Citation: F. Ssengooba, SN Kiwanuka, E. Rutebemberwa, E. Ekirapa-Kiracho (2017), Universal Health Coverage in Uganda: Looking Back and Forward to Speed up the Progress. Makerere University, Kampala Uganda.

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Decentralisation and the Uganda Health System:
What can we Learn from Past Experiences to Facilitate the Achievement of Universal Health Coverage?

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Key Messages

- Decentralisation was introduced in the Ugandan health system with the objectives of encouraging community involvement in health services management, improving management and the quality of health services and improving equity of access.
- Substantial efforts were made in terms of providing a policy and institutional framework, resources, and capacity enhancement for decentralised governance. However, the effect on health system objectives has been modest and the impetus has not been sustained.
- The factors that have been linked to the sub-optimal performance include: minimal fiscal decentralisation related to limited local government decision-space, proliferation of local governments, mismatch between power and responsibilities amongst stakeholders, inadequate resources for delivery of services, and limited capacity for decentralised governance at all levels.

- Decentralisation has the potential to contribute to the achievement of universal health coverage UHC), and building a robust Ugandan health system. For this to take place, a comprehensive review of the reform by key stakeholders is required to support the necessary adjustments to make local government systems more responsive to the service needs of the communities.

Background

Decentralisation is a form of governance which has been described as 'the variety of mechanisms that may be put in place to transfer authority from a central entity to alternate institutions' (1,2). This chapter provides a review of the implementation of decentralisation with regard to the Ugandan health system, and an assessment of how this governance model has influenced the attainment of health system goals and objectives. The chapter documents Uganda's efforts towards universal health coverage (UHC).

Decentralisation has been promoted among low- and middle-income countries (LMICs) because of its perceived potential to improve efficiency, equity, accountability, local participation and ownership (3). Decentralisation has been practised across different sectors of government, including health. At Alma Ata in 1978, the nations of the world recommended primary health care (PHC) as the key approach to fostering improvements in people's health (4). The PHC approach emphasises equity and the management of services close to the community with their full participation. More recently, national governments and international organisations assented to UHC as the health system goal for countries. UHC is the aspiration that all people can obtain the health services they need, of good quality, without being exposed to financial hardship (5). Although initial discussions on what is required to achieve UHC have tended to focus on addressing financial constraints, it is increasingly recognised that UHC requires strong health systems with appropriate governance arrangements (6). It is not surprising, therefore, that decentralised governance, and the PHC approach, have been recommended as appropriate for gearing health systems towards UHC (5–7).

Given Uganda's aspiration towards UHC, it is important to review current governance arrangements and their interface with the health system, and provide an assessment of how this is likely to affect the attainment of this goal. This chapter provides a review of the country's experiences in implementing decentralisation with particular reference to the health system,

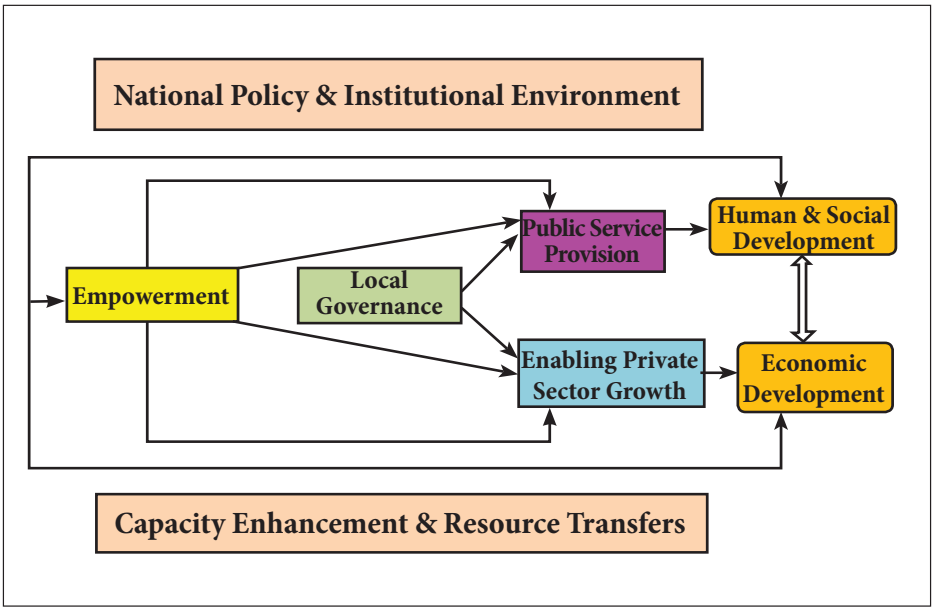
and an assessment of whether the reform facilitated the achievement of the sector's objectives. Based on the study findings, recommendations are made on how best the (re)design and implementation of decentralisation can be leveraged for the attainment of UHC. The chapter is organised into six sections: The first section provides the background anchoring the chapter into the cluster on governance and the entire book; the second section highlights the methodological approach; the third section documents the generic design and implementation of decentralisation in Uganda; the fourth section provides highlights of the adaptation of decentralisation in the Ugandan health sector; the fifth section is an analysis of the effects of decentralisation on Uganda health system objectives; and the sixth section provides the conclusion and the recommendations for leveraging decentralisation for UHC.

Methodological Approach

Mixed methods of research were used, as well as concepts from health systems research and socio-political organisation. Data/information was sought from peer reviewed publications, various government documents and databases. The historical approach was taken to facilitate the narration of a story of the implementation of decentralisation, thus enabling studying a broad time span, and bringing out issues of context, and concurrent reforms (8,9). The model developed by Helling et al., which conceptualises the operationalisation of decentralisation as taking place through the development and implementation of a policy and institutional framework, the transfer/provision of resources and capacity enhancement for decentralised governance, was utilised (10). According to the model presented in Figure 6.1, the aforementioned mechanisms influence local governance and empowerment to lead to improvements in public service provision and private sector growth. In this analysis we relate these expected effects of implementing decentralisation to the Ugandan health system objectives of community involvement in health system planning and management, improvements in management and quality of care and equity of access (11). According to the model by Helling et al., the ultimate goal of implementing decentralisation is to contribute to improvements in human, social and economic development. The implementation of decentralisation in Uganda was finally assessed for its contribution towards the health system goal of improvements in people's health. The Ugandan health system objectives indicated above, and which were published in Ugandan policy documents in the late 1990s, closely

rhyme with the principles and components of UHC. This review will utilise an assessment of the effect of the implementation of decentralisation on the health system objectives then in place at the time decentralisation was adopted, to support lesson learning for the Uganda health system today as it seeks to achieve UHC.

Figure 6.1: Conceptual model of the operationalisation of decentralisation



Source: *Helling, Serrano and Warren, 2005*

The Design and Implementation of Decentralisation in Uganda

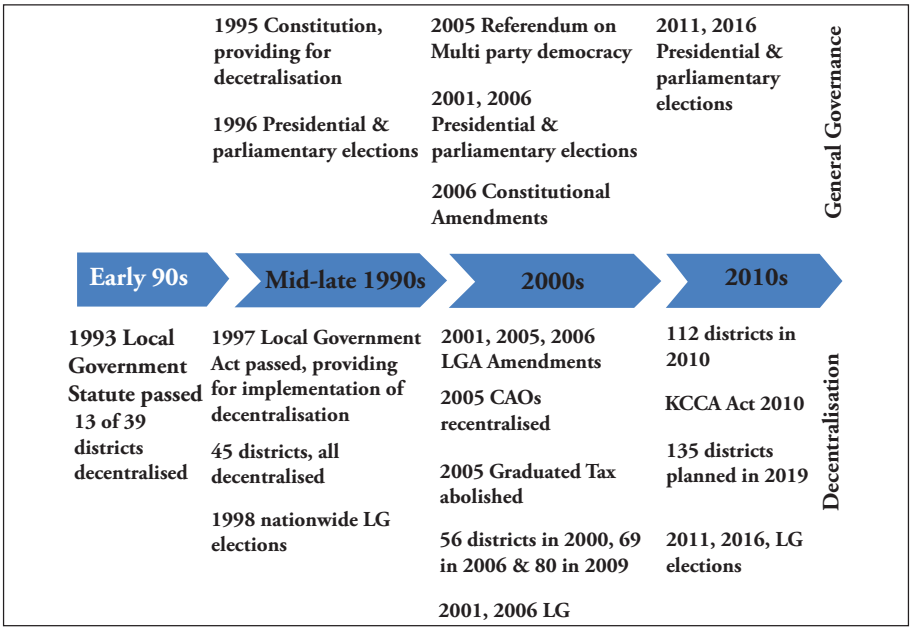
This section provides highlights of the implementation of decentralisation in Uganda, from a generic perspective, highlighting the policy and institutional framework, and the resources and capacity enhancement that have been made available to facilitate decentralised governance.

Legal, policy and institutional framework

In 1993 the National Resistance Council (NRC), the legislative organ at the time, passed the Local Government (Resistance Councils) Statute. The statute provided a framework to rationalise authority along a five-tiered hierarchy,

from the village/Resistance Council 1 (RC 1) to the district level (RC 5) (12). In 1995 a new constitution was promulgated which, amongst other provisions, laid out the framework for decentralisation. The objective of decentralisation was indicated as taking political and administrative authority closer to the population with the purpose of *improving accountability, responsiveness and effectiveness of public services* (13). The Local Government Act (LGA) 1997 laid out the various responsibilities and functions of local governments (LGs) in relation to the central government (CG). A number of changes were introduced in relation to the 1993 Statue, including the renaming of the councils from RCs to Local Councils (LCs) and providing further clarity on accountability links between the different levels (14). Figure 6.2 presents key governance and decentralisation milestones in the country since the early 1990s.

Figure 6.2: Key governance and decentralisation milestones from the 1990s to date



Source: *Author analysis*

Other documents that were intended to support the generic implementation of decentralisation include: the Local Government Financial and Accounting Regulations (LGFAR) 1998; the Public Finance and Accountability Act

(PFAA) 2003; and the Public Procurement and Disposal of Assets Act (PPDAA) 2003 (15).

The model of decentralisation introduced in Uganda was devolution, with political and administrative authority at the LG levels (1,12). Decentralisation was based on the district as a unit, below which were Lower Local Governments (LLGs) and administrative units. District and city councils were designated as LGs; sub-counties, municipalities and town councils designated as LLGs; and lower councils as administrative units (13,14). The LG council, which is the supreme political organ in a district, is a body corporate with perpetual succession and a common seal, and can sue or be sued. The council is the legislative forum where elected councillors serve as representatives of the people and make decisions on the governance of the district. The LGs can make ordinances and bye-laws in line with the constitution. The Chairperson, elected by universal adult suffrage, is the political head of the district and, together with a few individuals selected by him from among the elected councillors, forms the executive wing that provides day-to-day oversight of district affairs (13,14). The Chief Administrative Officer (CAO) at the district (rural) and the Town Clerk at the municipal and town councils (urban) are the accounting officers. Most sectors were represented by technical departments that operate at the district level; the District Medical Officer (DMO) was the head of the Health Department (14).

A number of other governance reforms have been implemented in the country over the last three decades. Following the 2005 referendum, elections at all levels of government are carried out under the multi-party dispensation; and Uganda has committed to affirmative action in politics for women, the disabled and the youth. The elections at LGs and LLGs are by universal adult suffrage (13,16,17).

Resources for decentralised governance

The constitution and the LGA 1997 provided that LGs could mobilise and expend resources according to local priorities. The sources of funds for LGs were indicated as including grants from the CG, donors and locally raised revenue. Grants from the CG included: unconditional grants; conditional grants; and equalisation grants. The grants from the CG were to be disbursed to the district and municipality levels, which were responsible for the disbursement and monitoring of their use within the LLGs. Possible sources

of funds within the LGs (locally raised revenue) were indicated as graduated tax, property tax, market dues and sector-specific fees such as tuition fees in the education sector and user fees in health facilities. The law also provided for corporate status – enabling LGs to have semi-autonomous roles in raising funds through taking loans and having direct accountability (13). At the time decentralisation was introduced, it was expected that the bulk of LG funding would allow for decision space to allocate the finances in accordance with the needs of the communities. The LGFAR and PFAA provided guidance for the management of these resources. Provisions in these laws include the posting of information on LG revenues and financial budgets on public notice boards. Human resources, infrastructure and commodities were identified as required by LGs and LLGs for the management and delivery of various services. Districts were given the mandate to recruit, remunerate, discipline and dismiss staff for decentralised services, a function supported by the District Service Commission (DSC). The CG was expected to provide standards and norms for the management of human resources. Districts were mandated to manage the procurement of works, equipment, various commodities and services for the decentralised services in line with the PPDAA 2003.

Enhancement of capacity for decentralised governance

The Decentralisation Secretariat (DS), a semi-autonomous organisation under the Ministry of Local Government (MoLG), was created in 1992 to support the roll-out of decentralisation. The DS provided technical guidance, including carrying out training programmes for political, technical and administrative leaders and community members; and published various manuals and guidelines. Subsequently, generic support for the decentralised model of governance was expected to be carried out by various CG entities according to their mandates. The offices expected to be involved included: the MoLG, the Ministry of Finance, Planning and Economic Development (MoFPED), the Office of the Auditor General (OAG), the Ministry of Public Service (MoPS) and the Local Government Finance Commission (LGFC).

Changes made to the decentralisation reform over time

A number of changes have taken place in the design and implementation of decentralisation since its formal introduction in the mid-1990s. Some of the key changes have been represented in Figure 6.2, and highlights are provided

here. The LC4, which was the equivalent of a county in the rural context, was abolished in 2001 (18). The constitution was amended in 2005 to provide for the regional level of government as a body corporate, with political, legislative, executive, administrative and cultural functions. The regional government was indicated as the highest political authority within the region (19). The regional government, however, has not been operationalised. The Kampala Capital City Authority Act (KCCAA) of 2010 provided for the establishment of the Kampala Capital City Authority (KCCA) from what was previously Kampala district. The KCCAA gave the City of Kampala unique status among decentralised entities; the oversight role for KCCA falls directly under the Office of the President, and the Lord Mayor is ceremonial rather than executive (20). In 1993 Uganda had 39 districts, which increased to 45 in 1997, 56 in 2000, 69 in 2006, 80 in 2009, and 112 in 2010. The Parliament of Uganda recently approved an additional 23 districts to be operational by 2019, making a total of 135 (21,22). Similarly, the number of sub-counties has increased from 884 to 1,132 and parishes from 5,238 to 7,241 between 2001 and 2014 (23).

The bulk of CG grants to LGs were initially unconditional grants. However, early on in the implementation of decentralisation, it was noted that some sectoral allocations by LGs were much less than those considered optimum, given national priorities. For example, LG allocations to the health sector for the fiscal years 1996/97 and 1997/98 were on average 27 per cent and 67 per cent of previous CG health sector allocations respectively (24). In response to these findings, funds for LG management and service delivery for national priority sectors (agriculture, education, health and roads) were subsequently provided in the form of conditional grants. By the early 2000s, the bulk of the LGs' revenues (80 per cent) were composed of conditional grants – thus negating the ability of the LGs to take decisions responsive to their communities. The Fiscal Decentralisation Strategy (FDS) was introduced in 2002 with the objective of improving inter-governmental resource allocations and flexibility. Under the FDS, LGs were given the authority to reallocate from sectoral conditional grants by up to 15 per cent. The FDS, however, was strongly resisted by the priority sectors, and was eventually suspended (25). In 2005 the collection of graduated tax by LGs was suspended, as it was deemed an unpopular and inefficient way of funding the LGs (15). Given the prominence of sector CGs in the late 1990s and early 2000s, the priority sectors were given the authority by MoFPED to provide LGs with guidelines for the management of these grants. The

sectors made the approval of LG sectoral strategic and operational plans and the submission of sectoral quarterly and annual reports a requirement for continued funding (24). At the time decentralisation was introduced, CAOs, municipal Town Clerks and other LG staff were employees of the individual LGs, recruited through the DSCs. The constitutional amendment of 2005 changed this; today CAOs (and Town Clerks) are managed by the central government (CG), specifically the Public Service Commission (PSC).

Decentralisation and the Ugandan Health System

The decentralisation reform that was introduced in Uganda in the 1990s was a broad civil service reform, across all government sectors, including health. In this section we document the implementation of the decentralisation reform in Uganda with a focus on the health sector, and the interaction with other reforms that were being implemented. The implementation of decentralisation in the sector is presented in terms of the policy and institutional framework, and the provision of resources and capacity-building for decentralised health system governance.

Policy and institutional framework

In the immediate post-conflict period of the mid-1980s, the management of most public services, including health, was centralised. National and regional referral and general hospitals were under the direct supervision of the Ministry of Health (MoH). Disease control interventions like immunisation against childhood illnesses and control of tuberculosis were managed through vertical programmes run by the MoH. The districts carried out functions delegated by the CG, including the management of health facilities below hospital level (26). In addition to decentralisation, a number of other generic reforms were introduced during the early 1990s, including budget reform and civil service restructuring. The national version of the Poverty Reduction Strategy Papers, the Poverty Eradication Action Plans (PEAPs), was developed with health as one of the key priorities (27). A number of development partners (DPs) channelled funds for poverty reduction through the national budget, specifically the Poverty Action Fund (PAF). Civil service restructuring led to the downsizing of the CG; the staff at MoH were reduced by 50 per cent, and there was a ban on recruitment across government institutions (24).

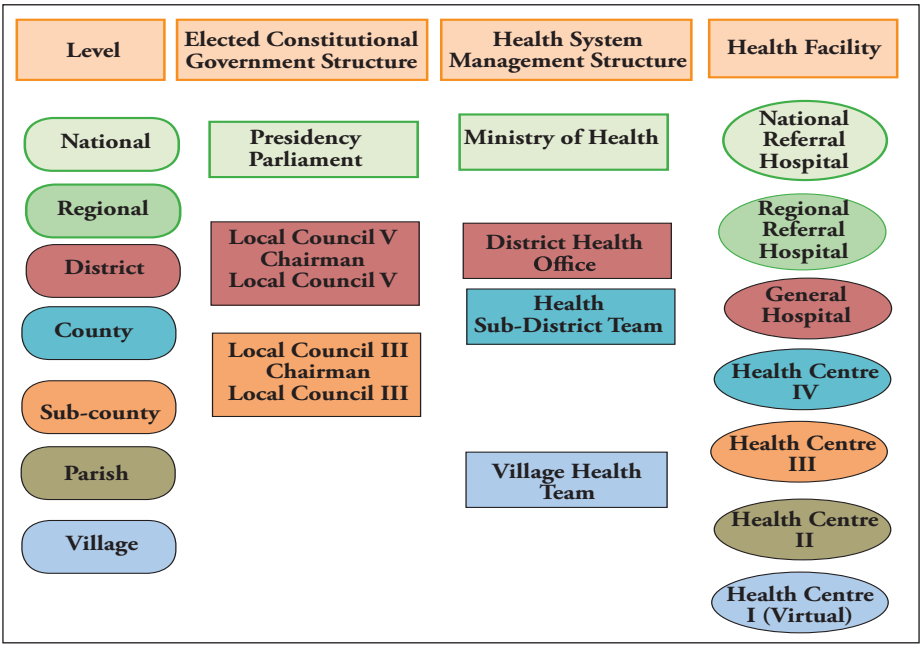
The first National Health Policy (NHP I) and the first Health Sector Strategic Plan (HSSP I) 2000/01 to 2004/5 were developed towards the end of the 1990s, and subsequently the HSSP II 2005/06 to 2009/10. These documents provided for the introduction (in some cases continuation) of a number of reforms in health financing, sector coordination and management of service delivery. The specific reforms included: the abolition of user fees (UF); the adoption of a sector-wide approach to health development (SWAp); introduction of Public Private Partnership for Health (PPPH); resources allocation reform; and continued adaptation of decentralisation to the needs of the health sector (28,29).

A key adaptation of decentralisation by the health sector was the *health sub-district (HSD) strategy*. The HSD was indicated as a functional sub-division of the district health system, equivalent to a constituency and covering about 100,000 people. The main objectives of further decentralisation to this level were: *to improve the quality and management of routine health services delivery; to increase equity of access to essential health services; and to foster community involvement in the planning, management and delivery of basic health care* (26,30). The district health offices were responsible for overall leadership, strategic planning, supervision, monitoring and coordination of district health services. The HSD management was responsible for operational planning and management of health care delivery within their catchment area. Services to be provided at each health facility level were elaborated in the Uganda National Minimum Health Care Package (UNMHCP). The UNMHCP was based on the most cost-effective interventions known at the time for dealing with the diseases that were contributing most to the burden of disease (2,11,29). The services to be provided increased in range and sophistication from community-based preventive and promotive services at Health Centre level I (HC I) to comprehensive clinical specialist services, teaching and research at the National Referral Hospitals (NRHs) (11,31). Services at HC I up to the general hospital were put under the management of the LGs.

To facilitate community involvement in health sector management, health facilities were linked to political and administrative structures of LGs. At the village level the Village Health Team (VHT) was created, composed of selected members of the village. The VHT was designated as HC I and was responsible for providing preventive and promotive health services. The lowest level of health centre with infrastructure, Health Centre II (HC II), was linked to the parish; Health Centre III (HC III) at the sub-county level;

Health Centre IV (HCIV) at the county level; and the general hospital at the district level (27). These relationships are illustrated in Figure 6.3.

Figure 6.3: Relating health systems management with LG structures



Source: *Tashobya et al 2016*

District and sub-county Health Committees were established, constituted by members of the LCs at these levels. The committees were mandated to consider and approve work plans and budgets prepared by the technical teams (district, HSD and sub-county health management teams), and to monitor their execution. The Health Unit Management Committees (HUMCs) at HCs, and Hospital Boards at general and referral hospitals, were introduced to provide oversight and community participation at these facilities. Guidelines for the running of these committees, including the composition and responsibilities, were provided by the MoH (26,32).

Resources for decentralised governance

In the mid-1980s, the country's economy was in a shambles. The health sector received very limited resources from the national coffers, and was heavily reliant on DPs (33). The health sector introduced UF in public facilities to supplement public and DP resources. In 1990, the MoH presented a User Fees Bill to the National Resistance Council (NRC), which was rejected. However, the levying of UF continued at the health facilities and was facilitated by the Local Government Act, guidelines provided by MoH, and the support of political, administrative and technical leaders of local government. Given the preferences of local governments and health management committees, UF implementation differed across the country with regard to rates, exemptions and use of funds. In the late 1990s, concerns were raised in various fora that UF were a barrier to utilisation for vulnerable groups, including the poor, women and children, and they became a major topic of debate during the 2001 election campaigns. UF in public facilities were abolished by the president of Uganda in March 2001 (34,35).

The PHC conditional grant funded by the PAF was introduced to facilitate decentralised health services delivery during the late 1990s (36,37). Simultaneous reforms at the MoFPED and the MoH contributed to marked growth in the PAF and PHC conditional grant. The district PHC conditional grant grew in absolute terms from 25 billion Uganda shillings in 1999/2000 (approx. US$ 17 million then) to 94 billion in 2002/03 (approx. US$ 65 million then), equivalent to 31 per cent and 48 per cent of the public health sector budget respectively. The MoH implemented resource allocation formulae that facilitated preferential treatment for LGs not benefitting from DP programmes, or those with documented poorer populations and other forms of vulnerability (38). Under the PPPH reform, the facility-based private-not-for-profit (PNFP) health services providers were provided with financial support. The support to PNFP facilities was first extended exclusively to facilities serving rural, remote and poor populations like Matany Hospital (Moroto district), Kalongo Hospital (present-day Agago district) and Nyapea Hospital (present-day Zombo district). Later the support was scaled up to cover the whole country, with preferential treatment given to facilities serving poorer populations. Financial support to PNFP facilities increased from US $ 0.6 million to US$ 10 million between 1997/98 and 2003/2004. Health services data from the PNFP health facilities was included in the HMIS (39). The MoH PHC conditional grant guidelines indicated how the funds were to

be spent under the different budget lines such as wages, development, PNFP and non-wage sub-grants (38). The increase in funding to the district health system was utilised to provide more health services inputs. In 2001/02 the health workers' payroll was recentralised to clear the salary arrears accumulated by LGs and to ensure that all health workers were being paid regularly and in a timely manner. Wage budgets, staff norms and public service standing orders were provided by the CG (MoH and MoPS), whereas the recruitment and posting of health workers was carried out by the LGs. The proportion of staffing norms filled with qualified health workers increased from 33 per cent in 1999 to 54 per cent in 2002/03. Modest salary increments for health workers were also implemented at the same time (26,40).

The MoH provided guidelines for two modalities for the procurement of essential medicines and health supplies (EMHS). Under the first modality, 50 per cent of the PHC conditional grant non-wage sub-grant was earmarked for the procurement of EMHS by the LGs. At the national level, a credit line provision was also made for each LG against which facilities could make orders for (draw down) essential medicines and supplies. The determination of LG EMHS budgets took into consideration the existence of public referral hospitals, general hospitals and PNFP health facilities, which had independent EMHS budgets. To ensure quality and efficiency, the MoH guidelines indicated that EMHS purchases were to be made at the National Medical Stores (NMS) or the Joint Medical Stores (JMS) and according to the EMHS list provided by the MoH. The budget for EMHS within the LGs (HSD + hospital) improved from US$ 0.22 per capita in 1999/2000 to US$ 0.59 in 2003/04[1] (41). The PHC conditional grant for development was established in late 1990s to support the extension and upgrading of the health infrastructure within the LGs. The allocation of the grant was determined by the MoH in consideration of base coverage of the population by appropriate infrastructure. Between 2000 and 2003, over 400 new HC IIs were constructed, and 180 HC IIs upgraded to HC IIIs with the addition of inpatient and laboratory services, and 150 HC IIIs were upgraded to HC IVs with the addition of a theatre and medical officers' house (26). At the beginning of the new millennium, the Millennium Development Goals (MDGs) were agreed as core development goals for United Nations member states, and the Global Health Initiatives (GHIs) were introduced to facilitate

1 This does not include the budget for items procured centrally like vaccines, contraceptives, anti-TB drugs, blood products, HIV tests and anti-retroviral medicines.

their achievement. As elaborated in chapters 3 and 8 on Global and Financial Mobilisation respectively, the GHIs became a significant source of funding for the Ugandan health sector from the mid-2000s (21,42).

Capacity-building for decentralised governance

Following the introduction of decentralisation, District Health Management Teams (DHMTs) were created, composed of the District Medical Officer[2] (DMO), other health managers in the district office and health workers in charge of health centres (26). Capacity gaps were noted with regard to both the technical and generic management aspects at the LG levels. Quality assurance (QA) teams were established within the MoH to provide technical support to the LGs and referral hospitals (15). The MoFPED delegated some of the responsibility for the supervision of LG financial management to sector ministries to facilitate quick follow-up. The MoH provided PHC conditional grant guidelines and Regional Health Planners to support LGs in preparing strategic and operational plans and to facilitate sector monitoring (21). Alongside these developments, a Health Information System (HIS) was introduced in the early 1990s for the purpose of collecting data for health services management, monitoring the impact of health programmes and for tracking health status of the population. By 1993, 21 out of 39 districts were covered by the HIS. In the late 90s, the HIS was updated to put more emphasis on management aspects, and renamed the Health Management Information System (HMIS) (43).

Over the late 1990s and early 2000s, efforts to enhance capacity for decentralised health governance were stepped up in the form of short- and long-term training, supervision, monitoring and mentoring. Training in the area of management included training in Masters of Public Health for the District Health Services, and a programme specifically developed for HSD managers was run by the MoH (44). Technical training programmes covered a range of disease control programmes (26). The SWAp reform emphasised common planning, funding, supervision and monitoring arrangements among sector stakeholders for improved efficiency and comprehensive and sustainable health system development. In 2003 the sector transitioned from

2 There has been change in nomenclature of the district health system manager from District Medical Officer (DMO) in the 1980s and early 1990s to District Director of Health Services in the late 1990s and early 2000s and District Health Officer (DHO) from the mid-2000s to-date – a close reflection of the reform cycle.

providing support in the form of the QA teams (technical) and regional planning/PHC conditional grant monitoring teams (health systems and financial management) to Area Teams. The Area Teams were intended to provide comprehensive support to the LGs, covering the preparation of operational and strategic plans, financial management, support supervision covering the spectrum of technical programmes, and to facilitate performance assessment. Each team covered an average of 5-14 districts (21).

In the early 2000s, the Yellow Star Programme (YSP) was introduced as a Quality Improvement (QI) tool at the health facility level. The YSP utilised a set of 35 service standards covering a range of technical and management aspects. The standards were used for quarterly health facility supervision by district managers, and a facility that met all the standards for two consecutive quarters was rewarded with a star (45). The Annual Health Sector Performance Report (AHSPR) – providing comprehensive documentation of sector performance of the preceding year – was first produced in 2000. Since 2003, the AHSPR has included the District League Table (DLT), which compares the performance of districts across the country. The DLT was composed of input, process and output indicators and a composite index to rank district health system performance across the country. The DLT supported identification of districts with particular challenges, which provided an opportunity for tailored support (26,46). Fora for stakeholder engagement in policy development and review, in line with the SWAp and PPPH, were introduced, including the Joint Review Missions (JRM), the National Health Assembly (NHA) and the Health Policy Advisory Committee (HPAC). To facilitate increased dialogue with the district health system technical managers, the District Health Officer Annual Meetings were initiated (21).

Changed implementation of decentralisation in the Ugandan health system

Over the last decade, new reforms were introduced at the international and national levels, and these affected the implementation of decentralisation in Uganda. A shift from MDGs to Sustainable Development Goals (SDGs) as the basis for the global development agenda was among the global reforms that affected the decentralisation of health services (47). The magnitude of resources disbursed by GHIs increased substantially over most of the last 15 years, although these brought on board additional stakeholders in the service delivery space (see the third section). At country level, the National

Development Plans (NDPs) replaced the PEAPs as the national development agenda. These changes necessitated adjustments in the implementation of decentralisation programmes, in the Ugandan health system. Some of these changes are discussed below.

The policy and institutional framework for this period is provided by the second National Health Policy (NHP II) the Health Sector Investment Plan (HSSIP) 2010/11 to 2014/15 and the Health Sector Development Plan (HSDP) 2015/16 to 2019/2020 (48–50). The increase in the number of districts has resulted in smaller districts, with 44 of the districts (38 per cent) currently composed of one HSD. This has resulted in the duplication and overlap of roles and responsibilities between the DHO and HSD management (50). The scrapping of the LC 4 left the HSD level hanging, with no equivalent LG management structure. Proposals have been mooted to scrap the HSD level. Efforts have been made to relate the HSD with the Constituency Task Force (CTF) which is chaired by the Member of Parliament and composed of district and constituency managers. The marked increase in the number of LGs, especially the districts, has stretched the capacity of the CG, including the MoH, to provide the necessary support for decentralised health system management.

Changes have been noted in the management of resources for decentralised health system governance. Under the NDP the social sectors (including education and health) lost their privileged status as core national priorities as more emphasis shifted to infrastructure development (energy and transport). The proportion of the national budget that is spent on the heath sector, for example, declined from 9.7 per cent in 2004/05 to 6.4 per cent in 2015/16 (51,52). Marked increases in funding from GHIs to Uganda were noted over the last decade. It has been estimated that of the US$ 600 million annual sector funding in 2010, half was from GHIs. The preference for project-based rather than national-budget funding by GHIs and DPs has expanded (42). These changes have had implications for health system public funding over the last decade, especially the LG levels. As an example, although the PHC conditional grant budget is reported to have increased between 2010/11 and 2016/17 from UGX 180 billion (US$ 50,400,000) to UGX 340 billion (US$ 95,200,000), the bulk of this increase is in the wage financing which increased from UGX 125 billion (US$ 35,000,000) to UGX 280 billion (US$ 78,400,000). The non-wage and development funds stagnated at around UGX 54 billion (US$ 15,120,000) combined. In 2016/17 the non-wage recurrent budget of a General Hospital was on average

UGX 166 billion (US$ 46,480,000), and for the HC II was UGX 3.7 billion (US$ 1,036,000) (53). These levels of funding are very low. Project funds are usually focused on specific programmes like HIV/AIDS and malaria control, rather than the broader UNMHCP, and not well aligned to decentralised health system governance. In the absence of UF at the public health facilities (with the exception of private wings) and the suspension of graduated tax, other sources of funds for LG health systems are very limited.

In view of the inadequacy of available resources, there has been implicit and explicit rationing with regard to the UNMHCP (54). Despite the observed increase in morbidity and mortality from non-communicable diseases (e.g. cancer, diabetes, hypertension), there has been hesitancy to include them in the UNMHCP, given resource constraints. There has been a proposal to replace VHTs (HC I) with Community Health Extension Workers (CHEWS) at the parish (LC II) level. In a related development, there has been a proposal to discontinue the HC II and instead consolidate and reinforce the HC III level (53). In view of UHC as the new health system goal, and the financing scenario highlighted above, the health sector stakeholders have been seeking out new/alternative health financing modalities. Consultations on the National Health Insurance Scheme (NHIS) were initiated in the early 2000s and have gained momentum in the recent past. The NHIS is intended to raise more funds for health, and to support risk-sharing. The Uganda NHIS has been conceptualised as a combination of social health insurance among formal sector employees, community health insurance schemes, and the provision of government budget subsidies for the poor (55). The NHIS is yet to be approved by Cabinet and Parliament. Results-Based Financing (RBF), which is intended to improve the efficiency of health sector resources, has been introduced on a pilot basis (56).

Changes have been noted with regard to the management of other resources required for decentralised health system governance. In 2009, the CG (MoFPED and MoH) moved to recentralise the procurement of all EMHS, specifically to the NMS. This decision was informed by the less than expected purchases of EMHS from the NMS and the JMS by the LGs, and the low availability of EMHS in health facilities (57). The role of the LGs and hospitals with regard to EMHS procurement was reduced to making orders against predetermined budgets at the NMS. Frequent requests by health workers and health managers for recentralisation of their management, especially medical officers, have been noted since the mid-2000s. The justification given for this include the precedent set by the recentralisation

of CAOs and Town Clerks, perceived poor career progression and alleged inappropriate handling by LG political leaders (17,58,59). The CG currently provides the staffing norms and budgets and, in most cases, prescribes cadres and advertises positions in the LG health systems. The LGs roles have been reduced in scope to covering recruitment interviews, posting decisions within the LG and making recommendation on termination of employment.

Some of the tools used to support capacity-building for LGs have been maintained, whereas a number have been changed or dropped. The HMIS was updated into the DHIS 2, a web-based digital application system that supports health data and information capture, storage, retrieval and analysis functions. The DLT was maintained with a few adjustments after 2010. However, in its current form it has been said to be inappropriate for supporting LGs decision-making (21). A number of partners have introduced new QI programmes, including 5S; the YSP was discontinued. In order to streamline QI initiatives, the MoH introduced a Health Sector Quality Improvement Framework (HS QIF), supported by strategic plans. The MoH has published a Supervision Monitoring and Mentoring Revitalisation Strategy, which is yet to be implemented (60,61).

Capacity enhancement efforts introduced in the early 2000s to support comprehensive health systems development, including at the LG levels, have not been maintained. The increased number of LGs has stretched the governance capacity of the central government. In addition, there has been a high turnover of managers in the health system, both at the national and LG levels, creating gaps in experience and competence at vital levels in the sector governance. Although national health policy documents maintain SWAp as the model for coordination amongst key sector stakeholders, the application of SWAp principles has degraded. For example, the sector has witnessed a resurgence of parallel programming by the GHIs and DPs for sector funding, supervision and monitoring. Comprehensive arrangements for the capacity-building of the LG health system are overstretched and poorly resourced in current times compared to the mid-2000s. Although a few have health system components, most GHI and DP programmes provide narrow support for system strengthening – commonly limited to information systems. Innovations such as the Regional Performance Monitoring Teams (RPMTs) implemented by the MoH and funded by the Global Fund between 2012 and 2017 attempted to combine the technical and health system aspects but this was discontinued. Recent studies find inappropriate central support systems that go directly to the health facility and community levels – thus bypassing the LGs and LLGs (21,60).

Did decentralisation support the achievement of Uganda's health system objectives?

A key objective of implementing decentralisation in Uganda was to facilitate community involvement in the planning, management and delivery of health services. The implementation of decentralisation, together with other governance reforms, made it possible for members of the community to choose political parties and leaders of their choice at LGs and administrative units. The leaders thus chosen were expected to represent the community's interests and provide oversight of public matters on their behalf. In the health system, additionally, HUMCs, Hospital Boards and VHTs were established, and the service delivery and management structures were linked to LGs. However, questions have been raised on the level of functionality of these structures and to what extent they have facilitated meaningful community involvement in the health system. For instance, there have been no elections of close to community leaders since 2001 – a situation that goes against decentralised leadership. There have been concerns that the HUMCs, Hospital Boards and VHTs have not been adequately facilitated in terms of capacity and resources. VHTs have been involved in the delivery of preventive and promotive services across the country in an ad-hoc manner depending on the availability of resources – usually by vertical programmes by some fund-holding agencies at the national level (53). Some analysts have noted that members of the LCs, HUMCs and Hospital Boards often have less formal education than the health workers they are supposed to supervise, which undermines the former's confidence and limits their capacity to supervise the latter (32). Overall community participation in the health system is yet to be augmented by more constructive engagement of the ordinary community member in health governance (62). The implementation of both decentralisation and multi-party democracy in Uganda is still in its infancy. Doubts have arisen on whether communities vote for the leaders most likely to ensure effective service delivery or whether they consider other factors unrelated to the participatory processes in the decentralisation policy (16).

Another objective of decentralisation in the Ugandan health system was to improve management and, ultimately, the quality and equity of health services available to the population. A major achievement of decentralisation in Uganda was the conceptualisation of the country, not as one homogenous entity, but rather as several heterogeneous entities, with varying contexts, peculiarities and needs. Strategic and operational plans using local

information were developed for all the management and service delivery levels. LG managers were motivated to develop these plans to try and solve local challenges. Other key reforms, such as the application of equitable resource allocation formulae, support to PNFP facilities, and the abolition of user fees, were aimed at improving equity in health services delivery. In 2003, for example, the support to PNFP providers was the equivalent of 30 per cent of their running costs, and this was used to recruit much-needed staff and to reduce charges to patients (39). Targeted interventions, such as the incentives for hard-to-reach areas , were developed and implemented to improve availability in previously poorly staffed regions (63).

The quality of care provided improved; for example, stock-outs of tracer medicines[3] for HC IIs to HC IV were noted to have declined from 30 per cent in 2001 to 18 per cent at all levels, and from 52 per cent to 20 per cent at the HC II level (41). The proportion of the population within 5 km of a health facility increased from 41 per cent in 1991 to 57 per cent in 1999 and to 72 per cent by the end 2004 (26). The Uganda National Household Survey (UNHS) reported that between 1999/2000 and 2002/03 the members of the community that did not seek care when sick declined from 50 per cent to 35 per cent, especially in previously underserved areas like northern Uganda, and among the poorest two quintiles (35). The improvements in access and quality translated into improvements in health system outputs, especially noted during the early 2000s. Between 2000/01 and 2003/04 new Out-Patient Department (OPD) attendance rates in public and PNFP facilities rose from 0.42 per capita to 0.79 and immunisation with the third dose of diphtheria pertussis and tetanus vaccine among infants (DPT3) rose from 41 per cent to 83 per cent. Deliveries by expectant mothers in public and PNFP health facilities stayed at less than a quarter of the estimated target population (28).

A number of challenges have been noted in the recent past. The stagnant public funding to the health sector, including the PHC conditional grant, led to a reduction in the speed of investment in health system inputs. In 2016 the proportion of the population within 5 km of a health facility was reported to be 75 per cent, whereas 73 per cent of staff positions according to norms were filled with qualified health workers. However, the staff norms are deemed to be modest at best and the level of salaries remains below the minimum costs of living. Frontline health workers and health system managers are poorly

3 Tracer medicines used at the time: chloroquine tablets, sulfadoxine pyrimethamine tablets, cotrimoxazole tablets and oral rehydration salts sachets.

motivated owing to poor salaries and poor working conditions, as illustrated by the recent health workers' strike and the high turnover of staff (59). The health facilities are not functional to the desired level; for example, only 45 per cent of HC IVs intended to provide emergency obstetric and surgical services are currently functional (53). Disparities still exist across LGs; the human resources for health vacancy rates in some districts, especially in rural and hard-to-reach areas can be as high as 60 per cent (64). The PNFP subsidy has stagnated since the mid-2000s – and fees in the facilities were raised to compensate for this. Overall modest progress is noted with regard to health system-wide output indicators: new OPD attendance has been reported between 1 and 1.2 per capita over the last several years; and 58 per cent of expectant mothers were reported to have delivered in public and PNFP facilities during the year 2016/17 (53). Good performance is noted in relation to specific programmes that have benefitted from DP and GHI support – immunisation, as portrayed by DPT 3 coverage, has been maintained between 90 and 100 per cent coverage in the recent past; the TB treatment success rate was reported at 80 per cent for 2016/17; and retention rates for anti-retroviral therapy for HIV at 82 per cent (50). The quality of health services in public health facilities is low, as illustrated by recently introduced quality indicators of maternal and perinatal deaths in health facilities, media reports and the tendency by many patients to seek services in the private sector (53).

Over the last three decades, Uganda has registered modest improvements in the health of its population. Between 1995 and 2016 the infant mortality rate decreased from a very high 81 to 43 deaths for every 1,000 live births; under-five mortality declined from 153 to 65 deaths per 1,000 live births; and total fertility rate improved from 6.9 to 5.4 births per woman. Maternal mortality has improved much more slowly from 527 deaths per 100,000 live births in 1995 to 336 deaths per 100,000 live births in 2016 (56,65). It is, however, difficult to directly relate the implementation of decentralisation to improvements in population health. There are many factors that are likely to have contributed to the improvements in population health. Within the health sector a number of reforms and innovations have been implemented, beyond decentralisation. Substantial investment has been noted, especially in the last decade, in the control of specific diseases such as HIV/AIDS, TB and malaria, and for immunisation against childhood illnesses. Childhood illnesses, especially measles, showed a marked decline in the health system. At the macro-economic level, investments and improvements in education and

food security have improved in the last three decades and are likely to have contributed to improvements in health indices.

Did decentralisation fail the health sector, or did the health sector fail decentralisation?

The above analysis has shown that, although substantial effort was made to operationalise the decentralisation reform, the overall effect on Uganda health system objectives remains modest, and some of the initial gains have not been sustained. A number of factors can be linked to the modest effect of decentralisation on the Uganda health system.

Firstly, the review has noted differences between the original design of the decentralisation reform and the version being implemented lately. The model of decentralisation provided for by the country's legislative framework, is devolution, with political and administrative power and mandates at the LGs and LLGs, for the management of resources for services delivery. In practice, however, the greater part of the control of the financial and human resources as well as medicines for decentralised health services is vested in the CG and DPs. This is largely due to the fact that the bulk of funds used for health services delivery by LCs are conditional grants from the CG and DP projects – with little, if any, local revenues from LGs. This is contrary to the intention of the decentralisation reforms. The structure of resourcing has marked implications for autonomy and the effective exercise of devolved roles. The concept of decision-space has been used to determine the level of autonomy enjoyed by an entity (3). The decision-space of the LGs in Uganda is much less than expected from the devolution accorded in the policy of decentralisation. The country has not realised fiscal decentralisation (25). The mismatch of responsibilities and resources has implications for effectiveness, accountability and ownership. There has been more emphasis on accountability from the LGs to the CG and DPs that provide the financial resources (upward accountability) than accountability from LGs to the communities and members of society (downward accountability). There has also been more emphasis on financial and performance (technical) accountability, and less emphasis on participatory accountability. When LG leaders are called to account for poor public services, the response is that the CG does not provide enough resources (25). It has been noted that urban LGs with more local revenue enjoy relatively more autonomy and demonstrate increased ownership (66).

Another change that has been noted with regard to the initial design and current implementation of decentralisation is the marked increase in the number of LGs, especially districts. Although there is no universally agreed understanding of the size of a district, the WHO has provided guidance with regard to a health district as one with a population of about 500,000 people, for whom a range of preventive, promotive curative and rehabilitative services at the primary and secondary levels can be efficiently and equitably provided (67). From a generic perspective, such an entity is more likely to be economically and managerially viable, balancing revenues and expenditures, benefiting from economies of scale, and balancing management and service delivery structures and functions. Uganda currently falls far short of this 'standard'. The average Ugandan district population in 2014 was reported as 300,000, with six districts having less than 100,000 people and a little over 25 per cent of the districts with less than 200,000. KCCA and Wakiso district had populations of over 1 million each (23). The increased number of districts has stretched the capacity of the CG, including the MoH, to provide the necessary support. Although the constitution provides for an intermediate level of government, this is yet to be implemented.

Secondly, the complexity and dynamism of the Ugandan context does not seem to have been taken into account in the design of the decentralisation reform. Decentralisation as a form of governance is closely linked to power dynamics. With the introduction of decentralisation, the MoLG, as the custodian of the reform and the LGs, was expected to wield substantial power. However, the introduction of conditional grants gave sector ministries control over policy and financial prioritisation within the LGs – thus shifting power away from the MoLG and the LGs, to the MoFPED and sector ministries. Power dynamics have also been noted within the health system. Prior to the introduction of multiple reforms in the late 1990s, the health sector was fragmented. With the introduction of decentralisation, SWAp and PPPH, efforts were made to develop a coherent sector, with common arrangements amongst stakeholders for policy formulation, planning and monitoring, which supported the development of coherent LG health systems. The MoH, as sector steward, wielded substantial power in this era and, to a less extent, LG health system managers (24). But since the late 2000s, fragmentation returned with the resurgence of parallel streams of funding from DPs and GHIs – with preponderance for NGOs playing major roles in the service delivery space at all levels. Many of the changes taking place in the decentralised health system are influenced by things that happen at international, national

and sectoral levels – thus converting LGs into "decision-takers" in contrast to "decision-makers". The result is a multiplicity of power centres, CG entities including the MoFPED, the MoLG and the MoH, the DPs and the LGs, with mismatches between political, technical and financial authority and legitimacy. The balance of power is not static, and has changed in relation to the wider context (21). The designers of Uganda's decentralisation reform seem to have put more focus on the administrative and organisational aspects of the reform, without appropriate consideration of the cultural, political, economic and other peculiarities of the country (32).

Thirdly, the level of resources available in the decentralised health system, and in LGs generally, is much less than required for the delivery of good quality public services. The cost of delivering the UNMHCP has been estimated at US$ 73 per capita. Public funding to the health system has been estimated at US$ 10 per capita (56,68). Public funding is best suited for the financing of the UNMHCP, as this can be directed where it is most required. Public funding for LG health systems has stagnated in the last decade, in the context of a very fast growing population, inflation, and the proliferation of LGs and LLGs. The effect on the health system has been a stagnation/ decline in quality, equity and coverage. The proposal to discontinue the implementation of VHTs and the HC IIs and replace them with the CHEWS is partly informed by this fact. The proposed replacement of community structures like the VHT with CHEWS may threaten community voice and participation in LG health system governance.

Fourthly, the limited capacity at all levels of government and the community to implement decentralised governance is another factor that is likely to have contributed to the less than optimal benefits. A very pertinent but not often highlighted issue is the capacity of the communities to implement and benefit from decentralisation. Decentralisation presupposes/ assumes that the communities are in a position to demand accountability from the LGs and CG. However, the capacity of Ugandan communities to demand accountability has been noted as limited (17). As an example, although the law provides for posting of information on financial budgets and releases of funds from the CG on notice boards in public places, this is not always done. Communities rarely request this information if it is not published. When the information is provided, it is often not in the format that is easily understood by members of the community. Overall, the capacity of the Ugandan population to demand accountability is still limited. This has been attributed to various factors, including political history, social norms

and socio-economic status. Similarly, civil society is also not highly developed (62) .

What are the lessons for uganda regarding universal health coverage?

The objectives of implementing decentralisation in the Ugandan health system were indicated as improving community involvement and ownership; improving the management and quality of health services; and equity of access. These objectives are very closely related to the aspirations of UHC (universal coverage of good quality services, and absence of financial hardship). This review has shown that in the first decade of implementing decentralisation, some achievements were made; however, these achievements were not sustained. It is particularly notable that decentralisation in its present form is not facilitating effective community involvement and ownership. A robust health system is required for the achievement of UHC, which decentralisation and the PHC approach are well suited to support. There is an emerging disconnect between the decentralisation reform as it has been implemented in the recent past and the ideals of decentralisation policy and related outcomes. The multi-sectoral emphasis highlighted by the SDGs further makes it desirable to strengthen governance at the levels closest to communities to facilitate synergies in the different sectors. Substantial political, economic, social and technical investments have been made by the country with regard to the decentralisation reform. However, currently it is not functioning optimally. It is necessary, therefore, to reconsider the decentralisation reform in the Ugandan context, to facilitate optimal contribution to the achievement of UHC.

Conclusions and recommendations: harnessing decentralisation for the achievement of universal health coverage

Uganda's decentralisation model is one of the most radical in LMICs. The model of decentralisation chosen by Uganda is devolution, with government at the national, district and sub-county levels (and their urban counterparts). Uganda's decentralisation model is across the government, inclusive of the health sector. The implementation of decentralisation over the last 20 years provides a wealth of experiences, and an opportunity for Uganda and other countries to learn from it for the future. Combination of concepts from both health systems research and socio-political organisation were used to provide a critical analysis of the effect of decentralisation on Uganda's health system.

The analysis has shown that substantial efforts were made in terms of the legal, policy and institutional framework, as well as the provision of resources and building the capacity for decentralised governance at the generic and health system levels. However, the extent to which the implementation of decentralisation achieved health system objectives was noted to be less than expected, with earlier achievements not sustained in the more recent past. A number of factors that may have contributed to this phenomenon include: the limited form of fiscal decentralisation with the resulting minimal decision-space at the LGs; a marked increase in the number of LGs; a mismatch of power and responsibilities at the national, DP and LG levels; inadequate resources; inadequate capacity at all levels for decentralisation governance, including the community level.

UHC has been indicated as Uganda's health system goal. To achieve UHC, there is need to build strong health systems. Decentralised health system governance and the PHC approach have been recommended for the achievement of UHC. It is necessary to make adjustments in the decentralisation reform to the Ugandan context so as to leverage the potential benefits to the health system. A number of recommendations are made here for this purpose.

a) At the national level, the recommendations deal with generic/cross-cutting issues. A comprehensive review of the decentralisation reform should be carried out to support the development of a coherent and comprehensive proposal for the redesign/adjustment of the reform in the country. The review should make use of currently available information and, where not available, seek primary information. The review should specifically consider:

    - the model of decentralisation, devolution, and the extent of fiscal decentralisation and the decision-space available to the LGs;
    - the need for an intermediate form of management/administration, between national and district levels, to support the implementation of decentralisation;
    - a plan for continuous capacity-building and stakeholder engagement for the effective redesign and implementation of decentralisation at all levels, including the communities;

b) Similarly, a comprehensive review is required at the level of the health system. This review should be linked to the generic review of decentralisation, and a broader health system reform. The mid-term review of the HSDP due in mid-2018 provides a good opportunity for this. Information for the review should include the analysis provided by the chapter and several other analyses; and new information should be sought where necessary. Some of the issues that should be incorporated into this review include:

- a number of strategies including: the HSD strategy; the regional level in the health system; and the alignment of health system and LG management structures, including VHTs and CHEWs.
- the resourcing framework for decentralised health governance including: the optimal balance between national and LG roles and responsibilities; the appropriate decision-space required at LG level for ownership and accountability; the appropriate roles for the CG, LGs and LLGs for the management of the NHIS and RBF; actions to improve health worker numbers, skills, performance management, motivation and retention in LG health systems; the appropriate management of EMHS, given decentralised governance. With improvements in the economy, there are more resources in the private health sector. The role of the LGs in relation to this should be reviewed.
- explicit agreement on the sector's approach to capacity-building for decentralised health governance. Issues to consider: community participation and empowerment for health; comprehensive and sustained capacity-building for LG health system priority-setting; financial responsibilities; efficient use of available resources; as well as skills for harnessing the political and socio-economic opportunities that are present in the LG health system governance.
- multi-sectoral approaches to health system development, which includes working with donor organisations, NGOs and CSOs, as well as the private sector. This will be important to ensure the implementation of the recommendations above.

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