BUSINESS UNUSUAL?

The Conceptualization and Implementation Readiness of the Global Financing Facility (GFF) in Uganda.

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CEHURD
social justice in health

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"... every time people talk about GFF, they get lost. They straightaway think about the World Bank. Unless GFF is discussed in a manner of what it was conceived to be, we lose the discussion. It is also important to reflect on how the developing world engages the World Bank because most times as people discuss these projects, they do not help their countries to come up with real solutions, which must come from the beneficiaries. The World Bank must not be expected to address political issues in developing countries because they have no mandate to do so ..."

Dr. Peter Okwero, Senior Health Specialist, World Bank - Uganda Office.

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LIST OF ACRONYMS

ACAO	Assistant Chief Administrative Officer
ANC	Antenatal Care
CH	Child Health
CSO	Civil society organisations
DHO	District Health Office(r)
FY	Financial Year
GDP	Gross Domestic Product
GFF	Global Financing Facility
GSF	Global Sanitation Fund
HC	Health centre
HPAC	Health Policy Advisory Committee
HRH	Human resources for health
IDA	International Development Agency
IHME	Institute for Health Metrics and Evaluation
M&E	Monitoring and evaluation
MCH(TWG)	Maternal Child Health Technical Working Group
MMR	Maternal Mortality Ratio
MOFPED	Ministry of Finance Planning and Economic Development
MOGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
PHC	Primary Health Care
PNFP	Private not for profit
PRSP	Poverty Reduction Strategy Paper
RBF	Results Based Financing
RMNCAH	Sexual, Reproductive, Maternal, Neonatal and Child Health
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approaches
U5MR	Under -Five Mortality Rates
UBoS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
URMCHSIP	Uganda Reproductive, Maternal and Child Health Services Improvement Project
UNICEF	United Nations Children's Emergency Fund
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organisation

EXECUTIVE SUMMARY

This report presents findings from a scoping assessment of the Global Financing Facility (GFF) for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)as a development funding model and Uganda's readiness to implement the project. The GFF model uses a hybrid funding approach that mobilizes, coordinates and utilizes resources from the World Bank (concessional lending), partner donor countries and private funders – pooled in the GFF Trust Fund. World Bank-hosted GFF secretariat uses trust fund resources to catalyze financing from multiple sources and to "crowd-in" additional domestic resources.

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1) To explore the level of participation by national level Ugandan technocrats in the conceptualization of the GFF
2) To explore the level of participation of sub-national actors in design of the in-country GFF project
3) To investigate the role of citizen participation in terms civil society inclusion in the GFF process
4) To examine the readiness to implement GFF in Uganda.

The study used a qualitative approach, which relied on primary and secondary data. Primary data was obtained through personal interviews with officials in Ministry of Health, GFF development partners, multilateral agencies, program managers at the national and district levels, and the civil society. Secondary data was obtained through a review of relevant documents.

The main finding of this study is that the GFF presents a mixed picture. On the positive side, the maxim of 'Every Woman, Every Child' is consistent with the cardinal virtue of the global Sustainable Development Goals – Leaving No One Behind. Secondly, the use of IDA credit is consistent with Uganda's status as a least developed country (LDC) and benefits by receiving foreign aid at concessional rates (or with a substantial grant component).

In addition, despite the fears of implementing results-based financing (RBF), the ideology of directly funding health facilities, hence eliminating "middle players" is novel. Further, the acknowledgement of the value added by civil society and the systematic engagement of the movement at global and national levels is business unusual and a unique effort to coordinate the previously fragmented efforts on RMNCAH.

GFF mobilizes, coordinates, and utilizes resources from the World Bank, leading donor countries as well as private charities for reproductive, maternal, newborn, adolescent and child health (RMNCAH). Uganda is a beneficiary in the second wave

However, the GFF appears to be flawed conceptually, procedurally, and at the level of system building. The RBF approach requires a strong health system and technical capacities on the part of service providers, which are not in place. The selection criteria for the beneficiary facilities based on the RBF concept of good performance could further undermine poorly performing facilities which could further lead in inequity as this fails approach is fails to address the underlying factors for the poor performance.

Since conceptualization, there has limited involvement of beneficiary countries which could be a reflection of the authoritarian paternalism of aid givers. This paternalism has since the structural adjustment program implementation demonstrated a limited understanding of the local dynamics which are critical in the implementation of development projects in critical sectors such as health.

There is limited conversation at the national and sub national levels, signifying a low level of local ownership. Engagement of Ugandan technocrats in the negotiations was limited, while involvement of the indigenous civil society, local governments and service providers in planning the project's implementation has been superficial, at best.

Despite Uganda's commitment towards the international human rights norms and indication of this commitment in the investment case, the mainstreaming of the human rights-based approach in the GFF conceptualization has been limited. Key human rights concepts such as participation were to an extent not adhered in the conceptualization process. This is contrary to Uganda's Constitutional and other legal and policy frameworks.

The emerging conclusion is that the GFF project in Uganda is substantively and materially closer to the new culture of business unusual than earlier forms of foreign aid, although procedurally falls in the age-old tradition of business-as-usual. GFF should be used to strengthen health system to through providing alternatives and better versions of concepts like RBF and a more cautious and balanced approach towards the engagement of the private sector in provision of public services like health.

The implementation of the GFF process in Uganda as a second wave country ought to pick lessons from the first wave countries and such lessons ought to be amplified in improving the process in Uganda. A competent team should be constituted and/or built to implement the project with support from indigenous civil society organizations and communities. Community engagement and consultations should be broadened through picking lessons from models implemented by other initiatives such as the Global Fund and implementation needs to be expedited.

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1. BACKGROUND

1.1 Introduction

A population's health and wellbeing is primarily a national responsibility. Every state owes its inhabitants a comprehensive package of essential health goods and services under its obligations to respect, protect and fulfill the human right to health. However, given the scope and intensity of today's health challenges, no country or agency can address them single-handedly. Multiple international, multilateral and bilateral agencies and institutions help shape global health polices by funding, implementing and evaluating programs. In essence, they complement the efforts of government and non-government entities. At their different levels, these actors are required to observe international human rights law, which is critical in the pursuit of global health. The contributions of these agencies and institutions has however over the years come with some criticism and calls for improvements in their governance and response to rule of law. One of such entities is the World Bank.

As a vital source of financial and technical assistance to developing countries around the world, the World Bank has overtime become a major investor in health and therefore has a critical role in shaping global health policy. The Bank provides credits (interest-free loans) and grants to poor countries to implement development projects in health and other sectors. Indeed, the Bank is the world's largest financial contributor to health-related projects –committing more than US$1 billion annually– and now regards investment in health, nutrition and population (HNP)programs to be fundamental to its role in the global economy. Under the Sustainable Development Goals (SDGs), the World Bank Group has committed to helping governments achieve universal health coverage (UHC) by 2030.

In September 2014, the World Bank Group and the governments of Canada, Norway and the United States announced the Global Financing Facility (GFF) for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) to support the Every Woman Every Child (EWEC) initiative in mobilizing support for developing countries to end preventable maternal, newborn and child deaths by 2030. The initiative was subsequently launched at the Financing for Development Conference in Addis Ababa, Ethiopia, in July 2015. At the conference, additional donors were announced, including the Government of Japan and the Bill & Melinda Gates Foundation (BMGF). The highlight was that up to $12 billion in domestic and international, private and public funding had already been aligned to country-led five-year investment plans for women's, children's and adolescents' health in the four GFF "front-runner" countries of Democratic Republic of the Congo, Ethiopia, Kenya and Tanzania where GFF started in 2015.

The second round of selection added Bangladesh, Cameroon, India, Liberia, Mozambique, Nigeria, Senegal and Uganda in 2016; the third round added Guatemala, Guinea, Myanmar, and Sierra Leone in 2016 ; and latest round has added Afghanistan, Burkina Faso, Cambodia, Central African Republic, Côte d'Ivoire, Haiti, Indonesia, Madagascar, Malawi, Rwanda and Vietnam in 2018. In November, a donor conference is planned, targeting to raise an additional US$2 billion to replenish the GFF Trust Fund by the end of 2018 to facilitate support to all the 50 countries that have requested support. A total 67 have been identified as eligible GFF.

The GFF model uses a hybrid funding approach that mobilizes, coordinates and utilizes resources from the World Bank (concessional lending), partner donor countries (Canada, Norway, USA, Japan), and private funders (BMGF,

MSD for Mothers) – pooled in the GFF Trust Fund – and disburses them to beneficiary countries through the World Bank's International Development Agency (IDA). GFF funding however, aims to close the RMNCAH funding gap in recipient countries and are meant to be additional to (rather than substitute) existing funding.

Hence, the World Bank-hosted GFF secretariat uses trust fund resources to catalyze financing from multiple sources and to "crowd-in" additional domestic resources. Selection of a country to participate in GFF is conditional on its commitment to increase domestic funding for RMNCAH and to allocation of World Bank funding to the GFF agenda. In addition, resources from the GFF Trust Fund are linked with concessional financing from the World Bank in a ratio of US$1 from the trust fund to more than US$5, on average.

GFF aligns with the global convergence on an ideology of inclusion code-named "Leaving No One Behind."

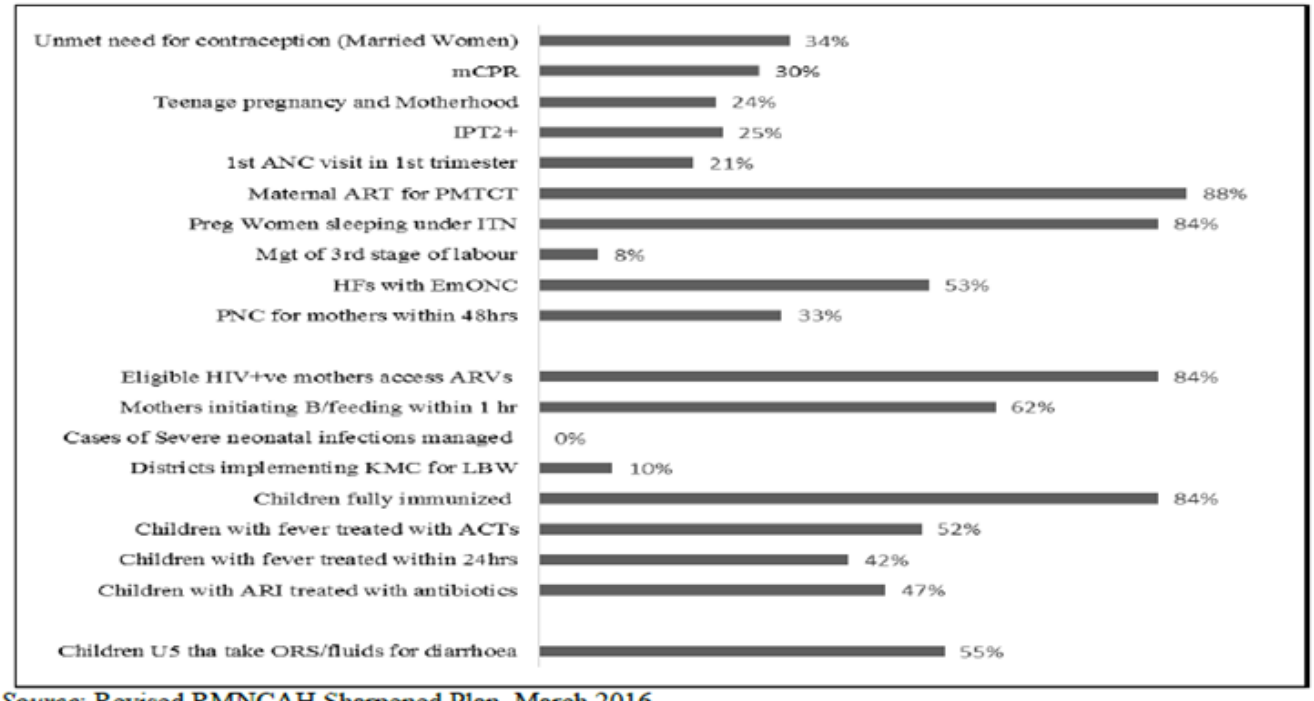
With support from Open Society Institute, Center for Health, Human Rights and Development (CEHURD) commissioned a scoping assessment of the GFF as a development funding model, and Uganda's readiness to implement the RMNCAH investment case with GFF funding. This report presents the results of the assessment: The next sub-sections present a review of the situation of RMNCAH in highlights from Uganda's RMNCAH Investment Case; and the global and national context of GFF. The subsequent sections present the methodology, results, conclusion and recommendations.

1.2 Situation of RMNCAH in Uganda

Uganda registered slow progress in improvement of RMNCAH between 1995 and 2016. RMNCAH conditions account for over 60% of years of life lost. The maternal mortality ratio (MMR) is estimated at 336 deaths per 100,000 live births, 28% of which is among young women aged 15-24years. The leading causes of maternal deaths are hemorrhage, obstructed labor and abortion-related complications.

Teenage pregnancy is a major problem, with too many girls starting to have children too early in life. By the age of 15-19, 25% of the adolescents have started having children, 19% have given birth and 5% are pregnant. Child bearing among adolescents rises rapidly with age. By the age of 15, 3% have had children. This percentage rises rapidly to 22% by the age of 17 years, and to 54% by the age of 19 years.

Figure 1. Coverage of Selected Reproductive, Maternal, Neonatal, Child and Adolescent Health Interventions along the Continuum of Care



Source: Revised RMNCAH Sharpened Plan, March 2016

Note: mCPR = CPR based on modern contraceptive methods; IPT2 = Second dose of intermittent prophylaxis therapy for malaria during pregnancy; ART – Antiretroviral Therapy; ARVs = Antiretroviral Drugs; PMTCT = Prevention of mother-to-child Transmission of HIV; ITN = Insecticide Treated Nets; KMC = Kangaroo Mother Care; HFs = Health Facilities; LBW = Low Birth Weight; EmONC = Emergency Obstetric and Neonatal Care; ARI = Acute Respiratory Tract Infections.

Modern contraceptive prevalence among married women is estimated at 35%, while prevalence of traditional methods among the same group is estimated at 4% – giving a total of 39%. Unmet need for family planning among the same group is estimated at 28%, while demand is estimated at 67%, of which 58% is being met. Among sexually active unmarried women, contraceptive prevalence is estimated at 51% (47% modern and 4% traditional methods), unmet need at 32%, and demand at 83%, of which 61% is being met.

THE largest absolute increases in total health spending have been in high-income countries [which are already well served], and the largest health spending growth rates have been in upper-middle- and lower-middle-income groups. Spending in low-income countries grew at a rate nearly as fast as the middle-income groups, but because in 1995 spending per capita in those countries was very low, the absolute gains [by 2014] were small (p. 11)".

The child mortality rate or under-five mortality rate (U5MR) is estimated at 64 deaths per 1000 live births. U5MR deaths are mostly due to neonatal sickness and the common childhood illnesses which include malaria, pneumonia and diarrhea. The infant mortality rate (IMR) is estimated at 43 deaths per 1000 live births; the neonatal mortality rate (NMR) at 27 deaths per 1000 live births; and the postnatal mortality rate at 16 deaths per 1000 live births. Considering this situation, in 2015, Uganda joined the world and made commitments to improve RMNCAH. To this effect, the country developed a costed roadmap – called the Investment Case for RMNCAH Sharpened Plan for Uganda 2016/17 - 2019/ 20.

1.3 Uganda's RMNCAH Investment Case

Uganda first published a national strategy to improve maternal and child health in 2013 as part of the global effort to accelerate progress on maternal and child health indicators that were lagging behind the pace required to achieve the targets of the UN Millennium Development Goals (MDGs) to reduce child mortality (Goal 4) and improve maternal health (Goal 5). Titled "A promise Renewed: Reproductive Maternal, Newborn and Child Health Sharpened Plan for Uganda" (RMNCH Sharpened Plan), the five-year (2013-2017) "sharpened plan" aimed to reduce excess maternal and child mortality by strengthening accountability and monitoring mechanisms as well as partnerships for social mobilization, funding and technical assistance. Unfortunately, this plan was never implemented due to lack of funding.

However, the strategy got a lifeline with the coming of the GFF, as Uganda became one of the countries selected in the second round in 2016 to benefit from the World Bank initiative. The plan was accordingly revised and updated to align with the GFF concept and renamed "Committing to maternal and child survival: Investment case for reproductive, maternal, newborn, child and adolescent health sharpened plan for Uganda 2016/17-2019/20" (RMNCAH Investment Case) and is currently being implemented under GFF as "Uganda Reproductive, Maternal and Child Health Services Improvement Project".

The Investment Case is broader in focus as it includes adolescent health, and birth and death registration. It is largely anchored on supra-national health priorities as set in the global Sustainable Development Goals (SDGs), Every Woman Every Child (EWEC) initiative and the GFF. It has five strategic objectives:

1. Emphasizing a comprehensive package of evidence-based, high impact interventions for each service level;
2. Increasing access for high-burden, under-served populations;
3. Geographical focusing/ sequencing by initially concentrating on priority districts where all elements of the package will be delivered together;
4. Addressing the broader multi-sectoral context by addressing key determinants of health outcomes (such as nutrition) that lie outside the health sector;
5. Ensuring mutual accountability for RMNCAH at all levels of the health system. It proposes to tackle the immediate causes of maternal deaths while also investing in broader, long-term interventions to strengthen the health system and improve the social determinants of health in partnership with other sectors.

The strength of the Investment Case is that it is anchored on human rights. The document recognizes that while Uganda has developed laws, policies and guidelines that would contribute to health and human rights and to global health goals, their implementation has been limited. The Investment Case points out that as a result of the limited implementation of policies and guidelines that address human rights, interventions that tackle negative social norms and non-health sector interventions against child marriages, elimination of child labor and women trafficking are weak. It notes that while children and adolescents have a right to participate in planning and decision-making, the realization of this right is "very limited and subdued" due to insufficient implementation strategy and investments. It further notes that

THE GFF Secretariat is hosted at the World Bank headquarters in Washington, DC signifying that the GFF simultaneously represents the clout of the World Bank and the US-led coalition of powerful capitalist countries. The governance structure underscores the underlying politics, power relations and democratic credentials of GFF

discrimination against women and girls through gender-based violence, economic exclusion and the lack of appropriate and affordable reproductive health services are common problems in Uganda.

Other human rights gaps identified by the Investment Case include unequal access to healthcare services between women and men; women's continued lack of full control over their own fertility; the continued inability of the public health system to address the needs of the most vulnerable individuals in society; high prevalence of sexual and gender based violence (SGBV) against women; "minimal" government spending on child protection; and inadequate access to RMNCAH services by persons with disabilities (PWDs), among others.

To address these gaps, the Government of Uganda, in its Investment Case, commits to a "client-centered approach as detailed in the Constitution of the Republic of Uganda (1995 as amended) and the Uganda's Patients' Charter. The client-centered approach is also fronted in international human rights standards that Uganda is party to, including the Universal Declaration on Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the African Charter on Human and Peoples' Rights, and the African Charter on the Rights and Welfare of the Child".

The Investment Case commits to protecting human rights; protecting vulnerable populations; providing children with their rights to legal identity and education through registration of births and addressing gender gaps in access to basic education, respectively; to supporting adolescents to realize their rights to health, well-being and full participation in health.

1.4 Global Context of GFF

Data from the Institute for Health Metrics and Evaluation (IHME) indicates health spending and government health spending are positively associated with development. Yet, substantial variations exist in health spreading across nation-states and within income groups. Between 1995 and 2014, a disturbing global trend has happened. According to IHME (2017):

"… the largest absolute increases in total health spending have been in high-income countries (which are already well served), and the largest health spending growth rates have been in upper-middle- and lower-middle-income groups. Spending in low-income countries grew at a rate nearly as fast as the middle-income groups, but because in 1995 spending per capita in those countries was very low, the absolute gains (by 2014) were small".

Development assistance has for many developing countries increasingly helped fill the funding gap for health programs. Development assistance for health accounted for 34.6% of total health spending in low-income countries in 2016 – compared with only 0.5% of total health spending for the upper-middle- and high-income countries which

generally do not receive development assistance. Between 2000 and 2010, development assistance for health grew rapidly – approximately 11.4% per annum – but gradually slowed down to only 1.8% per annum between 2010 and 2016. Development assistance for health totaled about US$37.6 billion in 2016, rising by only 0.1% from the 2015 level.

In the light of the foregoing, IHME identifies three key issues around which global attention has converged:
1) The amount of resources available to spend on health and the degree to which it is paid in advance and pooled across diverse groups, impacts overall access to, and quality of, care.
2) There is now global consensus that health is a human right and not a mere charity. Hence, leading health advocates, donors and governments have endorsed the concept of universal health coverage (UHC), the gist of which is that all people should have access to reliable, quality health care without the risk of financial hardship.
3) There are variations in the principal sources of health financing across countries by income level: High-income countries largely rely on public financing and health insurance; middle-income countries are transitioning from donor-dependence to domestic funding; while health financing in low-income countries is largely out-of-pocket.

GFF is grounded in the SDGs, which on their part, are themed on greater inclusivity. RMNCAH falls under SDG 3 that aims to ensure healthy lives and well-being for all at all ages. SDG 5, which seeks to achieve gender equality and the empowerment of women and girls, is also relevant to RMNCAH.

GFF is a multi-stakeholder partnership that supports "country-led" efforts to improve RMNCAH. GFF was announced at the 69th UN General Assembly in September 2014 by the World Bank, and the governments of Canada, Norway and the United States. The GFF governance structure includes the GFF Secretariat; the Investors' Group and the Trust Fund Committee. The GFF Secretariat is hosted at the World Bank headquarters in Washington. The Secretariat is responsible for resource mobilization, and for the day-to-day governance of the GFF. The Secretariat also manages the GFF Trust Fund, supports GFF implementation by beneficiaries, and supports the Investors Group.

The Investors Group consists of World Bank Group, Global Alliance for Vaccines and Immunizations (GAVI), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM or Global Fund, United Nations, MSD for Mothers, BMGF and the governments of Canada, Norway, Japan, UK and US. A key purpose of the Investors Group is to oversee the GFF. Members of the Investors Group "are privy to a wealth of information about the GFF operations and future plans. They make decisions regarding GFF operations that cut across countries, as well as funding decisions related to specific countries".

The third institutional arrangement within the GFF is the Trust Fund Committee. Working with the GFF Secretariat – and oftentimes in consultation with the governments of beneficiary countries, the Committee makes decisions regarding the allocation of Trust Funds.

GFF started with four “front-runner” (or “pilot”) countries: Democratic Republic of Congo, Ethiopia, Kenya and Tanzania, all of which allegedly contributed to the development of the GFF Business Plan in late 2014 and early 2015. The second category consisted of eight countries which were announced as the “second wave” beneficiaries at the GFF launch in July 2015. They include Bangladesh, Cameroon, India, Liberia, Mozambique, Nigeria, Senegal, and Uganda. The third wave consisted of four beneficiaries – Guatemala, Guinea, Myanmar and Sierra Leone. The latest selection has added Afghanistan, Burkina Faso, Cambodia, Central African Republic, Côte d’Ivoire, Haiti, Indonesia, Madagascar, Malawi, Rwanda and Vietnam in 2018.

In 2015, the funding gap for RMNCAH was estimated at USD 33.3 billion for 62 countries eligible for GFF support. The GFF is intent on engaging the private sector to close this gap and has developed a strategy for this engagement. The strategy describes two types of private sector actors–donors and suppliers. Health service consumers remitted over 50% of the total health expenditure in over 60% of GFF countries. This is also called private expenditure that is mostly in form of out-of-pocket payments, which promotes inequity compared to the public sector or mixed public – private mix. The poorest are disproportionately affected by out-of-pocket payments. GFF therefore seeks to addresses this inequity by promoting smart, scaled and sustainable funding through combining both public and private finances equitably. Private finances may be from local private entities or international sources.

Beyond finances, private sector actors are health suppliers for RMNCAH. These form a big percentage of all health care compared to the public sector and they include services providers, financial institutions, private insurers, information communication technology (ICT) firms, private training institutions, pharmaceuticals, business actors and medical technology companies. There is evidence showing increased occurrence of particular services such as antenatal care (ANC), and institutional deliveries, in the private sector in African countries. As such, the importance of the private sector in provision of RMNCAH services was not ignored by GFF. This could explain why GFF works across both public and private sector service providers.

Generally, GFF private sector engagement strategy harnesses the GFF principles, including equity, with intent to reach the most vulnerable women, children and adolescents. It has defined three main pathways for engagement with the private sector, including developing innovative financing mechanisms to catalyze private sector capital for Investment Case financing such as results based financing (RBF); facilitating partnerships between global private sector and countries; and leveraging private sector capabilities in countries to deliver on objectives in the investment case.

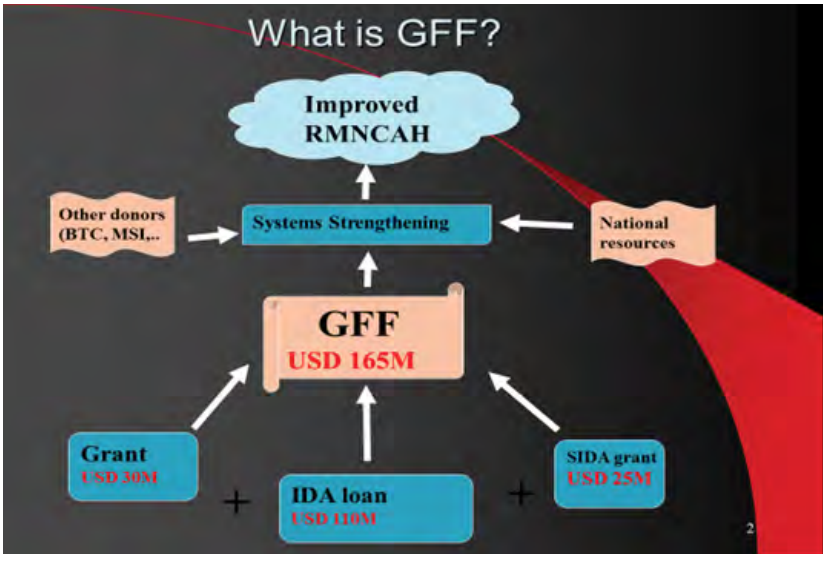
The private sector engagement by GFF needs a critical look especially within a country context since the regulation of the private sector in many countries is weak. In some cases, the private sector has not adhered to the equity and human rights principles hence compromising the service provision in the health sector.

1.5 Ugandan Context of GFF

Uganda submitted its Investment Case worth US$140 million to the World Bank in July 2016, and rapidly obtained approval of its request. It is worth noting that Uganda's Investment Case had a project implementation start-date of August 4, 2016, signifying the rapidity with which the project submitted in July 2016 was approved. The intervention had an "expected effectiveness date" of December 4, 2016, which apparently was not realized, and an end-date of December 31, 2020.

Uganda's investment case is funded by a concessional credit from the World Bank's IDA worth US$ 110 million and multi-donor GFF trust funds worth US$30 million giving a total of US$140million. By December 2017, SIDA had come on board with a grant of US$25 million. This raised the overall total to US$165 million, and pushed the grant component to 33.33%.

Figure 1: GFF in Uganda



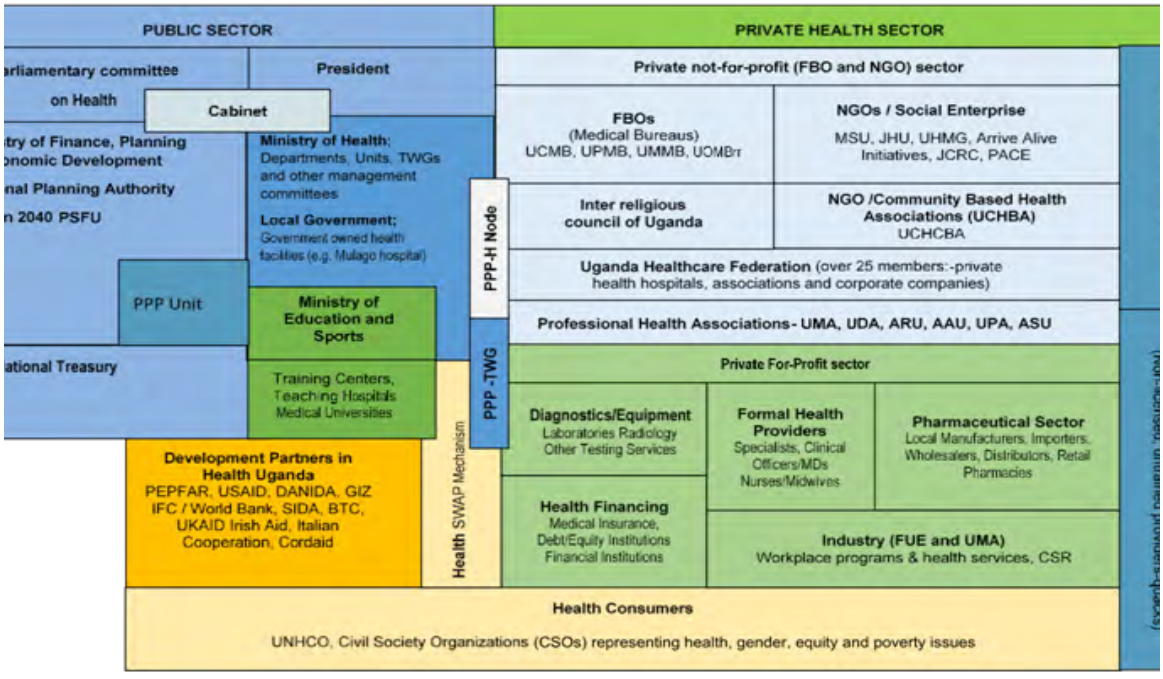
Source: Developed and Visualized by authors

UGANDA submitted its USD 140 million Investment Case to World Bank: USD 110 million concessional credit from IDA and USD 30 million from multi-donor trust funds. By December 2017, SIDA had come on board with a grant of USD 25 million. This raised the overall total to USD 165 million, pushing the grant component to 33.33%

The Health system in Uganda

Ministry of Health partnered with the Uganda Private Health Support Program, USAID, and GFF to analyze the landscape of the health system in Uganda. Figure two below shows a mixed delivery health system that includes public and private actors: Government of Uganda, development partners and their implementing agencies, private for profit actors (PFP), private not for profit actors (PNFP), civil society, and the informal sector which includes traditional an complementary medicine practitioners, as well as un-licensed private practitioners.

Figure 2: Landscape of the health sector in Uganda



(Source: Adopted from O'Hanlon et al., 2016. Exploring partnership opportunities to achieve UHC. Uganda PSA 2016)

According to this report, the number of health facilities increased by 2,498 from the year 2005 to 5,229 in the year 2012. There was a 50% increase in public health facilities; the PNFPs increase by 45% while the PFPs increased by 500% from 277 in 2005 to 1488 in 2012. One third of the health facilities is in the capital Kampala, and most of these are PFPs (1,488). The poorest regions in Karamoja, West Nile and the northern region have the least number of health facilities. The report further highlights that health practitioner's work both in public and private sectors, a factor which contributes to poor data quality on the health workforce.

The private sector includes:

- Informal unlicensed providers: drug shops, traditional healers and birth attendants, and quacks
- Formal providers: medical personnel, allied health providers, nurses, and community health workers
- Private health facilities: diagnostic centers, hospitals, geriatric homes, consultation rooms, nursing homes, clinics and academic institutions
- Pharmaceutical and health products and equipment: manufacturing, importers, wholesalers, distributors, retailers and drug shops
- Financiers of health: health insurers and health savings.

2. METHODS

2.1 Study design

This study took a qualitative approach.

2.2 Study team

The study team consisted of an academic researcher, hands-on health governance professional, and a health rights advocate.

2.3 Study scope

The study sought to understand and document the major stakeholders who were involved in the conceptualization of the international-level GFF mechanism. The study also sought to understand the diffusion channel of the GFF norms from the international level to country-specific contexts.

The domains of inquiry were: (a) participation and (b) implementation. Under the participation domain, the study design focused on three levels of inquiry:

1)The negotiations between World Bank, and the country-level actors, and whether there was meaningful participation of the latter.

2)The level of national and sub national participation, and whether or not spaces were created for meaningful participation.

3)The role of civil society as a proxy for citizen agency in the design of the GFF initiative in Uganda.

With regards to implementation, the study sought to assess Uganda's readiness to implement the GFF, i.e. implementation capacity. Implementation capacity was operationally defined in terms of Uganda's preparedness in terms of staffing and the qualifications of health sector workers in the health service units. These were used as indicative measures of the health system strengths – or the lack thereof. The study also sought to assess the functionality of the selected implementation modality, namely, results-based financing in view of Uganda's context-specific realities, such as the limited capacities of health facilities and the low purchasing power of citizens due to high levels of poverty.

Underpinning the domains of inquiry was the need to understand the governance structure of GFF, the dominant norms that shape policy choices, and the democratic spaces created or suffocated by the dominant stakeholders. This information was then used to contextualize the understanding of the design, content and implementation dynamics of Uganda's Investment Case.

2.4 Study objectives and data sources

The study had four objectives as presented below. The study methods document review, key informant interviews,

focus group discussions and stakeholder meetings, backed by the researchers' prior/expert knowledge of the political economy of health service delivery in Uganda.

Table 1: Study objectives and methods

Objective	Method
1. To explore the level of participation by national level Ugandan technocrats in the conceptualization of the GFF project in Uganda	• Review of relevant literature • Aconsultative meeting with Ministry of Health officials to map the stakeholders that were/are involved in the process as well as sources of relevant literature and contact information. • Key informant interviews were conducted with those who were mapped. These included face to face interviews with technocrats from Ministry of Health, Ministry of Finance, National Planning Authority (NPA), National Identification Registration Authority (NIRA), Uganda Bureau of Statistics (UBOS), Ministry of Gender, and Ministry of Local Government. • Interviews with officials from multilateral agencies including WHO, UNICEF, World Bank and IMF.
2.To explore the level of participation of sub national actors in design of the GFF project in Uganda	• An inventory of the first 25 districts that were identified for piloting of GFF was used to select a convenient sample of five districts to understand how the project is being implemented at sub national level. In these districts, interviews were held with district health leaders and/ or assistant district administrative officials. • The districts included Kampala, Wakiso, Buikwe, Mukono and Luweero.
3.To investigate the role of citizen participation in terms civil society inclusion in the GFF process	• CSO contacts of key players were collected from the meeting and these were used to map other CSOs that were involved in the design and negotiation of GFF, through the snowball approach. A distinction was drawn between (a) CSOs that were involved in RMNCAH related work, and (b) those involved in advocacy work around foreign aid and World Bank operations in Uganda. • Follow up interviews were conducted with CSOs that were knowledgeable on World and GFF processes in Uganda. • The organizations targeted included White Ribbon Alliance (WRA), Civil Society Budget Advocacy Group (CSBAG), World Vision and Uganda Debt Network (UDN).
4. To examine the readiness to implement GFF in Uganda.	Relevant literature and documents supplemented with key informant interviews with World Bank, Ministry of Health officials, and local government leaders.

The main research question underpinning this study was: What was the

level of participation of Ugandan stakeholders in the design of the GFF project?

The preliminary findings were validated at a meeting held on March 14, 2018. It was attended by 74 stakeholders who included representatives from the Ministry of Health, including the project coordinator for the GFF project; Members of Parliament including those from districts where information was collected, as well as members of the health and human rights parliamentary committees; representatives from the Swedish Embassy; the World Bank team lead of the GFF project; representatives from district local governments, representatives from the academia; members of civil society, and the media. Besides the core intention, the convening also aimed to create a platform to share information and learn more about the GFF. This platform was further used to collect more data from different stakeholders that were not reached during the interview.

2.5 Ethical Considerations

The researchers sought the informed consent of study participants following the approved consent form. Every study participant was reminded of their right to accept or refuse to participate, and their liberty to refuse to answer any questions they were not comfortable with. All respondents were availed with the CEHURD telephone contact number, which they could use to raise complaints or ask questions, if any.

STUDY OBJECTIVES

I. To explore the level of participation by national level Ugandan technocrats in the conceptualization of the GFF project in Uganda

II. To explore the level of participation of sub national actors in design of the GFF project in Uganda

III. To investigate the role of citizen participation in terms civil society inclusion in the GFF process

IV. To examine the readiness to implement GFF in Uganda.

3.1 General findings from review of documents

3.1.1 Intentional inclusivity

The maxim of "Every Woman, Every Child" is consistent with the virtue of inclusivity implied in the global Sustainable Development Goals, namely, "Leaving No One Behind". The use of IDA credit (at concessional rates) is also a plus. Contrary to the rhetoric of foreign aid critics such as Dambisa Moyo (2009) in her influential book entitled Dead Aid, the IDA credit represents development-enhancing aid, not "dead aid". It is consistent with Uganda's status as a least developed country with per capita income of under $1,000. Such a country benefits by receiving foreign aid at concessional rates (or with a substantial grant component).

The multi-donor grant component of $55million is also a welcome relief to Uganda's tight health sector budgets. In addition, considering that a $25million from SIDA was later added to the original GFF grant of $30million is a positive reflection of donor commitment to the investment case.

The ideology of results based financing (RBF), associated with rigorous research and continuous improvement of the approach, is novel. According to an impact assessment report, RBF promotes autonomy of a health facility. The ability of the provider to control the resources is reported to improve responsiveness of health workers to health facility needs, hence contributing to improved health outcomes. This direct disbursement also increases clarity of budget needs and contributes to improved quality of care.

3.1.2 Systematic engagement of the civil society

The GFF acknowledges the role of civil society in strengthening the project outcomes. As such, civil society engagement is included in the GFF business plan. GFF proceeded to develop a civil society guide to the GFF, and a GFF Civil Society Engagement Strategy (2017) to guide the operationalization of the engagement. Civil society is part of the governance structure of the GFF, with two representatives on the GFF Investors Group) and two alternating members, including one youth. These change every two years to allow for vast engagement. At global level, the Partnership for Maternal, Neonatal and Child Health (PMNCH) leads a global civil society organizations (CSOs) coordinating group, estimated to have 150 members who provide direction for CSO engagement with GFF. At Country level, CSOs engage with the GFF through country platforms, which are supposed to ensure inclusivity and transparency.

GFF acknowledges the role of Civil Society in strengthening the project outcomes. As such, Civil Society engagement is included in the GFF business plan. Civil Society is part of the governance structure in the GFF investors group represented by two representatives, and two alternating members including one youth.

The documented intention and efforts to systematically engage CSOs at global and national level is indeed business unusual, although challenges have been acknowledged and lessons have been documented from frontrunner countries – D.R. Congo, Ethiopia, Kenya and Tanzania. Some of these that Uganda should have been cognizant of include effective communication; and inclusive representation and participation of civil society. Most CSOs in those countries did not have knowledge about the GFF, the project was implemented hurriedly and meetings were called on short notice. As such, engagement was limited. Selection of CSOs was also not systematic or transparent. Many were international NGOs or those that had partnerships with government, and very few local organizations. The findings on participation of Ugandan CSOs in the next subsections.

3.1.3 Conceptual and procedural shortfalls

Notwithstanding the aforementioned positive dimensions, GFF also appears to have shortfalls conceptually and procedurally. Conceptually, the theory of change driving GFF is RBF. Also known as "cash-on-delivery" or "output-based aid", RBF is defined as "an instrument that links financing to pre-determined results, with payment made only upon verification that the agreed-upon results have actually been delivered".

RBF is premised on several assumptions which may or may not be consistent with verifiable country-specific realities. These are:(a) The existence of functional health delivery systems prior to the GFF intervention;(b) That service providers have the technical capacity to deliver; (c) That an enabling political economy context exists in which state elites are supportive of health as a human right; and (d) That the only missing variable in health service improvements is the incentivization of duty bearers to literally "go for results".

Procedurally, the GFF was an announcement that was made at the UN General Assembly (which is a space for democratic debates) and no evidence of popular consultations was found. The announcement in July 2015 of Japan and the Bill and Melinda Gates Foundation as additional donors also appears to have been devoid of popular debates and consultations. None of the second-wave or third wave beneficiaries appears to have had inclusive citizen-led debates on their country-specific funding priorities even though the national technocrats had substantial inputs in the country-specific RMNCAH investment cases. This may be interpreted to be "authoritarian paternalism" of Western aid givers. Authoritarian paternalism refers to the tendency by aid givers to treat aid-recipients with a firm hand so as to make them do the "correct" things – typified by the austere structural adjustment programs of the 1980s and 1990s otherwise they would deviate off-course.

3.1.4 Persistence of framing

One of the striking points of concern with the GFF is the survival of the World Bank framing in the supposedly new health sector financing modality. The Business Plan which was released by the GFF team on May 17, 2015, is a case in point. The plan is rich in fancy framing. It seeks to operationalize "smart financing" that will supposedly prioritize investment in "evidence-based,""high-impact" solutions. These impacts will supposedly be "delivered" in an efficient, results-focused manner" (emphasis added). An outline of the "smart financing" and other aspects of the framing are indicated in Box 1.

A participant makes a contribution during the validation meeting

NEW WINE IN OLD WINESKINS?

The GFF is premised on three key pillars. These include:

- Smart financing that prioritizes investment in evidence-based, high-impact solutions – such as nutrition, immunization and family planning, delivered in an efficient, results-focused manner;
- Scaled financing that mobilizes the additional resources needed to fully finance the maternal and child health agenda from both domestic and international, plus public and private sources; and,
- Sustainable longer-term financing strategies that anticipate the economic transition of countries from low- to middle-income status and secure universal access to essential services for every mother and every child.

Box 1: Key pillars of the GFF

- **Smart financing** that prioritizes investment in evidence-based, high-impact solutions – such as nutrition, immunization and family planning, delivered in an efficient, results-focused manner;
- **Scaled financing** that mobilizes the additional resources needed to fully finance the maternal and child health agenda from both domestic and international, plus public and private sources; and,
- **Sustainable longer-term financing** strategies that anticipate the economic transition of countries from low- to middle-income status and secure universal access to essential services for every mother and every child.

This developmental framing colonized the World Bank when the institution "re-invented" itself from a development finance institution into a global knowledge bank, particularly in the 1990s. The reinvention is understandable, even justifiable, given the need for the World Bank, like other adaptive institutions, to change with the changing business environment. The point of concern is that the impressive framing has not necessarily resulted in the promised donor-sponsored development dividends, particularly in Africa. For example, the celebrated global best practices in financial governance characterized by "prudent" (read "conservative") inflation targets have succeeded in attaining low inflation rates of under 10%.

However, these "best practice" policies have failed to create descent formal-sector jobs. Thus, while Uganda has registered rapid GDP growth rates of roughly 4.5% over the last five years, the unemployment of the youths aged 14-38 years is at an alarming rate of 65%. This suggests that Uganda has had jobless growth. It suggests that the global best practices are not necessarily good enough for poor market economies. The new framing, it would seem, is new wine in the old wineskin of the global aid policy establishment.

What raises hope is that certain new practices are evident. For example, the business plan was not produced in a cavalier fashion. It was a product of seven months of work by a 54-member Business Planning Team. This team worked under the GFF Oversight Group, which provided feedback and strategic guidance throughout the process.

Advocates of the GFF add one key point, namely collaborative partnerships. The claim is that the spirit of collaboration and strong partnership – among the GFF frontrunner beneficiaries and founding donors, development partners, UN agencies, foundations, and the private sector – is evident in the final document. What is not clarified is the quality of partnership – for example, between the founding donors and the pilot beneficiaries. This is important, given the asymmetrical power relations between these two parties. Was the GFF consultation process genuinely substantive or simply ritualistic?

3.2 Field findings

3.2.1 Participation of Ugandan technocrats in GFF design

Uganda was selected in July 2015as one of the "second-wave" beneficiary countries to receive support from GFF. A WHO official observed in an interview that Ministry of Health had to undertake "special negotiations to ensure they are part of the GFF". But Uganda's inclusion was not just because of lobbying. According to a World Bank interviewee:

"There were two simultaneous initiatives by 2014/15 – the international and the country-specific. The international initiative code-named the Global Financing Facility signified renewed emphasis on blended financing with multi-donor resource commitments. The Ugandan initiative consisted of the country's own health sector plans. Uganda was well advanced in terms of the requirements needed for inclusion in the GFF. The country had earlier prepared its national strategy officially termed 'the Sharpened plan' – and was in the final draft of its 10-year health financing strategy. These not only simplified the design and negotiation process for Uganda. They became key guides to the operationalization of reproductive, maternal, newborn, child, and adolescent health and nutrition in Uganda." (World Bank Interviews, Kampala, November 2017).

During the validation meeting of the preliminary findings, an official of the World Bank emphasized that the institution only negotiates with the Minister of Finance of the country and not anyone else. He further clarified that negotiations happen with the in-country World Bank team and not the headquarter team in Washington, DC. From the two responses of the WHO and World Bank representatives, it can inferred that the Minister of Health lobbied and the Minister of Finance negotiated. If this indeed is true, the capacity of the Finance Minister to negotiate a health project, especially in absence of a health technocrat, may be questionable. From the national level interviews, three senior officials within the Ministry of Health (Planning Department and the Reproductive Health Division) indicated general lack of understanding of GFF principles, with their discussions focused on just the Investment Case which is just one of the components of GFF. Their central claim is that the GFF Trust Fund is just a smaller part of the overall national strategy to guide the implementation of RMNACH in Uganda. In general, there was lack of engagement of Ugandan technocrats in the conceptualization and development of the different aspects of the GFF.

A senior official in the Reproductive Division of the Ministry of Health reported:
"I was only involved in the preparation of the Sharpened Plan which was later upgraded into Uganda's GFF compliant Investment Case. Regarding the, issues of the health sector loans and other aspects of GFF, the World Bank and top elites in the Ministry of Finance, Planning and Economic Development are better placed to answer"(Ministry of Health, Interviews, Kampala, November 2017)

Top officials of WHO and UNFPA interviewed upheld – to varying degrees – the aforementioned view. The dominant view was that the conceptualization of GFF, the funding modality, and the choice of beneficiaries all appear to have been predominantly shaped by the World Bank and other founding donors. This upholds William Easterly's (2012) critique of foreign aid as an instrument of donor authoritarianism. Simply stated, mainstream donors propagate the myth that poor countries – due to asymmetrical power relations – must be subjected to the preferences of a superior authority (donor countries).

Thus, while Uganda already had national strategy to guide the implementation of RMNACH, the actual timing for preparing the Investment Case was incentivized by the World Bank's official communication to the Ministry of Health stating that the Ministry would receive support from the GFF Trust Fund. The preparation and refinement of the Investment Case was part of the requirements for starting the GFF process. The development involved a two-phase process. Phase one resulted in a national strategy to guide the implementation of RMNACH. This was the "Sharpened Plan" of 2013-2017. Launched in November 2013, the Sharpened Plan became the basis for all health partners to finance RMNCAH in Uganda.

The second phase involved updating the Sharpened Plan into the Uganda RMNCAH Investment Case of 2016-2020. A World Bank official summarizes Uganda's preparedness for GFF as follows:

"Uganda was fortunate that it had earlier prepared the 'Sharpened Plan'. This helped with technical buy-in and political support during the development of the Investment Case for the GFF. In addition, the World Bank country staffs with Ministry of Health were already preparing a project related to the same issues that are targeted by the GFF. Uganda was also in the final stages of preparing its 10-year health financing strategy which was part of the requirements for the GFF".

A senior Ministry of Health official upheld this view. According to her, "Uganda being well advanced on the requirements needed for GFF inclusion, simplified the design and negotiation process for the Ministry of Health". Another Ministry of Health official reported that the presence of the Sharpened Plan prepared the Ministry adequately in terms of orientation of the GFF to Uganda's health sector priorities.

However, a UNFPA official disagreed somewhat. He indicated that there were "concerns on the general lack of engagement of Ugandan technocrats in the conceptualization and development of the Investment Case". Moreover, Ministry of Health reportedly limited the number of non-Ministry of Health participants involved in the development of the Investment Case:

"From the development partners, they only picked a few – the UNFPA, WHO, and UNICEF. And from civil society they only wanted one organization to represent the rest. From Uganda's local governments and health facilities, I don't even know of whether there was inclusion"(UNFPA Interviews, Kampala, November 2017).

Respondents suggest that there was lack of consensus amongst the Investment Case development team. As a UNFPA interviewee reported: "We would agree on certain things but come the next day, some of the things we had agreed upon … they had been removed overnight particularly on adolescent health issues".

UGANDA'S total health expenditure is roughly USD 50.1 per capita per year, far below the recommended USD 86 per capita per year (expressed in 2012 US dollar terms) for low-income countries to build a functional health system and provide basic health services.

According to a Ministry of Health official, adolescent health, was a new addition to the Investment Case, and was not originally in the Sharpened Plan. The bone of contention, it would seem, was the issue of contraceptives and/or comprehensive sexuality education, which included issues of gay and lesbian rights. These were emphasized by certain donors and underemphasized by Ugandan officials. On December 8, 2017, there was a special meeting of the Health Policy Advisory Committee (HPAC)on the contentious issue of adolescent health. The study team was unable to access minutes of this meeting to establish what transpired.

Notwithstanding some disagreements, multilateral organizations including UNFPA, WHO and UNICEF technically supported the Ugandan technocrats in the development of the Investment Case. A senior Ministry of Health official indicated that the range of tools that were used to help Uganda (led by UNFPA, WHO and UNICEF) included costing tools, and bottle neck analysis whose object was to help the Ugandan team identify high impact, low cost-strategizes for Uganda's Investment Case.

Uganda's Investment Case reportedly demonstrates the politics of donor-funded projects. It demonstrates that old habits die hard. The negotiations of Uganda's variant of GFF used the World Bank and government standard procedures for negotiating a government loan:

"Procedures for negotiating the GFF loan are specified in the Financing and Project Implementation Manual of the World Bank. The grant of US$30 million and the matched credit of US$110 million were negotiated as part of one package."(World Bank Interviews, Kampala, November 2017).

From the interviews conducted, senior officials within the Ministry of Health (Planning Department and Reproductive Health Divisions) lacked clear understanding of the negotiation process and terms, including the interest rate and the disbursement arrangements. A senior technocrat of the sector Ministry of Health interviewed noted that the Parliament, Ministry of Finance, Planning and Economic Development (MoFPED), and the World Bank are better placed to understand the negotiation procedures of the loan. This could indicate that Ministry of Health officials interviewed were not involved in the negotiation process. MoFPED which manages the interface between Uganda and the donors declined to participate in the research. Furthermore, as expected, legislators in Parliament have a duty to vet and approve grants and loans received by Uganda from the international development institutions. However, at the validation meeting, a member who was in Parliament at the time the GFF was brought to parliament for approval said:

"No one thinks about Parliament at the level of conceptualization, yet it is the same institution that approves grants and loans. Parliament is therefore left with no choice but to rubberstamp these loans and grants yet sometimes the country has a duty to pay back these loans." (Validation meeting, 14th March 2018)

One participant at the validation meeting expressed fear that some of the money the country receives as foreign aid may have an ulterior agenda and that, because

THE Investment Case for Uganda (RMNCAH sharpened plan 2016/17–2019/20) dated 14th July 2016, which was submitted and accepted as Uganda's investment case to the WB, largely negates the importance of the human rights framework

there no capacity to question, the country is at the mercy of funders.

Generally, all the respondents interviewed agreed that the GFF Investment Case is aligned to Uganda's priorities as it was developed and updated from an already existing national strategy of the "Sharpened Plan". According to one key informant, although the Investment Case covers all issues of RMNCAH,

phasis on child health and very little emphasis on family planning. Only moon beads were [apparently] accepted under family planning for the GFF/ Investment Case budget. There are claims that the Ugandan variant of GFF is a baby of the Commissioner for Child Health. This seems to explain the emphasis placed on child-health issues." (UNFPA Interviews, Kampala, November 2017).

3.2.2 Participation of local government technocrats

Qualitative field interviews were conducted with District Health Officers (DHOs) and Assistant Chief Administrative Officers (ACAOs) of Kampala (Kampala City Council Authority), Mukono, Wakiso, Buikwe, and Luwero.

While all respondents had heard about the GFF, some had heard about at a stakeholder meeting of February 6,2018, where they were officially informed about the project. The political leaders did not know about the investment case/ sharpened plan while the technocrats that knew about the case, were never involved in its development.

"I cannot speak about the GFF with confidence but with time, I will learn as the project progresses" – DHO interviews, February 2018

Three DHOs who had heard about GFF before this meeting only did so through informal conversations with colleagues. This is a reflection of ritualistic inclusion; GFF seemed to have been served to them as a prescription. One DHO specifically mentioned that the project should have been more demand driven. While the engagement of the private sector cannot be disputed; strengthening of that sector over the public sector weakens the latter especially in a setting where regulation of the private sector is weak. The private sector assessment was important to inform policy action, but one may question if it legitimizes the inclusion of the private sector in an unregulated environment, without a clear plan to cover the gap.

"This project should have been more demand driven. Ministry of Health could have placed an advert about the grant and areas for funding and invited districts to write concepts depending on their priorities. In my opinion, health systems strengthening is a more pressing need for Kampala because the health system is private sector led and there are more people paying for services. As a health service leader, this kind of system would require me to do more of regulation than service delivery." – KCCA interviews, February 2018

Nevertheless, the process that was to follow was communicated at this meeting. Each district would be invited to select a technical person who would participate in a one-week training of trainers' (TOT) workshop. The trained trainers would then be facilitated to conduct initial assessments of the health facilities and score them using pre-determined criteria. Only those that scored 65% and above were to be subjected to a second and final assessment by officials from the Ministry of Healthheadquarters. Those health facilities that selected in this second phase would then become the GFF beneficiaries.

During interactions with the district technocrats, the study team learnt that one of the five districts did not receive communication to send a representative for the TOT. On seeking clarification from a Ministry of Health official during the validation meeting, they acknowledged that not all the districts were invited to send representatives. Fortunately, for those for that sent representatives, two of them shared the information with other technocrats through meetings and one further trickled the information down to the health facilities.

"I shared the assessment tool with the health facilities so that they can assess themselves and put their houses in order" – DHO interviews, February 2018

The criterion that was used to invite some districts to send participants for the TOT, and not others was not clear. This puts those districts that did not have representation at a disadvantage because they would not be as prepared for the assessment as those that were represented. As such, they would unfairly miss the chance to be beneficiaries which may contribute to slow progress in realizing outcomes from those districts. Secondly, the technocrats were provided with information and not guided on how to use it following the TOT, hence the difference in action taken in the different districts.

Generally, however, local district leaders were optimistic about the results based financing as a vehicle for improved service delivery.

"Health facilities will be paid according to the results they produce. This is very exciting because it will compel facilities to provide quality service" – DHO interviews, February 2018

"I applaud the GFF for investing in local solutions to local problems" – A

"Health facilities will be paid according to the results they produce. This is very exciting because it will compel facilities to provide quality service" – DHO interviews, February 2018

The leaders also raised some concerns as follows:

- "The National Medical Stores is performing very poorly on the supply chain and therefore Ministry of Health needs to explore new outlets to ensure quality and timely services" – ACAO interviews, February 2018
- "There is a capacity building component and some of the cadres they plan to train a very few. Why are they considering pediatricians, obstetricians and the like who will end up working as consultants attending to a few cases, instead of training more enrolled midwives for example who provide decentralized care?" – ACAO

interviews, February 2018

- "Why will a government facility that does not meet the 65% mark miss to be a beneficiary if it is the role of government to facilitate that facility to provide quality services and government has failed?" – DHO interviews, March 2018
- "The indicators relating to HIV seem to have been left out among those to be tracked" –DHO interviews, March 2018
- "The health facilities are going to receive money directly on their accounts and they should be trained in financial management to ensure value for money" – DHO interviews, February 2018

While this information has not been obtained via a representative sample, it seems to point to a highly centralized process of developing sector-specific plans in Uganda. It contradicts the philosophy and practice of decentralized governance in Uganda. The limited participation of district-level technocrats also points to significant deficiencies in the realm of inclusivity cum people-centeredness of development initiatives. To the extent that this is true, local content may be minimal in what become Uganda's investment priorities.

More importantly, local populations are likely to have limited ownership of the proposed funding priorities and interventions. The literature suggests that limited local ownership weakens local commitment and motivation to make the project succeed. It also may trigger overt and covert resistance to the proposed intervention, thanks to the perception by local elites that paternalistic authoritarianism was used to push project implementation via a top-down approach.

3.2.3 Participation of Ugandan Citizen's in the GFF

The study investigated the role of citizen participation in terms of inclusion or exclusion of CSOs in defining the GFF priorities in Uganda.

Despite the literature review on the global inclusion of civil society that is "business unusual", the national level premier processes negated the value of meaningful civil society involvement. There is evidence that conceptualization of the GFF process in Uganda excluded civil society. Selected members of the civil society, specifically those working on family planning, are reported to have met obstacles as they tried to engage with the process. They sought and found audience with the World Bankand government officials and the engagements led to the inclusion of family planning in Uganda's investment case. There is no documented evidence of engagement of the wider civil society with a stake in RMNCAH, at the conceptualization stage.

While GFF included both loan and grant, civil society groups working on accountability and engagement of financial institutions and human rights generally were not viewed and considered as key in playing a role under GFF. Even within the limited space of civil society engagement, the UN, International and Regional Organizations had a much better opportunity to be involved than indigenous organizations. The involvement has been much better at the rolling

out of the implementation through development of a CSOs engagement strategy.

Results from the field interviews show that CSOs focus their critical voices on GFF and their advocacy energies on the Sharpened Plan (which was edited into Uganda's GFF compliant Investment Case). CSOs typically forget that GFF in Uganda consists of three institutional arrangements: (a) The Health Financing Strategy, (b) The Investment Case; and (c) The GFF Country Platform the differences and interconnectedness of these institutional arrangements are summarized in Box 2:

Box 2: The Health Financing Strategy; Investment Case, Country Platform Explained

The Health Financing Strategy is a long-term strategy for financing the health sector.

An investment case is a country-owned RMNCAH plan. It outlines the results a country wishes to achieve. It lists the priority investments; makes a costing of the priority investments; and outlines the mechanism for monitoring and evaluating progress towards the desired goals. Having an Investment Case was a requirement for accessing the GFF funds.

THE HEALTH FINANCING STRATEGY; INVESTMENT CASE, COUNTRY PLATFORM EXPLAINED

The Health Financing Strategy is a long-term strategy for financing the health sector.

An investment case is a country-owned RMNCAH plan. It outlines the results a country wishes to achieve. It liststhe priority investments; makes a costing of the priority investments; and outlines the mechanism for monitoring and evaluating progress towards the desired goals. Having an Investment Case is a requirement for accessing the GFF funds.

The GFF Country Platform is a government-led institutional space – at least in principle. It is a multi-stakeholder platform responsible for GFF operations in each country including developing an Investment Case, developing a health financing strategy, mobilizing resources, coordinating the technical assistance received; and coordinating country-specific monitoring and evaluation (M&E) and quality assurance initiatives.

More important than focusing on the Investment Case (where several CSOs have been involved) is the fact that the energies of CSOs have largely been uncoordinated.
Source: Ministry of Health Interviews, Kampala, November 2017

By implication, therefore, if the CSOs were really organized, they would adopt a more holistic approach covering the health financing strategy, the Investment Case, and the GFF Country Platform. By December 2017, there was no standardized process for civil society engagement in the GFF process in Uganda. According to a civil society member who was interviewed, many CSOs and coalitions were largely unaware about the GFF process and the Investment Case.

GFF financing signifies a departure from the old tradition of donors"working in silos" to a new era of cross-donor silo-bursting. It underscores an enhanced level of donor coordination, in line with the Paris Declaration on aid-effectiveness.

Yet, the Investment Case, like the global GFF, pledged that civil society inclusion would be part of the GFF modus operandi, and that citizen engagement and beneficiary feedback would be strengthened. Despite these pledges, senior officials within the Ministry of Health (Planning Department and Reproductive Health Division) reported that they struggled to find, let alone define, the appropriate spaces for civil society involvement in the GFF process. They agreed that this was mainly because CSOs are numerous, uncoordinated and/or fragmented without a common agenda.

A civil society interviewee agreed that civil society members that participated in the process were uncoordinated. The reason for this was largely intra-civil society politics. Most CSOs arguably looked at each other as competitors, not complimentary actors.

"We fight to be 'flag bearers' of the process, rather than promoters of the citizens' voices, interests and preferences. While all of us in civil society profess to work for the people, we compete as individuals as institutions for visibility, space and relevance – especially to the donors. What we seriously lack is a common sense of direction."(CSO interviews, Kampala, November 2017).

CSOs that were involved in the development of the Investment Case, participated mainly as representatives of civil society representatives on the Ministry of Health technical working groups. A CSO representative interviewed believes that organizations representing CSOs on the Ministry of Health technical working groups do not truly represent their constituencies but rather are there in their own right. He further believes that there has never been a procedure for selection of CSO representatives and that no input and feedback mechanism existed to facilitate consultation or the accountability of civil society representatives the wider civil society fraternity.

ACSO member on the RMNACH Civil society coalition group observed:

"Even those civil society organizations that participate in the process … their engagement is not meaningful at all. Ministry of Health seems to invite them only to legitimize the process. All the Ministry wants, it would appear, is to be able to claim that CSOs participated. One source of concern is that the engagement procedures of CSOs in the GFF and Investment Case processes are unclear to the CSOs. Nor are they clear to government officials. Invitations to the various processes are ad hoc, not organized. They always come in at the last moment, and CSO's are always unprepared for them. The Ministry will invite CSOs from family planning organizations today, and the other day invites CSOs working on malaria only. These anomalies suggest that Things Fell apart". (CSO representative, Kampala Interviews, 2017)

A Ministry of Health official confessed that they always find challenges of how to engage with civil society.

"It is always difficult to understand how they are organized. Different civil society organizations approach Ministry of Health claiming they represent CSO's on RMNACH issues. Yet, apart from the embryonic Baraza initiative, there is no formal mechanism for the Ministry to answer questions from civil society organizations."(MoH Interviews, Kampala,

December 2017)

A top official of the CSO which was taking lead in organizing CSOs articulated a different aspect of the problem at hand:

"There were difficulties in mobilizing CSOs to engage in the Investment Case development process. The problem was that Ministry of Health was not well coordinated. Nor was it organized. Meetings to draft certain sections of the Investment Case were called in an ad hoc manner, inviting different civil society organizations to engage at different stages of the drafting process. Accordingly, CSO representation in the drafting meetings was not consistent. In addition, some CSOs would send in very junior staff and interns to represent the organizations in the drafting meeting. This could explain the poor understanding of the Investment Case and the GFF Trust Fund by civil society."(World Vision Interviews, Kampala, December 2017).

In the light of the foregoing, civil society participation in the drafting of the Investment Case reportedly started to wane. The reasons for loss of interest were various. The ad hoc approach to civil society inclusion was a problem. To compound the problem, civil society inputs into the Investment Case were either ignored or largely diluted in the final Investment Case. However, a senior World Bank official attributed the waning of civil society interest a different reason. According to the respondent, some CSOs had participated in the hope of that they would, through their involvement, access GFF resources. This was not the case.

In addition, participants at the validation meeting complained that government has not prioritized the health its citizens, who have in turn lost trust in their representatives. One narrated having reached out to health leaders over the poor health conditions in the rural district he hails but for a long time they had never responded.

"When duty bearers live in the comfort of their palaces when they have over US$100million for their health tourism, they do not care about what happens to ordinary citizens, but when they are struck by what happens, that is when they wake up. Hon. Simon Lokodo visited Kalangala and while there, he got sick and collapsed. He was rushed to the nearby health facilities and none was able to fix his situation. They tried several means to get him off the islands for treatment in vain until they called Gen. Katumba Wamala , who sent a chopper to fly him out for treatment. The prayer can only be for the duty bearers for them to also taste the bad health system so that they can respond." (Validation meeting, 14th March 2018)

Nevertheless, the civil society made targeted efforts, albeit with challenges, to form a RMNCAH CSO Platform. In March 2017, CSOs appointed a steering committee to lead the development of an engagement strategy that was finalized in December 2017 and endorsed by about 150 CSOs. They include those in service delivery; professional NGOs and academia; membership NGOs, networks and professional associations; and grassroots organizations. The strategy envisions equitable, accessible and quality healthcare for RMNCAH information and services for all. It aims to strengthen an inclusive and strong RMNCAH CSO movement in the country in line with the global guidance. There is evidence that the CSO movement was not substantively engaged at conceptualization and it is difficult to say if they are involved at implementation since it is early stages. At the time of the district visits, the strategy had not

been popularized among district officials although the latter were willing to work with CSOs. Nevertheless, the effort to form a coordinated CSO response to RMNCAH is novel and if sustained, could lead to accelerated realization of intended outcomes of the GFF project, as well as other related projects.

3.2.4 Implementation readiness for GFF

The study sought to assess the implementation readiness of GFF in Uganda. As already hinted, implementation capacity was operationally defined in terms of Uganda's preparedness as proxied by staffing and the qualifications of health sector workers in the health service units. These were to be used as indicative measures of the health system strengths – or the lack thereof.

From the interviews conducted at national level, a mixed picture is presented in terms of preparedness of GFF implementation at district level. Ministry of Health officials interviewed indicated that preparation for GFF implementation is an ongoing and robust process, which includes district assessments and development of the RBF framework, among others.

The top officials of bilateral organizations who were interviewed, particularly within the WHO and UNFPA, upheld the view that preparedness in an ongoing process, and predominantly noted that Ministry of Health and the districts were ready (in terms of staffing/human resource capacity) for the implementation of the GFF.

"Different projects are coming in to support the GFF process, and to strengthen the health systems. The management skills of the people are being scaled up. Different pieces have to be strengthened and you can never sit there and say 'I'm not ready; or that am now ready.' You have to keep working."(UNFPA Kampala, November 2017)

The absence of a clear/unified position on the issue of preparedness comes out clearly in the responses from Ministry of Health officials. One interviewee reported that 25 districts had been selected and have already received communication, and that plans exist for starting GFF implementation in February 2018.

However, another senior officer of Ministry of Health contradicted this view. The respondent reported that "the assessments of the districts have not yet started". This information was consistent with that of a CSO member, who reported that none of the districts he had visited recently had any knowledge on GFF implementation plans:

"Just last week, I was in one of the districts that the Ministry of Health claims to have identified and communicated to – that is, Mukono district. The district officials are not aware of the implementation plans of the GFF or Investment Case in their district."(CSO Interviews, Kampala, November 2017)

In addition, several interviewees from CSOs reported that Uganda's districts predominantly lack functional structures

for purposes of supporting the implementation of the GFF at district and health facility levels. At the validation meeting, the GFF project coordinator mentioned that country team is cognizant of the need to strengthen these lower level structures especially the health unit management committees (HUMCs). Unfortunately, the HMNCAH Investment Case does not indicate intention to strengthen these structures and neither were they mentioned at the stakeholders meeting where the project was first presented. Further, one CSO member stated that some of the districts lack a fully constituted Expanded District Health Management Team (EDHMT) which is key to the monitoring and verification of the results-based financing approach at the district level.

"In some districts, the only CSOs that are on the expanded district health teams are education focused organizations… How do we make sure that if they are being given such expanded responsibilities outside their institutional mandates, expertise and competencies, the education-oriented organization will take care of the issues of reproductive, maternal, newborn, child and adolescent health and nutrition?"(CSO Kampala, November 2017)

"In addition there are concerns with the functionality of the Health Unit Management Committee's (HUMC) and the VHTs in many of the Districts. "How do we expect to implement results-based financing when many of the structures that are meant to verify outputs and results are not functional." (CSO Kampala, November 2017)

A final aspect of preparedness is the issue of the GFF Country Platform. As part of the preparation for implementation, GFF countries are urged to create Country Platforms to oversee GFF implementation. In Uganda's case, the existing structure, that is, the Ministry of Health technical working group is expected to serve as the Country Working Platform. From the interviews conducted, it was not clear how Uganda's GFF Country Platform will work. In addition, the CSOs interviewed reported lack of true CSO representation on these structures. All these point to one problem – poor institutional preparedness for GFF implementation.

Finally, in many parts of Uganda, the proliferation of new districts has resulted in a disturbing scenario. According to a respondent at Ministry of Health, "While districts are important units of local governance and service delivery, a substantial number of new districts lack a publicly owned, financed and coordinated general hospital." This point to key problems of health service access and inclusivity.

3.2.4 Limitations of the Study

The major limitation of this study is that it mostly focused on interviews and feedback in the central region of Uganda, because it was designed to be a scoping study due to resource constraints. Future studies should extend field research to a bigger sample of districts and health units in Uganda.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

This scoping study presents a mixed picture of World Bank business through the GFF initiative. Several business unusual aspects exist especially the coverage of the health subsectors that matter for the vulnerable population targets. The GFF sought to accelerate global efforts to end preventable maternal and child deaths, and improve the quality of healthcare for women, children and adolescents by 2030.

The GFF financing model is another business unusual aspect of the initiative. GFF financing signifies a departure from the old tradition of donors "working in silos" to a new era of cross-donor approach. It underscores an enhanced level of donor coordination, in line with the Paris Declaration on aid-effectiveness. Moreover, the intervention pioneers a dramatic shift from official development assistance to a new approach that combines domestic financing, external support and innovative private sector sources –what the 2015 Addis Ababa Conference on Financing for Development termed "blended financing".

The third business unusual aspect is that the GFF intends – at least in principle – to mainstream citizen participation in the GFF process through inclusion of CSOs. The rationale for this is simple. The resources used in the GFF initiative consist not just of foreign aid but also citizens' contributions to public finance, which are made through domestic taxes. The need to mainstream citizen participation is consistent with the new dispensation on citizen agency, defined as the ability of voters or taxpayers to hold government officials accountable for their commissions or omissions. In this spirit, citizens must hold duty bearers to account. Citizen agency is exercised through country-level consultations between the providers of RMNCAH health services and the relevant CSOs.

Fourthly, the key drivers of the GFF process are the country investment frameworks: 3-5 year plans that include national, evidence-based and high impact interventions, and a rigorous country assessment of RMNCAH needs and priorities. It is important to note that only 'best buy' interventions, which include clinical, health systems strengthening, and multi-sectoral approaches supported by multiple financiers are prioritized in the country investment framework – at least in principle. This means a country's national financing strategy will employ a health-sector-wide approach that runs up to 2030. Long-term financial sustainability (public and private) will be key to supporting the operationalization of the framework.

However, impressive as these ideas might be, several critical challenges persist. For example, study participants raised concerns over the results-based financing approach that has been adopted; whether the RBF modality is to be delivered via Uganda's public health systems, public/private partnerships (PPPs), or reliance on private sector actors.

Additionally, the conceptual rationales of RBF is persuasive – incentivizing or even pressuring health service providers to spring into action and deliver services. However, the practical reality is that health delivery systems – in post-conflict

Northern Uganda, for example – need revitalization, expansion, and upgrading before significant results can be expected.

4.2 Recommendations

1) GFF should be used to strengthen health system

GFF should be appreciated as having development-enhancing credentials, such as low interest rate of IDA loans and the substantial grant component, and Government should take advantage of it to strengthen thehealth systems and improve the health mothers, children and adolescents. Results-based financing calls for a strong health system. Lessons ought to be picked from the first wave countries to inform implementation in the second wave countries.

2) Put in place a competent project team

Ministry of Health should assemble the best and brightest team of professionals to negotiate with donors and implement the project professionally. The recruitment process should be transparent and credible enough to identify competent individuals with the requisite skills set and experience. The set of skills required needs to be mixed beyond just knowledge in the health systems to capture other key skills in correspondence with GFF requirements.

3) Hybridize results-based financing with systems strengthening

The financing modality of the GFF and, by extension, the GFF-compliant Investment Case of Uganda is results-based financing. While it is appealing, conceptually, to pay-for-results or disburses "cash-on-delivery," results-based financing appears to be decontextualized. As has been done in other poor country settings, cost effectiveness studies should be carried out in Uganda to show the merits and demerits of the approach in Uganda. This will inform government on whether or not RBF should be replaced with a new system that rewards systems strengthening or better still, citizen satisfaction with health services (established through consumer satisfaction surveys).Additionally, the capacity of different stakeholders should be built on RBF including the health workers who will implement it, and all stakeholders who will participate in monitoring and evaluation. The private sector involvement should be done in light of health systems strengthening.

4) Deepen domestic consultations and stakeholder involvement

There is need to deepen the conversation between the sector Ministry of Health and the donor institutions that are represented in Uganda. There is also need to utilize the decentralized governance structure by improving the conversation and flow of information between Ministry of Health, the districts local governments and lower local governments. This is extremely important given that health services are delivered via a decentralized governance framework in Uganda.

5) The role and functionality of civil society representation

Ministry of Health needs to improve the inclusion and functionality of civil society representatives precisely because these are the organized – if uncoordinated – voices of Ugandan citizens. At the same time, civil society needs to get better coordinated. While this is a tall order, given the superficial competition between different CSOs (for donor funds, visibility, and relevance), improved coordination is not impossible. Already, a national platform – the National NGO Forum exists – and should be used to replace the uncoordinated civil society noises with issue-based, evidence-informed and representative voices of civil society. The scope of CSOs should be expanded beyond UN agencies, International and Regional Organizations to include indigenous and community based groups. This scope should also look beyond institutions working on family planning and maternal health to include those in accountability, human rights, and debt management.

6) Human Rights-Based Approaches

A human rights- based approach ought to be adopted in the implementation of the project. Best practices could be picked from other financing mechanisms such as the Global Fund on main streaming human rights in the implementations of GFF.

7) Expedite the implementation process

The implementation of GFF activities seems to be behind schedule. Technocrats in the Ministry of Health and their partners within the local government jurisdictions should expedite the implementation process.

8) Regular monitoring and review

Government of Uganda and GFF development partners need to embark on a process of regularly monitoring and reviewing GFF design and implementation. The aim is to ensure that no one is left behind. The bottom line is that Uganda needs to replace business-as-usual with a new culture of business-unusual. There may also be concern that by the World Bank working in partnership with the private sector, the role of the state as the primary provider of healthcare is undermined. This may in addition result in the loss of Uganda's authority to govern its own health system with negative social outcomes such as reduced investment in health system. This is an area that the World Bank may need to regularly monitor in order to actively support sustainability.

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