



ESID Briefing No. 21

Governing health care in Uganda: explaining the mixed record on delivering rural maternal health services

KEY FINDINGS:

- The quality of public health care in Uganda, including the delivery of maternal health services, is highly uneven; this is closely shaped by politics at the global, national and local levels.
- The channelling of vast amounts of money into the health sector through internationally funded projects has created several power centres and bred rivalries. This has left the Ministry of Health highly factionalised and less capable of delivering on its remit.
- For much of the past decade, the health sector has been governed for political ends rather than geared towards higher levels of performance.
- Capacity for supervision, inspection and enforcement of standards by central government is lacking; accountability at district level is therefore dependent on local monitoring and evaluation systems that are often too weak to improve levels of performance.
- Local politics also closely shapes service delivery at district level: the quality and motivations of local leaders and their capacity to collaborate have a significant influence on the quality of service delivery.
- The highest levels of performance are driven by developmental coalitions with the capacity and commitment to devise and enforce innovative approaches to governing the sector

Table 1: Uganda's progress towards MDG 5 compared to Rwanda and Tanzania

	Uganda	Tanzania	Kenya
MMR target by 2015	195	350	227.5
Actual MMR in 2013	360	320	410
% change in MMR between 1990 and 2013	-53	-76	-55
Average annual % change in MMR 1990-2013	-3.2	-6.1	-3.5
Progress towards improving maternal health	Making progress	On track	Making progress

Source: WHO, UNICEF, UNFPA and World Bank estimates. Trends in maternal mortality: 1990-2013.

INTRODUCTION

Uganda's ruling party, the National Resistance Movement (NRM), came to power with a 'Ten-Point Plan'. This outlined clear and specific ideas about what was needed to improve service delivery, and the role the public would play in achieving this objective and wider ambitions. Government made some important advances in the health sector, particularly in terms of reducing the level of HIV-AIDS prevalence and improving the accessibility of primary health care centres for rural citizens.

In recent years, however, the imperative of maintaining power seems to have distracted politicians at national and local levels from building a more effective health service that can deliver high-quality provision. This problem is particularly evident in terms of providing for maternal and child health, with Uganda recording slower rates of progress than some of its counterparts towards key policy goals, such as the MDG 5 target to reduce the maternal mortality ratio (MMR) by three-quarters by 2015.

Maternal and child health conditions account for over 20 percent of the total disease burden in Uganda. The persistent poor maternal health outcomes stem from poor quality provision and low utilisation of health services at all stages. Despite having a roadmap for accelerating reduction in maternal morbidity and mortality, after nearly five years of implementing this plan, the successes have been modest. There are many bottlenecks in the system: limited availability of medicines and supplies, poor coordination, poor infrastructure, shortage of financial and human resources, and resistance at the household level to recommended practices. Other challenges include logistical problems of poorly maintained roads, and lack of amenities.

As with all social services, responsibility for delivering maternal health services was decentralised, following the 1997 Local Government Act. This mandated district local governments to plan, budget and implement health policies and health sector plans. The severity of constraints to service delivery varies from one district to another and is influenced by local-level political dynamics and how districts relate to national-level political institutions.

Our research traces the changing politics of the health sector in Uganda over the past two decades. It focuses first on the national level and then on a comparative case study of government performance in two districts in Uganda: Sembabule, which has a weak health infrastructure and poor performance indicators; and Lyantonde, which has a relatively well developed and maintained health infrastructure and better maternal health indicators. Given that the districts neighbour each other and are similar in many other respects, we argue that the best explanation for their divergent performances in providing health services flows from the ways in which politics and governance work in each district.

FINDINGS

There is nothing to suggest that government policies, especially in the health arena, are not technically sound. However, the picture that emerges from Lyantonde and Sembabule is one of significant differences in policy outcomes. Our evidence suggests that this

divergence is closely related to the ways in which national-level politics and governance have changed in Uganda over the past two decades and how this has shaped health sector performance at both national and local levels. In particular, we suggest that Uganda's changing political settlement has undermined the democratic dividend that some expected to emerge from the return of multi-party politics.

Up until the early 2000s, Uganda's health policy was coherent, donor fragmentation was minimal, and budgeting was closely tied to results. At this time, technocrats were driving the process and the Ministry of Health (MoH) enjoyed strong political leadership. However, since 2001 the Ministry has lacked stable leadership, with new ministers every electoral cycle and an absence of continuity and an overarching developmental vision in the top bureaucratic posts. In addition, presidential advisors and ruling-party cadres have been appointed to management positions within the health sector. This, along with the plethora of development agencies operating within the sector, has left the Ministry highly factionalised and with little sense of collective ownership over, or commitment to, key policies or initiatives.

“Policy-making has tended to follow a populist rather than long-term logic”

This political context informs the ways that policies are made and delivered in the health sector. Policy-making has tended to follow a populist rather than long-term logic, as with the abolition of user fees in 2001, and the failure of political leaders to consult with top bureaucrats when devising policy responses.

Sensing a vacuum in leadership, donors have moved into the sector and been allowed considerable room for manoeuvre. Large amounts of foreign and technical assistance have poured in, and key respondents within the sector acknowledge the critical role of donor resources in enhancing the sector's delivery capacity.

There is, however, a strong view that donors wield too much influence on decision-making processes, leading to a distortion of priorities and the undermining of already weak systems. For example, the mid-2000s saw a shift away from sector-wide approaches and since then over 50% of development assistance for health has been off budget. Project funding increased dramatically through vertical global health initiatives such as the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Alliance for Vaccines and Immunisation (GAVI), from USD250 million in 2004 to USD500 million in 2006. The influence of global health initiatives has contributed to dysfunction in policy-making and implementation, as well as tensions and fights within the MoH. This has stemmed partly from donor proclivity for establishing new, often parallel, decision-making and implementation structures.

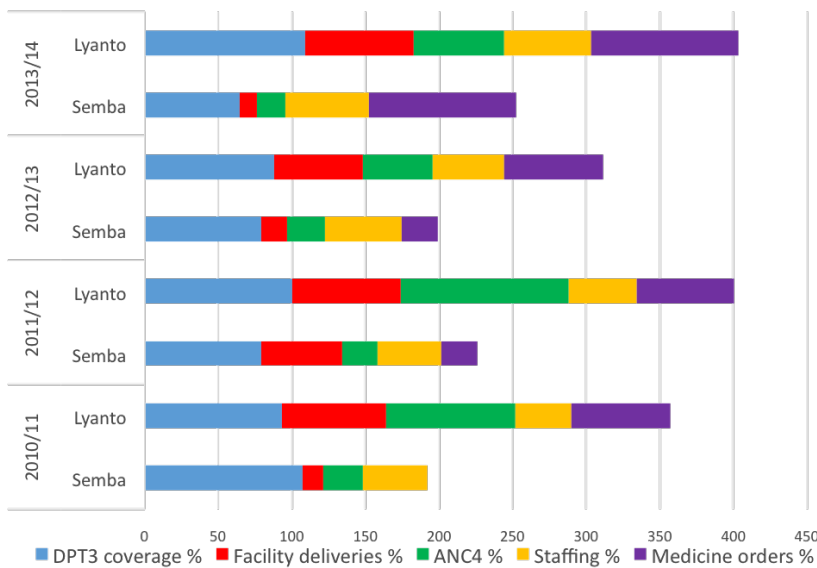
Figure 1: Maternal and child health outputs for Sembabule and Lyantonde 2010-14

Figure 1 indicates the comparative data from the two districts on maternal and child health outputs. The discrepancy is particularly stark for facility deliveries – 11.7% in Sembabule compared with 74.1% in Lyantonde in 2013/14 – and antenatal care – 61.5% in Lyantonde compared with 19.4% in Sembabule in the same year. This stark contrast is reflected in the league table positions of the two districts, with Lyantonde at number 4 while Sembabule was ranked number 107 in 2013-14.

At the sub-national level, donor-funded projects have made a tremendous contribution to efforts to improve service delivery, or even to extend it to remote areas that are otherwise under-served. However, government officials decry the skewed coverage that leaves some regions, especially Karamoja and Northern Uganda, under-served. Importantly, and as discussed in our comparative case study below, the national political context and dysfunctional governance arrangements within the health sector directly shape performance at the district level.

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Politics of failure: why things don't work in Sembabule

Reflecting the personalised character of patronage politics in Uganda, Sembabule's plight is directly shaped by a long-running rivalry between the two dominant local political actors, both of whom are strongly connected to the NRM chairman. This feud takes place over the terrain of district-level governance, with respective factions competing for control over local authority and resources.

Annual district budgets have been delayed, preventing the implementation of critical programmes. A standoff between the two factions over appointments prevented the establishment of the District Service Commission between 2006 and 2010, which meant that the district could not recruit, confirm, promote, discipline or retire staff. At the time of fieldwork, the district had no substantive district health officer, the previous one having left because of tensions with politicians. The feud has directly reduced performance levels within the civil service, as political figures shield individuals from being held to account and well-meaning technocrats lose trust in formal procedures and accountability mechanisms.

Politicians have sought to ensure that their constituencies benefit, regardless of level of need. Many citizens blame MPs for neglecting them and focusing disproportionately on politics and seeking to destroy their political opponents, while other service users decry their own failure as citizens to use the power of their votes to dislodge "unproductive" politicians.

Politics of success: why things work in Lyantonde

Unlike Sembabule, Lyantonde has a cohesive rather than factionalised district-level political settlement, which has helped drive up performance in all social services. At the centre of this success is a developmental coalition that is led by the district chairman, district councillors, national bureaucrats from the district and a proactive resident district commissioner (RDC); the two area MPs are also a positive force.

Spurred by the meagre resources that the district receives from the central government, and also a historical sense of feeling marginalised, the chairman and the RDC have mobilised financial and moral support from strategically positioned politicians, bureaucrats in government ministries, departments and agencies as well as members of the business community. There has also been a focus on community mobilisation, asking residents to contribute money to support health facilities, creating a strong foundation for community participation in health initiatives.

“Efforts have been made to cultivate a harmonious relationship between politicians and bureaucrats”

This developmental coalition also includes technical personnel and efforts have been made to cultivate a harmonious relationship between politicians and bureaucrats, with politicians working alongside health professionals once a month. The coalition has created the space for innovative solutions to be generated and enforced, including a mixture of top-down and bottom-up accountability mechanisms (e.g. data gathering, performance monitoring, toll-free complaint lines), capacity-building (e.g. staff training) resource mobilisation and cost-sharing initiatives. The district has thus attained a performance-enhancing equilibrium or 'win-win' context: health workers benefit from gaining the resources, support and direction to deliver the services to the best of their professional capacities, whilst elected leaders take the credit in terms of popular recognition.

These case studies help confirm that politics has a significant influence on service delivery in Uganda's health sector, both in terms of improving and undermining the quality of social provisioning. This suggests that building a more effective and accountable health service in Uganda constitutes a political as well as a technical challenge.

POLICY IMPLICATIONS

- Different configurations of politics and power at the district level create different conditions for service delivery in Uganda's health sector. A good understanding of political dynamics at district level is required for interventions to be relevant.
- Where developmental coalitions are in place, these should be nurtured and invested in: this includes supporting the role of politically-salient stakeholders as well as the capacity of bureaucratic actors. Where they are absent, steps could be taken to convene and support the emergence of such coalitions, including through reducing the costs of collective action and supporting forums through which dialogue and decision-making can take place.
- District-level differences suggest that one-size-fits-all solutions are unlikely to work well, and that an emphasis on supporting contextualised approaches to problem-solving is important.
- Inadequate allocation of resources from central government requires additional resource mobilisation from politicians, businesses and citizens, contributing to levels of buy-in.
- Centralised monitoring of health sector performance is generally weak and not transparent; major investments are needed to improve capacities in this area and to join up top-down accountability mechanisms with more bottom-up forms of accountability.

FURTHER READING

Bukenya, B. and Golooba-Mutebi, F. 'Political settlements and the delivery of maternal health services in rural Uganda'. *ESID Working Paper*. Manchester: The University of Manchester.

ABOUT THIS BRIEFING

This briefing was produced from an ESID project on the political economy of health service delivery, specifically maternal health, in Uganda. The research was conducted by Badru Bukenya (Makerere University) and Frederick Golooba-Mutebi (Independent Researcher and Honorary Research Fellow, University of Manchester). The briefing was drafted by Kate Pruce, adapted from an ESID working paper, with inputs from Professor Sam Hickey (ESID Research Director, The University of Manchester) and Badru Bukenya (Makerere University).

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