HERA

HEALTH RESEARCH FOR ACTION

Belgian SBS to health

Uganda

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Table of Contents

List of abbreviations and acronyms

AHSPR	Annual Health Sector Performance Report
BTC	Belgian Technical Cooperation
DP	Development Partner
EU	European Union
EMOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunisation
GoU	Government of Uganda
HDP	Health Development Partner
HERA	Health Research for Action
HIV / AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HR	Human Resources
HRD	Human Resources Development
HSSIP	Health Sector Strategic & Investment Plan
HSSP	Health Sector Strategic Plan
HQ	Headquarter
IHP+	International Health Partnership Plus
IPT	Intra-Partum Treatment (of HIV/AIDS)
JAF	Joint Assistance Framework
JANS	Joint Assessment of National Strategies
JBSF	Joint Budget Support Framework
JRM	Joint Review Meeting
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding

MTEF	Medium Term Expenditure Framework
NMS	National Medical Stores
OPD	Outpatient Department
PEAP	Poverty Eradication Action Programme
RR	Resident Representative
SA	Specific Agreement
SBS	Sector Budget Support
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UNMHCP	Uganda National Minimum Health Care Package
WHO	World Health Organisation

1. Introduction

HERA was contracted by BTC to contribute to the internal reflection on the Belgian contribution to the Sector Budget Support (SBS) to the health sector in Uganda. The mission was carried out at the time of the 16th Joint Review Meeting (JRM), held from 22 to 24 November 2010.

The objective of the mission is to support BTC and the Belgian Embassy in their reflections and the decision making around the Belgian budget support to the health sector (see TOR in annex). In particular the mission would:

- Review and assess the relevant documents, in particular the evaluation of Health Sector Support Programme II - HSSP II (being part of the AHSPR FY09/10) and the HSSP III[1];
- Participate in the JRM of the health sector; and
- Contribute to the internal reflection (HQ, BTC Uganda, Embassy) on the Belgian contribution to the Sector Budget Support in the health sector.

The mission was in Uganda from 20 to 26 November; held preparatory meetings with the health advisor based in Kampala, BTC headquarter staff and the BTC Residential Representative (RR); participated in the three-day JRM; and had debriefing meetings with BTC and the Embassy. During the formal debriefing at the Embassy, the Ambassador (Marc Gedopt), the Belgian attachés Ludo Rochette and Wilfried Fieremans, BTC headquarter staff (Paz Guzman and Charlotte Taylor), BTC RR (Koen Goekint) and the health advisor (Luc Geysels) were present.

2. Context of the SBS[2]

The Specific Agreement (SA) for the sector budget support was signed on 2 December 2008 and valid for a period of 24 months. It has come to an end by the time this report is out. The BTC expertise linked to the budget support will also terminate on 31 December 2010 (unless extended). As the sector strategic plan HSSP II has come to an end in June 2010, the related MoU between the Government of Uganda (GoU), the Health Development Partners (HDP) and other signatories has also terminated and needs to be renewed.

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 Specific Agreement specifies in Article 4 that:

[1] The Health Sector Strategic Plan III (HSSP III) is now called the Health Sector Strategic & Investment Plan (HSSIP). Both names are used in this document: the old name when referring to previous documents with this reference; the new name when referring to the final version the plan launched during the JRM.

[2] Main source is the quarterly report of the health advisor (august 2010) and discussions held during the mission.

- 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.
- The **outcome of the end evaluation of HSSP II** will determine the continuation of Belgian sector budget support to the health sector.

HDP together with MoH agreed not to organise a separate evaluation, but to integrate it in the analysis of the new HSSP III and to include a sector assessment for HSSP II in the Annual Health Sector Performance Financial Year 2009/2010 (AHSPR FY09/10).

In addition, the development of HSSP III and its MoU or Country Compact, as it is called under the IHP+, are essential for the signature of a new Specific Agreement by Belgium.

3. Appraisal of the conditionality linked to SBS

By the time of writing this report, the GoU has formally complied with the conditionality specified in the SA, as follows:

- 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 HSSPIII.
    - The AHSPR FY09/10 (dated November 2010) contains a (15 pages) chapter two, entitled "Overview of health sector performance – Summative Evaluation of HSSPII". 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 HSSPII 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 (see further).
    - The Health Sector Strategic & Investment Plan 2010/11-2014/15 (HSSIP, dated July 2010, but published in November 2010) 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 (see further for more comments).

  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. Further in this document we briefly discuss 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 HDPs intent to continue supporting HSSIP even if sector performance during HSSPII was below expectations.

- Regarding the **next strategic plan**:
  - The Health Sector Strategic & Investment Plan 2010/11-2014/15 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 10/11-14/15 (see further for a more detailed discussion of the plan).

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

- Regarding the **MoU for HSSP III** (now called HSSIP):
  - 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 DPs 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 DPs and other stakeholders will sign the MOU soon.

  Validation: The MoU is almost ready (pending finalisation of some annexes) for signature by Belgium

Overall validation of conditionality

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?). In the next sections of the report we will briefly review the content of the two main documents (previous performance and future strategic plan) providing some elements to support the Belgian authorities in this decision.

4. Health sector performance during HSSP II

The health sector has been confronted with serious problems during most of the 5 year period of HSSPII. One of the main problems, especially during the last two years, has been the overall weak leadership 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 too long). Weak management is one important reason why major health system issues such as the HR 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.

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 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 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 31% of facilities were without out of stock for 5 tracer medicines, compared to a target of 70%). 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. Out of the 8 PEAP indicators 5 are substantially below 90% of the 2009/10 targets.

Regarding the HSSPII indicators 15 out of 25 indicators are below 90% of the HSSPII targets; for 6 indicators no information is available in the AHSPR; for 4 indicators more than 90% of the target has been reached (OPD utilisation; couple year protection; latrine coverage; 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 TB cases are notified. These indicators do not compare favourably with the same indicators in the region and suggest a failing health system.

Based on the substantially low health system inputs it is not surprising that outputs of the system are so 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 20-25% 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 (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 evaluation presented in the AHSPR is not at all critical and does not present adequate recommendations or solutions to address the above constraints. The evaluation concludes "*Measured against the monitoring indicators, the health sector has performed considerably well* (sic!) *in view of the shortfalls in the required health system inputs. Most of the indicators showed an*

upward trend." This statement is naively positive. Many of the positive trends, while it is correct that some improvement was made as compared to the base value, remain largely below the set target, but importantly also below an acceptable level of good performance. The final statement "*The most notable short-comings in health system inputs are chronic low under-funding to the sector which affects the procurement of essential health commodities and maintenance of an effective work force*", is only partly correct. Beyond the issue of financial resources, there is much inefficiency in the system that needs to be addressed urgently. For example, effective HR management is much more than receiving a correct remuneration package: between 70% (doctors, dentists) and 80% (pharmacists) serve 13% of the population (urban areas). And regarding continuous and sufficient medicines supply it is unlikely that the recent change from a push to pull system will solve the problem of drug availability at facility level.

As indicated, the quality of the critical assessment presented in the AHSPR regarding HSSPII is below par. However, the complementary (or different) critical analysis presented in the HSSIP corrects this to a sufficient extent. More importantly, the strategies proposed in the HSSIP are based on the critical situation analysis presented in the HSSIP.

The situation analysis looks into overall health impact indicators (up to 2006 only, the latest demographic & health survey); health service coverage (4 clusters including promotion-prevention, maternal and child health, communicable diseases and non-communicable diseases); coverage of other health determinants; management systems; financing and financial management; and investments in infrastructure, human resources and medical supplies.

The analysis recognises the overall low health status, the too slow pace of change and the significant disparities in distribution of health status. In order to address these it is proposed to address three different areas, being the health services, the health determinants and the risk factors to health. Regarding the sector it is acknowledged that management capacity needs to be built, the human resource crisis effectively and fundamentally addressed, the medicines supply continuously and sufficiently ensured, the regular supervision maintained (and made more effective through a new regional set-up) and all investments equitably allocated. Based on the analysis, it is being recommended through HSSIP to:

- Put in place different strategies to address the challenges in different parts of the country;
- A comprehensive approach to addressing health services;
- A better understanding of the investments needed to achieve the desired health outputs;
- Scale up health services;
- A comprehensive knowledge management approach
- Achieve equity in health (equitable allocation of all resources including HR, equipment, facilities, operations);
- A comprehensive health financing strategy; and
- Scale up sector coordination and partnership.

These recommendations are reflected in the subsequent sector strategic plan, HSSIP (see below).

5. The Health Sector Strategic & Investment Plan 2010/11-2014/15

The latest (final) version of the HSSIP presented at the JRM has much improved compared to the June version reviewed by the IHP+ JANS team. The review provided detailed recommendations on gaps; policy / strategies; governance and accountability; the planning process; implementation and management; financial management, procurement and auditing; monitoring and evaluation.

Below we review to what extent the JANS recommendations have been taken into account and are being addressed in the new version of the strategic plan. We limit the review to the essential elements only.

- JANS: *HSSP III presents a well developed **comprehensive situation analysis** and underlying strategies are generally based on evidence*. HSSIP: The situation analysis now results in a critical analysis with clear recommendations for the strategic plan, which have been taken on board in the plan – to a large extent. This makes the presentation of the overall plan more coherent.

- JANS: *The **participation** in developing the plan was broad, including many relevant state and non-state stakeholders but engagement needs to be deepened and could become more meaningful.* HSSIP: This is a medium-term recommendation to be taken on board during implementation, evaluation and subsequent planning.

- JANS: *While participation has been impressive, mechanisms for **accountability** of different stakeholders are not well specified in the plan*. HSSIP: The plan now contains a separate section on technical accountability & risk analysis. For each of the 4 clusters under the first objective responsible units in MoH have been defined. Unfortunately, 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.

- JANS: *HSSP 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.* HSSIP: With the exception of health system strengthening which has become somewhat the consistent red line across the strategic plan, the other four priorities are only mentioned in section 6.1 (Service Delivery Priorities for investment). Although it is being confirmed that "investments made during the HSSIP period are geared at enabling the system deliver, at a minimum, the above interventions", the plan is not convincing with a view that these priorities will be respected; nor is the budget underscoring those priorities. Further:

    - JANS: *There will be a **need to prioritise the interventions and adjust some of the targets** following the planned costing of the HSSP III*. HSSIP: interventions have not been prioritised; most targets remained the same and some remain unrealistic over the plan period (e.g. increase the number of health facilities by 30%); the costing does not reflect priority setting.

- JANS: ***Some constraints well described in the situation analysis do not seem sufficiently addressed*** *by the proposed actions (the main example given was regarding HR).* HSSIP: Basically, the section on HR has remained unchanged. A section has been added under the investment focus regarding HR, but the provided figures are questionable in terms of the plan's feasibility (e.g. increase staff filled posts from 56% to 66% or employ an additional 6,521 staff in the first year). However, during the JRM the HR issue has been discussed at length and some priorities were set for the first year (see further). All stakeholders agree on the urgent need to address the crisis.

- JANS: *The next draft needs to improve the* ***internal coherence*** *between different sections of the plan*. HSSIP: This has been a major stumbling block in the planning process, also after the JANS exercise, as MOH units and TWG do not easily coordinate between themselves. The present version of the plan has tried to address this and achieved it partly, also through the costing exercise. There remain however a number of inconsistencies in the plan.

- JANS: *Clarify and strengthen the* ***link between the HSSPIII and the annual and decentralized planning*** *processes*. HSSIP: this has not been further developed in the HSSIP.

➢ JANS: *Sections or elements of the HSSPIII that* ***require further development*** *are:*

- *Costing of the plan*
- *Health financing section and projections*
- *Implementation arrangements (including a financial management plan, accountability, auditing, good governance)*
- *M&E plan and link with the plan for HMIS development*
- *Risk assessment and mitigation*
- *Requirements for technical assistance*
- *References to relevant sub-sector and sub-system plans under-pinning the HSSPIII*

HSSIP: With the exception of the requirements for technical assistance, all above elements have to a large and generally satisfactory extent been addressed in the latest version of the HSSIP.

The present version of the HSSIP is much better than the June version. Its main weakness remains:

- The lack of priority setting;
- The over ambitious plan in terms of 'trying to do it all', being the sum of over ambitious plans prepared by each department;
- The insufficient checks and balances between different sections of the plan in terms of consequences of planned activities in one section on resource requirements in other sections;
- The over ambitious costs of the plan vis-à-vis the available resource envelope. Even the so-called 'realistic scenario' requires a resource envelope three times the current one.

- The different cost scenarios which only take into account different scenarios regarding HR (remuneration and employment), while maintaining the same level of sector outputs which is of course not realistic.
- The basic assumption that the so-called basic package UNMHCP can be provided to all Ugandans.

6. The 16th Joint Review Meeting

The JRM was attended by a large audience including mid-level representatives from different ministries (unfortunately few or no high level representatives), senior representatives from MOH (but no presence of the Minister, and the acting PS only present day one), active representatives from civil society, church related organisations, health agencies, private sector providers and professional institutions.

Some quite critical presentations were made by the Monitoring Unit of the President's Office, by the Office of the Auditor General, by civil society and by the private sector apart from the more standard presentations regarding previous performance, the national health policy and the HSSIP. Discussions were frank and open but limited in time (and therefore also in substance).

The working groups came up with recommendations regarding key issues to be addressed during the first year of the plan. While this may be a rational approach leading to priority setting within a more realistic resource envelope, the fact that working groups did not always have the required technical expertise or the knowledge about cost consequences of proposed actions, the resulting indicative priority lists will have to be carefully reviewed by the formal TWGs.

The Health Development Partners were physically present but not very vocal during plenary discussions. However, the formal joint closing statement by the HDP, presented at the end of the JRM, did clearly point at the major issues in the sector that need to be addressed, including stewardship / leadership, the effective engagement of the private not for profit sector, the private health sector policy, the human resource crisis, the medicines supply issues, the financing issues (e.g. non wage recurrent budgets for districts), the overall low performance and poor service indicators. The statement included some practical actions to be taken that could be translated into benchmarks for the next year.

The JRM did not come up with a clear action plan or benchmarks for the first year of implementation of HSSIP, which is a missed opportunity.

The final Aide-Mémoire of the JRM may however still address some of those gaps.

7. Conclusions

Based on the above brief analysis, we would recommend the Belgian authorities to:

a) Engage the second phase of the health sector budget support and ensure that there is no discontinuity in annual payments; and
b) Extend the engagement of the technical assistance contract (health advisor) for the whole period and ensure that there is no gap between the present contract and the next one.

We would recommend to carefully addressing the issue of conditionality linked to the next SBS phase. 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 HISSP 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. Examples are:
    - 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[3].

The fact that Belgium is now member of the Joint Budget Support Framework (JBSF) Task Force is an important new given. Elements of the sector policy dialogue can now be discussed and taken forward at inter-sectoral level. The JAF exercise (including the health sector amongst other sectors) seems to become a high-level fruitful modality for highest level policy dialogue. Although too young to appraise, it seems to be taken seriously by the national authorities.
The technical advisor is also member of the Task Force. He has been absolutely instrumental in ensuring continuous critical analysis of health sector performance, maintaining and supporting meaningful policy and technical dialogue between all HDP and the GoU. This aspect should be maintained, especially that many HDP miss this technical in-house competence/support, make use of and appreciate the services of the health advisor.

In addition the capacity building programme implemented through BTC may become a key element of support enabling the sector to perform better. It addresses a key element of the sector that absolutely needs strengthening. In itself the programme may have only limited impact unless complemented by sufficient sector resources and political willingness to change and perform.

Leo Devillé
Reet, 3 December 2010

[3] Variables tranches linked to well specified targets or benchmarks, as used by the EU, are more effective in driving policy changes.