BTC UGANDA

IMPLEMENTATION OF THE HSSP II – UGANDA

FINAL REPORT

DECEMBER 2010

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Annexes

Abbreviations

ACT	Artemesinin-based Combination Therapy
AHSPR	Annual Health Sector Performance Report
ARV	Anti-Retroviral
CSO	Civil Society Organisation
DDHS	District Director of Health Services
DP	Development Partner
DPT	Diphtheria, Pertussis and Tetanus vaccine
FY	Financial Year
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to fight Aids, Tuberculosis and Malaria
GoU	Government of Uganda
HDP	Health Development Partner
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HSSIP	Health Sector Strategic and Investment Plan
HSSP	Health Sector Strategic Plan
IHP	International Health Partnership
IPT	Intermittent Presumptive Treatment
JAF	Joint Assessment Framework
JANS	Joint Assessment of National Strategies (IHP+)
JBSF	Joint Budget Support Framework
JRM	Joint Review Mission
M&E	Monitoring and Evaluation
MoFPED	Ministry of Finance, Planning & Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NDP	National Development Plan
NHA	National Health Assembly
NMS	National Medical Stores
OAG	Office of the Auditor General
OPD	Outpatient Department
OPM	Office of Prime Minister
PAF	Poverty Action Fund
PEAP	Poverty Eradication Action Plan
PEFA	Public Expenditure and Financial Accountability
PEPFAR	President's Emergency Plan for Aids Relief (USA)
PFM	Public Finance Management
PHC	Primary Health Care
PMI	President's Malaria Initiative (USA)
PNFP	Private non for profit
RR	Resident Representative (BTC)
SA	Specific Agreement
SBS	Sector Budget Support
SBWG	Sector Budget Working Group
SHI	Social Health Insurance
TA	Technical Assistance
UBOS	Uganda Bureau of Statistics
UNGASS	United Nations General Assembly Special Session
UGX	Uganda Shilling

1 Introduction

This report is the final report for the Sector Budget Support programme to the implementation of the HSSP II in Uganda. It covers the progress made in the Ugandan health sector over the five year period from July 2005 to June 2010 and it highlights some key findings of the programme. In particular, it will focus on the performance of the sector during HSSP II.

In light of the likely continuation of the Sector Budget Support as provided for in the Belgium – Uganda Indicative Development Cooperation Programme, the report focuses also on the new Health Sector Strategic and Investment Plan 2010/11 – 14/15 (HSSIP III). In a final chapter the report will discuss the conditionalities stated in the different documents; and based on the analysis and the evaluation of these, it will advise on the continuation of the programme.

As both these issues, the performance during the past HSSP II and the strategies of the new HSSIP III, were at the centre of the health sector JRM 2010, a BTC HQ mission (P. Guzman, C. Taylor) participated in the meeting. The team was reinforced by a health systems and budget support specialist (L. Devillé – HERA) to contribute to the internal reflection on the Belgian contribution to the SBS. Both mission reports are annexed and are referred to or quoted extensively in this document.

2 Performance of the sector programme

2.1 HSSP II performance

- **During HSSP I (FY00/01-04/05) the Ugandan health sector was widely praised for its performance and improving health indicators**. A substantial increase in financial resources for the sector, a strong leadership from MoH and the initial enthusiasm for the health SWAp, certainly contributed to this success.

- Over the entire five year period of HSSP II, **the performance of the health sector against the 25 HSSP II indicators has been weak**: none of the 25 indicators is on target, 5 have declined, and 11 improved (and 9 have no comparable data). 12 out of 25 indicators are below 90% of the HSSP II targets; and for 4 indicators more than 90% of the target has been reached: OPD utilisation, couple year protection, latrine coverage, and percentage of PHC funds disbursed quarterly.
  Importantly most indicators related to maternal and child health are far below acceptable standards: only 1 mother out of 3 delivers in a health facility; only 2.8 out of 100 pregnant mothers get a caesarean section (WHO standard is 15%); less than 50% of pregnant women attending the facility and in need of IPT receive it; only 14% of children with fever receive malaria treatment within 24 hrs and only 14% of malaria cases are correctly treated at a health facility. Only 1 household out of two has at least 1 insecticide treated net. Only 56% of expected tuberculosis cases are notified. These indicators do not compare favourably with the same indicators in the region and suggest **a failing health system**.

- The stabilisation of the health output and outcome indicators has different causes, and one should take into account as well some broader societal developments.
  - One of the main problems has been the overall **weak leadership and stewardship at the top of the MoH**; including the position of the Minister, the Permanent Secretary, the Director General Health Services and the Director Planning and Development, the last 3 positions have been acting for a long period. Weak management is one important reason why major health system issues and inefficiencies such as the human resource crisis, the insufficiencies in medicines supplies and logistical issues have not been adequately addressed. And also because of this, health output and outcome indicators have either stabilised or deteriorated over the plan period.
    The foregoing also contributed to a deterioration of the quality of the sector-wide dialogue and mutual trust between MoH and HDP, which affected sector performance to some extent.

  - The stagnation of the performance is also explainable in the light of the good progress made over the past (HSSP I): the "quick wins" were achieved during the previous period and thus the **marginal costs started increasing**.

  - Several issues related to financing of the health sector have contributed to the weak performance.
    - There is a general consensus that **the sector is highly underfunded**. Uganda needs about 28 to 42 USD per capita to finance its health strategy, but has only been able to raise 8 to10 USD per capita.

    - GoU funding to the health sector, including budget support, increased modestly over the last years, as is reflected in table 1.

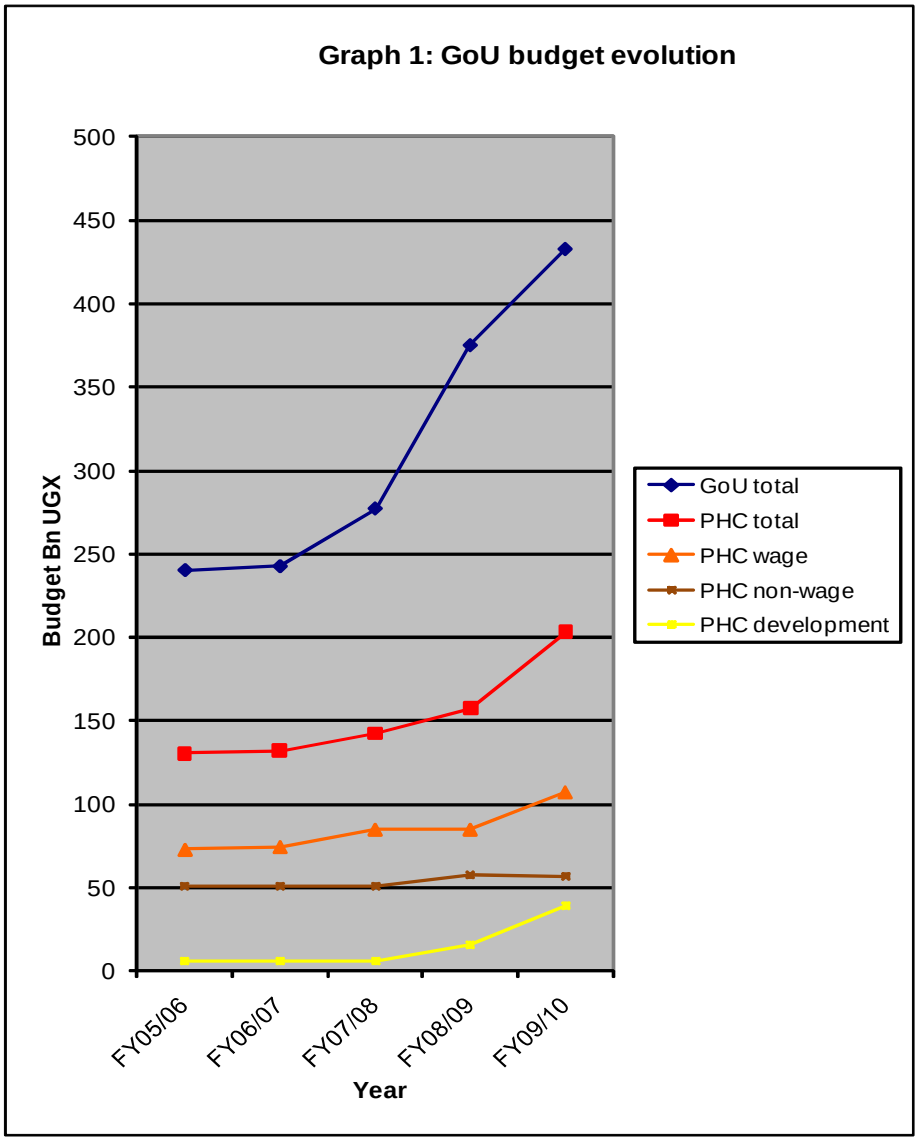
Table 1: MTEF allocations for the health sector over HSSP II

FY	GoU budget UGX Bn	Donor project budget UGX Bn	Total budget UGX Bn	Annual budget increase GoU	GoU health exp. % of total GoU exp.
05/06	229.86	268.38	498.24	-	8.9%
06/07	242.63	139.23	381.66	4.0%	8.6%
07/08	277.36	150.90	428.25	16.0%	8.2%
08/09	375.46	253.08	628.46	35.4%	8.3%
09/10	434.17	301.80	735.97	16.1%	8.1%

However, some apparent increases are simply budget reallocations, e.g. in FY10/11, GFATM funds shifted from donor project support to budget support and were thus included in the GoU budget. Also, over the last years, budget increases are highly earmarked by MoFPED, and are not necessarily allocated to the sector's priorities and needs; e.g. since FY08/09, 60Bn UGX has been ring fenced yearly by MoFPED for the purchase of ARV and ACT in a Kampala based factory (Quality Chemicals).
In reality, **the average annual increase for health in the GoU budget is not enough to cater for inflation (on average 5%) and population growth (3.4%)**. Moreover, the cost of services has increased from adoption of new expensive health technologies (ARV,

new vaccines, new malaria drugs, etc.) and expansion of basic services (new facilities and districts).

- In particular, **the stagnation of the non-wage recurrent budget for District Primary Health Care and PNFP health facilities**, as is reflected clearly in graph 1 below, has led to an overall decline in operational expenditures and basic services, and can partially explain the stagnating sector outputs. This is clearly reflected in graph 1 below. As a result government ability to finance its operations is being constrained.
  Also the suspension of GFATM and GAVI, both for corruption cases, cut off the districts from earmarked funding for key operational activities, e.g. immunisation outreach, etc.
  On the other hand, budget allocation commitments are respected to a large extent. The PAF protected budgets, which cover a large part of the health sector budget, are disbursed over 95% as prescribed. Particularly, disbursements against the wage grant have improved in the health sector over the last years from 92% to 98%.
  However, while the disbursement performance is rather good, in some cases, the absorption rate, which are the grants actually expended, can be a problem. The reason of this is unclear and could lie at different levels: late disbursements by MoFPED, delays in transferring allocations from the district general account to the DDHS health account, and/or lack of absorptive capacity in the health institution or DDHS.



- Donor external project funding, much of which is provided off-budget, remains a prominent source of health expenditure in Uganda. **This new aid architecture, with an increase of project funding due to huge worldwide initiatives (GFATM, GAVI, PEPFAR, PMI) is undermining the budget support structures and the health system itself**.

  These projects are earmarked for specific purposes and do not allow for allocation flexibility, thus increasing transaction costs for the Ministry and skewing the MoH budget prioritisation process. There also continue to be large discrepancies between donor project expenditure and the MTEF figures. All this generates the need for a comprehensive strategy to manage development assistance for health.

  This marked rise in project earmarked funding, together with a more or less stagnation of HSSP II indicators, should push all stakeholders to critically examine this dichotomy in order to address the challenges and to work towards achievement of the sector objectives. These funds from projects and Global Health Initiatives are certainly useful inputs; however in some cases their focus is not similar to agreed sector priorities. An analysis of donor projects for alignment to HSSP II

priorities indicated that up to 31% of project spending is on non-HSSP II inputs. It also leads to a problem of allocative efficiency where sub-sectors without earmarked development partner support were negatively affected.
Moreover these projects undermine stewardship from the MoH and stimulate rent seeking behaviour of MoH staff.

- **Essential key system inputs in the sector, as human resources and medicines, remain low**. Based on this, it is not surprising that outputs of the system are also low. Even with a 56% filled posts rate, the real staff availability stands only at 1 out of 4 (28%), given the high level of absenteeism. Equally important, filled posts vary greatly between districts with extremely low levels at 20 to 25% in some districts. In order to have an effective health system one needs to have the right staff with the right skills in place at the right time and with the right means available (infrastructure, logistics, consumables, supervision, etc.). For example, 2 out of 3 posts are vacant at health centre II, which is the first contact level with a fixed health facility. Combined with too low levels of medicines being available, weak supervision and insufficient logistical support, the low output indicators are no surprise.

- The **HSSP II strategic plan in itself had several weaknesses** and appeared to have been appraised insufficiently by the HDP. Country evaluation studies of SWAp have indeed shown that over ambitious strategic plans that are not prioritised or results-focused are less likely to achieve their objectives[1].
  - In his first report from August 2006, the health sector advisor already wrote: "*In general, [...] there is **need for better prioritisation**. Although HSSP II focuses on 4 clusters, these are very broad and cover many aspects and health problems [...]. Thus, the health sector is spread thin over many fronts, which is hampering the sector's effectiveness. Moreover, the need for better prioritisation is stressed by the budget gap*".
  - Moreover, the volume 2 of the strategic plan, which should have developed the M&E framework and the detailed costing, was never finalised.
  - Following this, **ambitious targets had been set unrelated to available resources.**

- Finally, some broader societal aspects should be taken into account, which influence the performance in the health sector.
  - One external factor hindering all social and service sectors is the **very high population growth of 3.2%**. This is a major constraint for the sector as inputs have to increase by at least 3.2% a year in order to maintain previous year's performance (measured in terms of sector outputs). Reducing population growth is very much a political and societal issue beyond the responsibility of the health sector, although the sector has the means to address this when political willingness exists.
    In that sense, it is an important accomplishment that outpatient utilisation has remained at a level of 0.8 to 0.9 per capita per year during the 5 year period (up from 0.5-0.6 before user fees were

[1] Vaillencourt D. 2009. Do Health Sector-Wide Approaches achieve results? IEG Working paper World Bank.

abolished in 2001). This is substantially higher than the average in Africa (0.6 per capita per year). The fact that this high rate has been maintained means that a certain quality service level, availability of human resources and medical supplies has been ensured, even though these are far from satisfactory. While some improvement has been noted regarding the filled health worker posts (now 56% up from 39% in 06/07) and medicines availability, performance is absolutely low; e.g. on average only 21% of facilities were without any out-of-stock for 6 tracer medicines. It is therefore not that surprising that some crucial service output data deteriorated significantly, such as the percentage of assisted deliveries and the DPT3 coverage.

- **Corruption** in Uganda is endemic and there is general consensus that it is on the increase in government departments as well as in the private sector. The 2009 Transparency International scores show a worsening trend for Uganda, with a drop from 126 to 130 out of the 180 countries. Also, the precondition in the JAF2 matrix on anti-corruption is the only precondition that is not met.
  In the health sector, there are reports on leakages at all stages of the drugs supply chain, informal payments and weak compliance across the sector, ghost health centres and lack of transparency and accountability at MoH and National Drug Authority. HDP have welcomed the recent interest from the MoH in developing an action plan on the OAG recommendations, and including an anti-corruption strategy in the HSSPIII. They also noted steps at NMS and the Medicines and Health Services Delivery Monitoring Unit to reduce leakages, but insist to see further follow-up on existing corruption cases, strong leadership from MoH and greater transparency and accountability.

- Performance related to crucial health output and outcome indicators is mainly achieved in the districts and is thus embedded in **a failing decentralisation process** since 2004/05. Most districts cannot execute their mandates because of limited funding and capacity. The earmarking of central level transfers in the form of conditional grants, the proliferation of new districts, from 56 in FY05/06 to 111 to date, with new management teams and inadequate facilities, and the inability to mobilise local revenue since the abolition of graduated tax, the former major revenue source, constrains the capacity to deliver services, included health care. In addition, operations in the health sector are not yet fully adapted to the decentralised environment, which pose a challenge of interaction between the centre and the districts in regard to their respective mandates.

2.2 JBSF performance

- Table 2 shows the performance of the health sector related to the JAF1 (FY08/09) and JAF 2 (FY09/10) indicators and prior actions (see final draft JAF2 appraisal annexed).
  Related to the health sector performance we read in the JAF2 appraisal report: "***The health sector's performance was poor against headline sector results***. *In some cases, performance even declined for the second year in a row. Most of these indicators rely heavily on the procurement of key*

inputs (essential medicines, vaccines, contraceptives) and a functioning supply chain. Even in the face of insufficient budget allocation, MoFPED have reported non-spending of funds released to the MoH for the procurement and distribution of key inputs such as vaccines/gas (only 14.42Bn UGX was spent by MoH of 33.6Bn UGX released). Further, the MoU between MoH and the NMS has not been signed. Also the medicines operational manual, which is needed to define issues like third party procurement procedures, the drug kit strategy, district budget allocation for essential medicines, and the drug pricing policy, has not been prepared. Broadly speaking, these oversights are symptomatic of characteristic deficiencies in the management of the health sector as reflected by the MoH weak leadership".

Table 2: Health sector JAF1 and JAF2 performance

Headline Sector Result	**JAF 1**		**JAF 2**	
	Target	**Status**	**Target**	**Status**
Proportion of deliveries in health facilities	34%	34%	35%	33%
Couple Year protection	361,080	549,594	600,000	460,825
Proportion of children immunised with DPT3	82%	83%	85%	76%
Performance Indicator				
Proportion of approved posts filled by qualified health workers	52%	53%	55%	56%
Proportion of health facilities without drug stock outs for 6 tracer drugs	35%	26%	50%	21%
Sector performance issues	**Total number**	**Number met**	**Total number**	**Number met**
	5	3	10	8

Colour legend: Green: target met; Red: target not met

- According to the same JAF2 appraisal, Uganda continues to achieve the basic conditions for budget support: "*Overall, GoU continues to show a sufficient level of commitment to the Underlying Principles* ***to enable the JBSF DP to continue with the provision of budget support****, although disbursement levels may be affected by poor performance in a number of critical areas*".

3 Evolution in quality of the policy and planning

3.1 National Development Plan

- The theme of the **NDP** FY10/11-14/15, which replaces the PEAP, is "*Growth, Employment and Socio-economic transformation for Prosperity*". It is designed to be the primary GoU national strategic plan, and thus it should provide a guide for the allocation of resources through the MTEF.
  The NDP identifies the 7 most binding constraints to economic growth: (1) weak public sector management and administration, (2) inadequate financing and financial services, (3) inadequate quantity and quality of human resource, (4) inadequate physical infrastructure, (5) gender issues, negative attitudes, mind-set, cultural practices and perceptions, (6) low application of science, technology and innovation, and (7) inadequate supply and limited access to critical production inputs.
  The section in the NDP on **the objectives and strategies of the Health and Nutrition Sector is relevant and quite well developed**. They guided to a certain extent the National Health Policy and the new HSSP III.
  On the other hand the **indicators for the health sector are unrealistic**. While some are not ambitious at all, e.g. DPT3 vaccination coverage will increase from 85% in FY08/09 to only 87% in FY14/15, others are very likely to be overambitious, e.g. the Maternal Mortality Rate will decrease from 435 in FY08/09 to 131 in FY14/15.
  The health sector advisor also seriously questions the MTEF projections in the NDP, and thus the feasibility of the entire plan; e.g. the health sector proportion in the total GoU budget for FY10/11 is not 14.5%, but only 8.2%. Similarly, the health sector budget FY10/11 in the NDP is projected at 1,152Bn UGX, while the actual allocation (incl. donor projects) from MoFPED is only 628.11Bn UGX (55%). And the same applies to all other sectors: the total GoU budget for FY10/11 in the NDP is 7,948Bn UGX, while the actual budget projection by MoFPED is only 5,351Bn UGX (67%). So it is obvious that **a large part of the NDP will remain unfunded, and thus it is likely that objectives and targets will not be reached**.

3.2 Health Sector Strategic & Investment Plan 2010/11 – 2014/15

[What follows is a summary extract from the HERA report on the quality of the HSSIP III.]

- The **HSSIP III** has been published in November 2010. It was formally presented and launched at the 2010 JRM meeting.
  In June 2010, an IHP+ JANS Review came up with substantial comments on the draft plan. Many of the comments and recommendations of the JANS team have been taken into account in the final version of the HSSIP III.
  - HSSIP III now presents **a well developed, critical and comprehensive situation analysis** with clear recommendations for the strategic plan. The underlying strategies are generally based on evidence.
  - The participation in developing the plan was broad, including many relevant state and non-state stakeholders. Engagement needs to be deepened during implementation, evaluation and subsequent planning in order to become more meaningful.
  - Mechanisms for accountability of different stakeholders are not well specified in the plan. Although the plan contains a separate section on

technical accountability & risk analysis, no responsibilities have been assigned for objectives 2 to 5 (dealing with issues such as equity, access, quality, safety, efficiency and stewardship). This is a missed opportunity.

- HSSIP III has set clear and appropriate core priorities. The five priorities of these are sexual and reproductive health, child health, health education & promotion, control & prevention of communicable diseases, and health systems strengthening. However:
  - The plan is not convincing how the budget will underscore those strategic priorities. Moreover **the over ambitious costs of the plan are not aligned with the available resource envelope**. Even the so-called 'realistic scenario' requires a resource envelope three times the current one.
  - **There is still a need to prioritise the interventions and adjust some of the unrealistic targets**. The costing of HSSIP III does not enough reflect priority setting.
  - Some constraints well described in the situation analysis, like HRH, do not seem sufficiently addressed by the proposed actions.
  - Although the internal coherence between different sections of the plan has improved a lot, there remain however a number of inconsistencies.
  - There is need to clarify and strengthen the link between the HSSIP III and the annual and decentralised planning processes.

  [The health sector advisor fully endorses these observations. Although the new HSSIP III is of a much better quality than the previous HSSP II, it remains a missed opportunity to make highly needed strategic choices for the sector, taking into account the huge challenges and the limited resources.]

3.3 Financing strategy - Social Health Insurance

- The current **Health Financing Strategy** was prepared in 2002 and is outdated. The need for a new strategy has already been a recommendation in previous documents (e.g. Mid Term Review, Public Expenditure Review 2008) and an undertaking in several JRM.
  The financing strategy should look at the various sources of financing, current and future potential, and put them within the context of an integrated financing system. It should discuss among others: (a) the appropriateness of payroll-tax based financing and social health insurance (SHI), (b) the role government or donor funds would play, (c) how health services would be financed, through provision of inputs or purchase of health services, and (d) the place for out-of-pocket payments in the overall financing framework. The answers to these and many other questions are needed in order to develop a clear approach and way forward, and to generate both popular and political support for major reform initiatives like the SHI.

- The introduction of a **SHI** has been on the agenda for several years now. As it is a pledge in the President's Manifesto, it is pushed by some in the MoH. It has however little support in the broader society: CSO, employers, labour federations, private sector, etc. Also the health sector advisor has raised, on behalf of the HDP, substantial concerns.
  - The public health sector in Uganda is, in principle, free of charge for the user. So why should one introduce an insurance system? Is this the end of the free health care principle in Uganda?

- SHI would be introduced for the civil servants followed by the formal private sector, both being the better-off in Ugandan society. The unemployed and those active in the informal sector remain uninsured and will not have the advantage of financial risk protection. These groups are in general the poor, relatively more women and these living in rural areas. But are these not the target groups in poverty reduction?
  Those groups (the better-off) that are insured will go to the private health clinics, leaving the public health sector for those not being insured, the poorer. What will be the impact of this "**cream skimming**" on the quality of the public health sector? What will be the impact of the introduction of SHI on to those people that are not insured?
- **No proper actuarial analysis** has been carried out. An actuarial analysis uses statistical and mathematical methods to assess risks and costs, and is essential in the elaboration of an insurance system.
- **Administrative costs and transaction costs for SHI systems are substantial** compared with general tax collection (which needs to be collected for other purposes anyway).The costs for accreditation, licensing, monitoring, supervision, etc., will be very high. Moreover, has GoU the capacity and skills to manage such a scheme? MoH at this moment has already big problems with supervision, and M&E of the public sector.
- SHI will introduce "**moral hazard**" on both provider as well as user side. In both cases costs will escalate; and no system has been proposed to reduce moral hazard and keep costs at an affordable level; e.g. an appropriate provider payment mechanism to guarantee quality care, without over-treating nor over-charging patients, co-payments or deductibles, gatekeeper strategies limiting access to specialised care, etc.
- GoU has not analysed the possibility to contract out the management of SHI to non-GoU institutions, or to introduce competition in the insurance market. The private sector or non-profit insurers could have the capacity and the experience to run such scheme.
  The scheme proposes a flat contribution to SHI: 4% for everyone. GoU has not looked into the possibility to impose a progressive contribution to SHI, which would mean that the better off would relatively pay more than the poor (fair financing)?

4 Evolution in quality of the PFM system

- The last **Public Financial Management Performance Report** was published in 2008. The assessment is based on the PEFA framework. The general conclusion of the report is that **despite progress made, significant challenges remain**. A summary of the findings is following.
  - The PEFA framework uses 31 standard indicators. Seven indicators appear to have deteriorated since 2005; twelve appear to have remained unchanged and another twelve appear to have improved. However the consultants are of the opinion that some of the ratings in 2005 now appear over- or underrated.
  - The biggest omission in the coverage of fiscal reports is still donor-funded project expenditure. This omission prevents full sectoral analysis or any complete analysis of budget execution.

- There has also been deterioration in the predictability of budget support and the use of GoU procedures in aid management is still below 50%, but the trend is toward greater use of government procedures.
- There are frequent unexplained changes in the MTEF estimates from year to year and within the year, even in poverty-related expenditures.
- There are poor ratings on procurement and personnel management systems. As both are together responsible for the greater part of public spending, this is indicative of waste.
- Basic systems for internal control are in place, but non-compliance and violation are common, which combined with high levels of corruption weakens accountability.

- The JAF2 appraisal related to PFM issues comes to similar conclusions:
  "*The preparation and implementation of the budget, internal budget accountability and external budgetary control satisfies the basic conditions for good PFM including transparency, accountability and effectiveness in use of resources. Similarly a credible and relevant programme to improve PFM and procurement systems is in place and some progress in performance has been recorded over the period under review. Still,* ***there is a need for better enforcement of compliance with existing PFM and procurement rules and regulations****. Linked to this is the importance of effective supervision and inspection, follow up of internal audit reports, as well as closure of the accountability cycle through issuance of a Treasury Memorandum to ensure executive follow up of the Public Accounts Committee's external audit findings and recommendations*".

- The health sector advisor has been following the **OAG reports** for three years now, and he makes summary reports for the health sector which are submitted to MoH. OAG reports have approved a lot and an appreciation of the last report follows in table 3.

Table 3: Appreciation of the OAG report (FY08/09)

1. Scope/coverage of the audit
- There is a focus on significant and systemic PFM issues in the reports. Compared to previous years the reports have improved in giving relevant information.
- Autonomous agencies have been included in the reports. On the other hand, inclusion of extra-budgetary funds is still not possible as donor funded project accounts are not consolidated in the GoU financial statements under the current accounting policy.

2. Nature of the audit
- The financial audits take quiet well into account issues such as reliability of financial statements, regularity of transactions, and functioning of internal control and procurement systems.
- The audits include well some aspects of performance audit, such as value for money in infrastructure contracts.

3. Evidence of follow-up on audit recommendations
- In the health sector, follow-up of audit recommendations is poor. As most general observations and weaknesses were already identified in previous audits, it seems that follow up in other sectors is also weak.
  In general the audited entity would be expected to follow up the audit findings through correction of errors and of system weaknesses identified by the auditors. Evidence of effective follow up of the audit findings can include the

issuance by the audited entity of a formal written response to the audit findings indicating how these will be or already have been addressed. Also the following year's external audit report may provide evidence of such implementation.

Following the submission of the summary report of the health sector advisor to MoH, an action plan has been developed in June 2010.

5 Evolution in aid effectiveness

- The success story of the Uganda health SWAp during HSSP I can partially be contributed to the increase of resources to the Local Governments, which constitute the operational level in the health sector. This increase was largely achieved through **increased budget support funding** from donors. We should however also take into account other contributing factors like the abolition of user fees for health services in the public sector, and the inputs from new initiatives as GFATM and GAVI.

- As mentioned before, conditions have changed during HSSP II: stabilisation of funding to districts, and the suspension of GFATM and GAVI.
  Also, there has been **a steady increase over the last years in donor project funding**. This can be explained partially because of the improved annual donor budget inventory by MoH, while previously incomplete data from MoFPED were used. But donor project funding has also increased in real terms. This is mainly contributed to earmarked interventions by the United States Government (PEPFAR and PMI: around 250 to 300M USD a year), and the Global Health Initiatives (GFATM: ±100Bn UGX/year, GAVI: 20 to 30Bn UGX/year). These funds are certainly useful inputs; however in some cases their focus is not similar to HSSP II agreed priorities. An analysis of donor projects for alignment to HSSP II priorities indicated that up to 31% of project spending is on non-HSSP II inputs (incl. TA and parallel project management).
  The highly earmarked donor project funding also leads to a problem of allocative efficiency where sub-sectors without earmarked development partner support are negatively affected. Thus, spending on HIV/AIDS is financed for 94% by donor project funding, mainly PEPFAR and GFATM. Budgets for this issue are excessive compared to all other health problems the sector has to address. E.g. according to an UNGASS report, 363Bn UGX was spent in FY05/06 on HIV/AIDS programmes in all sectors, while the GoU budget in that year for the entire health sector was at 230Bn UGX.
  Moreover these projects undermine stewardship from the MoH and stimulate rent seeking behaviour of MoH staff.
  Finally, there continue to be large discrepancies between donor project expenditure and the MTEF figures. The actual expenditure FY06/07 on donor projects was 540Bn UGX, while only 139Bn UGX were reflected in the MTEF. This trend raises serious concerns related to predictability of development assistance, harmonisation and alignment. Planning and budgeting for project resources continues to be challenging because information on donor funding expenditure is not systematically captured and reported upon as part of the budget process.
  Thus, the international drive for increased financing of priority health interventions becomes a two-edged sword. On the one hand, these additional

resources are much needed, but on the other hand, their vertical focus and planning and financing modalities can undermine health systems and comprehensive structures and processes such as a SWAp.

- The impact of **new donors**, like China and India, on the Ugandan health sector is still very limited and not many initiatives are going on. E.g. China is building and equipping a general hospital for the public sector in Kampala, but this has been planned and agreed with MoH after proper consultation.

6 Evolution in quality of the M&E system

- Although the principles and elements of the M&E system have been described in HSSIP III, a detailed M&E plan for the sector and the national strategic plan for developing and improving the HMIS are still being developed. These plans should include how HMIS quality will be improved and verified, which surveys will be used, realistic plans for staffing, and what is proposed to increase use of data by key stakeholders. They should be costed based on current functioning and scenarios could be defined for different funding levels.

- Following experience of two strategic plans, the HSSIP III has identified a shortlist of sector indicators which are measurable and have baselines, and that reflect key aspects of HSSIP III outcomes and results. Most of the multi-year targets are consistent with past trends; apart from funding targets and some over ambitious programme targets. The sector indicators are generally consistent with other frameworks such as the JAF and NDP. HMIS collects most of the indicators required. There is also a well established annual review and monthly follow up process in place with JRM and HPAC.

- Outside of the routine system, M&E will draw on various sources including surveys as well as facility based data; e.g. the annual panel survey by UBOS, malaria and HIV/AIDS indicator surveys, the 2011 Uganda Demographic and Health Survey, etc. This mixed approach including facility surveys, population surveys and HMIS is recommended by WHO and IHP+ partners under the Country Health Systems Surveillance approach.

- There are substantial efforts and resources used in monitoring and data collection under different programmes, including donor initiatives, but these are not well coordinated, which undermines efficiency and creates extra burden on frontline staff.

- As was the case over HSSP II, the Area Teams will be responsible for conducting quarterly support supervisions, mentoring and inspection to Local Governments. There is however a general consensus, even within MoH, that this strategy is largely inefficient and ineffective, as a consequence of the proliferation of districts and other factors.
  On the other hand, HSSIP III proposes to establish a structure at regional level that will gradually assume more responsibilities, focussing on supervision, providing support in planning, monitoring and evaluation for decentralised health service delivery.

- GoU has also been strengthening its internal M&E processes, and is making serious efforts of integrating the different reporting systems. There is now one framework developed for sectors to report to GoU: linking the progress reports on the NDP objectives (to National Planning Authority), with the general performance reports of the sectors (to Office of Prime Minister), and the financial performance reports (to MoFPED). This framework also covers the JAF matrix indicators and actions for the sectors.

7 Evolution in quality of policy dialogue

- Linked to the NDP, GoU will initiate the formulation of a new **Partnership Policy**, which will update the "Partnership Principles", signed in 2003. The Partnership Policy will be supplemented by a MoU that will be signed by GoU and the DP. It will pursue the following principles:
  - All development assistance is aligned with the objectives and priorities of the NDP.
  - All DP are following guidelines aimed at reducing transaction costs.
  - Structures are strengthening dialogues with all stakeholders.
  - Predictability of and information on aid flows is improved.
  - Measures and mechanisms are institutionalised for assessing mutual accountability.
  - Partner commitments beyond aid are incorporated within the Partnership Policy.

- A new MoU is also being developed for the JBSF partners and GoU.

- In the health sector, the **MoU** spells out the obligations and expectations of GoU and HDP in the SWAp partnership. **During HSSP II, important obligations of both parties were met:** e.g. yearly JRM/NHA, active HPAC, and Mid Term Review. However, GoU and HDP both did not fully uphold other obligations of the MoU.
  A key principle in the SWAp partnership is the financing obligations of both the government and DP. Government obliged to ensure that the proportion of overall Government budgetary allocation to the health sector increased annually in real terms over the five year period of the HSSP II. This has not been met: proportion increases in the budget allocations to the health sector did not occur. The obligations of DP were to provide comprehensive information regarding resources to support the health sector in Uganda and that these resources support the HSSP II. Partners were also to ensure that the support provided should as much as possible avoid distorting the existing government systems and strategies. DP have also not met this obligation. Information on resources for the health sector from a number of partners was not readily available during the yearly planning processes. The move towards alignment and harmonisation was also undermined by donor projects and Global Initiatives coming on board during the financial year.
  Another key obligation for both parties was to ensure an effective reporting system to provide financial and health management information data on time. Government has not always provided quarterly briefs on outputs and financial management. HDP on the other hand did not provide financial information on donor project expenditures in time.

The structures established in the MoU for open and transparent dialogue and consultation between GoU and partners in the implementation of the HSSP II (HPAC, JRM, NHA, Technical Review Meeting) were in general functional. As part of the move to rationalise structures with a view to improving the efficiency and effectiveness in the implementation of HSSP II, the Technical Working Groups were restructured. However, they are yet to be fully functional. HPAC had also been expanded to subsume the role of Country Coordinating Mechanisms as part of the Long Term Institutional Arrangements for the GFATM.

- The new MoU for HSSIP III, also called **Country Compact** under the IHP+, was presented during the JRM and signed by WHO, representing the HDP, during the formal ceremony. Other HDP will sign in the near future.
  The Country Compact, learning from the shortcomings in the previous MoU, aims to focus on mutual accountability. It was agreed that, not only HDP would be signatory, but also CSO and the PNFP Medical Bureaux. Although the document is not legally binding, it reflects the moral and ethical commitment of the partners in a spirit of fostering and promotion, and with peer pressure being central.

8 The Belgian Sector Budget Support: a reflexion

- The Belgian sectoral budget support had three components.
  - The main grant to the “Primary Health Care Conditional Grant” that co-financed the implementation of HSSP II. All instalments, since FY05/06, for a total of 18M EUR have been transferred to the Ugandan Treasury on the basis of fulfilment by GoU of the conditions of the SA.
  - In the first phase of the programme, a grant to the Joint Donor “Partnership Fund” for financing of the SWAp processes, e.g. annual Joint Review Meeting, etc. In the second phase, this component was left out, and the Partnership Fund has meanwhile been abandoned by MoH and HDP.
  - A technical expertise to monitor the implementation of the HSSP II. The BTC expert provides input to the ongoing health policy and technical and financial dialogue with GoU, and advises the Belgian Attaché for Development Cooperation at the Embassy and the group of Health Development Partners.

  The sectoral budget support is complemented in the health sector by a project on “Institutional Capacity Building in Planning, Leadership and Management”, a Scholarship programme and the Study & Consultancy Fund.

- Some reflexions on the programme.
  - The **SBS is fully in line with the Partnership Principles** and with national commitments. Budget support is the aid modality of preference of the country.
  - The **SBS permits a direct input in the sector policy dialogue**, allowing to put issues on the agenda of MoH, pushing sector priorities and participating in the sector budget process with MoFPED.
  - The SBS and the active involvement of the health advisor permits to develop institutional capacities.
  - **Visibility** was prominent as Belgium:

- through the attaché, became the Chair of HDP, initially for 6 months, but this period was extended to 1 ½ year.
- through the health sector advisor, who has been instrumental in supporting the different Chairs of HDP, and who is the focal person for JBSF, the SBWG and the Accountability WG.

As part of the Division of Labour exercise, Belgium has expressed its willingness to be a "lead DP" in health. This will mean a continuation of the active involvement at policy level as well as at technical level. Therefore a two-headed team of an attaché assisted by a health sector advisor will be compulsory. While the attaché focuses on the broader policy and development discussion and donor alignment and harmonisation, the health sector advisor targets the sector policy issues and the technical discussions with GoU.

- The **predictability of the Belgian contribution is weak**:
  - within the actual programme: disbursements were generally released very late in the Uganda Financial Year.
  - between the actual contribution and the future programme.

  It would be recommended to align fully with the JBSF framework: in Year $Y_{(n)}$, use data from $Y_{(n-1)}$ to decide on financing for $Y_{(n+1)}$.
- The **Belgian budget support is modest**: an annual 5M EUR to the GoU health sector budget of annually ±140M EUR (without donor projects). "*It is the ticket that Belgium has to pay to sit around the policy table*".
- **No exit strategy had been developed**.
  - An exit strategy in case of unforeseen circumstances; e.g. deteriorating performance, issues of good governance, war, etc.
  - A long term exit strategy.
- The **risk evaluation of SBS and thus the issue of conditionality** for disbursement should be carefully addressed in the next SBS phase.

  [What follows is a reprint from the HERA report. It is fully subscribed by the health sector advisor.]

  As such we would recommend to:
  - *refrain from requesting documents as outputs / conditionality: these type of soft conditionalities have limited added value.*
  - *refrain from using HSSIP III health sector performance targets as conditionality, as they carry the risk of being over ambitious anyway.*
  - *rather use some critical actions or agreed benchmarks as conditionality. E.g. the health financing strategy finalised and published, the resource allocation formula reviewed / established, the GoU health budget being at least maintained at the level of 2009/10 (as a percentage of the total GoU discretionary budget), the HR staff motivation and attraction plan being implemented (select a few concrete actions), a selection of the JAF 2 actions that have not yet been implemented, a selection of actions highlighted in the HDP Closing Statement at the JRM.*

  Conditionality should be clearly specified: what is going to be measured, how it will be assessed and what will be done if one or more conditionalities are not met.
  [End of quote.]

  Conditionalities should take into account that Belgium is part of the HDP Group and signatory to the JBSF exercise.
- The **institutional relationships health sector advisor-attaché-RR** within the framework of SBS, and the position of the health sector advisor in the portfolio approach need to be clarified more detailed.

- Although the Ugandan health SWAp is limping for the moment, it is still one of the most advanced in the country and the African continent. Some processes and partnership structures, e.g. JBSF, can be an example and lessons could be drawn from the experiences for other countries where Belgium is or will be involved in budget support.

9 Continuation of SBS by Belgium

9.1 Overview of conditions

- The **Specific Agreement** (SA) for the sector budget support was signed on 2 December 2008 and valid for a period of 24 months. Thus it has come to an end recently.
  To continue the budget support programme several conditions had been specified.
  - The Belgium – Uganda Indicative Development Cooperation Programme 2009-2012 specifies on the health sector support in Article 6.1 that:

    > *Continuation of the budget support will depend on the **signing of a new MoU for HSSP III**.*

  - And the SA specifies in Article 4 that:

    > *4.3 The Government shall organise an **End Evaluation** by all parties of the implementation of HSSP II, which will take place before the end of the third year and the last quarter of implementation respectively.*
    >
    > *4.4 The **outcome of the end evaluation of HSSP II** will determine the continuation of Belgian sector budget support to the health sector.*

9.2 Evaluation of conditions

[What follows is a reprint from the HERA report. It is fully subscribed by the health sector advisor.]

- Regarding the **End Evaluation of HSSP II**
  - It was agreed that no separate End Evaluation would be carried out but that the evaluation would be part of the AHSPR FY09/10 and also included in the situation analysis of the HSSIP III.
  - The AHSPR FY09/10 contains a 15 pages chapter two, entitled “Overview of health sector performance – Summative evaluation of HSSP II”. This chapter reviews the sector performance over the period 2004/05 to 2009/10 regarding the achievement of the 8 PEAP indicators, the achievement and trends of the 25 HSSP II indicators, the financial allocations to the health sector (including efficiency and equity), local governance performance based on the district league table performance, and the national, regional and general hospital performance (in principle based on hospital league tables – which details are not provided). The evaluation, based on evidence provided through different sources of information, is not very self-critical and interprets some of the (lack of) changes too positively.
  - The HSSIP III contains a 33 pages chapter, entitled ‘Situation Analysis’ providing a quite detailed analysis of the health sector performance over the past decade (and even over a longer period for some indicators), including the HSSP I and II periods. The analysis is very informative, self-

critical and comes up with a list of emerging issues and concrete recommendations for HSSIP, which have been taken on board in the strategic plan.

Validation: The End Evaluation of the HSSPII is documented in the two documents referred to above. In that sense the conditionality is being fulfilled. The conditionality however states that "*The outcome of the end evaluation of HSSP II will determine the continuation of Belgian sector budget support to the health sector*". No specification is given on how this outcome would be appraised. In this report we discussed the outcome in terms of sector performance and issues faced by the sector. However, it should be noted that, based on the discussions held in the JRM, the HDP intent to continue supporting HSSIP, even if sector performance during HSSP II was below expectations.

- Regarding the **next strategic plan**
  - HSSIP III has been published in November 2010. It was formally presented and launched at the JRM meeting.
  - The IHP+ JANS Review in June 2010 came up with substantial comments on the draft plan. Many of the comments and recommendations of the JANS team have been taken into account in the final version of the HSSIP III.

  Validation: The next strategic plan was published, formally presented and launched during the JRM. The conditionality has been fulfilled.

- Regarding the **MoU for HSSIP III**
  - The MoU was formally presented during the JRM and has been signed by a representative from WHO during the formal ceremony at the JRM.
  - Other DP have not yet signed the MoU, either because they were not yet in a position to sign or because some annexes (e.g. the indicators to measure accountability) were not yet complete.
  - It is being expected that most DP and other stakeholders will sign the MoU soon.

  Validation: The MoU is almost ready for signature by Belgium.

9.3 Other donor decisions

- As mentioned above, budget support donors come to the conclusion in the JAF2 appraisal report that: "*Overall, GoU continues to show a sufficient level of commitment to the Underlying Principles to enable the JBSF DP to continue with the provision of budget support, although disbursement levels may be affected by poor performance in a number of critical areas*".

- During JRM, none of the HDP has expressed its intention to withdraw its support from the health sector. Sweden, who is the only other DP doing SBS to the health sector, will continue its support until 2012 when a decision has to be taken around their new programme.

9.4 Conclusion

The three conditionalities have in principle been sufficiently fulfilled and should not pose a problem for Belgium to continue sector budget support. The phrasing of the conditionality regarding the outcome of the sector performance leaves space for interpretation as it has not been specified how the performance would be appraised (what is sufficient and what not?).

Activities of the BTC health sector advisor:

Aug – Dec 2010

The health advisor was on mission from:

- 16 – 18 Nov (Field visits JRM 2010)

The health advisor was on leave from:

- 1 – 5 Nov
- 24 – 31 Dec

Activities related to the BTC organisation.

- Management of the project: FIT, quarterly financial planning, monthly accounting statement.
- Participation in BTC staff meetings.

Activities related to the ToR.

- Working sessions with the Belgian attachés, L. Rochette and W. Fieremans.
- Working sessions with the Chair HDP, USAID (M. Rhodes) and the Co-Chair, UNICEF (C. Hudspeth).
- Introductory meeting with the new Deputy PS of MoH, Dr. A. Lukwago.
- Working sessions with MoH staff (Planning and Development Department).
- Participation in the health sector JRM (22 -24 Nov), including the field visits (15 – 19 Nov: visit Bududa district and NMS).
- Working sessions with the BTC HQ mission (P. Guzman, C. Taylor) and the consultant (L. Devillé) for the health sector JRM 2010.
- Participation in HPAC meetings.
- Participation in HDP meetings.
- Membership and HDP-Chair of the Sector Budget Working Group.
- Meeting at MoFPED for the alignment of NDP, NHP and HSSIP III in the budget FY11/12.
- Membership of the Supervision, Monitoring & Evaluation, and Research Working Group.
- Participation in a meeting of the MoH Steering Committee for Scholarships in the health sector.
- Focal person for the health sector in the Task Force for JBSF: appraisal of JAF2 for the health sector (8 – 19 Nov).
- Member of a World Bank Implementation Support Mission to lead the discussions on the JBSF (4 – 8 Oct).
- Working sessions with the BTC TA (H. Beks) for the Capacity Building project in the health sector.
- Working sessions with the consultant for the costing of HSSIP III. Participation in the costing Conference for HSSIP III.
- Working sessions with the consultant for the new Country Compact.
- Working sessions with the consultant for the review of the allocation formula in the health sector.
- Working session with consultants for the review of the implementation of the Paris Declaration in Uganda.

- Working sessions with the consultants for the Fiduciary Risk Assessment in the health sector.
- Participation in a debate around the health sector with the political parties for the Presidential elections.
- Meetings with the new BTC education sector advisor (J. De Ceuster).
- Assist BTC HQ with the preparation of their support mission for the health JRM 2010.
- Assist BTC RR with the recruitment of a consultant for the health JRM 2010.
- Meeting with Head of Mission for MSF (W. Robertson).