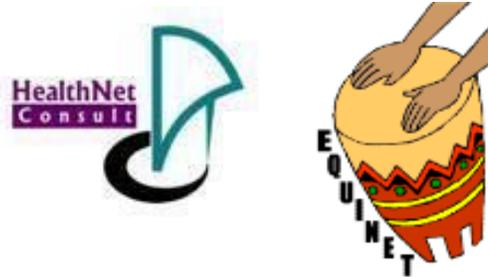


Financing for HIV, AIDS, TB and malaria in Uganda: An equity analysis

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Executive summary

Global health initiatives (GHIs) are an emerging and global trend in health that focus on partnerships. The introduction of GHIs in Uganda has had significant impacts on the overall health care financing, but there has been no assessment of their impact on equity in overall health sector financing in Uganda. This report, commissioned by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) from Healthnet Consult with mentoring from University of Cape Town Health Economics Unit and Training and Research Support Centre, explores and presents the current patterns of AIDS, TB and Malaria (ATM) financing within the health sector, and investigates the extent to which GHI financing for ATM has influenced health care financing reforms.

We obtained information for this paper through key informant interviews and extensive literature review from international and local sources. The key informants included the various funding sources and the key agents in managing and using ATM resources.

With an average 0.13% contribution by private health insurance schemes and no compulsory national health insurance scheme, financing for Uganda's health sector is largely not prepaid. However, there has been an improvement in ensuring access to services through the removal of user fees and increasing government funding of health services. There is limited cross-subsidy and high fragmentation between health financing mechanisms. Specifically, there is fragmentation between government and donor project funding, and also within donor project funds, which negatively impacts on creation of larger pools. Donor funding channelled through projects and global health initiatives targeting specific diseases may undermine equity between geographic areas. The lack of effective coordination of donor project funds is a potential source of inefficiencies and inequity.

Sources of funding for ATM in Uganda include government, donors, GHIs and households. It is difficult to estimate the proportion of government ATM funding because of the integrated nature of health service delivery in Uganda. The President's Emergency Plan for AIDS Relief (PEPFAR) and President's Malaria Initiative Programmes (both from the United States Government) seek to meet legislatively-mandated targets on prevention, treatment and care for HIV and AIDS and malaria. PEPFAR and US President's Malaria Initiative resources are primarily channelled outside government systems and are not aligned to government planning processes. The Global Fund for AIDS TB and Malaria (GFATM) seeks to strengthen country-ownership of programme activities. Initially channelled through projects, the GFATM funds in Uganda have been impeded by bottlenecks associated with poor management of resources, also affecting the flow of funds from the principal recipient (who receives the funds) to the sub-recipients (or implementers of the health services). The disbursement of funds has been unpredictable and has severely affected service delivery. The World Bank's Multi-country HIV/AIDS Programme (MAP) (which has been discontinued) was primarily focused on strengthening the national AIDS response. The largest share of MAP funding was directed to community-level activities, while funds under MAP were routed through government systems. The World Bank's stringent accounting procedures and requirements slowed the flow of funds, as did the government bureaucratic procedures.

One of the key reforms in health financing has been the development of long-term institutional arrangements (LTIAAs) for the management of the GFATM resources, following the temporary suspension of funds disbursed to Uganda in 2007. LTIAAs are a new mechanism designed to harmonise development aid within the health sector. They are a management mechanism for channelling donor resources agreed on by the government, the Uganda AIDS Commission and other stakeholders, which cover financing, planning, budgeting, co-ordinating, implementation,

procurement, monitoring and evaluation, as well as participation by civil society organisations. Actual implementation of the LTIA has not yet fully taken off. Another important change occurred when the Ministry of Finance, Planning and Economic Development (MoFPED) started allowing GHIs to help set the medium-term expenditure framework (MTEF) ceilings for the health sector, thereby allowing additional funds into the sector. We failed to establish the basis for this flexibility on sector ceilings.

GHI funding for ATM has had positive impacts on overall health sector financing and related reforms, including: significant increases in resources for the health sector; the ability to afford expensive, but life-saving technologies and interventions; and flexibility in MTEF ceilings for the health sector. It has also had negative impacts, including: undermining of sector-wide approach (SWAp) processes by creating parallel implementation channels and relying on the project mode for transmitting resources; unreliable funding and delays in disbursements to the country (especially for the GFATM); displacement of funding from other sources (bilateral and government); and retention of significant amounts of GHI funds at higher levels, with little funding reaching lower-level facilities. It is difficult to assess the overall effect given both positive and negative impacts.

We identified some key equity-related issues. Routing GHI resources in project mode does not allow for effective co-ordination and harmonisation, and not all GHI resources are aligned to sector priorities. This is likely to promote gender and geographic inequities, considering that project funds and some GHI funds are usually spent on selected geographic areas, the selection of which might not be always based on equity considerations, such as need. Although each GHI creates a relatively large risk pool, there is limited integration between the different GHIs. The lack of integration is likely to lead to inefficiencies, such as through an overlap in funding from different donors for certain areas or interventions. In the case of PEPFAR, the predetermined allocation of resources without Uganda's input or without considering specific country needs may enhance unequal allocations between the different types of interventions, as well as geographical inequities.

We recommend that the Ministry of Health redouble its efforts to improve co-ordination and harmonisation of all development aid, including support from GHIs. The LTIA is a starting point for this process, but more buy-in is required in order for it to be accepted by all stakeholders. Government will need to design mechanisms that will help integrate GHIs resources to allow for greater cross-subsidy and to reduce overlaps and inefficiencies. We suggest that the Ministry of Health (MoH) negotiate with development partners to channel GHI resources through one common structure within the MoH. When setting up this structure, the MoH would need to address the transparency and accountability concerns of the partners and other stakeholders.

We further propose that the MoH monitor equity in the health sector, including health financing equity, equity in access to care, geographical equity and gender equity. Initially, special equity studies could be conducted but regular equity indicators should be developed and reported on in the annual health sector performance reports. Technical programmes in the MoH should undertake in-depth spending assessments for HIV, AIDS, TB and malaria, including an assessment of private spending on these diseases. We also identified some research gaps, which need to be addressed. There is virtually no data on household expenditure for HIV, AIDS, TB and malaria, and, similarly, a lack of empirical evidence on who is accessing ART services and who needs or accesses the publicly funded health package. In addition, there are no specific requirements on the side of GFATM and no explicit guidelines on the side of government on how to allocate resources geographically, which creates the potential for inequitable allocations.

1. Introduction

Global health initiatives (GHIs) are an emerging and global trend in health that focus on partnerships and are considered to be one of the benefits of globalisation (WHO, 2008). GHIs are typically programmes targeted at specific diseases and are supposed to bring additional resources to health efforts. Three major global health initiatives were launched between 1998 and 2000 – Roll Back Malaria, Stop TB, and the Global Alliance for Vaccines and Immunisation. In addition, new GHIs emerged, mainly designed as funding mechanisms rather than as implementing initiatives. The most prominent financing GHIs are the Global Fund (to fight AIDS, TB and Malaria); the US President's Emergency Plan for AIDS Relief (PEPFAR); the President's Malaria Initiative; the World Bank's Multi-country AIDS Programme (MAP); and the Global Alliance for Vaccines and Immunisation (GAVI). These financing mechanisms that emerged as a means for development assistance for health are mainly focused on financing specific diseases or interventions. However, recently their need to support some components of health systems strengthening has become more apparent.

For a long time, health care financing in most African countries largely came from private sources (mainly household out-of-pocket funds), and from tax revenues augmented by external donors (mainly bilateral and multilateral agencies). (Out-of-pocket payments are payments made by an individual patient directly to a health care provider, as opposed to payments made by a health insurance scheme or taken from government revenue.) In the past decade, however, GHIs have brought in very significant amounts of resources for the health sector, thus enabling countries to achieve health outcomes they would have otherwise not achieved with existing resources. The collection, management and allocation methods used by these GHIs are usually different from the existing mechanisms in countries (Oomman et al, 2007) and this may result in financing reforms in some of countries.

The introduction of GHIs in Uganda has had significant impacts on the overall health care financing, but there has been no assessment of their impact on equity. HealthNet Consult has been commissioned and financially supported by the Regional Network for Equity in Health in East and Southern Africa (EQUINET), through the Training and Research Support Centre (TARSC) and Health Economics Unit University of Cape Town (UCT-HEU), to undertake an equity assessment for financing of AIDS, TB and Malaria (ATM) in Uganda. In addition, EQUINET (TARSC and UCT-HEU) has provided technical support throughout the period when this study was being conducted and has reviewed earlier drafts.

The main objectives of this study are to:

- examine trends in ATM financing patterns from an equity perspective; and
- explore the extent to which GHI financing for ATM has influenced health care financing reforms and equity in financing.

We consider several research questions. What are the sources of funding for ATM in Uganda? What are the levels of government spending on health vs. GHI funding for ATM? On what basis are GHI ATM resources allocated to the different levels of care and between different geographic areas? What are the GHI ATM funding priorities and strategies? To what extent has there been an adoption of the 'Three Ones' principles in improving integration, harmonisation and coordination of ATM funding? What impact has GHI ATM funding had on health financing reforms?

2. Methods and analysis framework

We obtained information for this paper through key informant interviews and an extensive literature review. The figures on funding presented in this report were obtained through interviews with various funding sources and with some key recipients of ATM funds. The key informants included various funding sources and key agents in managing and using ATM resources, such as the Ministry of Health, the Uganda AIDS Commission, the Ministry of Finance, Planning and Economic Development, and the Civil Society Fund.

In addition, we conducted interviews with a number of local and international non-governmental organisations (NGOs). We sought information from five categories of development partners, namely, bilateral agencies, multilateral agencies, GHIs and international and local NGOs:

- **Bilateral agencies** include the Japan International Cooperation Agency, the Norwegian Agency for Development (NORAD), the United States Agency for International Development (USAID), the United Kingdom's Department for International Development (DFID), the Swedish International Development Cooperation Agency (SIDA) and the Danish International Development Agency (DANIDA). It is important to note, however, that some Health Development Partners indirectly fund ATM through their direct support to the general budget. Such organisations include the Belgian Technical Cooperation (BTC), the Netherlands, and the German Technical Agency for Development (GTZ).
- **Multilateral agencies** include the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Bank.
- **GHIs** include the US President's Emergency Plan for AIDS Relief (PEPFAR) and the US President's Malaria Initiative, the World Bank's Multi-country HIV/AIDS Programme (MAP), and the Global Fund.
- **International organisations** include the Malaria Consortium, Hospice Uganda and Save the Children Uganda.
- **Local NGOs** include the Uganda Network of AIDS Support Organisations (UNASO) and the Malaria and Childhood Illnesses Secretariat (MACIS).

In addition, we obtained relevant literature from both international and local sources, including Global Fund-approved budgets, as well as annual reports and work plans of the different Health Development Partners and NGOs.

In collecting data from sources of funding, we mainly focused on establishing the amount of funding, modes of contribution and the basis of resource allocation, as well as where and how funding is channelled to reach final beneficiaries. We sought to understand the basis for funding, particularly to explore the degree of geographical and demographic (age, tribe and gender) considerations, if any. Another important inquiry regarding sources of funding was the extent to which there have been efforts in improving integration, harmonisation and co-ordination of ATM funding in Uganda. From implementers of ATM activities, we also obtained data on their sources of funding and the details of the areas of implementation (for example, prevention, treatment, mitigation of impact, co-ordination and management, etc.). However, a major setback in the analysis was that most implementers and some sources of funding were not able to disaggregate expenditure by these activity categories.

This study was conducted in Kampala, where most of the key informants are based. The study was restricted to the health sector and therefore excludes funding channelled through other sectors or line ministries. To ensure consistency during key informant interviews, we developed tools that guided the team in asking questions. Different interview guides were designed for the different

respondents. For instance the interview guide for 'sources of funds' was different from that of 'managers and/or users of funds'.

We categorised key stakeholders as bilateral, multilateral, global health initiatives and international and local NGOs. Based on our review of documents, interviews with Ministry of Health staff and our previous knowledge of the health sector's financing landscape, we selected all bilateral and multilateral agencies, and all GHIs involved in ATM funding. Certain GHIs, like the Global Alliance for Vaccines and Immunisation (GAVI), were not included in the study. International NGOs were more difficult to select because they are so many. However, we relied on our previous knowledge, guidance from the MoH and snowball techniques to select the most important ones for this study.

The team collected quantitative and qualitative data using interview guides. The quantitative data, mainly focusing on financing for ATM, were analysed in Microsoft Excel. The qualitative data was analysed by grouping the key themes emerging from the responses for the different questions. A lot of the results presented in this paper are based on an analysis of qualitative data from the interviews, where we looked at the key themes and drew out consistent views from the interviewees. In instances where there were exceptions, we indicate so (for example, in instances where a view was held by a few respondents). In the discussion, we also draw from international literature and reference it accordingly.

With the objective of assessing ATM financing from an equity perspective, the analysis framework of the basic principles of fair financing was used. In this framework, equitable financing is based on a specific set of fair financing principles:

- **Financial protection:** No one in need of health services should be denied access due to inability to pay and households' livelihoods should not be threatened by the costs of health care.
- **Progressive financing:** Contributions should be distributed according to ability to pay, and those with greater ability to pay should contribute a higher proportion of their income than those with lower incomes.
- **Cross-subsidies:** The healthy should help subsidise the ill and the wealthy should help subsidise the poor. Cross-subsidisation occurs when the wealthy make greater contributions to health care funding than the poor – or people with greater need – thereby enabling the poor to use more health services than the wealthy, irrespective of the difference in contributions.

In order to assess ATM financing in the right context, we carried out a preliminary analysis of equity in overall health care financing in Uganda (presented in *Section 3*). In our analysis, we assessed the extent to which financing for ATM in Uganda exhibits the fair financing principles listed above. So, financing mechanisms that do not enhance cross-subsidisation, do not allow for a greater population to be covered, and/or do not have progressive contributions were taken to be inequitable mechanisms. For the objective of assessing the impact of GHI funding for ATM on overall sector financing, we relied on the qualitative responses obtained through interviews and grouped them according to themes of interest. Using the same analysis methods, we explored whether the introduction of GHI funding for ATM-influenced health financing reforms in Uganda, by considering all changes in processes or structures related to sector financing in the past decade.

This assessment was conducted by three people: a health economist (as the principal investigator) and two economists, and took place between July 2008 and February 2009. The report was written and finalised between March and April 2009. Some limitations in the study were noted. From the data collected, areas of potential error arose from fact that some organisations categorised as sources of funding also received funding from other sources in the scope of our study, such as UNICEF, which receives funds from USAID. In addition, some organisations (like Japan International Cooperation Agency) availed some funding for activities that included some aspects

of ATM and non-ATM. Though ATM activities benefited from such funding, including it as ATM funding would exaggerate our data. We decided to exclude all such funding that was not provided exclusively for ATM activities, so the exclusion of such funding might have resulted in an under-estimate of financing for ATM. Another limitation of this study is the inability to comprehensively estimate the funding contribution from GoU and funding from Health Development Partners (mainly the bilaterals) that is channelled through general budget support. The estimates presented in this report are based on information reported by other studies (Lake and Mwijuka, 2006) and findings from key informant interviews, but mainly exclude funding from the general budget (GoU + donor funding) that is allocated for integrated delivery of health services (part of which supports ATM). This implies that the information presented in this report is an under-estimate of funding for ATM. However, we are convinced this limitation will not bias the equity objectives of this study.

3. The Ugandan health financing context

Resources spent on health care in Uganda come from both public and private sources. The private sources include households, private firms and not-for-profit organisations. There are two major sources of public funds for the Ugandan health sector: funding from government and funding from donors (through health projects and direct district support) and GHIs. The government's contribution includes central government funds (from other sources, such as taxes), local government funds and funds from donors/ development partners that are channelled through national budget support. Donor funding is channelled through central government (budget support), district budget support, projects and NGOs. *Figure 1* provides an overview of the flow of funds within the health sector. The sector-wide approach happens at the level of external revenue, where development partners either support the general budget of government or support health sector priorities through projects. (The sector-wide approach is a means of collecting funds to support a health policy and expenditure programme that is implemented and managed by the government through a common approach across the health sector. Note that *Figure 1* refers to the medium-term expenditure framework (MTEF), which is a system of three-year – or longer – rolling budgets. It creates a predictable medium-term planning environment, gives the health sector an advance indication of allocations likely to be made over the next few years and allows policy development and implementation to be linked with resources over time.)

Over the last decade, government spending on health has been increasing, both nominally and in real terms (see *Figure 2*). Although public spending on health increased from about US\$8 to US\$11 per capita from 2001/2 to 2006/7, it remains significantly lower than the target of US\$28 per capita estimated as the amount required for providing the Uganda National Minimum Health Care Package (MoH, 2002), and is also lower than the US\$40 per capita estimated by World Health Organization as minimum expenditure required for funding the health sector in developing countries. Currently, government spending on health is only 9.6% of total government spending. This is substantially lower than the Abuja target of committing 15% of annual government budget to the health sector.

Real figures have all been calculated in 2007/8 prices and are represented in billions of Ugandan Shillings. This includes both tax funding and funding from donors channelled through general budget support. Government funding includes donor funding channelled through general budget support, but excludes donor project support and some of the GHI funding (for example, PEPFAR) and includes funds from the Global Fund.

Figure 1: Overview of current health sector financing flows in Uganda (2008/2009)

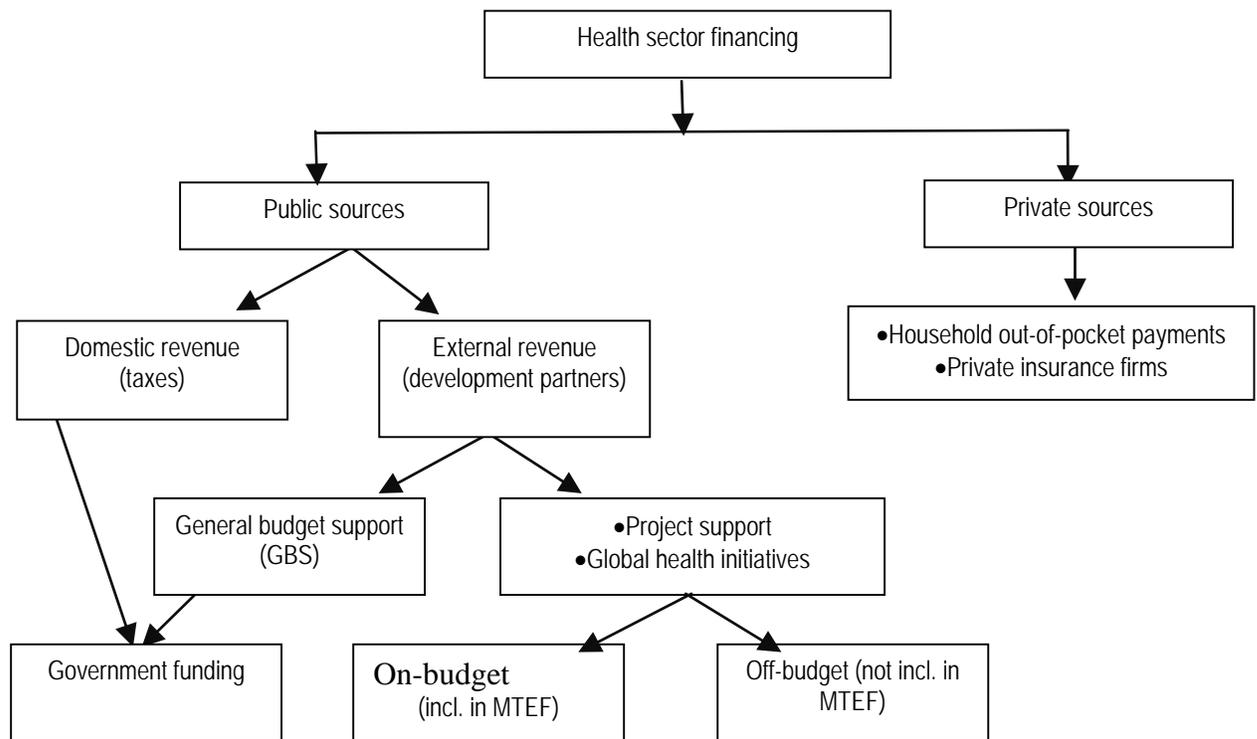
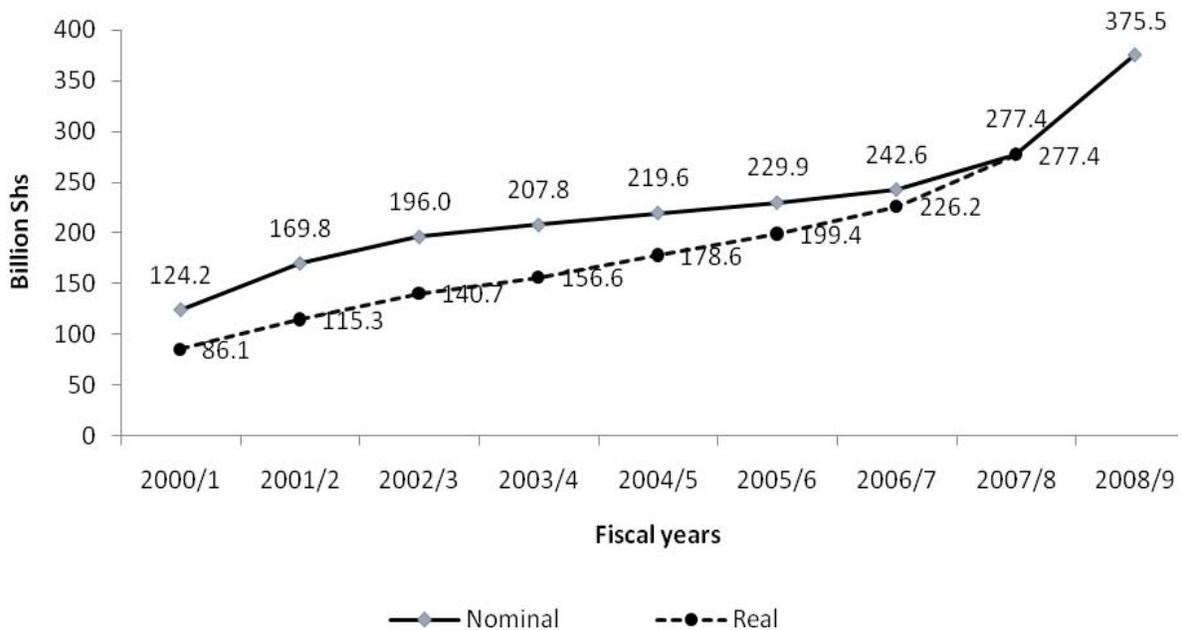


Figure 2: Government funding for the Ugandan health sector (2000/01–2008/09)



Source: Ministry of Health, 2005/06 and 2007/08

In Uganda, the key revenue collecting institutions include the Uganda Revenue Authority (URA) – a government agency – a few community-based health insurance (CBHI) schemes, private insurance funds and private health care providers. The collecting organisation for all public resources is the Treasury of the Ministry of Finance, Planning and Economic Development (MoFPED). Domestic revenue obtained from taxes is collected by URA for individuals working in the formal sector (contributing 30% of their income as pay-as-you-earn tax, or PAYE), while companies pay 30% as income tax). Resources from private sources are mainly from a few private (for-profit) health insurance companies, a few CBHIs and private health care providers (being the biggest collectors of private resources) through direct out-of-pocket expenses. Public managers of health care resources include the Ministry of Health, other line ministries, districts health services and parastatals, while private managers include private health insurance agencies, households, facility-based NGOs and private firms. According the National Health Accounts report, public institutions managed about 30%, while about 70% was managed by private institutions/ households (MoH, 2004). In the absence of more recent NHA data, it is difficult to tell whether this picture has changed in the last seven years.

Private resources for health have dozens of very small risk-pools, through small and highly fragmented CBHI schemes and voluntary private health insurance/ prepayment schemes. (Prepayments are payments made by individuals via taxes or health insurance contributions before they can use a health service.) To date, there are about three hospital-based CBHIs and about four relatively small urban-based private pre-payment/ insurance schemes. Funds from public sources are allocated by MoFPED to different sectors. The basis for determining the amounts to allocate to each vote holder include a formula that takes into consideration population size, special considerations (for example, areas affected by war or historically disadvantaged), the human development index, per-capita donor and NGO spending in the district, and historic budgeting. Over the past seven years, there has been a focus on shifting resources to lower levels of care, especially the district health services (which mainly cater for people living in the rural areas – that is, those with relatively lower incomes). Specifically, for the last seven years, the proportion of funds allocated to district health services steadily increased from 32% to 54%, while the proportions allocated to higher-level institutions and facilities (for example, MoH headquarters and referral hospitals) decreased consistently over the same period.

Benefit packages vary widely across the different financing mechanisms. (A benefit package refers to the services a health plan, insurer or an employer offers under the terms of a contract.) The Ministry of Health established the Uganda National Minimum Health Care Package (UNMHCP), which is described in the Health Sector Strategic Plan (HSSP II). This package generally includes a very wide range of health care services to be provided at different levels of care in the health system. The scope of services in the package is divided in four broad clusters: health promotion; disease prevention and community-based initiatives; maternal and child health; prevention and control of communicable diseases; and prevention and control of non-communicable diseases. This package is intended to be accessed by the whole population but, due to inadequate funding of the health sector, the quality and scope of services provided at health facilities is actually lower than that described in the HSSP II (MoH, 2007).

Table 1 provides a summary of health care financing in Uganda. (Note that contribution mechanisms refer to methods through which the consumers of health care contribute to health care financing in order to access health care. Risk pooling refers to the sharing of risk across a group of people – or across the entire population – so that unexpected health care expenditure does not fall solely on an individual or household and that individuals and households are protected from catastrophic health expenditures, such as those incurred after an accident or natural disaster.)

Table 1: Summary of health care financing in Uganda (2007)

Financial functions	Notes
Revenue collection	
Sources of funds	Donors account for 27.4% of health care funding. Households bear the burden of funding health services within the country (30%). Some households (the unemployed and the poor) are not expected to pay tax.
Contribution mechanisms	<p>General tax revenue is generated primarily from personal income tax and import taxes, with VAT and other taxes accounting for a small share of revenue: Personal income tax (PAYE) is progressive. At a minimum level of income, PAYE is not charged, while the highest income bracket is taxed at approximately 30% of an employee's salary. Income brackets in between are charged at varying percentages. Value-added tax (VAT) is set at 18%.</p> <p>Private health insurance accounts for less than 1% of total health care funding. Most companies pay the full contribution on behalf of employees. A few organisations require their employees to pay a small percentage of the total premium (about 20%). Premiums are related to benefit packages rather than to income level.</p> <p>For community health insurance, flat rate contributions are levied.</p> <p>Out-of-pocket payments:</p> <ul style="list-style-type: none"> • In March 2001, the government of Uganda abolished the charging of user fees for health services in public sector facilities, except in 'private wards' within public hospitals. • Private not-for-profit and Private for-profit (PFP) providers, including private clinics, hospitals, drug shops and traditional healers, continue to charge fees. • There are high levels of out of pocket payments in Uganda despite free services in public health facilities. Perceived poor quality of services, particularly due to lack of drugs and equipment (for example, X-ray machines), and limited numbers of health workers results in high use of private providers on an out-of-pocket basis.
Collecting organizations	Tax is collected by the Uganda Revenue Authority (URA), which has recently increased tax revenue collection through public education and demonstrating the benefits of tax for social services. Private health insurance contributions are collected directly from employers by the insurance company.
Risk pooling	
Coverage and composition of risk pools	Private medical schemes cover less than 1% of the entire population. These include high- and middle-income formal sector workers and, sometimes, their dependants. There is limited risk pooling and cross subsidies within individual schemes. Community health insurance schemes only cover a population of less than 0.2% of the entire population, mainly the informal sector in the rural areas. The remaining 99% of the population is either largely dependent on donor and tax funded services or services purchased on an out of pocket basis. There are some cross-subsidies in tax funding, as high- and middle-income earners primarily contribute to tax funds, thereby subsidising the poor who use publicly funded health facilities. Out of pocket payments are the single largest sources of health care financing in Uganda (accounting for well over 30% of total health care expenditure) – there is no risk pooling in out of pocket payments.
Allocation mechanisms	There is no risk equalisation between individual private health insurance schemes. Tax funds are centrally collected and allocated to individual districts, using a needs-based resource allocation formula.

Purchasing	
Benefit packages	There is a relatively comprehensive benefit package for those using tax funded public health care facilities, defined through a national minimum package. However, major resource constraints result in many services not being available at facilities. Most private health insurance schemes have a comprehensive package, which covers outpatient, inpatient, antenatal, dental and optical services. The precise package received is determined by the premium level paid.
Provider payment mechanisms	Public facilities receive budgets and staff receive salaries. All Private not for profit facilities also receive budget allocations from government aimed at subsidising use fees, especially for the poor and vulnerable within the catchment area. Patients referred to PFPs are paid on a fee-for-service and case-by-case basis.
Provision of services	About 54.5 % of the hospitals are public sector facilities, which provide the bulk of the services, followed by private not for profit accounting for 41.6% and PFPs for 3.9% of hospitals respectively. There are numerous private for-profit (PFP) clinics, drug shops and traditional and complementary medical practitioners.

Source: McIntyre et al (2008)

3.1 Key equity issues related to overall health care financing

Key positive trends in health care financing show an improvement in ensuring access to services through the removal of user fees and increasing government funding of health services. With government revenue mainly obtained through progressive income tax, this source of funding is relatively equitable. In spite of these efforts, out of pocket spending remains the largest source of funding for the health sector, which is a highly inequitable funding mechanism. Global health initiatives, whose funding is mainly focused on specific diseases (especially ATM), have recently improved health sector funding significantly. The health sector heavily relies on donor funding, which may be through health budget support or through donor projects. Donor funding channelled through projects is likely to increase inequity between districts, depending on the criteria used for selection of districts to be supported. Similarly, global health initiatives targeting specific diseases may undermine equity, depending on the methods of implementation of the disease interventions.

In the absence of a national health insurance scheme, and with an average 0.13% contribution by private health insurance schemes, financing for Uganda's health sector is largely not pre-paid. The only pre-paid funds for Uganda's health sector are those from government and the limited voluntary and community-based health insurance schemes. Private health insurance schemes mainly cater for the middle-income working population, as they are offered by their employers, and community-based health insurance schemes mainly enrol low-income informal sector employees. With limited risk pooling and no cross-subsidy, financing of the sector is currently fragmented and inequitable.

With limited voluntary health insurance in the country, out of pocket spending remains the most significant financing mechanism, accounting for half of all private funding for health. out of pocket spending is one of the most regressive funding mechanisms because those without money can be excluded from accessing services or become further impoverished as a result of having to pay for health care services. In addition, funds from out of pocket spending are not pooled, so there is limited cross-subsidy. The lack of effective coordination of donor project funds further contributes to inefficiencies and inequity.

An equity assessment of financing for Uganda's health sector is presented in *Table 2*.

Table 2: Equity analysis for health care financing in Uganda (2008/9)

Positive and negative aspects, opportunities and challenges	Notes
REVENUE COLLECTION	
Sources of funds	
Positive aspects	Recent increases in donor support, through budget support is encouraging and should be encouraged.
Negative aspects	Out of pocket payments are a major source of funds, and are highly inequitable.
Opportunities and challenges	Given the country's low GDP, the only way to reduce out of pocket payments would be through increasing donor support, especially support channelled through budget support. Estimating out of pocket expenditure on health is impossible due to lack of regular NHA data compilation. This is an area that needs to be addressed, to ensure proper monitoring of trends in out of pocket expenditure.
Contribution mechanisms	
Positive aspects	PAYE tax contributions are progressive. Removal of user fees has improved access to health services, thereby improving equity in access. Out of pocket payments are a highly inequitable way of funding health services.
Negative aspects	VAT is regressive form of revenue collection and is set relatively high at 18%. Annual increases in government contributions are minimal, falling far short of the 15% Abuja target. Very limited private health insurance, which is mainly funded by employers, can act as a disincentive for further investment. GHIs targeted at specific diseases have the potential of weakening health systems, especially in instances where implementation of funded disease-specific interventions is done vertically. Increased donor funding through the 'project' mechanism has the potential for retarding equity enhancement, as resource allocation decisions are made by different groups of people (with different interests), and sometimes this funding may not be aligned with sector priorities.
Opportunities and challenges	Government should be reminded of its commitment to meeting the 15% Abuja target. Lack of regularly collected information on out of pocket payments makes it impossible to assess whether removal of fees has resulted in the desired reduction in OOP payments. Potential exists to harness some of the out of pocket funds for risk-pooling mechanisms for revenue collection (such as social health insurance [SHI]). Current debates and preparations for SHI could be speeded up, but a significant amount of work is still required to put in place the required structures for SHI implementation.
Collecting organisations	
Positive aspects	None.
Negative aspects	In the current non-regulated health insurance environment, private health insurance agencies who are also providers of care are likely to behave unethically. Proposed NHI could explore ways of ensuring integration of pools and risk equalisation.
Opportunities and challenges	There is an urgent need for regulation of the health insurance industry. Proposed NHI could explore ways of ensuring integration of pools and risk equalisation.

RISK POOLING	
Coverage and composition of risk pools	
Positive aspects	None.
Negative aspects	Private health insurance schemes are few, covering less than 1% of population. Risk pooling and cross-subsidies are limited within individual schemes. About 99% of the population is either largely dependent on donor- and tax-funded services or services purchased on an out of pocket basis. There is some cross-subsidisation in tax funding, as it is primarily high- and middle- income earners who contribute to tax funds and the poor who use publicly funded health facilities. Currently, there is no risk pooling in out of pocket payments.
Opportunities and challenges	None identified.
Allocation mechanisms	
Positive aspects	None.
Negative aspects	There is no risk equalisation between individual private health insurance schemes. Donor project funding targeted at selected districts has the potential for increasing geographical inequity.
Opportunities and challenges	None identified.
PURCHASING	
Benefit package	
Positive aspects	There is a relatively comprehensive benefit package for those using tax funded (public health care facilities), defined through a national minimum package. However, major resource constraints mean that many services are actually not available.
Negative aspects	There are significant differences between the package accessed by those who use tax-funded (public) facilities and those who use the privately funded services, both in terms of scope and quality. With very little cross-subsidisation, this two-tier and highly inequitable system remains entrenched.
Opportunities and challenges	The introduction of SHI would partially close the equity gap if funds were used to improve the quality of services in accredited public facilities. If not, it would only serve to widen the gap between services in the public and private sectors.
Provision of services	
Positive aspects	Public-private partnership with private not for profits has improved physical access to services, and government subsidies to private not for profit organisations are useful in maintaining relatively lower user fees.
Negative aspects	Significant geographical inequities exist, with some districts having relatively better access to facilities. Also, health facilities are inequitably distributed between urban and rural areas. Access to hospital-level services is especially inequitable, given that there are so few hospitals in the country.
Opportunities and challenges	None identified.

3.2 ATM trends, policies and strategies in Uganda

Uganda was one of the first countries to acknowledge the HIV and AIDS challenge. In response, a very concerted campaign was launched to sensitise people about HIV and AIDS and to educate them about prevention. The AIDS Control Programme was established in 1986, and was charged with implementing a public health response for HIV and AIDS. Further, the Uganda AIDS Commission was established in 1992, and was tasked with co-ordination of a comprehensive national response in all sectors (namely, beyond the health sector). Currently, an average of 6.4% of Ugandans aged between 15 and 49 years are estimated to be HIV positive, with prevalence reported to be higher among women (7.5%) compared to men (5%), and with urban residents being more likely to be infected (10.1%) than rural residents (5.7%) (MoH and Macro International Inc., 2008). The key strategies for HIV and AIDS control include: the abstain, be faithful and condomise (ABC strategy), voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT), control of sexually transmitted diseases, antiretroviral treatment (ART), and care and support services.

Approximately 95% of Uganda (where 88% of the population lives) is exposed to moderate to very high transmission levels of malaria. Malaria is the number one cause of morbidity and mortality in all parts of the country. Deaths due to malaria are highest among children under five years. About 20-30% of deaths among children under the age of five seeking help at facilities are attributable to malaria (MoH, 2005). The main objective of the National Malaria Control Programme (NMCP) is to provide a package of effective and appropriate interventions to promote positive behaviour change and to prevent and treat malaria. The key interventions for malaria control in Uganda include: distribution of long-lasting insecticide-treated nets to pregnant women and children under five years of age (through antenatal clinics), indoor residual spraying in targeted parts of the country (mainly in areas with very low transmission that are prone to epidemics and areas with very high transmission), prompt treatment for children under five years of age through the Home-based Management of Fever strategy, intermittent presumptive treatment for pregnant women and prompt diagnosis and treatment using effective antimalarials (MoH, 2005). Although the importance of definitive diagnosis is acknowledged in policy documents, clinical diagnosis is the most widespread practice in most parts of the country due to a lack of adequate laboratory equipment, trained personnel and other logistics. Although significant steps have been made in the implementation of the key malaria control interventions, Uganda is still far from meeting the Roll Back Malaria targets for 2010 (Uganda Bureau of Statistics 2007; MoH and Macro International Inc., 2008).

TB is the seventh most important cause of premature mortality and disability worldwide. Uganda ranks among the world's top 22 high-burden countries, with an estimated annual risk of infection of 3% ~ equivalent to 150–165 new smear-positive TB cases per 100,000 per year (MoH and Macro International Inc, 2008). In 2003, the country reported a case detection rate of 52% and a 67.6% treatment success rate, but has yet to attain the global case detection target (70%) and global treatment success target (85%). The key strategy for TB control in Uganda is community-based directly observed therapy (DOT), which was adopted by the Ministry of Health as the best strategy for controlling TB in 1997 and has since been rolled out to all districts in the country. The approaches used in case detection in Uganda involve a high degree of supervision and have resulted in vertical implementation of activities. For the TB programme, the country has been subdivided into zones (which are made up of several districts) and each zone has a zonal TB focal person, who supervises the activities all districts within a zone and reports directly to the National TB and Leprosy Programme (NLTP) (MoH, 2007). In every district, there is TB focal person responsible for all activities at district level. The district TB focal persons are supervised by the zonal TB focal persons, who in turn report to the national supervisors at the programme.

The national priorities for ATM are described in the AIDS National Strategic Framework, the National Malaria Strategy and the National TB and Leprosy Programme documents. All global health initiatives (GHIs) are expected to be guided by the national strategic documents in formulating the priorities for funding.

3.3 How do GHIs for ATM function in Uganda?

In this section we briefly review the modus operandi of four GHIs: the Global Fund to Fight AIDS, TB and Malaria, the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative, and the World Bank's Multi-country AIDS Programme (MAP).

The Global Fund provides grants for HIV and AIDS, tuberculosis and malaria. A country qualifies to receive money from the Global Fund after it has established a Country Co-ordinating Mechanism (CCM) made up of stakeholders from government and civil society, and when its proposal has passed a rigorous review. The proposal is prepared and submitted by the CCM. The grant proposal spells out: programme activities to be undertaken; the organisation(s) that will receive and manage this funding; the expected outcomes of the activities; and a budget. If the proposal is approved by an independent expert committee (the Technical Review Panel), a local fund agent – usually a well-established international accounting firm – is selected to assess the capacity of the principle recipient (who is responsible for funds management and for ensuring that implementation is appropriately done and targets are achieved) to implement the proposal and to recommend a disbursement amount. Once this process is complete, the Fund disburses funds to one or more principle recipients, usually every quarter. All funding under the Fund is performance-based, requiring countries to meet specific targets for their proposed activities within given timeframes.

In Uganda, Fund activities started in 2004. Fund money is channelled primarily to the government, and is generally on-budget, in other words, registered in the MTEF and captured as being part of the sector ceilings. Preferably, it should flow through the national central bank and/or treasury accounts. (Initially a special project management unit was set up at the Ministry of Health to circumvent government budget-ceiling restraints for the health sector.) Although the Fund generally follows SWAp procedures, it does request some additional information and reporting that falls outside the normal reporting procedures of government, as well as special procurement procedures that do not necessarily coincide with government procurement procedures. In Uganda, Fund activities experienced major set-backs when the local fund agent (in-country agency that oversees funds management) reported mismanagement of funds – GFATM activities in Uganda were suspended in September 2005. Although implementation of activities under Global Fund was re-instated in 2006, progress on implementation has been slow and disbursement of funds is not always timely. As such, this source of funding remains unreliable to date.

The United States President's Emergency Plan for AIDS Relief (PEPFAR) was created in 2004 and was authorised to spend US\$15 billion over five years to prevent and treat HIV and AIDS in fifteen focus countries (Bernstein and Hise, 2007). The PEPFAR portfolio is overseen by the Office of the US Global AIDS Coordinator (OGAC), based in Washington DC. The programme is managed by a number of implementing agencies and departments, but the vast majority of funds go to the US Agency for International Development (USAID) and the Centres for Disease Control and Prevention (CDC) (Oomman et al, 2007). In creating PEPFAR, the US Congress legislated certain programmatic targets: treat two million people with anti-retroviral therapy (ARV), prevent seven million new infections and offer care to 10 million people infected or affected by AIDS. Progress against these targets is the principal way in which Congress assesses PEPFAR's performance. As a result, PEPFAR is highly oriented toward meeting these numerical targets. Each PEPFAR focus country has its own share of the targets and each PEPFAR recipient is expected to take on a portion of these country targets. Congress also legislates the way in which PEPFAR allocates its

funding. These allocation requirements are known as 'earmarks' and they require PEPFAR to use 55% of its funds for treatment, 20% for prevention, 15% for care and 10% for orphans and vulnerable children (Oomman et al, 2007).

In Uganda, PEPFAR funding is channelled largely outside the government system and follows PEPFAR-specific procedures. The Ministry of Health is a recipient of PEPFAR funding, but all monies channelled to the government must still follow PEPFAR-specific accounting and reporting requirements, which are separate from standard government procedures. Government has very limited involvement in the oversight of PEPFAR programmes in Uganda. Although PEPFAR does not contribute funds directly to the sector-wide approach (SWAp) in Uganda, it has established a board of government officials, PEPFAR staff and other civil society stakeholders which reviews and approves PEPFAR's annual Country Operational Plan (COP) for Uganda. All PEPFAR funding is off-budget and not included in the medium-term expenditure framework ceilings for the health sector. PEPFAR funds are spent on prevention (the ABC strategy and prevention of mother-to-child transmission); treatment (ARV drugs and services, and laboratory services etc) and on care (mainly for orphans and vulnerable children). The funds are mainly channelled through NGOs (including civil society, as well as not-for-profit and private-for-profit organisations and academic institutions).

The US President's Malaria Initiative, which was launched in 2005, operates in similar way to PEPFAR, with funding restricted to the prevention and control of malaria. In Uganda, US President's Malaria Initiative activities are overseen by the USAID Mission and there is little involvement by government in overseeing the programme. US President's Malaria Initiative support four main interventions: spraying with insecticides (indoor residual spraying in specific communities, supplying insecticide-treated bed nets (ITNs), providing lifesaving drugs, especially artemisinin-based combination therapies, and supplying treatment for pregnant women (intermittent preventive treatment (IPT)). All US President's Malaria Initiative funds are off-budget and are not channelled through the health SWAp.

The World Bank's Multi-country AIDS Programme (MAP) started providing funds to Uganda in 2000 after the Ugandan government requested International Development Association (IDA) support from the World Bank for the Uganda HIV/AIDS Control Project (UACP). MAP programmes were designed as a way to strengthen a country's capacity to develop a national response to the AIDS epidemic. UACP was in the first cohort of MAP projects and the only major source of external funding for HIV and AIDS in Uganda at the time. MAP funding was provided to Uganda as a loan, unlike in some countries where it was given in the form of grants (Oomman et al, 2007).

MAP funding was on-budget and designed to be multi-sectoral, with a particular emphasis on supporting a community response to the epidemic. MAP funding was provided to a wide variety of stakeholders, including multiple line ministries (not only the Ministry of Health), district governments, civil society organisations and for-profit entities. In particular, all MAP projects placed high priority on building the community response to the epidemic. As the first donor to channel significant sums of AIDS monies to the community level, MAP projects have often built local capacity where none previously existed. The project design was harmonised with the national response by supporting the HIV and AIDS National Strategic Framework (NSF) in line with the 'Three Ones' principles (which were later adopted by the international community in 2003). The project had three clear objectives – prevention, mitigation and capacity building – which are also among the objectives of the NSF. It had three distinct components organised by the type of implementers – at national level, district level and community level – which correspond to the Ugandan government's strategy to mobilise and unify a decentralised response to the HIV and AIDS epidemic. Project activities wound up in 2006.

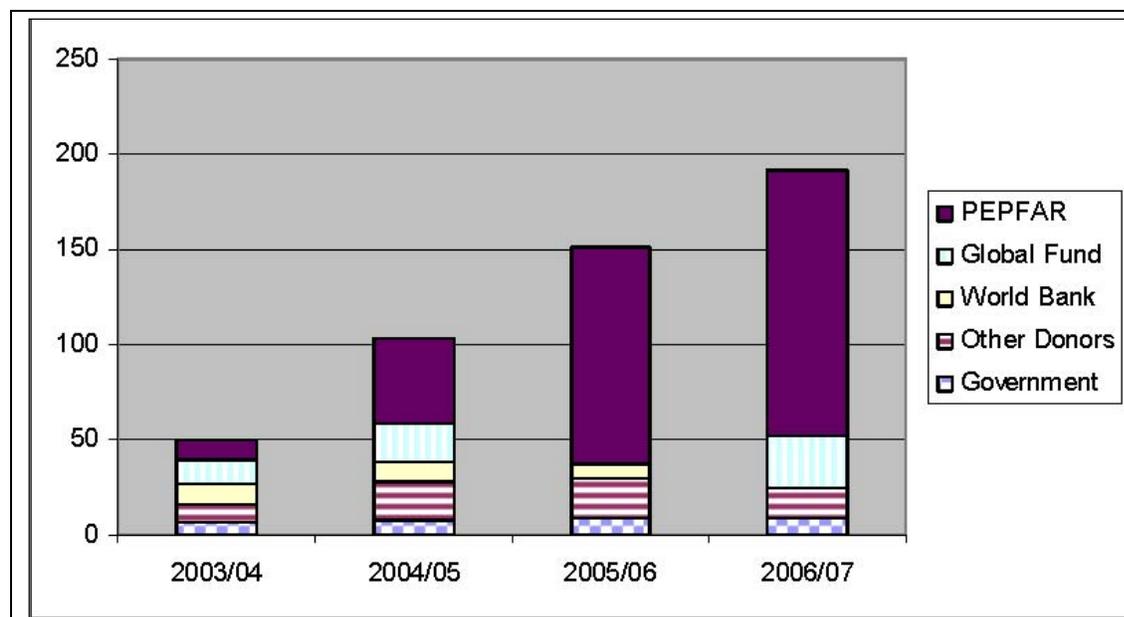
In Uganda, all MAP funding was sent initially to the government, although significant sums of money were later sub-granted to entities inside and outside the government. The MAP project followed standard World Bank processes rather than necessarily following standard government practices. The government assumed the lead role in designing, planning and overseeing the MAP project, with the close involvement of World Bank staff. In particular, World Bank officials worked closely with the government to design the project and plan how it would be implemented. These pre-implementation activities required the selection of the activities to be supported with MAP funds and the types of recipients to receive funding. Government staff then took the lead in implementing the project and monitoring the progress and performance of all organisations receiving MAP funds.

4. Trends in ATM funding in Uganda’s health sector

4.1 HIV and AIDS

In the same way that financing of the whole health sector takes place through government, donors, GHIs and households, the same sources of funding apply to HIV and AIDS. The relevant GHIs include PEPFAR, the Global Fund and MAP, while donor projects are mainly funded by bilateral agencies including Japan International Cooperation Agency, Norad, United Kingdom Department for International Development (DfID) and the Swedish International Cooperation Agency (SIDA), who also support the health sector through General Budget Support. As shown in *Figure 3*, PEPFAR is the largest source of funding for HIV and AIDS in Uganda, and its contribution has been increasing over the past years (for example, from 26% to 85% from 2003/4 to 2006/7) (Lake and Mwijuka, 2006; Bernstein and Sessions, 2007). To date, no work has been done on estimating out-of-pocket spending on HIV and AIDS in Uganda as part of estimating total spending on HIV and AIDS. However, estimates from the National Health Accounts indicated that 40% of total health expenditure came from households in 2000/01 (MoH, 2004). A study conducted in 2002 reported a two-month expenditure of US\$95 per household (in other words, US\$570 annually) by households infected/ affected by HIV and AIDS (Nabyonga-Orem et al, 2008).

Figure 3: Uganda National HIV and AIDS funding (in US\$ millions), 2003/4-2006/7



Source: Oomman et al (2007)

Table 3 provides a summary of public sources of funds and the amounts from each source for HIV and AIDS. Data for fiscal years 2005/6 and 2006/7 was obtained from the United Nations General Assembly Special Session on HIV/AIDS UNGASS report and 2007/8 data was obtained through our survey. Results show that GHIs contributed the highest proportion of funding for HIV and AIDS in Uganda in the three fiscal years. The government's contribution captured in Table 3 is not a total reflection of amount of money it contributed because it excludes the resources allocated to health facilities for integrated service delivery, from which HIV and AIDS would benefit. Instead, the contribution refers to the resources earmarked for institutions that exclusively implement HIV and AIDS activities, for example the Joint Clinical Research Centre, the AIDS Control Programme and the AIDS Information Centre. Results show that bilateral agencies contributed about 8% of total resources for HIV and AIDS for the first two fiscal years. For 2007/8, according to the survey information we obtained, their contribution increased to 25%. We believe that this significant increase is really due to the differences in estimation for the different timeframes, so the results for 2007/8 presented in Table 3 should be interpreted with caution.

Table 3: HIV and AIDS funding by source (millions), 2005/2006–2007/2008

Sources of funding	2005/2006			2006/2007			2007/2008		
	US\$	USh	% contribution	US\$	USh	% contribution	US\$	USh	% contribution
GHIs	156.1	284,9	84%	147.1	261,83	82%	164.5	279,052	65%
Government	12.1	22,095	6%	12.8	22,769	7%	13.9	23,651	6%
Multilateral agencies	3.8	6,868	2%	5.9	10,45	3%	10.1	17,986	4%
Bilateral agencies	14.9	27,154	8%	14.2	25,313	8%	64.2	108,869	25%
Total	186.8	341,017	[100%]	180	320,362	[100%]	253	429,558	[100%]

Sources: UNGASS 2008

Note: US\$/USh exchange rates used (shillings per dollar): 2005/06:1,825.15; 2006/07:1,780; 2007/08:1,696.45 (BOU average rates) Contributions by households are not included in this table because of lack of data.

The contributing mechanisms for HIV and AIDS funding are similar to those for overall health sector financing. Government funding is partly from taxes collected by the Uganda Revenue Authority and partly from donors contributed directly to the Ministry of Finance Planning and Economic Development (MoFPED) for general support. Funding from GHIs is mainly channelled in project mode, with funds being managed by an agency or unit on behalf of the donor. Similarly, donor project funding is usually managed by the donors themselves or by organisations they select to manage the funds. Recently, the Civil Society Fund was created as a channel for pooling all donor project funds that are earmarked for HIV and AIDS.

The Civil Society Fund was put in place in 2007 by HIV and AIDS development partners to ensure that civil society provision of ATM prevention, care, treatment and social support services are harmonised, streamlined, effective and support the National Strategic Plan, National Priority Action Plan and other national plans and policies. In the past, the support to the civil society by donors tended to be fragmented and not aligned to the national HIV and AIDS priorities. The purpose of this Civil Society Fund is to bring together multiple donor funds and disperse grants to civil society that are aligned with national plans and enable an effective, scaled-up and comprehensive national response to ATM. In 2008, there were only four development partners that were channelling their funding through the Civil Society Fund: the Danish International Development Agency (DANIDA),

DfID, Irish Aid and USAID. Under the Civil Society Fund, three agencies were instituted to ensure transparency in management of the fund: CARE in Uganda (hired through the CORE Initiative to serve as the technical and management agency), Deloitte and Touche (as the financial management agency) and, recently, Chemonics International (as the monitoring and evaluation agency). The Civil Society Fund is housed in the Uganda AIDS Commission (UAC).

The resources channelled through the Civil Society Fund are allocated to different implementers of HIV and AIDS activities (including government ministries, NGOs, CSOs and community-based organisations (CBOs). The Civil Society Fund was created to eliminate a fragmented and poorly coordinated response to national HIV and AIDS and orphans and vulnerable children efforts, and to strengthen partnerships with civil society and local government. This was particularly important in harmonising funding support to CSOs for non-health and non-facility based interventions in the fight against HIV and AIDS. There have been recent discussions aimed at making the Civil Society Fund a sub-principal recipient for Global Fund resources targeted for HIV and AIDS activities by the private sector (NGOs, CSOs and faith-based organisations, or FBOs) under the long-term institutional arrangements, which is the new mechanism in place for improving coordination and harmonisation of aid in the health sector.

Although there is some reasonable pooling of HIV and AIDS funds in Uganda it is difficult to estimate the extent to which there are proportionate risk pools (both in terms of coverage and composition), as far as resources from government, GHIs and donors are concerned. Funding from each of the sources is pooled and targeted at interventions that cover the whole population. It is important to note, however, that in some instances, funding from these different sources is not aligned to government priorities (especially in the case of GHIs and some donor projects). Private resources for HIV and AIDS care from households are not pooled. With very limited voluntary private health insurance covering less than 1% of the population, households are still likely to spend reasonable amounts of money on HIV and AIDS care, even when free services are available at government health facilities. A study in 2003 reported that, although 73% of the people interviewed lived within 5km of a public or private not-for-profit health facility, only 14% used government health facilities (Kikule, 2003). A more recent study reported that the average two-months expenditure on health care for households affected by HIV and AIDS was US\$95 compared to US\$25 for households not affected (Nabyonga-Orem et al, 2008).

In contrast, since the introduction of free ART and prevention of mother-to-child transmission (PMTCT) and increased HIV and AIDS funding through GHIs, resources from private sources (such as out of pocket payments and payments from employers) may play a relatively smaller role compared to the past when households had to pay out of pocket. It is important to highlight, however, that, even with increased funding, there remains a significant proportion of people who do not have adequate access to publicly provided services, and may have to pay out of pocket. For example, the number of people accessing ART in Uganda by April 2008 was 121,218 people out of an estimated 330,000 who need the drugs (MoH and Macro international Inc., 2008). A reported 286 sites were distribution points for ART in 2007 and, in terms of access to the services, 83% of ART services were offered mostly in hospitals, while only 17% of lower-level health units offered ART (MoH 2008). The lower-level units are the ones closest to the biggest part of the rural populations. From 2005 to 2007, the number of centres for PMTCT in Uganda more than doubled from 280 to 568, thereby taking these services nearer to the rural population. Over this period of time, the population coverage of the service for the people in need increased from 12% to 30% in 2007 for all expecting HIV-positive mothers on ART (Uganda AIDS Commission, 2008). Only 44% of antenatal care mothers were reached with PMTCT services in 2007 (MoH, 2008).

Clearly, there is a significant proportion of the population that has not been reached by PMTCT services. Unfortunately, to date, no studies have been conducted to explore whether household

expenditure on HIV and AIDS has declined since the introduction of GHI funding and publicly provided services, especially related to treatment, and this is a research gap that needs to be addressed. Similarly, there is hardly any empirical evidence on who is accessing ART services, both in terms of coverage and composition.

The publicly provided benefit package for HIV and AIDS, which is free to end users at all public facilities and programmes, is quite comprehensive and covers prevention, including supplying condoms, PMTCT and information, education and communication, treatment of opportunistic infections, antiretroviral therapy, nutritional support for Orphans and Vulnerable Children and PLWHAs, psycho-social support functions like counselling, and vocational and life skills for orphans and vulnerable children. HIV and AIDS control largely depends on prevention, so non facility-based programmes target behavioural change communication and information, education and communication, HIV and AIDS awareness and condom supply. Although the package is comprehensive, access to care services may not be equitable, especially from a geographic point of view. Firstly, there are urban-rural differences in terms of scope and quality of services. As expected, the HIV and AIDS services in the urban areas are of relatively higher quality and scope than those in rural areas (MoH and Macro International Inc., 2008). This means that people living in rural areas would either have to travel long distance to access better services (incurring transport and other costs) or they would stay at home without receiving these services. This shortcoming is particularly serious for services like PMTCT and ART, which are only available at selected (and accredited) centres and not necessarily at all levels of care in the health system. A recent survey by the Uganda Service Provision Assessment found that services were more likely to be available in urbanised regions (for example, the Central Region and Kampala) compared to other parts of the country, and also at hospitals rather than lower-level facilities (ibid). The survey also found that private health facilities are more likely to have laboratory capacity for monitoring ART than public facilities (67% vs. 34%). The benefit package purchased with out-of-pocket resources, outside the public sector, varies with income levels and ability to pay. This means that people with lower incomes can only afford smaller packages of care, and it is noted that household expenditure on HIV and AIDS sometimes results in impoverishment of households (Kikule, 2003; Nabyonga-Orem et al, 2008).

Providers of HIV services include the private and public providers at health facility and non-facility levels. Activities that are focused on prevention, such as positive living campaigns, voluntary counselling and testing, and condom use campaigns, are normally carried out by civil society through community programmes and mass media, and these providers are usually funded by government and/or donor funds. Their mechanism for reimbursement is usually based either on budgets that may or may not have a historic budget component or are supplied in project mode for a specified timeframe. Care services are usually facility based and are provided by both public and private providers. Publicly funded health facilities, including private not-for-profit health facilities, are normally reimbursed via annual budgets. Private service providers for those who can pay out of pocket or the few who are covered by health insurance are reimbursed on a fee-for-service basis. Providers of traditional medicine also play a significant role in providing services for HIV and AIDS patients – Kikule (2003) reported that 36% of the HIV and AIDS patients relied on traditional medicine – and they are normally paid fees for their services as well.

4.2 Malaria

Funding for malaria comes from the government, GHIs, development partners and out of pocket payments. In contrast to HIV and AIDS, there has never been a spending assessment for malaria in Uganda. Given that, until the fiscal year 2007/08, the government did not provide funding earmarked for malaria control (excluding funding given for the general provision of services), malaria funding has largely come from GHIs. In this study, we found that, apart from government

funds, the main sources of funding malaria control were the US President's Malaria Initiative, Japan International Cooperation Agency and DfID. *Table 4* provides the main sources of funding for malaria and the amounts they contribute.

Table 4 shows that GHIs are the largest source of contribution, followed by bilateral agencies. At the same time, the percentage contribution made by GHIs has been declining, while the percentage contribution made by bilateral agencies has been increasing. Other sources of funding for malaria control are out-of-pocket payments for commodities such as insecticide-treated nets and treatment at health centres. Unfortunately, there is hardly any information on household spending on malaria in Uganda. As in the case for HIV and AIDS, this is a research gap.

Table 4: Sources of funding for malaria control (millions), 2005/2006–2007/2008

Sources of funding	2005/06			2006/07			2007/08		
	US\$	USh	% contribution	US\$	USh	% contribution	US\$	USh	% contribution
GHIs	36	65,796	99%	42.4	75,457	98%	27.8	47,222	88%
Multilateral agencies	~	~	~	~	~	~	~	~	~
Government	~	~	~	~	~	~	0.5	913	2%
Bilateral agencies	0.4	816	1%	0.7	1,251	2%	3.4	5,768	11%
Other	~	~	~	~	~	~	~	~	~
Total	36	66,612	[100%]	43	76,708	[100%]	32	53,903	[100%]

Note: US\$/Ush exchange rates used (shillings per dollar): 2005/06:1825.15; 2006/07:1780; 2007/08:1696.45 (BOU average rates). A dash () means either there was no expenditure or expenditure was not specifically earmarked for malaria (although the funds might have been channelled through general budget support and thereby form part of the general provision of health services). (General budget support here refers to financial support through donor funds that are all given to Uganda's Ministry of Finance rather than to the Ministry of Health.) Contributions by households are not included in this table because of lack of data.

As with HIV and AIDS, the contributing mechanisms for malaria funding are also similar to those for overall health sector financing. Government funding is partly from taxes collected by Uganda Revenue Authority, and partly from donors contributed directly to MoFPED for general support. Funding from GHIs is mainly channelled in a project mode, with funds being managed by an agency or unit on behalf of the donor. Similarly, donor project funding is usually managed by the donors themselves or by organisations they select to manage the funds. Unlike HIV and AIDS, there is no special fund that pools donor project resources for malaria control activities undertaken by government ministries, NGOs, CSO and CBOs. This means that co-ordination of project funds for malaria is relatively less well co-ordinated. Funds from USAID's US President's Malaria Initiative are normally channelled through US-based NGOs, which sub-grant to local NGOs tasked to undertake implementation of activities. There is an umbrella organisation for CBOs and NGOs working in malaria – the Malaria and Childhood Illness NGO Secretariat (MACIS) – but it is not involved in funds management or granting donor funds to NGOs or CSOs. Resources from private sources are directly managed by households or by the very few voluntary health insurance schemes.

As in the case for HIV and AIDS, there is some reasonable pooling of malaria funds in Uganda, as far resources as from government and donors are concerned. Funding from public sources is targeted at interventions that cover the whole population, except for interventions like indoor residual spraying which is targeted at selected districts based on malaria endemicity, and

distribution of long lasting insecticide-treated nets targeted at pregnant women and children younger than five years old. Funding from GHIs and donor projects is, in some instances, fragmented and not aligned to government priorities, therefore weakening the potential for greater pooling of resources.

With regard to household resources that are spent on malaria, there is no pooling of resources and therefore no cross-subsidisation, even though malaria is listed as the number one cause of morbidity in Uganda. A person can have several malaria episodes in one year, depending on where they live and on whether they have any preventive measures taken to protect themselves against mosquito bites. Given the nature of the disease (acute, curable and relatively easy to diagnose clinically), people tend to heavily rely on self medication because the types of antimalarials available for treatment are commonly known by most people and are available both formally and informally (Nabyonga et al, 2005). For those who do not access publicly provided services, this means that the money they spend informally could more usefully be channelled into public malaria prevention and treatment. The amount of household **out of pocket** spending on malaria prevention is influenced by the malaria control interventions selected and implemented by the government. For instance, in situations where government-implemented indoor residual spraying is the strategy for malaria control, the communities benefiting usually do not incur significant expenses as a result. However, in places where government uses long lasting insecticide-treated nets as the main malaria control strategy, households are likely to incur relatively higher costs by purchasing nets (even if they are subsidised), especially where nets are not given free of charge to everyone. Consequently, those with higher incomes (and living in urban settings) are more likely to own a net than those with less income (and living in rural settings) (Uganda Bureau of Statistics, 2007).

Household expenditure on malaria in Uganda has not been recently documented, but 2002 estimates for the burden of malaria indicate that a household spent on average US\$3.08 per malaria episode (Nabyonga et al, 2005). As noted earlier, even with increased funding for malaria (from GHIs), there remains a significant proportion of people who do not have access to publicly provided services. A survey conducted in 2002 reported that 39% of respondents relied on self-medication (by buying medicines) for the treatment of malaria (ibid). A later survey reviewed available research and found that the poor and vulnerable experience a greater burden of disease but have lower access to health services than the less poor (Kiwanuka et al, 2008). It noted that distance to service points, perceived quality of care and availability of drugs were key determinants of utilisation.

The National Malaria Control Programme (NMCP) formulated a national package that includes both prevention and case management interventions. The prevention interventions include vector control and personal protection measures such as indoor residual spraying and use of long-lasting insecticide nets, as well as intermittent presumptive treatment for pregnant women. The case management interventions include improved diagnosis, use of efficacious first-line antimalarials, home-based management of fever (for children younger than five), improved referral and effective management of severe malaria cases. Although the whole package is intended to be available free of charge at publicly funded health facilities, the quality of services available is usually poor and characterised by regular drug stock-outs. In addition, availability of services is not equitable, with Kampala and the Central Region having relatively more advanced malaria services compared to those available in other regions (MoH and Macro International Inc., 2008). For example, the Uganda Service Provision Assessment found laboratory malaria diagnostic capacity is higher in private facilities (which are mainly in urban areas) compared to public facilities, and is more likely to be available in facilities in Kampala than in facilities in any other regions (MoH and Macro International Inc., 2008). The urban-rural differences in services provided are in terms of scope and

quality of services, and the benefit package purchased with out of pocket resources varies with income levels and ability to pay.

Providers of malaria control services include formal health facilities (public, private non-for-profit and private facilities) and pharmacies, as well as informal providers such as drug shops, drug vendors and practitioners of traditional medicine. The Home-Based Management of Fever programme is implemented through volunteer community medicine distributors, a group of volunteers formally trained and recognised as providers in the communities in which they live. Services for malaria control are provided free of charge to users of public facilities, are subsidised in private non-for-profit facilities and are available at varying prices in the private facilities. Public facilities are reimbursed through budgets, while private-not-for-profit facilities rely on grants from government, as well as raising funds through user fees and sometimes receiving additional funding from parent institutions or donors. Private providers are reimbursed through the fee-for-service mechanism.

4.3 Tuberculosis

The main sources of funding for tuberculosis (TB) control in Uganda are the government, WHO and the International Union against TB and Lung Disease (IUTLD). Funding for TB from WHO comes in the form of direct financial support, and TB drugs are also supplied via the Global Drug Facility (GDF). Support from UTLD is not financial, but they supply consultants to review TB programmes under the National TB and Leprosy Programme (NTLP). Compared to HIV and AIDS and malaria, TB receives the least funding. Also, there is relatively less funding for TB from GHIs. The only GHI supporting TB is the Global Fund. Table 5 summarises the sources of funding for TB in Uganda and the amounts from each source.

Table 5: Sources of funding for TB control in Uganda (millions), 2005/6–2007/8

Sources of funding	2005/6			2006/7			2007/8		
	US\$	USh	% contribution	US\$	USh	% contribution	US\$	USh	% contribution
GHIs	2.5	4,644	66%	~	~	~	0.9	1,529	22%
Government	0.04	67	1%	0.02	42	1%	0.01	25	0%
Multilateral agencies	1.3	2,373	33%	1.3	2,314	41%	1.3	2,205	32%
Bilateral agencies	~	~	~	1.9	3,343	59%	1.9	3,223	46%
Other	~	~	~	~	~	~	~	~	~
Total	4	7,084	100%	3	5,699	100%	4	6,983	100%

Note: US\$/Ush exchange rates used (shillings per dollar): 2005/06:1825.15; 2006/07:1780; 2007/08:1696.45 (BOU average rates). A dash () means either there was no expenditure or expenditure was not specifically earmarked for malaria (although the funds might have been channelled through general budget support and thereby form part of the general provision of health services). Contributions by households are not included in this table because of lack of data.

As with HIV and AIDS and malaria, TB funding is sourced from the government and donors. Government funding is partly from taxes and partly from donors contributed directly to general support. Compared to HIV and AIDS and malaria, there is relatively less funding for TB and fewer donors involved. TB funding from GHIs comes only from Global Fund, and is currently managed through government structures. Donor project funding is usually managed by the donors themselves or by organisations they select to manage the funds. For some of the donors, funding is channelled through the National TB and Leprosy Programme (NLTP) in the Ministry of Health.

Unlike HIV and AIDS and malaria, there are very few organisations involved in TB control activities. As such, there is no special fund that pools together donor project resources for TB control activities.

As for HIV and AIDS and malaria, there is some reasonable pooling of funds for TB in Uganda, as far as resources from government and donors are concerned. As TB is an opportunistic infection associated with HIV and AIDS, some of the HIV funding covers TB-related aspects (for example, testing). In Uganda, 60% of all TB confirmed cases are also HIV positive (Uganda AIDS Commission, 2008). All TB services are offered free in public and private not-for-profit facilities. These services include the sputum test, treatment of TB and prophylactic treatment. The Uganda Service Provision Assessment reported that TB diagnosis, treatment and/or follow-up services are available in only 44% of all health facilities, and that facilities in some regions (for example, Kampala, West Nile and North Central) were more likely to offer TB services than facilities in other regions (MoH and Macro International Inc., 2008). The use of X-rays for TB diagnosis was reported in only 5% of health facilities and was limited to hospitals and facilities located in Kampala (ibid). There is hardly any documentation of private expenditure on TB in Uganda. To the extent that household resources are spent on TB, there is no pooling of resources. Given the stigma usually associated with TB, it is possible that some people would opt to seek care in the private sector, where they would have to pay for services.

The National TB and Leprosy Programme (NLTP) formulated a national package that includes case detection and treatment interventions. Specifically, the package for TB control programme includes sputum testing and directly observed therapy for treatment and follow-up. Under the CB-DOT model, a public health worker (referred to as a sub-county health worker) links the formal health system to communities in their respective sub-counties. These sub-county health workers conduct community mobilisation, facilitate communities through their leaders to select community volunteers, train the selected community volunteers, supervise them and replenish their TB drug supplies fortnightly. The community volunteers are responsible for administering drugs, conducting directly observed therapy and referring TB patients to health centre for follow-up sputum testing and clinical reviews. The community volunteers are facilitated by the Ministry of Health through the NTLF, and beneficiaries of care do not pay for the services. The publicly-funded package is available to everyone, but it is difficult to estimate what percentage of the population who need these services rely on public facilities, and there has been no documentation of this in Uganda.

Providers of TB control services are formal health facilities (public, private not-for-profit and private facilities) and community volunteers (responsible for DOT). Public facilities are reimbursed through budgets, while private-not-for-profit facilities rely on grants from government, raising funds through user fees and they sometimes receive additional funding from parent institutions or donors. Private providers are paid fees for their services by their patients.

5. The impact of GHI ATM funding on health care financing in Uganda

This section addresses the first part of the second objective of this study, namely to explore the extent to which GHI financing for ATM has influenced health care financing reforms.

In the absence of health sub-accounts for ATM, it is difficult to comprehensively estimate the proportion of government funding spent on specific diseases, because delivery of health services in Uganda is integrated. Government funding for health services delivery is not allocated not on the basis of individual diseases but on the basis of a package of services to be delivered at a given level of care. As a result, we did not attempt to comprehensively estimate government funding for ATM. However, a spending assessment study for HIV and AIDS conducted in 2006 by Lake and

Mwijuka estimated government funding for HIV and AIDS to be between US\$6 and US\$8 million annually (between 2003/4 and 2006/7), and these statistics are different from the ones we presented earlier in *Table 3* because of different estimation techniques. Not surprisingly, Lake and Mwijuka cautioned readers about the accuracy of their estimates and cited the methodological challenges associated with the process of estimation and the difficulties associated with accessing relevant data. As noted in *Section 4*, no similar special studies have been conducted on government spending on malaria and TB.

5.1 Allocation of ATM funds: GHI funding vs. national funding

National funds are allocated to ATM in two ways: by allocating general resources for the integrated delivery of health services (to health facilities and districts) and by earmarking some resources for specific interventions or programme activities that are largely implemented at central level (to national control programmes in the Ministry of Health or other autonomous institutions that are directly involved in ATM control activities). In addition, resources from development partners channelled through the project mode are allocated to ATM according to the arrangements each partner has with government, and they aim to align with national priorities. Resource allocation under GHIs is mainly based on the activities listed in approved funding proposals.

Funding from the Global Fund to Fight AIDS/HIV, Tuberculosis and Malaria (GFATM) is aligned to sector priorities and, unlike some GHI funds, 100% of these funds are included in the medium-term expenditure framework, which means that all funds are on-budget. This means that funding from GFATM is subjected to similar allocation processes as those for national resources. The stakeholders involved in priority setting (at the stage of proposal development) are more diverse compared to those involved in national resource allocation because government, NGO and civil society sectors are all involved in writing the funding proposals.

An important difference between the allocation of GFATM funds and national funds is that they have different recipients. GFATM funds support activities implemented at health facility level, but not directly – the funds are usually allocated to government structures as sub-recipients (namely, the AIDS Control Programme, the National Malaria Control Programme and the National TB and Leprosy Programme), which, in turn, fund the implementation of activities at district and health facility level, and not at the health facilities themselves. For example, health facilities usually receive support in the form of health commodities (such as antimalarials, ARVs, long-lasting insecticide-treated nets and condoms) rather than receiving direct financial support to support their activities or for health systems strengthening. This contrasts with national funding, where health facilities are allocated a specific amount in the budget. For this reason, it is difficult to review allocation of funding from GFATM by level of care. As far as activities implemented by NGOs and CSOs are concerned, funds are managed directly by the principal recipient or given to one sub-recipient organisation that allocates them to implementing agencies in different parts of the country.

Resources from the GFATM are usually targeted at all districts in the country, and they are allocated by geographical area according to need, depending on the implementation strategies identified by government. For example, if funding from the GFATM is earmarked for indoor residual spraying, districts for spraying will be selected according to the national indoor residual spraying policy. For other interventions with nation-wide implementation, there are no specific requirements on the side of GFATM and no explicit guidelines on the side of government on how to allocate resources geographically. The absence of such guidelines opens the potential for inequitable allocations, and this is a gap that needs to be addressed.

With regard to PEPFAR and US President's Malaria Initiative funds, they are both off-budget, which makes it difficult to determine which proportion of these funds is aligned to national priorities. In contrast to the GFATM, information on expenditures by PEPFAR and US President's Malaria Initiative are not available to the public (Oomman et al, 2007). Funds from PEPFAR and US President's Malaria Initiative for specific interventions for HIV and AIDS and malaria are allocated according to the targets for each country and according to the overall targets of PEPFAR. Government has limited involvement in setting priorities and developing implementation proposals and plans. The development of funding proposals for PEPFAR and US President's Malaria Initiative is normally conducted by USAID, which also vets proposals submitted by organisations (with no input from government). The organisations that receive funds from USAID, PEPFAR or US President's Malaria Initiative are expected to collaborate with the Ugandan government when implementation of activities starts, but there doesn't seem to be a clear mechanism for assessing the degree to which government is involved in implementation activities. Activities funded by PEPFAR and US President's Malaria Initiative may or may not cover all districts of the country, depending on what was included in the funding proposal. Judging from the previous projects funded under US President's Malaria Initiative or PEPFAR, a trend emerges of implementing activities in a selected number of districts rather than in all districts, which is likely to enhance geographic inequities. As with GFATM resources, it is difficult to review the allocation of PEPFAR and US President's Malaria Initiative resources by level of care.

Resource allocation mechanisms for the World Bank's Multi-Country HIV/AIDS Programme (MAP) require the identification of implementers at three levels, namely national, district and community levels. Each implementer was given funding to undertake a specified list of activities (as stipulated in a work plan developed for the project activities). National level implementers' activities were mainly focused on developing capacity at the different levels of government. Funding for districts was given for integrated district plans, which included elements from activities supervised and implemented by communities under community-led HIV and AIDS initiatives. Although this project was initially intended for all districts, it was eventually implemented in only 30 districts (out of the 56 districts at the time of implementation). The three criteria used to select districts for MAP activities were the capacity to manage community-led HIV and AIDS initiatives, the availability of NGOs working in the area of HIV and AIDS, personal and political security (which is why northern Uganda, which had political instability at the time, could not benefit from this project). We would like to point out that the first criterion (capacity to manage community-led HIV and AIDS initiatives) was likely to lead to inequities because the most disadvantaged areas (poorest and deep rural areas, etc.), which need the most help, were least likely to have sufficient capacity. As the project expanded to other districts, other selection factors were included, such as an effort to achieve regional balance, district awareness about the project strategies and the response to calls for involvement.

5.2 ATM funding priorities: GHI priorities vs. national priorities

The extent to which GHI priorities are aligned to national priorities varies from one GHI to another. Given the processes of proposal development for GFATM, and the involvement of various stakeholders in these processes, priorities funded by GFATM are usually aligned to national priorities. However, although most HIV and AIDS projects have made the HIV and AIDS National Strategic Framework (NSF) their starting point for formulating their projects, some of the recommended strategies in the NSF may not be followed in all projects. For instance, while the NSF advocates for the ABC (abstain, be faithful and use a condom) strategy for HIV prevention, PEPFAR only funded the abstain and be faithful components in 2007/8, which resulted in a shortage of condoms in the whole country during this period. PEPFAR funding is largely allocated based on the requirements set by the US Congress, whose priorities may be different from the national priorities. The provision of ARVs funded by PEPFAR targets all parts of the country and

they are distributed through accredited centres. As the Ugandan government has very little involvement in setting PEPFAR and US President's Malaria Initiative priorities, there is potential for overlap in the funding of activities, and inefficiencies and inequalities may result. Inefficiencies may arise from having resources from different sources going to the same intervention in the same areas, and inequalities may arise from having funds not allocated on need but on the cultural and political preferences of donors, which may conflict with those of government (as in the case of PEPFAR refusing to fund condom supplies). Unfortunately, no evidence of this has been empirically documented.

For malaria, the priorities proposed for funding by the US President's Malaria Initiative and the GFATM in the short term are all in line with the Ugandan government's priorities for the health sector, as stipulated in National Malaria Control Strategy. However, in the absence of detailed information on expenditure, it is difficult to estimate what proportion of US President's Malaria Initiative funds are spent on non-sector priorities (such as salaries of expatriates, consultancies, travel expenses and project administrative expenses).

In the case of TB, US government priorities are mainly to support the supervision and training of health personnel and providers, and to help procure drugs and set up technical support supervision for TB and leprosy programmes. The US government also provides technical support to health facilities to establish infection control committees, implement infection control procedures and provide HIV screening for TB patients. It supports the training of health workers in TB diagnostics, routine TB screening for clients that test HIV-positive, and the provision of palliative care and treatment for co-infected patients. All these priorities are in line with national priorities. As with malaria, it is difficult to establish what proportion of US funds for TB are spent on non-sector priorities.

5.3 Is ATM funding aligned with the 'Three Ones' principles and SWAp?

As guiding principles for improving the country-level response to HIV and AIDS, the 'Three Ones' include: one national AIDS framework, which provides the basis for coordinating the work of all partners; one national AIDS authority with a broad-based multi-sectoral mandate; and a country-level monitoring and evaluation system (UNAIDS, 2005). Although these principles were initially defined for HIV and AIDS only, they have been found to be useful for other areas with a wide range of stakeholders and funders. In this section, we discuss the extent to which the 'Three Ones' have improved integration, harmonisation and coordination of ATM funding, as well as between ATM and general health financing.

In Uganda, increased funding for ATM from various sources made the need for improved co-ordination of funds and partner activities more apparent. In response, different co-ordinating bodies were put in place to monitor ATM funding. For example, Uganda HIV and AIDS Partnership mechanisms have aligned the coordination, harmonisation and monitoring and evaluation of the multi-sectoral responses to HIV and AIDS. Following this, the Civil Society Fund was put in place to coordinate HIV and AIDS funding and realign these funding priorities with the NSF. Similarly, a National Partnership to Stop TB was formed as a coalition of partners who jointly contribute to the fight against tuberculosis. All partners agree on the national strategy for TB control that is spearheaded by the Ministry of Health and each brings specific expertise, experience and resources to contribute to the expansion of TB control, resulting in better coordination of stakeholders, increased momentum to upgrade TB control and the ability to harness new inputs from non-traditional partners.

The first and second principles (one national framework and one co-ordinating authority) have already been adopted in Uganda. The co-ordinating authority for HIV and AIDS is the Uganda

AIDS Commission, housed in the Office of the President. This structure is unique when compared to the ones for TB and malaria because HIV and AIDS has a multi-sectoral response, while national responses for TB and malaria control are restricted to the health sector alone. The co-ordinating entities for TB and malaria are the National TB and Leprosy Control Programme (NTLP) and the National Malaria Control Programme (NMCP) in the Ministry of Health. Each disease (HIV and AIDS, TB and malaria) has one national strategy document.

The third principle (one monitoring and evaluation [M&E] system) is the most difficult to assess. For all three diseases, monitoring and evaluation is one of the weakest functions, so it needs strengthening. The M&E systems for the diseases are linked to the overall health management information system (HMIS) of the sector. Each of the national co-ordinating authorities for each diseases have an M&E system in place but, because of the weaknesses in the systems, partners in the national ATM responses have set up parallel M&E systems, especially on projects that need to collect specific information and meet certain targets to qualify for continued financial support. For most projects, funding for subsequent years is based on performance in previous years. There are key weaknesses in these M&E systems: the systems are not designed to obtain information at non-facility levels (for example, from communities); there are severe delays in submitting information from lower levels to national level (and even from lower-level health facilities to district level); the systems are mainly paper-based (and not computerised), making timely submissions difficult; incomplete data submissions; the HMIS only collects information on key indicators and does not collect all the information that would be useful for the Control Programmes; and severe logistical constraints (lack of HMIS forms, lack of transport and lack of staff, etc.) directly affect the compilation and submission of data. In the past years, some significant technical assistance and resources have been focused on enhancing the capacity of the co-ordinating authorities to undertake M&E for these diseases. However, some gaps still remain.

In this section, we also explore the factors that have enabled or impeded alignment of GHI ATM funding with the sector-wide approach (SWAp) and national health funding mechanisms. The introduction of SWAp in Uganda was motivated by concerns for improved government leadership, efficiency and equity, with the aim of improving sector performance by coordinating development assistance (Cruz et al, 2006). The defining characteristic of a SWAp is that all significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, which adopts common approaches across the sector and progresses towards relying on government procedures to disburse and account for all funds. Uganda's health sector adopted SWAp in 2000.

Some the GHIs funds for ATM, for example, those from GFATM, are partially aligned to the health SWAp insofar as funding of sector priorities is concerned. The alignment of GFATM resources is only partial, however, because some of the GFATM requirements (for example, for reporting and procurement) are not aligned to existing government systems and procedures, so special structures have had to be put in place to fulfil GFATM reporting and procurement requirements. Similarly, funds from PEPFAR and US President's Malaria Initiative are not aligned to national strategy in terms of government leadership, structures and procedures. In addition, M&E systems for GHI-funded activities are set up parallel to the existing national M&E systems and not integrated with them, notably PEPFAR and US President's Malaria Initiative funds. The disharmony between GHI funding and national funding mechanisms is reflected in six ways: by setting up structures different from government ones for the management of GHI funds; by the failure of GHIs to align their spending and reporting time frames with official government timeframes; by refusing to fund some of the activities reflected as national priorities (for example, the refusal of PEPFAR to fund condoms); by setting up different procurement procedures and entities alongside the existing national ones (for example, GFATM procurement requirements and procedures are different from the government procedures, which partly explains the difficulties and delays that Uganda has

experienced with managing GFATM resources); by setting up M&E systems alongside the existing national ones instead of integrating them; and by failing to align GHI funds to national budgeting and planning cycles and processes.

The key factors that have impeded the alignment of GHI funding to national funding mechanisms include: bureaucratic delays with financial systems in government institutions, which results in delays in accessing funds; extremely strict requirements by project funders to report in the timeframes that suit the donor countries/ organisations and not the country itself; bureaucratic delays in government procurement systems; restrictions imposed by donor countries that interfere with how procurement should be executed; and weak M&E systems in government institutions that GHIs are not willing to rely on for tracking progress of their activities.

5.4 Adjustments in GHI ATM funding and their impact on health sector financing

In this section, we look at adjustments in GHI ATM funding and medium-term expenditure frameworks ceilings, and the possible impact these have had on government and other sector funding. The most important adjustment in GHI funding in Uganda relates to the management of GFATM resources; as a result the GFATM is the only GHI that is reviewed here. Lessons have been learnt from the failures of the GFATM project mode of operation and new arrangements are centred on a commitment to strengthen national processes for decision making, coordination and financial management.

In 2003, when the GFATM started supplying funds to Uganda, resources were managed in a project mode under the Ministry of Health. However, within a few years, the local fund agent reported that there was gross mismanagement of funds, which led to the temporary suspension of GFATM disbursements in the country. To re-instate flow of resources, the GFATM laid down conditions for changes that Uganda needed to make. In response, the Ministry of Finance, Planning and Economic Development – in its capacity as the principal recipient for GFATM resources – submitted a country proposal on long-term institutional arrangements for managing the GFATM programme in September 2006. The proposal featured recommendations agreed on by the Uganda AIDS Commission, MoH, MoFPED and other stakeholders, which covered financing mechanisms, planning and budgeting, coordination, implementation, procurement, monitoring and evaluation, and civil society participation.

Under the new arrangements, parallel systems for project management fell away. GFATM grants started funding the priorities of the AIDS National Strategic Plan (NSP) and the Health Sector Strategic Plan II (HSSPII). The Ministry of Finance, Planning and Economic Development (MoFPED), continued to act as the principle recipient of the GFATM in Uganda and now disburses funds to implementing ministries, local governments and organisations. The GFATM secretariat agreed to pool funding into the Consolidated Fund (namely, general budget support). Under the new arrangements, it was agreed that Uganda's own systems of public financial management, accounting, procurement, auditing and monitoring would be used. Financial reports would be scrutinised by a capacity-enhanced accounts department within the Ministry of Health. There would be value-for-money exercises by the Ministry's internal audit section, which would be sent to the Permanent Secretary of Health. Several internal auditors and Inspectors would examine accounts to ensure accountability. National planning and financial management systems are currently being strengthened to enable these changes to take place effectively. On the planning side, steps have been taken to improve the planning processes within the health sector. The Ministry of Health has reconfigured the working groups to better integrate technical programmes into sector planning and budgeting. Proposals for GFATM funding would be developed by relevant technical working groups (TWGs) for malaria, TB and AIDS. Under the long-term institutional arrangements (LTIAs), the HIV and AIDS Partnership Committee (PC) became the country coordinating mechanism (CCM) for

HIV and AIDS control and the Health Policy and Advisory Committee became the CCM for TB and malaria control. This meant that GFATM grants for HIV and AIDS would be coordinated by the Uganda AIDS Commission. It was agreed that the previous GFATM CCM was no longer necessary and it was disbanded.

The structures named in the management of resources under the LTIA are still being strengthened and prepared for these roles and, as such, full implementation of the LTIA has not occurred. The shift of the GFATM funding mechanism from a project mode to budget support is expected to enhance the processes for harmonisation, integration and coordination of ATM funding within the sector. It will also enhance the planning of overall sector resources, through sector working groups and sector work plans, which are envisaged to be the basis for the development of future GFATM funding proposals. Although the LTIA were developed with GFATM funding in mind, it is hoped that all funding from donors could eventually be managed through the structures and processes stipulated in the LTIA (MoH, 2008). Whether or not other GHIs will buy into the LTIA remains to be seen.

In May 2007, the GFATM secretariat expressed satisfaction with the new institutional arrangements for managing GFATM grants in Uganda. Despite this, however, there have virtually been no disbursements since then, apart from a Round 6 TB grant, of which less than 1% has been disbursed (through LTIA structures), resulting in serious funding shortages. The GFATM sub-recipients and some of the respondents we interviewed noted that GFATM Secretariat 'seems to always be looking for flimsy excuses in order not to disburse' and raised their concerns about the GFATM Secretariat not communicating effectively, even when all GFATM requirements have been met (for example, having a third party procurement agent in place). Some stakeholders in the GFATM funds management have speculated that disbursements have been delayed due to a lack of trust by the GFATM Secretariat in the proposed LTIA structures and processes. Recent attempts by the Ministry of Health by means of direct written communication to GFATM Secretariat to explore the issue of trust have not been responded to.

Respondents from the Ministry of Finance, Planning and Economic Development (the principal recipient for GFATM resources) were 'tired of GFATM's unreliable disbursements and related processes'. As a result of delays for the current financial year, the Ugandan government had to mobilise 60 billion shillings (US\$30 million) to purchase life-saving health commodities (for example, anti-malarials) that would have otherwise been funded by the GFATM. Mobilising these funds would require government to reduce allocations to other sectors or to borrow the money from a financial institution. Because the GFATM was the main source of funding for the health sector, delayed disbursements in the past two years have heavily impacted on service delivery throughout the country. For example, there have been regular stock-outs of anti-malarials in health facilities and crisis procurements have been undertaken to try to fill the gaps in availability of drugs.

Another important change has occurred recently in health sector financing. Since 2007, the Ministry of Finance, Planning and Economic Development has started allowing GHIs to set medium-term economic framework (MTEF) ceilings for the health sector. Before 2007, the development of the MTEF heavily emphasised macro-economic stability, and there were stringent restrictions on allowing resources into the country over and above the sector ceilings. Prior to 2007, the sector ceilings were set by the Ministry and aimed at controlling government spending to achieve stability for macro-economic indicators. Within these ceilings, allocation of government resources took into consideration any resources coming from external sources targeted at a specific sector. This meant that a donor committed to increase 'on-budget' funding for the health sector would only do so insofar as there was a funding gap within the sector ceiling. If no such funding gap existed, additional funds for the sector would not be accepted by the Ministry. These strict sector ceilings for the health sector, combined with donors who were willing to support the

sector beyond the ceilings, resulted in having some donor resources being spent in the sector but off-budget (through projects). Although off-budget spending increased the resource envelope for the health sector, it also had some undesirable consequences because it weakened the systems in place for harmonisation and co-ordination of donor assistance and distorted the alignment of donor funding with sector priorities. With the more recent flexible MTEF ceilings for the health sector, new donor resources (including GHIs) are now being included in the MTEF in order to strengthen SWAp, through improved co-ordination and resource allocation of donor project resources and improved alignment with sector priorities. Currently, all GFATM resources are reflected in the MTEF, the disbursement uncertainties notwithstanding. It is important to note that a new health financing indicator has been introduced to regularly monitor the percentage of donor project funds to GHIs whose funding is included in the MTEF. For the year 2007/8, the figure for this indicator stood at 76% (MoH, 2008).

Anecdotally, respondents from the Ministry of Health and some development partners noted that the availability of increased funding from GHIs and the inclusion of GFATM resources under the MTEF have impacted overall sector funding in two main ways. Firstly, the inclusion of GHIs in the MTEF has resulted in improved co-ordination and resource allocation, thereby improving efficiency in allocation. Secondly, respondents pointed out that increased funding from GHIs has resulted in decreased donor funding from bilateral agencies and the stagnation of government funding. However, no empirical evidence of these claims exists yet. As these issues were beyond the scope of this study, we were unable to explore them any further. With regard to government contributions to the health sector, there were increases between 2006/7 and 2008/9, but government health expenditure (as a proportion of total government spending) stagnated at 9.6% between 2006/7 and 2007/8 and declined to 8.3% in 2008/9 (MoH, 2008). This trend does not bode well for Uganda's Abuja commitment to spend 15% of total government resources on health.

6. Impact of GHI ATM funding on health sector financing in Uganda

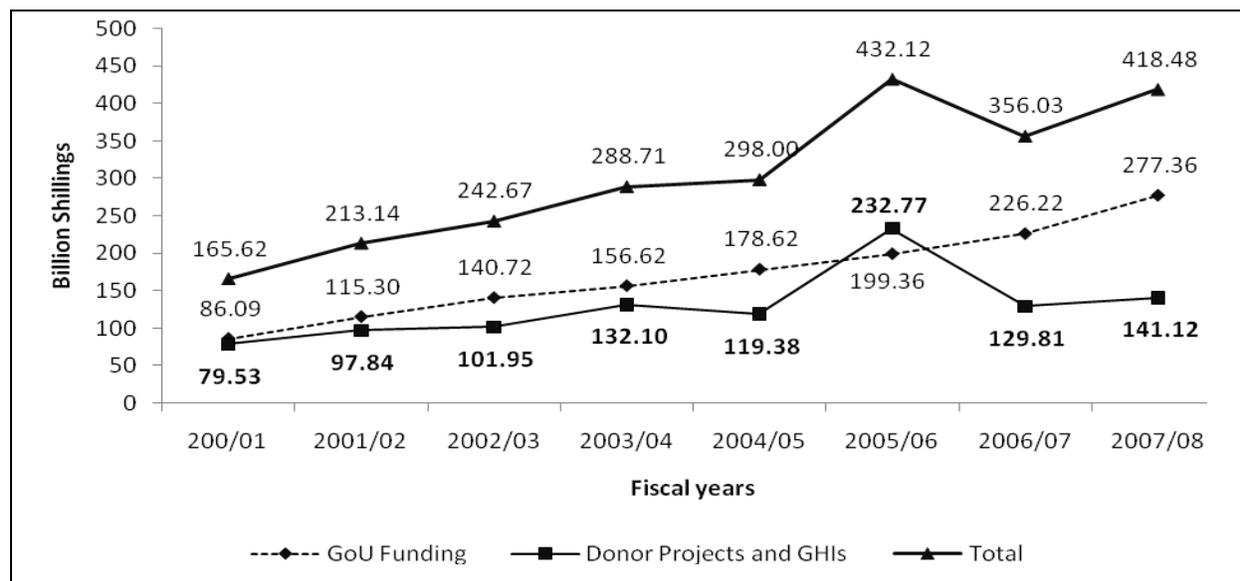
Here we discuss the impact that GHI ATM funding has had on health financing and related reforms in Uganda. It is important to highlight that one key health financing reform – the removal of user fees – was implemented in 2001, some time before most of the GHIs reviewed here came on board in Uganda. As such, GHIs did not have a part in influencing this financing reform. Similarly, a new financing reform is currently being debated (the introduction of national health insurance) and, once again, GHIs have not had any direct impact in the development of this reform.

6.1 Positive financial impacts of GHI ATM funding

GHI ATM funding has resulted in significant increases in resources for the health sector. Unmistakably, the availability of very substantial funding for ATM, through GHIs, has resulted in very significant increases in the amount of funding for the health sector. For the GHI resources reflected in the MTEF, *Figure 4* illustrates what happens when GHI resources are available and when they are not. Specifically, *Figure 4* demonstrates that the introduction of GFATM and subsequent disbursement of funds in 2004/5 resulted in a 45% increase in total funding for the sector in the subsequent year and the temporary suspension of GFATM disbursements in 2005 resulted in an 18% reduction in total resource envelope in 2006/7. (Only GFATM and the MAP funds are included here. Funding from the US government is excluded because it is off-budget.) The resources presented in *Figure 4* exclude funding from other GHIs (PEPFAR and US President's Malaria Initiative), which contribute very significant amounts of resources. For example, PEPFAR is estimated to have contributed about 70% to total AIDS spending in 2006/7 (Lake and Mwijuka, 2006). Inclusion of such off-budget resources would result in even higher increases in funding for the health sector over the years. *Figure 4* provides information on the trends in public funding for

health from government (tax plus donor general budge support), donor projects and GHIs over the past eight years.

Figure 4: Impact of GFATM resources on total health sector funding, 2007/2008



Note: GoU stands for government of Uganda.

Another benefit of increased funding for ATM from GHIs is an improvement in Uganda’s ability to provide life-saving medicines and other relatively expensive but necessary commodities that could otherwise not have been afforded. These include PMTCT and ART for control of AIDS, Indoor Residual Spraying, long lasting insecticide treated nets and artemisinin-based combination therapies for the control of malaria and triple-combination anti-TB drugs.

Flexibility in MTEF ceilings for the health sector has also been allowed due to GHI funding. Earlier, we noted that recently MOFPED has been more accommodative in allowing the inclusion of GHI resources under the MTEF ceilings for the health sector. Although no formal documentation has been done on the processes leading to this flexibility, it is believed that regular discussions among stakeholders about the need to effectively co-ordinate and align donor resources to sector priorities possibly contributed. These discussions emerged with the commencement of GHIs when stakeholders realised that having GHI resources outside the MTEF would weaken the health SWAp rather than strengthen it.

GHI funds have also highlighted Uganda’s need for improved management capacity. Increased funds have made it clear that existing structures and system were relatively weak and did not have the capacity to manage and absorb funds or effectively implement activities within specified timeframes. The funds provided the country with the opportunity to address gaps and weaknesses, and to strengthen capacities of institutions for, for example, improved financial management, procurement, reporting, monitoring and evaluation. Capacity gaps in the existing structures at the time of the temporary suspension of GFATM disbursements resulted in the reform of institutional arrangements for management of GFATM resources (discussed earlier).

6.2 Negative financial impacts of GHI ATM funding

GHI resources have undermined SWAp processes. Initially, all GHI resources were channelled through project mode, with some being on-budget (for example, GFATM and WB/MAP) and some being off-budget (for example, PEPFAR and US President’s Malaria Initiative). However, it became evident that using the project mode for such significant amounts of money was undermining the

objectives of the SWAp and that it was difficult to align the management of these funds to sector planning and budgeting processes. For the funds that are off-budget, it is even difficult to ensure that they are spent on sector priorities. Having a significant amount of resources off-budget is likely to result in both allocative and technical inefficiencies, as well as inequalities between geographic areas.

Unreliable funding and delays in disbursements to the country (especially for the GFATM) have weakened efforts to provide decent health care. As we noted earlier, Uganda depends a lot on GHIs for ATM funding. In instances where such resources are earmarked for the purchase of life-saving medicines (e.g. ACTs and ARVs) it has been demonstrated that unreliable resource flows result in major challenges for service provision. For example, the lack of disbursements of GFATM resources in 2006 and 2007 resulted in a crisis where there were severe shortages of ARVs and ACTs. To some extent, GHI funds have resulted in more emphasis on treatment than on prevention of disease. This particularly becomes evident when allocation of funds under GHIs is considered. For example, the allocation of funds under PEPFAR is legislated to follow mandatory proportions for the different interventions they fund (55% goes to treatment, while only 20% goes to prevention) (Oomman et al, 2007). As a result of such stipulations, about 68.8% of PEPFAR's funding for 2007 was spent on care and treatment, compared to 18.4% spent on prevention (ibid). While the support for expensive life-saving technologies is a positive contribution of GHIs, unreliable and unsustainable funding mechanisms only serve to put populations at risk and put government under pressure to look for funding to sustain the provision of these services.

Another disadvantage is that significant amount of GHI funds remain at the centre and less go down to lower levels where they are most needed. Two respondents – a representative of a major health development partner and a senior staff member at the Ministry of Health – raised this concern during the key informant interviews, highlighting that the way in which funds are transferred under GHIs results in significant amounts remaining at central level. Although no empirical evidence exists for this, it's likely that NGOs (the sub-recipients of some of the GHI resources) keep a portion of the funds to cover their management overheads.

GHI funding has also had an impact on human resources for health by luring staff away from facilities to GHI-funded projects. Two respondents noted that GHIs encourage the attrition of human resources for health (especially from health facilities or public sector to projects-based initiatives). The project mode used for GHIs and the ensuing sub-granting to NGOs and CSOs has resulted in a need for people, usually with medical training background, to manage and implement the projects. Similar findings are reported by Dambisya et al (2009) for some countries, while in other countries, they found the opposite. The overall impact of GHIs on human resources for health is difficult to assess, because there are both positive and negative impacts. For example, Dambisya et al (2009) report that HIV and AIDS programmes have had both negative and positive effects on the retention of health care workers (HCWs), and that GHIs have contributed to the expansion of HCW numbers through training and other support for HCWs in many resource-poor settings. However, they noted that well-funded AIDS programmes are attractive for HCWs and may contribute to the internal brain drain. They also noted that, by relying on the health system for the more skilled health professionals, HIV and AIDS programmes may also undermine other health programmes. However, Dambisya et al (ibid) also reported that, when used for general health system improvements and with proper planning, as shown by experience from Malawi, such funding can be used to support HCWs for the whole health sector. In addition, they report that some of the GHIs have used financial and/or non-financial incentives to support health workers in various countries, for example in Ethiopia, where GFATM resources were used to build staff houses at ART and PMTCT sites.

GHI funding has also impacted negatively on health systems in general. Three interviewees (one representing a major development partner and two from Ministry of Health) held the view that for a long time GHIs have given very little attention to health systems strengthening (for example, improving procurement and supply systems, information and monitoring and evaluation systems, and management capacities), and yet the GHIs heavily relied on these systems to implement interventions funded by them. For instance, the implementation of GHI-funded interventions comes with additional reporting requirements, and requires the procurement, storage and distribution of commodities in quantities normally larger than what existing systems can handle. Also, instead of strengthening the capacities for existing systems, GHIs opt for parallel systems. There has been much debate about the role GHIs should and should not play in strengthening health systems. Without more support to help countries to build the capacity of their health systems, the resources mobilised by GHIs are unlikely to reach their full potential (WHO, 2006). Since the WHO report, a trend has emerged where GHIs are increasing their support for health systems strengthening, such as through sector-wide approaches (SWAp) or budget support (Dambisya et al, 2009).

7. The impact of GHI ATM funding on health equity in Uganda

Based on our findings presented in *Sections 4, 5 and 6*, the biggest proportion of ATM funding comes from GHIs, donor projects and the Ugandan government. The contribution mechanisms for these sources of funding to a large extent do not involve the actual consumers of ATM services. Since GHI and donor resources originally come from relatively richer countries, we can say that a large part of ATM funding is progressive and there are cross-subsidies from the wealthier countries to relatively less wealthy people in Uganda. Furthermore, these funding sources exhibit the characteristics of financial protection because beneficiaries are not denied access to ATM services due to inability to pay, as these services are provided free of charge in public facilities. The benefit packages provided using public resources is quite comprehensive, although it might not be of reasonable quality and may therefore be unacceptable by end consumers. Therefore, these sources of funding provide a reasonable risk pool, and are used to purchase a comprehensive package provided mainly through public and Private Not-for-profit providers, community organisations and, to a lesser extent, private providers.

Private resources for ATM have not been well documented in Uganda. The only relatively relevant information may be found in economic impact studies, which usually involve estimation of direct and indirect costs related to seeking care, as well coping strategies for medical costs. In Uganda, the paucity of recent data on private spending and utilisation of private (formal and informal) providers makes it difficult to explore how significant out of pocket spending is for ATM services, especially in light of the comprehensive packages provided free to the user at public facilities. Nonetheless, given the poor quality and inadequacy these services in most part of the country, the private sector plays a role in providing services, which can only be accessed if one is paying for the service (MoH and Macro International Inc., 2007). A study of four districts in Uganda found that the use of traditional practitioners was reported in 23% of households infected/ affected by HIV and AIDS, compared to only 0.8% of the (control) households not infected/ affected by HIV and AIDS (Nabyonga-Orem et al, 2008). The study also found that about 20% of infected/ affected households visited private providers (including drug shops) compared to about 45% among the controls (ibid). Anecdotally, there is a relatively high use of private providers (both informal and formal) for all illnesses, a pattern that may be different for people affected by AIDS, TB and Malaria.

GHIs have emerged during the past decade as new models of development assistance in the fight against diseases in low- and middle-income countries. These GHIs are highly diverse in nature, scope and scale. They are rapidly evolving and have succeeded in leveraging significant new

amounts of funding (Hanefeld, 2008; Olusanya, 2000). Our review focused on four GHIs – PEPFAR, US President’s Malaria Initiative, MAP and the GFATM – the main GHI funding sources for ATM in Uganda over the past decade. The PEPFAR and US President’s Malaria Initiative programmes (both from the United States government) are driven by the need to meet legislatively mandated targets on prevention, treatment and care for HIV and AIDS and malaria. To achieve this, PEPFAR and US President’s Malaria Initiative work with NGOs based in the United States with the capacity to implement programmes quickly (Oomman et al, 2007). In turn, the NGOs select local organisations (who become sub-recipients of funds and implementers of programme activities). As such, PEPFAR and US President’s Malaria Initiative resources are primarily channelled outside government systems and are not aligned to government planning processes.

The GFATM operates from a philosophy of country-ownership of programme activities. As such, the Ugandan government is heavily involved in priority setting and funds management, and GFATM resources are channelled through existing government structures. However, GFATM funding was initially channelled through project mode, but was included in the MTEF ceilings for the health sector. The GFATM stipulates that principle recipients of funds come from both public and private/ CSO sectors, but to date there has only been one principle recipient in Uganda – MOFPED. There have been several challenges related to selection of a second principal recipient, some of which are politically driven, while others are related to the failure to find an appropriate, technically sound institution that would be able to handle technical matters for all three diseases. In Uganda, the flow of funds from the GFATM has been impeded by bottlenecks associated with poor management of resources. The flow of funds from the principal recipient to the sub-recipients or implementers was also fraught with obstacles. As such, disbursement of funds to Uganda has been highly unpredictable.

The World Bank’s funding through MAP (now closed) was primarily focused on strengthening the national AIDS response. Funding was targeted at Uganda AIDS Commission (the AIDS national coordinating entity), MoH, other line ministries, national level NGOs and community-based organisations. The largest share of MAP funding was channelled to the community-led HIV and AIDS initiatives. At community level, the main beneficiaries of funding were the local governments, CBOs and CSOs. Funds under MAP were routed through government systems and the bureaucracies in these systems sometimes posed serious challenges to implementation of activities. To some extent, there were constraints placed on programme implementation because of the slow flow of funds. Stringent World Bank accounting procedures and requirements contributed to the slow flow of funds, as did government bureaucratic procedures.

Given the diversity in GHIs in terms of flow of funds, reporting requirements, mechanisms for funds management, activities supported and implementing partners involved, it is not surprising that possibly the biggest impact of GHIs has been the burdening and weakening of existing systems and undermining the health SWAp. Moreover, the initial implementation of activities supported by GHIs did not include funding for strengthening of systems until recently. Additionally, we found that the different modes for flow of funds for GHIs have eroded the efforts previously achieved in harmonising and improving the co-ordination of development aid.

While significant increases in funding are highly celebrated, especially insofar as they have enabled the country to provide relatively expensive medicines and commodities, the unpredictability of the flow of funds and the failure for some GHIs to align to government systems, processes and priorities are posing serious challenges for overall health care financing for the country. On one hand, the unpredictability of funding has resulted in unexpected pressures on the government to step in to fill the gaps created by delayed in-flows, especially for life-saving medicines. On the other hand, failure to align GHI funding to existing financing mechanisms is creating further fragmentation in the sector’s funding.

From our assessment, we found the most important reform related to GHI funding to be the development of Long-term Institutional Arrangements (LTIA) for the management of GFATM resources (discussed in detail elsewhere in this report), following the temporary suspension of grants' disbursements. Another important reform has been the flexibility in MTEF ceilings to accommodate GHI funding.

8. Conclusion and recommendations

8.1 Conclusion

The project mode of routing GHI resources does not allow for effective co-ordination and harmonisation, and not all GHI resources are aligned to sector priorities. In some instances, for example for PEPFAR, the government is not involved in priority setting and resource allocation, and the selection of sub-recipients (who undertake implementation) is based on previous relationships with PEPFAR. The NGOs supported by these GHIs to implement activities usually cover only a selected number of districts and not the whole country. This is likely to promote geographic inequities.

Although each GHI creates a relatively large risk pool, there is limited integration between the different GHIs. The fragmentation of these financing mechanisms results in inefficient cross-subsidisation. Effective cross-subsidies could be achieved if the mechanisms were integrated. The lack of integration is also likely to result in inefficiencies.

The allocation of funding between different types of intervention (for prevention, treatment and care for PLWA etc) is pre-determined outside without the involvement of the recipient country (in the case of PEPFAR), without taking into consideration of the needs of the country. This approach is likely to skew inequalities between the different types of interventions. For example, in the case of PEPFAR funds, treatment activities receive the largest share (55%) compared to other interventions.

There is no pooling of private resources for ATM, which means that financial protection and private contributions towards ATM services are likely to be regressive. To the extent that private resources play a role in ATM funding, there are no cross-subsidies within this financing mechanism. The lack of pre-payment mechanisms, cross-subsidies and financial protection are likely to result in impoverishment for households with low incomes.

We were unable to establish how decisions are made to allocate ATM funds between different geographic areas so that those with the greatest prevalence/need benefit most or to target specific groups that are 'worst off' or have the greatest need. This is a research gap that needs to be addressed.

In conclusion, GHIs have so far paid insufficient attention to health inequities. Although the need to make health priorities equitable in addressing health disparities among populations of the world is widely acknowledged, there are presently no explicit mechanisms for achieving this goal at the global level.

8.2 Recommendations

Bearing in mind the new mechanisms proposed for improved co-ordination of development aid (for example, the LTIA), the Ministry of Health still needs to double its efforts in trying to improve the

co-ordination and harmonisation of all development aid, including support from GHIs. Specifically, measures should be put in place to ensure that annual commitments from all development partners are communicated to the MoH, with a detailed breakdown of amounts allocated to specific interventions supported by the donor. This information should be made available before the government planning cycle starts.

Because each different GHI creates large pool of resources, the government should design mechanisms that encourage the integration of GHI resources to allow for greater cross-subsidisation and a reduction in overlapping and inefficiencies. For example, government should seek to be actively involved in negotiating or directing the sites for the implementation of interventions funded by development partners through the project mode. In this way, it would ensure that resources are allocated equitably, taking into consideration the needs of different areas, as well as the level of funding already going to each of the areas of the country. The involvement of government in selection of areas for implementation could be included in the memoranda of understanding that government signs with each development partner.

While the project mode of channelling resources is preferred because of its relative speed in implementation of activities, the MoH should negotiate with DPs to channel GHI resources through one common structure within MoH. For example, a similar arrangement has worked for development partners supporting civil society organisations working in the HIV and AIDS area, and as a result the Civil Society Fund has been created. In order to get buy-in from development partners, the MoH would need to first streamline their internal procedures for funds management (in order to reduce bureaucracies) and would need to set up appropriate structures within the MoH to ensure the release of funds and the implementation of activities are expedited.

The Ministry of Health should start monitoring equity in the health sector. This includes equity in health financing, equity in access to care, geographic equity and gender equity. Given the lack of empirical evidence on many equity aspects, we recommend that the MoH initially undertakes specific studies on resource allocation equity within the health sector and equity in access to health services. Furthermore, the MoH should develop equity indicators for which information can be realistically compiled annually. Regular reporting on trends in equity should be included in the annual health sector performance reports.

In order to better understand how funding is made available for and spent on ATM, the technical programmes in the MoH (NMCP, ACP and NLTP) should each undertake a more in-depth spending assessment for each of the diseases, including the sources of funding, who the managers of these resources will be and what the funds are spent on. These assessments should include funding channelled through NGOs and CSOs. As much as possible, the MoH should investigate private spending on these three diseases and the equity implications associated with the different financing mechanisms.

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Acronyms and abbreviations

ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ATM	AIDS, Tuberculosis and Malaria
CBHI	Community-based Health Insurance
CBO	Community-based Organisation
CIDA	Canadian International Development Agency
CSO	Civil Society Organisations
DANIDA	Danish International Development Agency
DfID	Department for International Development
DOTS	Directly Observed Therapy
GDF	Global Drug Facility
GFATM	Global Fund to fight AIDS, TB and Malaria
GHI	Global Health Initiatives
GoU	Government of Uganda
GTZ	German Technical Agency for Development
ICRC	International Committee of the Red Cross
ITN	Insecticide Treated Nets
IUTLD	International Union against TB and Lung Disease
MACIS	Malaria and Childhood Illnesses Secretariat
MAP	Multi-Country HIV/AIDS Programme
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NMCP	National Malaria Control Programme
NORAD	Norwegian Agency for Development
NTLP	National TB and Leprosy Programme
PEPFAR	Us President's Emergency Plan for AIDS Relief
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
SIDA	Swedish International Development Cooperation Agency
TASO	The AIDS Support Organisation
UAC	Uganda AIDS Commission
UNAIDS	United Nations
UNASO	Uganda Network of AIDS Support Organizations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Education Fund
URA	Uganda Revenue Authority
US\$	United States Dollar
USAID	United States Agency for International Development
Ush	Uganda Shillings
WB/MAP	World Bank/Multi-country HIV/AIDS Programme

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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