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POLICY BRIEF

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Uganda

Accountability and Strategic Health Purchasing in Uganda: Implications for Primary Health Care Implementation

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Executive Summary

Uganda is committed to making progress towards the achievement of Universal Health Coverage (UHC) and recognizes strategic health purchasing (SHP) as a key lever to improve efficiency, equity, and accountability in the use of health resources. National policies, including the National Health Policy II, Health Sector Development Plan, and Vision 2040, provide strategic direction. However, persistent challenges such as weak accountability, fragmented financing, continued use of historical information in the allocation of resources to the health and limited funding, continue to hinder progress. SHP strengthens the relationship between purchasers and providers, ensuring that scarce resources are directed toward high-impact services, especially in primary health care (PHC). Its effectiveness relies on robust accountability systems encompassing financial oversight, provider performance monitoring, contracting, and community engagement.

This policy brief explores the relationship between accountability and SHP, and its implications for PHC implementation in Uganda. It draws on a qualitative case study conducted in four districts, analysing real-world practices in provider payment, fund flows, performance monitoring, benefit package design, and citizen feedback. The study was conducted by Makerere University School of Public Health, in collaboration with the Ministry of Health, through the Strategic Purchasing Africa Resource Centre (SPARC), implemented by Amref Health Africa. The findings aim to strengthen priority interventions in Uganda and other Low- and Middle-Income Countries (LMICs) as they strive to make progress towards the realization of Universal Health Coverage goals.

Uganda at a glance

- Population 2024 (GoU, 2024): **45.9 million**
- GDP per capita (World Bank, 2025a): **1,002.3 USD** in 2023
- Poverty headcount at $2.15/day (World Bank, 2025b): **42.1** in 2019
- Life expectancy at birth (WHO, 2024): **66 years** in 2021
- Current health expenditure (CHE) per capita (Macrotrends, 2025): **43.45 USD** in 2021
- Domestic government expenditure as % of CHE (P4H, 2023): **22.53%** in 2021
- Out-of-pocket expenditure as % of CHE (P4H, 2023): **34.1%** in 2021
- External expenditure as % of CHE (P4H, 2023): **42.46%** in 2021

Background

Accountability in health systems ensures transparency, performance monitoring, and trust. It requires individuals and institutions such as governments, providers, and funders to explain decisions and face consequences for unmet standards.[1] Accountability takes four forms: vertical (e.g., central to local governments), horizontal (e.g. across ministries), diagonal (citizen oversight), and mutual (partner co-responsibility).[2]

Strategic Health Purchasing (SHP) relies on strong accountability to ensure efficient resource allocation and improved service delivery.[3] Unlike passive purchasing, SHP links payments to performance, sets priorities, and selects providers intentionally. Effective SHP requires mechanisms to monitor performance, track spending, and hold actors accountable.[3,4] In Uganda, government agencies, donors, and private not-for-profit facilities drive SHP. However, weak oversight, poor financial transparency, and limited engagement constrain progress. Strengthening accountability is critical to reducing corruption risks, improving value for money, and achieving Universal Health Coverage (UHC).[5,6]

Uganda's health policies, including the National Health Policy II (2010), Health Sector Development Plan (2015–2020), and Strategic Plan (2020–2025), align with SDG 3 and Vision 2040 targets of achieving UHC by 2030.[7,8] However, challenges like low health financing, poor allocation, and inequities persist. SHP improves efficiency and equity at the primary health care (PHC) level by linking payment to results, defining service packages, and contracting providers. Uganda uses budget financing, donor support, and Results Based Financing (RBF) models.[7] Budget funding offers little flexibility and weak incentives, while externally funded RBF schemes strengthen accountability through performance-linked payments.[9] Yet, donor projects often create parallel systems often by-passing the public financial management systems and these short-term gains that limit sustainability.

Accountability frameworks promote transparency, prevent resource misuse, and support evidence-based decisions. [10,11] With Uganda's mix of government, donor, and household funding, better alignment and stronger oversight are essential. Despite policy focus, gaps remain in how accountability works in practice at the PHC level.[12,13]

This policy brief aims to provide an overview of accountability arrangements and practices in Uganda's SHP, examine existing opportunities and constraints and propose policy recommendations and strategic actions to enhance accountability in SHP, thereby supporting UHC progress in Uganda.

Methodology

This brief summarizes findings from a qualitative study by the Ministry of Health (MoH), Makerere University School of Public Health, and Amref's implemented Strategic Purchasing Africa Resource Center (SPARC) to assess accountability arrangements within SHP for primary health care (PHC) in Uganda. Data were collected through a comprehensive review of policy documents, grey and published literature and 43 semi-structured key informant interviews with national and district-level stakeholders. Findings were validated through stakeholder engagement to ensure validity and contextual relevance.

Findings: Current Situation, Successes and Challenges

Health financing in Uganda is obtained from multiple sources to includes government budgets characterized by limited spending, externally funded RBF schemes.[7] Within this context, strategic purchasing for PHC involves four key actor groups: stewards and overseers, purchasers, providers, and citizens. The MoH and Ministry of Finance, Planning and Economic Development (MoFPED) set policies, allocate funds, and provide oversight, supported by legal institutions such as the Auditor General and Parliament. MoH and MoFPED manage fundholding and purchasing for government budgets and RBF, while donors often bypass PFM systems and transferring funds directly to providers. Private and community-based insurance (CBHI) schemes also contribute to PHC financing but at a smaller scale.

Purchasers handle financial flows, contract providers, and monitor performance, relying on alignment with national policy and citizen engagement. Providers, including public, private, and faith-based deliver services, report data, and collaborate to enhance quality. Citizens participate by voicing needs, and giving feedback to promote accountability.

Although input-based payments dominate, recent reforms have expanded budgets, introduced efficiency measures, and enhanced oversight through digital systems.[7]Despite these reforms, fragmented purchasing arrangements persist, and PFM rules remain rigid limiting accountability, reducing provider motivation and limiting the full realization of SHP in Uganda.[3,14]

The section below reviews current accountability mechanisms in SHP, highlights progress, and outlines ongoing challenges.

Table 1: Overview of mechanisms under vertical, diagonal and horizontal accountability

Category	Mechanisms	Enablers (Including broader Opportunities)	Barriers (including broader Constraints)
Vertical Accountability			
Financial Accountability	Annual budget ceilings, PFM regulations, Audits, Integrated Financial Management System (IFMS), RBF	Clear legislative framework, direct facility transfers, e-cash, Program-Based Budgeting (PBB)	Continued application of Input-based budgets, weak audit enforcement at national, sub-national and health facilities level, delayed disbursements, ICT issues that may affect even use by all actors, political interference during the budget cycle
Contracting	Memorandum of Understanding (MoUs) with Private not for profit (PNFPs), Donor contracts, RBF contracts, Public Procurement and Disposal of Public Assets (PPDA) Act of 2003	Long-standing PNFP collaboration, RBF performance contracts, National Development Plan (NDP III)	Weak enforceability of MoUs, high administrative costs and parallel systems, political bias, and procurement delays

Performance Accountability	Health Management Information System (HMIS) tools, RBF reports, Annual Joint Review Missions, Donor missions	RBF mainstreamed, donor scrutiny, multisectoral coordination	Weakened district capacity, limited autonomy of PHC health facilities, fragmented monitoring by different actors, political protection of underperformers
Benefit Specification	Consolidated Uganda National Minimum Health Care Package (UNMHCP), Planning & Budget Guidelines, Community Report Cards	Explicit national benefit package, Human Capital Development (HCD) program, community transparency	Benefit package not costed affecting the availability at PHC facilities, tariffs do not attract the right incentives, Low community awareness, rigid standardization, donor priorities not fully aligned with government priorities
Provider Payment	Input-based budgeting, Salaries, Capitation grants, PBF, Operations research, Routine audits	Institutionalized RBF, focus on integration and efficiency, donor oversight	Continued use of passive provider payment mechanisms with little or no strong performance monitoring Misaligned salaries, limited focus using RBF, weak audit-linkage, Human resource centralization,
Horizontal Accountability			
Across ministries	Health Unit Management Committees (HUMCs), hospital boards, district councils, internal facility mechanisms	Active HUMCs, local budget transparency, district procurement rules	Some Inactive HUMCs, inconsistent district oversight, poor coordination, reluctance to challenge peers for poor performance
Diagonal Accountability			
Community feedback	Community meetings, suggestion boxes, client satisfaction surveys, media stories, local NGOs monitoring	Emerging tools, NGO involvement, community-triggered investigations	Weak community oversight due to information asymmetry, low awareness of entitlements in the health benefit package, ineffective feedback channels often not documented, inconsistent service charters

Uganda has formal structures for financial accountability guided by the PFM Act of 2023.[15] The MoF provides budget ceilings and disbursements, while the MoH oversees sector compliance.[14] Oversight relies on audits by the Auditor General and internal units, with districts managing fund flows. However, enforcement remains weak, audit recommendations often go unaddressed year by year, and chronic disbursement delays disrupt service delivery.[16,17] Digital tools to support transparency, but poor connectivity and limited capacity constrain facility-level effectiveness. External -funded projects create parallel systems, increasing oversight but adding administrative burden.[3] RBF integration into public systems improved financial control, but recent shifts to annual assessments reduced provider incentives.[14]

Contracting mainly occurs through MoUs, which are often lack legal enforceability.[18] Direct contracts with private providers are rare. RBF models include pre-contract assessments, but application is inconsistent. The Public Procurement and Disposal of Public Assets (PPDA) Act, 2003 provides for transparency, yet enforcement gaps and political interference persist.[19,20] Donor programs use enforceable contracts and framework agreements, strengthening accountability but this comes with increased reporting demands especially among health providers parallel to the established national health information management systems through DHIS2.[9]

Performance accountability is tracked via Annual Sector Reports and District League Tables.[21] While performance data is increasingly available, supervision is weak, is mainly seen as a routine exercise and rarely triggers corrective action. Government RBF strengthens oversight but lacks performance bonuses and frequency of assessments. Donor initiatives enforce stricter performance expectations but contribute to fragmented accountability streams since they are more aimed at the donor rather the broader health systems objectives.

The Uganda National Essential Health Care Package (UNEHCP) attempts at being more explicit on the priority health services. However, lack of costing and alignment with the available resource envelop, limited socialization to citizens and allocation inadequate resources hinder effective service delivery. Donor programs often focus on select priorities, provide incentives not available in the public health system hence distorting broader PHC goals. Many facilities lack the capacity to implement the explicit defined health benefit package.

Provider payments mechanisms remain largely input-based, with weak links to health systems performance. While annual financial audits occur, they focus more on compliance rather performance but also lack clearly defined consequences especially where audit reveals financial management gaps. Early RBF models defined clear incentives linked between payments and performance, but current models lack incentives. Donor PBF schemes offer better incentives but operate in parallel to the national health systems.

Horizontal and diagonal accountability mechanisms are underdeveloped often characterized by routine rather than their ability to contribute health systems performance. HUMCs and district councils vary in effectiveness; many rarely meet or challenge decisions. Community mechanisms like barazas and suggestion boxes are weak, often un-documented and patients often lack awareness of entitlements.[9]

Policy Implications and Recommendations

Uganda health systems can build up on existing accountability frameworks to strengthen the application of strategic health purchasing and hence improve PHC performance. This can be practically achieved through accountability enforcement, financing alignment and local empowerment. Strategic health purchasing has potential to strengthen PHC system to become transparent (track funds, enforce outcomes of accountability mechanisms), performance driven (integrated across all levels and strategic health purchasing levers) and citizen empowerment (building on existing oversight, facility autonomy and progress on health facility performance).

1. **Institutionalize Performance Accountability via National RBF Scale-Up**

To strengthen performance accountability in PHC, the Ministry of Health (MoH), in collaboration with development partners, should institutionalize RBF nationwide. This includes pre-contract capacity assessments, timely fund disbursement, enforceable contracts with measurable indicators, and expanded facility autonomy linked to performance. RBF reporting should be integrated into the national Health Management Information System (HMIS), with regular audits and independent verification to ensure transparency and accountability. These actions will embed results-oriented financing in Uganda's health system, aligning with Health Sector Development Plan III and UHC goals.

2. **Build Managerial Capacity for Effective SHP Implementation**

The MoH and district governments should also invest in strengthening managerial and leadership capacities of health facility in-charges and district teams. This includes training in financial management, planning, and audit response, as well as improved oversight of human resources and procurement. Promoting data use for performance tracking and institutionalizing supervision and mentorship will support SHP reforms and enhance stewardship.

3. **Improve Financial Accountability Through Adequate Funding and Digital Systems**

To promote transparency and reduce resource leakage, the MoH, MoFPED, and Ministry of ICT should improve fund predictability through better planning and expand digital tools such as the IFMS and mobile e-cash platforms. Investments in infrastructure and digital literacy at lower-level facilities will support real-time fund tracking and strengthen vertical accountability.

4. **Empower Communities and Strengthen Feedback for Diagonal Accountability**

The MoH, working with local governments and civil society organizations, should empower communities to monitor PHC delivery through awareness campaigns, community scorecards, barazas, client charters, suggestion boxes, and stronger Health Unit Management Committees (HUMCs) and Village Health Teams (VHTs). Structured feedback systems will enhance responsiveness and trust.

5. **Strengthen Governance, Regulation, and Data Use for SHP**

The MoH, in coordination with key regulatory bodies and stakeholders, should strengthen governance by establishing a central coordination unit, enforcing regulations, involving stakeholders in decision-making, and investing in interoperable data systems. These actions will reduce fragmentation, promote transparency, and align stakeholders toward shared accountability goals. Sustained political commitment, predictable financing, and robust monitoring will be essential for successful implementation of these recommendations.

Conclusion

Strengthening accountability in Uganda's strategic health purchasing is vital for achieving UHC. While donor-driven models such as RBF have demonstrated promise, persistent fragmentation and weak integration into national systems undermine sustainability. Closing the policy–practice gap requires empowering providers with autonomy, effective engaging communities in oversight, and embedding data-driven decision-making into routine management. Aligning government and partner roles will reduce duplication and enhance mutual accountability. By focusing on system alignment, stakeholder collaboration, and performance-linked financing, Uganda can improve health outcomes, boost efficiency, and build public trust in the health system.

References

1. Brinkerhoff, D. W. Accountability and health systems: toward conceptual clarity and policy relevance. Health Policy Plan. 19, 371–379 (2004).
2. Political Accountability: Vertical, Horizontal, and Diagonal Constraints on Governments. www.v-dem.net.
3. Ekirapa-Kiracho, E. et al. Strategic Purchasing Arrangements in Uganda and Their Implications for Universal Health Coverage. Health Syst. Reform 8, (2022).
4. Umuhoza, S. M. et al. Strengths and Weaknesses of Strategic Health Purchasing for Universal Health Coverage in Rwanda. Health Syst. Reform 8, (2022).
5. Ezenwaka, U. et al. Strategic Health Purchasing in Nigeria: Investigating Governance and Institutional Capacities within Federal Tax-Funded Health Schemes and the Formal Sector Social Health Insurance Programme. Health Syst. Reform 8, (2022).
6. Ogbuabor, D. C. & Onwujekwe, O. E. Scaling-up strategic purchasing: analysis of health system governance imperatives for strategic purchasing in a free maternal and child healthcare programme in Enugu State, Nigeria. BMC Health Serv. Res. 18, (2018).
7. Health Financing Progress Matrix assessment: Uganda 2023. https://www.who.int/publications/i/item/9789240078611.
8. Uganda vision 2040 – National Planning Authority. https://npa.go.ug/uganda-vision-2040/.
9. Kirabo-Nagemi, C. DONOR POWER AND PRIORITIZATION IN DEVELOPMENT ASSISTANCE FOR HEALTH POLICIES: THE CASE OF UGANDA 1*. 2, 54–74 (2020).
10. Local Governance Briefer - Issue 08. https://www.acode-u.org/vol/article/issue8-A2.html.
11. Hinojosa, C. Implementation Toolkit Public Policy Evaluation. (2025).
12. Kuwawenaruwa, A. et al. The role of accountability in the performance of Jazia prime vendor system in Tanzania. J. Pharm. Policy Pract. 13, (2020).
13. Meessen, B., Soucat, A. & Sekabaraga, C. Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform? Bull. World Health Organ. 89, 153 (2010).
14. Ssennyonjo, A. et al. The Government Budget: An Overlooked Vehicle for Advancing Strategic Health Purchasing. Health Syst. Reform 8, (2022).
15. Public Financial Management Reforms Strategy 2018-2023 – Public Financial Management Reforms Secretariat. https://www.pfmr.go.ke/pfmrstrategy2018-2023/.
16. Kyohairwe, S. B. & Agatre, C. Y. Funding primary health care service delivery in the West Nile sub-region, Uganda. Commonwealth Journal of Local Governance 28, 24–41 (2023).
17. (PDF) Public financial management and health service delivery : A literature review. https://www.researchgate.net/publication/317010908_Public_financial_management_and_health_service_delivery_A_literature_review.
18. Asasira, J. & Ahimbisibwe, F. Public-Private Partnership in Health Care and Its Impact on Health Outcomes: Evidence from Ruharo Mission Hospital in Uganda. Int. J. Soc. Sci. Stud. 6, 79 (2018).
19. Basheka, B. C. Public procurement governance: Toward an anti-corruption framework for public procurement in Uganda. Public Procurement, Corruption and the Crisis of Governance in Africa 113–141 (2021) doi:10.1007/978-3-030-63857-3_7.
20. Mukobi, R. Corruption in Public Procurement and its Implication on Public Service Delivery and Development in Uganda. Rule of Law and Anti-Corruption Center Journal 2024, (2024).
21. Kirungatashobya, C. et al. A critique of the Uganda district league table using a normative health system performance assessment framework. BMC Health Serv. Res. 18, (2018).