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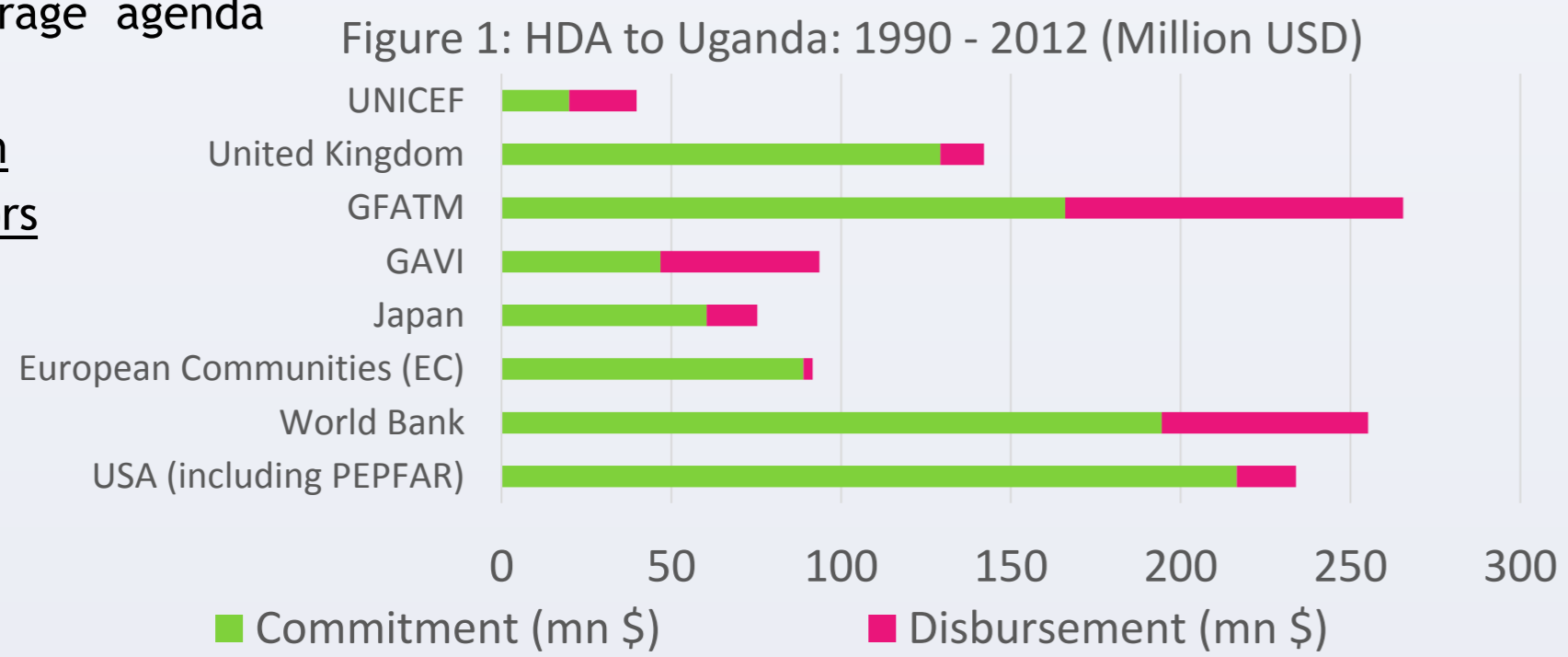
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HEALTH DEVELOPMENT AID (HDA) TO UGANDA

Ugandan health sector has over the years received substantial aid - relatively stable
Most of the aid channeled to develop health infrastructure/system - vital for Universal Health Coverage agenda

Major health sector donors



Globally, most studies on aid effectiveness are cross-country and at macro level with mixed evidence

- Aid is ineffective (Williamson, 2008; Wilson, 2011; Gebhard et al., 2008)
- Aid is effective (Mishra & Newhouse, 2007; Bendavid & Bhattacharya, 2014)

UGANDAN CONTEXT AND MOTIVATION

❖ Aid effectiveness evidence remains anecdotal

❖ There is substantial HDA inflow BUT most health indicators remain unimpressive & below desirable global health standards

E.g. (1) Maternal Mortality Rate is one of the highest in Sub-Saharan Africa at 438 per 100,000 livebirths

(2) Substantial HIV/AIDS and malaria burden - UBOS & ICF International 2012, MoH, 2010).

❖ This study is the first of its kind in Uganda based on panel analysis and geo-referenced data

❖ Study provides insights for policy makers and development partners/practitioners to improve targeting of HDA

OBJECTIVE: To analyze the impact of health aid on health outcomes in Uganda

Policy Questions:

- How effective is HDA in improving health outcomes and how can effectiveness be enhanced?
- How can HDA targeting be improved?

DATA AND METHODS

Data:

- Uganda National Household Survey (UNHS – 2005)
- Uganda National Panel Survey (UNPS – 2011/12): Balanced panel of 10354 individuals
- Geo-referenced foreign aid data – AidData : (Aid projects effective 2006-2010)

Analysis

- Descriptive statistics
- Difference-In-Differences estimation (Diff-in-Diff) with Fixed Effect

Treatment: Health aid

Outcome: Disease severity & disease burden

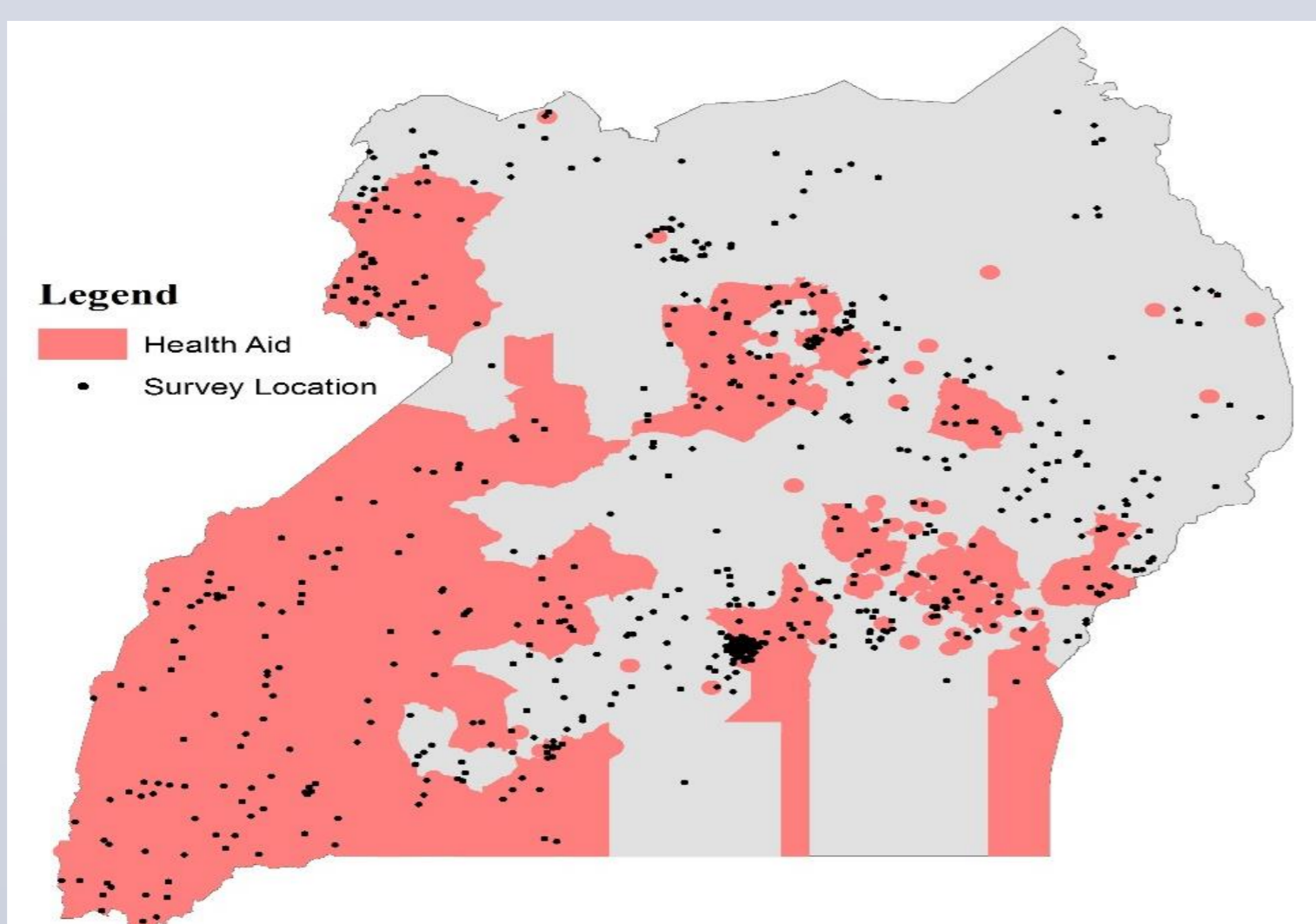
FINDINGS

AID TARGETING

Location of HDA & survey areas

- Aid allocated to Better-off areas

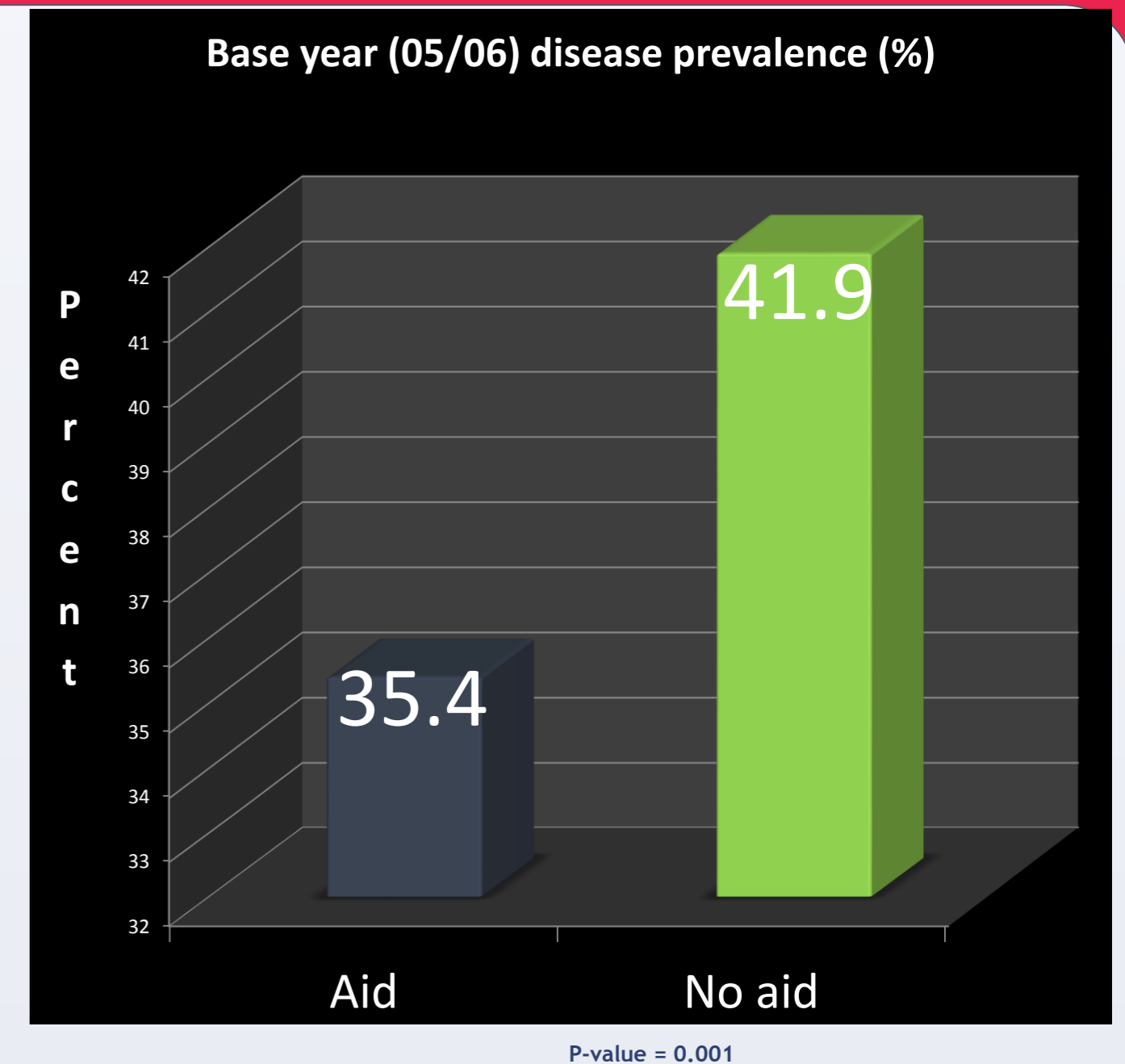
Those who received aid were associated with relatively better welfare status



Aid targeting

While aid reached some localities with worst health conditions, it was not preferentially targeted to these areas

(Living in worst health conditions didn't increase chances of receiving aid)



EMPIRICAL RESULTS - IMPACT OF AID ON HEALTH OUTCOMES

	Sub-Sample (Only sick)			Full Sample		
	3km	5km	7km	3km	5km	7km
Disease severity						
Aid Impact	-0.1009 (0.0717)	-0.0749 (0.0722)	-0.0250 (0.0727)	-0.031** (0.0145)	-0.03** (0.0146)	-0.0195 (0.0146)
Observations (weighted)	8920613	8920613	8920613	27840398	27840398	27840398
Disease burden						
Aid Impact	-0.2345** (0.1048)	-0.1414 (0.1074)	-0.0208 (0.1074)	-0.0504** (0.0220)	-0.0529** (0.0222)	-0.0391* (0.0223)
Observations (weighted)	6557885	6557885	6557885	27798525	27798525	27798525

Source: Author's computation based on UNHS (05/06), UNPS (11/12), AidData database

CONCLUSION

- Aid was not preferentially targeted to localities with worst health conditions
- Health aid is instrumental in reducing disease burden (both in the sub & entire population). But estimates are lower in full sample
- Relationship between aid & disease severity is less robust, as it is only significant using full sample
- Aid impact is stronger for individuals closer to aid projects - aid is more effective if channeled closer to intended beneficiaries

RECOMMEDATION

- Results point to the need for development partners to better target health aid into areas with higher disease prevalence
- Aid ought to be channeled as close to intended beneficiaries as possible – additional advantage of driving Universal Health Coverage strategy of “close to client” health system.