 2016b). The selected areas were health promotion, disease prevention and community health initiatives, maternal and child health, and finally communicable, as well as non-communicable disease prevention and control (HSSIP, 2010).

The Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) were also used to guide the planning process for the health sector (NHP II, 2010). GoU negotiated with donors in line with country priorities and MoFPED submitted grant proposals to donors. To supplement funding for Health System Strengthening (HSS), GoU implemented the Uganda Health System Strengthening Project (UHSSP) in 2011. The project aimed to improve the health workforce and infrastructure, using a five-year US\$ 130 million loan from the World Bank (UHSSP, 2010)

4.2 United States Agency for International Development

As Uganda's largest bilateral donor, USAID has contributed to the health sector for over five decades. Its motivation was the need to strengthen Uganda's health care system to accommodate the fast-growing population's demand for health care (USAID, 2015). USAID currently works with GoU and NGOs to assist in the prevention, care and treatment of HIV/AIDS through PEPFAR. In 2008, USAID shifted focus towards HSS and workforce capability in an effort to embrace the Sector Wide Approach (SWAp) and have a wider impact on Uganda's health sector (USAID, 2016a). USAID invested in training health workers in Tuberculosis and Malaria treatment and prevention, childhood immunisation, nutrition, water and sanitation programmes, as well as maternal, infant and reproductive health (Cardno, 2015).

USAID ran the Health Initiatives for the Private Sector, Business Preventing HIV/AIDS and Accelerating access to Antiretroviral Therapy and the Private Health Support programmes. This approach focused on increasing presence of private health services by training, funding and reducing costs, through Public-Private Partnerships (PPPs) and market-based solutions. In 2015, US\$ 182.4 million of the total US\$ 292.7 million from USAID was allocated to Uganda's health sector, with HIV/AIDS taking up almost 50% at US\$ 90.3 million (USAID, 2016b). USAID's contribution increased steadily from US\$ 160.4 in 2011 to US\$ 205.6 in 2014 but dipped in 2015.

4.3 Department for International Development

The UK government has supported Uganda's health sector for several decades through DFID (DFID, 2012). In 2013, DFID's motivation for financing the health sector was to support the health-focused MDGs. DFID also reduced GBS and concentrated on funding cost-effective and previously successful projects (DFID, 2016a).

DFID funded malaria control and treatment through distributing 1.5 million Long Lasting Insecticide-treated nets (LLINs) to hospitals, improved use of malaria kits, spraying of households and health worker training. About £ 26.4 million, had been disbursed to implement the project through UNICEF and USAID, accounting for 10.6% of the allocated aid for the study period (DFID, 2016b).

DFID also supported increased utilisation of modern contraception through private sector service delivery modes like social franchising and marketing. About £ 30.6 million, was disbursed for the project through USAID and this was 12.3% of DFID's allocated budget from 2002 to 2015 (DFID, 2016b). Finally, DFID funded HIV/AIDS prevention and GAVI's childhood immunisation efforts (DFID, 2012).

4.4 Unitaid

Unitaid was established by Brazil, UK, France, Chile and Norway in 2006, to offer advanced solutions to support the global health movement. It focuses on discovering innovative ways to prevent, treat and diagnose HIV/AIDS, Tuberculosis and Malaria using faster, cheaper and more effective methods (Unitaid, 2016a). Unitaid awarded grants to UNICEF, GFATM and CHAI among others and by the end of 2014, it had delivered products of approximately US\$ 158 million to Uganda (Unitaid, 2016b).

Unitaid supported HIV/AIDS prevention and treatment efforts through HIV tests for pregnant women and children, as well as prevention of mother-to-child transmission (PMTCT) between 2006 and 2014. It also funded Malaria programmes through rapid diagnostic testing, health worker training on Injectable-Artesunate use, Tuberculosis first line treatments, and detection of incident-Tuberculosis, as well as Tuberculosis HIVpositive patients, using Tuberculosis-Xpert project commodities (Unitaid, 2016b). Negotiation for funding was done between Unitaid and donor partners who implemented their projects in Uganda.

4.5 The Global Fund

This GHI was formed in 2002 as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and is currently known as the Global Fund. GFATM funded Uganda's health care

system as it is one of those most affected by HIV/AIDS, Tuberculosis and Malaria (The Global Fund, 2015a). Decisions on priority areas and funding were approved by GFATM's board, using an allocation-based funding model (The Global Fund, 2015b).

GFATM initially supported projects such as the WHO-Roll-Back-Malaria campaign which was implemented by MoH and NGOs. In 2015, GFATM renewed its support through the approval of new grants for all three diseases, channelling them to the AIDS Support Organisation, as well as MoFPED, which submitted grant proposals (The Global Fund, 2016a).

By 2015, GFATM had disbursed US\$ 759 million of the US\$ 886 million committed to Uganda's health care since 2002. GFATM also financed the distribution of LLINs, control and treatment of Tuberculosis through easing access to screening in 2009 (The Global Fund, 2016b) (The Global Fund, 2016c). After 2015, GFATM added Resilient and Sustainable health care systems to its agenda by supporting the improvement in delivery of medicines, supplies and the quality of health data.

4.6 The Vaccine Alliance

Formerly known as the Global Alliance for Vaccines and Immunisation, GAVI was founded in 2000 by the Bill and Melinda Gates Foundation. The alliance is a global partnership with donor and recipient governments, WHO, UNICEF, the World Bank, the vaccine industry and research bodies, among others. GAVI has a unique funding model supported by innovative finance through PPPs and direct contributions like grants, as well as private sector philanthropy (The Vaccine Alliance, 2016a).

GAVI's involvement in Uganda was motivated by the high rates of infant and child morbidity and mortality due to immunisable diseases. It financed immunisation campaigns for polio, measles, yellow fever, and more recently the Human Papillomavirus. GAVI also funded vaccine introduction support, Injection safety support, as well as HSS, which received an estimated US\$ 12.7 million from 2002 to 2015 (The Vaccine Alliance, 2016b).

Decisions on grant approval were made by the GAVI board to which GoU would submit proposals (The Vaccine Alliance, 2016c). Of the US\$ 286.1 million disbursed by GAVI to-date, 90% was geared towards vaccine support. 49.3% of these funds were allocated to the pentavalent vaccine, while the second largest allocation at 22% went to Pneumococcal conjugate vaccine (The Vaccine Alliance, 2016b).

4.7 The United States President's Emergency Plan for AIDS Relief

The donor agency also known as PEPFAR, was launched in 2003 and works through USAID and closely with GFATM and other IDPs. It was motivated to fund HIV/AIDS programmes in support of Uganda as a leader in the global response to the disease (PEPFAR, 2015). In 2009, PEPFAR partnered with the Joint United Nations programme on HIV/AIDS (UNAIDS), to focus on severely decreasing HIV infection in children, adolescent girls and young women by 2020. PEPFAR also formed PPPs with AstraZeneca to increase access to HIV/AIDS products and services (PEPFAR, 2016a).

PEPFAR financed Antiretroviral Treatment (ART), Voluntary Medical Male Circumcision and ART for expectant mothers to foster PMTCT. In addition, it funded HIV/AIDS Voluntary Counselling and Testing, as well as orphans and vulnerable children affected by HIV/AIDS (PEPFAR, 2016b). PEPFAR's commitments increased gradually from US\$ 97 million in 2004 to US\$ 286 million in 2009, but fell slightly by US\$ 9 million in 2010. 2011 saw a US\$ 21 million upsurge and gradual increase to US\$ 338 million in 2015. Funding decisions were made by the PEPFAR board to which GoU submitted grant proposals.

4.8 The International Health Partnership plus

The IHP+ was formed in 2007 to fast-track achievement of the three health-focused MDGs in middle and low-income countries. It brought together national stakeholders like Uganda, donors like Germany, GFATM, BMGF, UNAIDS, UNICEF, USAID, as well as CSOs (IHP+, 2015a).

IHP+ aimed at ensuring the efficient use of DAH for better health outcomes. After 2015, IHP+ focused on the health SDG, which partly aims at achieving Universal Health Coverage by 2030 (IHP+, 2015b). IHP+ consequently transformed into UHC2030, focusing on HSS for the attainment of Universal Health Coverage. IHP+ policy decisions were motivated by the 2005 Paris Declaration on aid effectiveness, which centred on ownership, alignment, harmonisation, managing for results and mutual accountability. IHP+ collaborated with GoU to transform these objectives into more practical ones for Uganda (IHP+, 2015b).

Through policy dialogue, Uganda selected priority areas based on its National HSSIP, without IHP+ interference. This process reaffirmed Uganda's health priorities as health promotion, disease prevention, community, maternal and child health initiatives, communicable and non-communicable disease prevention and control (IHP+, 2015b). IHP+'s operations were guided by the global compact, as well as one between Uganda and donors, while fund acquisition was through grant submissions by MoFPED (IHP+, 2015c).

4.9 The Bill and Melinda Gates Foundation

This foundation also referred to as BMGF, was formed in 2000 when the William H. Gates Foundation partnered with GAVI, policy makers and global health organisations to increase access to childhood vaccines in middle and low-income countries (BMGF, 2016).

BMGF supported Malaria and Tuberculosis prevention and treatment in Uganda through GFATM. In addition, it aimed at reducing HIV/AIDS infections through availing simplified regimens and effective use of resources to prevent new infections. It also funded HIV-vaccine development and contraceptive use (BMGF, 2016).

Focus on Malaria was fuelled by the need to support innovative ways to lower the burden of disease, as well as fast-tracking efforts to wipe it out as envisaged in BMGF's 2013 Accelerate-to-Zero malaria strategy. Decisions on choice health issues and the disbursement of funds, were made by the BMGF board.

4.10 The Clinton Health Access Initiative Inc.

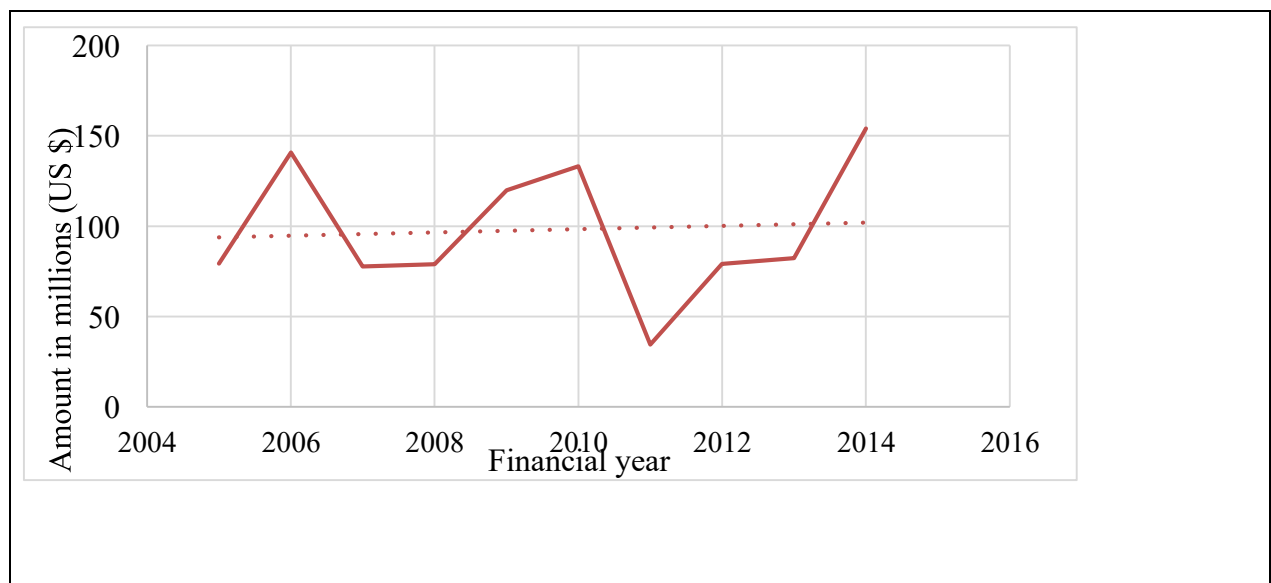
Founded in 2002 by the Clinton Foundation, CHAI aimed at increasing access to ART for millions of people living with HIV/AIDS in middle and low-income countries. CHAI collaborated with GoU, as well as donors like the Canadian government's Department of Foreign Affairs Trade and Development, DFID, BMGF, Unitaid, IKEA foundation, UNICEF and WHO. CHAI offered technical assistance geared towards HSS, so as to support life-saving treatment by negotiating for lower costs of ART in Uganda (CHAI, 2016).

CHAI also supported the increase in paediatric HIV/AIDS treatment to match the adults', malaria and malnutrition programmes, as well as fast-tracking new vaccine affordability. Focus was on easing accessibility of vaccines to children in remote areas, through improving cold chain storage and distribution. CHAI supported improvements in Tuberculosis diagnosis and treatment, availing affordable contraception methods, health worker training, as well as maternal and infant health. CHAI's board made the fund allocation decisions based on the donor's interests (CHAI, 2014).

4.11 Changes in DAH landscape

The researchers recorded a number of changes in DAH policy in Uganda from 2002 to 2015, which may have led to a gradual power shift, from GoU to the donors.

There was an increase in the number of donors which led to changes in the amount of DAH contributions. There were fluctuations in DAH contributions over the years with the lowest amount being US\$ 34 million in 2011 and the highest US\$ 154 million in 2014, but the overall trend was upward. Overall, there was a US\$ 74.83 million increase in DAH from 2005 to 2014, and a US\$ 61.99 million drop from 2006 to 2008, followed by a US\$ 54.33 million rise by the end of 2010. A more significant US\$ 98.74 million reduction was recorded from 2010 to 2011, after which funding steadily increased by US\$ 119.58 million by the end of 2014. The changes and overall trend in DAH from GHIs to Uganda from 2005 to 2014, are illustrated in figure 1. The GHIs included were; GAVI, BMGF, GFATM, PEPFAR, as well as CHAI.



Amount in US \$ millions ———— Trend – linear (Amount in US \$ millions)

Figure 1: Development Assistance for Health from Global Health Initiatives to Uganda (2005-2014)

Sources: (Bank of Uganda, 2017), (Uganda Health System Strengthening Project, 2010)

Amounts were converted from original reported Uganda shillings to US dollars using the historical midexchange rate for each of the years.

Figure 1 illustrates the aid received by Uganda from the various donors or Global Health Initiatives. It shows contributions made by various Global Health Initiatives towards Uganda's Health system from 2005 to 2014, in United States million dollars. Overall, the contributions increased by US \$ 30 million from 2005 to 2014 although there were marked drops 2007, 2008 and 2011.

There was an increase in the variety of donors, as bilateral and multilateral donors, as well as IDPs were joined by GHIs. This affected the type of DAH, as GBS gradually reduced and OBS increased from 2002 to 2014. An increase in partnerships between donors like USAID, GAVI and DFID and NGOs was also noted.

4.12 Donor power

The researchers observed that overall, policy decisions on prioritisation of health areas and fund allocation were predominantly made by donors as per their interests, global, political, economic and technological agenda, as well as their contributions. From 2002 to 2015, the average annual DAH from USAID, DFID, Unitaid, PEPFAR, GFATM and GAVI was US\$ million 179.8, 24.07, 19.72, 256.08, 59.02 and 17.19 respectively.

The way in which GHIs like CHAI and BMGF were formed, their contributors as well as partners, guided their agenda. Their goals influenced the selection of priority areas and fund allocation modes, which differed from those initially used by traditional donors like USAID and DFID.

4.13 Debates on prioritisation and fund allocation

4.13.1 Vertical versus horizontal mode

GAVI, GFATM, Unitaid and PEPFAR used the vertical mode of allocation in which donors chose specific priority areas to channel their funds to. DFID and USAID historically provided GBS, which was allocated by GoU to different parts of Uganda's health care system, as in the horizontal fund allocation mode. After 2006, DFID and USAID gradually changed to OBS and adopted the vertical mode of fund disbursement, although a small amount of their support was still horizontally allocated.

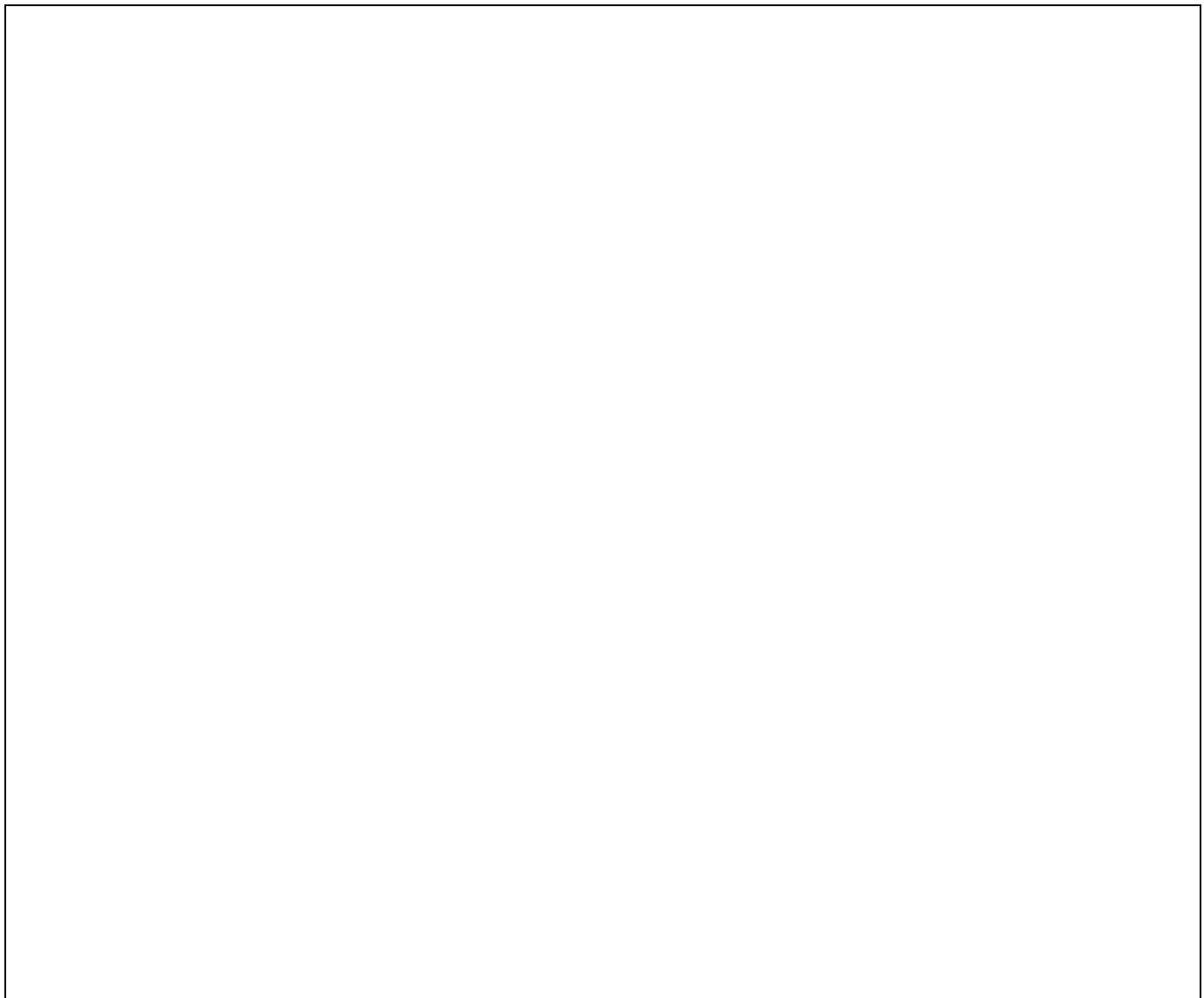
4.13.2 Diagonal mode

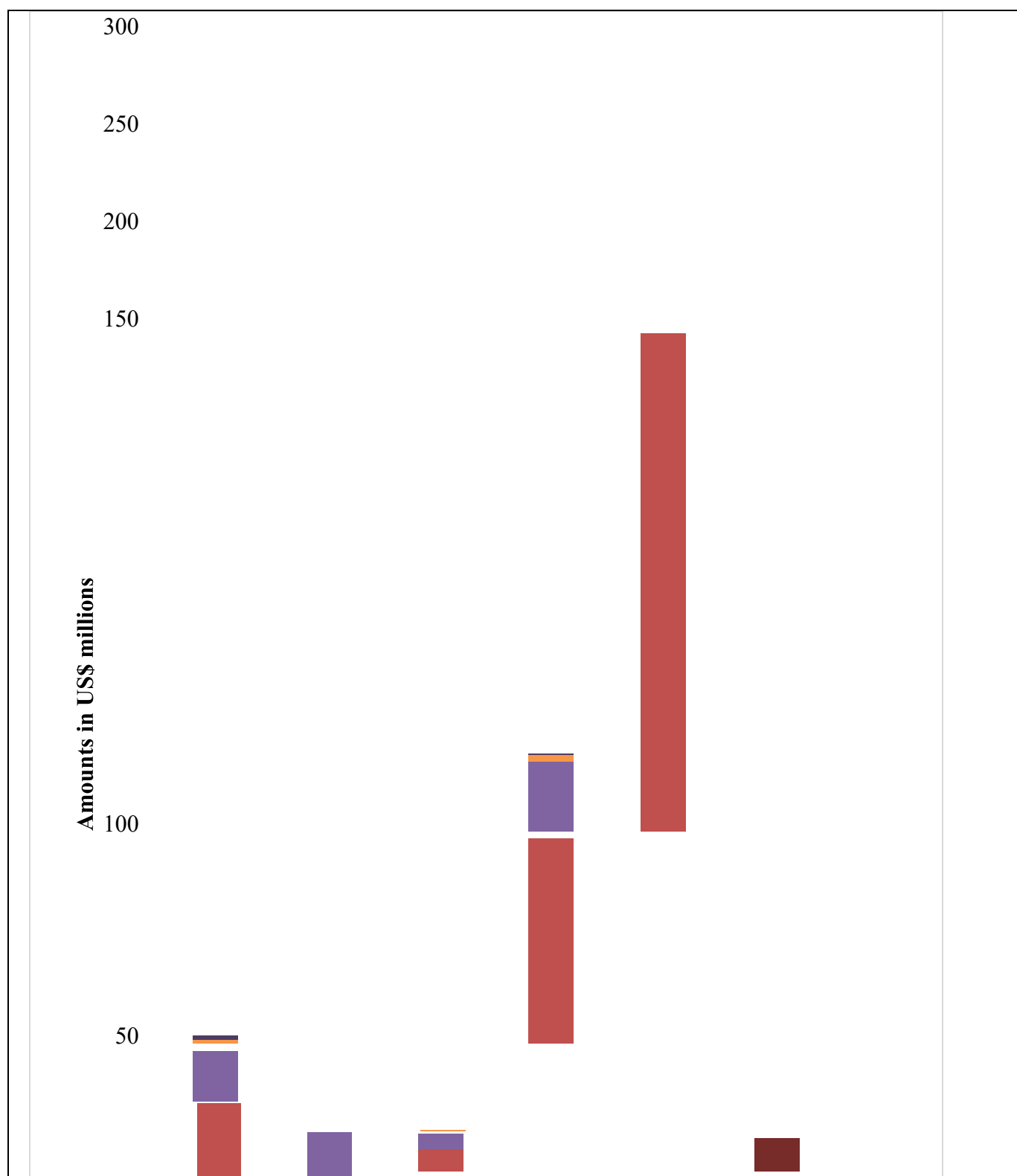
The diagonal fund allocation mode focused on supporting the health care system as a whole such that it would be resilient enough to handle the country's health issues such as diseases, maternal and infant mortality, water and sanitation and more. IHP+, BMGF and CHAI used the diagonal mode, supporting several aspects of HSS such as health infrastructure and workforce improvement, alongside the usual donor priority areas like HIV/AIDS, Malaria and Tuberculosis.

4.13.3 Disease-specific versus PHC funding

HIV/AIDS-focused efforts received 78.2% of average annual funding, followed by Malaria at 16.7%, Tuberculosis at 3.4%, childhood-immunisable diseases at 1.2%, while the remainder went to other diseases. In the fight against Malaria, BMGF funded areas with potential for influence and took risks that other donors wouldn't.

PHC was barely funded by donors despite its potential to improve the population's access to health care. GoU was the dominant funder of PHC as a priority under the health promotion category. The average annual contributions of donors to disease-specific programmes are illustrated in figure 2. HIV/AIDS received the highest amount of DAH from four major donors while the category of other diseases received the least funding.





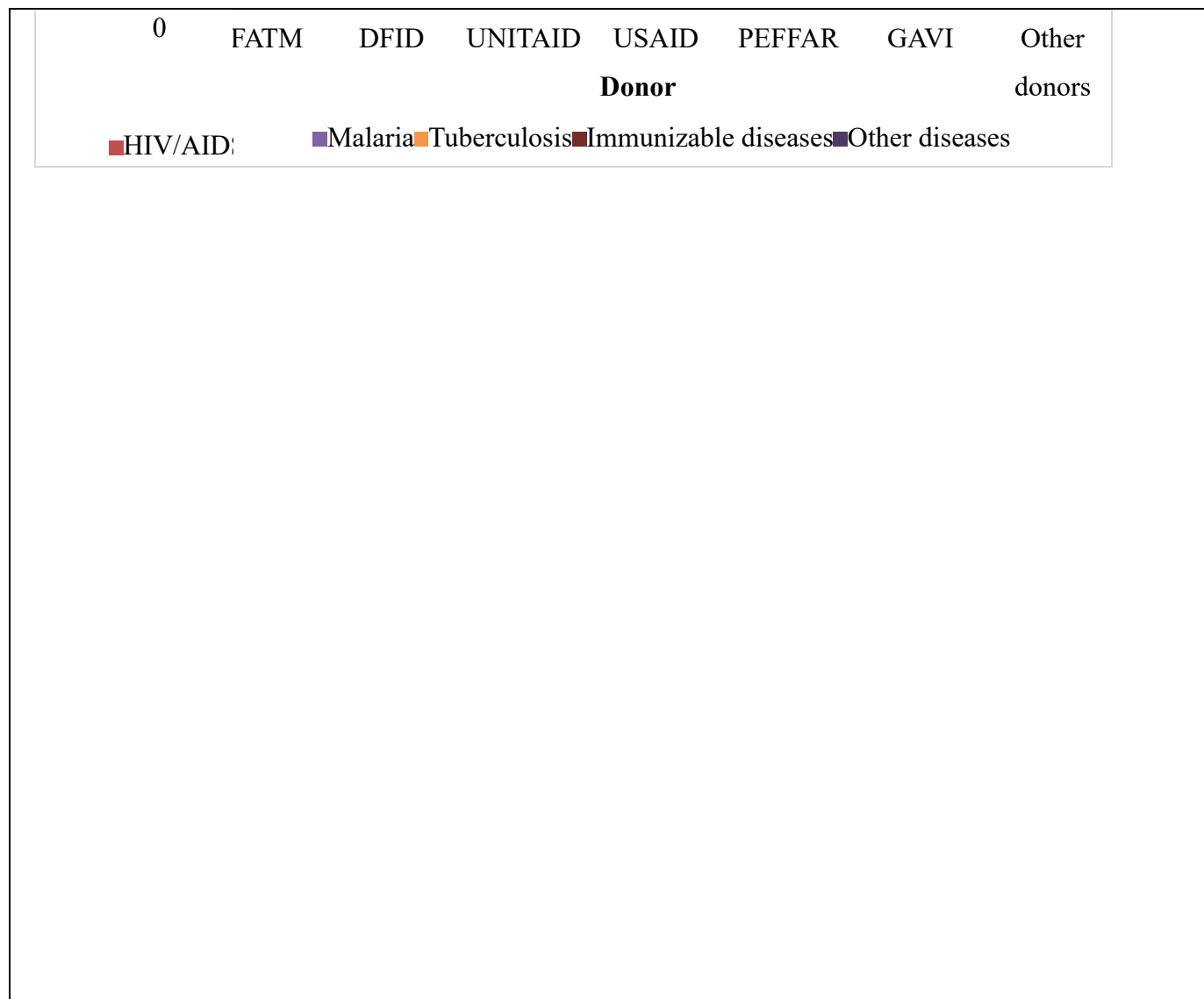


Figure 2: Average annual contributions of individual donors to disease-specific initiatives

Sources: (USAID, 2016a), (DFID, 2016b), (Unitaid, 2016a), (The Global Fund, 2016c), (The Global Fund, 2016d), (The Vaccine Alliance, 2016a), (PEPFAR, 2015), (PEPFAR, 2016a).

Figure 2 illustrates the allocations from specific donors to disease programs such as HIV/AIDS, Malaria, Tuberculosis, Immunisable diseases and others. From the figure, PEPFAR is seen to have contributed the highest amount of funding overall (US \$ 256 million) and it all went to HIV/AIDs. USAID followed contributed more to HIV/AIDS programming than the other programs that it supported for Malaria and TB. GAVI and DFID contributed to immunisable diseases and Malaria respectively, while like USAID, GFATM and UNITAID diversified their contributions to the three main diseases.

PEPFAR, USAID, GFATM and Unitaid disbursed US\$ million 256.08, 105.54, 25.8 and 7.93 respectively to HIV/AIDS interventions per annum. GAVI contributed US\$ 17.19 million to childhood-immunisable disease initiatives.

debate in this study. The average annual DAH by priority area and a breakdown of the disease category are illustrated in table 1.

Table 1. Average annual Development Assistance for Health to Uganda by priority area

Priority area	Amount (US \$ million)
Diseases	
Amount (US\$ million)	513.67
<i>HIV/AIDS</i>	401.94
<i>Malaria</i>	85.97
<i>Tuberculosis</i>	17.19
<i>Childhood-immunisable diseases</i>	6.37
<i>Other diseases</i>	2.2
Health Systems Strengthening	28.54
Nutrition	1.68
Water and Sanitation	4.49
Vaccination	17.19
Maternal and Infant health	7.58
Reproductive health and family planning	18.50
Health Infrastructure	37.54
Other threats	2.52
Total	631.71

Sources: (Uganda Budget Information, 2016), (USAID, 2016a), (DFID, 2016a), (Unitaid, 2016a), (The Global Fund, 2016c), (The Vaccine Alliance, 2016a), (PEPFAR, 2015), (PEPFAR, 2016a) Table 1 shows that average amount of funding for health the Uganda receives per year as per the specific disease and non-disease specific priorities. It can be seen that diseasespecific priorities receive majority (81%) of the total funding from donors, with the biggest portion going to HIV/AIDS. Health infrastructure, Health Systems Strengthening, Reproductive Health and Vaccination take up majority of what is left of the funding to non-disease specific health issues.

Despite the fact that HSS was highlighted by MoH as one Uganda's priority areas, some donors did not fund it. CHAI, BMGF and IHP+ however included HSS as a cross-cutting element in their projects, while USAID and GAVI allocated low amounts of DAH to it.

5.0 DISCUSSION

The increase in DAH to Uganda was attributed to the commencement of GHIs which increased OBS (Okwero et al, 2010), (Bank of Uganda, 2017). We noted that donor interests gradually moved towards the global health agenda, which likely affected Uganda's health policies (Stierman et al, 2013). We argued that the boost in funding from GHIs, might have enhanced donor influence despite the gains in health care associated with it. We noted that the increase in DAH for HIV/AIDS possibly led to a reduction in

Uganda's commitment, with GoU contributing only 15% to financing the epidemic (Dieleman et al, 2016).

The findings of this research asserted the mismatch between donor interests and Uganda's health priorities as indicated in the National Health Accounts (2015). The JANS also highlighted the disparity between Uganda's priority areas and donor interests, while evaluating the performance and impact of DAH. We argued that the increase in DAH contributed to stronger donor involvement in prioritisation and disbursement decisions, possibly fuelling a power shift in the DAH policy making process.

The absence of robust health policy plans amidst different donor agenda, led to uncoordinated policies wherein the strongest actor's interests would prevail. Since donors had clearer goals and modes of operation than GoU, it might have been easier to push their agenda and not Uganda's health priorities.

GoU's failure to increase health financing augmented its reliability on DAH, weakened its bargaining position and crippled national health policy. Since DAH was more than thrice the government health financing, donor influence in policy decisions was unavoidable. Dependency on donors led to the re-assignment of funds meant for health, to other sectors (Nabyonga, Sengooba, and Okuonzi, 2009). Immunisable diseases were the least recipients of public funding, as GoU might have taken comfort in the fact that GAVI would finance that area.

Poor coordination of Uganda's health care system may have contributed to the shift in power from GoU to donors. Audit reports of aided programmes revealed inadequacies in procurement systems, health data systems, fund allocation and service delivery (Agaba, 2009). DAH for HIV/AIDS, Malaria and Tuberculosis had been mismanaged and not fully absorbed, which might have motivated donors to assert more influence in aid dissemination.

Similar to Zikusooka, Kyomuhang, Orem and Tumwine's research (2009a), analysis in this study noted the lack of agency by the Government of Uganda, which might have given donors more clout in DAH policy making. The lack of country ownership reduced the success of DAH programmes and we argued that donors might have decided to take over, as they lost confidence in Uganda's ability to run them.

Although IHP+ sought GoU's input regarding priority areas and fund allocation, policy decisions were ultimately made by donors (Ooms et al, 2008). We noted the replication of activities, as well as seemingly competing and parallel priorities in earmarked funding, which Van De Maele, Evans and Tan-Torres (2013) and Zikusooka, Tumwine and Tutembe (2009b) had also highlighted. This indicated the lack of country engagement and ownership of the DAH policy making process, which should have guided donors.

On the contrary, replication might have been justifiable in cases where donors allocated funds to different aspects of the same priority areas. Evidence-based policy decision making would help to address such challenges as noted by Ooms et al in 2008, Behague, Taiwah, Rosato, Some and Morrison in 2009, as well as Bendavid, Holmes, Bhattacharya and Miller in 2012.

Changes in donor interests particularly after 2005 may have contributed to the power shift in DAH policy decision making from GoU to donors. Donors converged towards the GHI goals, MDGs and the SDGs as motivation to provide DAH. Further variations in priority areas and fund distribution were attributable to individual donor goals, power dynamics among IDPs, and the relationship between donors and GoU.

The vertical mode of funding was widely retained by donors according to World Bank data (World Bank, 2016b). We argued that this was due to its clearer targets, measurable outcomes, tangible results and shorter turn-around-times. In reality however, the everchanging nature of health challenges made their anticipation difficult and majority of donor targets thereby impractical.

More than 75% of donor commitments were channelled to disease initiatives like HIV/AIDS, Malaria and TB, as they accounted for 54% of Uganda's disease burden. The study showed a disconnect between donor interests and Uganda's health priorities, with emerging threats of non-communicable diseases like cancer and diabetes being neglected (Orne-Gliermann, Perez, Leroy, Newel and Dabis, 2003), (Bendavid et al, 2012). GFATM however argued that financing HIV/AIDS, Malaria and Tuberculosis freed up other funds for the workforce, equipment and infrastructure, thereby indirectly contributing to HSS.

IHP+ and CHAI were diagonal in their approach, financing Uganda's health care system to fight diseases. IHP+ made efforts to move towards a SWAp and country-led approach, so as to strengthen Uganda's health care system to address more health issues (Van de Maele et al, 2013) (Enyaku, 2014).

Although PHC forms the foundation of Uganda's and other low-income country health care systems, donors did not fund it due to its extensive and daunting nature. Save for IHP+ and CHAI, donors allocated low resources or none to HSS, which further showed misalignment of priorities. We argued that to achieve better results with disease-specific and other efforts, the health care system needed strengthening through more funding.

The researchers identified collaborations among CHAI, DFID, Unitaaid, GAVI, GFATM, PEPFAR, USAID and BMGF (USAID, 2016a). These partnerships however increased the complexity of funding decisions and possibly made the negotiation process more difficult for GoU. We underscored the increasing roles of NGOs and CSOs in implementing DAH projects. USAID, CHAI and GAVI championed PPPs as more effective avenues for DAH utilisation, than traditional ones.

6.0 CONCLUSIONS

Overall, donors gained more influence in prioritization and fund allocation decisions from 2002 to 2015. They generally funded interests that fit their agenda, which did not necessarily reflect Uganda's priorities. The influence gradually led to the power shift in Uganda's DAH policy making process, from GoU to the donors.

Trends over the years showed that Uganda was still heavily reliant on external assistance to finance the health sector and there were hardly any efforts to increase government

funding to improve the health care system. A continuation of this would keep donors in the position of the final decision-maker regarding priority setting for the health sector.

6.1 Implications and recommendations

The implications of the study were advisory for future DAH policy in Uganda and other middle and low-income countries, as the researchers provided an overarching guide to the actors, whose policy decisions impact health outcomes. To improve practice in health financing, the researchers reiterated the need to increase integration, foster country engagement and ownership of DAH, to create a balance of power and align Uganda's health needs with donor interests.

GoU should reinforce coordination, increase accountability, monitoring and evaluation to strengthen Uganda's negotiating position and regain influence in DAH policy. These efforts would achieve efficient and effective utilisation of resources hence better health outcomes for Ugandans.

Further analysis of health policies, with more attention to processes would help inform DAH in low-income countries (Oleribe and Nwanwanyu, 2015). The researchers recommended that more studies are conducted on the effects of the changes in health financing in middle and low-income countries like Uganda as these would help to guide policy makers in making evidence-based decisions for the countries.

Additionally, the researchers recommended that studies are conducted to explore alternative forms financing for health care to ensure sustainability and reduce overdependency on DAH which is dwindling.

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