



COUNTRY REPORT UGANDA

HEALTH WORK FORCE FINANCING IN UGANDA: CHALLENGES AND OPPORTUNITIES

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This document is part of Wemos and ACHEST's contribution to the Health Systems Advocacy Partnership

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LIST OF ACRONYMS

CSO	Civil Society Organisation
DAH	Development Assistance for Health
EAC	East African Community
FY	Financial Year
GDP	Gross Domestic Product
GFF	Global Financing Facility
GHED	Global Health Expenditure Database
HC	Health Centre
HEEG	Health Employment and Economic Growth
HRH	Human Resources for Health
HSDP	Health Sector Development Plan 2015/16-2019/20
HSSIP	Health Sector Strategic Investment Plan
HSSP	Health Sector Strategic Plan
ILO	International Labour Organization
IMF	International Monetary Fund
LG	Local Government
LIC	Low Income Countries
LMICs	Lower Middle-Income Countries
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
NC	Non-Communicable Diseases
NDP	National Development Plan
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NGO	Non-governmental organisation
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
OOP	Out-of-pocket
RBF	Results-Based Financing
SDG	Sustainable Development Goals
UBoS	Uganda Bureau of Standards
UGX	Uganda Shilling
UHC	Universal Health Coverage
UNMHCP	Uganda National Minimum Health Care Package
URA	Uganda Revenue Authority
USD	United States Dollar
WHO	World Health Organization
WISN	Workload Indicators of Staffing Need

EXECUTIVE SUMMARY

For any health system to operate well and serve its purpose of improving the population's health and leaving no one behind, it must have a workforce that is sufficient in number, well-trained, gender-balanced, equitably distributed and adequately remunerated.

Uganda has had a shortage of human resources for health for many years now, with approximately one skilled health professional for every 1,000 inhabitants in 2019. This has dire outcomes on critical health indicators, which are lagging behind national and international targets, especially pregnancy-related maternal mortality, which stood at 368 deaths per 100,000 live births in 2017.

Wemos and ACHEST, as part of the Health Systems Advocacy Partnership, and with the support of IDA Charity Foundation, conducted an extensive literature review on the health workforce and interviewed representatives of the government of Uganda, the donor community and civil society organisations. The findings were presented and validated by the Human Resources for Health Technical Working Group of the Ugandan Ministry of Health in May 2019.

Despite the efforts made by the Ugandan government and its development partners, the shortage of health workers still persists. The staffing norms have not been revised since 1999 when the population of Uganda was just over 21 million people. By 2019, the population has almost doubled to 40 million. As a consequence, although the absolute numbers of filled positions between 2010 and 2019 have increased, the health worker to population ratio has hardly improved in the given decade.

The issues are recognized and highlighted at the policy level. However, insufficient funding and poor management of the funds are identified as impeding factors for improvement in the recruitment and retention of health workers. The domestic resources of USD 8 per capita in 2019 are insufficient to fund a health system that can offer the Ugandan population a minimum healthcare package. A large share of the health budget in Uganda (40%) is funded by donors, and in many cases, these funds cannot be used to pay health workers' salaries. Besides, Uganda is lacking a national health insurance scheme, keeping household out-of-pocket spending on health at unacceptably high rates; approximately 40% of the total health expenditure.

The report concludes with policy recommendations for the Government of Uganda, development partners and international financial institutions to work towards:

1. Adjust the health workforce needs to the current population, taking into account population size, health needs and life expectancy;
2. Mobilise more domestic resources and manage them efficiently;
3. Mobilise and use development assistance for health more effectively.

The need to invest in health workers in Uganda is crystal clear. If not, the global aim to achieve Universal Health Coverage and the Sustainable Development Goals will never be reached.

INTRODUCTION

The Global Strategy on Human Resources for Health: Workforce 2030 (Global Strategy 2030) (1) emphasises that health systems can only function well when they have a health workforce with sufficient numbers, and equitably distributed health staff that is competent, responsive, motivated and productive. The World Health Organization (WHO) has calculated that, in order to achieve Universal Health Coverage (UHC) and the United Nations' Sustainable Development Goals (SDGs), a country needs to have at least 4.45 skilled health workers for every 1,000 inhabitants (2). Shortages of skilled health workers lead to reduced access to healthcare, the inefficient functioning of the health system, health inequities, and adverse outcomes in the population's health. In many low-income countries (LICs) there is a significant mismatch between the **need** (the number required to attain a health system's objectives), the **demand** (the number of funded positions for health workers based on the country's domestic and external resources) and the **supply** (the actual number of trained health workers recruited) (2). A 2016 report by the WHO, the International Labour Organization (ILO) and the Organization for Economic Co-operation and Development (OECD) estimates a need of 40 million new jobs in the health sector globally by 2030, based on population growth. Concurrently, there is an estimated shortage of 18 million health workers, mostly in LICs and lower-middle-income countries (LMICs), due to the disconnect between the need and the demand of health workers in countries with chronically underfunded health sectors (3).

The most fundamental factor for this shortage and a key challenge for all countries is the low investment in health workforce development.

The shortage of human resources for health (HRH) is a global health issue that goes beyond national borders and the health sector. Adequate investment in HRH is a global responsibility and a matter of global social justice, as it is an essential requirement for exercising the human right to health for people all over the world. The international community has rightfully made strong commitments for realising the Global Strategy 2030 (1), but we still need to take bold actions to live up to these commitments.

BACKGROUND

Between 1990 and 2015, 10.7 million women worldwide died from maternal causes (4). The world will not achieve UHC and the SDGs without acting decisively upon the factors that lead to unnecessary deaths of mothers due to poor maternal care and health. Maternal mortality persists and remains unacceptably high. Globally, about 830 women die from pregnancy- or delivery-related complications each day. 99% of these deaths occur in least developed countries and more than half of them in Sub-Saharan Africa (5). Most maternal deaths are preventable, as the health-care solutions to prevent or manage complications are well known. However, we need health workers within robust health systems to provide this care.

Uganda is no exception to the global challenge to reduce maternal mortality: the Millennium Development Goal (MDG) target was not met and the SDG target is still far below the current figures (figure 1).

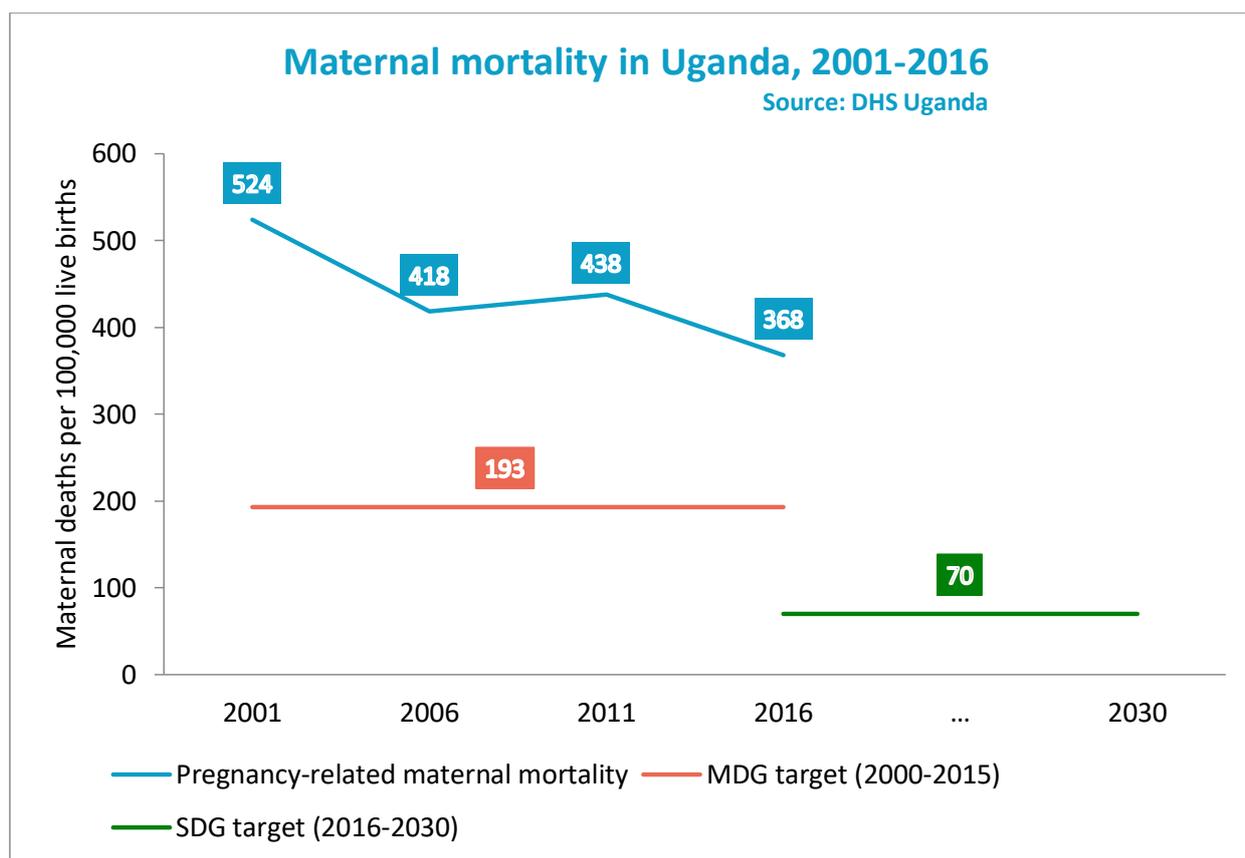


Figure 1. Maternal mortality ratio trends compared with the MDG/SDG targets. Source of data: DHS Uganda¹

There is some progress in key health indicators, such as a decline in neonatal, infant, child and maternal mortality rates (Box 1) that can be attributed to programmes like child vaccination and Water, Sanitation and Hygiene (WASH) programmes. However, to sustain and improve this progress, we need enough health workers to implement decent reproductive, maternal, child health and other essential services.

Shortages in HRH are especially linked with poor maternal and child health. To substantially reduce the numbers of mothers dying in childbirth, the whole health system has to function well, with sufficient qualified health workers. In that case, if there are complications during birth, the patient can rapidly be referred for higher levels of care, like for example an emergency C-section. Women in Uganda, however, face multiple barriers to accessing critical routine and lifesaving maternal health care. The barriers fall into the “Three Delays Model”: 1). delay in recognizing the need and deciding to seek care, 2). delay in reaching a healthcare facility, and 3). delay in receiving adequate and appropriate care. The latter is strongly linked with the absence of critical human resources (6). In Uganda, the leading causes of maternal death are sepsis, haemorrhage, eclampsia (high blood pressure), unsafe abortion, and

¹ Clarification of the indicators in Annex 1.

infection, all of which can be prevented with appropriate care.

BOX 1: Key health indicators: targets and progress

The Maternal Mortality Rate (MMR), Neonatal Mortality Rate (NMR), Infant Mortality Rate (IMR), Under-Five Mortality Rate (U5MR), Total Fertility Rate and Adolescent Pregnancy Rate are health impact indicators in the Health Sector Development Plan 2015/16-2019/20 (HSDP) that track the progress towards UHC. According to the mid-term review of the HSDP, even if some targets are met, there is still a lot that needs to be done, especially approaching the end of the plan's timeline and the SDGs in the long-term (Table 1).

Table 1. HSDP Impact Indicators at the Mid-Term Review and future targets

Indicator	Baseline 2011*	Achieved 2016**	Target for 2021***	SDG Target 2030	Target Vision 2040
MMR (per 100,000 live births)	438	368	211	70	15
NMR (per 1,000 live births)	27	27	10	12	-
IMR (per 1,000 live births)	54	43	30	-	4
U5MR (per 1,000 live births)	90	64	53	25	8
Total Fertility Rate	6.2	5.8	5.1	-	-
Adolescent Pregnancy Rate	24%	25%	14%	-	-

*UDHS 2011, **UDHS 2016, ***Ministry of Health (2018). Mid-Term Review Report for the Health Sector Development Plan 2015/16-2019/20.

Uganda has a tradition for training high-quality health professionals in the East African Region. However, this pool of health workers is not fully utilised due to a number of factors. One is the weak coordination between the health and education sectors in training the most needed and underrepresented cadres. Also, decentralisation of recruitment and management lead to a mismatch of vacancies and employees. In addition, there have been declining trends in the health sector budgets in recent years.

OBJECTIVES OF THE STUDY

The specific objectives are to 1). evaluate the policy environment with respect to the health workforce; 2). analyse the current health workforce status, financing mechanisms and management practices; and 3). explore macro-economic policies, policy conditions and advice

from external actors that influences the country's resource envelope for health and health workers.

The scope of the report is to present the situation in the public health sector of Uganda. The authors acknowledge the feedback received from stakeholders on the scope of the study including the significance of the private for-profit and not-for-profit health services sub-sector, training of health workforce and health promotion. This feedback will inform plans for and focus of future investigation on the wider subject of health workforce financing.

METHODOLOGY

ACHEST and Wemos, as part of the Health Systems Advocacy Partnership (Box 2) and supported by the IDA Charity Foundation, have analysed the current status of HRH financing in the wider macro-economic environment in Uganda. This study was informed by a mix of qualitative data collection methods that evaluated the policy environment, staffing situation, financing mechanisms and management practices. Desk review was undertaken of academic and grey literature on national and international policies, reports, plans and guidelines on health workforce development. Semi-structured interviews were conducted with key informants at the country level, namely representatives of the Ministry of Health (MoH), the Ministry of Public Service, the Parliament, the Health Service Commission, civil society organizations (CSOs) and development partners (Annex 1 and 2). Stakeholder consultations were carried out through meetings with the HRH Technical Working Group at the MoH to validate the findings.

Regarding Uganda's health expenditure data, two databases were explored: the WHO's Global Health Expenditure Database (GHED) and Uganda's National Health Accounts (NHA). The most recent NHA report available is from the year 2015/16. Even though the WHO uses the NHA to inform its database, there were some discrepancies in the data. This is possibly due to the different population projections used by the WHO and the Government of Uganda, different exchange rates between United States Dollar (USD) and Uganda Shilling (UGX), and other factors used by the WHO to ensure comparability of the data between countries. The WHO GHED adjusted the numbers to include revenues from corporations, which were not included in the NHA. Moreover, Uganda's fiscal year 2015/16 corresponds to the 2015 figures of the GHED, which was a special request of the country itself. Therefore, the 2016 data points in GHED are from international sources and estimations derived using estimates from the previous years plus macro data.

For this report we mainly use the data provided by the NHA and the Government of Uganda, although we also refer to the WHO GHED when necessary. The authors used data available in the public domain up to June 2019.

BOX 2: Health Systems Advocacy Partnership

The Health Systems Advocacy Partnership (HSAP) is a consortium of ACHEST, Amref Health Africa, the Dutch Ministry of Foreign Affairs, Health Action International (HAI) and Wemos. The HSAP is active in Uganda, Malawi, Kenya, Tanzania and Zambia, and aims at strengthening health systems and supporting SRHR through practices that combine advocacy, research and civil society engagement.



The HSAP advocates for strengthening HRH, access to essential sexual and reproductive health commodities, good governance and equitable health financing. National and international policies that affect health systems and assess their impact and implications are analysed. Findings are translated into evidence-based advocacy nationally and internationally, towards governments, donors and global institutions.

The HSAP partners in Uganda are ACHEST, Amref Health Africa in Uganda, and HEPS/HAI Uganda.

FINDINGS

POLICY ENVIRONMENT

Since many years, the Government of Uganda recognises the shortage of health workers as a key bottleneck for the Ugandan health system to provide a minimum health care package for the population. In 2005, the Health Sector Strategic Plan II (2005/06-2009/10), stated that “availability of trained health workers is perhaps the most critical limiting factor for the delivery of the minimum package” (10, p.51). The MoH then published the first HRH Strategic Plan 2005-2020, in order to provide a framework for planning, development and management of the Ugandan health workforce (8). This plan does not mention, however, any mechanisms to stimulate action by the Ministry of Finance, Planning and Economic Development (MoFPED) and other non-health actors to allocate more funds to healthcare. Notably, the strategic goal of the plan related to financing HRH is limited to the management of the already existing “scarce financial resources in support of HRH in a cost-effective and efficient manner” (8).

Similarly, in the 2008 Mapping of the Human Resources Management Processes report, the main recommendation for HRH is to “*assure that available resources are used in the most*

efficient manner”, even though it is acknowledged that additional funds would resolve some of the issues (9). To address high vacancy rates and low motivation, the MoH placed recruitment and retention of health workers at the centre of the Health Sector Strategic Plan III (2010/11–2014/15). Since then, staffing has indeed improved, based, however, on the staffing norms established in 1999, as will be discussed later on (figure 3).

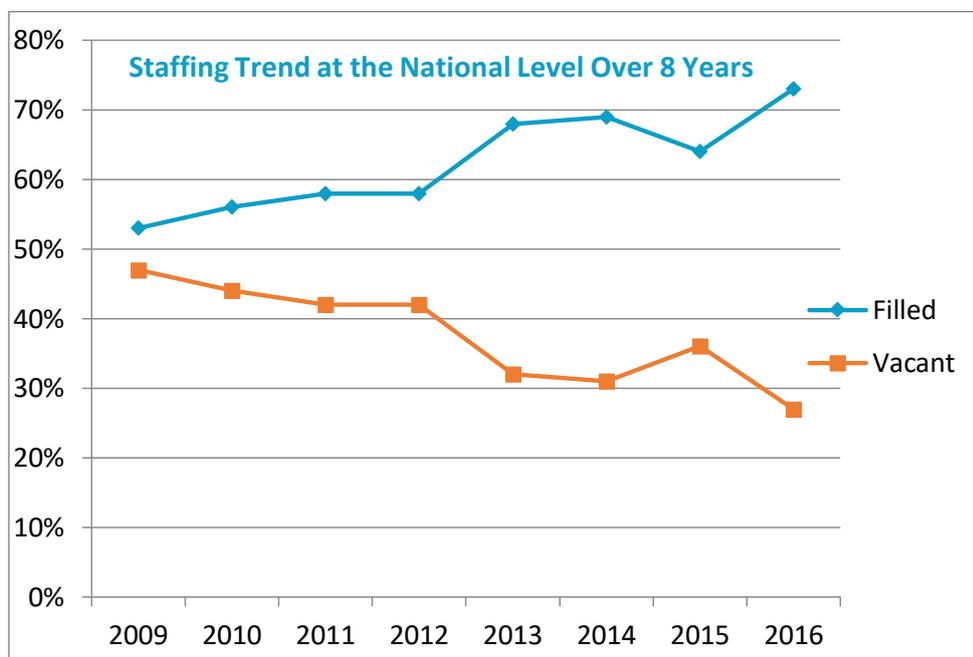


Figure 2. Staffing trends 2009-2016. Source: HRH Audit Report 2017 (10).

A different stance, aimed at increasing overall resources instead of solely increasing efficiency, was adopted ten years after the publication of the HRH Strategic Plan, in the Health Financing Strategy 2015/16-2024/25. One of its proposed strategic interventions is evidence-based advocacy for increased government resources for the health sector and for a guarantee that the health sector will benefit from the oil-generated government revenue (11). In addition, the latest Health Sector Development Plan 2015/16-2019/20 (HSDP) calls for the mobilisation of sufficient financial resources in order to attain its goals (12). The HSDP emphasises the need to accelerate movement towards UHC in line with Uganda’s Second Health Policy (NHP II). It argues that HRH is a critical element of the health system to deliver health services and to drive the UHC agenda and addresses the key challenges of Uganda’s health system. It also sets out priorities and key areas for health investment in the medium term, for both public and private partners. This way, the HSDP will optimally contribute to the attainment of both the health sector goals and the national goals as outlined in the National Development Plan. To align with the HSDP, the National Budget Framework Paper FY 2019/20-2023/24 includes an HRH-specific programme to reach 100% fulfilment of the recruitment plan and improve the overall HRH situation in Uganda (13).

HEALTH WORKFORCE STATUS

Staffing norms, establishments and gaps

The WHO has recommended that in order to realise UHC as part of the SDGs, a country needs at least 4.45 professional health workers for every 1,000 inhabitants. If we apply this formula to Uganda, the total number of skilled health workers required by the country would be 167,765. In 2019, however, the number (i.e. of doctors, midwives and nurses) stands at just 27,761².

The WHO threshold considers only doctors, midwives and nurses for reasons of comparability and data limitations. Whereas it is very useful to draw attention to the sizeable shortages of health workers, for country-level planning and advocacy more detailed targets need to be developed, including the entire spectrum of cadres. In the case of Uganda and other African LICs, significant numbers of HRH service providers do not fit in the three cadres of the WHO ratio.

In assessing the current situation in Uganda, it would be logical also to take account of what is known as 'allied health professional cadres', namely clinical officers, laboratory staff, theatre staff, orthopaedic officers, dental officers, pharmacy staff, radiographers, dispensers and anaesthetic officers. If these are indeed included in the equation, the number of health workers employed in Uganda comes to approximately 39,000 (10). Although a higher figure than the number mentioned above, it still means that **Uganda has only one employed professional health worker for every 1,000 inhabitants**³. The exact current need of the Ugandan population is still yet to be determined, as the MoH has not yet released the report on the outcomes of the use of the Workload Indicators of Staffing Need (WISN) tool that investigates this need. Nevertheless, policy-makers and health workers recognise that the current supply is certainly too low to cover the growing population's needs.

Uganda has defined staffing norms based on the prescribed positions for each cadre at the various levels of the health facilities in the country. The staffing norms define the HRH *demand* by cadre and they are a practical approach to evaluate the ability of the country to respond to the agreed HRH demand and supply.

Analysis of the vacancy rates per facility level shows that the staffing levels of doctors, clinical officers and nursing staff in Uganda have been increasing in absolute terms during the last decade (Table 2). According to the upcoming 2019 HRH Audit Report of the MoH, the overall staffing of the health sector is at 76%⁴. Although this rate is much higher than the 56% rate of 2010 and closer to the 80% target of the HSDP, it is based on staffing norms that were established back in 1999, when the population of Uganda was just over 21 million. Today, in 2019, the population has almost doubled to 40 million. (14). The staffing norms have not been

² Data provided by IntraHealth.

³ Including doctors, nurses, midwives, clinical officers, laboratory staff, theatre staff, orthopaedic officers, dental officers, pharmacy staff, radiographers, dispensers and anaesthetists employed in the public sector (2019 data supplied by IntraHealth), plus the 4 private not-for-profit medical bureaus (2017 data, last published and available).

⁴ Data provided by IntraHealth.

revised since 1999, and therefore have not been adjusted to the rapid population growth, the changing epidemiologic trends and the increasing life expectancy. As a consequence, in spite of increased numbers of health workers, the health worker to population ratio has hardly improved. Wemos and the Association of Malawian Midwives identified similar trends in the absolute and relative numbers of HRH in Malawi in their report, published in 2018 (15).

Table 2. Uganda’s health worker to population ratio 2010, 2017, 2019⁵ for an example of four selected cadres of the public sector.

Profession (public sector)	2010 (total)	2017 (total)	2019 (total)	2010 (per 1,000 pop.)	2017 (per 1,000 pop.)	2019 (per 1,000 pop.)
Doctors	791	1298	1210	0.03	0.03	0.03
Clinical officers	2014	2756	3399	0.06	0.07	0.08
Midwives	3574	5353	5157	0.12	0.14	0.13
Nursing staff	12404	17258	17995	0.40	0.46	0.45

Population growth from 31.1 million in 2010 to 37.8 million in 2017 and further to 40.3 million in 2019 (10)(14)

Apart from the numbers, the **distribution** of the health workers around the country is also of most importance, as rural and hard-to-reach areas are extremely underserved. Even though Uganda’s population is predominantly rural, 90% of the health workers posts were filled in Kampala district, while only 53% of the posts were filled in the rural, Moroto district, for example.

Moreover, if we examine the vacancy rates per facility level, we see that Health Centres (HC) II, which serve patients at the parish level, have the highest vacancy rate at 45%, followed by HC III at 20% and HC IV at 13%, which serve patients at the sub-county and county level, respectively.

Health workforce migration

Outmigration of health professionals enlarges the health workforce gap. Outmigration of health professionals to other countries and to other sectors is perceived as one of the main issues that have impacted negatively the health services. It has resulted in the loss of senior and specialised experts and increased the workload of those left behind, in the lower cadres (16). A case study by ACHEST and the Uganda Medical and Dental Practitioners Council for the years 2010-2015 estimated the net loss of doctors due to migration at 10% of those who enter the market annually. However, this rate may be higher, because the estimation is based only on the letters of good standing issued by the Medical and Dental Practitioners Council (17).

⁵ Idem

There is limited literature on the comprehensive costs of training a health worker in Uganda. A 2011 study estimated the government-subsidised cost of a doctor's training at approximately USD 21,000 (18). Another study, undertaken in 2002, calculated the cost of training a doctor at Makerere University at USD 11,635, without including the one-year internship and the personal expenses of the student (19). In 2018 terms - and thus corrected for inflation - this is equivalent to about USD 16,240 in purchasing power, a difference of USD 4,605 over 16 years⁶.

Uganda pays these training costs. When a health worker emigrates, this lowers the recipient country's health workforce training costs, because it needs to train fewer health workers. On the other hand, Uganda is not only a *source* but also a *destination* country that receives health workers from other countries. According to the Medical and Dental Practitioners Council, in 2017, 19.6% of registered and licensed medical doctors were born elsewhere.

Ugandan health workers have several reasons to migrate abroad or to leave the public health sector for another job. Inadequate wages, job insecurity and lack of basic working standards play an important role. There is also the fear of unemployment, which may lead to employment in fields other than health; a phenomenon described as "*brain waste*". Those who migrate, apart from better remuneration and work conditions, are also anticipating safer and better living conditions. Families and governments often even encourage migration, seeking for remittances and flow of foreign currency at home (20).

As discussed in the previous section, most health policies in Uganda mention the willingness to improve retention of health workers in their objectives. In 2008, a more specific policy document was developed by the MoH and the USAID-funded Capacity Project in response to the HRH challenges: the Motivation and Retention Strategy (21). The HRH motivation strategy had three major implementation strategies: 1). enhancing salaries and other financial incentives for health workers; 2). giving non-monetary benefits, and 3). development of leadership and management. It emphasised that both financial and nonfinancial incentives must be considered. In response to the challenge of poor motivation as a result of low salaries, the strategy suggested mainly financial incentives in the form of development of an appropriate salary and remuneration package with periodic reviews. Special allowances were also suggested, e.g. for hardship, lunch and pay-for-performance. Additionally, non-monetary benefits were intended to supplement the financial incentives. The strategy required considerable funds from the government, and support from other stakeholders and donors. The major implementation challenge for the motivation strategy was the limited availability of funds to operationalise the strategies (22).

When it comes to outmigration, besides the importance of salary, factors that reduced the odds of health workers leaving their posts for other sectors or for other countries include active involvement in the facility, manageable workload, flexibility to balance the demands of work and personal life, and better opportunities for promotion (21). Importantly, female health workers may require additional measures of retention in order to be ensured that they

⁶ Inflation Calculator. U.S. Official Inflation Data, 28 May. 2019, <https://www.officialdata.org/2002-dollars-in-2018?amount=2327>.

can do their job in a safe and secure environment, free from violence, harassment of any kind, and discrimination.

The gender perspective of the health workforce

A 2019 report from the WHO, the Global Health Workforce Network (GHWN) and the Women in Global Health (WGH), which analysed gender and equity of the global health and social workforce, revealed that at the global level, women account for 70% of the health workforce. However, these women are mostly concentrated in nursing and midwifery positions and support roles (23). Men typically cluster in more prestigious and highly paid medical, managerial and decision-making roles. It is already established that roles within the health workforce are highly gendered and that health systems rely on a foundation of health workers that are disproportionately female and at the same time often poorly supported and poorly paid or not paid at all, and work in an informal setting (24–26). For example, in Uganda, the majority of unpaid community health workers that are part of the village health teams are female (26).

Of the Ugandan health workforce, 54% consists of women and 46% of men, including all positions and all levels. Although there would, at first sight, appear to be a gender balance, the picture is very different if we zoom in more closely. Men fill 61% and 67% of positions in the ministerial and district health office level respectively. The difference is even more prominent for specific health cadres. 80% of senior medical officers are men, whereas 94% of enrolled nurses are women. Uganda is no exception in the trend of global health to be *“delivered by women, but led by men”* (23).

Gender equality is not only relevant to the composition of the health workforce itself but also to access to health and service delivery. Gender and human rights are one of the programme areas of the HSDP, in order to address key determinants of health. The MoH, together with CSOs, developed a manual for training health professionals in gender and human rights issues, that was published in July 2018 and has been in use since (12,27). Gender equality is also a target of the Uganda Vision 2040 strategic plan, in which the Government aspires to bring the Gender-related Development Index⁷ from 0.51 to 0.90 (28).

The link between HRH, maternal health and SRHR

HRH shortages are linked with poor maternal health. Quality antenatal care and deliveries assisted by skilled health professionals can prevent unnecessary maternal and perinatal deaths (figure 2). Most maternal and perinatal deaths occur around the time of delivery. One of the strategies to improve survival rates and health of women and newborns is to ensure that deliveries are conducted by skilled birth attendants (29). Skilled birth attendants are doctors, nurses, midwives and medical assistants or clinical officers.

⁷ The Gender Development Index was introduced in 1995, to be used together with the Human Development Index. It measures the development levels in a country corrected by the existing gender inequalities.

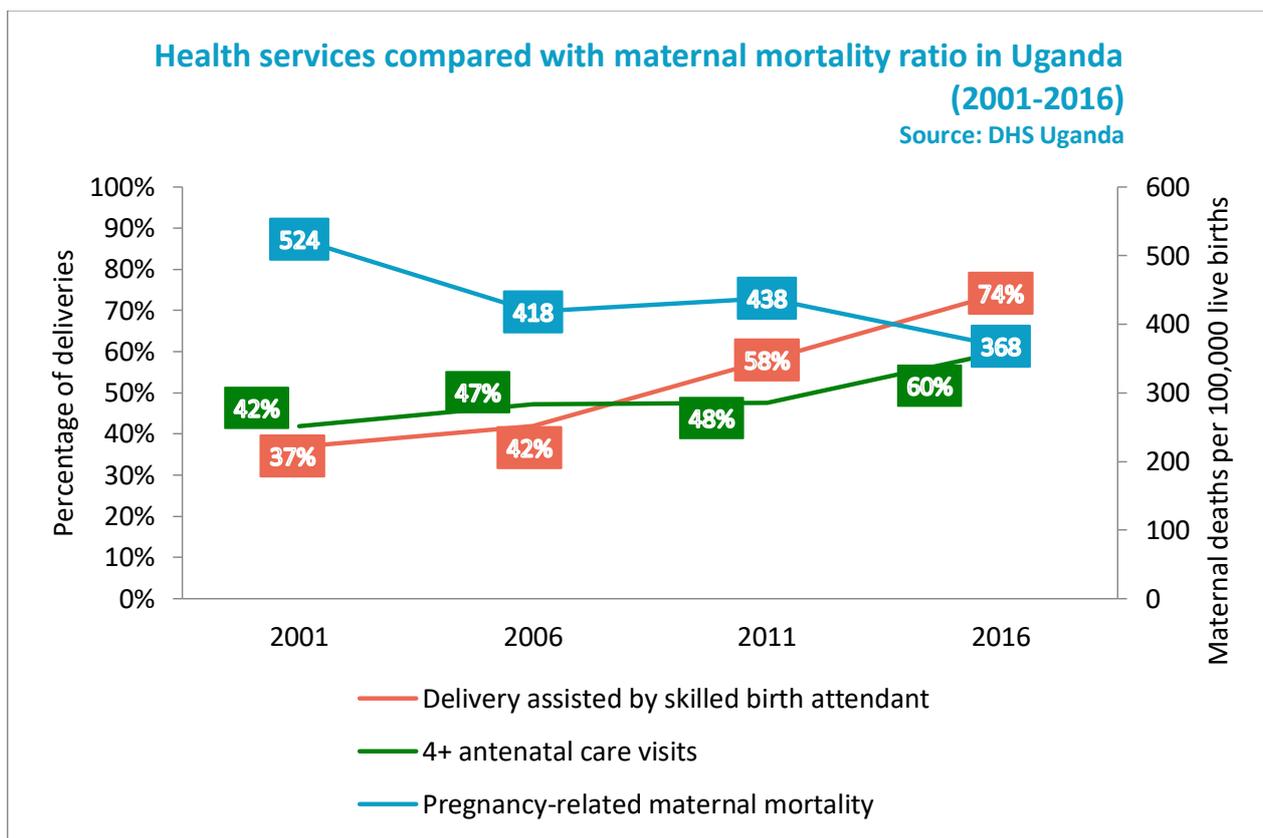


Figure 3. Comparison between MMR trends and maternal health services. Source of data: DHS Uganda

HEALTH WORKFORCE TRAINING, RECRUITMENT, AND MANAGEMENT

Recruitment into the public sector in recent years is largely restricted to replacements of retired, deceased or migrating cadres, with hardly any new recruits. In the immediate post-conflict period of the mid-1980s, the management of most public services in Uganda, including health, was centralised. This was followed by a broad civil service reform in the 1990s that decentralised all government sectors, including health. The decentralised system is based on the district, under which fall lower local governments and administrative units. The health care system was designed in line with this decentralised public system, with a corresponding health unit level for each level of local government or administrative unit. This resulted in a multi-layered health care system, with a range between the Health Centres I to IV at the lower level, to the district hospital at the district level (30). The District Health Officer is responsible for the overall leadership, strategic planning, supervision, monitoring and coordination of all district health services. Currently, the public sector has two broad categories of employment: 1) staff employed by the central government and 2) those under the employment of the local governments at the district level, under the decentralised framework. The decentralised setting brought with it a number of challenges, including limitations in the mobility of health workers from one geographical location to another. There is now a growing push among stakeholders to advocate for the re-centralisation of Health Workforce Management.

HRH information systems have been introduced to facilitate management. However, they are

and updating of digital records on entry, stocks, mobility, retention and migration. Currently, the data on the health workforce is managed in - often unlinked - databases held by training institutions, examination boards, professional associations and regulatory bodies. Moreover, for a long time now the Human Resources Department of the MoH, who manages HRH, has been understaffed and underfunded. Additionally, there are no sector specialists to undertake health workforce planning at the MoH. Instead, the Human Resources Department is manned by Personnel Managers who have limited technical grasp of the dynamics of health workforce planning and development. Uganda has not taken up yet the Country Coordination and Facilitation mechanism, proposed by the WHO and the Global Health Workforce Alliance. This is a multisectoral mechanisms that brings together Ministries of Health, Education, Public Service, Local Governments as well as other relevant stakeholders to forecast and plan the training of the health workforce according to defined needs (31).

The pool of qualified health professionals

With the ever-growing number of institutions training health workers, the rate of production of various cadres is on the increase for doctors, nurses, midwives, clinical officers and pharmacists. However, due to limitations in funding for new positions in the public sector the rate of absorption is not keeping up with the production leading to unemployment and fertile ground for migration to 'greener pastures'.

There is a large stock of qualified and licensed health professionals ready and available for employment. Their number rose from 90,412 in 2017 to 101,350 in 2018 (27). Out of those, more than 6,000 are doctors, more than 47,000 are nurses and more than 18,000 are midwives, according to the registry of the Uganda Medical and Dental Practitioners Council. If the existing stock was to be absorbed into the workforce, the ratio of doctors, nurses and midwives per 1,000 inhabitants would rise correspondingly from 0.60 to 2.9. Although this is clearly a much higher figure, it is still below the WHO target of 4.45.

HEALTH WORKFORCE FINANCING

The investment case for HRH

Worldwide, there is a paradigm shift regarding the health workforce; it is now acknowledged as an investment and a contributor to economic growth, instead of only a cost (1,3). Health workers not only promote but also protect and sustain population health. They add economic value because economic growth and development depend on a healthy population. The Lancet Commission on Investing in Health reported that around one-quarter of economic growth in low- and middle- income countries between 2000 and 2011 resulted from improvements in health (32). Better health can stimulate economic development via different pathways. First of all, it improves labour productivity, because healthy children attend school and receive improved education. Healthy citizens are more likely to invest in the economy and healthier populations can attract foreign investment. The workers-to-dependants ratio increases and the demographic dividend can be harnessed. Moreover, investing in decent jobs in the health sector contributes to social protection and social cohesion. The health sector is an important source of jobs for women, youth, and in rural areas, where other sectors do not

invest (3). Investing in health employment can tackle the “twin” crisis of youth unemployment and the global shortage of health workers, and contribute to gender equality.

The public health sector

Despite the growth in Uganda’s gross domestic product (GDP) between 2007 and 2016, the public health sector has not been able to attract an adequate share of resources. The government’s health budget has been on the decline as a proportion both of GDP and of general government expenditure (figure 4). In monetary terms and according to the WHO GHED, total health expenditure per capita has fallen, after peaking at USD 63 per capita in 2010, to USD 38 per capita in 2016. Of the latter figure, only USD 6 came from the government’s domestic budget (33).

The NHA 2015/16 report itself paints a different picture of the health expenditure in Uganda. According to this report, the total health expenditure per capita in 2016 stood at USD 51 per capita, out of which only USD 8 came from the government’s domestic budget (34). Nevertheless, even if these figures are higher than the ones provided by the WHO, they are still below international recommendations (Box 3) and it is still notable that health expenditure derives more from external and domestic private resources than from the domestic government budget.

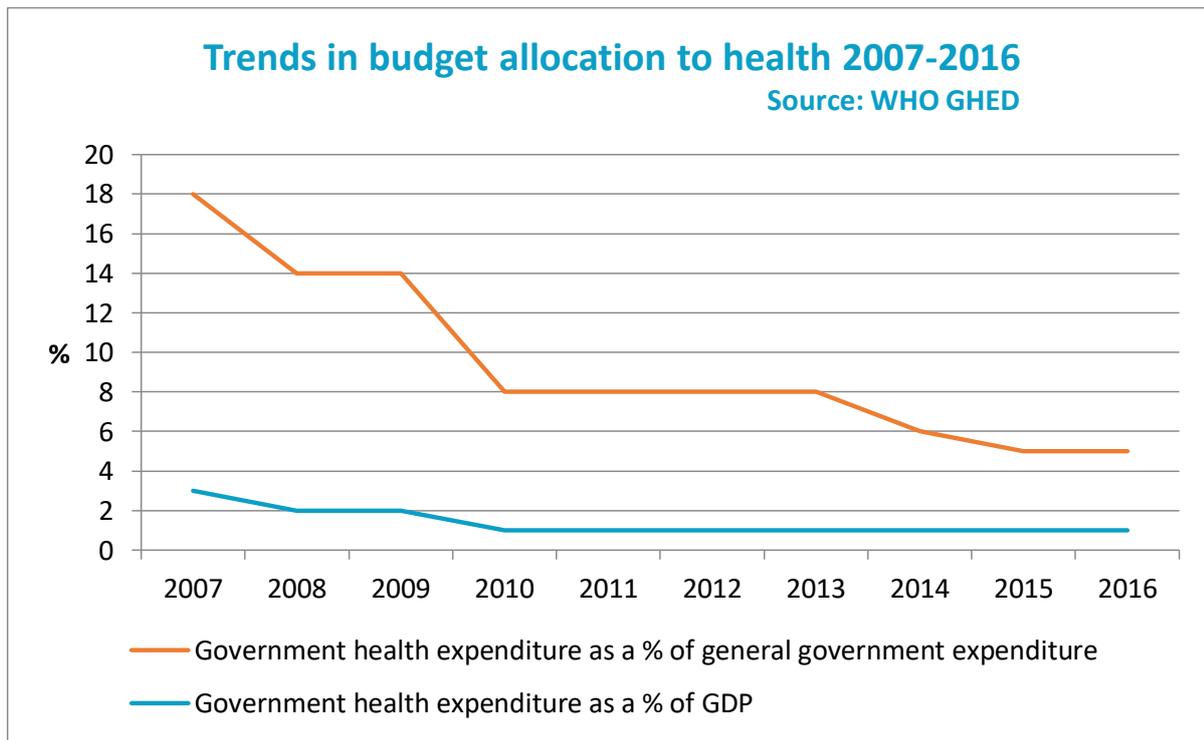


Figure 4. Trends in budget allocations to health 2007-2016. Source: WHO GHED

Between the financial years (FY) 2017/2018 and 2018/2019, the government **domestic** budget for the health sector decreased from USD 492 million to 334 million. The proposed budget for the FY 2019/2020 is - at the moment - even lower, at USD 323 million, which equals USD 8 per capita⁸ (13).

BOX 3: International targets and recommendations

The absolute financial targets for achieving UHC vary, but are all in a range between USD 86 and USD 112 for LICs.

The WHO's Commission on Macroeconomics and Health estimated that by 2015, the per capita resource requirements in LICs would total in USD 71. The High-Level Task Force on Innovative International Financing for Health Systems updated that figure to USD 86. Analyses by McIntyre, Meheus and Rottingen (35) point towards a relative target of 5% of the GDP for progressing towards UHC, supplemented by the USD 86 per capita target. A costing exercise by WHO in 2017 though came up with a number of USD 112 for realising SDG3 in LICs (36). The World Bank uses the number of USD 90 for an essential package of healthcare.

In addition to these targets, in Abuja in 2001, the African Union countries pledged to set a target of allocating at least 15% of their annual government budget to improve the health sector. It seems that there is no "magic number" for spending targets for health. However, if we take the wide range of estimates into account, Uganda is far below even the lowest estimate.

In the National Budget Framework 2019/20-2023/24, the budget allocation to the health sector is announced to be 8.9% of the general government expenditure. It is important to note though, that in this amount the external financing of the health sector is also taken into account, and not only the domestic resources. **Without external aid, the allocation to health accounts only for 6.4 % of the government budget** (13). This figure is in accordance with the Annual Health Sector Performance Report 2017/18 (the latest available) and the National Budget 2019/20 speech, as announced in June 2019 (37,38).

The health sector in Uganda receives support from development partners through direct in-kind contributions, financial contributions, technical expertise, medical and non-medical supplies and equipment. If we add external financing to the proposed budget for 2019/2020 (USD 323 million), it reaches USD 610 million. The sector's traditional bilateral partners include the United States, (the largest), Belgium, the United Kingdom, Sweden, Japan and Denmark, whose total contributions represent 74.5% of the total Development Assistance for Health (DAH). Multilateral agencies, whose contributions represent 24.1% of total DAH, include UNAIDS, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), the Global Alliance for Vaccines and Immunization (GAVI), the African Development Bank, the World Bank, the Global Fund and others. The remaining 1.5% of the DAH comes

⁸ According to the Ugandan Bureau of Statistics, Uganda's population for 2019 is projected to be 40,3 million (14).

from private donors, like the Bill & Melinda Gates Foundation and pharmaceutical companies (34).

With the projected population of Uganda for 2019 (14) and in order to reach the recommendation of USD 86 per capita, the total health budget should have been USD 3,500 million, which is over ten times more than the provision of USD 323 million, and almost six times more than the combined domestic and external health budget of USD 610 million.

Domestic prioritisation of health is important, but not sufficient. If Uganda allocated 5% of its GDP to health, that would amount to USD 1,169 million, which would mean only USD 29 per capita in 2019. This last fact also explains the importance of a combination of an absolute and relative target for health spending, as proposed by McIntyre et al. (35), and the need for both domestic and international resources to contribute to the health sector.

The HSDP 2015/16-2019/20 provides three different scenarios for the health sector (HSDP plan, moderate scale-up, ambitious scale-up), each one with different per capita spending targets and funding gaps. Below, we present the estimated resource requirements by source and per scenario for the last year of the plan (2019/20) and the funding gap per scenario, calculated based on the proposed budget of USD 323 million for 2019/2020 (Table 3). It is clear that the funding gap, even for the base scenario of the plan, remains vast.

According to the HSDP, the resources would come from the government, bilateral and multilateral donors, health insurance and household out-of-pocket (OOP) spending. However, the funding estimates were projected using the assumption that 1) the government would allocate between 10-15% of the national budget for the health sector during the HSDP, 2) health sector funding would increase by at least 10% annually, and 3) total contribution from existing and new foreign partners would grow by at least 5% annually. None of these assumptions has actually been realised though, during the period of HSDP implementation.

Table 3. Resource requirements and funding gaps per scenario for 2019/2020

Scenario	Resource Requirement in USD million *	Resource Requirement in USD per capita **	Estimated Private Domestic Contributions in USD million *	Estimated External Contributions in USD million *	Funding gap in USD million ***
HSDP Plan	3,789	94	717.8	1,115.6	1,955.6
Moderate Scale-up	7,942	197	717.8	1,115.6	6,108.6
Ambitious Scale-up	15,484	384	717.8	1,115.6	13,650.6

*from HSDP, **calculated with the UBoS 2019 population projection of 40 million, ***authors' calculation

Government budget allocation

The government does not allocate sufficient funds to the health sector in Uganda. As a comparison, the transport sector, which is considered to be central to Uganda's economic development was allocated USD 1,237 million in 2017/2018, representing 20.8% of the total government budget (39). For 2019/20, this budget is proposed to reach USD 1,435 million (13). The trends in budget allocation in six sectors can be seen in figure 8. Notably, between 2018/19 and 2019/20, the health sector saw a decrease of 1.5% in its budget, whereas the transport sector saw an increase of 2%.

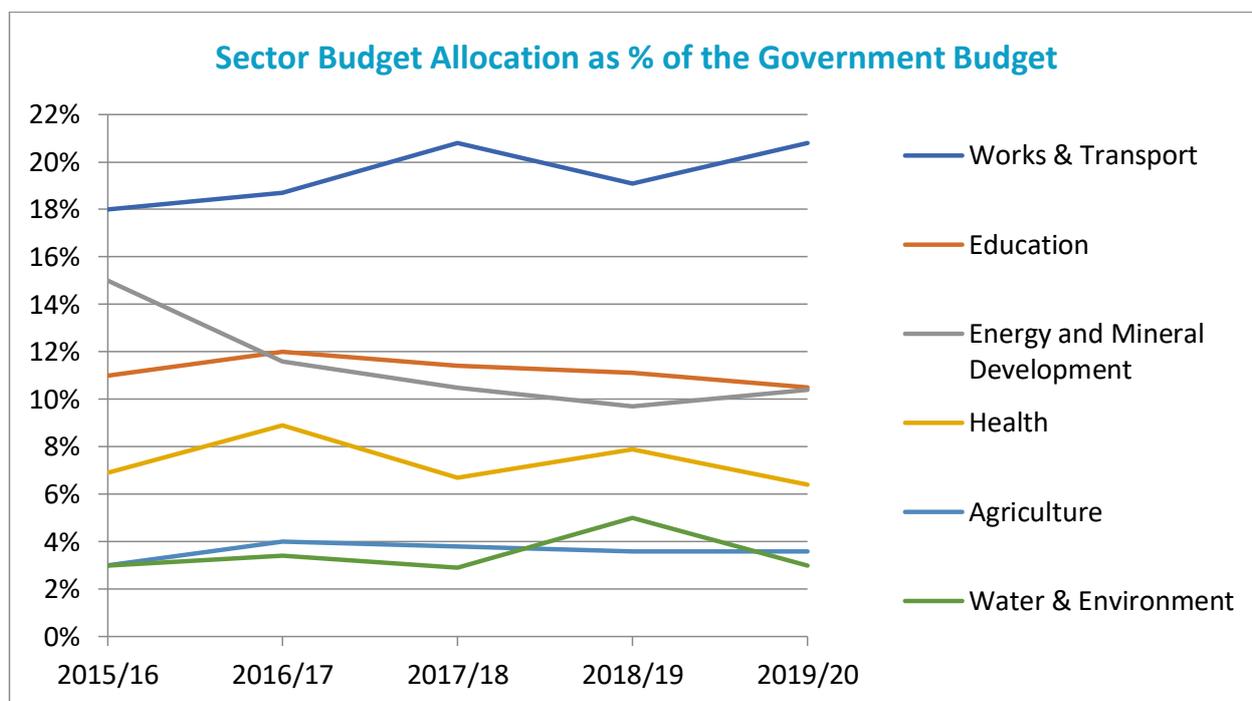


Figure 8. Budget allocation per sector. Source: MoFPED budget papers and CSBAG discussion papers.

In the Article IV Consultation and the Eighth Review under the Policy Support Instrument (PSI), which took place in 2017, the International Monetary Fund (IMF) considered the prioritisation of the infrastructure and the oil sector to be appropriate. Importantly, the IMF recognised that Uganda's health spending was relatively low, at 2%⁹ of GDP, in fact lower than the East African Community average, but advised the authorities to consider increasing social spending only once economic growth had recovered (40). The latest Article IV mission in Uganda was completed in February 2019. In this consultation, the IMF concluded that the trend towards lower spending on health and education should be reversed in order to create more inclusive growth. This shows a possible shift towards a more socially-concerned IMF that advises in favour of the protection of the social sectors (41).

The health sector's wage bill

The wage bill of the health sector saw an increase last year, from USD 108 million in 2017/2018 to USD 160 million in 2018/2019, probably as a result of industrial action by the

⁹ According to the NHA health spending is around 1% of GDP.

health workers. However, these extra funds were spent on higher salaries, not on filling more staff positions. The wage bill is proposed to remain the same for the 2019/2020 (13,39).

Wastage and efficiency in HRH

The Global Strategy on HRH 2030 estimates that around 20-40% of global health spending is being wasted due to inefficiencies of the health workforce, weaknesses in governance and lack of oversight. This wastage seems to be more prominent in resource-poor countries (1). In 2019, USD 4.3 million was returned to Uganda's Treasury from the MoH, because it was not spent due to limited capacity.

The Government of Uganda has identified HRH to be one of the core causes of the financial inefficiency of the health system. The two main inefficiencies are the significant rates of work absenteeism and the existence of "ghost workers" on the public payroll, which are attributed to weak personnel management and demotivation (11). Absenteeism compromises the quality of health services because fewer workers are left on duty and they become overloaded with work. Overall absenteeism at the health centres in Uganda has been recognised as a major threat to the national health care system, just like in other LICs and LMICs with low health worker to patient ratios. The rate of medical professionals absent from their assigned posts were 25% in Kenya, 35% in Bangladesh, 40% in India and Peru and 37% in Uganda (42). A study to assess the factors contributing to staff absenteeism in public health facilities in Bushenyi district in Uganda identified the following major contributing factors to absenteeism: residing outside the health facility (i.e. over 10 km walking distances to get to work), family conflicts, overstay in one work station without rotations to other major health facilities, increased administrative duties, poor remuneration and inadequate supervision (43). Apart from tackling absenteeism, efficiency gains can also be achieved by optimising the health workers teams, ensuring an appropriate mix of skills.

As a way towards efficiency gains, the Government of Uganda has been scaling up a Results-Based Financing (RBF) system (Box 4), after some pilot programmes were considered to have been successful (44). RBF schemes have been in place since 2009. They are all donor-funded with the World Bank being the major donor. Schemes were also implemented by Cordaid and by Enabel. And RBF is part of the Global Financing Facility (GFF) programme in the country. From 2016 onwards, the Health Finance Strategy (HFS) stated that *"Uganda will need to move away from relying on mainly input-based purchasing towards more RBF"* (14, p.22). Moreover, the Investment Case of Uganda for the GFF called for scaling-up of RBF, e.g. by means of voucher schemes. This is expected to bring *"more efficiency gains [...] from the introduction of PBF/RBF schemes/mechanisms to scale in the public and private sector"* (29, p.41).

BOX 4: Results-Based Financing (RBF)

RBF is a strategic purchasing concept and refers to demand- and supply-side incentives to increase output, which in this case is improved access to and quality of health care. Providers and users are paid for pre-defined and verified results. The main principles are: (a) governance through contracting, (b) planning for results (priority results are defined by the purchaser, representing the patients, and not by the provider), (c) checks and balances (independent verification, split of the functions of purchaser, verifier, provider), (d) autonomy at the operational level, (e) “managed market” (competition, incentives for clients) and (f) providers responding to demand (46).

In 2016 the MoH developed a national RBF framework with the goal of promoting efficient delivery of and access to quality, cost-effective services, which is an improvement compared to the hitherto parallel operation of RBF schemes. Only recently public facilities were considered in RBF schemes; most pilots have been implemented in private not-for-profit facilities. Moreover, the MoH and District Health Management teams are now undertaking more functions, previously held by non-governmental organisations (NGOs) (47).

Health Insurance status and comparison with other countries

OOP spending in Uganda has been around 40% of total health expenditure during the last decade, even if the absolute OOP per capita has decreased (figure 9). But lower absolute OOP spending does not necessarily mean lower financial barriers, as it can also be explained by no access to healthcare exactly due to inability to pay. One of the targets of the HSDP is to bring this percentage down to 30%¹⁰ by the end of 2020.

According to the NHA 2015/16, household OOP represented the 95.6% of the overall private health expenditure, while employer-based insurance, (compulsory and voluntary) and community-based insurance together stayed under 5% (34). Uganda currently has 5% of the population covered under health insurance and only 11% of persons aged over 15 years are even aware of health insurance (48).

There is no operational national health insurance scheme (NHIS) in Uganda. This is one of the end term targets for the completion of the HSDP. The NHIS Bill has been presented to Cabinet and the Parliament for approval. The scheme is expected to reduce OOP and ensure affordability of health services for individuals under both formal and informal employment.

¹⁰ This is above the suggestion of the WHO, which proposes that it is only when the reliance on direct payments falls to less than 15–20% of total health expenditures that the risk of financial catastrophe falls to considerably low levels.

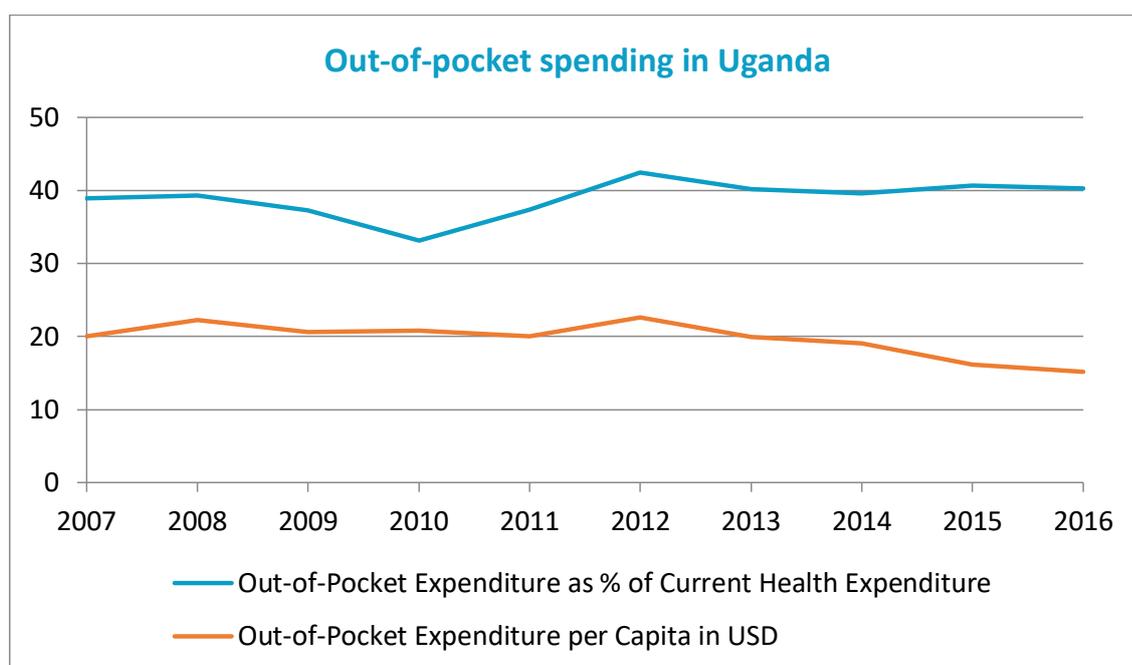


Figure 9. Relative and absolute out-of-pocket spending 2007-2016. Source: WHO GHED

If the NHIS bill is ratified, Uganda will join Kenya¹¹ and Rwanda¹² as countries in the East African region that have implemented such a scheme. Notably, the NHIS Bill has been waiting for approval since 2007, when it was initially drafted, whereas the plans to launch a compulsory public social health insurance scheme started back in 2002.

In Rwanda, for example, the community-based health insurance scheme has significantly contributed to UHC, with coverage of more than 90% of the population, taking care of the majority of the poor. To avoid catastrophic health spending, the Rwandan government introduced and implemented a three-tiered premium contribution system in which the poorer contribute smaller premiums. Part of the scheme also aims at the revitalisation of community participation, mobilisation for health, empowerment of individuals and communities regarding their health, and involvement of individuals in decisions that affect their health (49).

RESOURCE MOBILISATION FOR HRH

Taxation

Uganda has a low tax base, due to the massive size of the informal economy. As a result, the percentage of the GDP captured by taxation in 2019 is approximately 14%, which is lower than the Sub-Saharan average of 15.8%. Formalisation of labour, that will increase the tax-to-

¹¹ In Kenya, more than 3.5 million people from the formal sector and a further 2.5 million in the informal sector are currently enrolled to the National Hospital Insurance Fund.

¹² Rwanda in 2010 enrolled 8.5 million members in the national health insurance scheme known as Mutuelle de Santé, which depends on citizens' contributions based on their economic status, though the government pays for those who cannot afford to.

GDP ratio, is already happening in agriculture but needs to be implemented wider to facilitate resource mobilisation through taxation. Raising domestic revenue from taxation is of great value because it is more sustainable in the long-term and allows a state to reduce donor resource dependency and reliance on borrowing. It also empowers citizens to be critical with their government's spending decisions and to demand public returns from their contributions.

Apart from expanding the domestic tax base, an important step forward is to decisively address the issue of illicit financial flows (IFFs), tax avoidance and tax evasion. It is estimated that Uganda loses more than USD 547 million annually as a result of IFFs. This represents almost USD 14 per capita. Mostly, IFFs are being perpetuated by some multinational companies through illegal and immoral actions, like tax evasion, money laundering, transfer pricing and false declarations (50). In 2015, for example, *Finance Uncovered*, a global network of investigative reporters, revealed how Africa's biggest cell phone company, MTN, was shifting billions of USD from its subsidiaries in Ghana, Nigeria and Uganda to Mauritius (51).

Uganda also loses domestic revenue by granting tax incentives to foreign investors as a way to attract them. Data shows, however, that while inward Foreign Direct Investment (FDI) has been on the increase, there has been no significant change in the level of real income for the country. This means that the increase in inward FDI stock has been matched by a similar increase in outward FDI. Moreover, these tax incentives not only enable foreign firms to avoid taxation but in turn give rise to illegal tax evasion activities of domestic companies¹³ (52).

The donor environment

Grants, being free from debt-related risks, can definitely increase fiscal space for health, provided that they are added to the government health basket and handled with good governance, accountability, transparency, and anti-corruption measures. But, because they may generate future financial obligations (like the maintenance of a project), **they need to have a predictable flow and follow a smooth transition to domestic funding.**

In Uganda, the share of externally funded health expenditure peaked at 50% in 2010 and has been volatile ever since, ranging between 40% in 2016 and 17% in 2007. The Government's contribution on the other hand has been floating around 15% of the total health expenditure. (figure 10). The percentage of external health expenditure that is channelled through the government before its project allocation has increased in the last years; from 20% in 2011 to 36% in 2016 (33). This is something the Government of Uganda has been advocating for towards their international development partners.

¹³ This is done by re-labelling domestic investments as FDI (round-tripping) or selling businesses to subsidiaries disguised as new investors as a means to become eligible for tax holidays that are exclusively granted to new investors (double dipping).

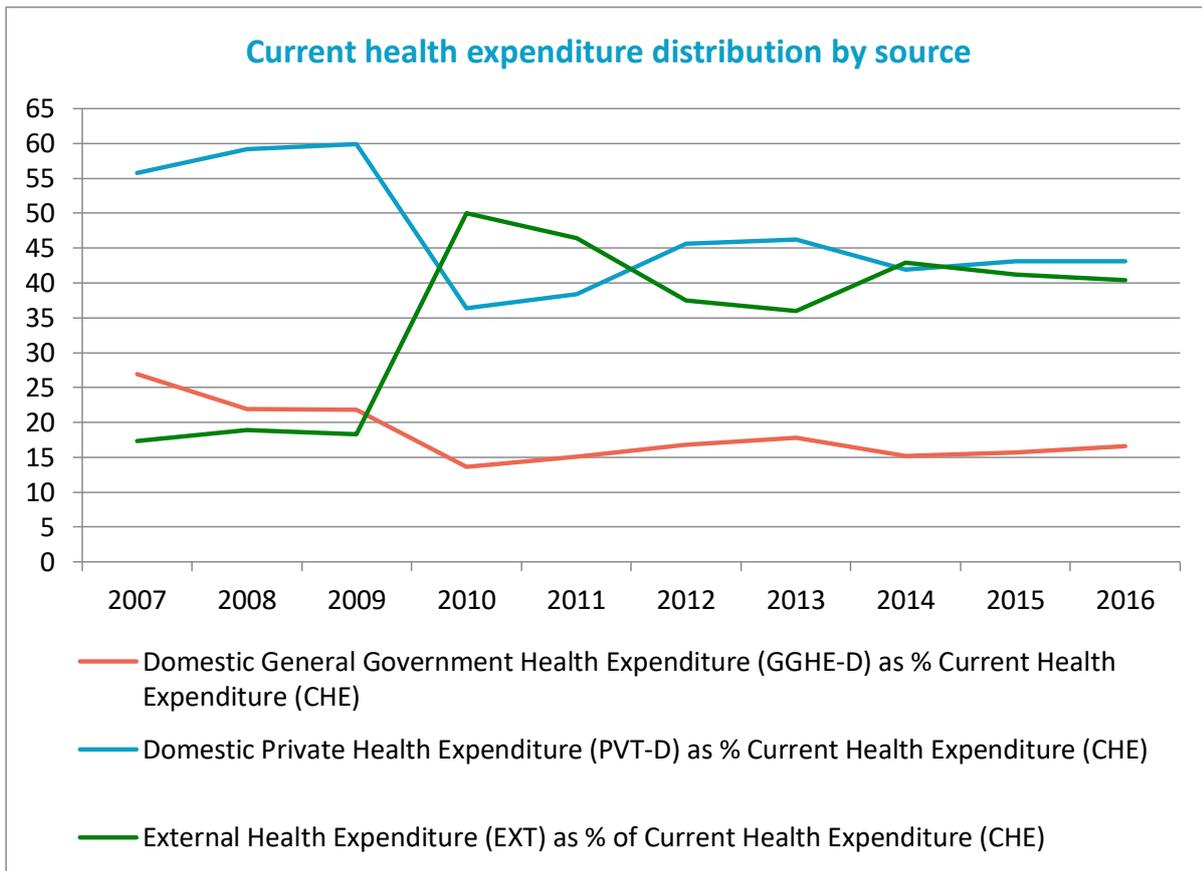


Figure 10. Distribution of Current Health Expenditure by source 2007-2016. Source: WHO GHED and Uganda's NHA

External funding brings with it the risk of corruption. Uganda has experienced several cases of aid embezzlement. For example, a 2018 report by the UN's Office of Internal Oversight Services revealed that UNHCR Uganda and Ugandan officials wasted tens of millions of USD, overpaying for goods and services, awarding major contracts improperly, and failing to avoid fraud, corruption, and waste. Following this report, Germany and the United Kingdom froze their funds to UNHCR Uganda. An older example, in 2012 almost USD 13 million in foreign aid for the recovery of northern Uganda was embezzled by officials in Uganda's Prime Minister's office. The money was channelled to unauthorised private accounts. As a response, the European Union, the United Kingdom, Germany, Norway, Denmark and Ireland withheld their funds towards Uganda. Corruption is also one of the reasons for donors preferring to circumvent the Government and directly fund projects NGOs.

Another challenge of DAH is the lack of coordination and alignment of resources. It is one of the objectives of the Health Financing Strategy to improve this. The *Memorandum of Understanding between MOH and Development Partners* signed in 2000 requires development partners to make **firm financial commitments for at least three years**, to address the unpredictability of DAH. Due attention will be paid to overall joint planning and budgeting of resources from major development partners and global health initiatives, for both on- and off-budget funds, to ensure alignment with national priorities. The main objective is to finally create a **single pool** for all external resources, also known as a Joint Action Fund (11). A more long-term objective is to combine the Joint Action Fund with the

NHIS and establish a single One Health Fund, pooling resources from both pools. A general overview of the aforementioned planning can be seen in figure 11, taken from the Health Financing Strategy (11).

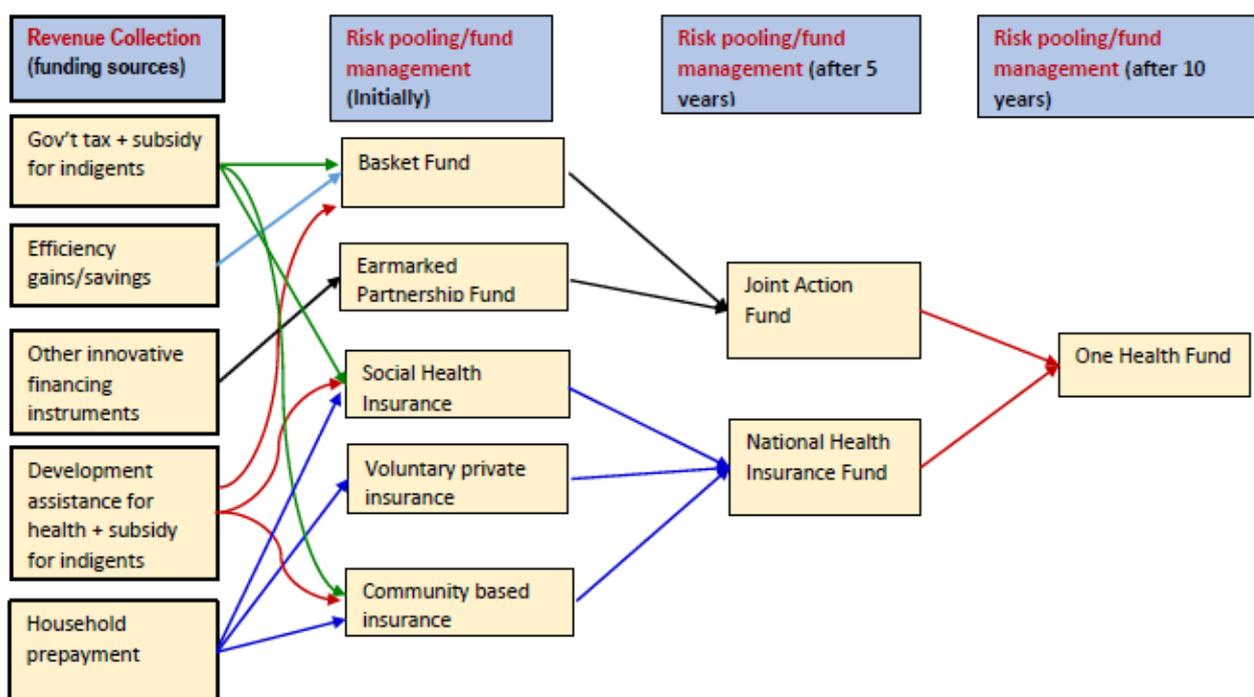


Figure 11. Illustration of pooling arrangements. Source: Health Financing Strategy (11)

One of the main conclusions of the latest National Health Accounts report 2015/16 is that even though donor financing has doubled since 1998, the increase leans towards HIV/AIDS spending. If we analyse the funds by disease, in FY 2015/16, HIV/AIDS received 70.4% of the donors' funds. If the donors' funds are analysed by function, 75.1% went to preventive care, out of which 86% in epidemiological surveillance and risk and disease control programmes (34).

Most external funds have been programme-specific, with very little or no flexibility on expenditure choices. In order to achieve better quality health care delivery and positive health benefits, the government needs to address health systems problems in a holistic manner. Most donors prefer to finance one-off expenditures e.g. procurement of medicines, vaccines, equipment or training of health workers, and neglect recurrent costs, like health workers' salaries. This is because, if they fund health workers' salaries, it is not guaranteed that the governments will absorb these health workers when the donors pull out.

An example of this is the case of the GFF in Uganda. Uganda was prompted to intensify its efforts towards improving reproductive, maternal, newborn, child, and adolescent health (RMNCAH) outcomes when it was selected as a second wave GFF country. The "Sharpened

RMNCAH Plan 2016/17-2019/20 (45) was formulated addressing both supply-side and demand-side constraints. Various financiers are considering providing complementary financing for Uganda's Investment Case, including DfID, USAID, GAVI, and the World Bank, with financing from both the International Development Association (IDA) and the GFF Trust Fund. However, in Component 2 - Strengthen Health Systems to Deliver RMNCAH Services (IDA: USD 54.5 million) - of the project appraisal document, it is clearly stated that *"the project will not provide salaries"* (33, p.14, footnote 36). Instead, it will fund training, infrastructure, equipment and improvement of HRH management.

The question is whether Uganda, as well as other LICs, can rely on donor support and ODA to fulfil their specific health development aspirations. Eurodad, the European Network on Debt and Development, has stated that *"unpredictable donor behaviour distorts consistency in developing country planning and undermines the effectiveness of aid"*. It advocates for the building of Uganda's own capacity and self-reliance, which will allow the pursuit of its own development and social agenda (54).

In this high aid-dependency lies a substantial risk. Uganda envisions to move from being LIC to a LMIC by 2020 due to the predicted commencement of the oil extraction in 2022 (with a delay from the initial target of 2020) (39,55). If this happens, Uganda will no longer qualify for the current donor funds. Therefore, in order for the highly externally funded health system to be supported, the expected oil revenue should be sufficient and allocated in such a way to supplement the lost of external funds for health. The IMF also recognises that cuts in aid flows would undermine the sustainability of spending, particularly in the social sectors (40).

Examples: The Global Fund

The Global Fund has been a major provider of DAH in the areas of HIV/AIDS, tuberculosis and malaria, and has also contributed to health systems strengthening projects. The disbursement of funds has been increasing sharply since its inception in Uganda in 2002, with a total amount of USD 1.16 billion in 2019 for all programmes. Approximately 90% of Global Fund grants to Uganda are spent on the procurement of medicines and health products (56). When it comes to supporting HRH, the Global Fund includes training of staff in its programmes but does not fund or contribute to their salaries. In fact, according to the Global Fund's Budgeting Guidelines, before any remuneration of HRH is approved, a feasible plan for the absorption of the cost needs to be in place by the government; and even then, this can be done only under exceptional circumstances (57).

An example of that is the case of Malawi, where the Global Fund supports more than 2000 health workers who are on the government payroll but receive their salaries from the Global Fund (15). Even if this was not a challenge-free initiative, donors can draw lessons from it; investment in training of health workers can be combined with investment in their salaries.

Examples: PEPFAR

An example of health workers being funded by a foreign donor is the case of PEPFAR. The guidelines of PEPFAR headquarters for the Country Operation Plans (COPs) 2019 require the following when it comes to investing in health workers' salaries and recruitment:

- Provide a summary of cadre shortages presenting as current barriers to achieving epidemic control in developing community health care workers.
- Summarise the approach used to determine staffing needs and how PEPFAR supported HRH are being allocated/redistributed to enable efficiency gains
- Describe plans for monitoring to assess the impact of HRH support.

PEPFAR supports health workers salaries across countries. Some of the health workers were hired with the intention to be absorbed by the governments and some as part of surge strategies. To identify the need for HRH support, PEPFAR calls countries to use HRH information tools, like WISN or HRiS. They also provide their own tool, the PEPFAR Solutions Platform and call for coordination with other donors supporting HRH (e.g. Global Fund) to avoid duplication. PEPFAR does not accept monthly salary supplements or "top off" as a strategy, but it does accept hiring specific numbers of specific cadres on behalf of governments to fill critical gaps, with salary levels, job descriptions and supervision defined by the MoH. It also accepts paying overtime hours (no more than 20% of the salary) and paying NGO staff to deliver health services.

The Country Operational Plan 2018 planned to support 1,235 health workers, who would progressively be transitioned to government payroll in the medium term according to an agreed transition plan.

BROADER MACRO-ECONOMIC CONSIDERATIONS

Debt repayments

At the end of June 2018, Uganda's total public debt stock (both domestic and external) amounted to USD 10.7 billion. This is equivalent to 41.5% of GDP, of which domestic debt accounts for 13.3% and external debts for 28.2%. In the 2018/2019 budget, the government has allocated 32.7% of the total revenues towards debt repayment, taking the biggest portion of the budget (13). Amortisation¹⁴ of external debt in the FY 2019/20 is projected at USD 171 million and external interests at 108 million (13). For countries at high debt distress, restructuring existing debt may be justifiable if the legitimacy of the debt is questionable or the opportunity cost in terms of worsening economic growth and living standards is high (58). Even though Uganda is currently at low risk of debt distress, prioritisation of debt service repayment absorbs essential funding that could otherwise be directed to health services.

Reflections on a more conducive macroeconomic environment for HRH

Low-inflation and low-deficit targeting regimes, as well as the independence of central banks in keeping interest rates high, date back to at least 2002, when restrictive fiscal and monetary

¹⁴ Amortization of a loan is when the face amount of the loan is paid over the life of the loan in equal instalments

policies were introduced to Uganda by the IMF and the World Bank, and protecting against inflation was deemed more important than protecting the population's health (59). More recently, at the 4th Global Forum on HRH in Dublin, the director of the Ugandan think-tank ACHEST, Professor Omaswa, noted that the World Bank and IMF have taught African leaders that health is a consumptive sector and a bottomless pit. He called for a big effort to reverse and “*un-teach*” this out-dated message which partly explains why investment in health in Africa is not yet at the desired level (60).

One possible channel of a more accommodating macroeconomic policy is expanding government expenditure through larger, though reasonable, fiscal deficits. An empirical study carried out in 2017 for the ILO on fiscal space for social protection in relation with the SDGs in 187 countries, showed that a 2% increase of a country's fiscal deficit could result into vast increases in the resources available for public health. In the case of Uganda, this increase was estimated to be 4.5% (61).

Another channel of a more accommodating macroeconomic policy is via a looser monetary policy. Low inflation, meaning below 5%, has been considered the tool for macroeconomic stability and growth but has become a goal in itself by International Financial Institutions (IFIs). The IMF, for example, has been praising the Ugandan authorities for keeping inflation rates close to 5% (40). However, opinions on what an “acceptable” and “safe” inflation level is, have been very diverse and conflicting, ranging from 3 to 40% (61,62). The most common tool to maintain low inflation is by setting high interest rates, currently at 10% in Uganda¹⁵. This keeps the cost of doing business in Uganda high. If this policy was loosened and hence interest rates lowered, it would be less costly for both government and entrepreneurs to borrow money and make investments, including in the health sector.

DISCUSSION

The findings of this study have showcased the situation of the health workforce in Uganda, particularly on financing the public health workforce, and how shortages contribute to the unacceptably high maternal mortality rates and poor health outcomes in general. The HSDP, which is the latest policy instrument analysed, indeed recognised that the health workforce is a key bottleneck for the appropriate provision of health services to the population. It recommends that continued efforts are required to enhance the density of critical cadres to ensure attainment of UHC and the SDGs.

The demand for and supply of HRH in Uganda is based on staffing norms that should be revised on a regular basis to respond to population and disease burden dynamics. The MoH is preparing a WISN report, which will configure the national need for health workers. The current ratio of approximately one employed professional health worker per 1,000 inhabitants is clearly too low. At the present time, the health workforce is not keeping up with the population growth, nor the epidemiologic changes and demographic trends, including increased life expectancy. Paradoxically, this is a case of **a shortage in the middle of plenty**, as

there is a large pool of qualified and licensed health professionals, who remain unabsorbed and out of the labour market. Notably though, even if all the unemployed health professionals were absorbed, Uganda would be still far from the international requirements for UHC. In addition to that, **brain drain**, qualified health workers leaving the country, is enlarging the already existing gap. The remaining health workers have to deal daily with a heavy workload and lack of essential medicine, equipment and basic infrastructure, especially in hard-to-reach rural areas. According to the leadership of the Ugandan Medical Association, health workers regard the inadequate working conditions as more crucial than low salaries. Finally, Uganda, with its **gender-imbalanced** health workforce, is following the trend of global health in which health is “*delivered by women, but led by men*”. This occupational gender-segregation contributes to the gender pay gap and economic disadvantage for women. Moreover, the health sector is weakened by the loss of female talent, knowledge and ideas that women in decision-making position could bring.

The problems and gaps of the Ugandan health workforce are persisting due to the insufficient financial allocation, as well as the poor management of HRH and existing funds. Weak technical leadership for HRH at the MoH, mismatching of education and training to health needs, and decentralised recruitment and management are major contributing factors. There is an irony in the high donor investment and declining government investment in health amid Uganda’s economic growth. Total health expenditure has been decreasing in the last decade; as a percentage of the total government expenditure, as a percentage of the GDP, and per capita. Moreover, since 2007, increases in external financing have been accompanied by decreases in domestic government financing.

Why was the public health sector not able to attract a greater share of resources, or at least retain their share of government funding? The complex political economy of the budget allocation process explains why the public sector has consistently not been prioritised. The prioritisation instead of the transport and infrastructure sector, which contributes to the development of the nascent oil sector of the country, is a political decision of the Government of Uganda. The question is whether this is in the best interest of the population and their health.

RECOMMENDATIONS

Based on the findings of this study, we make recommendations towards all stakeholders on three main issues.

1. BUILD HEALTH WORKFORCE THAT RESPONDS TO POPULATION NEEDS

The Staffing norms of the health sector in Uganda were approved back in 1999 and thus are not in sync with the population growth over the years.

The Ministry of Health should therefore update the staffing norms of the health sector taking into account the population growth, increasing disease burden of the country and internationally agreed standards. The on-going review of the Human Resources for Health Strategic Plan should prioritise the issue of updating the staffing norms.

2. STRENGTHEN HEALTH WORKFORCE PLANNING MANAGEMENT

Utilisation of accurate, reliable, standardized, and timely data of health workers at national and sub-national levels is weak.

- The training of health professionals should be adjusted to address the cadres that have highest shortages.
- Uganda should establish the WHO recommended Country Coordination and Facilitation (CCF) mechanism. This brings together the ministries of Education, Health, Local Government, Public Service, Finance and other relevant stakeholders to forecast and plan the training of health professionals according to needs.
- The government should ensure the timely disbursement of resources to the MoH, so that fresh recruitment of trained and currently unemployed health workers can be done to enable their absorption into the public sector and address prevailing staffing shortages.

3. MOBILISE DOMESTIC RESOURCES

The current investment in health is below WHO recommended levels. This is reflected in the dissatisfaction with public health services including capacity to recruit, retain and develop Human Resources for Health.

- The Government should reverse the declining per capita expenditure on health by incrementally moving towards the internationally recommended allocation of 5% of GDP to health.

4. NATIONAL HEALTH INSURANCE SCHEME

The Out of Pocket Expenditure (OOP) on health in Uganda stands at 40% of total health expenditure which is higher than the regional average; resulting in catastrophic and impoverishing costs of health care for vulnerable and low income households.

It is recommended that Government Expedite the passage of the National Health Insurance Scheme Bill to minimise the exposure of the population to the exorbitant cost of health care.

5. CONTROL ILLICIT FINANCIAL FLOWS

Uganda is estimated to be losing more than USD 547 million annually due to Illicit Financial flows (IFFs) which amounts to USD 14 per capita!

- The Government of Uganda should undertake tax reforms to reduce leakages, tax evasion, unfair tax exemptions and capital flight.
- In addition, Government should expand the tax base by tapping into hard-to-reach economic activities, as well as improve efficiency of revenue administration mechanisms.

5. USE DEVELOPMENT ASSISTANCE FOR HEALTH MORE EFFECTIVELY

The planning and implementation of health services in the country is done in silos within and between government institutions and development partners. Development partners have moved away from basket (i.e. Sector-Wide-Approach; SWAs) to project based funding. This has resulted in fragmentation of development assistance for health at national and sub national levels with limited success.

- Development partners and donors should increase and expand support for health workforce development, including recruitment and salaries, through more flexible and dependable funding.
- It is recommended that the previously strong SWAs in the health sector be revived.
- Development partners should also increase the share of funds channelled through the Government and support the plan for a Joint Action Fund.

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ANNEXES

ANNEX 1: MATERNAL MORTALITY INDICATORS

There are two important differences between how the Ugandan 2016 and previous demographic and health surveys (UDHS) defined maternal mortality. In previous surveys, data were not collected on whether deaths were due to accident or violence, and the time limit between the end of a pregnancy and death was 2 months rather than 42 days. The term “maternal mortality” used in previous UDHS surveys corresponds more closely to the ICD-10 definition of pregnancy-related death: “death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death” (WHO 2015), although a two month time period was used instead of 42 days. Although maternal mortality estimates from the 2016 UDHS are not strictly comparable to estimates from previous UDHS surveys, trends can be examined by calculating the 2016 UDHS pregnancy-related mortality ratio and comparing it with the maternal mortality rate from previous surveys. Pregnancy-related mortality was calculated for the 2016 UDHS in the same way it was calculated (as maternal mortality) in the previous UDHS surveys. The Maternal Mortality Ratio for UDHS 2016 is 336 per 100,000 live births.

ANNEX 2: QUESTIONNAIRES

Questions for the Meeting Wemos/ACHEST and the Health Service Commission

1. When was the last time that the staffing norms for the public health sector were updated? Have they been adjusted for population growth? When are they going to be updated again?
2. Is a recruitment freeze still in place?
3. Are there any exemptions in place on the recruitment freeze for critical cadres of health workers? Or health workers in general?
4. Is there any new recruitment plan in place, regarding human resources for health?

5. The HRH Strategy 2005-2020 comes to an end next year. Are you already in the process of formulating an updated strategy? Are there any specific measures to be taken in order to address the HRH shortages?
6. What is the contribution of the Allied Health Professions to the workload in the health services?
7. What are the challenges to the full recruitment of HWF at central and local governments?

Questions for the Meeting ACHEST/WEMOS WITH the Ministry of Public Service

1. In 2012 Uganda's Ministry of Public Service announced a recruitment freeze for all public sectors—including health. Is this recruitment freeze still in action? What short term measures are in place to bridge the Human Resource Gap in the interim period?
2. Are there any exemptions in place on recruitment the freeze for critical sectors of health workers?
3. Is there a wage bill ceiling in place (e.g. issued by the MoFPED) if so what is the current ceiling?
4. What are the trends in the wage bill for health over the last five years or longer?
5. What are the trends in the absorption capacity for the wage bill over the last five or more years?
6. Is there any new recruitment plan in place, regarding human resources for health?
7. What is the distribution of the health workforce in the country if possible by gender/rural/peri-urban/ urban divides?
8. Is there coordination between the Ministry of Public Service and the local governments in health worker management?

ANNEX 2: LIST OF KEY INFORMANTS' ORGANISATIONS IN UGANDA

1. Amref Health Africa
2. Center for health, Human Rights and Development (CEHURD)
3. Civil Society Budget Advocacy Group (CSBAG)
4. Coalition for Health Promotion and Social Development (HEPS-Uganda)
5. Cordaid
6. Embassy of the Kingdom of the Netherlands

7. Foundation For Integrated Rural Development-Uganda (FIRD-UG)
8. Health GAP
9. Health Service Commission
10. Human Rights Research Documentation Centre (HURIC)
11. IntraHealth
12. Makerere University School of Public health
13. Ministry of Health
14. Ministry of Public Service
15. Open Society Initiative for Eastern Africa (OSIEA)
16. Oxfam
17. PEPFAR/USAID
18. Southern and Eastern African Trade, Information and Negotiations Institute (SEATINI)
19. Uganda Healthcare Federation
20. Uganda Medical Association

Colophon

Wemos Foundation

Ellermanstraat 15-O
1114 AK, Amsterdam-Duivendrecht
The Netherlands
T +31 020 435 20 50
E info@wemos.nl
www.wemos.nl

ACHEST

Plot 13 B Acacia Avenue,
Kololo P.O.Box 9974, Kampala
Uganda
T +256 414 237225
F +256 414 237226
E info@achest.org
www.achest.org

author Wemos and ACHEST

layout Wemos