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Strategic Program for Analyzing Complexity and Evaluating Systems (SPACES) Systems Map of the Ugandan Health System

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SPACES SYSTEMS MAP OF THE UGANDAN HEALTH SYSTEM

STRATEGIC PROGRAM FOR ANALYZING COMPLEXITY AND EVALUATING SYSTEMS

June 30th, 2017

From April 2017 – May 2017, the Strategic Program for Analyzing Complexity and Evaluating Systems (SPACES) Monitoring, Evaluation, Research, and Learning (MERL) consortium implemented a systems mapping tool to map the Ugandan health system and point to potential leverage points within the system.

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ACRONYM LIST

Community Health Workers	(CHW)
Country Development Cooperation Strategy	(CDCS)
Health Information System	(HIS)
Health Management Information System	(HMIS)
Human Immunodeficiency Virus	(HIV)
Human Resources for Health	(HHR)
Gross Domestic Product	(GDP)
Government of Uganda	(GoU)
Key Informant Interviews	(KIIS)
Leverage Point	(LP)
Monitoring, Evaluation, Research, and Learning	(MERL)
Ministry of Education	(MOE)
Ministry of Finance	(MOF)
Ministry of Health	(MOH)
National Medical Store	(NMS)
Non-Government Organizations	(NGOs)
Non-Communicable Diseases	(NCDs)
Out-of-Pocket	(OOP)
Project Appraisal Document	(PAD)
Strategic Program for Analyzing Complexity and Evaluating Systems	(SPACES)
Tuberculosis	(TB)
Village Health Teams	(VHT)
United States Agency for International Development	(USAID)
Water, Sanitation and Hygiene	(WASH)
World Health Organization	(WHO)

OVERVIEW

This set of maps and accompanying narrative is based on a number of key informant interviews (KIIs) and background research conducted by the SPACES consortium partners GOPC and LINC. This document can be used to identify points of leverage within the Ugandan health system with the purpose of framing-up United States Agency for International Development (USAID) Uganda's Health Systems Project Appraisal Document (PAD). The systems map framework includes many of the key actors and institutions comprising the Ugandan health system and draws linkages between them. The actors, institutions, and linkages are presented broadly with a focus on the most critical structures and themes that emerged from our research. Though not exhaustive, our teams have identified over 20 systemic leverage points within the system where concerted action might prove useful.

DESIGN, METHODS AND LIMITATIONS

METHODS

A systems map is a visualization and communication tool used to represent a system of interest. A systems map is generally comprised of key elements in the system and the linkages between them, which can be classified or grouped according to different themes. The systems map of the Ugandan health system was constructed by first defining the primary elements within the system through interviews and background research, and then connecting the elements according to the goals of the project – highlighting potential leverage points within the system. As described below, the systems map was structured broadly by both the World Health Organization (WHO) building blocks and the design of the Ugandan health system from the international level to the local and individual level.

WHO BUILDING BLOCKS

The systems map is characterized by the six WHO-devised building blocks for health systems: health governance, health financing, human resources for health (HRH), health service delivery, health information systems (HIS), and access to essential medicines. Each map below includes the actors, processes, and leverage points that are integral to each of the six building blocks. A number of health systems actors are included across the six building blocks – while the primary function of each actor may be financing or governance, for example, these actors tend to have multiple functions and roles, and, as such, span multiple aspects of the health system.

READING THE MAPS

Each map consists of a number of elements, actors, and institutions (represented by large circles), connections between these elements (represented by lines), constraints on each connection (represented by the labels on each line), and potential leverage points (represented as small red dots). The map moves left to right from international actors (multinational donors and manufacturers) to village-level medicine distributors, and includes a level for each of the national, district, and sub-district actors.

LIMITATIONS

The findings and subsequent recommendations in this document and set of maps have not been “validated”. Normally, in a system mapping exercise, a draft map is shown to and discussed with numerous stakeholders, with the feedback drafted into multiple iterations of the map. This process was truncated to a quick-turnaround review on the part of a limited number of staff in the USAID mission. As such, elements and linkages between elements are not exhaustive and may benefit from broader validation.

SEE MAP 1: UGANDA HEALTH SYSTEM MAP COMPLETE

SUMMARY OF KEY POINTS FROM INFORMANT INTERVIEWS & RESEARCH

National health care expenditure in Uganda remains largely financed by the international donor and development community (Uganda Health Accounts 2013/2014; Uganda Health System Pre-Assessment Report, 2016; KII). Health system donors in Uganda focus on financing vertical, development priorities: Maternal-Child Health (MCH), Human Immunodeficiency Virus (HIV), Tuberculosis (TB), malaria, Water, Sanitation and Hygiene (WASH), and nutrition programs and services. The GoU and donors dedicate inadequate funds to systemic programming aimed at strengthening primary care, health prevention, or targeting the rise of Non-Communicable Diseases (NCDs), which places a significant strain on Uganda's already weak health system. Largely as a result of this, the Government of Uganda (GoU) maintains a "disease-specific" agenda, allocating on average 72 percent of its national budget towards curative services and only 16 percent towards prevention efforts (Uganda Health Accounts 2013/2014).

While a large donor presence can drive the mobilization of resources towards specific national health needs, underlying competing interests and development priorities can confound overall development efforts. This can lead to a lack of harmonization and coordination of efforts between both external and internal stakeholders. While great opportunity exists to engage stakeholders and negotiate mutually agreeable and sustainable ways going forward, the current landscape poses challenges to utilization of a systemic approach to health system strengthening and overall sustainability.

The GoU's national health system is weak. Chronic national underfunding, inefficiencies and limited accountability characterize the system (Uganda Health System Pre-Assessment Report, 2016; Uganda Health Systems Assessment 2011; KII). These characteristics significantly compromise the six WHO health building blocks that comprise a health system – health governance, health financing, and human resources for health, health service delivery, health information systems, and access to essential medicines. While the GoU hoped that a shift towards health sector decentralization would improve the quality of the country's health services and outcomes, the GoU has not successfully implemented this policy. The GoU's continued allocation of limited resources to the district and sub-district levels results in a shortage of a trained and adequately skilled health workforce that in turn hinders effective and efficient health service delivery. Medicine and supply chain bottlenecks prevail in Uganda's underfinanced system where human resource management and health information systems are weak. In a system that boasts a "free universal care for all," access to quality care is rarely free of charge. The inability of the GoU to finance a free, national health care system has left the most marginalized Ugandans at the mercy of the private sector's high out-of-pocket (OOP) costs. Coupled with Uganda's rapidly changing epidemiological health patterns, this places significant burden on the country's already strained health system.

Nonetheless, there are promising signs of progress and great opportunity to build, strengthen and sustain an efficient and equitable health system in Uganda. The following sections will provide an overview of the Ugandan health system building blocks and discuss realistic and sustainable interventions for the Mission to address key leverage points in the system.

HEALTH GOVERNANCE

SEE MAP 2: HEALTH GOVERNANCE MAP: ACTORS, PROCESSES, & LEVERAGE POINTS

HEALTH GOVERNANCE: SUMMARY OF KEY THEMES AND LEVERAGE POINTS

Uganda's inability to finance fully its public health care system hinders effective health governance (Okecho, 2009; AHSPP, 2010/2011). The fragmented nature of this system has led to inadequate and

unenforced legislation, corruption, patronage, a lack of accountability, transparency and a subsequent lack of commitment by all stakeholders across the country.

Leadership to demand and enforce regular monitoring and inspection remains weak in Uganda. While there is a great need for better monitoring and supervision of health training and practice, regulatory agencies and health professional councils remain understaffed, poorly funded and largely ineffective, both in the private and public sector as well as at the national and local level. As a result, both the private and public sector poorly understand and poorly adhere to health policies and guidelines. The lack of reliable health data, as well as a trained workforce to generate, manage and implement data for decision-making, further makes these efforts difficult.

Weak regulation negatively affects budget planning and hinders effective decision-making and policy implementation. This often blurs the lines of accountability and hinders sound, evidence-based policy-making. The poor relationship between the Ministry of Health (MOH), the Ministry of Finance (MOF) and the Ministry of Education (MOE) further aggravates Uganda's weak performance and resource management. The significant lack of harmonization and knowledge sharing between the three ministries has led to poor management of resources and coordination of efforts (Uganda Health Systems Pre-Assessment, 2016; KII).

Related Systemic Leverage Points (Refer to Leverage Points Section for explanation, potential interventions and indicators):

- Weak civil engagement/ advocacy (LP12)
- Weak evidence-based decision making (LP7, LP18, and LP5)
- Lack of collaboration and knowledge sharing between MOH, MOF and MOE (LP10)

HEALTH FINANCING

SEE MAP 3: HEALTH FINANCING MAP: ACTORS, PROCESSES, & LEVERAGE POINTS

HEALTH FINANCING: SUMMARY OF KEY THEMES AND LEVERAGE POINTS

Uganda's small national health budget exacerbates the country's weak health governance. While healthcare is technically free and universal in Uganda, the realities on the ground are quite different. The national, public health sector remains significantly underfunded. Government spending on health as a ratio of Gross Domestic Product (GDP) is well below the global recommended 5 percent of GDP, totaling only 1.4 percent (Uganda Health Accounts, 2013/2014). In addition, the total health care expenditure by the GoU is \$56 per capita, approximately \$28 per capita lower than the recommended investment by WHO (Uganda Health System Accounts, 2013/2014). Uganda's reliance on external financing and donor support strongly affects health governance. Ugandan health financing policy tends to reflect donor priorities, which in turn, weakens resolve for reform and complicates coordination efforts.

The donor community has a tendency to over-develop disease-specific agendas, allocating limited resources towards primary and preventative care (Uganda Health Systems Pre-Assessment Report, 2016). The inability of the GoU to raise sufficient tax revenues to cover the gaps for essential public health services has led to an inequitable access to basic health services and increased OOP expenditures for many. According to Uganda Health Accounts, 2013/2014, household OOP "increased from 37 percent in 2011/12 to 41 percent in 2013/14, owing to the increase in population spending on health care outside the public facilities." These figures are well above the 15 percent WHO maximum recommended level of OOP expenditures on health care (Uganda Health Accounts, 2013/2014). This has been particularly detrimental to the poor and vulnerable groups who lack the financial resources to

access private services. The Uganda Health System Assessment 2011 reports that, “stock-outs in public sector facilities, informal payments in public sector, and high prices in the private sector continue to pose challenges to equity and access- about 65 percent of households in the lowest socioeconomic bracket face monthly catastrophic expenditures on pharmaceuticals.” The prohibitive cost of private care places a significant burden on the poor, forcing many to forgo or delay necessary care and treatment (Uganda Health System Assessment, 2011; KII).

While a lack of government funding and innovative health financing schemes are the primary factors that inhibit free access to public health care and services, weak patient advocacy and demand for better health services inadvertently and indirectly uphold and enable the persistence of the status quo. While healthcare is deemed by law “free for all,” a large majority of the Ugandan population continues to believe that they not only need to pay for healthcare, but also that services rendered would be inevitably of better quality if they were to pay for them (KII). This, is exacerbated by the fact that “formal sector employers finance their employees through private health insurance but this covers only a small proportion (<1 percent) of the population in regular employment” (MOH, 2010; Pre-Assessment 2016). This financing system places the poor and marginalized groups (often employed in the informal sector) at an increased disadvantage, forcing them to rely on a failing and underfunded public health system.

Related Systemic Leverage Points (Refer to Leverage Points Section for explanation, potential interventions and indicators):

- Weak civil engagement/ advocacy (LP12)
- Emphasis on disease specific programs detracts from basic public health care services (LP6)
- Need for meaningful and realistic healthcare financing options (risk pooling, national subsidies etc.) (LP23)
- Need to consider the poor and marginalized groups exclusion from access to quality essential health services, especially at the local, district level (LP4)
- Outsize role of donors in health funding (LP1 and LP9)

HUMAN RESOURCES FOR HEALTH

SEE MAP 4: HUMAN RESOURCES FOR HEALTH (HRH) MAP: ACTORS, PROCESSES, & LEVERAGE POINTS

HUMAN RESOURCES FOR HEALTH: SUMMARY OF KEY THEMES AND LEVERAGE POINTS

A major weakness within the Ugandan health system lies in the availability of adequately skilled labor. Due to a severely strained budget, the GoU is unable to attract and retain sufficient human resources for health. As a result, there is a consistent shortage of trained labor available to respond efficiently and adequately to the population’s health needs. This phenomenon is particularly widespread within the remote and hard to reach areas of the country.

Due to the country’s limited wage bill, healthcare workers’ wages are not commensurate with the demand and provision of health services. As result, health facilities report a low morale and motivation among workers that has led to tardiness, absenteeism, moonlighting and health worker migration (both nationally and regionally, as well as to the private sector). This has led to significant staffing gaps and poor population health outcomes, especially in rural Uganda, where the population must rely on the efforts of community health workers (CHWs). Although 75 percent of Ugandan villages currently have trained village health teams (VHTs), there is a significant lack of central investment, leaving many VHTs with limited supplies and dilapidated and dysfunctional equipment (Uganda Health System Pre-Assessment, 2016).

In addition, Uganda's human resource management system remains weak. The MOH, which remains understaffed by approximately 50 percent, has been unable to recruit healthcare professionals in manner that aligns that Uganda's rapidly growing population (KII). Performance management systems, especially at the local and district level, are weak or non-existent, hindering adequate monitoring, training, quality of service provision (both at the national and local level) and the overall functionality of the health system.

The lack of educational and financial incentives further exacerbates the problem. The GoU does not offer educational subsidies or financial remuneration to those working in remote Uganda. This has led to high vacancy rates and attrition rates, as many health service providers have either opted to practice in urban centers or left the public health space to seek better paying opportunities elsewhere.

Related Systemic Leverage Points (Refer to *Leverage Points Section* for explanation, potential interventions and indicators):

- Weak human resource and performance management (LP16, LP17)
- Limited training and access to necessary medical supplies and medicines (LP3, LP22)
- Limited number of motivated, trained workforce (LP15, LP16, LP3, LP7)

HEALTH SERVICE DELIVERY

SEE MAP 5: HEALTH SERVICE DELIVERY MAP: ACTORS, PROCESSES, & LEVERAGE POINTS

HEALTH SERVICE DELIVERY: SUMMARY OF KEY THEMES AND LEVERAGE POINTS

Health service delivery remains largely underfunded in Uganda. Provision of services is unable to keep up with the rapid population growth, straining already finite national public health coffers. Largely reliant on financing by external donors, the government has been unable to fund fully its national healthcare program, leading to shortages of well-equipped health facilities. Although private health sector has been able to step in and fill the large gaps in service delivery, this has been, arguably, to the detriment of the rural, poor, and marginalized populations unable to access and afford the high out-of-pocket expenses and fees associated with private care (Uganda Health System Assessment, 2011; KII). Thus, significant opportunities exist for private and public stakeholders to work together to prioritize equitable access and autonomy.

Despite the existence of regulatory agencies and health professional councils tasked with ensuring compliance with service provision guidelines and monitoring the quality of care, quality remains low. Regulatory agencies cannot adequately monitor and enforce regulations, as they are poorly staffed and underfunded. In addition, while the district level implements central health policies and manages district service delivery, there are limited planning, monitoring, and supervision structures in place to ensure coordinated efforts and consistent application of policies and guidelines (Uganda Health Systems Pre-Assessment, 2016).

In addition, while 75 percent of the Ugandan population lives within 5 km of a health facility (regionally, a competitively high percentage), it is important to keep in mind that proximity does not always mean accessibility (NSDS, 2013). Disparities in access exist beyond simple physical access. Poor infrastructure limits the quality and prevents many from accessing care, weakening the efficiency of the referral system. Facilities remain poorly equipped and dilapidated, lacking essential medicines and medical supplies. In addition, lack of transportation facilities and high transportation costs inhibit access to specialized and intensive care, leading patients to forego or delay necessary care (Uganda Health

Systems Assessment, 2011). Uganda faces a broken referral system, unable to “cater to the poor [due to the]: lack of funds for movement of the patient to higher care levels, lack of transport facilities, lack of necessary medicines, logistics and competent human resources at the reference health facility, and the lack of upkeep costs expected to be met by patients. Most Ugandans, especially those living in rural areas, are poor and cannot afford these costs.” (Uganda Health Systems Report, 2016)

Related Systemic Leverage Points (Refer to *Leverage Points* Section for explanation, potential interventions and indicators):

- Poor health infrastructure (LP19)
- Significant barriers to care, especially for the poor and marginalized populations (LP4)
- Weak monitoring and supervision (LP18, LP14)

HEALTH INFORMATION SYSTEMS

SEE MAP 6: HEALTH INFORMATION SYSTEMS: ACTORS, PROCESSES, & LEVERAGE POINTS

HEALTH INFORMATION SYSTEMS: SUMMARY OF KEY THEMES AND LEVERAGE POINTS

While Uganda’s national HIS is vital to health planning, financing, and budgeting for the other five WHO health building blocks, it is largely underfunded and understaffed. The donor community fails to prioritize HIS outside of disease surveillance systems and the GoU allocates insufficient resources towards sound, routine data collection. As a result, there are many information gaps in the current HIS. Many health facilities continue to lack the necessary human resources, equipment and infrastructure (including reliable internet, electricity and mobile connections) to effectively collect and act on the information gathered.

At the sub-district level, where human resources are already limited and there is little funding for recruiting and paying a data manager, capacity is particularly weak. Tasking nurses and clinical officers at health facilities to collect and analyze data particularly affects health service delivery. This not only places a significant strain on the already weak health workforce, but also accelerates the attrition rate of health workers.

Moreover, the information collected often does not inform evidence planning, budgeting and decision-making. This has significant negative implications on the ability of the MOH and district health offices to effectively target the provision of health services, recruit and train a health workforce and predict the supply and demand of essential medications. Inevitably, the country’s weak HIS has led to significant inefficiencies and waste.

Related Leverage Points (Refer to *Leverage Points* Section for explanation, potential interventions and indicators):

- Lack of funding (LP4)
- Poor data collection and quality (LP20)
- Poor data utilization for decision- making and informing legislation and budget (LP18)
- Limited motivated and trained personnel for data collection and analysis (LP5)
- Poor infrastructure and tools to collect and analyze data at the local, district level (LP19)

ACCESS TO ESSENTIAL MEDICINES

SEE MAP 7: ACCESS TO ESSENTIAL MEDICINES: ACTORS, PROCESSES, & LEVERAGE POINTS

ACCESS TO ESSENTIAL MEDICINES: SUMMARY OF KEY THEMES AND LEVERAGE POINTS

Uganda's medical supply chain is broken. Staffing and funding for essential medical supply institutions, such as the National Medical Store (NMS), remains grossly underfunded. The GoU fails to allocate sufficient funding towards essential needs, relying strongly on donors and NGOs to procure and distribute disease-specific medicines and medical supplies. As a result, distribution of and access to essential supplies and medicines remains dependent on donor interests and priorities.

Legislation, policies and guidelines surrounding essential medicines are outdated and weak, inhibiting the ability to effectively plan and monitor the health supply chain. Inefficiency and waste characterizes Uganda's ability to procure, deliver and manage inventory systems.

Due to weak "monitoring and supervision of medicines management at both public and private facilities" supply and demand forecasting is difficult and inefficient (Uganda Health System Pre-Assessment Report, 2016). Poor planning and forecasting of supply and demand leads to routine stock-outs of medical supplies. This not only inhibits the work of health workers and the provision of effective service delivery to patients, but also places a significant burden on the poor and marginalized.

Related Systemic Leverage Points (Refer to Leverage Points Section for explanation, potential interventions and indicators):

- Reliance on donor funding raises issues of eventual sustainability (LP1, LP2)
- No accountability, opportunities for graft (LP11)
- Poor legislation and adherence to policies and guidelines (LP18, LP21)
- Lack of medical supplies drives patients to the more expensive private sector (LP3)

LEVERAGE POINTS, INTERVENTIONS, AND INDICATORS

Leverage points are coded in the systems map as “LP” and highlighted with red boxes, representing dynamics between actors. For the purpose of this analysis, leverage points are defined as systemic drivers oftentimes impacting across multiple building blocks in the system, and preliminarily assessed to be within USAID’s manageable interest. In many cases there are multiple related leverage points in the system, which have been consolidated and outlined in the below narrative outlining potential interventions, indicators and associated building blocks.

Leverage Point: Civil Engagement and Advocacy/ Role of civil society for the creation and demand for change and accountability (LP12): There are already several advocacy platforms and initiatives at multiple levels of the health system. Such initiatives offer strong opportunity for strengthening and expansion, given the imperative for reform efforts to take place across multiple building blocks and areas of the system. Health advocacy efforts offer potential to shine lights on pressing health issues, stimulating government and policymakers to exert increased leadership, allocate funding, enhance quality of services, and increase citizen awareness of rights and responsibilities. Organizational networking strategies bear strong potential, utilizing systemic design, monitoring and evaluation tools such as Social Network Analysis. Public scorecards for service delivery facilities can also be employed. In addition, targeted advocacy training, technical assistance to multiple stakeholders, including government, service providers and civil society, can be strongly considered.

Potential Indicators:

- Advocacy networks strengthened (Social Network Analysis)
- Reforms undertaken as a result of advocacy efforts (Output)
- Increased organizational capacity for advocacy (Organizational Capacity Index)
- Systems mapping and network analysis helps organizations to better define roles and coordinate advocacy efforts (Systems Mapping, Social Network Analysis)
- Enhanced bridging social capital between civil society, government and service providers (Social Network Analysis)
- Enhanced index scores for accountability, transparency (Scorecards)

Related Building Blocks:

- Health governance
- Health financing
- Health service delivery
- Access to essential medicines

Leverage Point: Strengthen Human Resource Management (LP16): USAID might consider activities that focus efforts at strengthening HRH management across multiple job areas and functions in the health system. Leadership, skills development, accountability and worker remuneration are key issues. There are a number of innovative staffing and training activities that might be undertaken at health care facilities and community levels, including CHWs. Capacity development, policy reform, advocacy and awareness appear to be key levers of systemic change. Analytical tools that can be effectively utilized to design, monitor and evaluate specific activities including Organizational Network Analysis, Organizational Capacity Indices and Modelling.

Potential Indicators:

- Increased consensus around optimal staffing and management structures / reforms (Modelling)
- Increased coordination among staff and between organizational / governmental units (Social

Network Analysis)

- Increased capacity to undertake responsibilities (Organizational Capacity Index)
- Increased job satisfaction (Perception survey)
- # of capacity/ refresher training sessions provided by facility level, region (Output)

Related Building Blocks:

- Human Resources for Health
- Health Governance

Leverage Point: Strengthen Performance Management (LP17): Implementation of a performance appraisal system to evaluate provision of care as well as link to performance goals exhibits potential for systemic change in HRH and healthcare governance. Accountability and quality of performance may be enhanced through distribution and availability of performance data, dashboards and scorecards. Financial and non-financial incentives to boost health worker's performance and motivation may be weighed. In consideration of the value of VHTs to district health, the Mission may consider the prioritization of investment in rural CHWs and midwives, as well as continuous capacity strengthening and training of health workers, both at the central and local level. Tools such as perception surveys, scorecards, capacity assessment and Organizational Network Analysis are anticipated to assist in design, monitoring and evaluation efforts.

Potential Indicators:

- Health worker performance enhanced (Scorecard, Indices)
- Enhanced levels of trust between healthcare workers and management / regulatory authorities (Perception Surveys)
- Health worker capacity increased (Organizational Capacity Index)
- Roles and responsibilities rationalized (Organizational Network Analysis)

Related Building Blocks:

- Human resources for health,
- Health governance

Leverage Point: Improving Incentives for Addressing Health Worker Distribution and Retention Challenges (LP5, LP7, LP15, and LP16): Given the growing gap between the supply and demand of health services, especially at the local district level, investment in healthcare workforce shows strong potential for systemic change impacting upon multiple building blocks in the system. Policy advocacy and reform efforts promoting incentive strategies ensuring that remote, rural districts in Uganda have adequate trained/specialized health personnel exhibits potential. Both financial and non-financial incentives should be considered. Financial incentives may include: wages that commensurate with demand of health services, provision of housing, performance linked payments, educational subsidies. Non-financial incentives might include: opportunities for professional development, positive work environments, access to benefits, manageable workloads, and access to needed supplies and medicine. Analytical tools that will assist in guiding and evaluating these initiatives include Modelling and Organizational Capacity Indices.

Potential Indicators:

- Government and donor healthcare financing rationalized and coordinated (Modelling)
- National – local healthcare financing rationalized and coordinated (Modelling)
- Distribution of health workers by specialization, region and sector (Output)
- Number of related policy reforms undertaken (Output)

- Capacity of workers and health units increased (Organizational Capacity Indices)

Related Building Blocks:

- Human Resources for Health
- Health Service Delivery
- Access to Essential Medicines
- Health Financing

Leverage Point: Investing in Health Infrastructure for Better Health Outcomes (LPI9):

According to the Uganda Country Development Cooperation Strategy (CDCS), information on the exact state of infrastructure is currently non-existent. Activities programming resources for improved health infrastructure inventory that would allow for mapping and addressing the infrastructure barriers that are currently hindering access to basic provision of care. By investing in health infrastructure, the Mission can further support the GoU efforts to attract and retain health workers to rural, hard to reach areas as well as improve health information collection and quality. Systems infrastructure mapping, including stocks and flows diagramming can be helpful in designing and monitoring such activities. Driven by the government, collective impact facilitation methods may assist in prioritizing needs, planning and budgeting for them in a participatory way that incorporates diverse priorities and voice.

Potential Indicators:

- Key constraints in health infrastructure identified (Systems Mapping / Stocks and Flows)
- Infrastructure improvement priorities identified and planning and budgeting undertaken (Collective Impact Method)
- Increased budget for infrastructure improvement (Output)
- Infrastructure improvements undertaken (Output)

Related Building Blocks:

- Service delivery
- Human resources for health
- Information systems
- Health governance

Leverage Point: Reinforce monitoring, evaluation, and quality mechanisms within the national public health system (LP4, LP8, LP11, and LP14):

To enhance sufficient levels of essential medicines, a strong and motivated health workforce, effective and efficient health service delivery, and the collection and application of sound health information, support may be provided to the GoU to strengthen regulation, oversight and inter-governmental collaboration. For example, the capacity of health professional councils and the NDA may be increased to monitor, supervise and regulate the health system so quality standards and quality of care are achieved and that sound information drives evidence based planning, budgeting and decision making. Careful attention should be paid to the balance between enforcement and support with the ultimate objective of enhance quality, efficiency and compliance. Systems process analytical methods such as Stocks and Flows analysis may provide helpful guidance for design, monitoring and evaluation. Scorecards and dashboards may be developed to help monitor progress and increase accountability.

Potential Indicators:

- Improved processes for monitoring, supervision and quality assurance (Systems process analysis)
- Enhanced service delivery scores (Scorecards)
- Capacity increased for monitoring, supervision and regulation (Organizational Capacity Indices)

- Planning and budgeting processes incorporate monitoring, supervision and regulation priorities (Output)
- Improved levels of trust between monitoring, supervision authorities and service providers (Perception surveys)

Related Building Blocks:

- Health governance,
- Health financing,
- Health delivery,
- Human resources for health,
- Access to essential medicine,
- Health information systems

Leverage Point: Strengthen HIS (national level down to local facilities) (LP10 and LP18):

While great strides have been made, there remains a need to improve data collection, quality and the utilization of data for decision-making both on the local level and at the central / donor level. Support may be provided to advocate for increased funding to HIS as well as provide technical support for strengthening information systems for evidence-based public health decision making and intervention. Capacity development and technical assistance may promote standardized frameworks, methodologies and data collection/monitoring tools across the MOH, MOF, and MOE that will allow for consistent, quality and central access to data. Electronic entry may be extended to the sub-district level where practical, currently a weak link in the Health Management Information System (HMIS) system. Advocacy efforts may create or increase demand for information to be shared, discussed and available to all stakeholders. Strengthening dialogue and coordination across the MOH, MOF and the MOE will be vital to strengthening the national HIS.

Potential Indicators

- Increased use of health information systems by policy-makers, researchers, program implementers and other key stakeholders (Output)
- Enhanced quality and reliability of health information (DQA)
- Human resource capacity enhanced (Capacity Assessment)
- Health information systems contribute to modelling, scenario planning and forecasting tools and methods (Modelling tools)

Related Building Blocks:

- Health information systems
- Human resources for health

Leverage Point: Increase Coordination between Health Stakeholders (LP8, LP9 and LP10):

To address the lack of coordinated efforts between national and international stakeholders and increase dialogue and engagement. A thorough stakeholder analysis (at the international, national, district and local government) is needed in order to determine influence, positions, and interests of each stakeholder's ability to influence policy, levels, and budgets. The utilization of systemic tools such as Social Network Analysis and Political Economy Analysis may be considered both at the portfolio level, and on an activity-by-activity basis, identifying pivotal actors and the means of strengthening or diminishing them. The Mission could work with the GoU to conduct such an analysis, which will allow them to better inform USAID's understanding of coordination barriers as well as potential policies and next steps.

Potential Indicators:

- Number of joint stakeholder initiatives (output)
- Number of public-private partnerships (output)
- Enhanced perceptions between competing or overlapping systems actors (Survey, Social Network Analysis)
- Improved understanding of Health Systems Political Economy (Political Economy Analysis)
- Improved understanding of roles and responsibilities in the system (Social Network Analysis)

Related Building Blocks:

- Health governance
- Health financing

Leverage Point: Decrease Role of Donors in Health Financing (LP1, LP2, and LP3): As

Uganda's poor and marginalized populations continue to bear high health expenditures; there is a need to ensure an increased allocation of public resources for basic health care services. This is a difficult space, requiring long-term efforts, where pressing humanitarian and health care safety nets come into conflict with the need to instill political will and encourage responsibility on the part of the GoU and key local actors / financiers in the healthcare system. In addition to the creation of political will, one area of potential appears to reside in market-based, pro-poor financing schemes. Technical assistance and seed financing may aid the GoU in piloting and strengthening existing efforts for domestic financing schemes (e.g. risk pooling and health subsidies) and creation of market-based incentives. Increased efforts at coordination and long-term strategy development between the government and various donors for more effective utilization of limited resources is an important first step in this process, though we understand that there have been numerous coordination efforts to date and a number of government and donor strategies elaborated.

Potential Indicators:

- Political will for enhanced government responsibility for healthcare financing (Political Economy Analysis)
- Coordination enhanced between government, donors and other financiers of the system (Social Network Analysis)
- Coordination strategies elaborated (Output)

Related Building Blocks:

- Health financing
- Health service delivery

ANNEX A: SOURCES OF INFORMATION

I. Documents Reviewed:

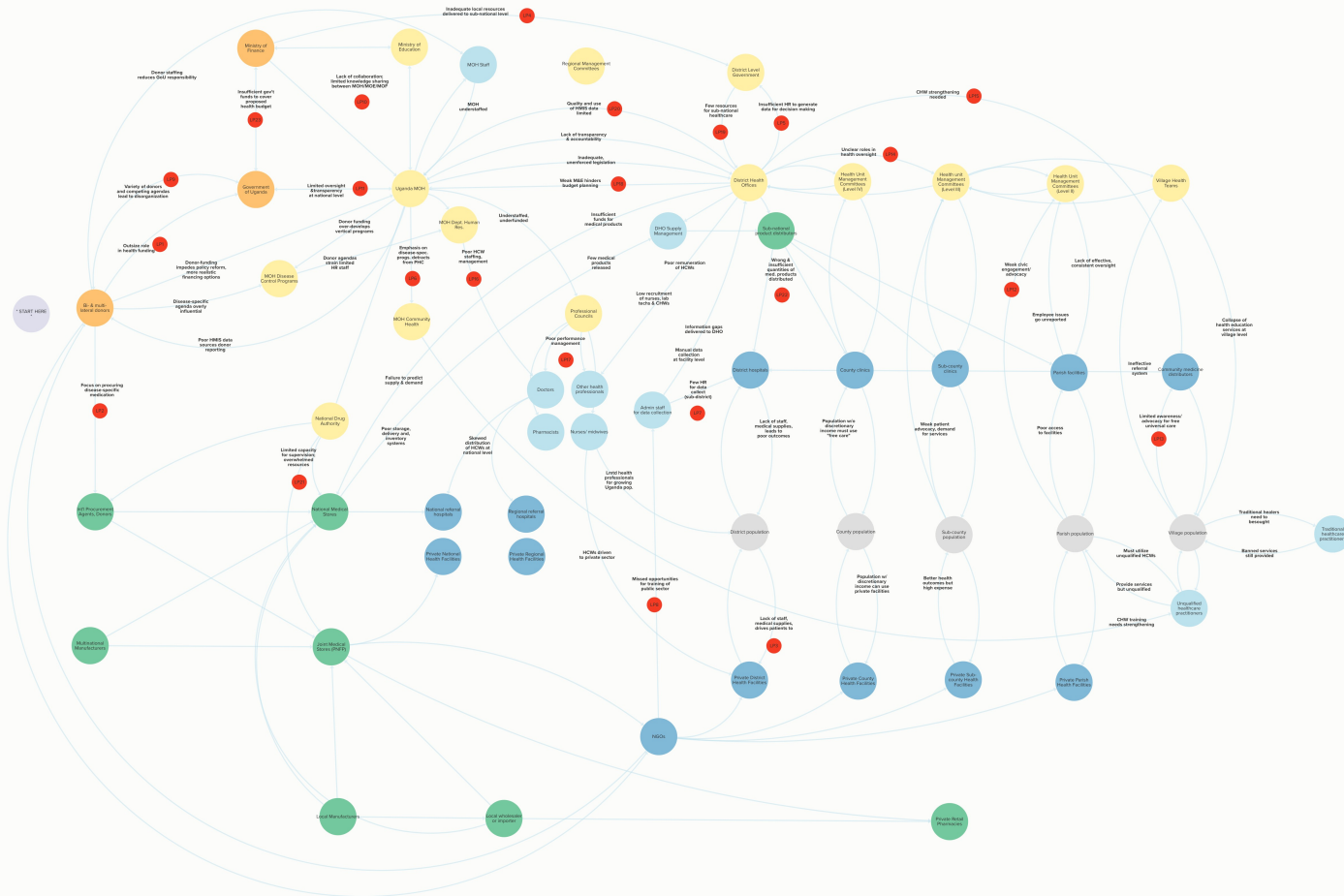
- Moyer, J et al. (2015). “Advancing development in Uganda: evaluating policy choices for 2016-21 and selected impacts to 2040.” Frederick S. Paree Center for International Futures.
- “USAID/Uganda Country Development Cooperation Strategies (CDCS) 2011/2015” USAID. 2016.
- “Uganda Health System Pre-Assessment Report.” USAID. 2016.
- “Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies.” WHO. 2010.
- Ministry of health Sector Budget Framework Papers 2010 - 2015
- “Uganda Health System Assessment.” Abt Associates. 2011
- Okecho EA (2009). The challenges of decentralized health services in Uganda: a case study of Tororo District <http://hdl.handle.net/10570/2428>
- Uganda Health Accounts: National Health Expenditure, Fiscal Years 2012/13 and 2013/14
- National Service Delivery Survey, 2013

II. People Interviewed:

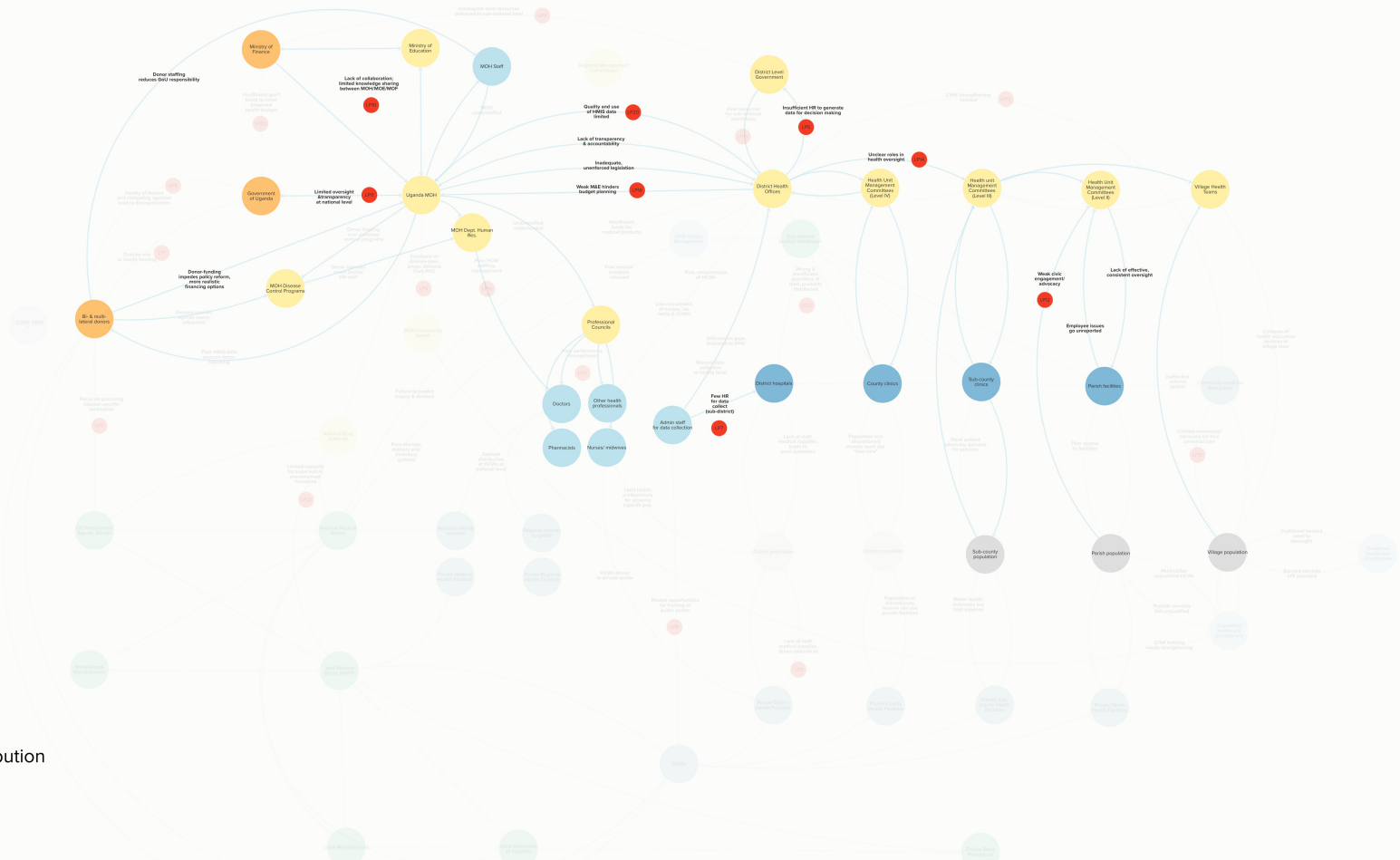
- USAID/Uganda PPD, Project Development Officer, May 2, 2017
- USAID/ Uganda PPD, STIP Fellow, May 8, 2017
- USAID/ Uganda – Health & HIV Office, Deputy Team Leader, May 8, 2017
- USAID/ Uganda- Health Systems, Sr. Health Systems Advisor, May 9, 2017
- SHRH, Chief of Party, May 9, 2017
- USAID/Uganda- Family Health Team, MCH Specialist, May 9, 2017
- MEEP, Supervisor/ Program Director, May 11 2017
- UHSC, Chief of Party, May 11, 2017
- PATH/ Advocacy for Better Health, Chief of Party, May 11, 2017
- PATH/ Advocacy for Better Health, Monitoring and Evaluation Specialist, May 11, 2017
- ASSIST Project, Chief of Party, May 12, 2017

ANNEX B: MAPS

MAP 1: UGANDA HEALTH SYSTEMS MAP

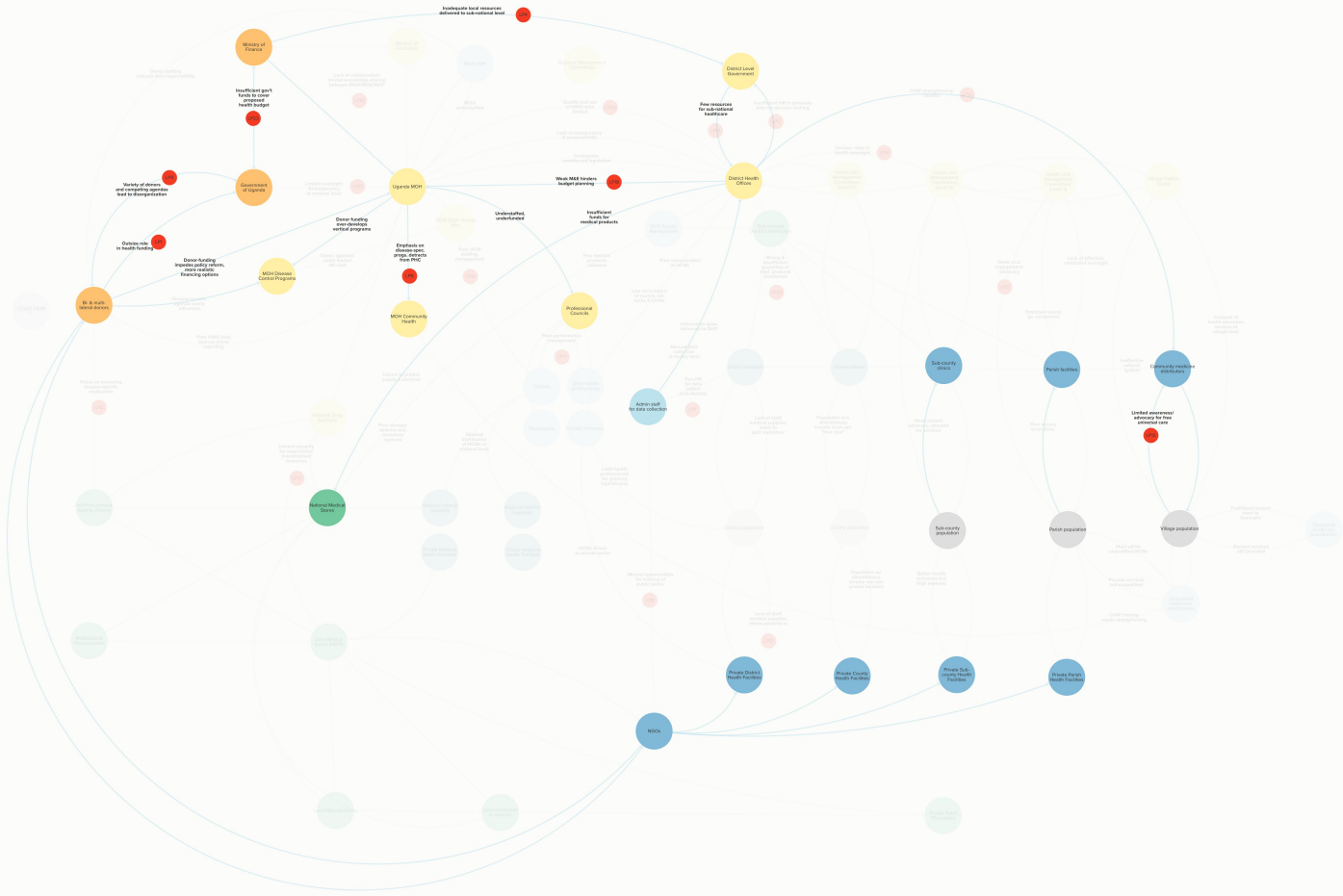


MAP 2: HEALTH GOVERNANCE

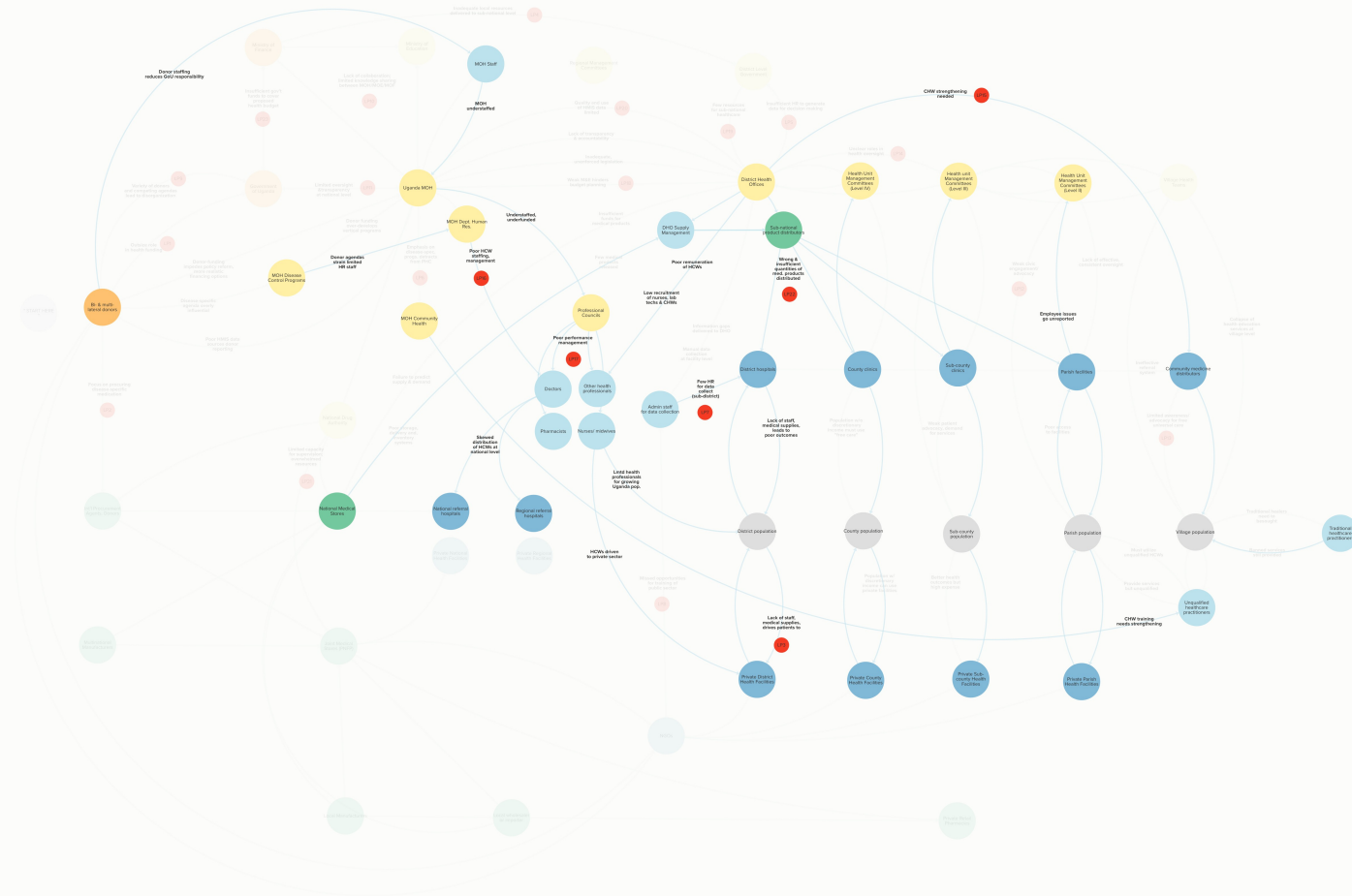


-  Health Product Distribution
-  Human Resources
-  Health Financing
-  Health Governance
-  Leverage Point

MAP 3: HEALTH FINANCING

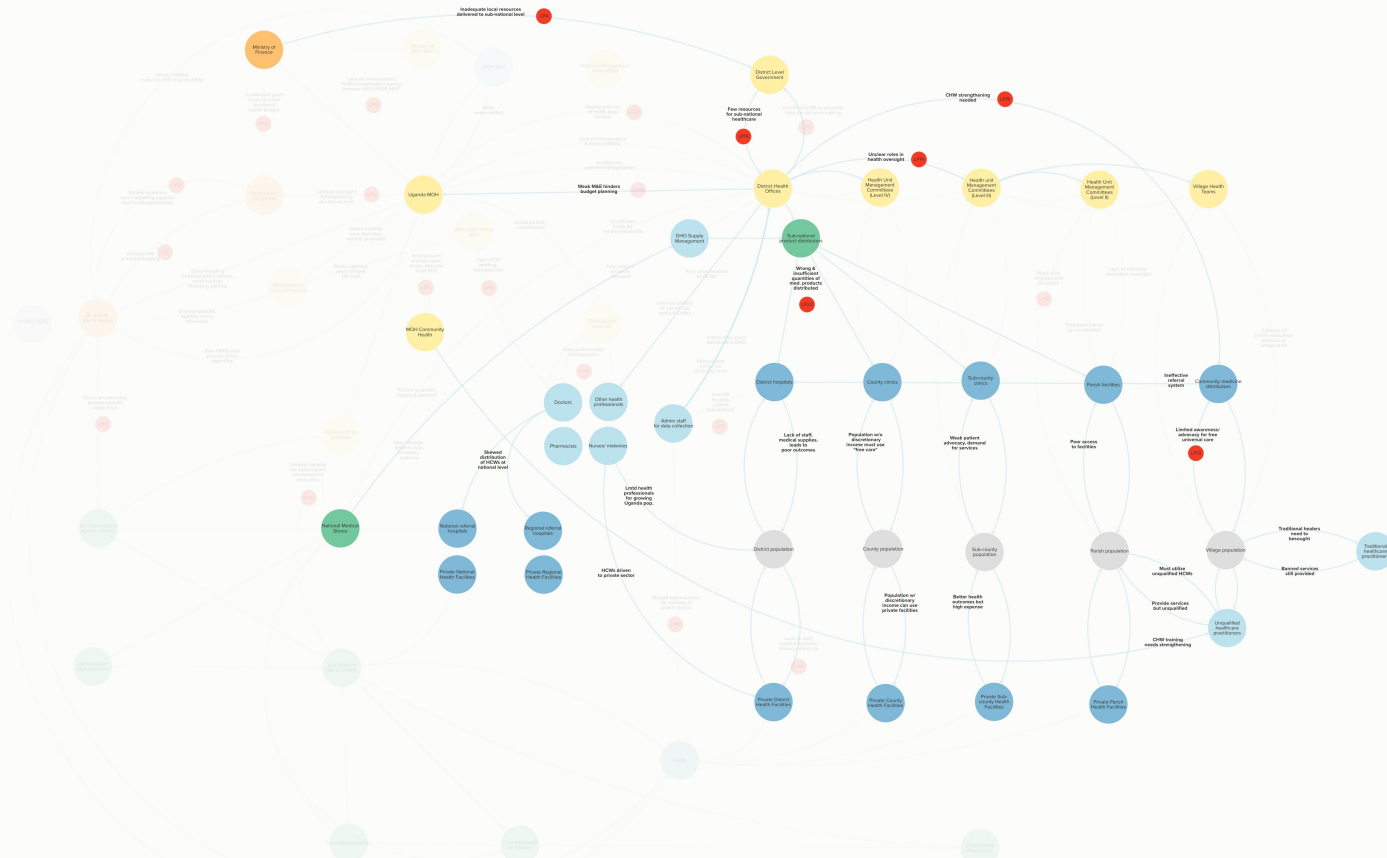


MAP 4: HUMAN RESOURCES FOR HEALTH

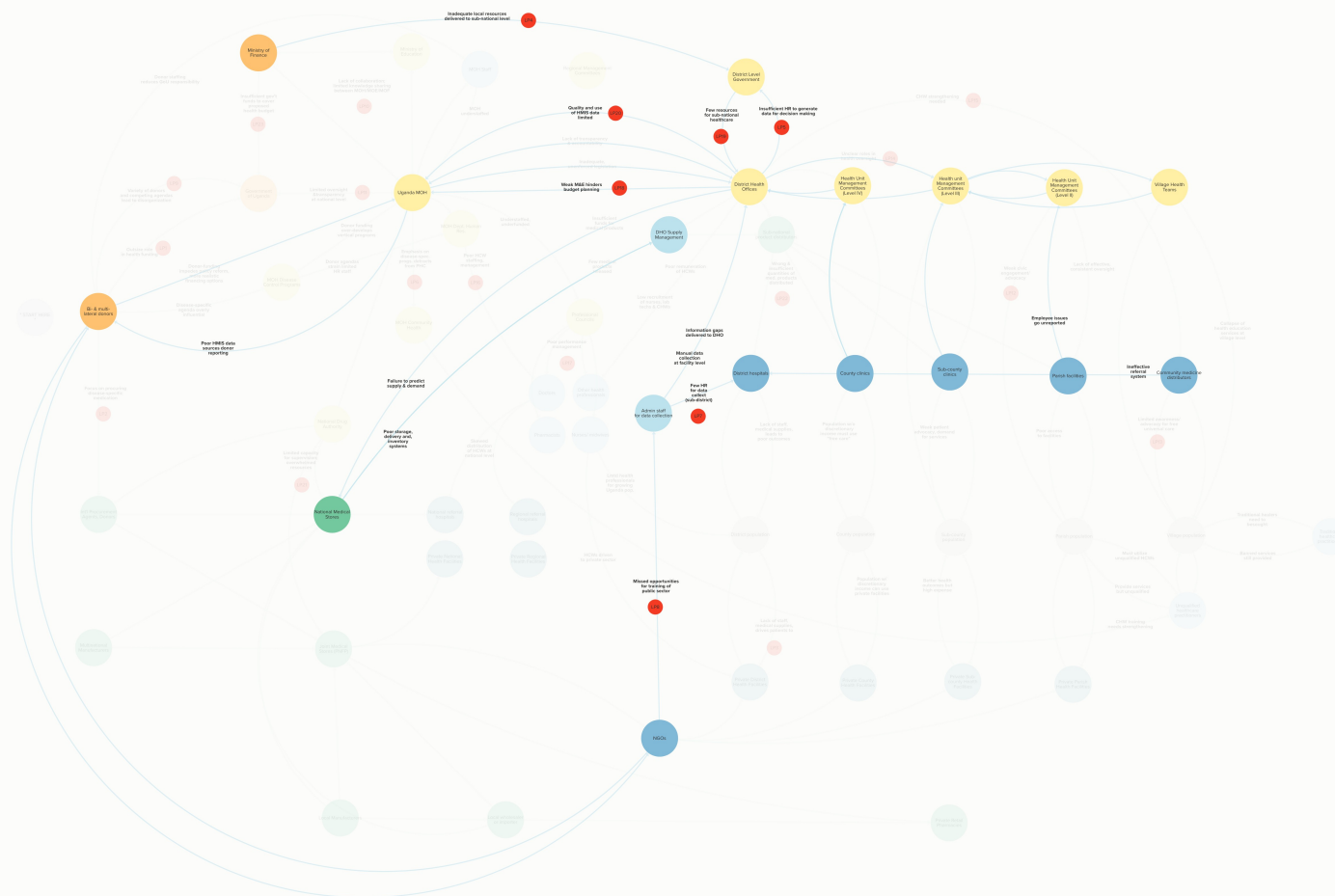


- Health Product Distribution
- Human Resources
- Health Financing
- Health Governance
- Leverage Point

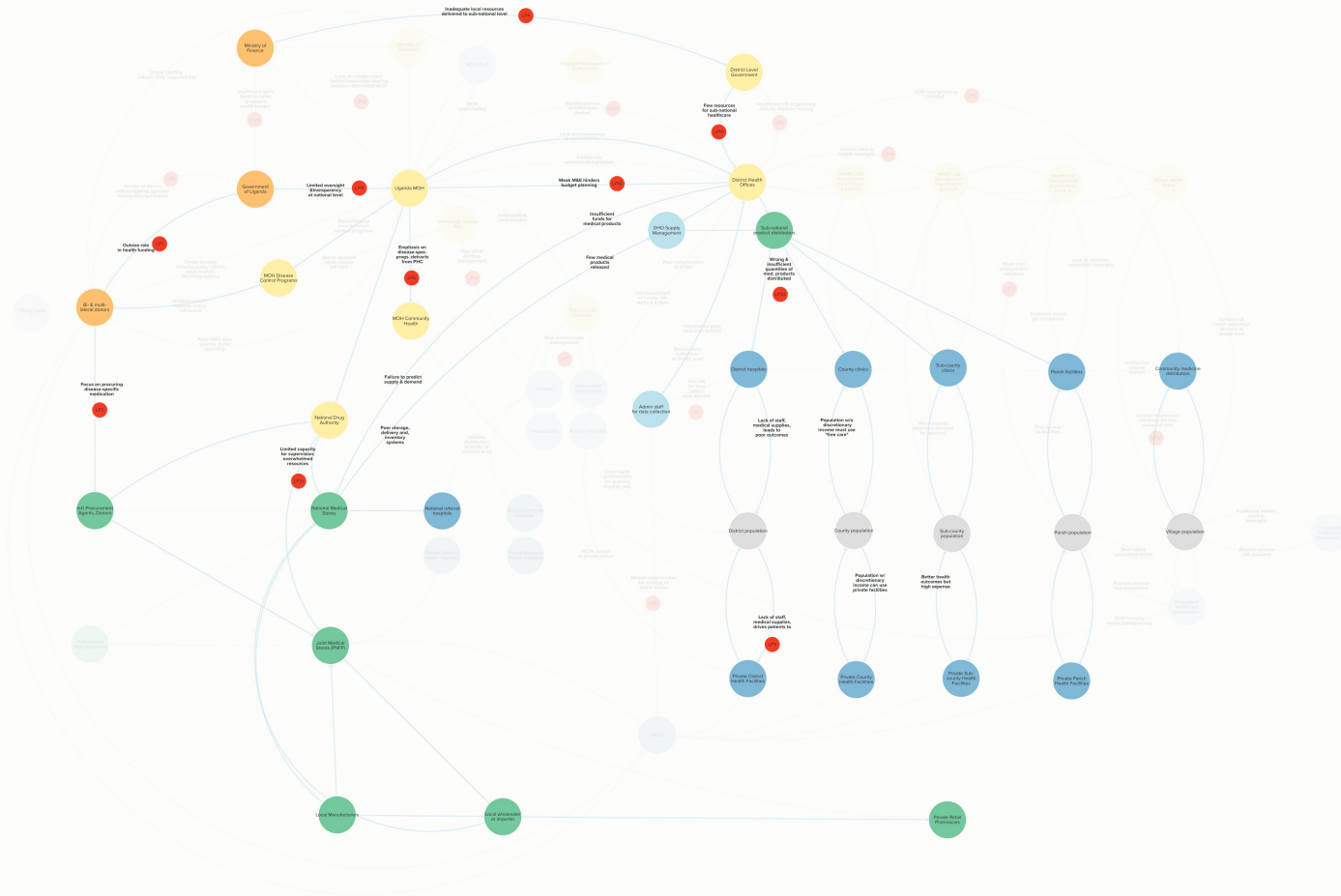
MAP 5: HEALTH SERVICE DELIVERY



MAP 6: HEALTH INFORMATION SYSTEMS



MAP 7: ACCESS TO ESSENTIAL MEDICINES



- Health Product Distribution
- Human Resources
- Health Financing
- Health Governance
- Leverage Point

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