Beyond aid: Closing Uganda's health financing gap and building domestic resilience

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In January 2025, the United States dismantled USAID and froze approximately USD 27.7 billion in global health financing. For Uganda, which received over USD 520 million in assistance from USAID, the impact was immediate: HIV clinics shuttered immediately, drug stockouts plagued facilities across the country, thousands of workers were laid off, and health monitoring infrastructure crumbled. Bilateral health assistance dropped by roughly 50% from 2023 to 2025, and about 30,000 health-sector jobs are estimated to be lost.

The damage extends far beyond USAID. Prior to the 2025 aid cuts, the US was the largest contributor to the Global Fund (38% of its total), Gavi (21%), and the WHO (12%). Each of these organizations will experience its largest funding cuts seen in years. Furthermore, Uganda relies on external financing for roughly 40-60% of its total health spending, of which the US makes the largest share.

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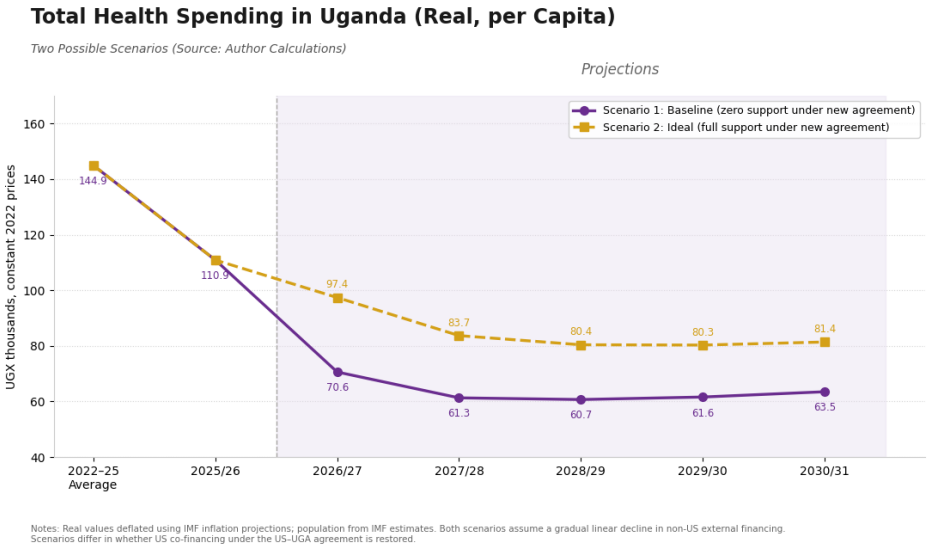
The New US-Uganda Agreement is an insufficient solution

In December 2025, the US and Ugandan governments signed a bilateral health agreement committing USD 1.7 billion over five years.[1] While it is a welcome improvement, the agreement does not restore previous levels of assistance. Rather, it represents a roughly 23% reduction from 2024 levels and excludes several key programs, such as family planning, nutrition, and broad health systems strengthening, from its priority areas. The arrangement also does nothing to arrest the broader multilateral retrenchment caused by the US withdrawal. As a result, non-US off-budget aid continues to shrink regardless.

Our analysis constructs original financing estimates from government and donor databases. During 2022–2025, total health spending averaged UGX 6,500 billion annually, of which domestic resources contributed only about one-third. We model two forward-looking scenarios:

- **Baseline (no US-UGA agreement)**: Real per capita spending falls from UGX 145,000 (the 2022–2025 average) to UGX 64,000 by FY2030/31, a 56% decline.
- **Ideal case (full agreement implementation):** US on-budget flows commence in FY2026/27; all co-financing obligations are met. Real per capita spending still falls to UGX 81,000 by FY2030/31, a 43% decline. Non-US, off-budget declines only account for 11 per cent of the decline.

Figure 1. Real per capita spending on health in Uganda



Under both scenarios, the share of foreign finance falls from 64% to 5–19% by FY2030/31, representing a structural transformation of the financing envelope.

[1] Uganda commits an additional USD 577 million in additional domestic financing

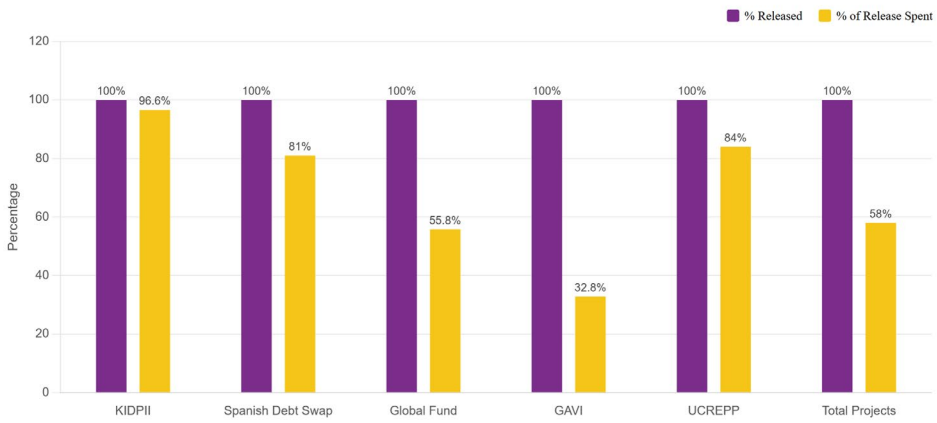
In the face of several aid cuts and a rising population, Uganda's spending on health is severely strained. The increasingly urgent question is: can Uganda reduce the gap fast enough?

Weak budget performance is draining foreign assistance

Uganda's public financial management in health has long suffered from weak budget execution. In FY2024/25, the Ministry of Health had an approved external financing budget of UGX 1.28 trillion. Of this, 100% was released by the Treasury, but only 58% was spent. Nearly half of donor-financed health resources sat idle, compared with an 83% execution rate for domestically financed programmes.

Externally financed projects have consistently recorded execution rates between 30% and 80%. The causes remain poorly understood. Procurement delays, misaligned donor disbursement schedules, and insufficient project preparation have resulted in massive under-efficiencies. Despite this, the new US–Uganda agreement will channel aid on-budget through government systems for the first time. If Uganda cannot dramatically improve absorption, the agreement's headline figures will remain largely theoretical, and most US support will remain unused.

Figure 2. Budget performance for externally financed health projects
FY 24/25 Central Ugandan Budget



Uganda is paying for services that are never delivered

Budget execution is not the only efficiency drain. Health worker absenteeism has been a persistent problem in Uganda's public facilities. Multiple surveys have found that 40–50% of health workers are absent from their posts on any

given day. The World Bank has consistently ranked Uganda among the worst performers in the region.

When health workers are absent, salaries are wasted on empty clinics. Patients who find facilities unstaffed turn to private providers or forgo care entirely, driving up out-of-pocket expenditures, which are already the largest single source of health financing in Uganda. Uganda has piloted biometric attendance tracking and community scorecards with mixed results. Scaling these interventions alongside stronger district-level supervision would significantly improve the effective coverage of existing spending.

Fragmented aid results in duplicated effort

Even before the cuts, Uganda's donor coordination was poor. Over 95% of US health funding was delivered off-budget through NGOs, functionally opaque to government monitoring systems. The government's Aid Management Platform captures only a fraction of actual disbursements, and estimates from different sources differ substantially.

This fragmentation produces duplication in some areas and critical gaps in others. Three accounting problems compound the challenge: (1) inconsistency between commitments and disbursements, (2) differing fiscal-year periodicities across donors, and (3) a lack of standardised classifications or centralised monitoring.

As remaining aid shrinks, every dollar of duplication is a dollar that could address an unmet need. Uganda must urgently establish a unified health financing framework with mandatory off-budget reporting, pursue virtual pooling of donor funds, and register all aid flows in the Integrated Financial Management System. The Government should establish a transparent baseline of health financing flows against which both donor compliance and domestic co-financing commitments can be monitored.

Weakened global procurement could signal opportunities for domestic strengthening

As some multilaterals, like the Global Fund and GAVI step back from Uganda, the burden of procurement for key commodities like HIV medicines and immunizations will fall on government agencies. Uganda should respond by deliberately rebuilding procurement capacity at the regional and national levels. In the short term, it should pursue East African Community pooled procurement

for high-volume, low-complexity commodities. Even partial pooling would recover some lost scale economies and improve bargaining power.

Furthermore, Uganda has a nascent but rapidly developing pharmaceutical industry. However, the sector remains constrained by limited scale, weak demand certainty, and regulatory bottlenecks. Strengthening it will require predictable public procurement commitments, including volume guarantees from the National and Joint Medical Stores, alongside faster and more consistent quality certification through the National Drug Authority. Targeted industrial support can help crowd in private investment and expand the range of locally produced essential medicines over time. Increased domestic supplies would not only bolster a weakened domestic supply chain but also support the national 'Build Uganda, Buy Uganda' policy.

Efficiency alone is not enough, but it is an essential starting point

Efficiency reforms will not compensate for a 43-56% decline in real health spending. New domestic revenue is essential. Uganda's tax-to-GDP ratio of 14% is below the sub-Saharan average. Raising excise taxes on alcohol, tobacco, and sugar-sweetened beverages by 10-20% could mobilise hundreds of millions of dollars per year. Rationalising tax expenditures, which in low-income countries can recover at least 2.5% of GDP, would generate additional resources that could be ring-fenced for primary and preventive care.

Figure 1. Policy solutions for health spending

Uganda's experience with performance-based financing offers evidence of a further lever. Findings from a World Bank–supported project indicate that payments tied to verified outputs increased utilisation of key health services and strengthened facility-level autonomy. This model, now operational in over 130 of Uganda's 146 districts, should be expanded and given real facility-level autonomy.

But revenue mobilisation takes time and remains an ambitious goal. In the near term, efficiency reforms offer the fastest route to stretching existing resources. Pre-budget readiness assessments, a joint disbursement calendar, and milestone-based releases would address the absorption bottleneck. Tackling absenteeism would ensure wage spending translates into services, and transparent coordination would eliminate duplication.

These solutions are not without obstacles

Raising excise taxes and rationalising exemptions will face political resistance from affected industries and consumer groups. Improving budget execution requires overcoming entrenched bureaucratic bottlenecks and procurement delays that have persisted for decades. Building local pharmaceutical manufacturing capacity is a medium- to long-term endeavour that cannot address immediate commodity shortfalls. The shift to on-budget aid delivery demands rapid strengthening of public financial management systems, including the capacity to track and disburse large volumes of external financing. Finally, effective donor coordination requires willingness from development partners to accept greater government oversight of their spending, a condition that has historically met resistance.

The greatest risk, however, is inaction. Without deliberate reform, the adjustment to shrinking aid will be absorbed through reduced service delivery and deteriorating health outcomes.

Investment in health is not a competing priority to growth, but a necessary precondition

Uganda targets a tenfold growth in GDP by 2040, and yet, a child born in Uganda today will reach only 38% of her productive potential. The 2025 aid shock, while ravaging in its effects, presents an opportunity to build the health financing architecture that Uganda will ultimately need to reach its tenfold growth goals. Whether that transition is managed through deliberate reform or absorbed through deteriorating outcomes is Uganda’s choice.