BTC

BELGIAN
DEVELOPMENT AGENCY

JOINT REVIEW MISSION REPORT

SECTOR BUDGET SUPPORT TO THE HEALTH SECTOR STRATEGIC PLAN

(HSSP II – PHASE 2)

UGANDA

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Introduction

In the context of the sixteenth Joint Review Mission (JRM) of the Health Sector, a BTC team from HQ traveled to Uganda to participate in annual field visits organized by the Ministry of Health (MoH) and to attend the three-day Joint Review meeting, which was held in Kampala from 22nd to 24th November.

In addition to reviewing the performance of the health sector for the fiscal year 2009/10, this year's JRM marked the end of the second Health Sector Strategic Plan (HSSP II) and the launch of a new Health Sector Strategic and Investment Plan (HSSIP), which will run from 2010/11 to 2014/15.

Belgium has disbursed 18.080.000 EUR as budget support to the health sector since 2005. The Specific Agreement signed between Belgium and Uganda in 2008 was aligned with the second phase of the HSSP II and will come to an end on 31 December. Prospects for the formulation of a new health sector budget support operation for a remaining 10 million EUR (as per the Indicative Cooperation Programme for 2008/09 – 2011/2012) were therefore a central point of discussion between BTC and the Belgian Embassy in Kampala.

In this context, the objectives of the HQ mission were to:

- Participate in the annual Joint Review of the Health sector, as per the CMO
- Evaluate the Belgian contribution to the implementation of HSSP II
- Support BTC and DGD in their reflections around the Belgian budget support to the health sector and formulation of a new Technical Note to support the Health Sector Strategic and Investment Plan

The HQ team worked closely with the BTC health sector advisor based in Kampala and with an external health expert contracted by BTC Uganda to provide support with the assessment of key documents and give an overall appreciation of the health sector performance in the past five years and of the new strategic plan. The final report of the BTC health sector advisor and the report of the external health expert will complement this mission report by providing more in-depth analyses of the health sector in Uganda and additional recommendations towards Belgium's future involvement in the sector.

1. Pre-Joint Review Mission field visits

1.1. Scope and methodology

The JRM was preceded by a week of field visits organized by the Ministry of Health. Eight groups composed of representatives of MoH, Health Development Partners (HDP) and Civil Society travelled to different districts with the following objectives:

- To assess performance of districts in implementing health service delivery (strengths and weaknesses);
- To identify priority areas of focus for discussion during the JRM meeting in Kampala.

The teams met with District Health Officials and visited public and private not for profit (PNFP) health centres of different categories (II, III and IV), hospitals, schools and homesteads. In particular, the teams focused on issues related to human resources, medicines and health supplies, access to HIV/AIDS basic care, malaria treatment and control measures, maternal and child health, health infrastructure and community participation.

Information was compiled using a reporting tool developed by MoH and members of all the teams came together after the visits to harmonize their findings and agree on key recommendations to be addressed at the JRM.

Though many practical details were left to the last minute, the visits ran smoothly. District Health Officials were available to meet with the teams and accompany them to visit health centres throughout the districts. The team joined by BTC staff visited Luwero and Bududa districts as well as the headquarters of the National Medical Stores in Entebbe where a meeting was held with the General Manager.

1.2. Key findings and recommendations[1]

Inadequate staffing levels

Many districts have reached their budget ceiling for recruitment of health workers and are still highly understaffed. A comprehensive policy to attract and retain staff in rural areas is yet to come into effect. Though the wage bill was adapted for health workers based in “hard to reach” districts to receive a salary increase of 30%, housing and

[1] In this part, the mission’s intention is to highlight key challenges arising from the structure of the health budget and functioning of the health sector in general.

working conditions remain unsatisfactory. Moreover, some districts that were visited showed clear challenges in terms of access to health centres but they are not included in the "hard to reach" classification done by the Ministry of Local Development. It was therefore advised that the classification methodology be revised.

Stagnation of the non-wage recurrent budget

The stagnation of the Primary Health Care non-wage recurrent budget in comparison to the increase in the health budget in recent years is having negative impacts on the delivery of health services. For example, many health centres are lacking funds to cover their electricity and water bills and some do not have the means to ensure continuous gas supplies for the storage of vaccines. In addition, quarterly disbursements usually arrive to the districts in the last month of every quarter. It is therefore essential that the non-wage recurrent budget allocations and timing of disbursements be revised so as to allow health centres to function adequately.

Essential medicines and health supplies

Health centres are facing great constraints in terms of access to basic medicines as a result of the policy shift that came into effect last year with regards to the funding and delivery of essential drugs. The parastatal organization National Medical Stores (NMS) is now fully responsible for the execution of the essential medicines budget for public health centres. In addition, drugs are now being delivered by NMS to the districts using a "PUSH" system meaning standardized kits are delivered on a periodic basis based on allocations provided by the Ministry of Finance, Planning and Economic Development (MoFPED) for each district (though there is no information available on the formula used for these allocations).

Previously, essential medicines for public and private not for profit (PNFP) health centres II, III and IV were funded by DANIDA through a credit line established within the MoH. In addition, there was also a separate budget line that provided additional funding to districts for their own purchase of essential medicines and health supplies when necessary but this has now been abolished. As a result of the Division of Labour, DANIDA has narrowed down its scope and is channelling its financial support to Joint Medical Stores (JMS) for the delivery of drugs to PNFP health institutions.

Districts submitting specific requests to NMS (to complement drugs provided in the standardized kits) are not receiving what they ask for. Standardized kits are often incomplete themselves and the reason put forward by the NMS for this gap is the fact the MoH has not allocated sufficient additional funding for essential medicines since DANIDA pullet out.

The meeting held with the NMS General Manager allowed the team to receive clarifications on certain issues however much remains to be done to ensure adequate and ongoing access to essential drug supplies by the districts. A Memorandum of Understanding between MoH, NMS and MoFPED has been finalized and it is expected it will be signed shortly.

2. Joint Review Mission of the Health sector

2.1. Overall appreciation of the JRM

The JRM was held during three days and counted with a wide range of participants from the MoH central level, district health services, Parliament, State House, civil society, PNFP organizations and the private sector. Although the acting Permanent Secretary was present for the opening of the meeting, the absence of senior and top management of MoH as well as high level staff of other key ministries (namely the Ministry of Finance, Planning and Economic Development and the Ministry of Local Government) throughout the three days was noted and strongly criticized by the HDP. On the other hand, the newly appointed Advisor to the President on Health and Population issues was present through the most important plenary sessions. The upcoming elections may have played in explaining the absence of the MoH leadership, as well as this newly appointed Advisor.

The table below provides an overview of the performance of the key health indicators that are also comprised in the Poverty Eradication Action Plan (PEAP 2004/05 – 2008/09).

Table 1. Performance against the 8 PEAP indicators for the HSSP II period.

Indicator	Baseline FY 2004/05	Achieved FY 2005/06	Achieved FY 2006/07	Achieved FY 2007/08	Achieved FY 2008/09	Achieved FY 2009/10	Target HSSP II (09/10)
Proportion of approved Posts filled by Trained Health workers	68%	75%	38.4%[1]	38.40%	56%	56%	65%
Proportion of Health facilities without stock –out of 5 tracer medicines & supplies	35%	27%	35%	28%	26%	41%[2]	70%
OPD Utilization in Govt & PNFP Units	0.9	0.8	0.9	0.8	0.8	0.9	1
Percentage of deliveries taking place in health facilities (Govt and PNFP)	38	29	32	40	34	33	50
Couple Years of protection (CYP)[i]	234,259	309,757	357,021	361,080	549,594	460,825	494,908
DPT 3 /Pentavalent vaccine coverage	89%	89%	90%	82%	85%	76%	95%
Household latrine coverage	57%	58%	58.50%	62.40%	67.50%	69.7	70%
National Average HIV Sero-Prevalence at ANC Surveillance sites	6.20%	6.20%	9.70%	7.00%	5-10%[3]	No data	4.4

[2] This analysis excludes availability of Coartem® which is procured through the Global Fund

2.2. Assessment of HSSP II (2005/06 – 2009/10)

The overall performance of the health sector during the implementation of HSSP II was stable however some critical indicators related to maternal and child health and immunization showed very poor results and were highlighted as key issues that need to be addressed urgently. Results and explanations related to the evolution of the performance of indicators since 2005/06 are presented in the 2009/2010 Annual Health Sector Performance Report (AHSPR) while the situation analysis included in the new strategy (HSSIP) provides a comprehensive overview of the evolution and trends of the health sector in previous years.

Some constraints that contributed to the poor performance or stabilization of most health indicators were the lack of human resources, the stagnation the non-wage recurrent budget for health service delivery, the increasing marginalization of PNFP health services with regards to access to funds from the state budget and the mixed reports on access to basic medicines (as a result to the new drug order and delivery "PUSH" system centralized within the National Medical Stores since last year).

One of the main drawbacks in the past year has been the lack of leadership within the MoH due to long-term vacancies of several key senior management positions, which led to heavy fragmentation and poor coordination among the different departments. Some recent progress has been made with this regard as a Deputy Permanent Secretary (acting as PS) was appointed a few months ago and a new Director of Planning came into office three weeks before the JRM. No further changes are expected to take place before the presidential and general elections scheduled for February 2011 however these two key personalities seem to be driven by a strong will to address the challenges faced by the health sector and development partners are hopeful the management of MoH will deliver positive results.

2.3. Presentation of HSSIP (2010/11 – 2014/15)

Following months of preparation, the Health Sector Strategic and Investment plan was officially launched at the JRM. Though it is still regarded as highly ambitious, much progress was noted since the presentation of the earlier draft in June 2010. The costing of the plan has now been done and many recommendations made by the independent joint assessment of the JANS mission[2] in July were considered and integrated into the plan[3]. A key issue however is that more prioritization needs to be done as the new

[2] The JANS mission was carried out in the framework of the International Health Partnership (IHP+).

[3] More details on the HSSIP will be provided in the BTC health advisor and the external health expert's reports.

strategy remains extremely ambitious and is not aligned with the actual resource envelope. Currently, MoH only has an estimated 26% of the total amount of resources required for the implementation of the HSSIP. Expected outputs are therefore not aligned with the amount of available resources and although the targets set seem less unrealistic than in the previous strategic plan donors are sceptical they will be met given the experience of the previous years and the mismatch between expected results and the estimated resource envelope.

To add on to these challenges, there is an urgent need to address the issue of the high population growth the country has been facing in the past ten years which is seen as critical by the development partners however it does not appear to be a key priority on the agenda of the Government of Uganda.

Table 2. HSSIP core performance indicators

Indicator domain	Indicator	Related reports	Source of data	Baseline, (year)	2010/11	2011/12	2012/13	2013/14	2014/15
Health Impact	Maternal Mortality Ratio (per 100,000 live birth)	MDG, NDP, JAF	UDHS	435 (2006)					131
	Neonatal Mortality rate (per 1000)		UDHS	70 (2006)					23
	Infant Mortality Rate (per 1000)	MDG, JAF	UDHS	76 (2006)					41
	Under 5 mortality rate (per 1000)	MDG, NDP	UDHS	137 (2006)					56
	% of households experiencing catastrophic payments	-	HH survey	28 (2009)	25	22	19	16	13
	% clients expressing satisfaction with health services (waiting time)	-	MoH survey	46 (2008)	50	55	60	65	70
Coverage for Health Services	% pregnant women attending 4 ANC sessions	--	HMIS	47 (09/10)	50	53	55	57	60
	% deliveries in health facilities (public and PNFP)	NDP, JAF	HMIS	33 (09/10)	40	50	65	75	90
	% children under one year immunised with 3rd dose Pentavalent vaccine	NDP, JAF	HMIS	76 (09/10)	80	82	83	84	85
	% one year old children immunised against measles	MDG	HMIS	72 (09/10)	75	80	85	90	95
	% pregnant women who have completed IPT 2	-	HMIS	47 (09/10)	50	55	60	65	70
	% of children exposed to HIV from their mothers accessing HIV testing within 12 months	-	HMIS	29 (08/09)	35	45	55	65	75
	% U5s with fever receiving malaria treatment within 24 hours	MDG	HMIS	13.7 (09/10)	20	40	60	70	85
	% eligible persons receiving ARV therapy	NASP	HMIS	53 (2009)	55	60	65	70	75
	% of new smear + cases notified compared to expected (case detection rate)		NTLP reports/ HMIS	56 (09/10)	60	65	70	70	70
Coverage for health determinants	% of households with a pit latrine	-	HMIS, UDHS	69.7 (09/10)	68.5	69.5	70.5	71.5	72
	% U5 children with height /age below lower line (PR)	MDG	UDHS	38 (2006)	36	34	32	30	28
	% U5 children with weight /age below lower line (PR)	MDG	HMIS, UDHS	16 (2006)	15	14	13	12	10
Coverage's for risk factors	Contraceptive Prevalence Rate	MDG, JAF	UDHS	24	25	28	31	33	35
Health System outputs (availability, access, quality, safety	Per capita OPD utilisation rate (m/f)	NDP	HMIS	0.9 (09/10)	1.0	1.0	1.0	1.0	1.0
	% of villages with trained VHTs, by district		HMIS	31 (09/10)	50	60	75	90	100
	% of health facilities without stockouts of any of the six tracer medicines in previous 3 months (1st line antimalarials, Depoprovera, Suphadoxine/pyrimethamine, measles vaccine, ORS, Cotrimoxazole)	JAF	Annual MoH survey (Drug availability)	41 (09/10)	50	55	60	70	80
	% of functional Health Centre IVs (providing EMOC)		HMIS	23 (09/10)	28	33	38	43	50
	Annual reduction in absenteeism rate (m/f)?	JAF	Panel survey	-	20	20	20	20	20
Health investments	% of approved posts filled by trained health workers	JAF	HMIS	56 (09/10)	60	65	70	72.5	75
	General Government allocation for health as % of total government budget	NDP, JAF	MoFPED	9.6 (09/10)	8.8	8.6	9.8	10	10

To complement the two monitoring tables presented above, the table below compares the performance of some of the key health indicators against targets that were set under HSSP II and new targets presented in the HSSIP.

Table 3. Performance of some key HSSP II monitoring indicators & new HSSIP targets

Indicator	**2004/05** (baseline)	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**HSSP II target**	**HSSIP target (2014/15)**
Percentage of Government of Uganda (GoU) budget allocated to the heath sector	9.7	8.3	9.6	9.6	9.0	9.6	**13.4**	**10**
Total public (GoU and donors) allocation to health per capita	$ 7.8	$ 9.98	$ 7.8	$ 8.4	$ 10.4	$ 11.1	**$ 16**	**-**
Percentage of facilities without stock outs of 5 essential drugs[4]	35	27	35	28	26	41	**70**	**80 ([5])**
Percentage of children < 1 receiving 3 doses of DPT/pentavalent vaccines	89	89	90	82	82	76	**95**	**85**
Proportion of approved posts that are filled by health professionals	68	75	38.4	38.4	56	56	**65**	**75**
Percentage of deliveries taking place in a health facility (GoU or PNFP)	38	29	32	40	34	33	**50**	**90**
Per capita Outpatient Department utilization rate	0.9	0.8	0.9	0.8	0.8	0.9	**1**	**1**
Proportion of pregnant women receiving a complete dose of Intermittent Presumptive Therapy (IPT2)	30	37	42	42	44	39.6	**70**	**70**
Percentage of households with a pit latrine	57	58	58.5	58.5	67.5	69.7	**70**	**72**

[4] Antimalarial drugs/Fansidar, measles vaccine, Depo provera, ORS and cotrimoxazole

[5] This also includes a sixth drug: suphadoxine/pyrimethamine.

2.4. Launch of the new Memorandum of Understanding

A new Memorandum of Understanding (MoU) entitled as “Compact between the Government of Uganda and Partners for the implementation of the HSSIP 2010/11 – 2014/15”, was presented by the MoH and signed by the representative of the World Health Organization in Uganda. The Compact was developed in close consultation with the HDP in the past months however most of these will need approval from their respective headquarters before signing and adhering to the Compact.

3. Policy and Political dialogue

The BTC health sector advisor took up his duties in Kampala in August 2006 and has played a crucial role within the HDP group and as an advisor to the Belgian Embassy in the past four and half years.

The health sector advisor participates in the monthly meetings of the Health Policy Advisory Committee (HPAC – highest level forum between the HDP and MoH) and of the HDP where he plays an active role in providing ongoing technical support to the chair (currently USAID). He is also a key member of the budget sector working group and the HDP focal point for providing input on the performance of the health sector for the Joint Assessment Framework (JAF) carried out by the budget support donors within the Joint Budget Support Framework (JBSF – currently chaired by DFID). The health sector advisor is considered to be a key person in the HDP group as he collaborates closely with MoH on a number of important technical issues and has been providing ongoing technical support to the chair of the HDP since 2006.

The HQ mission noted that the liaison and information flow between the BTC health sector advisor and Embassy could be optimized and encourages the Embassy to make full use of the health sector advisor's expertise and experience when preparing its participation in the political dialogue platforms such as the HPAC and the JBSF[6].

Recommendation: The BTC HQ mission recommends the working relationship between the health sector advisor and Attachés be mutually reinforced. As per his ToR, one of the key roles of the health expert is to be an advisor to the Attachés and his input should be sought on a more regular basis in order for the Embassy to be best informed on the evolution of the health sector in the context of the role it has to play in the political dialogue with other development partners and high level representatives of the Government of Uganda.

[6] Belgium became a member of the JBSF in May 2010.

4. Future perspectives

The Specific Agreement signed between Belgium and Uganda for support to the implementation of HSSP II comes to an end on the 31st of December of this year, following two instalments of 5 million EUR made in fiscal years 2008/09 and 2009/10. The SA specifies that an end evaluation of HSSP II is to be organized by the Government of Uganda and its outcome will determine the continuation of the Belgian sector budget support to the health sector (for an additional 10 million EUR as per the current ICP).

The Technical Note prepared by BTC for the formulation to support HSSP II states that a new strategic plan and a new Memorandum of Understanding should be developed and approved by all stakeholders for the Belgian budget support to continue beyond June 2010. Belgium highlighted these conditions as additional pre-requirements for its continuation to support the health sector in a letter sent by the Embassy to the Ministry of Health on 28 September 2010 whereby it was announced that the sector budget support would be postponed until all three conditions cited above had been met.

Following the closing of the JRM, the BTC HQ mission team, the BTC Uganda Resident Representative, the BTC health sector advisor and the external health expert met with the Belgian Ambassador and Attachés. While acknowledging the key issues and challenges mentioned under point 2 of this report, all parties came to the agreement that it was advisable to continue the Belgian budget support to the health sector and that following steps could be undertaken as the three pre-conditions for the preparation of a new Technical Note had been met. Therefore it is expected that DGD will request BTC to carry out the formulation of a new budget support operation for the remaining 10 million EUR indicated in the ICP in the first quarter of 2011 with the objective that a new Specific Agreement and disbursement be settled by the end of fiscal year 2010/11 (ie: June 2011). The Embassy also praised the role of the BTC health sector advisor and expressed the need to ensure ongoing technical expertise throughout the upcoming formulation period and the during the implementation of the new operation expected to be approved in the early months of 2011.

It is worthy to note that SIDA/Sweden is the only other donor providing budget support to the health sector and its current engagement runs until June 2011. On the other hand, DFID will be operating a shift from General Budget Support to Sector Budget Support in the near future and it is very likely they will to enter the health sector. Additional information with regards to other donors' involvement in budget support to the health sector will have to be gathered during the upcoming formulation so as to ensure Belgium will not stand alone as BS donor in the sector.

Finally, the Embassy asked the mission team to take the following concerns to the BSWG for discussion:

- What would be the scenario when things are really not working, whether in a sector where Belgium is involved or in general?
- The “portfolio approach” is not working well. How can it be optimized so that input coming from projects is used for discussions at the sector level?