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The Politics of Blended Health Sector Financing in Uganda: Unpacking the World Bank's Global Financing Facility

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Abstract

This paper examines the politics of blended financing with reference to the World Bank-inspired Global Financing Facility for maternal, newborn, child, and adolescent health (RMNCAH) in Uganda. Critical literature review was conducted, followed by interviews with government technocrats, multilateral agencies (World Bank, WHO and UNICEF), civil society organizations and selected district health officers. Our main finding is twofold. Procedurally, blended finance takes the trodden path of developmental paternalism characterized by asymmetrical power relations between donors (who determine fundable priorities) and beneficiaries (whose inclusion hardly counts). Substantively, however, Uganda's Investment Case uses concessional IDA credit worth US$110m, multi-donor trust funds worth $30m and a SIDA grant of US$25m. This raises the total to $165m, with a grant component of 33.33%, far above the 25% recommended by the OECD. The emerging conclusion is simple: blended finance is imperfect, but is not 'dead aid' *a la* Dambisa Moyo (2010).

1. Introduction

This study examines the politics and power dynamics underpinning the relatively new form of development assistance, code-named blended financing. Also known as hybridized funding, blended financing is, by definition, the "… strategic use of development finance and philanthropic funds to mobilize private capital flows to emerging and frontier markets" (Convergence, 2019). It is a 'catalytic' approach to resource mobilization for development assistance. The catalyst is evident in the hedging strategy that is adopted. A credible development agency—particularly the World Bank—commits concessional funding not as an end in itself but as a means of 'crowding in' non-traditional lenders (such as the Bill Gates and Melinda Foundation) and private companies which are incentivized to invest in the otherwise 'risky' frontier markets of the global South (Makerere Interviews, 2019). The political economy arithmetic is simple: concessional loans, plus philanthropic grants, plus commercial loans (at market rates), equal blended finance.

This creative approach was recognized by the Third International Conference on Financing for Development that took place in Addis Ababa in July 2015; hence the term Addis Ababa Action Agenda (AAA). The AAA identified blended financing as a panacea to the perennial problem of underfunded development priorities in

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poor market economies. The underlying argument was simple but not pedestrian. The 17 voluminous Sustainable Development Goals (SDGs) agreed by the global community in September 2015 require substantial investments, and will remain underfunded unless creative approaches to development financing are adopted.

The rationale for creative financing is simultaneously pragmatic and ideological. Pragmatically, the UN estimates that the total finance needed to achieve the SDGs is about $4tr annually. The 2019 level of development financing is $1.5tr, leaving a funding gap of $2.5tr per annum. Admittedly, the UN passed a resolution on 24 October 1970 in which donor countries agreed to give 0.7% overseas development assistance (ODA) as a proportion of their gross domestic income (GNI). To-date, the 0.7% ODA/GNI target is only met by a handful of donors.

Ironically, today's largest donor is China (a non-member of the Development Assistance Committee), not USA, which is the world's largest economy. Between 2000 and 2014 China offered $350bn worth of aid to 140 countries and territories, sponsoring over 4000 projects. In 2009 alone, China's total development aid reached a whopping $69.9bn, two times that of USA (Vadlamannati et al., 2019). By 2016, China's foreign aid of $38bn was still the world's largest, but as a proportion of GNI, this was only 0.36% of its GNI, far below the UN target of 0.7%.

Among the DAC members, USA—which gave a total development aid worth $31.08bn in 2016—was the most generous donor. However, the USA's ODA/GNI was only 0.17%. Following USA in the volume of aid was the UK at $18.70bn (giving an ODA/GNI ratio of 0.71%); Germany at $17.78bn (0.52%); Japan at $10.4bn (0.22%); France at $9.23bn (0.37%) and Sweden at $7.09bn (1.40%). In terms of net ODA as a percentage of GNI, only six DAC countries met and/or exceeded the UN target of 0.7%. These were Sweden (1.40%), Norway (1.05%), Luxembourg (0.93%), Denmark (0.85%), Netherlands (0.76%), and the UK (0.71%).

In addition to the minute number of DAC members who meet the UN benchmark of 0.7%, is the disconnection between the official versus the real purpose of development aid. China's aid is a case in point. About 50% of China's aid is spent on infrastructure projects such as energy and roads. These are, without a doubt, development-enhancing investments. However, the top recipients of Chinese aid are the members of the One Belt Road Initiative, a program pushed by President Xi to deepen cross-national trading routes in the interest of China, not aid recipients.

But China is not alone in using aid to pursue its national interests. The largest recipients of US foreign aid are Israel, Afghanistan, and Egypt, which get $3.10bn, $1.51bn and $1.46bn, respectively, of largely *military* assistance. Germany's development aid is also worth noting. Between 2015–2016, the country's aid budget dramatically increased by 36.1%, causing Germany's ODA to GNI ratio to hit the 0.7% target. However, the major reason for this boost was the influx of refugees. With effect from 2016 Germany reclassified its in-country expenditure on

humanitarian assistance as international development aid. In other words, Germany hit the United Nations' ODA/GNI target via increased in-country, not overseas, expenditure.[1]

Compounding the pragmatic politics of development aid is the ideological factor. Ideologically, traditional donors (such as the World Bank) appear to be suffering donor fatigue: real or perceived. Yet, anecdotal evidence suggests that extreme poverty and social exclusion continue to serve as breeding grounds of violent extremism, which threatens human civilization across the world. In the light of this, the global political economy has gravitated towards an ideology of inclusion code-named '*Leaving No One Behind*'. This ideology can hardly gain traction without increased development financing.

It is in this context that blended finance seems to make sense. The different investors in blended financing have different return expectations, ranging from concessional to market-rates. Concessional lenders use their resources to maximize global power and influence (for themselves as institutional actors and for their sovereign creditors such as the US, Britain, or France). Philanthropic donors invoke the logic of corporate social responsibility—defined as capitalism with a human face—to maximize their developmental relevance. Aid-recipients such as Uganda or Tanzania seek to maximize country-specific developmental outcomes (such as maternal and new-born health). The unifying denominator, it will be argued, is the new politics of aid, defined as the struggle by different actors to shape today's development policy space in furtherance of their cherished values, interests or preferences, whether they are commercial or ideological.

This paper examines the politics of blended financing with reference to the World Bank-inspired Global Financing Facility (GFF) for maternal, newborn, child, and adolescent health (RMNCAH) in Uganda. The work is articulated in the context of the global consensus on increasing health sector financing with an eye on widened inclusivity, which is implied in the notion of *Every Woman, Every Child*. To what degree is the new dispensation genuinely shifting from ritualistic inclusion to substantive inclusion via a consultative approach?

To answer this question, we assess whether, or to what extent, the GFF shifts from business-as-usual to a new culture of business-unusual in the use of foreign aid to pursue health sector outcomes for the targeted RMNCAH beneficiaries. The presence or absence of 'business unusual' is assessed with reference to four factors:

(a) The level and quality of participation of Ugandan technocrats in the design of the global GFF;

[1] In the same vein, in 2016 the UK became the third largest foreign aid donor among DAC countries by spending a substantial proportion of its total of $18.01bn in development aid largely on humanitarian programs and other crisis-relief projects in nations close to the European Union. These include Pakistan, Ethiopia, and Afghanistan; each receiving more than $300m in UK aid. Additionally, Nigeria, Syria, Sierra Leone, South Sudan, and Tanzania all received more than $200m.

(b) The quality of country-specific participation (at national and sub-national levels);
(c) The role of citizen participation in the GFF process proxied by civil society inclusion or otherwise in the definition of Uganda's health sector investment priorities; and
(d) The implementation modality underpinned by the pro-market ideology of results-based financing (RBF).

The GFF arguably presents a mixed picture. On the positive side, the maxim of '*Every Woman, Every Child*' is consistent with the cardinal virtue of the global SDGs – *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 Moyo (2010), the IDA credit represents development-enhancing aid, not *dead aid*. This credit 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). A concessional loan is one where "… its grant element is above 25% and where the interest rate charged by the lender is below the market rate for interest on a similar loan" (Mustapha et al., 2014: 9). Uganda's Investment Case of $165m has a substantial grant component of $55m (or 33.33%). This figure is higher than the 25% grant element recommended by the OECD (signifying its developmental credentials).

The multi-donor grant component of $30m is also a welcome relief to Uganda's tight health sector budgets. Uganda's total health expenditure is roughly US$50.1 per capita per year, substantially below the recommended US$86 per capita per year (expressed in 2012 US dollar terms) for low-income countries to develop a functional health system (McIntyre & Meheus, 2014).

However, the GFF appears to have substantial shortfalls conceptually, procedurally, and at the level of system-building. Conceptually, for example, the theory of change-driving GFF is embedded in what has been baptized as results-based financing (RBF), 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" (World Bank, 2013). Results-based financing is premised on several assumptions, namely:

(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.

These assumptions are inconsistent with the realities in Uganda, such as the dysfunctional health delivery system, with most state elites using tax-payers' money to seek healthcare overseas.

The paper is organised as follows. Section two highlights the global context of GFF, with an eye on the SDGs, particularly SDG 3 which seeks to promote healthy lives and wellbeing for all at all ages. Section three outlines the Ugandan context of the GFF. Section four presents the methodology that guided this study. Section five provides the major conclusions and policy recommendations.

2. Global Context of GFF

As already hinted, the GFF is a multi-donor funding mechanism. As a variant of blended financing, it mobilizes, coordinates, and utilizes resources from the World Bank, leading donor countries (such as Canada, Norway, USA, and Japan), as well as private foundations—typified by the Bill and Melinda Gates Foundation (IPPF, AFP & RHSC, 2016). The ascent is on scaling-up commercial financing of health sector budgets of poor countries. The objective is to maximize positive results for concessional lenders, commercial investors, and aid recipients.

Evidently, the GFF uses a hybridized funding model that includes the use of multi-donor trust funds and World Bank concessional lending, disbursed through the International Development Agency (IDA). The cardinal goal of GFF is to "… contribute to collective efforts to end preventable deaths of women, adolescents, children, and newborns by 2030" (GFF, 2018:1). The GFF aims to realize this by closing the funding gap for reproductive, maternal, newborn, child, and adolescent health (RMNCAH) among financially constrained aid recipients. However, the reliance on concessional credit and donor grants does not preclude the use of the resources of aid recipients; in cash and/or in kind (MoH Interviews, Kampala, October 2017). This signifies one key point in the discourse on foreign aid: the GFF seeks to complement, not substitute, country-specific funding modalities.

A review of documents suggests that the GFF springs from the recent global dynamics on health sector financing, as emphasized, for example, by the Institute for Health Metrics and Evaluation (IHME). The IHME (2017) presents health data that confirm that a country's total health spending is positively associated with its level of development. Indeed, substantial variations exist in health spending across nation-states and within income groups. Between 1995 and 2014, a disturbing global trend happened. According to IHME (2017: 11):

> … 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 1995 spending per capita in those countries was very low, the absolute gains [by 2014] were small.

For many poor countries, development assistance for health (DAH) has become a critical source of 'gap-filler' health financing. DAH 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 DAH). Between 2000 and 2010, DAH grew rapidly (at an average rate of 11.4% per annum), but eventually slowed down to only 1.8% annually between 2010 and 2016. DAH totalled about $37.6bn in 2016, rising by only 0.1% from the 2015 level (IHME, 2017).

In the light of the foregoing, the gravity of global public opinion converged on three things. First, and as IHME (2017: 12) notes, "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." Second, global consensus now exists that health is a right, not a matter of charity. Thus, leading health advocates, donors and governments now endorse the concept of universal health coverage. The universality of health coverage is premised on the welfarist view that all people —male or female, rich or poor, young or old, in the labour market or outside, in the global North or the South—"… should have reliable, good-quality health care without the risk of financial hardship" (ibid: 11). Third, important cross-national variations exist on the sources of health financing. High-income countries largely rely on public financing, which includes health insurance. Middle-income countries typically evolve from donor-dependence to greater reliance on domestic revenue as a source of funding. However, low-income countries (such as Uganda or South Sudan) finance most health spending from out-of-pocket expenses, backed by low and often declining government financing; hence the need for gap-filler development assistance as an instrument of inclusive health access.

A key factor contextualizing the rise of GFF is the global consensus on the 17 SDGs. These global compacts were informed by the quest for greater inclusivity, defined in terms of 'evening-up' things that matter most for global, regional, and national development. For example, Goal 3 seeks to promote healthy lives and well-being *for all at all ages*. Clearly, the pursuit of reproductive, maternal, newborn, child and adolescent health (RMNCAH) falls under this SDG goal. But RMNCAH also echoes SDG 5, which seeks to achieve gender equality and the empowerment of women and girls.

An additional factor worth noting is the 'origin' of the GFF initiative in the UN/ World Bank circles. In theory, the GFF is a "… multi-stakeholder partnership that supports *country-led* efforts to improve the health of women, children and adolescents" (World Bank, 2017, *emphasis added*). In practice, the country-ownership of the GFF, like the nationality of the old structural adjustment programs, is questionable. For example, the 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. 'Announcement' here signifies that certain elites in the global political economy took decisions and only communicated them to the 'others' in poor market economies.

As a venue of the announcement, the UN General Assembly is important precisely because it is a space where the 'democratic' voices of UN member-states may be heard. But this does not discount the fact that the GFF was merely announced, not democratically debated. As the World Bank (2017: 1) observes:

> The World Bank Group and the United Nations launched the GFF at the Third International Conference on Financing for Development in Addis Ababa in July 2015 in support of *Every Woman Every Child*, and as part of a global conversation about how to finance the Sustainable Development Goals.

It is also worth noting that the governance structure of the GFF underscores its underlying politics, power relations and democratic credentials, or the lack thereof. The GFF governance structure includes the GFF Secretariat, the Investors Group, and the Trust Fund Committee. As Dennis (2016) notes, 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. We hasten to add an important point. The Secretariat is responsible for resource mobilization from donors, and for the day-to-day governance of the GFF initiative. The influential Secretariat manages the GFF's trust fund, supports GFF implementation by beneficiaries, and coordinates the powerful Investors Group.

The Investors Group is the second key institutional arrangement at the GFF. According to the World Bank (2017: 1), the Investors Group consists of "… the World Bank Group; … Gavi, the Vaccine Alliance; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the United Nations; MSD for Mothers; the Bill & Melinda Gates Foundation; and the governments of Canada, Norway, Japan, the United Kingdom and the United States." The key purpose of the Investors Group is to oversee the GFF. Dennis (2016: 3) argues that 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. This implies that they have significant political economy power vis-à-vis the global South.

The third institutional arrangement within the GFF is the Trust Fund Committee. Members of this committee make tough decisions regarding the allocation of trust funds. While they work with the GFF Secretariat—and oftentimes in consultation with the governments of beneficiary countries—members of the Trust Fund Committee are difficult to reach and/or influence.

Overall, the governance structure of the GFF, like that of the IMF or the World Bank, does not lend credence to the hopes of popular, democratic participation of the poverty-stricken countries of the global South in the business of the GFF.

A gleaning of the literature underscores three categories of countries that have so far benefitted from GFF: the 'front-runner' (or 'pilot') countries; the 'second wave' beneficiaries; and the 'third wave' cohort. The first category includes the

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 consists of eight countries that 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 (GHV, 2016: 8). The third wave consists of four beneficiaries: Guatemala, Guinea, Myanmar, and Sierra Leone. According to the GFF Secretariat (2018), an expansion strategy for the GFF has been developed. A key element of this strategy is the replenishment of the GFF by raising an additional US$2bn for the Trust Fund over the period 2018–23. The aim is to support a total of 50 eligible countries.

While the aforementioned countries are all eligible aid recipients—thanks to their status as poor nation-states—they appear to have been *merely* announced as GFF beneficiaries. No evidence has been found of a genuine consultative-cum-participatory approach to the selection of GFF beneficiaries, or the exclusion of other potentially eligible beneficiaries (such as Somalia or Libya). What seems likely is the perpetuation of what Easterly (2013) calls 'developmental paternalism'. Developmental paternalism signifies the importance of top-down, as opposed to bottom-up, approaches to development. It underscores the asymmetrical power relations between the major stakeholders in the development realm: authoritarian parents versus little kids; donors versus aid-recipients; dictatorial rulers versus intimidated citizens. This study focuses on the selection of Uganda as a second-wave beneficiary.

3. Uganda's Context of GFF

Directly and indirectly inspired by the experiences of the pilot GFF countries, Uganda submitted its Investment Case worth US$140m to the World Bank in July 2016, and rapidly obtained approval of its request. True to the GFF's hybridized financing model, Uganda's Investment Case involves the use of concessional credit from IDA worth US$110m, and multi-donor trust funds worth $30m, adding up to a total of US$140m (World Bank Interviews, 2017; MoH Interviews, 2017). By December 2017, SIDA had come on board with a grant of US$25m. This raised the overall total to $165m, and pushed the grant component to 33.33%. Additionally, the IDA contribution of US$110m is a concessional loan, not a commercial loan.

As Fig. 1 indicates, the Ugandan variant of GFF is an intervention that leverages concessional loans, philanthropic grants, commercial loans (from the private sector) and national resources to deliver substantial RMNCAH outcomes for vulnerable mothers, newborns and girls. Uganda's Investment Case had a project implementation start-date of 04 August 2016; signifying the rapidity with which the project submitted in July 2016 was approved. The intervention had an 'expected effectiveness date' of 04 December 2016 (which was not realized), and an end-date of 31-Dec-2020 (MoH Interviews, 2017).

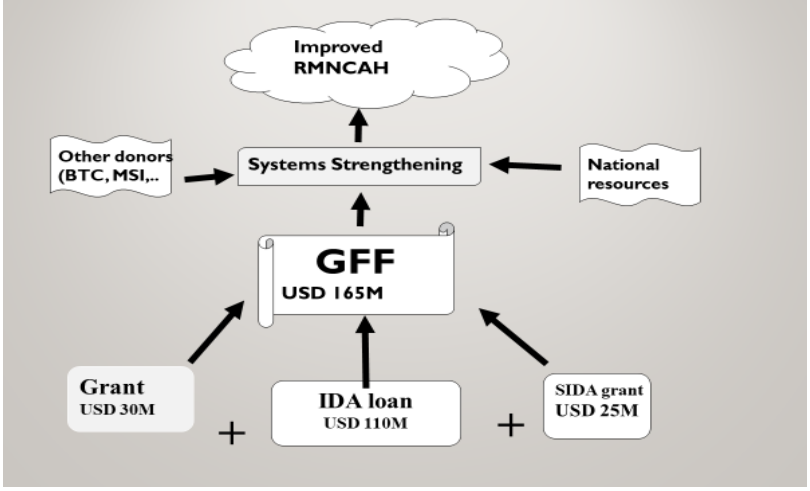

Figure 1: ***The GFF in the Context of Uganda***
Source: Developed and Visualized by Authors

A critical review of official documents shows that the Investment Case for Uganda's GFF is associated with country-specific challenges. According to the UBoS (2014), Uganda's urban population is less than 20%, signifying that roughly 80% of Uganda's 40m people live in the rural areas primarily as peasant agriculturalists. The peasants, who are victims of economic exclusion, till their land using primitive hand hoes. They depend on rains to irrigate their farms, and fight pest and diseases through prayers, not science. Their household incomes are among the lowest in the land. Yet, they lack health insurance and can only access healthcare using out-of-pocket expenses.

It is worth noting that Uganda has registered impressive gross domestic product (GDP) growth rates of about 4.6% over the period 2013–2015. However, per capita GNI has increased at a much slower pace. In 2014 it was estimated at US$670, slightly above the average (US$629) for low-income countries. This signifies a weak tax base for financing public health services. Ironically, the GFF proposes to use a pro-market 'results-based financing' to supposedly increase health access for the poor and vulnerable victims of exclusion. What is not clear is 'how' the financing model will work in Uganda's poverty-stricken political economy.

Headcount poverty in Uganda has declined from 56.4% of the population in 1993 to 19.5% in 2013, but dramatically rose again to 27% in 2017. Compounding the rise in poverty is the fact that inequality—measured by the Gini index—increased from 0.36 to 0.40 over the period, and is now at roughly 0.45. Most Ugandans live in rural areas where poverty is prevalent (over 30% compared to 8% in urban areas). In addition, a large share of the population (43.3%) remains highly vulnerable to collapsing back into poverty.

Compounding the poverty metrics is Uganda's significant problem of a young population. Almost half (48.5%) of Uganda's population is below the age of 15 years. Moreover, the country has high fertility levels. The population growth rate, estimated at slightly above 3% between 2002 and 2017, is mainly driven by the high total fertility rate (TFR) of 5.8 children per woman (UBoS, 2014; WPR, 2018).

According to McNee (2012), a recurring theme in the politics of health financing is the search for improved effectiveness. The dominant discourse in the mid-1990s was the inefficiency associated with projectized aid. The antidote to projectization was the 'Sector Wide Approach' (SWAp), which opened spaces for greater alignment, harmonization, and coordination of health service delivery. The aim of the health SWAps was to ensure, as McNee (2012) notes, that health aid is "… more efficiently provided through processes that were aligned and harmonized both amongst donors, and with Government systems."

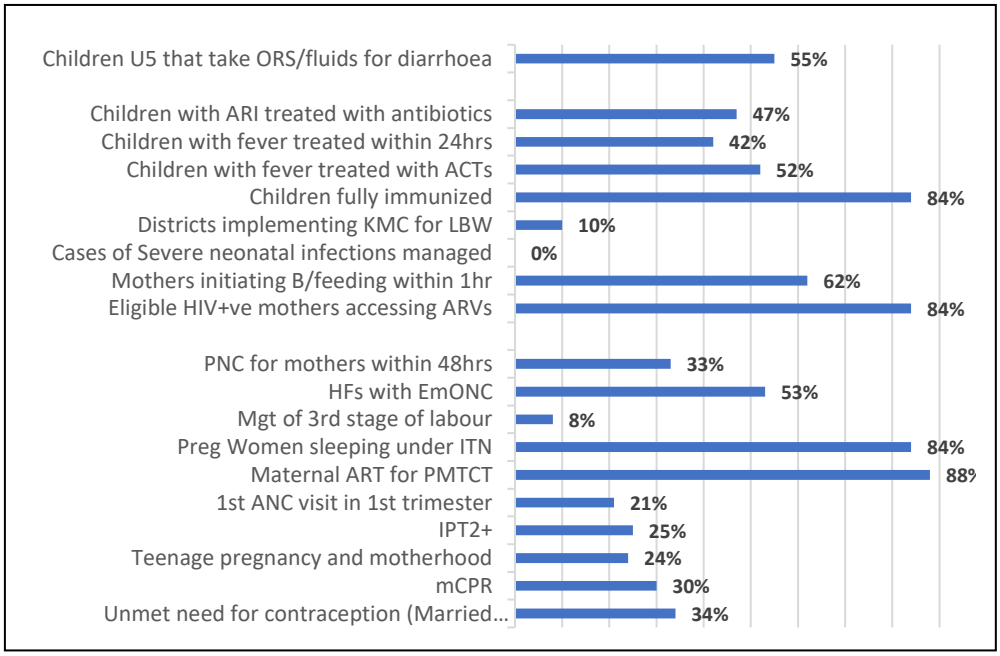

Figure 2: Coverage of Selected Reproductive, Maternal, Neonatal, Child, and Adolescent Health Interventions Along the Continuum of Care

Source: Revised RMNCAI-I 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

Today's GFF appears to be the reincarnation of yester-years' health SWAps. The unresolved question is how to overcome Uganda's high burden of disease including, but not limited to, malaria (the leading killer disease in 2015-2017), HIV/AIDS, tuberculosis, lower respiratory infections, peri/neonatal complications, and diarrheal diseases (see Fig. 2). Despite the country's advances in malaria control, for example, malaria is still the top cause of under-five morbidity and mortality. Second, neonatal mortality, estimated at 27 deaths per 1,000 live births in 2017, has remained relatively unchanged mostly due to inadequate neonatal care.

It is worth noting that malnutrition, infant mortality, and under-five mortality rates have steadily dropped since 1995 (UBoS, 2014). The reduction in child mortality is attributed to improved immunization, expansion of the activities for the elimination of mother-to-child transmission of HIV, and malaria control. Unfortunately, several (inexcusable) challenges persist. For example, malnutrition is causally linked to 33% of stunting among children. It is the underlying cause of nearly 60 and 25% of infant and maternal deaths, respectively. Vitamin A deficiency rose from 19% to 38% for children, and from 20 to 36% among women between 1995 and 2017. Additionally, progress with tackling pneumonia has been slow, and its share of deaths increased from 10% in 2008 to 23% in 2017.

Women and children continue to be the most affected population groups, bearing a disproportionate burden of disease in Uganda. While communicable diseases remain prevalent, non-communicable diseases are rising. In short, the burden of disease remains high, and calls for a new culture of business-unusual. Yet, there appears to be an over-supply of business-as-usual.

4. The Methodology

This study proceeded with a critical review of the GFF-related documents in both soft and hard copies. We sought to document the major stakeholders who were involved in the conceptualization of the GFF, and the diffusion channel of the GFF norms from the international level to country-specific contexts.

The study employed a multidisciplinary research team (consisting of an academic researcher, a hands-on health governance professional, and a health rights advocate). The team developed doable domains of inquiry in the broad spectrum of the governance of health rights. Following a broad consultative approach, the team zeroed down on two domains of inquiry: (a) participation and accountability; and (b) Uganda's implementation capacity of the GFF proxied by the degree to which different actors were consultatively brought on board to lubricate policy implementation.[2] The study also sought to assess the functionality of the selected implementation modality, namely, results-based financing in view of Uganda's

[2] Other factors that may impact implementation capacity (such as the presence or absence of enabling regulations) were not examined due to time and resource constraints

context-specific realities, such as the prevalence of low purchasing power of citizens, thanks to the high levels of poverty.[3]

Based on our domains of inquiry, we reviewed the relevant literature and documents, including the Uganda Investment Case and the IDA project appraisal documents. We then conducted key informant interviews with the relevant government technocrats. Interviewees were drawn from the following institutions: The Ministry of Health, Ministry for Finance; National Planning Authority, Uganda Bureau of Statistics (UBoS), Ministry of Gender, Labour and Social Development, and the Ministry of Local Government. In addition, relevant officials from multilateral agencies were interviewed, including those from the World Health Organization (WHO), UNICEF, and the World Bank.

Additionally, a civil society organizations' (CSOs) mapping was utilized to identify CSOs that were involved in the design and negotiation of the GFF. A distinction was drawn between (a) CSOs that were involved in reproductive, maternal, newborn, child and adolescent health-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 the World Bank and GFF processes.

Sampling Strategy

We first sought, from the Ministry of Health, a list of the 25 districts that were selected to pilot the GFF. From this list, we picked a purposively selected sample of 5 districts, close to and including the capital city, for a rapid assessment on how the GFF project was implemented at sub-national level. We held one-on-one interviews with a total of 4 district health officers (DHOs) and 3 assistant district administrative officials. The latter are the leaders responsible for health in the districts, and the DHOs are the lead technocrats for health in the districts. While these were not statistically representative, they revealed deep insights into the subject matter.

Limitations of the Study

The main limitation of this study is that we hardly conducted any interviews outside the central region of Uganda. This was primarily because the study mainly examined the politics underpinning the conceptualization of the GFF and its diffusion to Uganda to inform the country-specific Sharpened Plan that metamorphosed into Uganda's Investment Case. These politics of conceptualization were characterized by the centralization of power globally and nationally. Globally, power was concentrated at the World Bank headquarters. Within Uganda's national context, power and influence were concentrated at the Ministry of Health and the powerful Ministry for Finance (which officially

[3] Field surveys to determine the staffing levels of health facilities, and the qualifications of health workers were not carried out. For one thing, interviewees at the sector Ministry of Health reported that the roll out of Uganda's Investment Case had not yet advanced beyond headquarters.

interfaces with all foreign donors). Future studies will have to extend field research to a representative sample of Uganda's districts and health units.

5. Findings: Business-as-Usual with Strong Dozes of Business-Un-usual?

Persistence of Jargon

One of the striking points of the GFF is the survival of the World Bank jargon in the supposedly new health sector financing modality. The business plan that was released by the GFF team on 17 May 2015, is a case in point. The plan is rich in romantic jargon. It seeks to operationalize 'smart financing' that will supposedly prioritize investment in 'evidence-based', 'high-impact' solutions, in such areas as nutrition, immunization and family planning. These impacts will supposedly be 'delivered in an *efficient*, *results-focused* manner' (*emphasis added*). Box 1 indicates an outline of the 'smart financing' and other aspects of the jargon.

BOX 1: NEW WINE IN OLD WINESKINS? KEY PILLARS OF THE GFF

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

1. **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;
2. **Scaled financing** that mobilizes the additional resources needed to fully finance the maternal and child health agenda from both domestic and international, and both public and private sources; and,
3. **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.

Source: GFF Business Plan, May 2015.

This developmental jargon 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 re-invention is understandable, even justifiable, given the need for the World Bank, like other adaptive institutions, to change with the changing business environment. Our point of concern is that the impressive jargon 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 not succeeded in attaining low inflation rates of under 10%.

Similarly, these 'best practice' policies have failed to create decent 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% (UBoS, 2014). 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 jargon, it would seem, is new wine in the old wine skin of the aid policy establishment.

However, 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 front-runner beneficiaries (DRC, Ethiopia, Kenya, and Tanzania) and the 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. Was the GFF consultation process substantive or simply ritualistic? This is important given the asymmetrical power relations between these two parties.

Questionable Local Ownership

Uganda's Investment Case has questionable country ownership precisely because it was characterized by limited conversations at the national and sub-national levels. Yet, country ownership was identified as the first—and perhaps the most—cardinal principle of the Paris Declaration on aid effectiveness (AAA, 2008).[4] Making matters worse is the limited involvement of CSOs in voicing popular priorities in Uganda's Investment Case.

Yet here, again, both documentary evidence and field interviews point to an interesting finding. The list of fundable priorities is manifestly comprehensive. Emphasis, as already hinted, is placed on funding for reproductive, maternal, newborn, child, and adolescent health (RMNCAH). The guiding philosophy of Uganda's Investment Case is *Every Woman, Every Child*. This has a substantial doze of inclusivity; the only problem being its gender blindness in the specific case of excluding adult *males* in the RMNCAH agenda.

The emerging inference is simple and clear. Uganda's Investment Case, like the global GFF and structural adjustment programs, *procedurally* falls in the age-old tradition of business-as-usual. Its democracy deficits procedurally put it in the tradition of authoritarian paternalism. This signifies, as Easterly (2013) would observe, that today's financially powerful donors continue to determine, with limited grassroots inputs, what is good for the poverty-stricken aid recipients of the

[4] The full list of the five principles of aid effectiveness includes (a) country ownership; (b) alignment of donor interventions with national developmental objectives; (c) harmonization of donor efforts and resources; (d) impactful/measurable results; and (e) mutual accountability of donors and aid recipients for developmental outcomes, or the lack thereof.

global South. It signifies, as Swahili anthropologists would argue, that *maskini hawana sauti!* [the poor are voiceless]. However, in terms of content, Uganda's Investment Case is *substantively* and materially closer to the new culture of 'business un-usual' than earlier forms of foreign aid.

Participation of Ugandan Technocrats in GFF Design

Uganda was selected in July 2015 as one of the 'second-wave' beneficiaries of the GFF Trust Fund. Uganda's inclusion was negotiated by the then Minister of Health, Dr. Elioda Tumwesigye, after hearing about this opportunity during the 10th Ordinary Meeting of the East African Community Sectoral Council of Ministers of Heath in Arusha in October 2014. A WHO official whom we interviewed observed that "*The Ministry of Health had to do special negotiations to ensure that Uganda is part of the GFF*" (WHO Interviews, November 2017).

But Uganda's inclusion was not just because of lobbying. According to a World Bank interviewee,

> *"There were two simultaneous initiatives by 2015: 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 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"* (Interviews, Kampala, November 2017).

Three senior officials within the Ministry of Health (in the Planning Department and the Reproductive Health Division) indicated a general lack of understanding of the GFF principles, with their discussions focused on just the Investment Case, which is just one of the components of the GFF. The reason for this is clear, if not worrying: "*Apart from the Investment Case, 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 as follows:

> *"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 health sector loans and other aspects of GFF, the World Bank and top elites in the Ministry of Finance are better placed to answer"* (MoH Interviews, Kampala, November 2017).

The top officials of bilateral organizations, particularly within the WHO and UNFPA, upheld—to varying degrees—the aforementioned view. The dominant view was that the conceptualization of the 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 Easterly's (2013) critique of foreign aid as an instrument of donors' paternalistic authoritarianism. Simply stated, donors propagate the myth that poor countries are like school children whose

'childish' preferences must be subjected to the choices of a superior authority, this time represented by donors. To the extent that aid recipients are uncomfortable with the asymmetrical power relations, they have no one to blame but themselves for being citizens of what US President Trump reportedly calls 'shithole countries'.

Thus, while Uganda already had a 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 Global Financing Facility Trust Fund. The preparation and refinement of the Investment Case was part of the requirements for starting the GFF process. The development involved two phases. Phase 1 resulted in a national strategy to guide the implementation of RMNACH. This was the Sharpened Plan of 2013–2017. Launched in November 2013, the Plan became the basis for health sector financing 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 the 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 staff and the 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. This dovetailed well with the GFF requirements."* (Bank Interviews, Kampala, November 2017).

A senior Ministry of Health (MoH) 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"* (MoH Interviews, Kampala, November 2017).

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*" (UNFPA Interviews, Kampala, November 2017). Moreover, the MoH reportedly limited the number of non-MoH 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 the civil society they only wanted one organization to represent the rest. From Uganda's local governments and health facilities, I doubt if there was any inclusion or even consultation"* (UNFPA Interviews, Kampala, November 2017).

The study participants suggest that the politics of negotiating health sector financing was characterized by the lack of consensus amongst the Investment Case development team. A UNFPA interviewee reported that:

> "*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"* (UNFPA Interviews, Kampala, November 2017).

According to a MoH 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 a comprehensive sexuality education (which included issues of gay and lesbian rights). These were emphasized by certain donors and resisted by Ugandan officials. Notwithstanding some disagreements, multilateral organizations—including UNFPA, WHO and UNICEF—technically supported Uganda. A senior MoH official indicated that the tools that were used to help Uganda (led by UNFPA, WHO and UNICEF) included costing tools, and bottleneck analysis whose object was to help the Ugandan technocrats identify high impact, and low cost-strategies for Uganda's Investment Case.

Uganda's Investment Case reportedly demonstrates the politics of donor-financing. It demonstrates that old habits die hard. The negotiations of Uganda's variant of the 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 $30m and the matched credit of $110m were negotiated as part of one package"* (World Bank Interviews, Kampala, November 2017).

It is evident from the interviewees that the state officials lacked a clear understanding of the negotiation process, including the interest rates, and the disbursement arrangements. A senior technocrat of the sector Ministry of Health reported that the Parliament, Ministry for Finance, and the World Bank were better placed to understand the negotiation procedures. This suggests poor preparedness of the MoH officials in the negotiation process. The Ministry for Finance, which manages the interface between Uganda and donors, declined to participate in this study.

Quality of Participation of Local Government Technocrats

While all respondents had heard about the GFF, some only got to know of the initiative at a stakeholder meeting of 6 February 2018, in which 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. Three DHOs who had heard about GFF before the aforementioned meeting of 6 February 2018 only did so through informal conversations with colleagues.

The Luwero District Health Officer (DHO) emphasized that *"… a multi-sectoral response was needed*" in Uganda's Investment Case. This is because health issues are too important to be left to health professionals. The issue of teenage pregnancies, for instance, can only be effectively addressed if:

> *"… the health ministry works in partnership with the Ministry of Gender, Labour and Social Development; the Ministry of Education and Sports; the Ministry of Local Government; and cultural institutions who are custodians of social norms. CSOs also have a role to play here in connecting the dots"* (Interviews, January 2018).

However, our interviewees reported that an organic, multi-sectoral approach was not used. For example, local government officials were not involved in the design

of Uganda's Investment Case. While this information has not been obtained via a representative sample, it undoubtedly points to a highly centralized process of developing sector-specific plans in Uganda. It contradicts the philosophy and practice of decentralized governance. The limited participation of district-level technocrats also points to significant deficiencies in the realm of inclusivity-cum-people-centeredness of development initiatives. This is injurious to the logic of local content and national ownership of the GFF in Uganda.

Role of Citizen Participation

Another important point of inquiry was the role of citizen participation proxied by the inclusion or exclusion of CSOs in defining the GFF priorities in Uganda. Interviewees reported that most CSOs focus their critical voices on the GFF and their advocacy energies on the Sharpened Plan (which was edited into Uganda's GFF compliant Investment Case). CSOs typically forget that the GFF in Uganda consists of three institutional arrangements, namely (a) the Health Financing Strategy; (b) the Investment Case; and (c) the GFF Country Platform. Box 2 summarized the differences and interconnectedness of these institutional arrangements:

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; lists the priority investments; makes a costing of the priority investments; and outlines the mechanism for monitoring and evaluating progress. Having an Investment Case was 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 M&E 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: MoH 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. Nor was CSO representation specified. According to a civil society interviewee, many critical CSOs and coalitions are largely uninformed or under-informed about the GFF process and the Investment Case.

Yet, the Investment Case, like the global GFF, pledged that civil society inclusion will be part of the GFF *modus operandi*, and that citizens' engagement and beneficiary feedback would be strengthened. Despite these pledges, senior officials in the Ministry of Health reported that they struggled to find, let alone define, the appropriate spaces for civil society involvement in the GFF. They agreed that this was mainly because CSOs are numerous, uncoordinated, and/or fragmented.

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 viewed each other as competitors, and not complimentary actors. Succinctly stated:

> *"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 and as institutions for visibility, space, and relevance – especially to donors. What we seriously lack is a common sense of direction"* (Interviews, Kampala, November 2017).

Indeed, a CSO interviewee asserted that organizations representing CSOs in the MoH technical working groups do not truly represent their constituencies, but rather are there in their own right. ACSO member on the RMNACH Civil society coalition group made interesting observations that are worth quoting at length:

> *"Even those CSOs that participate in the process … their engagement is not meaningful at all. The Ministry of Health seems to invite them only to legitimize the process. All that the Ministry wants is to be able to claim that CSOs participated. The engagement procedures of CSOs in the GFF and Investment Case processes are unclear to 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. The Ministry will invite CSOs from family planning organizations today, and the other day invite CSOs working on malaria control. These anomalies suggest that 'Things fell apart. The centre can no longer hold'* (CSO representative, Kampala Interviews, 2017).

A Ministry of Health official reported that they always find challenges with civil society engagement:

> *"It is always difficult to understand how they are organized. Different civil society organizations approach MOH claiming they represent CSOs on RMNACH issues. Yet, apart from the embryonic Baraza initiative, there is no formal mechanism for the Ministry to answer questions from CSOs"* (Interviews, Kampala, December 2017).

A top official of the World Vision, an NGO that took lead in organizing CSOs, articulated a different aspect of the problem. According to her,

> *"There were difficulties in mobilizing CSOs to engage in the Investment Case development process. The problem was that the 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 their organizations in the drafting meetings. This could explain the poor understanding of the Investment Case and the GFF Trust Fund by the 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 the loss of interest were various. The ad hoc nature of approach to civil society inclusion was a problem by, and of, itself. To compound the problem, civil society inputs into the Investment Case draft were either ignored or largely diluted in the final Investment Case document. However, a senior World Bank official reported a different source of declining civil society interest. According to him, some CSOs had participated in the hope of that they would, through their involvement, access GFF resources, which was not the case.

Readiness Proxied by GFF Implementation Capacity

The study also sought to assess the implementation readiness of the GFF in Uganda. Implementation capacity was defined in terms of Uganda's preparedness at the level of districts, which are Uganda's units of decentralized governance. MoH officials reported that the preparation for GFF implementation is an ongoing and robust process, which includes district assessments and refinements of the implementation framework (MoH Interviews). Interviewees from the WHO and UNFPA upheld the view that preparedness in an ongoing process, and predominantly noted that the Ministry of Health and the districts were ready (in terms of staffing/human resource capacity) for the implementation of the GFF. According to one of Uganda's development partners,

> *"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 must 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 unified position on preparedness comes out clearly in the interviews held with MoH officials. One interviewee reported that 25 districts had been selected, had received communication, and that plans were crafted to start GFF implementation in February 2018. Another senior officer of the same Ministry contradicted this view. His claim was that "… *the assessments of the districts have not yet started*" (MoH Interviews, November 2017). This view was upheld by a CSO member, who stated that none of the districts he had visited six months prior to our study had any knowledge of the 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: the Mukono district. The district officials are not aware of the implementation plans of the GFF cum Investment Case in their district"* (CSO Interviews, Kampala, November 2017).

To make matters worse, several interviewees reported that Uganda's districts predominantly lack functional structures for supporting the implementation of the GFF at district and health facility levels. 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:

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

Additionally, there are concerns with the functionality of Health Unit Management Committees (HUMC) and Village Health Teams (VHTs) in many 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).

Implementation Modalities of GFF in Uganda

Critical reviews of the relevant literature reveal an important finding. Several business un-usual aspects exist in the GFF initiative. For example, the GFF financing model involves a departure from the old tradition of donors 'working in silos' to a new dispensation of cross-donor silo-bursting. It underscores an enhanced level of donor coordination, in line with the Paris Declaration, on aid-effectiveness. However, study participants expressed anxieties over the results-based financing (RBF) approach. It was arguably unclear whether the RBF modality is to be delivered via Uganda's public health systems, public/private partnerships (PPPs), or via reliance on private sector actors.

The participants also reported that private-not-for-profit health facilities (PNFPs), as well as private-for-profit hospitals, predominantly target the urban population, which constitutes under 20% of Uganda's population. Neither the SDG philosophy of *Leaving No One Behind,* nor the inclusivity goal of *Every Woman, Every Child,* will be deliverable to the rural (and urban) poor unless Uganda hybridizes the results-based financing with a new business-un-usual dispensation. To effectively reach the poor, Uganda needs to adopt universal health insurance, à la Rwanda. Universalized health insurance must be heavily subsidized by the state using tax-payers' money.

We must emphasize that RBF, and its baptism name 'cash-on-delivery (CoD)' signifies, for some commentators, the rebirth of donor conditionality. As Mustapha et al. (2014: 4) noted: "… disbursement of the grant [is] linked to compliance with *ex ante* defined conditions or service-level performance targets." Simply stated, RBF links financing to pre-determined results. Payment is made only upon verification that the agreed-upon results have been delivered. The conceptual rationale 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, for example in post-conflict Northern Uganda, need resuscitation before any credible results can be expected.

In other parts of Uganda, the proliferation of new districts—thanks to the dominant politics of presidentialism and patrimonialism—has resulted in a disturbing scenario. According to a MoH interviewee, "*A substantial number of new districts lack a publicly owned 'district' hospital*." This compromises inclusive health service delivery.

6. Conclusion

This paper has examined the politics of blended financing with reference to the World Bank-inspired GFF for maternal, newborn, child, and adolescent health (RMNCAH) in Uganda. Clearly, blended financing offers hope for operationalizing emerging consensus on inclusivity implied in the notion of *Every Woman, Every Child.* The GFF mobilizes, coordinates, and utilizes blended finances drawn from multiple sources. This hybridized financing underscores the rise of a new business-un-usual dispensation in development financing. It offers hope for silo-bursting and coordinated development aid. The devil lies in the politics of asymmetrical power relations between donors (represented by the combined fist of the World Bank, leading donor countries, and philanthropic actors) on the one hand, and aid recipients (such as Uganda) on the other hand. The balance of power is obviously tilted in favour of the combined fist of donors.

A mixed picture emerges. The maxim of *Every Woman, Every Child* is consistent with the cardinal virtue of the global SDGs of *Leaving No One Behind*. The use of IDA credit (at concessional rates) is also positive. Contrary to the rhetoric of foreign aid critics—such as Moyo (2010)—the IDA credit is appropriate for Uganda, whose per capita income of under $1,000 qualifies it as a poor country. Additionally, Uganda's Investment Case has a substantial grant component of $55m, trumping the 25% grant component recommended by the OECD.

However, the GFF appears to have substantial shortfalls conceptually and procedurally. Conceptually, the theory of change-driving GFF—that is, results-based financing (RBF)—is widely seen as the reincarnation of the donor conditionality associated with structural adjustment programs (SAPs). Procedurally, the democratic credentials of the GFF are shaky. As clearly noted, the GFF was a product of a mere *announcement* by the World Bank and other big donors. Within the national political economy, consultation with domestic stakeholders was limited. This reduced *wananchi* (ordinary citizens) to the status of mere recipients of preferences that were curved out by donors in alliance with local state elites. This *modus operandi* suggests that citizens are still vulnerable to authoritarian paternalism. Ironically, the shortfalls in the participatory credentials of blended financing have *not* compromised the GFF as a distinctive form of development-enhancing aid. Uganda's Investment Case, as already noted, has been funded using low interest/concessional credit and grants (which are, by definition, free monies). Second, the list of fundable priorities has a substantial degree of inclusivity. It covers reproductive, maternal, newborn, child, and adolescent health (RMNCAH) propelled by the philosophy of inclusion baptized *Every Woman, Every Child*.

The emerging conclusion is simple. Uganda's Investment Case, like the global GFF, *procedurally* falls in the age-old politics of business-as-usual. However, in terms of content and scope, the Investment Case is *substantively* and materially closer to the new politics of business-un-usual than earlier forms of foreign aid.

Future use of foreign aid in Uganda—and elsewhere in Africa—must be guided by the understanding that foreign aid is, by definition, *foreign*. As Henry Kissinger asserted, the primary object of foreign aid is to promote the interests of the aid-giver, not the recipient. Thus, aid recipients must use health sector aid and other forms of assistance strategically and catalytically. The object is to trigger structural health system improvements while the aid lasts. In the long-term, and as the national economy growths, aid recipients must expand their domestic revenue base. They must wean off the aid, and finance national budgets using domestic finance; not aid.

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