International Scholars Journals

African Journal of Internal Medicine ISSN 2326-7283 Vol. 7 (9), pp. 001-008, September, 2019. Available online at www.internationalscholarsjournals.org © International Scholars Journals

Full Length Research Paper

Analytical review of health care reforms in Uganda and its implication on health equity

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Accepted 21 March, 2019

Uganda Government has continued to strengthen the country's health system by initiating policy reforms aimed at enhancing equity in health care. In this report, analytical review health care reforms are provided with their corresponding equity outcomes. This report is based on a review of both published and unpublished reports from the government of Uganda and multilateral stakeholders in the health sector from the review, various health equity issues were identified including high incidences of inefficiencies in health care such as stock-outs, low quality of health care under-table payments, increase of out-of pocket payments which continue to contribute towards high incidences of catastrophic health expenditures. Others include dilapidated health infrastructure, low morale among the health personnel, and low levels of spending by the government on health. The reforms have however, contributed towards efficiency gains in terms of increased use of lower-level government health centers and concomitant reductions in the use of hospital services. Various recommendations were suggested in lieu of the findings. These include increased investment in the health sector; strengthening supply of essential medicines, rehabilitation of health infrastructure, provision of incentives to health personnel. Other recommendations include supporting the operations of community health insurance and other pre-payment schemes meant to caution the poor from health expenditure catastrophe. Political commitment in increasing government spending on health care in line with the Abuja Declaration of 2001 is also recommended while putting in place policies aimed at efficiency in health care delivery.

Key words: Equity, health care reforms, financial protection, catastrophic health expenditure.

INTRODUCTION

Historical background

Prior to late 1980s, Uganda's health sector was in a state of near collapse with dilapidated, dirty and ill-equipped public health facilities. Personnel were demoralized due to very low wages, which at times was not forthcoming. During this period, public funding for the sector was as low as 2.5% of the national budget and quite irregular. Health services were mostly sought from private Not for Profit (PNFP) facilities and Private Health Practitioners' (PHPs) sector. This was occasioned by decades of neglect, looting and massive brain drain, which were

reflections of the general decay in the country. This institutional breakdown was worsened by the re-emergence of diseases that had been previously controlled such as sleeping sickness, TB, guinea worm, measles and HIV/AIDS.

Over this period, the health indicators in the country were among the worst in the region and the whole world. Due to the lack of confidence in the existing public institutions, the bulk of the donor funding was off-budget a. Under this arrangement, donors could determine which part of the country as well as which type of services to fund. Whereas the government tended to fund services at health facilities including salaries of health workers, donors funded primary health care (PHC) services' and some extension and rehabilitation of infrastructure (Baraza et al., 2010; MOH, 2010). Starting early 1986, Uganda embarked on major reforms in the wider public arena including the health sector. The reforms included rehabilitation of the existing facilities to restore functional capacity, and a shift of emphasis to PHC with a defined package of cost effective services. Development partners, on the other hand increased funding to the health sector although other alternative financing mechanisms were encouraged in the longer term. Alternative considered was the development of user fees whereby the public would make some contribution for the use of health services. This was however, not unique to Uganda, as many multilateral and bilateral agencies were recommending alternative mechanisms of financing for health services in developing countries as part of structural adjustment programmes (SAPs) initiated by World Bank and IMF (Owino et al., 2000; Kutzin, 2001).

In the early 1990's, the government embraced decentralization as part of a crosscutting public sector reform. Under the broad initiative, the mandate of the central government remained policy formulation, standard setting and resource mobilization, while the mandate of the local governments was to implement the policies and mobilize additional resources at the local level. These initiatives contributed towards improved access to safe water and sanitation (improved pit-latrine coverage) and better nutrition at the household level. All these contributed to the improvement of health status.

In mid-1990s, the government developed two policy documents namely, a ten-year National Health Policy (NHP) and a five-year Health Sector Strategic Plan (HSSP) wherein decentralization was further emphasized. In the policy documents, the government introduced a minimum package of services that were meant to address the major causes of disease burden and allocation of public resources including health inputs. Key issues were the control of communicable diseases like malaria, HIV/AIDS and TB, the integrated management of childhood illnesses, sexual and reproductive health and rights. Others were public health interventions like immunization, school health, health education and promotion, environmental health to mention a few (GoU, 1995). Various changes were later incorporated in the first NHP including the Sector Wide Approach (SWAp), public-private partnership, abolition of user fees, autonomy for the National Medical Stores (NMS) and decentralization of the responsibility of delivering health services to local authorities (MoH, 2010a). The appropriate health infrastructure was also drawn up in the Health Infrastructure Development and Maintenance Plan (HIDMP). Additionally, a Human Resource Development Plan (HRDP) for addressing the major constraints of inadequate numbers and inappropriate distribution of trained health personnel was equally developed.

The NHP and HSSP also laid out plans for the health care delivery system with improved alignment of structures and responsibilities for with core functions at both the central and district levels. Whereas the central level retained the responsibility of policy formulation and stewardship, the decentralized units remained with the responsibility of service delivery (MoH, 2008). This was meant to enhance access to quality health care by the majority in the country who by then had access issues.

The government further considered a sustainable broad-based national Health Financing Strategy (HFS) to facilitate the realization of efficient, effective and equitable allocation and utilization of resources in the health sector. Similarly, stronger donor co-ordination was institutionalized through the Sector Wide Approach (SWAp) for health development (GoU, 2010). At around the same time, autonomy was granted to the decentralized units to raise revenue locally for their activities and improving the health personnel (Baraza et al., 2010; MOH, 2010).

To fast track the process, other reforms were also initiated among them health financing, stewardship, stakeholder organization, as well as management reforms and decentralization. In the case of health financing, an immediate supplementary budget of US$ 1 million was released followed by an increase in the budget allocation of US$ 17 million for the following year. Management reforms and decentralization, recruitment and salary increases for health workers were also accorded priority. Others were higher budget and better management systems for medicines and supplies, and further decentralization of health services management (Kirunga et al., 2005).

User fees in Uganda

In the 1960s, health services run by the government of

Uganda (GOU) were offered at no direct charge to patients (World Bank, 2004) The socio-political problems experienced in the 1970s and 1980s however led to funding shortages that resulted in corruption and the adoption of informal charges among public health providers. In 1987, the Health Policy Review Commission (HPRC) recommended the introduction of user fees at the national level.

The proposal was however, rejected by parliament. In 1993, the Local Government Act of 1993 mandated elected district councils to adopt user fees in government health facilities. At the same time, the Ministry of Health (MOH) and donors encouraged districts to impose fees. The decisions on adoption and the amount to be charged were however, left to the locals although the fees imposed were considered modest and well below the charges levied by private providers. There were however no clear guidelines from the Central Ministries of Health and Finance to support this at the district level. User fees introduced were *ad hoc* with charges being determined largely at service delivery needs. Revenue generated could readily be used to not only provide incentives to health workers (top ups), but also to purchase medicines and ensure cleanliness of the health facility. By 1999, almost all districts had introduced user fees mainly to supplement health workers' salaries. Following the implementation of user fees in most districts, an Inter-Ministerial Task Force was formed to evaluate the impact of the fees.

The task force established that whereas there were improvements in quality, there was a public outcry over the poor people's inability to pay and therefore access health care. There is no doubt that the government of Uganda in deed took the necessary initiatives to reform the health sector with the primary objective of enhancing equity in the health sector. Against this background, the report provides an analytical review of the existing literature to provide the linkage between health care reforms and its implication on health equity in terms of to access, quality of care and financial protection against catastrophic health expenditures.

METHODOLOGY

In this study author only utilized secondary data collected from various sources that included published and unpublished reports. The reports included government health official policy documents such as strategic plans, financing reports, development reports among others. Other document reviewed included reports by World Bank, World Health organization and commissioned reports by donors and the government through the ministry of health.

FINANCING OF HEALTH REFORMS IN UGANDA

Although there exist various financing models for health care in Uganda, in this sub-section, only user fees and pre-payment mechanisms are discussed. The first sub-section reviews the phased approach the government of Uganda adopted following the abolition of user fees followed by pre-payment mechanisms.

Implementation of user fees in Uganda

Following the abolition of user fees, hospitals were however, allowed a dual system with both amenity and general wards for those who could afford and those who could not afford to pay, respectively. The decision to abolish user fees was taken amidst concerns that ill-health and high costs related to accessing services were hindrances to the realization of poverty eradication goals (MOFPED 2004). The policy was meant to improve access to health services among other things, especially for the poor who could not access health care because of its cost. The expectation was that more people would use the public health services and that out-of-pocket (OOP) expenditure for health care would decrease thereby cautioning the poor against catastrophic health expenditures. This was saw the release of US$526 315 representing US$0.02 per capita for the purchase of drugs alongside the revision of the procurement guidelines, to minimize delays in the delivery of drugs at lower levels (MOFPED 2004).

Similarly, there was an increase in the health sector allocation to compensate for the loss in revenue from user fees, and more flexibility in the utilization of funds which allowed districts to channel funds to areas previously supported by user fees. Wages for health workers were also increased in the 2001/02 financial year by 14 to 63% across the different cadres of workers (Nabyonga et al., 2011). It was however argued that this initiative was populist in nature meant to solicit for votes given the policy coincided with the campaign for general elections of 2001. Despite the policy change, user fees continued to be levied in public facilities (UBOS, 2004; Lundberg, 2008). For instance, in a study by Uganda Bureau of Statistics (UBOS) revealed that over thirty percent of women who attended antenatal care (ANC) in public facilities paid informal fees. Similar findings were reported by Lundberg (2008), that ten percent of those leaving public health facilities reported paying fees while 4% of those leaving public facilities reported paying for medicine.

In terms of per capita spending, the government of Uganda (GoU), increased health sector funding from US$ 7.20 per capita in 2001/02 to US$ 8.20 and US$ 9.98 per

capita in 2003/04 and 2005/06, respectively. Since then, the government of Uganda has continued to increase investments in the health sector, as a bold step towards enhancing access and quality of care in the facilities. In addition, the per capita on medicines increased from US$ 0.8 per capita in 2000/01 to US$1.2, US$ 1.7 per capita in 2002/03 and 2006/07, respectively. Physical access also improved from 57% in 2001/02 to 72% in 2005/06 (MOH 2006; MOH 2007; MOH 2008b; MOH 2008c; MOH 2009). Over the same period, the structure of health financing also changed considerably, with households increasing their share of total financing from 37 percent to 58 percent The Ministry however, recognized that some sectors of the population could not afford the charges and therefore suggested a system of waivers and exemption. In the 2001 presidential elections, user fees became the most important issue making the policy decision adopted in 1999 and consequently, a new national policy of abolishing user fees was adopted. The abolition of user fees was not however, an isolated policy measure, but as part of a broader reform package.

Pre payment mechanisms

The health sector policy of 1999/2000 to 2009/2010 provided for the development of additional sustainable financial mechanisms provided that they did not adversely affect the poor. Among those considered were Community Based Health Insurance (CBHI) as a financing mechanism was considered as a source of finance for the health sector. Similarly, the National Resistance Movement Presidential election manifesto of 2006 CBHI schemes as an alternative financing mechanisms for enhancing access to quality health care. The mechanism was considered as a financial protection measure against catastrophic health expenditure for both formal and informal sectors (Baraza et al., 2010). It was envisaged that would be implemented in both PNFP and public owned facilities.

An inventory of the Ugandan Community based Health Financing Association (UCBHFA) indicates that there are fourteen schemes with a total membership of 100,000 while coverage varies between 5-10% of the catchment population with contribution of 5-10% of the facility budgets. The schemes are widely implemented in faith-based facilities because they generally perceived as providing good quality health care. Since then, there have been quality and efficiency improvements to meet demands by members of the schemes. These are in terms of waiting time, introduction of laboratory services and availability of qualified staff to treat members of the scheme. Most of the schemes cover both in-patient and out-patient care, and the premium is on average USD5-10 per person per year. In all the schemes, members pay a small co-payment at the time of service (UCBHFA, 2007) to discourage misuse of the scheme.

Reports however reveal existence of poor knowledge and understanding of the principles and activities of CHI in the country by staff at (Baraza et al., 2010). Like in most low income countries, most of the health facilities are located in urban areas, whereas majority of the members of the schemes live in rural areas. There is also lack of understanding of the principles of insurance, such as the expectation of benefit even if not ill. Further, there has never been any specific national stakeholders' consultative meeting, guidelines or deliberate attempt by MOH to promote CHI in public units while on the other hand the government has not come out with explicit regulation mechanisms for the operation of the CBHI.

HEALTH REFORMS AND EQUITY CONCERNS

As a result of the abolition of user fees in Uganda, a number of studies have been conducted to assess the impact of the policy change. The impact is in terms of access, quality improvements and financial catastrophic to households.

Access to health care

Studies show that physical access to health facilities has been improving over time following the reforms. In 1999, the average reported travel distance to a health facility was 5.6 km, with 75.4% of respondents reporting living within 5 km of a health facility or hospital. In 2002, the average distance was estimated at 5.5 km with 78% reporting living within 5 km of a health facility. By 2006, the average distance had dropped further to 4.1 km, with 82.5% reported living within 5 km of a health facility or hospital (Kasirye et al., 2004; MOH, 2010).

The national average for the percentage of people living within 5 km radius to a health facility was 57% as of 2000. However, there are variations with access ranging from as low as 7% of the population within 5 km of a health facility in rural areas to 100% in urban centres especially Jinja, Tororo and Kampala districts. Reports attribute the variations to the concentration of health facilities in urban centres typical of low income countries (LICs) (MOH, 2010; Kasirye et al., 2004).

Utilization of health care

A sizable increase in utilization in public referral facilities between 2000 and 2003 was reported compared to lower

level public facilities where utilization remained stagnant (Nabyonga et al., 2005). Overall, studies show a steady increase in health care utilization rates in public and private health facilities as well as pharmacies and traditional healers between 1996 and 2006, from below 60% in 1996 to almost 88% in 2006 (World Bank, 2008; Nabyonga et al., 20110). Surprisingly, available statistics show that private utilization also increased following the abolition of user fees at government facilities. This is a paradox based on the intended policy initiative. A preference for private providers was observed throughout the period with about 46% seeking health care in these facilities followed by about 22% in a government health unit, and 13% in a drug store/pharmacy. Out of the remaining, 7% sought care in a government hospital, while 6% in NGO health facility. Over the same period, there was also a large increase in the numbers of those seeking treatment from alternative health providers, including community health workers, HOMAPAK drug distributors, ordinary shops, drug shops/pharmacies, and traditional healers (Nabyonga et al., 2005; Nabyonga et al., *2*011). The surge in the number seeking treatment in the alternative system could be a pointer to either continued imposition of user fees in public health facilities despite the policy or that quality had been compromised.

A significant income-related difference in utilization patterns was observed in the country. Based on 2006 data, persons from the poorest quintile were most likely to seek care in a government health unit (34.4%) whereas those from the wealthiest quintile were most likely to seek care in a private clinic (58.8%). A larger percentage of the wealthiest quintile utilized both government hospitals and NGO hospitals as opposed to those in the poorest quintiles. The utilization patterns across the regions were fairly consistent except those in the northern region, who were most likely to utilize government health services compared to all other regions where private clinic utilization predominated. Household survey data indicate that roughly 2.05 million individuals utilized healthcare from health centers, and about 625,000 utilized government hospitals.

Disaggregating the utilization of publicly provided services utilization among the poorest quintile increased only for primary services while utilization of hospital services decreased. For the poor, the utilization of public provided and financed services OPD has been rising while the utilization of public hospitals decreased. According to Kirunga et al. (2004), abolition of user fees led to an immediate and sustained increase in outpatient utilization in government hospitals. In addition, they observed that a subsequent reduction in user fee levels in PNFP hospitals also resulted in a swift increase in demand in these facilities. The results were attributed to both abolition of user fees (a demand-side intervention) and improved quality and coverage of services (on the supply side). Notwithstanding this, utilization of maternity services however, remained low even after the removal of user fees.

Further, the abolition of user fees promoted health equity in utilization of health service across all providers - public and private, inpatient and ambulatory. The increase in utilization of private facilities, was lower among the poor. Among those in the poorest quintile, the increase in use of PNFP provider (11.4%) exceeded their increase in use of public providers (8.6%) (World Bank, 2004). Utilization of PNFP providers increased significantly everywhere, and was almost entirely responsible for the increase in total utilization. The household data did not provide enough information to undersstand why there was such a major increase in total demand, and the large shift from public to private providers. This further confirms the earlier findings that pregnant women visiting ANC were subjected to informal payments. This may however, be linked to households' perception of quality and efficiency concerns that were associated with the policy change.

Prior to the abolition of user fees, districts, which had never adopted user fees, showed utilization rates of almost 6 percent higher than districts where the user fees were operational. After the abolition, utilization improved in both groups of districts, although the increase was greater in the districts where abolition had been effected. The inconstancy in the findings could e attributed to methodological differences implored in the various studies. The highest increase in utilization was noticed in some of the most important public health problems such as malaria, measles, and diarrhea, while non-utilization for conditions such as dental problems, intestinal infections, and skin conditions remained rather unchanged. Regardless of the existence of user fees, patients increasingly use private facilities, suggesting that the GOU should examine and further improve quality of care in the public sector. This is an indication that not all facilities had implemented the policy. Inability to implement the policy as required has negative implications on the utilization of healthcare in public health facilities.

Quality of health care

Following the abolition of user fees, studies show that incidences of stock outs of drugs and informal charges become common in Uganda's health sector. For instance, while analyzing survey data from a sample of health facilities Martina and Jacob (2008) noted that health care was listed as the area of service provision most fraught with corruption. Corruption issues were also

reported by Konde-Lule and Okello (1998) when user fees were in operation. For instance, the distribution of essential drugs was listed by the Anti-corruption Coalition of Uganda as the key objective in reducing corruption in the health sector. In terms of availability of essential drugs, Martina and Jakob (2008) established that in facilities, only Chloroquine was available more than 50% of the time while Cotrimoxazole, a commonly prescribed antibiotic, was only on a few occasions. This situation continued to be experienced despite the creation of a drug credit line system in the country. This finding is an indication of weak monitoring and supervision by the Ministry headquarters on the implementation of government policies.

Over the same period, in public health facilities, more than half of those visiting public health facilities reported lack of drugs as the reason for not using the public health facility. This is an issue of concern given that as a policy half of the non-wage portion of district level health budgets is allocated towards the purchase of drugs. Due to the high stock-out rates and concern over availability of drugs at the facility level, the large and growing proportion of household expenditure on health that goes toward paying for drugs is therefore not surprising. Although the poor seek care at public facilities at a greater rate, still purchase drugs for treatment in the private market (Martina and Jakob, 2008; Nabyonga et al., 2011). Similar findings were also reported in the MoH report of 2009 where almost a third of health facilities had continuous availability of essential tracer medicines.

In the Annual health sector performance report of 2008/2009 financial year, the government reported that over 74% of government health units reported monthly stock outs of tracer medicines in 2008-2009 (MoH, 2009). The shortage according to the report translated into lower use of outpatient care services with districts that spent all their essential medicines budgets reporting higher utilization of OPD services. In Nabyonga et al. (2011), poor quality of services were noted and was primarily attributed to shortage of drugs and other supplies, as well as low and irregular salaries.. This is in contrast to the situation that prevailed when user fees were in operation as reported by Konde-Lule and Okello (1998).

In the Health Financing Review of 2010 by the Ministry of Health, less than 25% of facilities had all essential equipment and supplies for basic antenatal care (blood pressure machine, foetoscope, iron and folic acid tablets, and tetanus toxoid vaccine), while basic equipment and supplies for conducting normal deliveries (such as scissors or blades, cord clamps or ties, and a disinfectant) were available in only 33% of facilities offering delivery services (MoH, 2010). In the document, the Ministry acknowledged that a major challenge to the health sector is the shortage of essential medicines. Further lack of adequate resources was also singled out as limiting hospitals in their effort to provide the services expected from them. In many instances, basic emergency infrastructure, supplies and equipment for support services were inadequate. In terms of health personnel, Nabyonga et al. (2011) quoted some households saying that some government health workers had become inefficient after the abolition of user fees.

User fees and catastrophic health expenditures

Using household-level data for 1997, 2000 and 2004, Xu et al. (2006) reported reduced incidence of catastrophic health expenditures amongst non-poor households. For instance, between 1997 and 2003, the report revealed incidences of less catastrophic expenditure among the non-poor households. The situation, however, seemed to have worsened as reported by Nabyonga et al. (2011) For instance, user payments continued to be levied even after its formal abolition in public facilities (Nabyonga et al., 2011). The report further reveals that out-of-pocket expenditures have continued to grow since patients continue to pay more for the services. For instance, patients who sought treatment in the lowest wealth quintile, the proportion of household expenditure going towards health care increased from 4.6 percent in 1996 to 7.8% in 2006. Similarly, for the highest wealth quintile, the proportion increased from 4.4 percent in 1996 to 8.9 percent in 2006. Using 2000 prices as base year, Nabyonga et al. (2011) shows that total annual average expenditures on health per household remained fairly stable between the 1999/2000 and 2002/2003 with an estimated increase of US$21 between the 2002/2003 and 2005/2006.The highest increase in the expenditure categories between the 2002/2003 and 2005/06 surveys was in the category of hospital/ clinic expenses: expenditure increased by US$42.

As mentioned earlier, household expenditure on health care increased for all quintiles between 2002/03 and 2005/06. This increase was similar across quintiles, ranging from 7% among the poorest quintile to 30%, among the richest quintile. Hospital/clinic charges experienced the greatest increase compared with other items of expenditure with an increase of 56%. In the 1999/2000 survey, traditional healers, who on the whole play a relatively marginal role in health care provision, accounted for the highest expenditure. This is an indication that the abolition of user fees seem not to have resulted in lasting financial protection for the poor. Thus other alternative financing mechanisms are necessary. Similarly, there has however, been a large increase in the amounts of household health expenditures that go towards paying for drugs and other medicines, especially

amongst the poor despite the creation of a new drug credit line system in Uganda. While the poor are able to enter in contact with health care more readily due to the abolition of user fees, the combination of increased out-of-pocket expenditures on health and a large percentage of those costs going to pay for medicines, shows that financial access to treatment has not improved. This together with the problem of physical access is an indication of catastrophic health expenditures by the poor.

CONCLUSION AND WAY FORWARD

Overall, publicly provided primary services have become more pro-poor with considerable equity concerns. Studies show that public providers face severe quality problems following the policy change on user fees. For instance, drugs and other pharmaceutical supplies were reported to be limited in supply in the public health facilities as demonstrated with frequent stock-outs, physical access especially in rural areas inhabited by the poor continue to raise health equity concerns. The high level of out-of-pocket spending is worrying given the poverty levels in the country since households continue to bear a large burden in the financing of health services. The review reveals that patients continue to pay more for services than before since user payments and out-of-pocket expenditure--including catastrophic expenditures have continued to be experienced. The new policy has however, contributed towards efficiency gains especially in the increased utilization of lower-level government health facilities. User fees have clearly failed here but it is important for stakeholders to consult and agree on which mechanism or combination of mechanisms, will best suit the needs while at the same time minimize on transaction costs.

From the review various recommendations are made including increased investment in the health sector by constructing and equipping facilities especially in rural areas strengthening of government standard operating procedures for the management of essential medicines and protocols on quality of care as well as improved monitoring and supervision is in the enforcement of government policy is prioritized. Other recommendations include putting in place an efficient procurement and distribution system to avoid stock outs of essential drugs while minimizing transaction costs; supporting the operations of CBHI and other pre-payment schemes meant to cushion the poor from health expenditure catastrophe need consideration. Political commitment in increasing government spending on health care in line with the Abuja Declaration of 2001 is important. This may however not translate into better health outcomes and unless efficiency issues in terms of procurement, distribution, quality of staff, monitoring, health infrastructure among others. There is need for developing sustainable health financing mechanisms to raise substantial sums coupled with efficiency in collecting, pooling, allocating and purchasing of the health services.

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