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# Consensus and contention in the priority setting process: examining the health sector in Uganda

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## Abstract

Health priority setting is a critical and contentious issue in low-income countries because of the high burden of disease relative to the limited resource envelope. Many sophisticated quantitative tools and policy frameworks have been developed to promote transparent priority setting processes and allocative efficiency. However, low-income countries frequently lack effective governance systems or implementation capacity, so high-level priorities are not determined through evidence-based decision-making processes. This study uses qualitative research methods to explore how key actors' priorities differ in low-income countries, using Uganda as a case study. Human resources for health, disease prevention and family planning emerge as the common priorities among actors in the health sector (although the last of these is particularly emphasized by international agencies) because of their contribution to the long-term sustainability of health-care provision. Financing health-care services is the most disputed issue. Participants from the Ugandan Ministry of Health preferentially sought to increase net health expenditure and government ownership of the health sector, while non-state actors prioritized improving the efficiency of resource use. Ultimately it is apparent that the power to influence national health outcomes lies with only a handful of decision-makers within key institutions in the health sector, such as the Ministries of Health, the largest bilateral donors and the multilateral development agencies. These power relations reinforce the need for ongoing research into the paradigms and strategic interests of these actors.

## Keywords

Priority setting, development assistance, aid modalities, disease prevention, human resources for health, Uganda, health system strengthening

## Key messages

- There is a strong consensus on the need to prioritize human resources for health, disease prevention and family planning in order to improve the sustainability of the health system, but these priorities are not manifested in resource allocation because of political and financial pressures.
- The allocation of bilateral health development assistance often strongly reflects the interests of bilateral agencies, rather than the priorities identified in partnership with government and health-care providers in the recipient country.
- Government officials' prioritization of expanding the resource envelope conflicts with most other health actors prioritization of improving governance and efficiency, leading international actors to preferentially use project-based financing instead of the government-preferred budget support mechanisms. This has particularly been true for multilateral agencies.

## Introduction

In most public health systems, but especially in low-income countries, prevention and treatment of all health problems in accordance with the best medical knowledge is not possible. These countries have limited resources, requiring decision-makers to choose among alternative health-care goods and services. This creates a need for priority setting ([Kapiriri and Norheim 2004](#)).

Priority setting in public health involves developing normative and technical rules to determine what health-care package is offered by the state ([Tragakes and Vienonen 1998](#); [Mitton et al. 2004](#); [Glassman et al. 2012b](#)). Criteria for priority setting could include 'benefit, evidence, cost, efficiency, equity, equality, benefit to a country's economy, prevalence of disease, solidarity, protection of the vulnerable, and more' ([Tomlinson et al. 2011](#), p. 21). Each decision-maker could therefore potentially propose and justify a different minimum health-care package according to their individual and institutional priorities. They may also consider the political costs of including or excluding particular goods and services. Priority setting is consequently a controversial, negotiated process rather than derived from a systematic or technical approach ([Glassman et al. 2012b](#)). This is particularly true in low-income countries, which face a heavy disease burden, comparatively smaller resource envelopes and a lack of strong governance processes, relevant expertise or effective service delivery

systems (Samb et al. 2010). Governments may therefore lack both the will and capacity to prioritize meaningfully.

This problem is exemplified by Uganda's National Minimum Health-care Package (UNMHCP). The UNMHCP had an estimated per capita cost of US\$47.9 in financial year (FY) 2011, but government expenditure of less than US\$12 per capita is projected until 2015. Official development assistance provides a substantial additional contribution, but there remains a deficit of over US\$20 per capita projected for 2010/11–2014/15 (Ministry of Health 2010a). Under these circumstances, ineffective priority setting leads to opaque resource allocation processes among programmes or arbitrary rationing within programmes rather than informed choices among health services (Sengooba 2004).

Inadequate public funding and implementation capacity often introduce non-state actors into health provision in low-income countries. Returning to the example of Uganda, the government contributed 14.4% of public health expenditure in 2010 while development assistance provided 35.6% (private households met the shortfall) (Ministry of Health 2010b; Okwero et al. 2010). While health development assistance has a demonstrably positive impact (You et al. 2011), intervention by foreign actors in key social services raises concerns that different interests among donors and recipients are manifested in priority setting and subsequent resource allocation (Glassman et al. 2012b). Kipiriri (2012) has consequently sought to stimulate debate about the roles and legitimacy of official development agencies in national priority setting processes.

Quantitative economics can provide a scientific basis to improve allocative efficiency and protect against arbitrary priorities driven by advocacy or vested interests. However, it is not necessarily enough to address procedural and governance failures in the high-level priority setting stages. For this reason, Kipiriri among other authors calls for qualitative primary research to explore the influence of decision-makers' political, institutional and environmental contexts on the high-level priority setting process (see also Jan 2003; Hauck et al. 2004; Williams et al. 2007; Smith et al. 2008).

Uganda's health-care system was the envy of Africa in the 1960s. However, civil war, rampant corruption and economic decline meant that the public health budget in 1986 was only 6.4% of 1970 levels (Okunzi and MacRae 1995; McPake et al. 1999). While health indicators for Uganda have seen modest improvements over recent decades, health-care quality and access remain very poor on average and the total health envelope is increasingly stretched by the high population growth rate (Ministry of Health 2010a). The heavy burden on infant, child and adolescent health care and steep rise in non-communicable diseases (NCDs) mean that Uganda, like many other low-income countries, is facing an 'increasingly diverse and complicated epidemiological profile' (Jamison et al. 2006, p. xvii). These challenges are

borne by a health system that is notorious for leakage, misappropriation of funds, absenteeism and informal charges (Ministry of Health 2010b; Government of Uganda 2010; Tabaire and Okao 2010).

The second Health Sector Strategic and Investment Plan (HSSIP) (Ministry of Health 2005) sought to establish the architecture for more open and inclusive priority setting processes. However, even with development assistance, the health budget has consistently been below the level required to fund the proposed health-care package. This disparity between health funding and planned expenditure has been widely observed across sub-Saharan Africa (Jenniskens et al. 2012) and suggests that decision-makers consistently do not work within established budgets. This phenomenon has not been thoroughly explained in the literature, nor has there been adequate primary research on the resulting informal round of priority setting that too often lacks transparency and inclusivity (Kapiriri 2012).

The Ministry of Health is not explicit about which of the priorities identified in the HSSIPs it will actually fund, while development assistance is frequently earmarked according to donor interests (Okwero et al. 2010). There is therefore a need to ground academic debates about the legitimacy of priority setting processes with evidence about how stakeholders' health priorities differ and the implications for resource allocation. This article describes the results of research designed to meet this challenge. It explores how key actors' priorities align and differ in low-income countries and the extent to which these differences are manifested in the allocation of development assistance, extending Kapiriri's use of Uganda's health sector as a case study.

## Methods

The first part of this study analyses secondary data on health expenditure by development agencies. Health development partners were identified from the Uganda Joint Assistance Strategy (2005) and the HSSIP II and III (Ministry of Health 2005; 2010a). Health expenditure categories and data were derived from country strategy documents (DFID 2011; Danida 2007; European Community 2007; Irish Aid 2007; 2010; SIDA 2012; UJAS 2005; UNFPA 2006; 2010; UNICEF 2006; 2010; World Bank 2010), development assistance overviews or reviews (BTC 2011; Bugnion et al. 2009; Danida 2012; JICA 2008; GFATM 2012; Norad 2012), foreign aid budgets (US Department of State 2008–2012) and project reports (Ba 2007; Kuruneru 2011; UNDP 2012; World Bank 2007–2008). Where there were discrepancies among figures, historical records were preferred to planned expenditure, published data were preferred to interview transcripts and information from the Annual Health Sector Performance Report (Ministry of Health 2011) was preferred to development agency reports. All figures

were converted into US dollars (USD) using the mean midpoint exchange rate for the past five years (2007–2011) ([Olssen & Associates 2012](#)).

Development assistance channelled through multilateral organizations has been presented independently of bilateral aid to avoid double counting and permit a comparison of their resource allocation. Sector budget support was included for Belgium and Sweden, as data were publicly available. Water, sanitation and hygiene (WASH) funding was excluded from this study because of ambiguity regarding its intersection with non-health infrastructure expenditure.

A comparison with the Ministry of Health's resource allocation was not possible because of the different categories used to track public expenditure.

The primary research in this study moves the literature beyond a theoretical discussion of power dynamics in priority setting processes by identifying commonalities and divergences among decision-makers in the health sector. This article used qualitative methods to explore how key stakeholders' priorities differ, and the scientific, economic and political factors shaping these differences. This research is of particular relevance in countries where priority setting and resource allocation in the health system is determined by a small group of elites. Their influence in these contexts is based on formal responsibility to allocate resources and informal advantages derived from a superior education, socio-political network and/or capacity to mobilize resources ([Harvey 2011](#)). Elite studies demand different methodological tactics to non-elite research. For example, obtaining an adequate number of interviews through random sampling is not viable when the potential pool of participants is small: in this study, an interview was requested with almost the entire population. The small pool of relevant organizations in Uganda was identified during the collection of quantitative data. Each organization was contacted by email to request an interview with appropriate representatives.

Semi-structured interviews were used with open-ended, non-testing questions. This method was adopted to allow participants to explain their prioritization and elaborate on the political and organizational context. One consequence of this approach was that participants, as experts in their field, tended to dictate the conversational subject or challenge the way the questions were framed, a common challenge when interviewing elites ([Aberbach and Rockman 2002](#); [Stephens 2007](#)). However, the key points that were addressed throughout the course of each meeting were the following:

1. What health issues are your organization/department working on?
2. What do you personally regard as the biggest disease threats in Uganda?

3. What do you consider to be the biggest challenges facing the health sector? Why?
4. What differences, if any, have you observed between the priorities of domestic health policymakers and development agencies? What do you believe explains these/any differences?
5. Do you believe that international development agencies significantly influence domestic health policymaking in Uganda? How?

Interviews ranged in duration from 20 to 95min, and were recorded and transcribed. The transcripts were evaluated using a conventional approach to content analysis as defined by [Hsieh and Shannon \(2005\)](#). The data were coded using words and phrases that recurred throughout the interviews and effectively captured key ideas. The transcripts were repeatedly re-read to sort the codes according to the way the participants themselves related and appraised labels and concepts.

## Results

The quantitative analysis of resource allocation revealed that over 70% of bilateral health development assistance in Uganda is committed to communicable diseases ([Figure 1](#)). An absolute majority goes to HIV/AIDS, both because it attracts the largest number of bilateral donors and because it is prioritized by the largest bilateral donor, the USA. A further 15% is committed to maternal health and family planning, leaving very little bilateral funding for other issues identified in the HSSIP.

Resources from multilateral agencies averaged around 18% of official health development assistance in Uganda during FY2008-2011, although their contribution is growing rapidly in both net and proportionate terms. The main trend over the past five years is multilateral agencies' shift away from expenditure on communicable diseases towards health system strengthening, family planning and infrastructure projects ([Figure 2](#)). This is driven by a few large projects, such as a grant for health system strengthening from the World Bank and an infrastructure project led by the African Development Bank.

**Figure 1 The allocation of development assistance within the health sector by bilateral agencies as net resources (top) and as a proportion of health development assistance (bottom). These trends are overwhelming driven by the resource allocation decisions of the largest bilateral donor, the United States.**

**Figure 2 The allocation of development assistance within the health sector by multilateral agencies as net resources (top) and as a proportion of health development assistance**

(bottom). Data were drawn from historical rather than planned expenditure, so only figures until the end of FY2011 have been used in order to avoid discrepancies.

There was an adequate response from multilateral development agencies (75%), private not-for-profit health-care providers (PNFPs) (100%), bilateral development agencies (56%) and the Ministry of Health (32%). The low response rate from the ministry was partially because many candidates did not respond to emails and partially because, rather than be interviewed themselves, several candidates provided introductions to senior staff with more participation in the priority setting process. Not-for-profit organizations had to be excluded from the study altogether because 88% did not respond or had a 'no interview' policy.

Interviews were obtained with 16 people:

1. n = 3 bilateral agencies. The health experts or team leaders from the Belgian Cooperative Agency (BTC), UK's Department for International Development (DFID) and the Swedish International Development Cooperation Agency (SIDA);
2. n = 5 multilateral agencies. The directors or health advisors from the European Commission for Humanitarian Aid (ECHO), United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA) and the World Bank;
3. n = 3 PNFPs. Upper management from the Uganda Catholic Medical Bureau (UCMB), the Uganda Muslim Medical Bureau (UMMB) and the Uganda Protestant Medical Bureau (UPMB); and
4. n = 5 bureaucrats from the Ministry of Health including two Commissioners, two Programme Managers and a Senior Planner.

### *Prioritizing health system strengthening*

The interviews revealed that participants shared a long-term commitment to strengthening the health system and addressing the socio-economic determinants of health. This was evident in both the major concerns identified by participants (Figure 3) and the responses that they proposed issues that they identified as most urgently requiring additional attention or support (Figure 4): disease prevention, human resources for health (HRH) and family planning. While recognizing the high burden of disease, most participants were willing to divert resources from disease treatment or infrastructure spending in order to improve the sustainability of the health system.

The economic arguments in favour of large-scale investment in addressing these long-term issues were succinctly summarized by one participant, in this case with particular reference to family planning:



*If we were to address the issue of unplanned pregnancy, then there would be a net saving of \$112-120 million a year from averting the costs of pregnancy, Caesareans, unsafe abortions, whatever. So that would be a net saving, if you like, it could be...about a quarter of the health budget. And to really put the focus much more on the prevention side and look at family planning as part of prevention. And with all the associated health in terms of maternal health, fistula, avoiding fistula and the like...And then, with this opportunity goes not only the savings that we were talking about, but also it enables women to have choice, to fulfil their lives in other opportunities . . . It's socio-economic, it's about women's empowerment, women's status and human rights.*

**Figure 3 The most significant challenges facing the health sector as identified by participants.**

The arguments favouring greater prioritization of disease prevention were similar: prevention is generally cheaper than treatment, easier to implement in a challenging operating environment and avoids the socio-economic costs of illness.

The HRH 'crisis' in Uganda was clearly illustrated by the following anecdote:

*There's this wonderful story where the Minister of Health at this time went to West Nile, and he was going to visit a health centre, Health Centre III, one morning. And he gets to the health centre at 10:30 one morning and it was closed, so he got furious and asked "How could this be?" And they explained that the person who was in charge had not shown up yet. And he was furious, people sitting outside waiting and sick and so on, and eventually the officer in charge shows up in his little Toyota Corolla. The Minister blasts him and orders his security attach'e to arrest him and the officer says, "Oh, I am so sorry Minister, but my mother fell ill last night." Oh, okay, so there were mitigating factors. And the officer continues, "So I had to rush her to the witchdoctor down the road." . . . It exemplifies very well this dichotomy where you have a qualified health officer who prescribes malaria treatment, but when it comes to his own mother, he rushes her to a witchdoctor.*

An overwhelming majority of participants emphasized the importance of improving the retention and motivation of health workers in order to strengthen the health system. Participants identified a range of factors contributing to the current HRH crisis including poor management, a lack of political interest at an executive level, low salaries combined with limited

fiscal space to increase wages and—where health workers are present—a lack of infrastructure, equipment or medicines for them to fulfil their role. However, unlike the discussion around disease prevention and family planning, there was no consensus on whether additional resources would improve HRH in Uganda. Participants from the Ministry of Health were inclined to focus on increased wages as a cornerstone of their HRH strategy (e.g. [Ministry of Health 2010a](#)), while other actors in the health sector typically regarded this as a supplementary measure because of the ineffectiveness of past salary increases and lack of long-term fiscal space for additional funding. Non-government actors instead expressed concerns mainly about management and accountability of health workers. Representatives of PNFs in particular focused on the potential of non-financial solutions: these organizations match public sector salaries, but have substantially reduced absenteeism and turnover rates through non-financial incentives and improved management. One participant illustrated this dichotomy succinctly:

*Particularly for us in development health, one side of it is economic incentives and the other side of it is some people have chosen health in the public sector because they want to do something, they care about people. And the government does a disservice to both of those. Neither [does] it pays a lot nor is it talking about technical or emotional satisfaction. So in general . . . how the health institution treats health people, that's not something the government does a good job of.*

In principle, therefore, there was a strong consensus among participants that disease prevention, family planning and HRH should be prioritized. In practice, financial and political pressures often appeared to constrain successful implementation. Many actors (including representatives of the Ministry of Health) felt that meaningfully addressing HRH or large-scale disease prevention was beyond the scope of their organization without external support. This led them to prioritize immediate health-care pressures, as evident with the high level of expenditure on treatment of communicable diseases in [Figure 1](#).

Political considerations similarly emerged as a challenge. For example, several commented on the difficulty of accommodating bilateral partners' need for attribution, as illustrated by this quote:

*In the bilaterals . . . home country priorities shape priorities in-country despite the evidence. I'll give an example . . . If you say, we will ensure 500000 children successfully delivered in Africa, that's a promise. That's something a British citizen will understand. They will not understand the system issues in health, like making the private–public partnership work. In a way, the things that require changing the system are not*

*getting enough attention because they are not a priority you may say when you are campaigning.*

Participants from every stakeholder group observed that the most significant discrepancies in prioritization occurred between the Ministry of Health and other branches of government, rather than within the health sector itself. The influence of the political executive over the priority setting process was of particular concern to international actors, who cited the formal prioritization of election promises over established programmes in the annual health budget as an example of political rather than evidence-based priority setting.

### *Contentious financing*

Of the 16 participants, 12 identified funding as one of the most critical concerns (Figure 4). There was a marked divide, however, between those who focused on improving efficiency and those who focused on increasing resources as a means to redress this problem. The former outlined the need to reduce corruption and leakage because a more efficient health sector would not need as many additional resources and would attract more funding. The latter proposed a range of strategies including restoration of user fees, community-based health insurance and performance- or output-based aid. Significantly, the Ministry of Health officials comprised 80% of respondents who identified lack of resources, but not inefficient use of resources, as a problem. The Ministry of Health formally acknowledges that the problems financing the UNMHCP reflect both resource shortfalls and inefficiencies (Ministry of Health 2010a; 2010b). In practice, however, those government officials interviewed seemed to be either less conscious of (or more sensitive about) resource misuse and misallocation, and therefore focused on gaining additional funds. This suggests that Ministry of Health officials prioritize achieving an expanded health package rather than addressing inefficiencies in the system.

Concerns over inefficient resource use underpinned a strong debate over aid modalities. Some participants (particularly from the Ministry of Health) advocated for an expansion of budget support mechanisms while others doubted the absorption capacity of the public health system and endorsed project-based funding in its place. Participants justified development partners' reluctance to use budget support mechanisms by their experience of low absorption capacity, budget displacement and a growing disparity between government policies and their own priorities. Certainly, recent evidence suggests that ongoing corruption and inadequate HRH in the public system affect the quality and efficiency of health-care delivery (Bouchard et al. 2012; Conrad et al. 2012). However, as one participant outlined:

*In the short term, [project-based funding] definitely may be beneficial. However, it then doesn't build up capacity or strengthen the system, which really needs to be done if you are building the system to give better health care rather than trying to do direct service delivery . . . There's a huge general argument there. The more and more you bypass the Treasury and the government financing system in the hope that you can be more efficient, they will become more and more inefficient because you're bypassing it, just because you are delivering their contribution, so you are making them redundant.*

The prioritization of district health-care strengthening and expanding private health-care options (Figure 4) reflects two ways to reconcile these approaches. Both provide a way to feed development assistance directly into health system without bearing the costs of inefficiency at the national level, revealing a belief that private and district health service providers are more efficient and accountable than the national public system. These strategies were recommended primarily by representatives of PNFPs and development agencies.

## Discussion

Donors and recipients in low-income countries are working with complex social conditions, under severe resource constraints and amid diverse politico-economic interests. Where these actors have different priorities, we can assume that they are all first and foremost committed to improving public health. However, prioritization is also likely to reflect individual or institutional interests (Smith et al. 2008), so the technical grounds for alternative health policies and resource allocation— cost-effectiveness, disability-adjusted life years (DALYs), burden of disease, etc.—are only a part of the priority setting equation.

Official health development assistance to Uganda clearly falls within the priority interventions (clusters) and areas of investment listed in the HSSIPs (Ministry of Health 2005, 2010a). However, results described in this article highlight that bilateral health development assistance in Uganda is skewed towards international agendas such as the Millennium Development Goals, a finding consistent with the experience of other low-income countries (Shiffman 2006; Jenniskens et al. 2012).

There are two ways to understand the allocation of bilateral health development assistance. The formal health targets are unrealistic relative to the resource envelope, so the government could be criticized for its reluctance or inability to prioritize in accordance with the available funding. This analysis suggests that prioritization within budget constraints would

allow the government greater determination over the allocation of development assistance. More clearly prioritizing health education over HIV/AIDS treatment, for example, would compel development agencies to re-distribute funds towards this area. Alternatively, the overly ambitious health targets could be seen as a strategy to maximize health development assistance, since prospective partners can provide aid wherever they have an interest and can offer comparative advantage. There is no further prioritization because all international support for the health sector is regarded as a boon. Whichever interpretation might more accurately explain the trends in bilateral actors' resource allocation, it is apparent that development partners significantly shape health priorities in low-income countries like Uganda.

While bilateral development assistance corresponds to the 'priority interventions' in the current HSSIP, the multilateral agencies' expenditure on HRH, infrastructure and information systems conforms to the 'areas for investment' ([Ministry of Health 2010a](#)). This implies that multilateral agencies have aligned their funding much more closely with the government's desired pattern of resource allocation than their bilateral counterparts. On the other hand, until very recently multilateral agencies have made less effort to align with the government's preferences for budget support aid modalities than bilateral actors.

There has been a strong push over the past two decades to promote aid coordination, from the Paris Declaration on Aid Effectiveness and International Health Partnership Global Compact to the implementation of Sector-Wide Approaches (SWAPs) ([Balabanova et al. 2010](#)). Aid coordination is intended to integrate improved health services into the public system and to reduce transaction costs associated with duplicated efforts ([House of Commons 2008](#); [WHO 2009](#)). The process is typically though not invariably associated with budget support or basket funding mechanisms, which are widely viewed as the most sustainable and appropriate aid modalities to improve public health (where the recipient government demonstrates adequate stewardship) ([Balabanova et al. 2010](#); [Kipiriri 2012](#)).

Only bilateral European donors and the World Bank proved willing to adopt budget support aid modalities in Uganda's health sector during the 2000s ([UJAS 2005](#)), and even these organizations have largely reverted to project financing over recent years ([BTC 2011](#); [DFID 2011](#); [SIDA 2012](#)). The European bilateral development agencies deserve credit for pioneering these aid modalities, but it seems likely that multilateral agencies will have better success with budget support modalities as they have the geopolitical and financial might to advocate more effectively for improved governance and resource efficiency.

The dispute over aid modalities reflects a more fundamental divide over financing health care in Uganda: greater resource efficiency or additional resources? In practice, both perspectives have an element of truth: there is certainly more room for efficiency gains ([Okwero et al. 2010](#)), but the funding shortfalls are also real and require increased financial outlays. There was generally agreement, however, that the Ministry of Finance should meet the targets laid out in the Abuja Declaration by committing 15% of its budget to the health sector [current health expenditure remains just below 10% ([Government of Uganda 2010](#))].

Although funding shortfalls and low absorption capacity pose a significant challenge to health service delivery, three areas emerged as particularly urgent priorities because of their capacity to reduce long-term stresses on the health system: HRH, family planning and disease prevention.

HRH pose a challenge across the developing world due to the low number of health workers being trained relative to the disease burden; migration of health workers from rural to urban regions and from developing to developed countries; and chronic absenteeism and poor retention of qualified staff due to low salaries, poor management and difficult working conditions ([WHO 2010a, b, 2011](#)). New evidence suggests that the practices of major donors may actually exacerbate these problems due to the lack of long-term planning surrounding remuneration and training ([Vujicic et al. 2012](#)). However, the universal prioritization of HRH in this study reflects a widespread commitment to health system strengthening among policymakers, health-care providers and donors.

Responses to the HRH crisis in low-income countries have been studied extensively (e.g. [Chen et al. 2004](#); [Naicker et al. 2009](#)). Non-financial solutions, such as offering health workers clear career development paths or imposing compulsory rural placements on health qualifications, have been successfully demonstrated in Ghana and Malawi ([Palmer 2006](#); [WHO and GHWA 2008](#)), and recent research from Uganda confirms that both financial and non-financial incentives have the potential to improve HRH retention ([Rockers et al. 2012](#)). However, the success of Ghana and Malawi is widely accredited to strong executive support ([Palmer 2006](#); [WHO and GHWA 2008](#)), and participants emphasized that engaging presidential support will be essential to ensure the effective implementation of HRH strategies in a Ugandan context.

Expanding access to family planning was primarily emphasized by participants from development agencies. There is growing global evidence to support their arguments that family planning is one of the most cost-effective and popularly supported mechanisms to achieve diverse social, economic and environmental goals (e.g. [Smith et al. 2009](#); [Tsui et al. 2010](#); [Speidel and Grossman 2011](#); [Canning and Schultz 2012](#)). Family planning offers immense potential benefits in terms of improved infrastructure,

social services and economic productivity per capita, and consequently a healthier and more educated population. More generally, the demographic bonus or 'window of opportunity' created by reducing the dependency ratio is often credited with the transition from low- to middle- income countries ([Bongaarts and Sinding 2011](#)). Yet a number of participants reported that formal government support for family planning is undermined by the lack of resources and pro-population messages at an executive level. With presidential support, this study suggests that family planning could serve as a flagship for preventative health care and aid co-ordination in Uganda. Allocating more resources to this issue would arguably signal a government commitment to sustainability, gender equality and human rights, and thereby attract additional development assistance through the government's preferred aid modalities.

The topic of disease prevention proved more controversial. While many actors in the health sector expressed concerns over lack of expenditure on disease prevention, they were reluctant to acknowledge that most of this spending would fall outside the traditional health budget. Currently the Ugandan government has prioritized investment in agricultural productivity and water, transport and energy infrastructure ([Government of Uganda 2010](#)). These areas are critical to improving health through prevention: clean water and improved nutrition reduce exposure and vulnerability to disease, while energy consumption is one of the biggest predictors of socio-economic development ([Martinez and Ebenhack 2008](#)). In other words, the government is to some extent addressing the environmental and socio-economic determinants of health, albeit through a vehicle other than the traditional health sector. While there is scope to redirect additional resources from treatment to prevention and the social determinants of health, there are also grounds to argue that a multi-sectoral approach to health should be more widely acknowledged within the traditional health sector.

Discussing the extent to which resource allocation should conform to development agencies' priorities begs a critical question: to what extent can different actors influence health priorities in low-income countries such as Uganda?

In most low-income countries, the power to influence the public health agenda and outcomes lies with only a handful of decision-makers. The largest channels of health assistance are US Agency for International Development (USAID), the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI) Alliance and the United Nations ([IHME 2012](#)). While much more generous per capita, other European health donors' collective contribution proves only a small proportion of official development assistance ([IHME 2012](#)) and their influence is proportionately less. The capacity to mobilize and withdraw funds in resource-constrained

environments creates unequal power relations in low-income countries. The promise of aid allows international donors to influence governments' priorities, and even to shape their institutions and policies (Daniels et al. 2000; P'erin and Attaran 2003, Jenniskens et al. 2012). It is worth noting here that smaller donors' contribution to multilateral organizations such as the United Nations, GFATM and GAVI provides a significant potential channel of influence, but adds further opacity to the priority setting process.

The fragmented nature of development assistance and widespread use of project-based modalities in low-income countries demands strong policy frameworks and institutional mechanisms to ensure a consultative, evidence-based approach to priority setting. Even this statement entails an assumption—questioned by Kipiriri (2012)—that donor organizations are entitled to a say over the way in which development assistance is allocated. Certainly, current political realities require that governments in low-income countries that wish to increase the proportion of health development assistance channelled through their national budgets must respond effectively to donors' priorities in terms of both allocation and efficiency. This reinforces the need for ongoing research into the paradigms and strategic interests of these actors, as well as the establishment of strong institutional mechanisms to ensure accountability and transparency in the priority setting process.

## Conclusion

This case study reveals that health development assistance in Uganda continues to be allocated according to individual and international priorities, typically disease-specific targets rather than the broader health system strengthening envisioned in the national HSSIP. This research also illuminates profound disagreements among decision-makers with respect to financing health care in Uganda. Government officials tended to focus on increasing net health expenditure and advocate for budget support mechanisms; representatives of development agencies typically prioritized increasing resource efficiency and improving governance, if necessary through adopting project-based aid modalities. Large-scale multilateral support for health system strengthening may be the most effective response to this deadlock, as these agencies have the political and financial weight to demand accountability and deliver change at scale.

Despite the contention over financing, there was a strong consensus on the need to prioritize HRH, family planning and disease prevention, all of which generate disproportionately high returns to the public health-care system. Participants indicated that meaningful prioritization will require both preferentially allocating resources to these issues and effectively engaging the largest donors and political executive. Despite scarce resource and



ongoing concerns over governance, this may allow actors in the health sector to more effectively deliver public health improvements and sustainably strengthen the public health system in low-income countries.

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