Reproductive health financing in Uganda

World Health Organization
African Region

Results from the national health account study, 2019–2021

1. Background

1.1 Introduction to reproductive maternal, newborn, child and adolescent health (RMNCAH) in Uganda

Uganda has made significant progress in its journey towards achieving the Sustainable Development Goals (SDGs) by improving the well-being and survival of women and children during pregnancy, childbirth and adolescence. This journey began in 2013 with the development of the first RMNCAH Sharpened Plan to accelerate progress towards the Millennium Development Goals (MDGs). In 2015, the country furthered its efforts by developing the RMNCAH Sharpened Plan and Investment Case I (2015–2021) to expedite progress through five strategic shifts, including focusing on high-burden populations, high-impact solutions, education, empowerment, economy, environment and mutual accountability *(1)*.

The shifts were considered crucial for achieving universal health coverage (UHC) in Uganda. Subsequently, Uganda developed the new RMNCAH Sharpened Plan II (2022–2028) to expedite progress towards the achievement of the SDG targets by building on the lessons learnt from the previous plan. The main objectives include reducing preventable maternal, neonatal, child and adolescent deaths while prioritizing the well-being and health of women and children in the country *(2)*.

The Government of Uganda (GoU) implements RMNCAH programmes through a tiered health system, from the community level through health centres (HCs) and general hospitals to referral hospitals. It is working to upgrade HC IIs and establish HC IIIs in each sub-county to increase access to quality health care services nationwide *(2)*.

For children, the global under-5 mortality rate (U5MR) declined from 76 deaths per 1000 live births in 2000 to 42 in 2015, then 39 in 2018. The neonatal mortality rate (NMR) dropped worldwide from 31 deaths per 1000 live births in 2000 to 18 deaths per 1000 in 2018. Regardless of this patchy progress, it was still strange to have approximately 5.3 million children dying before reaching their fifth birthday in 2018 alone *(3)*, with almost 50% of these deaths (U5MR) occurring within the first 28 days of life. Again, this trend is headed by SSA, where 1 out of 13 children died within that period before celebrating their fifth birthday, which was 16 times higher than the rate in high-income countries *(3)*.

1.2 Reproductive health (RH) indicators

The RH indicators in Uganda have improved towards meeting country-level targets, but some important global goals are yet to be achieved. For example, according to the 2022 SDG Report, the maternal mortality ratio (MMR) decreased from 461 to 372 deaths per 100 000 live births between 2000 and 2011. Subsequent Uganda Demographic and Health Survey (UDHS) reports indicate that MMR further reduced to 336 deaths per 100 000 live births in 2016 and to 189 deaths per 100 000 live births in 2022 (Figure 1A). This represents better progress compared to the 2020/21 target for the National Development Plan (NDP III), which was 311 deaths per 100 000 live births.

In the past 10 years, the neonatal mortality rate decreased by 19% from 27 to 22 deaths per 1000 live births from 2010 to 2022 (Figure 1B), better than the NDP III target of 24 deaths per 1000 live births. The use of modern contraceptive prevalence rate (CPR) in Uganda increased from 26% in 2011 to 38% in 2022, which is still low compared to the NDP III target for 2021/22 set at 43%. In addition, the use of traditional contraception within the same population stagnated at 4% (UDHS, 2022).

Figure 1. ***Trends of maternal and neonatal health indicators in Uganda***

Figure 1B

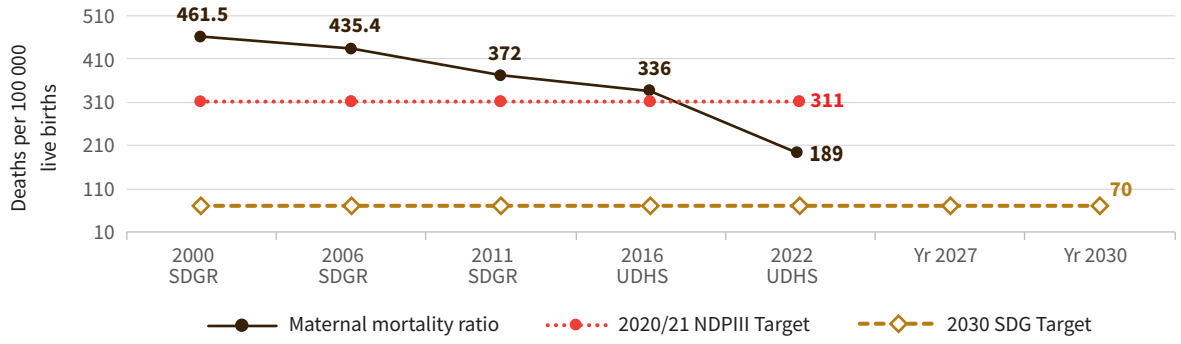
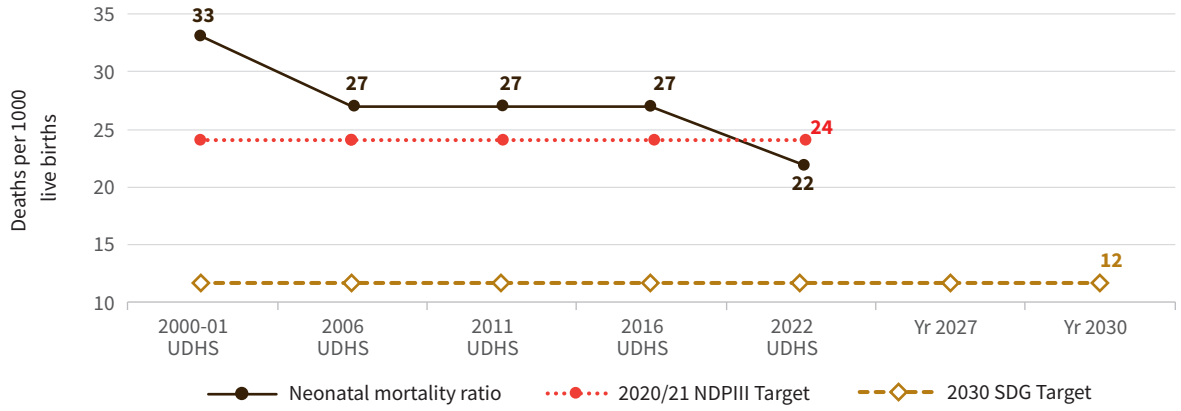


Figure 1A



Source: UDHS 2022

Based on current trends, it appears that Uganda is unlikely to achieve the 2030 SDG targets for neonatal mortality (12 deaths per 1000 live births) and maternal mortality (70 deaths per 100 000 live births) which will require significantly more effort, as indicated in Figure 1A report by Save The Children *(4)* has ranked Uganda among the top 10 countries worldwide for high maternal, newborn and child mortality rates, with the urban poor being 1.9 times more likely than the urban rich to die before the age of 5 years.

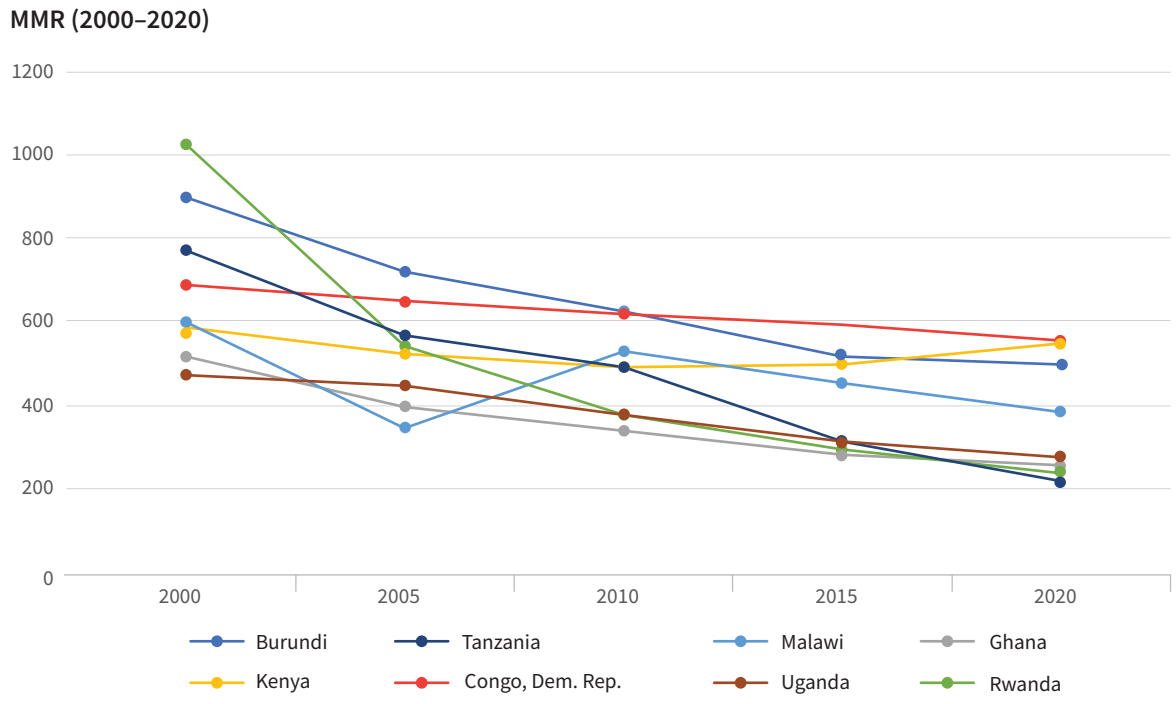
According to the Uganda Bureau of Statistics (UBOS, 2023), the statistics indicate that one in 28 children in Uganda do not survive to their first birthday, and one in 19 do not reach their fifth birthday. Uganda's SDG Index in 2021 was 142/166, with an SDG Index score of 55.51/100, indicating the country's progress towards achieving the 17 SDGs. Hence, despite the improvements in maternal and newborn mortality rates, they remain unacceptably high because they are preventable.

By comparing Uganda's progress with other countries (Figure 2), it is clear that Uganda's MMR in 2020 (284) was better than for some countries like Burundi (494), Democratic Republic of the Congo (DRC) (547) and Kenya (530). A closer look at the situation in 2005 shows that Uganda's MMR (435) was still better or at the s ame level as for Burundi (713), DRC (635) and Kenya (503).

However, countries whose MMR was worse than that for Uganda in 2005 include Rwanda (532) and Tanzania (559), but their progress has surpassed that of Uganda for 2020, as shown in Figure 2. This indicates that while Uganda has made good progress in improving MMR, there are still areas for improvement and lessons to be learnt from countries in the same context such as Rwanda and Tanzania.

Some studies *(4, 5)* have shown that the lack of intentional financing for maternal and child health issues continues to be a significant impediment to achieving global targets. Further studies are required in Uganda to identify any underlying factors that could explain slower progress compared to peer countries.

Figure 2. ***Cross-country comparison between Uganda and other countries on MMR***



This brief, therefore, aims to study the financing landscape for Uganda in relation to reproductive, maternal and neonatal health services using the national health accounts (NHA) for 2019/20 and 2020/21 as shown in the next section.

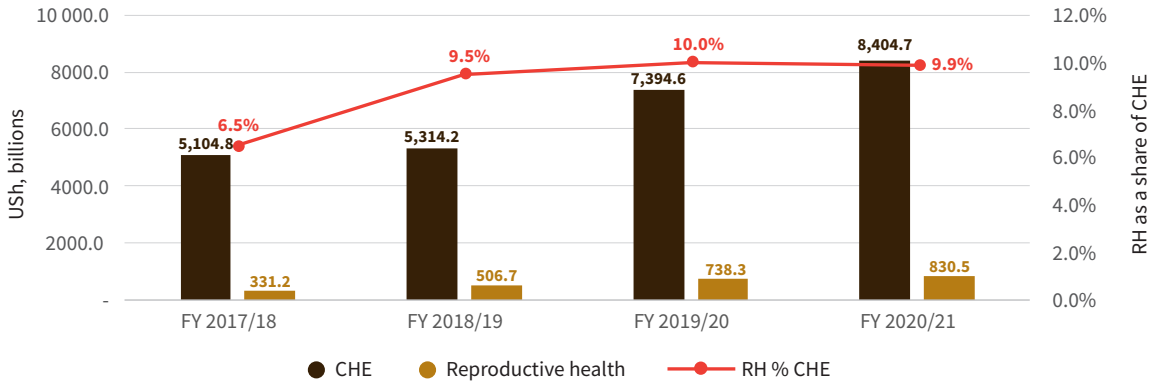
2. Reproductive health financing in Uganda, 2019–2021

2.1 General health financing

Uganda's total expenditure on health (THE) increased from USh 7.79 trillion in 2019/20 to USh 8.71 trillion in 2020/21. The 2019/20 figure shows a 42% increase in THE from the previous year (2018/19) at USh 5.49 trillion, which could be linked to expenditure shifts during the COVID-19 pandemic. The current health expenditure (CHE), on the other hand, increased from USh 7.39 trillion (US$ 1.99 billion) in 2019/20 to USh 8.40 trillion (US$ 2.30 billion) in 2020/21.

Health expenditures on Reproductive Health (RHE) increased from USh 738.3 billion in 2019/20 to USh 830.5 billion in 2020/21. As a share of CHE, reproductive health programmes registered a proportion of 10% for 2019/20, which reduced slightly to 9.9% in 2020/21 (Figure 3).

Figure 3. ***Trends in expenditure on reproductive health in Uganda***



Overall, the trend of RH expenditure in Uganda as a share of CHE has been increasing annually from 2017/18 except for 2020/21 (Figure 3). Hence, while the nominal expenditure on RH increased between 2019/20 and 2020/21, its allocation in terms of all resources was reduced. This trend aligns with global findings *(6)* that health care systems were forced by the pandemic to not only reorganize hospital wards and staff but also to transfer equipment and supplies from other departments to take care of COVID-19 patients, all within budget constraints. For Uganda, ministries, departments and agencies (MDAs) reallocated funds to finance the national pandemic response, and similar efforts were repeated at the subnational levels *(7)*.

The general patterns of health expenditure can reveal important insights at the national level, but breaking down these expenditures based on the beneficiaries provides a more accurate picture of what each beneficiary receives. Table 1 below displays the RHE converted into per capita terms for Uganda.

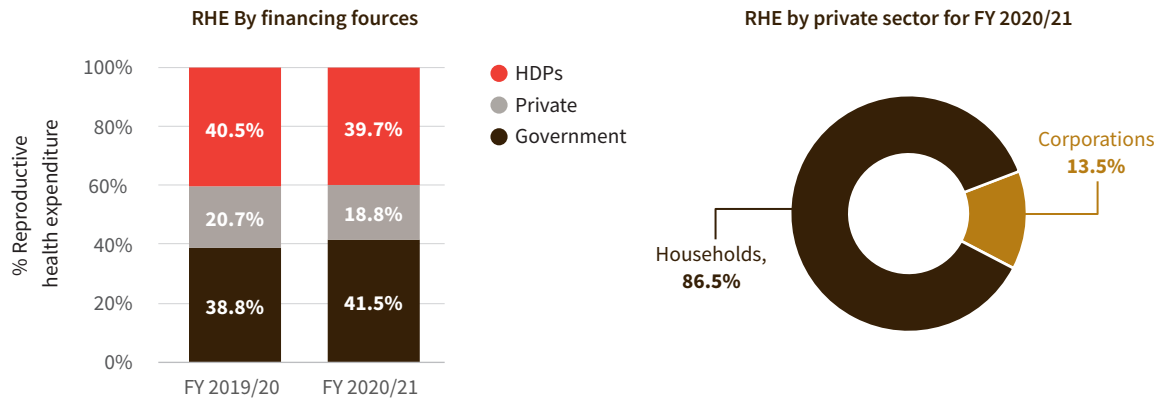
Table 1. ***Trends of expenditure on RH in Uganda, financial years (FY) 2017/18–2020/21***

Variables	Units	FY 2018	FY 2019	FY 2020	FY 2021
RHE	*USh, Millions*	331 210	506 730	738 262	830 507
RH population	*Millions*	38.54	39.78	40.31	41.58
RHE per capita	*USh*	8 595	12 739	18 316	19 972
RHE per capita*	*US$*	2.35	3.40	4.93	5.46

2.2 Financing sources for reproductive health

NHA findings (Figure 4) show that reproductive health was largely financed by health development partners (HDPs) in 2019/20 for 40.5%, government resources came second at 38.8%, and the private sector contributed 20.7% of RHE. In 2020/21, an increase in the share of government resources for RH accounted for 41.5% of RHE, while the HDP portion was 39.7% and the private sector contributed 18.8% (Figure 4). It should be noted that the largest contribution to the private sector allocation is household resources, which accounted for 86.5% of all private expenditure on RH for FY 2020/21 as shown in Figure 4.

Figure 4. ***Financing sources for reproductive health in Uganda, 2019–2021***



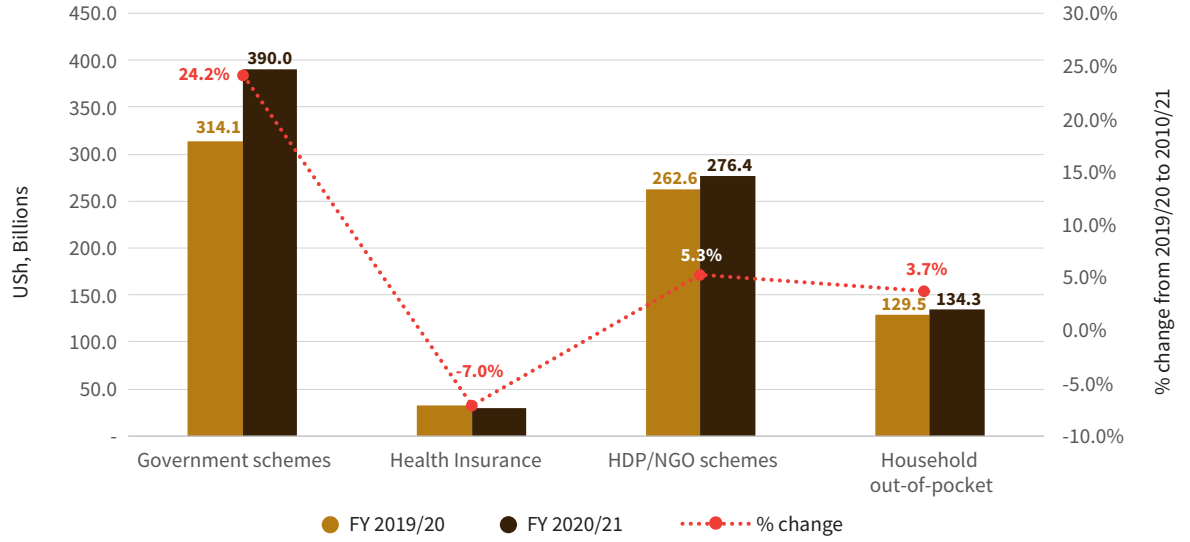
Resources from HDPs declined in 2020/21 as a share of RHE in comparison to government expenditure, which could have been the result of donor resource reallocations towards the COVID-19 pandemic. NHA data for Uganda shows that the HDP contribution towards Public Health Emergencies of International Concern (PHEIC), including COVID-19, increased from 81.1% to 98.9% of all PHEIC expenditures from 2019/20 to 2020/21, while the government's contribution reduced from 15.5% to less than 1% in the respective years.

Previously, the RHE distribution for 2018/19 showed that the majority of RH financing was by HDP resources at 39.1%, followed by the private sector at 31.4% and the least share (29.5%) was from government resources. A theory holds that the reduction in private sector expenditure could be due to the COVID-19 movement restrictions that curtailed household income-generating activities as well as their care-seeking modalities, which left nongovernmental organizations (NGOs) and the government with the role of filling these gaps.

2.3 Financing schemes for reproductive health

Financing schemes refer to the mechanisms through which health resources are collected and pooled to pay for health services. In Uganda, NHA findings reveal that government schemes contributed the largest share of resources spent on RH from 2019/20 to 2020/21. Funds pooled through government schemes increased from USh 314.1 billion to USh 390.0 billion while the HDP/NGO resources increased from USh 262.6 billion to USh 276.4 billion in the respective years (Figure 5).

Figure 5. ***Financing schemes for reproductive health in Uganda, 2019–2021***

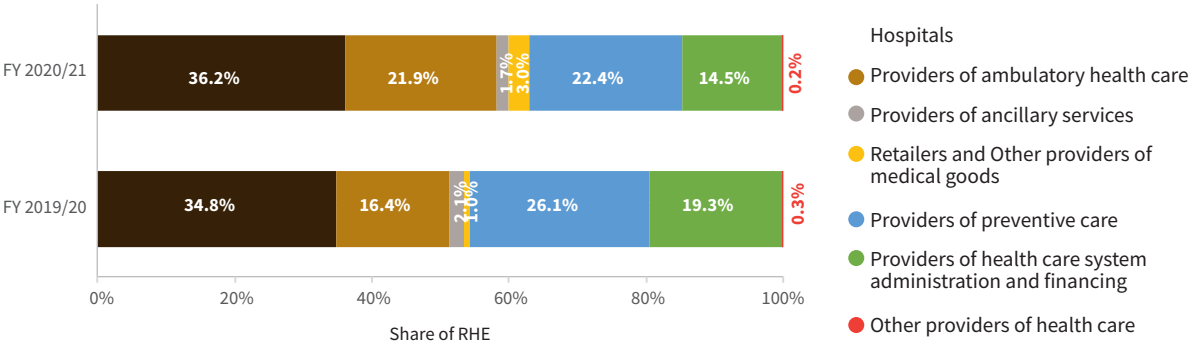


Findings also reveal that while government and HDP/schemes increased by 24.2% and 5.3% between 2019/20 and 2020/21 respectively, resources pooled under health insurance towards RH reduced by 7.0%. This can be an indication that health insurance mechanisms did not perform properly due to countrywide lockdowns which led to temporary closures of businesses that provide most of the health insurance coverage for their employees and dependents in the country. Research studies have found that expanding the availability of various types of health insurance can play a crucial role in enhancing the utilization of antenatal care and delivery of care services in low- and lower-middle-income countries like Uganda *(8)*.

2.4 Providers of reproductive health services

NHA findings reveal that hospitals remained the key providers of RH services, taking on 34.8% of all RHE in 2019/20, which increased to 36.2% in 2020/21. In 2019/20, the hospitals were followed by providers of preventive care, accounting for 26.1% of RHE, followed by providers of health system administration and financing (19.3%) and providers of ambulatory health care (16.4%). Similar to 2019/20, providers of preventive ranked second, representing 22.4% of all RHE in 2020/21. They were followed by providers of ambulatory care (21.9%) and providers of health system administration and financing (14.5%).

Figure 6. ***Providers of reproductive health services, 2019–2021***



There was also an increase in the share allocated to retailers of medical goods from 1.0% in 2019/20 to 3.0% in 2020/21, an indication that more people purchased over-the-counter medical goods in 2020/21 than the previous year. In a related scenario, the share of providers of ambulatory health care increased to 21.9% of RHE in 2020/21, from 16.4% in 2019/20, which might be an indication that the population received more services through HCs and clinics during country-wide lockdowns.

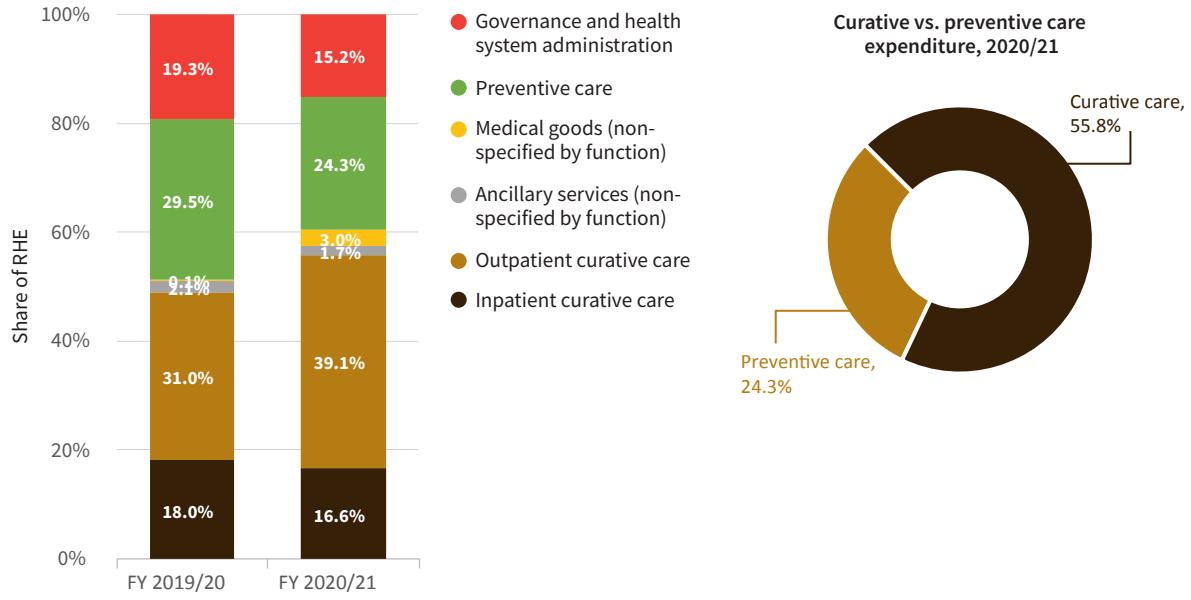
The providers of ancillary services and medical goods accounted for a combined 3.1% in 2019/20, which increased slightly to 4.7% the following year. These represent providers of specific ancillary types of services like laboratory and patient transportation services and over-the-counter health goods needed for reproductive health not covered within the episode of treatment by hospitals and HCs.

2.5 Reproductive health services provided

From the service perspective, curative care consistently consumed most of the resources allocated to RH in Uganda. Overall, inpatient and outpatient care services consumed 18.0% and 31.0% of RHE in 2019/20. In 2020/21 the share of inpatient care reduced to 16.6% of RHE while the share of outpatient care increased to 39.1% (Figure 7).

This was followed by preventive care services at 29.5% of RHE in 2019/20, which reduced to 24.3% in 2020/21. The share of governance and health system administration services reduced from 19.3% of RHE in 2019/20 to 15.2% in 2020/21.

Figure 7. ***Reproductive health services provided in Uganda, 2019–2021***



In 2020/21, curative care for RHE accounted for 55.8%, more than double the share of preventive care services, which stood at 24.3% (Figure 9).

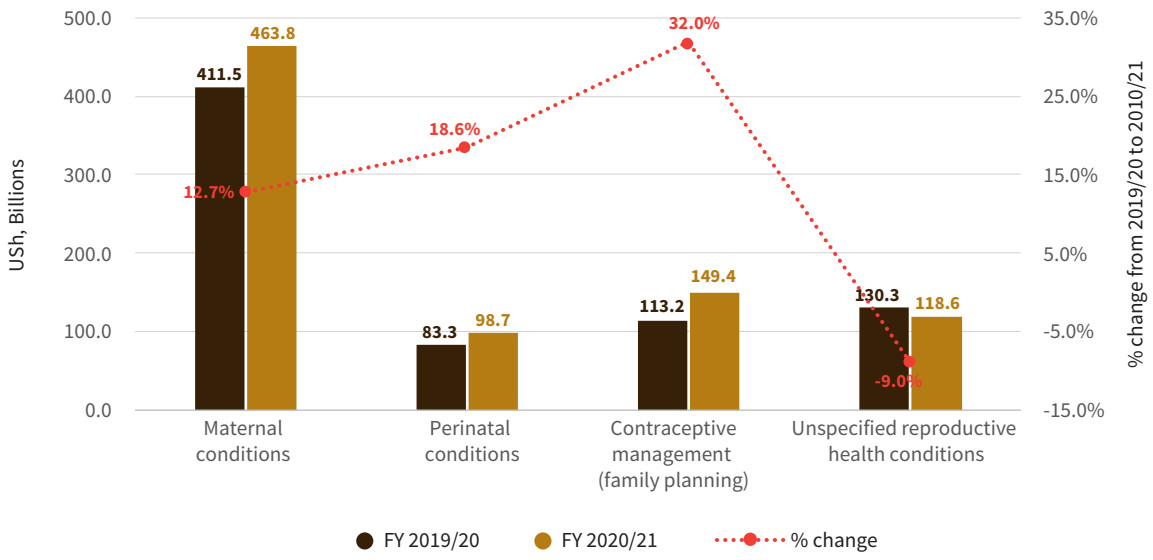
It is crucial for Uganda to heed the advice of Douglas and Fenton (2013), who argue that a more comprehensive sexual health promotion message, emphasizing the right and responsibility to make healthy choices, is more likely to address concerns relevant to individuals and, consequently, be internalized and acted upon by them *(9)*. Therefore, emphasizing preventive care is important due to its multifaceted benefits, which include a lasting impact on the population's behaviour and reduced expenditure on curative aspects of health care.

2.6 Reproductive health components financed

With regard to the RH components, the System of Health Accounts 2011 (SHA-2011) provides the international standard categories, namely maternal conditions, perinatal conditions, contraceptive management and unspecified RH conditions.

In Uganda, maternal conditions consumed most of the RH resources, accounting for USh 411.5 billion in 2019/20, which increased to 463.8 billion in 2020/21. This category was followed by contraceptive management (family planning), which accounted for USh 113.2 billion in 2019/20 and increased to USh 149.4 billion in 2020/21. The least of all segregated expenditure was for perinatal conditions, which accounted for Ush 83.3 billion in 2019/20 and increased to Ush 98.7 billion in 2020/21 (Figure 8).

Figure 8. ***Expenditure on reproductive health components in Uganda, 2019–2021***

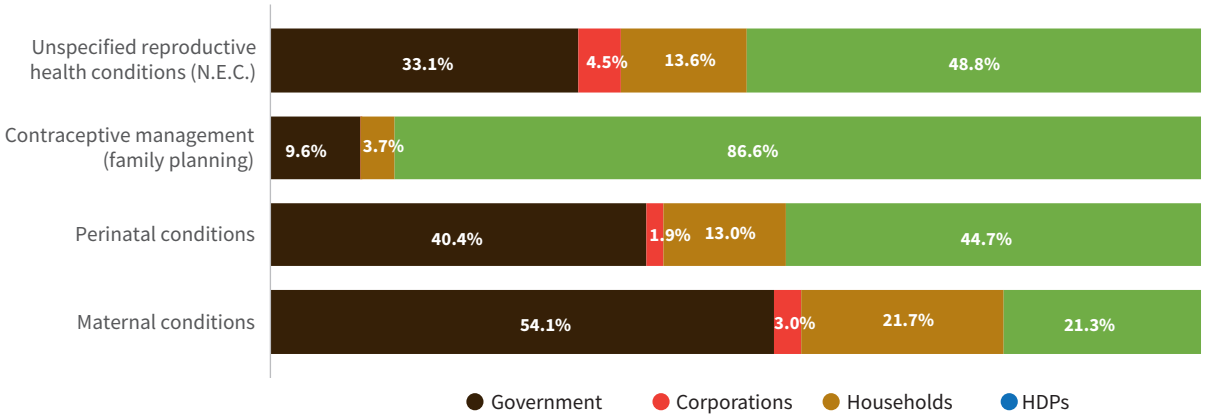


Of all the RH expenditure categories for Uganda, the biggest percentage change was in contraceptive management (family planning), which increased by 32.0% between 2019/20 and 2020/21. This was followed by expenditure on perinatal conditions, which increased by 18.6% and the least percentage change was in maternal conditions at 12.7%. The low financing of contraceptive management (family planning) could be the reason why the total unmet need for family planning among married women was high at 23.8% both for spacing (15.3%) and for limiting (8.5%) across the country *(10)*.

While most of the expenditure on RH was fully categorized, a huge amount of data was allocated to "unspecified reproductive health conditions," which accounted for USh 130.3 billion in 2019/20 and reduced by 9.0% to USh 118.6 billion in 2020/21 (Figure 8). This implies that a data segregation gap exists in the information from respondents.

With the knowledge of how much is spent on which categories of RH, the next policy-related question is, "Who provides financing for each category?". NHA findings for 2020/21 show that in Uganda, maternal conditions are largely financed by government resources (54.1%), followed by households (21.7%), HDPs (21.3%) and lastly corporations at 3.0%. The government resources and HDP resources finance perinatal conditions almost equally at 40.4% and 44.7% respectively, followed by households (13.0%) and by corporations (1.9%) as shown in Figure 9.

Figure 9. ***Financing sources for reproductive health components in Uganda, 2019–2021***



Uniquely, expenditure on contraceptive management (family planning) was predominantly from HDPs (86.6%) as compared to the government share of 9.6% and household contributions of 3.7% (Figure 9). This kind of funding landscape has heavy implications on sustainability, especially on aspects of RH which are predominantly financed by external sources such as contraceptive management and perinatal conditions.

Concerning the issue of missing data, according to NHA findings, the gap was contributed to by HDPs (48.8%), government information (33.1%), household datasets from UBOS (13.6%), and information from private employers' questionnaires (4.5%), as shown in Figure 9. The current problem concerns RH data that lack information on how resources were allocated to different components.

Therefore, it is essential to improve data collection in alignment with resource allocation to gain a better understanding of reproductive health-specific information for programme managers at all service delivery levels in the country.

3. Key policy implications and recommendations

This brief contains vital health financing information from the NHA study, covering the financial years 2018/19, 2019/20 and 2020/21 and offering a comprehensive overview of health sector expenditure patterns in Uganda, with a focus on reproductive, maternal and neonatal health. It aims to provide a foundation for policy-makers to design strategies to improve reproductive, maternal and neonatal health in the country.

1. **Even with an increase in RHE, there is a high share of CHE, 40% on average, from HDPs and largely off-budget.** This points to the need to rationalize all on-budget and off-budget resources to increase efficiency and accountability among government and nongovernment actors at national and subnational levels. Coordination across all stakeholders is key to reducing duplication across reproductive, maternal and neonatal health interventions.

2. **There has been a significant increase in government schemes for maternal and reproductive health from 2019/20 to 2020/21. However, the household out-of-pocket expenditure on the same also increased by USh 4.8 billion (3.7%) while health insurance expenditures decreased by 7.0%**. Achieving UHC requires reducing financial barriers to health services and preventing catastrophic health expenditures. To support this, risk-pooling mechanisms such as the National Health Insurance Scheme and social health insurance should be pursued, given that they can be effective when the necessary conditions are met.

3. **Health development partners still led in providing key maternal and reproductive services and commodities like contraceptive management (family planning) by almost 90% in 2020/21.** This raises concerns about the sustainability of these services, particularly as Uganda strives to achieve middle-income status or in the context of uncertain donor financing. To safeguard long-term stability, policy-makers must prioritize establishing a strong and sustainable financing framework, which focuses on domestic pooling mechanisms.

4. **Relatively little expenditure is allocated to preventive services (24.3% in FY 2020/21) as compared to curative care (55.8% in FY 2020/21) within maternal and reproductive health services.** Prioritization of resources towards preventive and promotional activities within reproductive, maternal and neonatal health is essential to creating lasting changes in population behaviour and reducing long-term health care costs.

5. **A huge portion of reproductive, maternal and neonatal health expenditure (USh 118.6 billion for 2020/21) lacked detailed information for allocation to required sub-categories within the SHAs.** The category “unspecified reproductive health conditions” is unhelpful for policy-makers. To enhance data collection, analysis and evidence generation, the Ministry of Health should enhance coordination will all stakeholders, including MDAs, HDPs and NGOs to provide detailed information that aligns with the requirements of the health accounts system.

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Estimating health spending through the "System of Health Accounts 2011" (SHA 2011)

Time trends of overall health spending and its components guide future policies and investments to make health systems more responsive to people's needs. They are essential for improving the performance of health systems while enhancing transparency and accountability. Health expenditure data also provide insights for assessing the adequacy of health resources, evaluating the efficiency, effectiveness, and equity of resource allocations, benchmarking against peers, and monitoring the progress towards the key goals of universal health coverage and health security.

"A System of Health Accounts 2011" (SHA 2011) establishes an integrated and comprehensive methodology for systematically tracking health expenditure through a set of uniform accounts comparable across countries. The framework, which focuses on final consumption, tracks resource flows through the health system: from its sources (funding sources, financial arrangements), patterns of provision (providers and factors of provision), and through to its use (health care functions, diseases/programs). This framework is used by countries globally to conduct their National Health Accounts (NHA) and estimate their health spending for a given time period.

WHO works closely with member states to establish and institutionalize harmonized, integrated mechanisms for the routine and timely collection and publication of health expenditure data (https://apps.who.int/nha/database), as well as using Health Accounts (https://www.who.int/health-topics/health-accounts) information in policymaking. At a technical level. WHO has developed methodologies, practical guidance, and IT tools, and provides direct technical support. At an institutional level, it involves efforts to help countries build their capacity to undertake such functions.

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