WHO/GPE/00.3
Original English
Distribution: General

CURRENT ISSUES IN SECTOR-WIDE APPROACHES FOR HEALTH DEVELOPMENT

Uganda Case Study

Adrienne Brown
Overseas Development Institute

WORLD HEALTH ORGANIZATION

Strategies for Cooperation and Partnership
Global Programme on Evidence for Health Policy

ABOUT THE INTER-AGENCY GROUP ON SECTOR-WIDE APPROACHES AND DEVELOPMENT COOPERATION

The Inter-Agency Group on Sector-wide Approaches and Development Cooperation (IAG) is a small informal group of experienced senior technical people from international development agencies. WHO provides its secretariat.

The group's interest is in advancing policy and practice of development assistance for health development. Toward this end, members of the group meet to review and discuss specific issues and topics in development aid, commission new analytic work, review results and disseminate information both through the communication networks of their own organisations and through WHO's publications series.

In 1999, the Inter-Agency Group commissioned five country case studies and a synthesis report to review experience with sector-wide approaches to date. Additional case studies are planned to document the evolution of sector-wide approaches in the context of other development initiatives and instruments, particularly poverty reduction strategies.

For additional information, please contact:

Dr K Janovsky, Secretary
Inter-Agency Group on Sector-wide Approaches and Development Cooperation
World Health Organization
CH 1211 Geneva 27
Switzerland
tel 41 22 791 2568
fax 41 22 791 4881
e-mail janovskyk@who.int

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ACRONYMS

CDF	Comprehensive Development Framework
DFID	Department for International Development
FY	Financial Year
GDP	Gross Domestic Product
GoU	Government of Uganda
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPD	Health Planning Department
HPIC	Health Policy Implementation Committee
HSD	Health Sub District
HSSP	Health Sector Strategy Programme
HSRC	Health Sector Reform Committee
LC	Local Council
MoE	Ministry of Education
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service
MTBF	Medium Term Budget Framework
MTEF	Medium Term Expenditure Framework
MP	Member of Parliament
NGO	Non Governmental Organisation
ODA	Overseas Development Assistance
OAG	Office of the Auditor General
p.a.	per annum
PAF	Poverty Action Fund
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PHCCG	Primary Health Care Conditional Grant
PPA	Participatory Poverty Assessment
UMHCP	Uganda Minimum Health Care Package
UPPAP	Uganda Participatory Poverty Assessment Project
SWAp	Sector-wide Approach
WHO	World Health Organization

EXECUTIVE SUMMARY

Uganda is notable amongst the five case study countries reviewed[1] for the context in which the health sector-wide approach (SWAp) is developing. The strong political commitment to poverty reduction is manifested in the national Poverty Eradication Action Plan (PEAP) which has had a significant influence on sector strategy policy and implementation. Funds are earmarked for poverty reduction and channelled to primary health care activities with monitoring procedures that stress transparency and accountability. This is supported by an increased emphasis on improved public expenditure management at all levels of the service. The policy of decentralisation aims to link service provision with local needs, backed up by conditional grants for primary health care to reflect national priorities.

Although a number of questions about programme priorities and financing remain unanswered, and much remains to be done on capturing donor contributions and defining the programme, the fact that the debate is taking place in the context outlined above means that the Ministry of Finance (MoFPED) is a key player in the sector strategy, and the Medium Term Expenditure Framework (MTEF) has lent rigour to these debates. The problems therefore stand a more favourable chance of being resolved.

The capacity of the Ministry of Health (MoH) to lead the programme and fulfil its role as sector policy maker and regulator has increased. This has partly been through donor assistance, but more importantly through the process of negotiating the programme and taking a broader sector-wide view. Capacity beyond the Ministry remains limited, a key constraint at district level and below, but one which may be addressed through improved financial planning and management processes, and staff supervision. It is hoped that this approach will have the dual impact of reducing informal user charges, and improving service quality thereby increasing utilisation.

The health SWAp does not sit easily with decentralised service delivery through districts, partly because of capacity problems, but also because of unclear policy links. These are in part being addressed by the use of conditional grants which are beginning to reorient services to primary care and prevention. There is evidence of success in the use of the grants, which will be enhanced by better disbursement and planning so that allocations can be made and spent in a timely fashion.

[1] Case study countries include Mozambique, Uganda, Tanzania, Cambodia and Vietnam. See inside front cover for full references.

1 BACKGROUND AND METHODOLOGY

This case study is one of five carried out for the World Health Organization and the Inter-Agency Group on Sector-Wide Approaches and Development Co-operation, conclusions from which have been drawn together in a synthesis entitled *Sector-wide Approaches for Health Development: A Review of Experience*[2]. For full references of other country case studies in the series, see inside front cover. The work was carried out by the Centre for Aid and Public Expenditure at the Overseas Development Institute.

This report is based on findings from interviews and review of available literature. Field work was carried out for one week in late October 1999, and entailed interviews with donors, representatives of other agencies, and NGOs. The researcher also attended the two day government - donor consultative meeting. Unfortunately it was not possible to meet many government representatives during the field work as they were taking part in two review missions. A list of people met is attached in Annex 3. A week was a very short time to become familiar with complex and sensitive issues, and conclusions should therefore be taken in the spirit of the Terms of Reference: "*Given the breadth of the concerns, the aim will be to make well informed judgements, rather than collect large amounts of quantitative data*" (see Annex 2). It should also be noted that the report refers primarily to the situation at the time of the field work. The Uganda development process is very fast moving, and the Health Sector Strategic Plan and its supporting information and analysis are under constant revision, so material and opinions gathered during the mission may since have changed.

[2] Foster, M., Brown, A., and Conway, T., Sector-wide Approaches for Health Development: A Review of Experience WHO/GPE/2000.1, April 2000.

2 CONTEXT

2.1 General context

2.1.1 Economic situation

Uganda experienced a steep decline in economic activity throughout the 1970s and early 1980s. Coming to power in 1986, the Museveni Government started to introduce structural adjustment reforms. Annual economic growth over the last decade has averaged around 6.5% and per capita GDP grew at 3.4% p. a. between 1987/8 and 1996/7. After two below average years due to adverse weather conditions, the economy recovered in 1998/99 with real GDP growth of 7.8% (5.1% per capita). Agriculture dominates the economy employing close to 80% of the labour force in 1997 and accounting for nearly 45% of GDP in 1996.[3] Within agriculture the non monetary sector is very large, providing work for 44% of the labour force and producing 21% of national income. Employment and output in the formal non-agriculture economy is mostly in government services and in trade. Government's future economic outlook continues to be positive, forecasting growth rates of around 7% p.a. on the back of privatisation, investment in the social sectors, reform of public utilities and increased investment in infrastructure.

2.1.2 Poverty profile

The strong economic growth performance in recent years has led to an overall reduction in poverty levels from 55.6% in 1992/3[4] to 44% in 1997[5]. However, Uganda's economic growth "*has not been broad-based enough to address the problem of mass poverty in the country.*"[6] Real per capita income is around $300 p.a.

Most of the poor live in rural areas, and the urban / rural differential continues to sharpen as poverty is falling more quickly in urban than in rural areas. While poverty incidences have fallen in all areas, poverty reduction has varied across regions and between different occupation groups. The poorest regions have experienced the slowest decline in poverty, which in the North is partly due to ongoing conflict. Subsistence food farmers have not benefited as much from economic growth as coffee and other cash crop farmers. The poorest 20% of the population are particularly vulnerable to climatic changes and fluctuations in prices, and there is a danger that they may be further marginalised in the economy.

Non-monetary poverty indicators are poor. Some, such as child mortality, immunisation coverage, literacy and access to safe water have improved in the 1990s, but others, especially female literacy and child nutrition, have not. Life expectancy has fallen substantially since 1980 as a result of AIDS. Uganda's Human Development Index is slightly below the Sub Saharan African average and well below that of Kenya.[7]

[3] MoFPED 1999.
[4] MoFPED 1998.
[5] MoFPED 1999.
[6] MoFPED 1997.
[7] UNDP, 1998.

2.1.3 Trends in development assistance and relationship to national politics

Since 1986 Uganda has relied heavily on donor support: on average ODA has accounted for around 10% of GDP. In 1999/00 around 70% of donor support is in the form of grants, and the remainder in loans. Foreign aid finances around 80% of government capital expenditure[8] and about one-third of total public expenditure[9]. Structural Adjustment assistance has constituted a substantial part of ODA, and Uganda has an effective Ministry of Finance highly committed to economic reform on lines consistent with the views of the Bretton Woods institutions. Compared with other countries there has been little disagreement over policy reform. Over the last decade increases in government capacity to manage and co-ordinate donor funds coincided with donors' willingness to move towards budget support and SWAps.

The Poverty Eradication Action Plan is the backbone of the Ugandan Government's poverty reduction policy. It was published in mid 1997 after a consultation process started in late 1995. As well as government officials and donors, GoU consulted MPs, district administration officials, employers' and workers' organisations, the NGO community, social researchers, and academics. Consultation took place at the central and at the sectoral policy level. Subsequent consultation, however, showed the need to conduct a participatory poverty assessment to understand local variations in poverty. Civil society has been involved in both the formulation and the implementation of the PEAP which provides a framework for the development of sector plans and investment programmes by focusing on key priorities: continued macro-economic stability, increasing economic opportunities for the poor, providing basic social services, promoting transparency and accountability, and developing the capacity to respond rapidly to economic crises. MoH provided minimum standards for health delivery for the PEAP, but has not yet fully institutionalised the process by which performance is measured against them. The PEAP is expressly linked to the MTEF. The revised Public Investment Plan forms Part II of the PEAP. The PEAP also forms the basis for developing Uganda's Comprehensive Development Framework (CDF). The influence of the PEAP on SWAp development is discussed in section 4.2.

Uganda qualified for debt relief under HIPC I in April 1998 and received a reduction in its debt stock of about 20% ($350 million). In each of the next three years this will save more than US$40 million[10]. These funds are channelled to priority areas through the Poverty Action Fund (PAF) (see Box 1, p. 16). In 1998/99 health has received Ush 10.6 billion[11] of additional funding as a result of debt relief, and more is expected from HIPC II.

Initially the Poverty Action Fund was set up as a transparent mechanism to ensure that the debt service savings were used for poverty eradication policies. The PAF raised the profile of social sector expenditures and its quarterly meetings provided an opportunity to publicly discuss related policies. Government's commitment to monitoring and accounting under the PAF has led to greater transparency and better services as a result of the extra funding. Donors recognised these efforts and have provided an additional USh 21 billion to the PAF in 1998/99 alone.

[8] Tumusiime-Mutebile, E., 1999.
[9] DFID 1999.
[10] Tumusiime-Mutebile, E., 1999.
[11] MoFPED, 1999c.

2.1.4 Budgetary and public sector reform

Uganda's budget is centred around the Medium Term Expenditure Framework which specifies the overall resource envelope available to government as well as the likely levels of finance for each of the sectors. The MTEF has enabled the government to redirect its resources towards the policy priorities specified in the PEAP, so that resources to the social sectors now account for around 35% of the government budget (see also section 2.1.1).

Decentralisation was introduced step by step, starting with political decentralisation, followed by administrative and finally partial financial decentralisation. All districts receive a mixture of grants: conditional for funding of 'delegated' services, and unconditional for some local priorities. Eventually all development expenditure decisions will be made locally. The current half-way situation of district funding causes some tensions between earmarking of funds by the centre and local accountability.[12] The implications for SWAp implementation are discussed in section 4.4.

Civil service reform is a priority for the government. It has divested some activities to the private sector, reduced the size of the civil service (including removing ghost workers), and enhanced pay and working conditions for the remaining staff. However, lower level officials still earn below private sector incomes, which exacerbates petty corruption and low motivation. GoU recognises the problem and may introduce real wages linked to the poverty line. Remuneration at all levels will be linked to performance indicators. This is in line with GoU's move towards output oriented budgeting.

Reform and decentralisation efforts are aided by the government's willingness to own problems and its commitment to transparency. For example, to improve the transparency of public expenditure at district level the government publishes disbursements in the mass media.[13] This gives civil society a role in monitoring that the allocated funds are used for the (poverty focused) purposes intended. Similarly, the public is informed about its rights and the standards of service they can expect from local health facilities and schools.

2.2 Health context

The health status in Uganda is very poor. Life expectancy in particular is low even by comparison with other African countries.

The country suffers heavily from infectious and non-communicable diseases. Just under 10% of the population are HIV positive[14], and although infection rates have halved nationally due to a rapid fall in urban areas, they have yet to be reversed in rural areas, where people with HIV/AIDS have little or no access to preventative health care. Nation-wide over 9% of premature deaths are caused by AIDS. Malaria and diarrhoea are other main causes of premature deaths with 15.4% and 8.4% respectively. Non-communicable diseases such as hypertension, cancer, diabetes, mental illness and chronic heart disease are increasing.

[12] MoFPED, 1999.
[13] Government of Uganda (1999:35).
[14] MoFPED 1999.

Table 1 Indicators of health status

Indicator		Date and source
Infant mortality rate (per 1000 live births)	97	1995; Uganda Demographic and Health Survey 1995
	88	1996; HDR 1998
Under-5 mortality (per 1000 live births)	147	1995; Uganda Demographic and Health Survey 1995
Life expectancy (years at birth)	42	1996; HDR 1998
Maternal mortality ratio (per 100,000 births)	506	1995; Uganda Demographic and Health Survey 1995
Infants fully immunised (12-13 months)	47 %	1995; Uganda Demographic and Health Survey 1995

SOURCES: 1995 Uganda demographic and Health Survey; 1998 Uganda Human Development Report.

The latest data on the pattern of health provision revealed that over a third of Ugandans do not seek any medical attention when they are sick. Those who do are more likely to opt for home treatment (21.6%) and private services (23%) than to go to government health facilities (15%)[15]. Access to public health facilities is skewed geographically. Only 49 percent of the population live within five kilometres of a health service unit[16]. Access varies within and between districts from 8.9 to 99.3%[17].

Within government, minimum standards for health service delivery have been established in guidelines on the delivery of health care. Targets for health care are co-ordinated with the national administrative structure at all levels of decentralisation. Although government resources to the health sector are expected to increase by around 20% per annum over the next three years[18], there are several major problems in the sector which further reduce the health impact of the limited resources available. Health care organisation and management is weak. Collaboration between the public and private parts of the sector is inadequate and the imbalance of public to private expenditure in the health sector is exacerbated by the inefficient allocation of resources. Moreover, a disproportionate amount of recurrent expenditure and trained staff is being allocated by tertiary care.

[15] Uganda Bureau of Statistics 1995/96 Monitoring Survey.
[16] Health Facilities Inventory 1992, quoted in Uganda National Health Policy, February 1999.
[17] MoH, 1999d.
[18] MoFPED, 1999d.

3 PROGRAMME SUMMARY

3.1 Background

The Government of Uganda and donors has been discussing the transition to a sector-wide approach to health development since mid 1997. This built on a previous shift in focus with the 1993 White Paper in Health which acknowledged the need to increase resources to the health sector from both government and individual users, develop better community participation, improve planning and management, and make government and NGO services more complementary. There was also an increased emphasis on the role of primary health care.

The National Health Policy and implementation plan which were later prepared attempted to address some of the problems of health delivery, namely the shortage of recurrent funds, the outdated health infrastructure, a weak management structure, services which were too oriented towards providing curative rather than primary care, and poor coverage. GoU had also identified a number of barriers to rational planning and implementation in their working arrangements with donors which led to duplication of effort, gaps in funding, competing priorities, uncertainties about sustainability, and a heavy burden on both donors and government to plan, monitor, and evaluate the plethora of projects. GoU saw a sector-wide approach as a way of starting to solve these problems.

GoU and development partners are in the process of finalising the sector strategy plan, with the intention of starting implementation in July 2000. Steps towards reaching the current point were as follows:

• the concept of a sector-wide approach was introduced to GoU, donors and stakeholders	April 1997
• SIDA, WHO and DFID joint mission to review whether conditions were favourable for adopting a sector-wide approach	September 1997
• GoU invited donors to support a health SWAp	January 1998
• Health Sector Investment and Strategic Plan drafted	September 1998
• aide memoire signed outlining consensus on how the SWAp should be approached	October/November 1998
• Consultative Group meeting held to review programme development plans	December 1998
• joint MoH / donors workshop to develop programme goals and objectives, targets and indicators. Programme logframe drafted	April 1999

• GoU / donor consultative meeting held in Geneva - health policy was endorsed as the basis for the SWAp. Some donors[19] agreed to contribute to a Partnership Fund in order to support SWAp development	May 1999
• National Health Policy finalised and approved by Cabinet	September 1999
• GoU / donor consultative meeting held in Kampala to review progress on preparation for the SWAp. Statement of Intent signed by some development partners present, and soft endorsement of revised strategic plan given by donors	October 1999
• first joint mission (GoU and donors) to plan next steps. The meeting focussed on: costing and financing; SWAp process; priority technical programmes; financial management including cost sharing; and procurement and drug management.	November 1999

The draft Health Sector Strategic Plan (2000/1 – 20004/5)[20] proposes to reduce morbidity and mortality from the major causes of ill health and reduce health disparities among various groups and regions, as a contribution to poverty eradication and economic and social development. This will be achieved through five strategies:

- implementing a minimum health care package
- strengthening the health organisation and management system
- establishing and making operational a legal and regulatory framework
- strengthening and delivering an integrated support system
- developing and implementing systems for policy planning, health information management, and research and development.

3.2 Programme financing

GoU has expressed its intention to:

- increase public expenditure allocations to health, thus effecting a per capita increase
- shift allocations from tertiary and curative services to primary and preventative care through districts.

At the time of writing, neither the programme costs nor the resource envelope have been agreed. Issues in trying to establish them are discussed in section 4.1.2. The MTEF presented at the October 1999 Joint Review Missions gives MoFPED approved recurrent and development figures as follows:

[19] Ireland Aid, Norad, DfID, and SIDA.
[20] MoH, 1999c.

Table 2 Proposed resource envelope

In constant 98/99 US$ million	2000/01 (MTEF)		2001/02 (MTEF)		2002/03 (MTEF)		2003/04 (Projection)		2004/05 (Projection)		Total	
	$	%	$	%	$	%	$	%	$	%	$	%
Resource Envelope												
GoU	57.0	*37*	63.5	*39.1*	71.8	*41.6*	74.0	*41.9*	81.1	*43.6*	347.4	*40.8*
Donor	79.1	*51.4*	81.0	*49.9*	82.9	*48.1*	84.9	*48*	87.0	*46.8*	414.9	*48.7*
Community/NGO / Local revenue	17.8	*11.6*	17.8	*11*	17.8	*10.3*	17.8	*10.1*	17.8	*9.6*	89.0	*10.5*
Resource Env. Total	153.9		162.3		172.5		176.7		185.9		851.3	
Estimated costs	156.6		166.8		173.9		178.8		190.0		866.1	
Resource gap	**2.7**		**4.5**		**1.4**		**2.1**		**4.1**		**14.8**	

NOTE: These figures were a snapshot prepared for the October 1999 joint consultative meeting and have since changed, as they are in an ongoing process of revision.
SOURCE: Based on MoFPED, 1999 'Projected resource envelope for health sector, based on Medium Term Expenditure Framework' (as published at Budget workshop 22 October 1999)

From this the following per capita increase in expenditure may be calculated.

Table 3 Estimated per capita expenditure (GoU / donor / community, NGO, & local revenue contributions)

US$	2000/01	2001/02	2002/03	2003/04	2004/05
Per capita expenditure	$7.36	$7.76	$8.25	$8.45	$8.89

NOTE: These figures exclude resources utilised in the private sector. It is estimated that total per capita expenditure is approximately $14, including household expenditure. Calculations are based on proposed resource envelope (see Table 2).

At the Geneva meeting it had been agreed that different partners would need to move at varying paces towards full participation in common working arrangements. Four donors have since agreed to provide budgetary support[21]. Development of GoU systems to meet donor needs will be addressed under the health financing component of the integrated systems support strategy.

3.3 Programme monitoring

The Health Sector Strategic Plan is built on an extensive series of logframes. There is an overall one, plus logframes for each component of the Uganda Minimum Health Care Package (UMHCP), as well as a set for each of the other four programme outputs – a total of 24. The logframes detail verifiable indicators, and means of verification for each output. However indicators for activities remain to be completed later on as programmes reach the planning stage.

[21] Ireland Aid, Norad, DfID, and SIDA.

Goals for the programme as stated in the logframe are "*expanded economic growth and increased social development*"[22] and indicators have been defined for these e.g. investment, business, production levels for the first goal, and governance indicators such as increased participation of civil society for the second. These will not be the responsibility of the health sector to monitor.

Programme process is measured at activity level, and indicators are awaited, to "*be formulated by the Programme District Authorities and other stakeholders at the appropriate time*"[23] which presumably is when work plans are drawn up. For the period until July 2000 when HSSP is due to start implementation, MoH has drawn up a "*scope of work for preparatory activities*"[24] which identifies activities, timescales, who is responsible for implementation, and the expected outputs. This was agreed at the Geneva meeting in May 1999 and is a point of reference for ongoing MoH and donor discussion.

Financial monitoring is captured through a separate logframe, indicators covering such things as per capita expenditure on health, proportion of expenditure allocated to health by government, donors etc, and number of facilities with functioning accounting systems etc. Baselines and targets have yet to be specified.

The logframes and indicators are in the process of being revised as government and donors agreed they were too long and attempting to be too comprehensive, such that they would be unworkable. Also many of the indicators were very ambitious. Table 4 is one such example. Not all the logframes in the October 1999 HSSP draft are logically constructed, some resembling lists of activities. Also some of the indicators are not measurable, nor likely to be for some time to come given the weaknesses in the health management information system. The logframes as they stand in this draft are therefore not likely to be useful for annual monitoring. It is to be hoped that in the course of revision, government and donors are able to agree one shorter logframe for programme monitoring.

An ongoing problem remains with the number of different indicators that are being developed through different processes, including the working group responsible for developing sector monitoring, the MTEF, and recent PEAP related work. In order to help tie the programme together, it will be necessary to rationalise these.

3.4 Programme management

3.4.1 Management structure

The SWAp development process relies on government resources rather than parallel additional structures. GoU was a strong advocate of this approach and persuaded those donors who were doubtful of its merits at the May 1999 Geneva meeting; donors agreed on condition that MoH capacity was strengthened. A series of committees guides the process.

[22] MoH, 1999c.
[23] MoH, 1999c.
[24] MoH, 1999e.

Table 4 Programme Purpose indicators[25]

	Baseline 00/01	Target 04/05
Infant mortality rate	97/1000 live births	68/1000 live births
Child mortality rate	147/1000 live births	103/1000 live births
Maternal mortality ratio	506/100,000 live births	354/100000 live births
HIV prevalence		Decrease of 35%
Total fertility rate	6.9	5.4
Contraceptive prevalence rate	15%	30%
Life expectancy at birth	52	55
Malnutrition: stunting in under 5s reduced	38%	28%
Disparities between highest and lowest quartiles of districts		Reduced by 10%

The Health Sector Review Committee (HSRC) acts as the steering committee for the health sector development process, meeting quarterly. Its functions are to:

- generate consensus of all stakeholders in the implementation of health policy and sector strategic plan
- review and endorse reports and recommendations of the Health Policy Implementation Committee
- provide support and guidance in the implementation of policy in general[26].

Membership totals 83 people including representatives from MoH and MoFPED, MoLG and MoE, donors, NGOs receiving grants from GoU, professional councils, health related bodies such as the Uganda AIDS commission, medial schools, local associations, commissioners of health services, parliamentary committees, chairpersons of Local Councils (level 5), Chief Administrative Officers, District Directors of Health Services, Medical Officers of Health, Town Clerks, Mayors and Secretaries for Health Services. Although this makes the group unwieldy, it does encourage broad participation and information-sharing in the HSSP development process.

The Health Policy Implementation Committee (HPIC) reports to the HSRC and has responsibility for moving the SWAp development process along by:

- setting the agenda for, and monitoring the implementation of, the Health Policy
- preparing for the introduction of the SWAp
- refining the Health Policy and Sector Strategic Plan
- co-ordinating stakeholders
- defining key tasks and nominating lead agencies[27].

[25] MoH, 1999c.
[26] MoH, 1999g.
[27] MoH, 1999h.

There are 23 members including the Director General Health Services (chair), two MoH directors, donors, representatives from health implementing NGOs, assistant commissioners of health services, and representatives from MoFPED, MoLG, and the Ministry of Education. The committee meets weekly. It has proved to be an effective forum for donor co-ordination, and addressing issues on a regular and timely basis.

In addition there are eight Working Groups which report to the HPIC and focus on health infrastructure; human resource management; the basic package; finance and procurement; monitoring and supervision; decentralisation; public-private sector collaboration; research and development. MoH has adopted this arrangement as a way of widening participation in the SWAp development process. The success of these Groups vary - some are working well and making a useful contribution to the debate, whereas others were slow to start meeting.

Donor co-ordination is actively pursued by MoH with the assistance of the WHO Country Representative, an arrangement that seems to work to the broad satisfaction of everyone. The success of the WR in this position has been highly dependent on the person filling it, and is not likely to be sustainable after he leaves the post. Although this is of concern to donors, it may be that MoH will then be ready to develop further its already growing co-ordination capacity, and donors could then make similar arrangements to those adopted in other countries where the 'focal donor' role is rotated or nominated by the donor community.

3.4.2 Managing the annual cycle

The November 1999 Joint Mission agreed[28] that the annual monitoring and review cycle would be based on two programme review meetings, for October/November and March/April. These would be linked to the GoU planning and budgeting cycle. The October/November review would focus on performance of the previous fiscal year and establish ceilings for the following year. The April mission would review the draft budget for the following year, the district health plans, and an agreed plan of action. Each year technical areas of focus would be identified for special attention. Planning and preparation work before each mission would be done with the assistance of consultants if necessary. Presumably this means carrying out any additional reviews that are necessary, in order for results to be tabled at the meeting. Mission members would include MoH, MoF, MoLG, MoE, MoPS, local authority and NGO representatives, other GoU personnel as required, beneficiaries and other stakeholders, and development partners. Potential financial partners would be invited as observers. Draft terms of reference were agreed for the joint missions.

3.5 Participation in programme development

Participation beyond government in the development of the health sector plan has been through direct and less direct channels:

- representatives of NGOs have been present at a number of the joint consultative meetings as observers, have played a full role in recent initiatives to determine grant mechanisms for support to their services and are also members of all of the HSSP development working groups

[28] MoH/partners 1999.

- the process of developing the PEAP has involved consultation with a broad range of people from civil society
- this has been followed up by a Participatory Poverty Assessment Programme which in its second phase is supporting capacity building for local participatory planning which will be of relevance to health districts. Findings from the assessment survey will be disseminated to line Ministry planners including MoH, although a recent study of poverty reduction initiatives in Uganda[29] suggested that government officials were less aware of the programme than NGOs, which will have an impact on how the information is used
- the Poverty Action Fund (see Box 1, p. 16), is subject to monitoring by NGOs, and it is here that they could have a more significant impact on implementation of HSSP.

Participation by NGOs reflects their important role in health service delivery in Uganda. They have responsibility for 45%[30] of the health facilities including clinics, maternity units, aid posts and hospitals. These have high utilisation rates and thus provide approximately 55% of total services in the country, recovering a significant proportion of their running costs through user fees. Many also receive direct donors' funding. Since FY97/98 NGOs have also received direct budgetary support from the government which means they are being taken account of in national plans, although in practice the system is rather ad hoc at the moment. MoH has afforded NGOs considerable leeway in establishing how they wish to work with government and distribute funds. The NGOs developed a formula for grant allocation which was accepted without much amendment and service level agreements were subsequently drawn up to formalise arrangements and enable MoH to see what additional services their money was buying. There have been problems in that disbursement of grants has not occurred entirely as planned[31] but in general NGOs are satisfied with the direction in which the relationship is moving, as MoH clearly acknowledges their contribution to health provision, and their right to run those services largely autonomously, but accountably. At the same time however, there is still scope for greater participation by NGOs in HSSP development, by ensuring that they are privy to policy and implementation discussions, and given the opportunity to influence key decisions.

3.6 UNDAF and role of the UN

The Common Country Assessment is in the process of being developed, with leadership by UNICEF. It started in April 1999 and the agencies interviewed suggested that it was too early to say whether it would have an impact on how the UN Agencies interact with the SWAp.

The donor co-ordination with GoU carried out by the WR is notable for the respect and trust he inspires in both donors and government. He aims to tread a narrow line of offering advice and liaison without being seen to be allied to one or other party. This is not an easy role, but the fact that it is played by someone who has a recognised advisory remit to MoH and has little money to disburse through the SWAp, means that he is not seen as having a strong organisational agenda. The capacity of MoH to

[29] Goetz, Jenkins, R 1999.
[30] From interview.
[31] MoH, 1999f.

co-ordinate donors itself has been limited and therefore he has played an essential role in keeping the SWAp on track and moving.

4 KEY ISSUES

4.1 Government financial framework

4.1.1 The current situation

The sector programmes, including that for health, are nested within the Medium Term Expenditure Framework (MTEF): the first three years of the programme are essentially the MTEF budget line. The Ministry of Finance is an ally of donors in pressing line departments to present realistic budgets, in which the resources available from GoU and from donors are related to the outputs expected to be achieved with them. The SWAp budget cycle should eventually be fully integrated with the MTEF cycle: the MoFPED sets out the expected resource envelope for each sector, including anticipated donor flows, within a budget guidelines paper. The line ministries then prepare their three year budget proposals, adding a year to the previous MTEF. These are discussed in budget hearings, subsequently approved by Cabinet and Parliament, and reflected in the expenditure releases during the budget year. There is a meeting to discuss the proposals for the coming budget year, with donor participation, in March / April, to enable the integration of donor flows within the expenditure programme for the coming year to be discussed. When the SWAp process is fully established, the discussions of the annual SWAp review will form a major input into the budget hearings for the sector, and the sector programme documentation could form the basis for the MTEF submission. The effectiveness of the MTEF depends on political willingness to make the difficult decisions needed if resources are to be allocated in line with priorities, and to stick with them. In the case of Uganda, government has sought to tie its own hands to agreed priorities by ring-fencing expenditures on key poverty programmes within the Poverty Action Fund (see Box 1). There is commitment by MoFPED to strengthen accountability by a mix of both improved financial accountability, better monitoring of outcomes, and transparency and empowerment of users, to know what they can expect from government and be able to demand it. There has been an impressive openness in acknowledging problems, and seeking solutions, including very open discussion of corruption.

4.1.2 Moving towards an agreed budget

GoU and donors are currently in the critical stage of agreeing a resource envelope and budget for the five year programme. Intrinsic to this process is the question of affordability of the proposed programme. Several issues are under debate:

- ***size of resource envelope*** The total resource envelope presented by MoFPED to the joint consultative group meeting in October 1999 for the first year of the programme represented an increase of 17.4% over the current financial year, and excluded the possible HIPC II allocation. This was thought by donors to be overly optimistic. Some donor funds were already committed to specific activities over the course of the next few years. (It was estimated that only 25-40% of significant donor project money in Uganda would directly underwrite HSSP costs in year 1[32].)

[32] Subsequent comment from donor

Box 1 Poverty Action Fund

The Poverty Action Fund (PAF) was established as part of the budget in 1998 as a way of earmarking allocations to the key sectors identified in the Poverty Eradication Action Plan (PEAP) – primary health, primary education, agriculture, water, and road infrastructure. Expenditure programmes are thus protected from pressures to spend moneys on other programmes. Funds are released through conditional grants or the development budget and tracked through disbursements channels down to health sub-districts. Since its inception PAF has grown from Ush56.75 billion in 1998, to Ush155.16 in 99/00. Further savings from HIPC II may mean this growth continues.

The PAF has been shown to have a positive impact on the five priority sectors despite problems in monitoring and the timeliness of fund release[33]. These are being addressed by improving financial management at the district level, and improving the Health Management Information System (HMIS). Monitoring plans for reporting on PAF will also be developed and implemented.

GoU has adopted a consultative approach to monitoring the performance of the PAF, involving NGOs in pre and post budget meetings to discuss the Fund's priorities, inviting them to report on programme and accountability issues at quarterly monitoring meetings, and enabling them to participate in the development of monitoring procedures. They may also be invited to carry out some monitoring functions themselves using the money (5%) allocated within the fund for such purposes. The media are also invited to the quarterly meetings.

- ***scope of programme and priorities*** The crucial issue is the relative priority of expanding infrastructure to provide a complete range of delivery points, available nationally, or improving existing services. Politically this has been a difficult for MoH to resolve. Expectations outside government are high that infrastructure will be extended to under served areas, and local politicians are supporting this, but the limited expansion programme as it is currently planned under the SWAp may not meet these demands[34]. Moreover, MoH is concerned to increase coverage through facility expansion because it anticipates a long delay in programme impact if expansion is dependent on improved performance and staffing at existing facilities[35].

  However there is a risk of creating an unsustainable network that could neither be staffed nor funded. Additional donor money (if any) and HIPC savings will not be enough to meet the cost of an expanded service and, moreover, there may be opportunity costs of investment in infrastructure relative to other investments that may offer greater health benefits to the poor. MoFPED has clearly stated that no expansion should take place in the first year other than in under served areas, and more emphasis should be placed on operationalising facilities that already exist. Donors are united in their support for this view, and it is clear that expansion at the cost of service improvement will deter some from contributing to budget support. MoH is engaged in the debate with MoFPED and donors, and all parties are putting considerable effort into reaching an agreement on this key issue[36].

[33] MoH, 1999f.
[34] From interview.
[35] From interview.
[36] Subsequent to the field work, the author was advised by a senior GoU official that a compromise had been reached to improve the performance of existing priorities whilst providing new construction in underserved areas.

There is a further problem with defining the scope of the programme as it relates to the MTEF, as total contributions to the health sector as reported by donors to the MoFPED are far greater than the value of resources committed to HSSP, which MoFPED (and often MoH) take as co-terminous with the MTEF. One analysis suggests that the reason for this is that the conceptual boundary of the SWAp has not been clearly defined, so that some expenditure by donors such as those going to central support functions have been excluded[37]. There is therefore a possibility that the costs of HSSP are being underestimated

- ***efficiency of programme*** Donors have some serious concerns about the current efficiency of the health service which has proved to be very low, with poor staff performance and high levels of informal user fees. HSSP discussions focus on improving supervision and transparency, and increasing other incentives, such as salaries and allowances where possible. The example from the Education sector shows that posting user charges (school fees) along with parental participation in local expenditure decision making and monitoring can reduce rent seeking. (See Annex 1)

- ***effectiveness of programme*** The current expenditure proposal is expressed in input categories. Government and donors are now trying to draw out the linkages between inputs, volume of activities and outputs, and ultimately changes in health status[38]. At the same time some donors are encouraging MoH to move away from needs based planning and concentrate on the resources available. This could be assisted by MoFPED's intention to introduce output based budgeting, which is expected to encourage departmental managers to move away from a preoccupation with spending inputs, to achieving outputs and results (while at the same time retaining control over commitments and spending within the approved estimates)[39]. There is however the risk that priorities will be selected on the basis of the ability to monitor them rather than their importance[40]. This initiative will be built on the work of the sector programmes - in FY01 each departmental vote will begin with a statement of main programme objectives, and detail a small number of performance indicators.[41] Indicators will need to be consistent with the PEAP.

As a way of moving the planning and budgeting process forward, GoU and donors agreed that following on from the November 1999 Joint Mission, the following steps would be taken:

- donor funding would be disaggregated to determine realistic figures available for implementation of programme
- disbursement mechanisms and drugs and supplies management systems should be specified
- GoU would establish the size of the wage bill

[37] Comment by donor.
[38] Comment by donor.
[39] World Bank, 2000.
[40] Foster, Naschold, 2000.
[41] World Bank, 2000.

- modalities for disbursement to NGOs would be worked out
- GoU would rework the resource envelope and costings plan to try to close the gap
- the infrastructure development plan should be finalised so that rehabilitation and expansion plans could be made more explicit
- GoU and donors should try to develop an output oriented budget[42].

4.1.3 Moving towards budgetary support

GoU is taking steps to improve the reliability and transparency of financial management systems. MoFPED is undertaking an Economic and Financial Management project which has developed an integrated and consolidated financial management system, expected to be operational from FY2001/02. MoH will be among the first Ministries to benefit. The system will link central and local governments to improve planning, budgeting and management of public funds. The Local Government Development Project is running in parallel to strengthen central and district financial management, with a focus on recruiting qualified accountants, training district staff, decentralisation of the capital (development) budgets, and modernisation and computerisation of budgeting and accounting systems. The willingness of some donors to provide budgetary support is an indication of their faith in the ability of GoU to implement and manage these initiatives.

The Poverty Action Fund provides a good model of how accountability and transparency are being improved for national budgetary management (see Box 1, p. 16). GoU and donors are in the process of finalising agreement on modalities for donor disbursement through the PAF; one step towards this was a review of PAF Monitoring and Accountability[43]. The Education sector-wide programme (see Annex 1) offers a model for how budgetary support may be managed in health.

At the October 1999 Joint Mission, DFID, SIDA and Ireland Aid committed budget support and gave indicative figures to MoH for the first three years of HSSP implementation. These figures have been incorporated into the MTEF. The World Bank may also use government financial systems. Many other donors still have reservations about the ability of the government systems to account for and report against expenditure adequately, especially at the lower level where corruption levels are high and there is already a serious problem of misappropriation and wastage.

4.2 Health sector reform and national poverty reduction

Uganda is notable among the case study countries for the progress it has made in creating a poverty focussed framework in which the health sector programme can be developed. The Poverty Eradication Action Plan was developed after long consultation with a wide range of stakeholders, and since its inception in 1997, has guided the formulation of government policy. It has been very influential in guiding the preparation of sectoral plans and investment programmes and improving the poverty focus of GoU's three year rolling expenditure programmes.

[42] MoH/partners 1999.
[43] Zolghadri, M., 1999.

Responsibility for implementation of the Plan, policy formulation, and analytical support for it is located within the Ministry of Finance, Planning and Economic Development (MoFPED) which gives it significant political backing and influence:

- the Poverty Monitoring Unit integrates annual household surveys, conducted by the statistics bureau, with other data sources (e.g. participatory analysis, sector surveys, line ministry data sources) in order to track progress, and ensure that policy is continually influenced by poverty data and perceptions of the poor
- the Expenditure Management Reform Programme will support regular Service Delivery Surveys, to monitor service quality and access
- the Participatory Poverty Assessment Project is working with 10 districts on participatory approaches to planning for poverty reduction.

Findings from these initiatives are fed into the budget formulation process - expenditure programmes important for poverty are identified within the Medium Term Budget Framework, and then protected from cuts by including them in the Poverty Action Fund (PAF). Monitoring is also built into the process: donors and NGOs are members of the Poverty Working Group, monitoring PAF implementation, and participating in meetings to review and roll forward the MTBF, on which the media is invited to report (see Box 1, p. 16). Donors also carry out joint reviews of sector spending against agreed targets and indicators. This process thus links poverty strategy, participation, accountability and monitoring systems to macro and sector budgets.

This has had an impact on the health sector strategic plans because:

- there is clear political support for poverty reduction, which the HSSP must reflect
- there is increasing consistency between poverty reduction strategies and the expenditure made available to implement them.

In practice some of the immediate impact has been:

- to highlight the link between public perceptions of poor service delivery, and low utilisation, based on the findings of the UPPAP, the Service Delivery survey of 1995, and Integrity Survey of 1998
- to recognise the need to address these problems by tackling remuneration and the quality of training and management
- to help clarify the debate between MoH and development partners agreeing the HSSP on the balance between extending capital and recurrent costs. The first Discussion Draft of the Revised PEAP Vol. 1[44], notes the findings of the rapid appraisals by the MoH, that the combination of rehabilitation of facilities with qualified staffing has produced significant increases in utilisation in the facilities. The Plan thus emphasises that *"the location and volume of construction should ideally be based on a demonstrated link between*

[44] MoFPED, 2000.

increasing the physical availability of the system and increased usage by patients"[45].

The linking of poverty reduction with improved service delivery is a key issue for government and donors, and one which has exercised both parties in the course of programme development. In order to achieve poverty reduction through HSSP it will be essential not only that services are made available to the poor, but when they are available they are utilised. At the moment this is not the case. Service utilisation is very low partly because of poor quality, which in turn is due to a lack of resources and effective supervision, weak incentives for improved performance, and lack of support for primary health care by local government. People are also deterred by informal user charges. The donor community is clearly concerned by these problems and is endeavouring to focus the MoH on addressing the problems behind poor quality through HSSP. The analysis presented by the PEAP as outlined above is therefore a welcome contribution to the debate.

4.3 Capacity issues

4.3.1 Capacity in MoH

Improving the capacity of MoH has been the subject of support from both donors and the Civil Service Reform Programme. In December 1998 the donors described the Health Planning Department (HPD), the lynchpin of the reform process, as being "*Widely perceived to have lost its sense of purpose and leadership. The department is inadequately staffed, poorly housed and equipped and is consequently unable to come up with the most basic of the services it is expected to provide.*"[46] The Civil Service Reform Programme attempted to address some of these problems; unfortunately three reorganisations in a short period of time damaged morale and encouraged a sense of self protection rather than a focus on the programme.

However since then HPD has undergone major restructuring and is much extended from the Health Planning Unit of a year ago. It is now headed by an able Commissioner/Planner. New staff have been appointed, and plans have been put in place to strengthen the department further. Programme management functions are now more integrated into two directorates and five departments, and officials are able to concentrate on HSSP again. The role of MoH as a whole has been clarified to focus on policy-making, planning, resource mobilisation, human resources development and quality assurance. A needs assessment of HPD undertaken in January 2000 confirmed that it is now well resourced with respect to human capacity, and that although some changes are needed concerning the organisational structure and management, HPD is well placed to move forward with HSSP implementation.

In the short term the development of HSSP has placed an additional burden on MoH capacity as the process has been labour intensive. Donors expected a high degree of participation in the formulation of the health policy and subsequent sector strategy which led to a long iterative process involving constant revisions. However as a result government and donors feel they have a better understanding of each other and an improved working relationship.

[45] MoFPED, 2000 p 77.
[46] Donors, 1998.

It will be important that in order to continue to foster capacity, the sense of ownership which exists within MoH is allowed to flourish by donors, by not making too many demands on the government or expecting sensitive political decisions to be made too quickly. Interviewees outside MoH suggested that the Ministry is increasingly in the driving seat as it becomes more skilled at handling often contradictory and strong donor demands. MoH is also showing an open approach to handling contentious issues e.g. on drug procurement and management, health infrastructure and human resources; good progress is being made on tackling these. This is an indication of growing capacity and commitment to the programme. One MoH official reported that it is also indicative of a sense gained at the Geneva meeting, that donors were prepared to *'do business'* with MoH and there was sufficient trust to move forward into a SWAp[47].

4.3.2 Capacity in Districts

This is where the main capacity problem lies in implementing the HSSP. A fundamental problem for delivery of services is the shortage of staff, which is partly the legacy of a four year recruitment ban. In 1998 only 34% of health service posts were filled, and of those working at health posts, only 33% were trained[48]. This presents a huge challenge to improving service volume and output, even before the number of facilities has been increased. In terms of management of services, districts have relatively little experience of determining priorities, and then planning and implementing programmes against them, as the majority of the resources allocated to them are earmarked for specific activities by central government or donors, and of what remains they are restricted in reallocating between wage and non wage inputs. This is more acute in poorer districts which are less able to mobilise resources from either central government or donors which diminishes the scope districts have for providing anything other than very limited services. An equalisation formula for central government grants has been designed to reduce this inequality, and staffing is being improved by the use of Conditional Grants[49] (see Box 2, p. 23). However central and local auditing and monitoring of performance, both technical and financial, are weak and prevent information and accounts from being used as management tools. The District Health Services Pilot Project is addressing these problems with some degree of success, and the Conditional Grants allocation and monitoring process is improving, but much remains to be done, especially in regularising disbursements from the centre and improving monitoring.

4.3.4 Capacity at service delivery level

Some of the reasons for poor service delivery are summarised in section 4.2. The widespread practice of invoking informal user charges is also being addressed as a capacity building issue with donors encouraging government to improve staff management further, improve incentives and working conditions and use allowances more strategically. At the November 1999 Joint Review, donors made a number of recommendations to address these issues, especially that staff performance should be addressed as a matter of urgency, and actions taken to expedite recruitment, confirmation, payments of salaries, allowances and benefits. Ending informal charging will be a major challenge for HSSP, and will have to be addressed in tandem with wider government reform programmes.

[47] From interview.
[48] From interview.
[49] MoH, 1999f.

4.4 Decentralisation

The decentralised structure of health delivery in Uganda presents MoH with one of its biggest challenges for HSSP implementation. Decentralisation of services and budget management began in 1993 when district councils were given the responsibility for managing recurrent health facilities and later, district hospitals (see section 2.1.4). The rationale was that district health managers would know local needs best and allocate accordingly. A review in 1998 and other research has suggested that there was some improvement in the quality of services[50], that local officials and communities were more involved in health systems management, capacity for planning and managing budgets had increased, and that in some cases there was an improved range of services[51].

Despite these indications of positive impact, tensions remain between MoH and districts about allocation of resources and the degree to which the central government Ministry should be allowed to exert control over district spending priorities. The discussion around the use of Conditional Grants is part of this (see Box 2). The proposed implementation of the Health Sector Strategic Plan has been hotly debated for the same reason. Part of the problem is that there does not seem to be any great clarity on what MoH can oblige districts to do by way of implementing centrally determined policies. A recurring theme at the October 1999 Consultative Meeting was the link between policy setting at MoH, joint planning between MoH and districts, and implementation at local level, and how a line of accountability could be developed between the two levels that allowed local needs to be met whilst following government policy; this was a particular concern for donors wishing to increase stakeholder participation and ensure service delivery. A clear message came from the districts that although there were many areas of agreement between MoH and districts on health policy, it was up to the districts to undertake local consultation to ensure that these policies were right for their local population, and then implement programmes accordingly. One interviewee predicted that if it came to a difference over priorities, then the commitment at Presidential level to decentralisation was such that the district view would win over. Part of the problem is that whilst the role of the districts is reasonably well defined, that of the MoH is in a state of development, as it moves from being an implementing body to one that makes policy, monitors service provision and gives technical support.

One manifestation of this has been the development of new health centres in Health Sub Districts (HSD). The HSDs had been set up at Local Council (LC) 4 level as a way of bridging the gap between the ideal of provision at the lower LC3 level and the financial and technical impracticality of doing do. Despite the recognition that an expanded infrastructure is unsustainable, and HSDs should rely on existing provision

[50] Omaswa et al, 1997.

[51] Hutchinson, Paul 1998, '*The effects of decentralisation on the health service in Uganda*' (draft mimeo) quoted in World Bank and GoU, p7.

Box 2 Primary Health Care Conditional Grants

Primary Health Care Conditional Grants (PHCCG) were introduced in FY97/98 to counteract the huge decline on spending on primary health care that occurred after decentralisation in 1993. They were chosen as a quick and feasible way of ensuring that resources reached their specified destination rather than being directed to other purposes by politicians and officials. The Grants channel funds directly to districts, earmarked to cover expenditure on primary health care services. Grants are sometimes made to district hospitals, but most are ring-fenced for the development and running costs of Health Sub-Districts, upgrading of health units, setting up epidemic funds and priority areas of PHC. Allocations are worked out on the basis of a weighted formula (currently under review) which takes into account:

- population (20%)
- district level Human Development Index (20%)
- NGO spending and access to donor funds (20%)
- other factors including lack of a hospital and security problems.

The basis for receiving a PHCCG is the District Health Annual Workplan, which is drafted by the District Medical Officer's office, and discussed with the Management Team and Administrative Officer before submission for approval to the Local Council. One condition of release is that activities to be funded are clearly indicated in the workplan, as these then form the basis for financial reporting to MoH.

Experience of the first year of implementing PHCCGs was mixed. Guidelines were developed late, after district plans were set, and then the grants were disbursed in an ad hoc manner; therefore when they did appear they tended to be used to meet urgent needs, rather than planned expenditure[52]. However it was found overall that district administrations allocated further funds to PHC from block grants and from their own revenues, thus increasing the total amount spent on PHC, as was intended. In the second year guidelines were rewritten to give more detail on how funds should be managed, and standard forms were issued for reporting purposes. Although districts have complained that grants are too tight and difficult to report on, disbursement in this year was shown to have improved, as was utilisation. Even though it is still not possible to evaluate the impact of grant usage a number of achievements in poverty alleviation have been noted in the last PAF report[53] on the grants:

- improving access to health care by supporting lower level health units in the health Sub-district through (a) construction / upgrading of health facilities (b) recruitment of staff
- enhancing response to epidemics
- procurement and distribution of drugs and other supplies
- improving the quality of PHC activities e.g. immunisation, and malaria control
- community mobilisation for health through raising awareness of community leaders on health sector reforms.

Initially PHCCGs had been planned as an interim measure to build capacity and support good practice until districts realised the importance of spending on primary health care. Since then grants have been increasingly recognised as a way of ensuring that districts follow centrally set priorities. This is not acceptable to everyone and there is concern voiced from the districts at the appropriateness of this in a decentralised system, seeing this as a signal of top down management from MoH and an attempt at re-centralisation. A number of other issues still need to be resolved. The capacity of districts to utilise additional funds is questionable and will need to be the subject of some serious attention by MoH especially as additional debt relief funds and donor fund may be channelled to the grants through the PAF (see Box 1, p. 16). Moreover although financial monitoring by MoH seems adequate, and specifications and standards for performance against grants are issued, evaluation of use and impact is weak. An important issue is the absence of penalties for non-compliance with grant conditions. The MoH Health Planning Department intends to address this issue in collaboration with MoFPED and MoLG.

[52] Bergmann, Claesson, 1998.
[53] MoH, 1999f.

including that from NGOs, districts have continued to build new health centres. HSD boundaries correspond with those of electorates so there is often a political motivation for establishing a high profile indication of a health programme.

Part of the problem with the response that HSSP is receiving may be the way it has been developed. At the October 1999 GoU / donor Consultative Meeting representatives from districts expressed their lack of enthusiasm about producing additional five year plans in addition to their usual integrated three year programmes. The Joint Review Mission in November made a number of recommendations to improve relations with districts and planning processes including clarifying roles and responsibilities for district leaders, strengthening and institutionalising planning at Sub County level, and developing a strategy for community mobilisation and participation in health programmes[54].

[54] MoH/partners 1999.

5 PROGRESS AND PROSPECTS

5.1 What has and has not changed

5.1.1 What has changed

What has changed is that:

- MoH is gaining a better overview of the sector as a whole and its relationship and responsibilities to the elements within it
- there is a close working relationship between donors and MoH
- health policy is continuing to change to place greater emphasis on primary health care, with funding being allocated accordingly
- there is a growing appreciation in MoH of the value of information as a management tool, not just for monitoring
- NGOs are playing a more structured role in programme design and service delivery
- there is increased capacity for SWAp management in MoH and growing commitment to it
- there are better links between health and poverty
- the MTEF has improved discipline in the health budget
- the gap between the resource envelope and programme cost is getting smaller
- GoU is making increased efforts to record donor expenditure and direct it to areas of greatest need
- there are improvements in the financial management system both centrally and locally.

5.1.2 What has not changed

What has not changed is that:

- MoH and districts still have a lot of consensus building to do
- donors have as yet made no concessions in terms of harmonising procedures, but are putting pressure on government to make major changes to its practices
- transaction costs have probably increased
- donor contributions are not yet captured in full, presenting problems with defining the programme and MTEF.

5.2 Prospects

A good base has been built for continued joint working for implementing the Health Sector Strategy Programme (HSSP). There is obviously a good relationship between donors and MoH which has been strongly facilitated by the WHO Representative. The lack of clarity on programme priorities and costings has been a concern but it is being addressed through continuous negotiations so that the programme is becoming increasingly realistic. The involvement of MoFPED is a valuable contribution to the debate as are the links between the health programme and wider government initiatives. A concern is the strength of the autonomy that districts perceive themselves to have. It will be essential to resolve this so that they take on board

national policy, but still have the scope to implement it to meet local needs, as without their compliance implementation of HSSP will not succeed. It will also be important for donors to move towards amending their own practices, as GoU are with theirs. GoU has made considerable progress in internal reform to develop capacity to manage the programme and it will be important that MoH sees gains in terms of better donor co-ordination and reduced transaction costs in order to see benefits in the sector-wide approach.

ACKNOWLEDGEMENTS

The author would like to thank all those in the Government of Uganda, and development partner agencies who so willingly gave up their time to support and inform this research and provide much valuable insight and material. Thanks are also due to those who kindly commented on drafts of the report, and especially the WHO Representative and his staff who organised the programme.

The views expressed in this case study are those of the author and should not be taken to be representative of any other party. Responsibility for any remaining errors of fact or interpretation are also those of the author.

Annex 1 Financial management of sector programme funds in Uganda: Education model

Financial management environment: general

Treasury Office of Accounts has produced final accounts within 4 months of year close in 1996 and 1997, and an OAG audit has been produced within the statutory 9 months. Internal auditors within the Ministry of Health carry out a pre- audit of all payments to check they are authorised and within the vote. There are also OAG staff within Ministries, continuous ex-post audit of transactions throughout the year, and queries to the Secretary of the Ministry. The centralised payment system prevents accounting Officers exceeding vote allocation and provides accurate and timely data on level of payments. In Education, the Payroll Monitoring Unit has to authorise any changes to the payroll (e.g. recruitment, promotion and change of grade).

Financial management in the social sectors

OAG provides audit reports on all education expenditures to donors by March of each year. Additional assurance is obtained through annual independent evaluation to determine the degree to which recurrent and development expenditures are disbursed and used as intended. Ministries operate manual accounting systems and provide hard copies to Treasury.

In Education, Conditional Grants are paid by Ministry of Finance to districts, who are required to pass the full amount on to schools at a standard rate per pupil enrolled, with 9 monthly releases. Guidelines to schools advise how the grant should be spent. The district provides a return recording the releases made. Each school provides termly accounts of amounts received and expenditures made to sub-county and district. Each school has a School Management Committee and School Finance Sub Committee, with teachers and non-teachers. SFSC approves the school budget, signs the school accounts. One non-teaching member of SFSC is a signatory on the school bank account.

For transparency and accountability to parents, there is a requirement to publish and display to the public details of all fund releases and how they are spent at all levels down to the school. A June 1998 sample survey found that over 90% of schools and districts do display this information. Government also publishes details of releases, the schools they are intended for, and the use to be made of them, in national and local media.

Problems include:

- delays in receipt of funds. It can take 2-4 months for funds to get from MoFPED to schools. Funds are received late in the term (or after it finishes), due to bureaucracy, banking inefficiency and district delays
- independent DFID audit revealed some problems of funds being retained at local government level when intended for Conditional Grants to schools (6%), and

problems of poor monitoring of fund use, but these were not as serious as might have been expected (given the results of earlier fund tracking studies)

- Audit said up to 9% of payroll data was of doubtful accuracy. Further system strengthening, and independent audits, were planned under the economic management project
- the 1998 National Integrity Survey said 10% of parents were still paying school fees for education which should be free. However, the education service has the lowest level and incidence of bribes
- overall monitoring of compliance with financial management and accounting requirements was judged to be weak.

Measures to strengthen financial management

Overall, the expenditure management reform programme includes:

- an enhanced Budget Framework Paper process, integrating recurrent and development planning, sectoral and local
- an action plan and skills development for introducing outcome oriented budgeting
- a mechanism for decentralised funding of development activities by local governments
- a staff development plan in financial management at centre and local level, including non-salary measures to improve motivation and recruitment
- computerisation of local accounts
- an improved audit and audit follow up, including supporting accountability to Parliament, supporting Parliamentary Accounts Committee
- performance monitoring support for statistics, economic and poverty data systems (within MoFPED), support to Delivery Surveys
- specifically within education, a programme to clarify roles, develop financial management capacity, and raise compliance with formal accounting requirements.

Annual cycle for the management of donor funds

April:	Review progress; MoE rolls forward sector Work Plan in detail for following FY, indicative actions to end of strategic plan in 2003.
End April:	government and donors agree targets/indicators derived from the Work Plan, sign individual financing agreements.
December:	Joint review of mid-year progress feeding in to annual PER.
March:	collection and analysis of data for progress review.
April:	Joint mission, review progress, and release of funds for following year.

Annex 2 Terms of reference

Background

The Partnerships for Health Sector Development Project seeks to commission a consultant to carry out and report on a series of country case studies - and subsequently to prepare a synthesis paper - on current issues in sector programmes and development assistance in the health sector.

The work will be carried out on behalf of *Inter-Agency Group on Sector-Wide Approaches and Development,* for which WHO provides the Secretariat. The purpose of the assignment is to provide insights and recommendations relevant to the policies and practices of agencies which are members of the group, as well as to the governments with whom they interact.

The scope of work which follows is based in part on discussions and issues arising at a preliminary meeting of the Inter-Agency Group (1 June 1999). It will be further refined following the completion of a preliminary desk study by the Centre for Aid and Public Expenditure (to be completed by 31 July 1999), and comments received from members of the Inter-Agency Group (IAG).

Countries

Case studies will be carried out in Mozambique, Tanzania, Uganda, Cambodia and Vietnam. These countries have been selected because of their engagement in the development of sector approaches as well as the nature of their cooperation with international financial institutions (CDF, ESAF). Their physical proximity within Eastern and Southern Africa and South East Asia will allow efficiencies in travel. Work in additional countries may be financed by other partners in the IAG. In preparing the synthesis paper the consultant will also draw on relevant experience from other countries. The studies in each country will take the form of policy analyses and will be based on interviews with key actors and reviews of documents. Given the breadth of the concerns set out below, the aim will be to make well informed judgements, rather than collect large amounts of quantitative data.

Scope of work

Reports should assume an understanding of the rationale for and basic concepts of sector-wide approaches. They will focus on issues emerging as sector programmes are implemented in practice. In each of the country studies, and in preparing the synthesis paper, the consultant will pay particular attention to the following questions:

- **policy quality and policy process:** what evidence is there to suggest that the process of developing sector programmes has influenced the content of sectoral policies? Most agencies supporting SWAps see them as a way of promoting pro-poor health policies: how has this intention been expressed in practice? Is there any evidence to suggest that sector programmes have been successful in promoting a greater concern for health outcomes? To what extent do donor concerns about ownership and national concerns about consensus limit the scope for real policy negotiation?

- **managing relationships between governments and development partners:** what have we learnt about the negotiation/transaction costs of SWAps? How effective are the various types of accord/compact / MOUs? What conclusions can be drawn about the need for and effectiveness of, conflict resolution systems? Is there any evidence that processes such as UNDAF have increased the effectiveness of UN agencies as participants in sector programmes?

- **planning:** a great deal of emphasis has been placed on the preparation of sectoral plans of different kinds: what conclusions can be drawn about sectoral planning processes? Are sector programmes over-determined? Is there a risk that the focus on planning reduces flexibility and the need to adjust policies in the light of changing levels of performance? Do donors demand too much detail in preparing programmes work and operational plans? How much variation in planning processes is beginning to emerge between countries?

- **scope of sector programmes:** does it remain true that many SWAps constitute a discrete programme *within* the sector? To the extent that this hypothesis is correct, what elements of sectoral spending tend to be omitted? With what implications? What needs to happen to move on toward time-slice funding of national sectoral budgets? What evidence is there to suggest that sector programmes have been successful in influencing intra-sectoral resource allocation in line with stated policies?

- **links with the PFP and medium-term budget frameworks:** to what extent are sector programmes fully reflected in overall budget plans? Is new thinking on the comprehensive development framework likely to influence this process? Where is there scope for more effective macro-sectoral dialogue?

- **preconditions and conditionalities:** do we need to revisit the whole idea of preconditions for SWAps if it is a term that is increasing being applied indiscriminately? To what extent do donors still impose conditionalities within the context of sector programmes? What form do these conditionalities take? Is there any evidence for their effectiveness?

- **capacity building:** to what extent does adequate capacity in national management systems have to be in place prior to the implementation of pooled funding arrangements? Is there a risk of a hiatus in the provision of essential services when moving toward a SWAp?

- **sector performance:** have we got any further in developing manageable ways of monitoring performance? Does monitoring improve over time? Does it take into account distributional issues which are often overlooked by routine systems?

- **decentralisation**: it was predicted that designing sector programmes in decentralised systems would be difficult - what has been the experience to date? To what extent have fears about SWAps acting as a centralising force been realised in practice? What national approaches to earmarking of sector priorities have been agreed and applied by central and local governments?

- **civil society and NGOs:** most governments and development agencies emphasise the importance of broad participation in the development of sector programmes: how has this intention been reflected in practice? with what effects?

OUTPUTS AND TIME FRAME

The consultant will submit draft reports and make a presentation to the Inter-Agency Working Group in November. Final reports are to be completed by 31 December 1999.

Additional ToRs on debt relief (added later)

1. Is there a government policy on poverty reduction in place or in the process of production?
2. Are there plans for the production of a poverty reduction strategy paper (PRSP)? If the answer to 1 is yes, what is the relationship between the government policy and PRSP?
3. If the answer to 2 is yes, what is the process for producing it - who will? Government? IMF, Bank, all three? Others? Time frame?
4. Is the MoH involved in writing/advising on the health component of the PRSP? If not, why not? If so, how?
5. What do we know about negotiations (if any) and about conditionalities (if any) attached to HIPC Initiative II?

How is the poverty focus reflected in the health policy and in the health sector expenditure framework?

Annex 3 List of people met

Organisation	Name	Position
Government		
Ministry of Health	Professor Francis Osmaswa	Director General Health Services
	Dr Martinus Desmet	Technical Advisor
	Karl-Erik Lindberg	Financial Management Advisor
Ministry of Finance, Planning and Economic Development	Mr Jacob Anjuli	Principal Finance Office
Bilaterals		
European Commission	Mr Wolfram Brünger	Technical Adviser, EDF Health Programme
DFID	Ms Bella Bird	Social Development Adviser
	Ms Ros Cooper	Health and Population Field Manager
Italian Embassy	Mr Armando Borghesi	Development Co-operation Officer
Irish Aid	Ms Nicola Brennan	Programme Officer
Embassy of Japan	Mr Motoharu Watanabe	Second Secretary, Economic Co-operation
SIDA	Mr Lennart Ljung	Regional Health Advisor
USAID	Ms Rebecca J Rohrer	Population, Health and Nutrition Officer
UN Agencies		
UNDP	Mr Aeneas Chapinga Chuma	Deputy Resident Representative
UNICEF	Dr Uhaa	Deputy Representative
WHO	Dr Hatib Njie	Representative
	Dr Giuliano Gargioni	Medical Officer, Tuberculosis Control
Other		
Catholic Medical Bureau	Dr Danielle Giusti	Director

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