Joint Assessment of Uganda's Health Sector Strategic & Investment Plan (HSSIP)

Final report

31 January 2011

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JANS team composition

The Joint assessment was carried out by an international team of experts together with some national counterparts

National counterparts included a range of experts who used the JANS tool for an internal assessment of the HSSIP. The full list of experts is provided in annex 2.

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Introduction

Uganda signed the International Health Partnership+ (IHP+) Global Compact in February 2009. Central to IHP+ is a commitment to get better health results by increasing support for national health strategies and plans in a well-coordinated way. There is also a strong emphasis on mutual accountability for results.

Uganda has developed its new Health Sector Strategic Plan 2010/11 – 2014/15 (HSSIP) which was formally launched during the 16th Joint Review Meeting (JRM) of 22nd to 24th November 2010. In parallel it has revised its existing Memorandum of Understanding (MoU) with health development partners. During the 16th JRM the Compact (or new MoU) between the Government of Uganda (GoU) and Partners was signed. The MOH requested support from IHP+/Harmonizing for Health for Africa (HHA) to carry out a joint assessment of the new HSSIP (hereafter called JANS; Joint Assessment of National Strategies); and, through a separate consultancy, to carry out a review of the Sector Wide Approach and to facilitate the development of a new MOU with its partners.

In Uganda, the main perceived added value of the joint assessment of HSSIP is to create an opportunity for strategic discussion and thus strengthen the plan. Related expectations are that the assessment will increase confidence in the plan; help to get more partners on-plan and on-budget, and reduce at least some of the burden of separate appraisals / proposal preparations. The independent element is desired in order to provide a fresh, systematic perspective on the plan.

The first phase of this joint assessment mission allowed for an in depth review using the JANS (Joint Assessment of National Strategies) tool on an advanced but not final draft of HSSIP in July 2010 (the draft version was called HSSP III; the final version is the HSSIP). The main limitation of the first phase of the review was that the draft plan was not yet costed and therefore not prioritised based on available resources. The JANS team has shared a draft report with the MoH and key stakeholders in July 2010 with its comments and recommendations regarding the draft plan. Thereafter the MoH reviewed and costed the draft HSSIP. The present report provides the views of the JANS team on the final version of the HSSIP launched in November 2010.

The **objectives** of the joint review, as per TOR (see annex 1) are:

- To make a joint assessment of HSSIP using the JANS Tool and accompanying Guidelines as the guiding framework [1]
- To present and discuss the analysis of strengths and weaknesses of HSSIP with senior policy makers and other stakeholders, and possible courses of action on specific issues.

Specifically the review is supposed to produce an **assessment profile of the strengths and weaknesses of five sets of attributes**:

1. The situation analysis, coherence of strategic plan with that analysis
2. The process through which the national plans and strategies have been developed; alignment with national development frameworks, multi-sectoral strategies
3. Adequacy of financing projections and strategies; financing and auditing arrangements
4. Implementation and management arrangements, including for procurement
5. Results, monitoring, review mechanisms

[1] http://www.internationalhealthpartnership.net/CMS_files/documents/joint_assessment_guidelines_EN.pdf

The first phase of the review took place from June 24th to July 2nd 2010 and was preceded by a two day field trip (to Kamuli and Jinja districts). Only part of the international team was present during the whole period. The consultant engaged to facilitate the development of a new MoU also attended the last days of the JANS mission in July.

During the whole review the team has been liasing closely with the local IHP+ Task Force and the HSSIP Task Force. It has had access to most key stakeholders and institutions relevant to the assignment, including top level officials of different ministries, with the exception of the Ministry of Finance, Planning and Economic Development (MOFPED- e.g. : Planning, the Accountant General and Treasury, IFMS staff, Internal Audit), Inspectorate General, Auditor General's Office and National Medical Stores management. The main reason was the busy end of the Financial Year (FY) period and the new FY budget processing schedule. This, together with the absence of a costed plan, influenced the scope and the detail of the first assessment, and more specifically of the financing and audit aspects of the review (section 3.3). It was therefore agreed that the JANS review would produce a draft report at that stage and finalize the report once the HSSIP had been costed and prioritised. The present report presents the final comments and recommendations of the JANS team regarding the finalised, costed HSSIP.

The final report is organized along the 5 main set of attributes of the JANS tool. Main observations (with a view to inform high level policy makers) are summarized in section 1. Section 2 presents a brief 'road map' for finalizing the plan. Section 3 reports on the strengths, weaknesses and proposed actions for each of the five set of attributes.

1. Main observations

- HSSIP presents a well developed **comprehensive situation analysis** and underlying strategies are generally based on evidence (see section 3.1). The situation analysis leads to specific recommendations for HSSIP, based on identified emerging issues.

- The **participation** in developing the plan was broad, including many relevant state and non-state stakeholders but future engagement needs to be deepened and could become more meaningful (see section 3.2).

- **Coordination** between multiple consultation platforms could be more effective (see section 3.2).

- While participation has been impressive, mechanisms for **accountability** of different stakeholders are not well specified in the plan (see sections 3.2 and 3.3). Each sector partner's commitments have been specified in the Compact (version July 2010) but accountability mechanisms are unclear and compact monitoring indicators do not capture well implementation of different partner commitments. This may however be partly addressed through the IHP+ Mutual Accountability monitoring.

- HSSIP has set **clear and appropriate core priorities**. The four main priorities that would be delivered as a minimum are sexual and reproductive health; child health; health education & promotion; and control & prevention of communicable diseases. These priority areas are consistent with long term developmental objectives as per the National Development Plan, Health MDGs and National Health Policy II and are justified by the burden of disease and situation analysis. Health systems strengthening is the underlying strategy enabling the system to deliver the above priorities and focuses on the following resources: human, infrastructure, medical products & commodities, and finances for operations. Underlying strategic plans are the Human Resources for Health, the Health Infrastructure, the Pharmaceutical Sector, and the Health Management and Information System Strategic Plan.

- However:

    - The four stated main priorities are not reflected as such in the resource scenarios. Health systems strengthening, although present throughout the document, is not captured in a consolidated way and therefore may receive less focus (while it was still on the priority list in the draft plan).

    - Besides the four core priorities it includes many other ambitious interventions that may not be fully feasible given the expected lack of adequate financing. Consequently, there will still be a need to prioritise the interventions and adjust some of the targets (e.g. on new infrastructure; public funding of essential drugs; increased geographical access to health facilities; functional HCIV; percentage of filled positions). Costing the strategic plan has not resulted in making fundamental choices and priority setting on the basis of different resource scenarios. Output levels remain the same under each of the different resource scenarios that are mainly based on different levels of human resource inputs (numbers and remuneration). Obviously outputs will differ with different levels of inputs. The risk is now that budget cuts will affect all budget lines, and not protect priorities. Targeting of resources, ring-fencing of key interventions, use of global frame budgets with

clear priority result indicators are some of the options that could have been considered. Given the much lower budget ceilings (as compared to the budget scenarios) the MoH will have to decide on priorities each year again. Without much guidance from the HSSIP this may well become a difficult process, with high risks of deviating from or under financing of the four initial core priorities.

- Some constraints well described in the situation analysis do not seem sufficiently addressed by the proposed actions (examples provided in section 3.3 are the lack of specific strategies to deal with the high population growth; the need for an effective motivation and retention package in order to attract and retain staff; the missing strategy for staff housing under the infrastructure component (except for the regional level) and no mention in the costing of infrastructure; the lack of compliance with the national PFM regulations)

- Internal coherence between different sections of the plan requires further attention (e.g. extension of infrastructure versus lack of HR and limited financing for recurrent costs; scope of UNMHCP versus resource envelope; low targets set for functioning equipment and transport; no access to central medical stores (CMS) by the private, not for profit (PNFP) sector; human resources (HR) strategy to address critical shortage of staff at health centre (HC) II level not specified while aiming at increased number of HCII; and on the capital budget there are unexplained inconsistencies across the HSSIP and in relation to the Costing Report (see sections 3.1, 3.3 and 3.4)

- Clarify and strengthen the link between the HSSIP and the annual and decentralized planning processes (see section 3.4)

- Sections or elements of the HSSIP that still could be strengthened during plan implementation:

  - Costing of the plan (see further)
  - Implementation arrangements (see further)
  - Risk assessment and mitigation
  - Multi-year plan for technical assistance (see also Compact, para 4.12)

- The **health financing strategy** (mentioned as an activity in year 1) needs to be developed as a matter of urgency, including elements of health insurance and covering both domestic and non-domestic resources. Both the health financing strategy and the proposed National Health Insurance Scheme (NHIS) should indicate a clear focus on access for the poor and protection against catastrophic health expenditure. Also, the strategy should clarify how key inputs such as human resources and medicines will be financed (see section 3.3).

- Contrary to the ingredient methodology used for costing with maximising inputs, a **pragmatic costing** of the HSSIP is recommended (see section 3.3):

  - Its point of departure should be the cost of the current level of services.
  - Adding what it would cost to rectify current main shortcomings: reasonable level of human resources, and sufficient drug supply, equipment & transport; as well as maintenance of infrastructure which relates to the level of staff and the absorptive capacity
  - Subtracting where savings can be made and efficiencies can be gained
  - And then allocate remaining resources to other key priorities.

- The present costing scenarios have only changed the level of HRH and everything else remained the same at full as if the HR positions were completely filled. This is unrealistic as both outputs and inputs would vary with different levels of HRH. Present costing scenarios are maximising inputs, do not look at efficiency gains and are not within realistic resource envelopes.

- The HSSIP makes repeated reference to appropriate national regulations, acts and procedures relative to **financial management, auditing and procurement** (see section 3.3):

  - Country systems and national regulations are substantially adequate as designed, except for audit matters
  - Accountability and transparency issues emanate from lack of compliance (which is not addressed), not from lack of regulations
  - HSSIP provides several policy statements and a relatively appropriate fiduciary framework and a list of actions for improvement, but no clear situation analysis to understand the underlying reasons, nor an action plan. In addition to the description of what are the national requirements or what laws and regulations apply, the situation analysis could have analysed what is happening and how the FM performance is.
  - HSSIP requires a time bound and costed implementation plan (as part of the HSSIP or of a sub-system plan), including:
    - Enhanced and integrated external audit by the Auditor General, undertaking regular value for money and procurement audits
    - A different type of internal audit, with revised scope in order to ensure effective internal controls and compliance and well functioning systems; and
    - Addressing effectively the corruption issue (as being suggested as an intention in HSSIP, section 10.1).

- Regarding **implementation and management** (see section 3.4):

  - Responsibilities for implementation have not been properly assigned in table 10.2, p 178. Measurable targets are, with few exceptions, developed. Annual targets have been developed for selected sector indicators. All relevant targets should be time-bound and sufficient milestones defined.
  - A mechanism for prioritization that will protect the core priorities of the HSSIP when resources are insufficient needs to be developed and used during annual planning exercises.
  - The plan provides some indication of how resources will be allocated (mention of resource allocation formula and equity concerns in allocation but no strategy or suggestion beyond general statement that better allocation mechanisms and formula should be found).
  - Appropriate supervisory and oversight systems are in place but require the right human and financial resources in order to function optimally. A regional structure for supervision and quality assurance, as proposed in the NDP, could enhance proximity and efficiency of those systems.
  - Strategies to realise the potential advantages of a decentralised system in terms of democratic oversight of health sector performance should be included.

- Regarding **monitoring and evaluation of results** (see section 3.5)

  - Most core sector performance indicators reflect the framework with input, output, outcome and impact indicators. They mirror indicators presented in national documents (e.g. JAF, NDP) and the MDGs. The indicators cover issues that are stated priorities in the HSSIP, including coverage of communicable disease control, child health and maternal health services, and improving quality of services. Overall the set of indicators look sensible and feasible for monitoring the sector.
  - Intra-sector resource allocation by level of the health system is not part of the list of core sector performance indicators and is not mentioned under the indicators in section 5.2.4 (improving efficiency and effectiveness). This will need to be monitored during plan implementation. Most indicators have the required data collection systems in place although some additional data collection mechanisms may be required e.g. on user satisfaction. Baselines are defined for 25 of the 26 core indicators and targets are set for all these indicators. Additional indicators or milestones are included under the individual strategies, with five year targets.
  - The HSSIP proposes to monitor performance across districts, analysing them in terms of poverty, gender, literacy and security, which should help to assess whether equity is improving over time and help with targeting of strategies. This focus on equity is welcome and could be developed further. Data collection and analysis on performance including the above criteria should remain practical and doable.
  - Development of an M&E plan is underway. Key elements of the M&E process are set out in HSSIP and include quarterly reporting at each level and an annual review of progress. The forthcoming M&E plan is expected to provide more detail on methods, tools and processes. It will need to identify how to tackle long standing problems of capacity and quality in the information system. It will also need to clarify how the planned analysis of equity and gender will be carried out.
  - Meanwhile the costs for strengthening the information system and other aspects of M&E have been included in the HSSIP [p162]. It will be important to identify who will fund the core costs for M&E including HMIS and relevant surveys, and prioritise within the resources available.

2. Assessment of the HSSIP[2]

3.1 Situation analysis and programming

Situation analysis and programming – Soundness of analysis/assessment underlying identification of the programming contained in the national strategy
Attribute 1 – 1.1-1.3; Attribute 2 – 1.4-1.5; Attribute 3 – 1.6-1.9; Attribute 4 – 1.10
Strengths *Attribute 1-4 (cross-cutting)* • Generally, the situation analysis is well developed, sufficiently critical/analytical and underlying strategies generally based on evidence. *Attribute 1: Strategy based on sound situational and response analysis* • The situational analysis sections provide a comprehensive assessment of the health situation in Uganda, including analysis of national trends in the major indices of health status (IMR, CMR, U5MR, MMR, TFR, prevalence of malnutrition) and progress and underlying constraints in reaching various coverage targets under HSSP II. Previously under emphasized areas such as nutrition are highlighted in this analysis. • Proven cost effective interventions based on global evidence constitute the majority of interventions comprising the UNMHCP. Maternal, newborn and child health was accorded priority during HSSP I and II; and this emphasis is retained in HSSIP. The government has adopted internationally recommended standards and clinical guidelines to address the major causes of illness and preventable deaths in Uganda. • HSSIP, Section 5: Objectives, strategies and targets for the HSSIP for the most part summarizes the main issues and technical interventions described under various sub-strategies/plans reviewed by the JANS team for reproductive and newborn health, child health, malaria, TB, HIV/AIDS and nutrition. *Attribute 2: Clearly defined priority areas* • Realising that funding for the full UNMHCP will not be available during HSSIP, four appropriate areas of priority has been identified within the broader UNMHCP; these are sexual & reproductive health; child health; health education & promotion; control & prevention of communicable diseases. These priority areas are consistent with long term developmental objectives as per the National Development Plan, Health MDGs and National Health Policy II, and with medium-term objectives as defined by health-related PEAP targets. • Objectives are generally underpinned by time bound and measurable targets.

[2] The assessment uses the JANS tool and guidelines, as indicated before (see footnote 1 for reference). The attributes refer to the numbered attributes and characteristics used in the JANS tool.

Attribute 3: Feasible, appropriate, equitable interventions based on evidence

- HSSIP and its underlying strategies and plans overall addresses key priorities, in terms of outcomes and quality, as well as key systems issues, and are based on knowledge of effectiveness and impact. While equity is addressed, a more thorough analysis and comprehensive approach to equity are lacking.
- The plan identifies key system issues that impact on sustainability, such as lack of adequate funding for the UNMHCP, and ongoing management and implementation issues.
- Plans and implementation arrangements for emergency preparedness and response will be strengthened in accordance with a new IDSR/EPR/IHR strategic plan, notwithstanding the problems of inadequate resources and delayed release of funds.

Attribute 4: Risk assessment

- The plan provides a rather general risk analysis (HSSIP, section 10.2).

Weaknesses

Attribute 1-4 (cross-cutting)

- Generally the lessons from the low level of implementation of many areas of the HSSP II should have led to more realistic level of ambition for HSSIP. Target setting is not always realistic within the time frame and resource envelope available. While the costing done has clearly highlighted the severity of the underfunding, this has not lead to a clear strategy for how to prioritise and target the limited resources.
- A more detailed analysis of successes and failures in different geographical and contextual settings (e.g. urban versus rural; poor versus non-poor; secure versus insecure areas; district or region-based performance) would allow for specific targeted strategies better adapted to different contexts. It is however noted that planned investments in the PRDP districts (Peace, Recovery and Development Plan, Northern Region) are integrated in the HSSIP (HSSIP, section 5.2.1.6).
- Some strategies and actions do not adequately address issues discussed in the situation analysis (e.g. lack of staff housing; family planning as a critical strategy to counter population growth and reduce maternal mortality).

Attribute 1: Strategy based on sound situational and response analysis

- The information available on the high cost of UNMHCP (according to the MSS Report: Development of Minimum Service Standards in Uganda's Health Sector, MoH & HLSP Nov 2008 the cost is US$ 41 per capita) and possible options for limiting the package and/or coverage should have been reflected more clearly and used to identify the priorities .
- In general, for health services including SRH, the emphasis is much more on the supply than on the demand side (e.g. maternal health).
- The plan would benefit from further disaggregated analysis of data to highlight geographic, socio-economic and gender inequities in health status and coverage. For example, while some regional variations are cited; disaggregated rates such as those for U5MR are quite dramatic, ranging from a low of 94 per 1000 U5MR in Kampala to a high of 185 per 1000 in West Nile region. Women in the poorest households (in terms of wealth quintiles) have twice as many children as women in the wealthiest households (8.0 and 4.3, respectively). The national stunting level in Uganda is noted as declining to 39%, yet for <5 children in South West Uganda and Karamoja, it remains a very high 49.6% and 53.6% respectively. Further disaggregation of data could guide resource allocation and needs-based planning while reinforcing government's commitment to ensure equitable service delivery.

Attribute 2: Clearly defined priority areas

- As indicated, the plan highlights four main priority areas and suggests that resource allocation including HRH will reflect those priorities (section 5.2.1 & 6.1). While there is data scattered throughout the situational analysis which supports these priorities, the plan does not outline succinctly enough why these specific four areas have been prioritized, and on what basis (i.e. burden of disease, past priorities, the MDGs, etc). Also, it does not indicate how other (non-priority) areas such as NCD will be treated when resources are scarce.
- It is not clear which mechanisms of priority setting, planning and budgetary allocations will be applied to ensure the focus of the four priority areas within a very limited overall resource envelope.
- Given that HR and drugs are identified as main bottlenecks in terms of improving service delivery, more concrete strategies would have been appropriate, not least addressing retention of health workers and curbing absenteeism. This could be addressed by references to more detailed plans on HR.
- Many targets seem more aspirational than realistic given the available financing and timeframe. The selected sector performance indicators provide a mix of realistic and ambitious targets.
- Overall, relevant strategies do not always explicitly address equitable access across all population sub-groups, especially vulnerable groups.

Attribute 3: Feasible, appropriate, equitable interventions based on evidence

- The expected lack of sufficient financing generally and in particular for HR, drugs, equipment and transport, may mean some activities and many targets are not feasible.
- The intention to construct new facilities (target of 30% increase of facilities; HSSIP, section 5.2.2.4, p.107) is – apart from what is financed under the PRDP – questionable given the current gross lack of HR, drug supply and functioning equipment for the current infrastructure. Achieving an increase in Ugandans living <5km from a health facility from 72% to 90% may imply constructing, manning and equipping more than 1000 new facilities (HC2 mainly; to be noted that present HC2 facilities are already confronted with a 67% vacancy rate!), and does not seem in line with the NDP's emphasis to "prioritise renovation, maintenance and rational use of infrastructure". However, the HSSIP section 6.3 on health infrastructure investments does not at all reflect the above targets and seems to focus mainly on upgrading of existing facilities. And unit cost tables for health infrastructure again mention completely different numbers of health facilities (p. 161).
- On the same note, quite large capital investments are planned for Regional level and up, namely 42% of total (and almost 10% of Scenario 1b total cost of HSSIP), in conflict with the stated (e.g. 6.1) priorities. The overall capital budget is 21% of total budget (Scenario 1b). And ICUs (5.2.2.1) are still a priority at Regional Hospitals (where for example in Jinja it gobbles up half of the recurrent budget).
- On the capital budget there are unexplained inconsistencies across the HSSIP and in relation to the Costing Report. For example HCII are 215 units in the HSSIP budget (Table 9.3), 190 on HSSIP p. 133 and 160 in Costing Report, for HCIII the figures are 312, 120 and 170 respectively.

- While lack of staff accommodation is identified as a major constraint to attract and retain staff, the plan does not provide a specific strategy to counter this (apart from the PRDP in Northern Uganda), although it is mentioned as an area for infrastructure investments. Costing tables do not explicitly mention staff housing (assuming that these are part of the health facility package?).
- The plan does not comprehensively address TA requirements. The need to develop a multi-year TA plan is stated in the Compact (version July 2010, signed in November 2010; para 4.12).

Attribute 4: Risk assessment

- The HSSIP presents a fairly general risk assessment. The by far greatest risk, namely that insufficient funding renders the service delivery inefficient if resources are not properly prioritised and targeted is only superficially dealt with.

More specific issues related to different thematic areas include:

- CMR and U5MR are both used but the rates referenced in the text and graph (HSSIP, Figure 2.1, p. 9) are U5MR (UDHS 2006) assuming standard definitions: Child mortality rate (CMR) is the number of deaths among children between age one and five years per 1,000 live births per year; Under-five mortality rate refers to the number of deaths among children below five years per 1,000 live births per year.
- The Nutrition analysis has been expanded and is programmatically well integrated in the MCH section. The HSSIP does not mention that with the signing of the CAADP Compact in March 2010, the GOU has committed itself to investing in the agricultural sector to achieve MDG 1 to decrease poverty and hunger. The Development Strategy and Investment Plan (DSIP), drafted by the Ministry of Agriculture, Animal Industry and Fisheries (MAAIF), is the medium term plan for achieving Uganda's CAADP Compact. While agriculture is the primary focus in the DSIP, the document recognizes the importance of tackling malnutrition as a critical element to achieving food security and the MDG 1 in Uganda. The Development Partners were highly involved in the GOU's process.
- Gender-based violence has specific programme components. Family planning / population issues are addressed (but not very strategically). The contextual analysis section (2.3.1) provides compelling reasons to more aggressively address the very high population growth. Uganda has the 5th highest total fertility rate in Africa at an average of 6.7 births per woman and has seen little change since 1995. While the needs are mentioned late in the document under Maternal Health and high population growth is bulleted as a critical threat to delivery of HSSIP , a more strategic emphasis could be given to family planning programs given the lack of progress in this area (fertility has changed little since 1995; contraceptive use is low at 24%), supported by mention of key policy documents including The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2005 – 2010); The Family Planning Advocacy Strategy, and national Reproductive Health Strategy.

Implications for successful implementation

- The considerable risk that financing will be grossly insufficient to implement the UNMHCP may not only render some interventions ineffective, but if no effective prioritisation is done within the package or its coverage, it may render most core programmes inefficient as well.
- Sufficient HR, drug supply, equipment and transport are key to improve service delivery, and if not comprehensively addressed, this will hamper the efficiency of the sector. While these critical inputs are being addressed in terms of investments, it is not clear how these investments will be prioritised within a realistic resource envelope.

Suggested action

- Based on the costing and projections of financing likely to be available, develop a clear strategy on how to address priority areas and achieve key outputs and outcomes within a realistic (presumably very limited) resource envelope, taking Uganda's decentralised system into consideration.
- The issue of prioritisation needs to be addressed not only in terms of what to prioritise, but also how to achieve this prioritisation (see also section 2 on process). Prioritising should be as much as possible

strategic and evidence-based, but, as indicated before, it is acknowledged that this is both a technical and political process. Alternatives could be rationalisation of infrastructure or reducing the size of the UNMHCP, as suggested in the MSS report; or to define a more limited 'free' basic package and a complementary package (to be paid for or covered by health insurance); or to use a combination of global-frame budgeting combined with few clear output targets. Or utilise combinations of these and other approaches (see also section 4 on financing).

- Targets need to be revised in accordance with the resources available and revised priorities.
- Plan and budget for TA needs to be elaborated, either as part of HSSIP or as an initial specific activity under HSSIP.
- A more thorough risk assessment and identification of mitigating actions would enhance trust in the plan.

<u>More specific issues related to different thematic areas include:</u>

- There is some disaggregation of data to show gender differences i.e. for mortality and malnutrition, but there is a need for further disaggregation (particularly with regard to differential coverage and access to care).

- There is good discussion of Sexual Gender Based Violence and data for the situational analysis is drawn from DHS and other surveys which specifically targeted these issues. Also, gender dimensions are discussed as a major social determinant of health and collaboration with Ministry of Gender, Labour, and Social Welfare is specifically mentioned. Gender sensitivity is also listed as one of several social values prescribed in the Constitution as well as Patients' Charter and will be upheld by HSSIP. The bulleted actions include the need for more gender-sensitive analyses in all programming and more CSO involvement.
- That said, more precise actions could be articulated, across various programs especially sexual and reproductive health and HIV/AIDS, which at minimum emphasize inclusion and leadership of women, and informed consent and empowerment for decision-making as well as positive male involvement. Under Health Promotion, an understanding of gender barriers should be incorporated into strategies for community mobilization and promotion of healthy behaviours.

3.2 Process soundness

Process Soundness and Inclusiveness of development and endorsement processes for the national strategy

Attribute 5 – 2.1, Attribute 6 – 2.2-2.5, Attribute 7 – 2.6-2.7

Strengths

Attribute 5-7 (cross-cutting)

- Government has been proactive in the engagement of stakeholders (traditional and non traditional) in the HSSIP planning process
- Participation was broad and included engagement of non state actors at central level

Attribute 5: Participation

- Various platforms and mechanisms for consultation have been established and/or strengthened. These include task forces, working groups, development partner platforms and some inter-sectoral platforms linked to the wider development process for the national development Plan (NDP) and the ongoing budget processes
- Government leadership of this process is visible, with proactive efforts to ensure the engagement of a very broad range of non state actors in health including the religious bureaus, private sector and civil society organizations. Sub-national engagement has also been sought with consultations held with districts as well as with other sectors and initiatives relevant to health
- Civil society (CS) participation is very vibrant and active and several consultations and reviews of the document have been held. Recommendations have been submitted for the consideration of the planning team.
- Development partner participation and engagement in the sector is via several platforms, the AIDS Development Partners Forum (ADP) and the Health Development Partners Forum (HDP) and the HPAC. Development Partners are also engaged in other engagement platforms outside the sector including those related to the process of budget support to the Government of Uganda as well as for the implementation of action related to the PRGP for Northern Uganda
- A consultant has also been identified to review the current MOU with development partners and expand this to support the consultation across stakeholders. The Compact between the GoU and Partners (dated July 2010) was signed during the 16th JRM in November 2010.

Attribute 6: Political Commitment

- Within the health sector, sub-systems and issue plans are well developed; consultation and engagement platforms exist for the development and review of these plans.
- Technical leadership in the Ministry of Health is very engaged in this process, and in many instances are very proactive to ensure that issues and actions related to their work are submitted to the Technical Team leading this process.
- The plan identifies bottlenecks to implementation including the limitation of HR, financing and coordination.
- HSSIP puts emphasis on reviewing relevant health policy and legislation, including new legislation. It also plans to recruit additional staff to the Policy Analysis Unit (including a legal officer and gender focal

point).

- HSSIP proposes a regular health impact analysis of non-health policies and inter-ministerial clusters for cross-cutting thematic areas.
- The plan suggests a willingness of GOU to progressively increase the GOU resource envelope for health and take more charge of some critical expenditure such as essential drugs.
- HSSIP reflects the aspiration of the Government and people of Uganda to expand access to health care and improve service delivery effectiveness. There is clear evidence of Government commitment to the major strategies of this plan as reflected in the NDP.
- Government and non-state partners are committed to the HSSIP. Task forces and working groups have been established to contribute to the process, review the drafts of the HSSIP.

Attribute 7: Alignment with central strategies and plans

- Four priority themes have been identified in the HSSIP. The identification of these themes has taken on board local needs and global targets as established in the MDGs and other global programmes/initiatives.
- The HSSIP refers thoroughly to the National Development Programme (NDP) and there was an ongoing budget process at the time of the JANS review. Main strategies of the HSSIP are in line with the health chapter of the NDP, as clearly outlined in the HSSIP. The same applies to the NHP.
- Proactive efforts have also been made to include sub-national managers and processes in the situational analysis, finalising strategic choices and intervention actions including a review of effect of decentralization on procurement of drugs and medical supplies, HR management and service delivery effectiveness.

Weaknesses

Attribute 5-7 (cross-cutting)

- Engagement needs to be meaningful. Selection of representatives of non state actors as members of the various taskforces and working groups needs to follow an agreed and transparent process that engages the various constituencies and permits feedback to constituency groups.
- HPAC not very proactive and technical capacity of development partners could be strengthened in order to maximize effectiveness of participation.

Attribute 5 : Participation

- Although the participation has been broad, it still requires to be expanded to include non state actors active at the sub-national level.
- Moving towards meaningful participation and engagement will require that non state participation be better resourced. The process of selecting CS membership to the various platforms will also need to be more representative.
- CS organizations and other non state partners also need to be better coordinated and organized for participation. Currently, there are too many platforms for consultation and engagement – both government and their non state partners do not have enough time and resources to engage and meaningfully participate in all the working groups and task forces in health.
- HPAC has been identified as the highest consultative and policy forum in the health sector. The HSSIP acknowledges that the HPAC could fulfil its assigned role more effectively. While there is scope for improving effectiveness of participation, it appears that government, CS including the faith based

organizations and DPs are engaged in this forum.

Attribute 6: Political Commitment

- Government commitment is visible but its effectiveness might be limited by the need to complete the process of filling leadership positions in the Ministry of Health.
- The engagement of some development partners at sector level on the other hand appears to reflect frustration caused by the leadership vacuum in the MoH due to senior posts not formally filled. This has made DP participation in the sector platforms appear more focussed on identification of gaps and funding consultancies with more buy-in to the implementation of sub-sector and issue related plans than in the over arching HSSIP.
- Non State organizations also need to be better organized for representation in the platforms. Mechanisms and resources to support wider dissemination, constituency feedback and strengthened organizational effectiveness of the non state participation are required.
- While relevant legislation seems to be properly addressed by HSSIP, its enforcement may remain the stumbling block. The establishment of a Joint Professional Council maybe a good idea. Less clear is how its planned decentralised supervisory authorities will operate and how the capacity of the National Drug Authority (NDA) will be effectively strengthened.
- The plan is confusing regarding the future resource envelope for health. The document presents 4 different targets in different sections of the report that need to be harmonised. The data are also not in line with those presented in the NDP. The NDP projects an increase of the health budget as part of the national budget from 11.0% in 2010/11 to 11.6% in 2014/15, remaining largely below the expected 15% as stated in the HSSIP. Political commitment to health therefore seems to be sustained but remains modest, when compared to some other countries in the region (e.g. Ghana 14.9%).

Attribute 7: Alignment with central policies and plans

- The links between the HSSIP, some sub-sector (HR, financing, organization including decentralization, M&E) and issue related plans needs to be clearer.
- The timing of the sub-sector and issue related review and plan development process also needs to be better harmonized with the overall timelines for the development of the HSSIP.
- It is not quite clear how health sector actions and investment in the PRDP and LRDP are reflected in the overall strategies and actions reflected in the HSSIP. The section 5.2.1.6 on PRDP mainly mentions investing in infrastructure and equipment. It suggests a list of priority actions (some of which are different from the 4 core priorities) but these are not consistently reflected in the other sections of the plan. The single indicator proposed ('increased access to functional health facilities') is not part of the HSSIP core performance indicators. It is also unclear if the implementation arrangements for this are related, and how these are to be coordinated. It is also not clear how the HSSIP actions and investment will link to, and provide improved support for non state actions within the context of the PPP policy and programmes. Although non state actors have been involved, there is a need to better specify their responsibilities, actions and resource flow and reporting channels within the plan if this is to be a country owned plan and country is to reflect engagement that is broader than the public sector.
- The greatest challenge however remains the alignment and prioritisation processes between investments and actions by development partners and governments in the HSSIP and in the sub-sector plans. This is of great importance as Uganda is very aid dependent, and public sector resource envelopes are constrained.

Implications for successful implementation

- In a decentralised system ensuring sufficient capacity and providing clear direction and the right incentives for each level to effectively implement key priorities are paramount to success.
- In order to facilitate and maximise effective participation of CSOs, coordination of the various platforms and processes for contributing to, reviewing and implementing the HSSIP need to be identified and resourced. The current limited clarity in coordination represents a great potential for sustained fragmentation to planning, review and progress of the HSSIP.
- Separate platforms for coordinating HIV/AIDS DPs and health DPs seems to be inefficient and counterproductive. Several DPs have expressed the wish to have one integrated sector coordination platform.
- Ongoing costing process needs to ensure that there is a linkage between the first year actions and plans that has already gone forward to the budgeting process. It is important that this first year be identified as a bridging process so that clear linkages in actions and investments can be identified for other actions in the plan.
- Although four priority themes have been identified, actions and interventions within these themes still require to be further prioritized. This process is both a technical and a political process, requiring leadership of all stakeholder platforms health to negotiate prioritization. Parameters and guidelines to support this highly political process need to be discussed (see also sections 1 and 3).
- The process of identifying substantive leadership positions in the Ministry of Health needs to be fast tracked. Within this effort, it is also important that the roles and responsibilities of the various leaders in this process be further discussed and clarified, so that coordinating roles and the provision of the required technical and political support to working groups and implementing arrangements can be strengthened in the prioritisation discussions.
- Accountability modalities / mechanisms need to be identified and strengthened to ensure that technical and political commitments are both achievable and can be tracked through existing structures and platforms. At the moment, sector platforms are mainly focusing on consultations and engagement with limited attention for peer, independent and mutual accountability.

Suggested actions

- Making participation and engagement meaningful. This will involve incorporating actions that will improve the organizational effectiveness of non state actors as well as strengthening the capacity to reflect the needs of vulnerable, marginalized and socially excluded groups in the plan including but not limited to sexual minorities.
- Resourcing participation and engagement, of all partners, especially of civil society and sub-national service delivery units.
- Determining and communicating a process for prioritisation and financing. This will require the technical leadership of HPAC as well as the political leadership in both the Ministry of Health, among the Development Partners and with non state actors. There is a need to establish a process and guidance document for prioritisation as a part of the ongoing process.
- Financing – making an investment case for the HSSIP. This should be a joint action of all stakeholders, development partners, civil society, private sector and government. This is a role of HPAC but participation and engagement of development partners needs to be proactive, deepened and meaningful.

- Strengthening the coordinating role of HPAC of the various consultation platforms that exist.
- There is a need to review DP participation in the health sector, strengthen the coordination of DP investments and cooperation as a part of this process, and develop mechanisms for assessing and monitoring mutual accountability.
- Aside from further defining and clarifying the processes that would give prioritisation there is also a need to strengthen and clarify implementing roles in the HSSIP. A key important document to support this is the proposed approval and legislative processes of the policy on Public Private Partnership. The consultancy and consultation on the compact development process could also provided an opportunity to further define and clarify implementing roles, behaviour change required and how these can be incorporated into monitoring, learning, accountability and evaluation plans for the HSSIP. The agreed Compact has achieved this to some extent.
- The ongoing review presents an opportunity to deepen engagement and improve both coherence and linkages in the plan. The leadership role of HPAC needs to be reviewed and positioned to take on the tasks of linkages and coherence before the costing and financing profiles are completed .

3.3 Finance and auditing

Notice: The JANS assesses the strengths and weaknesses of the national strategy. What follows, is an assessment of the presented plan and the country Public Financial Management (PFM) situation as perceived by the JANS team and as reported in diagnostic reports such as the PEFA measurement and PFMP reports. The attached presentation should be read together with the Financial Management (FM) annex to this report (annex 4.5).

FINANCE AND AUDITING: Soundness of financial and auditing framework and systems

Attribute 8 -3.1, Attribute 9 - 3.2- 3.4, Attribute 10 - 3.5-3.9, Attribute 11 - 3.10-3.13, Attribute 12 - 3.14-3.15, Attribute 15 (section 3.4)

Strengths

Attribute 8-12 (cross-cutting)

- The HSSIP adequately highlights resource inadequacy, particularly concerning the UNMHCP.
- The need for the development of a health financing strategy is well stated in the document. The process is already set in motion to complete it by June 2011.
- The HSSIP provides a clear executive summary with the main issues to be addressed. Those issues are further amplified in the plan document with a situation analysis, strategic direction and recommendations and actions to be taken during the 5 year plan.
- The HSSIP refers to the appropriate legislation and regulations governing Financial Management for the public sector. This is adequate in order to establish the legal and regulatory basis and basis for accountability and reporting. However, the situation analysis does not provide the baseline information and evidence to allow an independent conclusion about the strengths and weaknesses and their underlying causes. As such, it does not actually provide a good analysis of the present situation in a complete manner.
- Several years of MTEF exercises and other Public Financial Management Reforms (FINMAP) under implementation by the GOU has already benefited the sector (e.g. IFMIS deployed at the MOH and several districts) and the preparation of the HSSIP has been quite robust.
- With the results from many studies and exercises available, weaknesses and issues are well known to the management which would hopefully speed up their resolution without further studies.

Attribute-8: Sound expenditure framework with a costed plan

- HSSIP partly fulfils this by discussing the resource requirements for the UNMHCP. It is supported by the *Minimum Service Standards (MSS) study estimates.* The estimates are based on a normative approach of meeting all the requirements to attain the UNMHCP. This is employed as a strategy to attract more resources towards the implementation of the UNMHCP.
- The costing has been done with several scenarios and some details and analysis. The document is clear as what method has been used for the costing. Reservations by the JANS team on the methodology are expressed below.

Attribute-9: Financial gap analysis

- A pro-active approach is employed in the document wherein it provides an optimistic future estimate of government finance by assuming that the budgetary allocation may meet the 'Abuja target' of 15%. Also, it assumes that by setting the ambitious target of full coverage of the UNMHCP (estimated at from US$

39 to US$ 51 per capita over the HSSIP period), more per capita resources could be attracted. Further economic analysis will help sharpen the focus and have more realistic targets. Moreover, unit cost may change when the level of outputs changed.

- The UNMHCP is based on the principle of minimizing the household out-of-pocket spending on essential health care. If the UNMHCP targets are met, it is likely to ease households from incurring catastrophic spending on minimum essential health care services.

Attribute 10: Financial Management System

*As designed, the **Country PFM** generally meets the JANS attributes, but with substantial risk and non-compliance in practice.*

- Financial allocation criteria across districts and for the private not-for-profit sector exist for PHC and PNFP non-wage recurrent budgets. Their appropriateness (criteria used) and impact are however not discussed in the HSSIP situation analysis.
- Fund negotiations between the government and the not-for-profit sector use adequate transparent mechanisms at the national level.
- The Financial Management System meets international standards, as well as produces some reports appropriate for decision-making, oversight and analysis. One of the stated objectives of the HSSIP is to establish the National Health Accounts and a standardized/ uniform Chart of Accounts of the sector actors. This would be a welcome and important achievement but specific dates and targets should be set to monitor progress. Also Technical Assistance might be necessary and should be costed.
- The financial instructions are clear but the level of compliance is low. The Internal Audit has been established relatively recently which is an enhancement of the prevention and detection measures. The capacity is however limited and the results are not yet fully visible. It is not clear if enhancement of internal audit has been included and costed or not.
- The disbursements are reported to have improved this FY and as long as the quarterly financial returns are submitted on time, disbursements have been made within a reasonable time. No further disbursement is made without submission of adequate quarterly reports during the year. About 70- 80 % of the districts submit their quarterly returns on time. No other systematic mechanism to identify bottlenecks and their resolution were reported. The finance department of the MOH or the Internal Audit should include this as part of their function or the audit program.

Attribute 11: Audit procedures

***Country audit arrangements** substantially compare with International good practices but some additional mitigating measures are needed against existing inherent risks.*

- The Auditor General (AG) is fully independent, reporting directly to the parliament. The transparency and public access to the reports is one of the best practices as the AG's reports are posted on the SAI's web site. The AG is supported by well qualified staff in the Office of the Auditor General (OAG). External audit is performed by the OAG and more recently its financial independence has been enhanced, as its budget is now discussed directly with the parliamentary committee in change of budget and the cost of the office is a direct charge to the National Revenue Account.
- The OAG has the competency and qualified staff to perform financial, compliance, and "Value for Money" audits, albeit insufficient staffed in some areas. Any delay in the audit reports is the consequence of delays by the auditees to submit their accounts and financial statements to the Auditor General and to some extent shortage of staff as compared to a heavy workload. Given the workload of the office and level of staffing, the AG has the ability to sub-contract the audit work to private auditors.

Moving forward, we recommend that this type of audit be contracted out by the AG to private auditors, but under his supervision and guidance.

- The Internal Audit has also been strengthened recently but with uneven capacity and competencies which mainly continues the pre-audit work, and the contracts committees fulfil the procurement function. The procurement risk has been assessed as substantial due to the environment in which it operates. The external financial audit should be complemented with regular "value for Money" and Procurement audits, under the supervision of the Auditor General; the role and attributes of the Internal Auditors need revision and more qualified staff is required to enhance effectiveness and efficiency. The National Procurement rules and procedures are, in some areas, different from the international good practices.
- No meaningful parliamentary investigation takes place. However, there are several independent bodies such as the Inspectorate General of the Government, which are tasked to investigate allegations of corruption. Most recently, some high profile investigations have been carried out.

Attribute 12: Funding sources and fiscal space

- Plan has explicit guidance on how programmes will manage the fiscal space constraints to scaling up. However, a more in-depth economic analysis would improve it further.

Weaknesses

Attribute 8-12 (cross-cutting)

- HSSIP does not have a clear *focus on poverty*. Regarding financial accessibility it is mentioned only 'that options to subsidise up to 80% of the health insurance premium for the poor will be explored'.
- Marginal costs have not been used and is has been assumed that scaling up will have the same cost as lower level of production. Also, efficiency gains have not been explored.
- HSSIP is viewed as a *resource mobilization tool*. In order to effectively serve as such, it needs careful revision with improved coherence between different sections of the plan regarding priorities, proposed use of resources and financing mechanisms.
    - Situation analysis concerning health financing should be strongly linked with priorities and targets.
    - Scenario analysis (low case, high case, most likely case) linked to corresponding level of services would be a useful way to guide discussions and decisions. The presented scenarios are unclear and confusing and there is insufficient information to appreciate the correlations. For example there is a correlation between staff level and level of other investments, as the absorptive capacity is linked to staffing level (but not with a linear relation).
    - Alternative options in government vs. non-government level of financing could be considered and discussed.
- *Cost estimates* are not pragmatic. The UNMHCP itself is a broad-based package. One option could be to scale down the scope of the basic package provided for free or to gradually increase population coverage.
- *Resource prioritization* needs more clarity as to whether it will be based on the resource envelope or what is achievable within a time span of five years. The HSSIP seems to have followed an 'arithmetic approach' adding all the resource needs (compilation) and not a 'chemical approach' (consolidation) wherein different resource options and needs are well synthesized into a single compact plan for the sector.

- *Resource implications* of the increasing number of districts on the health sector are not discussed in the plan. More districts could mean more administrative cost of managing the health care system besides taking a section of the human resources away from the clinical work. Similarly, resource implications of the envisaged expansion of VHTs is not yet factored into the plan, nor has the planned extension of the coverage of the population within 5 km access of a health facility. In order to be operational, these groups and additional facilities would need resources.
- In terms of *strategic resource planning* the plan needs more adequate consideration as to what are the strengths and weaknesses and what are the strategic approaches to building upon the strengths or overcoming the weaknesses or how those are practiced in the sector. It also does not provide the basis for strategic planning on resource mobilization, management, or allocation and on plans for overcoming the fiscal constraints to scaling up.

Attribute 8: Sound expenditure framework with a costed plan

- Based on the historical cost and performance known to date, the Plan assumes a *'big bang' approach* of meeting all the requirements at one go. In practice, service and population targets may be gradually achieved over a period of time and norms for certain inputs (e.g., human resources) may not be met even during the entire HSSIP period given their production, procurement/recruitment and deployment scenario in Uganda. These aspects are not factored into the costs for the UNMHCP.
- Costing is problematic and unclear in several respects. The cost is a compilation of cost of individual sector activities (unsure if all activities of all ministries and agencies are included and also financing to those agencies is included in the financing side) rather than a consolidation in order to eliminate the overlaps. The "ingredient" approach is used without attempts to link the inputs to outputs. The standard per unit costing is said to have been used, thus not marginal costing. Due to lack of information from off-budget activities and financing as well as activities by other ministries and agencies, it is very likely that the gap between financing and cost is over estimated.
- The costing is in current term. Assumptions made, such as the rate of inflation and exchange rate are not explicit. The Cost and financing information in the scenarios do not seem to add up (discrepancy between tables) and there seem to be some confusion in the numbers ($15 per capita vs. $ 12). Any salary increase and hiring needs negotiations with the MOFPED and Ministry of Public Service. The scenarios need to be discussed with those central agencies.

Attribute 9: Financial gap analysis

- *HSSIP does not adequately take into account the availability of resources* (the NDP projects an increase of the GOU allocation to health from 11% in 2010/11 to 11.6% in 2014/15, largely below the projected 15% in the HSSIP) and hence looks ambitious. For instance, increasing the functionality of Health Centres - IV from 5% to 50% or reaching the target concerning health workforce would mean substantial additional resources. One could extend this list to include all the targets mentioned in the plan[3].
- Household out-of-pocket spending finds mention in the situation analysis, and figures in the priorities as well. However, starting NHIS with government staff and the statement that NHIS will be used to address the out-of-pocket spending are contradictory. Similarly, there are *no activities listed to eliminate impoverishment* due to out-of-pocket spending or to enhance access to health care by under-

[3] For example, based on the 2006/07 GoU and DP expenditure on EMHS (4.06 US$ per capita out of an estimated need of 6 to 7 US$ per capita for EMHS; and including a contribution of global initiatives of 2.39 US$ per capita), as presented in the HSSIP, GoU contributed 1.67 US$ per capita, equivalent to almost 29% of the lower estimate of medicines needs. Increasing GoU coverage to 80% of the needs would require an additional 2.8 US$ (lower estimate of needs) to 3.5 US$ per capita (higher estimates of needs).

impoverishment due to out-of-pocket spending or to enhance access to health care by under-served groups. However, the plan does talk about some measures to achieve social health protection.

- There is a mention of the proposed *National Health Insurance Scheme* (NHIS), which may become an additional source of funding for the sector in the future. The HSSIP provides however little information, as the plans are still in their infancy. As a new strategy in the HSSIP it is mainly described in terms of a prepayment scheme with a view to reduce OOP. Existing community level initiatives in health financing that could be considered for scaling up are also not discussed.

Attribute 10: Financial Management System

- The HSSIP needs to describe the financial management system strengths and weaknesses and shortcomings in practices, analyze the underlying causes, and provide evidence that the systems, capacity and practices are adequate, accountable, and transparent or in case of deficiencies, lay out the strategy a clear time bound action plan to make them so. Adequate references to specific sections of existing documents (e.g. guidelines, sub-system analysis or plans) have been provided and national PFM requirements are listed and actions are suggested. The analysis is absent so as to demonstrate that the proposed actions are related to all the shortcomings (for example the lack of compliance is a serious matter in Uganda). Assuming that the suggested actions are adequate, a time bound action plan and costing of inputs would help monitor the implementation. It is understood that this action plan is still to be developed. Also some of the proposed actions in the HSSIP would have undesirable consequences and some compensatory actions are required to minimize the negative impacts of actions proposed.

Attribute 11: Audit procedures

- The parliamentary committee has not fulfilled its role of investigating alleged irregularities nor has the parliament debated the Auditor General's 2002 report and after. However, many other Anti-Corruption institutions exist in the country to investigate fraud and corruption. Furthermore, the AG forwards cases found by his auditors to the prosecutor general. As suggested above, annual procurement, Value for Money and financial audits, complemented with a modern Internal Audit would reduce wastage and improve compliance.

Attribute 12: Funding sources and fiscal space

- While on-budget resources are discussed, planned and monitored, there are external resources that flow directly to the facilities. Allocation of these resources is not very transparent, as acknowledged by the GoU. The GoU makes substantial efforts to address the issue of off-plan donor support but not all donors are willing to align their support to the sector plan. As a result, there could be duplication of efforts. Similarly, fund flows from households are not known. Whether or not such resources contribute towards attaining national health goals is not clear.
- *Plans to overcome fiscal space constraints are not in place*. The document refers to a study carried out by the World bank which concluded that there are some USH 36 billion estimated wastage and inefficiencies in the system that if tackled could open the fiscal space. The HSSIP however does not address this issue, doesn't think beyond budgetary resources and doesn't seem to count what is outside the government budget.

Implications for successful implementation

- One major requirement for the successful implementation of the HSSIP is financial. Successful implementation of the plan demands a huge amount of resources, probably beyond the affordability and

capacity of the country. Since the plan reflects the wider aspirations of the Ugandan population, a clear *long-term vision for the country could be developed using the document*. But, its implementation has to be timed carefully keeping the resource potential in mind.

Suggested actions

- The plan still requires pragmatic costing taking into account the context in which the plan will be executed. Simple academic costing may indicate a very high amount. The fact that all the targets will not be achieved in a single year (or even during the entire 5-year period) needs to be reflected upon.
  - A pragmatic costing of the HSSIP, easy to understand for all stakeholders, would be as follows:
    - ✓ Its point of departure should be the cost of the current level of services.
    - ✓ Adding what it would cost to rectify current main shortcomings: reasonable level of human resources, and sufficient drug supply, equipment & transport; as well as maintenance of infrastructure which relates to the level of staff and the absorptive capacity.
    - ✓ Subtracting where savings can be made; efficiencies can be gained
    - ✓ And then allocate remaining resources to other key priorities.
  - The costing should develop a low, high and most likely case scenario.
  - Various future health financing scenarios need to be considered in the light of certain new developments including the growth of the GDP, population, ageing, non-government funding mechanisms, etc. This could be done as part of the costing exercise. Analysis provided in the recent health financing review could be used for this purpose.
  - Financing of critical inputs such as medicines and human resources could be given further attention as part of the costing exercise.

- Usefulness of the normative approach (for example, Abuja target and costing of aspirations) to attract more resources to health and its relevance in the past could be debated. A realistic approach may be more suited to the resource mobilization efforts than the normative approach. The above proposed scenario approach could help.

- The HSSIP poverty focus needs to be strengthened and made more visible both in terms of accessibility, equity and affordability of services.
  - Household out-of-pocket spending is mentioned as a major health financing challenge. But, the document does not provide any strategy to overcome the challenge (apart from the NHIS) and is relatively silent on how poverty and catastrophic costs of health care will be addressed. It will be useful if the document provides an action plan to minimize the household reliance on the out-of-pocket spending to finance health care. It could spell out how these resources could be channelled using the existing or to be developed pre-payment mechanisms. Alternatively, the above strategies could be developed as part of the health financing strategy being planned for year 1.

- Health financing and audit section could discuss ways to expand the health resource base and its management in the future taking into account current and future developments in health financing. For instance, it could provide ways to guide non-government resources to attain national health goals. The current broader stakeholder consultative process for the HSSP could, in future, include alternative health financing options prevalent in various settings. The information thus generated could be used to plan the effective use of those resources.

- There is a need to provide a road map for resource generation and allocation based on realistic assumptions. It should reflect the health sector priorities, where resources are required the most. Alternatively, if optimistic assumptions are made, the document could list the ways to get there. Similarly, steps to ensure the resource flow in the desirable direction may be provided.
  - A main activity during the first year of HSSIP should be to develop specific criteria for the allocation

of resources across levels and institutions guided by the key priorities of the sector and including implementation issues such as work-load and own revenue generating potential, as well as equity and possibly performance (see also sections 3.1, 3.4 and 3.5) .

- As the HSSIP is the national plan including all parts of the sector, as much as possible resources (household payments, off-budget, domestic resources) and expenditures should represent the full sector, and implementation arrangements and analysis should include all major players (e.g. NMS).

- There could be clear policy guidance for the development of a health financing strategy. At present, the document merely says that a health financing strategy will be developed. A statement on how the proposed strategy will be useful to achieve the national health goals could be included. The development of the health financing strategy in year 1 could also include the following:

  - Address strategies for out-of-pocket expenditures, catastrophic health care costs, and other *poverty/equity* related issues.
  - Scalable health financing pilots (e.g. health insurance) and additional health financing means such as domestic philanthropic resources could be tracked so as to streamline them or scale them up for their wider and targeted use.

- The plan provides the appropriate list of legislation and regulations governing the sector and financial transactions. The situation analysis presented in the HSSIP regarding the financing, financial management capacity and systems, procurement, and audit should be more informative and be used as the basis for better pin-pointing the strengths and weaknesses and in order to develop the strategic plan. These can be presented in a tabular/matrix format (see annex 4.5).

Additional observations

- Some of the earlier sub-sector analyses in the past included costing of the proposed strategies as their part of their review. Such estimates provide an option for the government to better reflect on the strategies. Similar estimates were not provided by other Sub-sectors. It weakens their case because decision making is difficult if a review includes only aspirations not costed. Future sub-sector or disease specific reviews could include a system-wide analysis to contextualise the needs against the resource base and a costing of strategies. This will help the planning and prioritisation processes.

- As cost-effectiveness analysis is not always the best suited for the Health sector activities and programs, for better prioritization and selection of actions, analysis could include other methods such as:
  - Least-cost analysis, when the outcome is the same from alternative options;
  - Best outcome analysis, when the resource envelop is fixed;
  - Sensitivity analysis on each of the critical assumptions. For example, the plans should be presented if the resources increase or decreases by x% (where can/should be scaled-up or down), what if the IFMS is not implemented in all districts (how the sector will be impacted in terms of release of funds due to late submission of quarterly reports).

3.4 Implementation and management

IMPLEMENTATION AND MANAGEMENT: Soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy

Attribute 13 – 4.1-4.2, Attribute 14 – 4.3-4.5, Attribute 15 -4.6, Attribute 16 – 4.7-4.9

Strengths

Attribute 13-16 (cross-cutting)

- The draft HSSIP specifies and analyses most / all health system bottlenecks and weaknesses for increased sector performance.

Attribute 13: Implementation of operational plans

- Each strategy and intervention (as described in Section 2.0 of the HSSIP) briefly describes the roles and responsibilities of implementing partners, and many strategies have measurable milestones to assess progress towards implementation. Roles and responsibilities for different areas are reasonably clear and planning modalities well established.
- The plan does provide annual targets for selected sector performance indicators (annex 1 of HSSIP; see section 5 on M&E).
- Implementing partnerships with PNFP and PFP providers (Public Private Partnership for Health) gets special attention in the plan. Also, according to the plan, the long awaited (since 2003) National Policy will be approved in 2011.

Attribute 14: Resource allocation

- Roles and responsibilities of service providers as well as supervision and referral systems are identified.
- The HSSIP acknowledges the human resource crisis in the sector. The HRH Supplement 2009 clearly identifies the present HRH situation and constraints; identifies the gaps to implement the national strategy; and the way forward in terms of consolidation of present staff availability and functionality; and needs for selective scaling up.
- Public Service Commission has developed a retention scheme (awaiting signature) for selected staff in selected hard-to-reach areas.

Attribute 15: Procurement policy

- See section 3 for discussion

Attribute 16: Governance, management and coordination for implementation

- Uganda has appropriate supervisory and oversight systems, although not described in detail in the HSSIP; they are specified in other documents.

Weaknesses

Attribute 13-16 (cross-cutting)

- Generally, the HSSIP does not convince that critical health system issues such as human resources, essential drugs, infrastructure, equipment, transport and staff housing are adequately addressed.

Attribute 13: Implementation of operational plans

- Not all targets have a specified timeline. It would also be useful to establish annual milestones to support costing and monitoring. Some indicators are not having targets.
- District plans an budgets are developed through an elaborate process within the District (preparing 3 year District Development Plan, District Budget Conference etc.) but also involving central level people, e.g. Regional Planning Meeting; and reportedly the UNMHCP is the guiding principle. Nevertheless the links to annual as well as decentralized district planning and budgeting processes could not be fully ascertained. In principle the District health sector plan (DHSSP) should undertake strategic planning to ensure that health sector priorities are addressed and partner resources captured.
- While systems are in place to communicate national priorities to the district level, it is not clear how efficient they are.
- Capacity at District level is reportedly low, particularly in the many newly created districts.

Attribute 14: Resource allocation

- Allocation criteria are still to be further developed as planned for in HSSIP.
- Problems regarding allocation of resources for the decentralised levels are mentioned under Attribute 7. It was reported to the team that despite insufficient funding, the health sector is one of the better funded sectors at the decentralised level, often leading to the use of health sector resources for other sectors by the decentralised authority and further aggravating the resource constraints for the health sector.
- Furthermore, Districts themselves have not adopted a coherent, logical and transparent formula for onward allocation of funds to lower health centres (CAPE report 2010). This could further hamper effective priority setting.
- Allocations of HR and drugs are often more guided by the level of the facility rather than the workload, resulting in inefficient use of resources. The plan does not provide a strategy to counter this.
- The HC2 level is confronted with a 67% vacancy rate as acknowledged in the HSSIP. The plan does not provide a specific strategy to counter this; or a specific strategy to attract and retain staff in hard-to-reach areas; or a strategy to mitigate the potential emigration of critical staff as a consequence of the East African Common Market; or a strategy to expand support to health staff in PNFP facilities.
- While the NDP explicitly refers to the need to implement the 2009 Motivation and Retention Strategy for HRH (including the provision of staff houses, especially in rural and hard-to-reach areas), the HSSIP does not refer explicitly to this (well developed) strategy. While elements of the plan are provided for in general terms, it is not clear how the human resource strategy will implement an effective motivation and retention strategy.
- The HSSIP does not mention the initiative of Public Service to address retention of critical staff in hard-to-reach areas.
- While the PRDP for Northern Uganda and the Public Service initiative are commendable and relevant strategies, they will have a geographical limited impact and not solve the cross-sector human resource crisis. A cross-sector motivation and retention scheme would have to be developed.

- Possible recentralisation of some aspects of health services delivery, training and recruitment of (selected) health staff is mentioned in the HSSIP (p.50), but potential consequences (positive and negative) are not discussed.
- Availability, accessibility and financing of essential drugs are a major issue both for public and PNFP facilities. It is unclear how recentralising district or facility drug budgets (already implemented) and moving from pull to push system (under discussion) will solve the above issues. Also lack access of PNFP facilities to CMS is not addressed.
- The issue of counterfeit drugs mentioned in the situation analysis is not addressed in the strategies.
- While Public Private Partnerships in Health (PPPH) gets a specific chapter in the plan, it is not mainstreamed in the plan. As such it is unclear for example how the HRH strategy addresses HR issues in the PNFP and PFP sectors; the same applies to access to essential drugs, access to training, coaching, supervision, etc. The PPPH plan does mention a drug basket fund to be established for the PNFP sector, but this is not explicit in the health financing section or in the essential drug section.

Attribute 15: Procurement policy

- See section 3 for discussion

Attribute 16: Governance, management and coordination for implementation

- Supervisory and oversight systems are reportedly not functioning optimally due to lack of human and financial resources as well as low level of management control, as acknowledged by HSSIP. It is unclear how proposed strategies will effectively address this.
- Given the high (and still increasing) number of districts (more than 120), supervision and oversight functions would need to be decentralised to a region-like level. The HSSIP includes the establishment and operationalisation of a regional tier, as also recommended in the NDP.

Implications for successful implementation

- Measuring progress against the sector plan would require that all targets have a specified timeline and sufficient annual milestones.
- Efficient and equitable resource allocation is key for sector performance and effective service delivery. The plan should be more explicit how this will be implemented.

Suggested actions

- Annual targets and milestones to be reviewed or developed. Further milestones can be set and monitored for each annual operational plan.
- A main activity during the first year of HSSIP should be to develop specific criteria for the allocation of resources across levels and institutions guided by the key priorities of the sector and including implementation issues such as work-load and own revenue generating potential.
- Reviewing the institutional set up for coordination, support and supervision are a crucial part of

implementing the HSSIP, including establishing a regional tier.

- Given the importance of the human resource crisis, an effective motivation and retention scheme for health staff is of great urgency. Examples of other countries could inspire the scope and the financing of such retention schemes[4].
- The availability and accessibility of ED in both the public and PNFP sector needs to be addressed as a matter of urgency.
- A clearer communication of core priorities for example in terms of key output indicators should be build into monitoring and effectively followed up by supervision both from MOH and District authorities.
- Improving transparency and clarity of priorities regarding resource allocation at the decentralised levels should be part of the planned revision of resource allocation mechanisms.
- Furthermore, strategies to realise the potential advantages of a decentralised system in terms of democratic oversight of health sector performance could be pursued.

[4] Countries where cross-sector or sub-sector retention schemes have been initiated recently are for example Zambia, Zimbabwe and Malawi.

3.5 Results, monitoring and review

RESULTS, MONITORING AND REVIEW: Soundness of review and evaluation mechanisms and how their results are used

Attribute 17 – 5.1, Attribute 18, 5.2-5.3, Attribute 19 – 5.4-5.5, Attribute 20 – 5.6-5.8, Attribute 21- 5.9

Strengths

Attribute 17-21 (cross-cutting)

- The HSSIP has a short list of core sector performance indicators (Table 8.1 of the HSSIP) that include a mix of output, outcome and impact measures. The indicators are measurable; all apart from one have baselines and there are annual targets set based on experience. The health management information system (HMIS) has wide coverage and collects many of the indicators required. There is also a well established annual review and monthly follow up process in place with the Joint Review Meeting (JRM) and the Health Policy Advisory Committee (HPAC).
- Work is underway to develop a comprehensive M&E plan for the HSSIP and the costs for M&E have been included in the HSSIP. Providing funding is available, this should enable effective monitoring and evaluation of the sector that will contribute to achieving results.

Attribute 17: Clear output and outcome indicators and targets

- Sector indicators (HSSIP, Table 8.1) reflect key aspects of HSSIP outcomes and results including the coverage of services in investment priority areas of sexual and reproductive health; child health; control of communicable diseases and prevention. The impact indicators relate to the MDGs and measure health status. There are also clear indicators of health service quality and investment and plans to monitor equity.

- All indicators have targets defined. The targets have been developed in discussion with stakeholders and most appear consistent with past trends (apart from funding targets and some over ambitious programme targets as indicated elsewhere).They are generally consistent with other frameworks such as the Joint Assistance Framework and National Development Plan.

Attribute 18: Data collection and information flows

- HMIS provides many of the planned core indicators. Collection mechanisms are well established and monthly return rates are already high. There is some experience of data verification. Data is collected and can be analysed at district and lower levels – hence geographic disaggregation can be done e.g. for hard to reach districts or sub-districts. The system covers PNFP services. Data flows are well established and districts have an incentive to report on time. HMIS feeds back quarterly to districts. Districts are also supposed to produce their own quarterly performance assessments.

- M&E will draw on various sources including surveys as well as facility based data e.g. the panel survey by UBOS; malaria and AIDS indicator surveys, Uganda Demographic and Health Survey (UDHS) in 2011, surveillance at ante natal care. This mixed approach including facility surveys, population surveys and HMIS is recommended by WHO and IHP+ partners under the Country Health Systems Surveillance (CHeSS) approach.

- MOH is working with partners to update HMIS forms so they reflect HSSIP needs and to reduce parallel

data collection systems.

- The M&E plan that is currently being developed will need to address gaps in data collection for example, service use by gender.

- The HSSIP includes the plan to look at equity in various dimensions – by disaggregating performance by poverty, gender, security and literacy at district level. This approach should provide a way to use existing data to monitor equity and identify needs to improve targeting of interventions. There will need to be further work to refine the approach, especially on gender inequity. In addition to looking at geographic equity, it will also be useful to review access to services and health impact by socio-economic group, when data is available (e.g. from the UDHS), to see how far lower income groups are benefitting from services.

Attribute 19: Data management

- In line with the second National Health Policy (NHP II) policy objective, HSSIP includes plans to strengthen the information system to address the issues identified including increasing staffing, training, ensuring utilisation of data at all levels, and agreeing tools and implementing collection of data on service quality. Given the low level of staffing in the HMIS/Resource centre of MOH and in districts, some strengthening of staffing and funding is justified. The budget for HSSIP includes these measures.

Attribute 20: Performance Reviews

- There have been recent assessments of HMIS (2008) and data validity (2007). HMIS monitors timeliness and completeness of monthly reports and there are sector indicators for reporting.

- District league tables have been used to compare performance and stimulate improvements. The plan to make these more context related (by grouping districts to make comparison fairer) may help to increase the impact and lessons from this tool.

- Quarterly reviews of performance are planned at each level, to look at inputs, processes, outputs and coverage of services. These provide the opportunity to take corrective action where problems emerge.

- The Annual Health Sector Performance Report (AHSPR) is a well established format for reporting progress that covers many issues including some data on performance of development partners. It is reviewed in the annual JRM.

- The JRM is an established mechanism for annual progress review involving Government, private not for profit (PNFP) and for profit private sector and health development partners (HDPs). Each JRM follows up on implementation of the previous annual review's findings. A more substantial Mid Term Review (MTR) is planned for HSSIP as well as an end of period review.

- The biannual NHA (National Health Assembly) includes more stakeholders (CSOs, districts, hospitals).

Attribute 21: Monitoring results influence decision making

- General budget support funding under the Joint Budget Support Framework depends on performance in 4 sectors including health. There are 13 health and AIDS indicators in the first Joint Assessment Framework (JAF1). This affects the GOU budget and reportedly also selected sector budgets. This appears to have stimulated management efforts to address problems in service delivery at various levels in Government.
- Ministry of Local Government conducts annual performance assessments and uses the findings to adjust district development budgets.
- MOH uses resource allocation formulae for primary health care and PNFP non-wage recurrent funding which consider needs (poverty, infant mortality rate, birth rates) but not performance.

Weaknesses

Attribute 17-21 (cross-cutting)

- The M&E plan for the sector and the national strategic plan for developing and improving health management information (including HMIS and use of data) are in development and therefore could not be assessed in this Joint Assessment. It is encouraging that there is broad stakeholder engagement in developing the M&E plans.
- There are substantial efforts and resources used in monitoring and data collection under different programmes but these are not well coordinated, which undermines efficiency and creates extra burden on frontline staff.

Attribute 17: Clear output and outcome indicators and targets

- Some aspects of HSSIP and sector performance are not measured by the proposed sector indicators. These include: efficiency in financing; functioning of central level institutions; and service efficiency/ value for money. However value for money audits and inspections are planned. Institutional performance indicators can be developed within the performance review process.
- Targets for funding, while based on the existing budget envelope of the GoU, do not match the costs of providing the priorities as outlined in the HSSIP.

Attribute 18: Data collection and information flows

- HSSIP includes plans to increase the scope of information collected (to measure service quality, include the private (PHP) sector, and community health information). While these would be useful, adding all these seems ambitious when there is much to be done to strengthen the quality of the existing system (for example automating the system; data validation). Priorities need to be set as part of agreeing the M&E plan.

Attribute 19: Data management

- Weaknesses in HMIS quality are recognised and HSSIP proposes measures to strengthen the system, including providing training and tools. However it has been difficult to recruit and retain staff in practice and funding has been piecemeal and unpredictable. This limits the capacity to take forward plans and produce regular and good quality data. The M&E plan will need to identify how to address these long standing constraints.

Attribute 20: Performance Reviews

- The size of the JRM and increasingly of the NHA can make it difficult to get good value from such events.

Attribute 21: Monitoring results influence decision making

- The HSSIP includes mechanisms for supervision and decision-making based on the HMIS, including Health sub-district monthly reports, District Health Teams quarterly M&E and supervision reports, and Area Team supervision visits. These plans need further development.
- There is a commitment to develop resource allocation mechanisms further; so far, it is unclear whether performance analyses will influence resource allocation and financial disbursements.

Implications for successful implementation:

- The HSSIP identifies the need to improve functioning of existing facilities, including more staff and funding and regular drug supplies for health centres, and ways to motivate staff and reduce absenteeism. Various strategies are being tested, and it will be important to monitor whether they are having the intended effects or need remedial action.
- The targets have been set without considering the funding scenarios, and some will not be achievable as funding will be insufficient. As budgets become clear, realistic annual targets will need to be set.
- If HMIS can demonstrate improved performance (data quality and useful and timely outputs) this will help increase confidence in its outputs and attract resources. There is a case for more staff and reliable funding for HMIS to become more useful for all stakeholders as a key health system component.
- However, if the information systems plan is too ambitious this carries a risk that data quality will not improve, and this will lead to loss of confidence in the shared IS and continuation of parallel systems that are a burden for health staff.
- Recent experience shows that linking budgets to indicators has provided incentives for performance. This also carries risks e.g. to exaggerate results or neglect unrewarded aspects. The need for data verification/quality audits, etc. becomes stronger, with a mechanism to reconcile inconsistent findings (e.g. between UNEPI and UDHS data).

Suggested actions

- Complete the Health Sector M&E plan. This should include definition of the health services coverage index and health determinants index proposed in the HSSIP, and development of useful approaches to gender analysis.
- Identify how partners will support the M&E plan and how much funding will be available so that priorities can be agreed each year. This would ideally include coordinated and predictable support for the Resource Centre to carry out its core roles in information system leadership, enabling data collection, analysis and dissemination. And agreement on the priority surveys to be conducted.
- Monitor the commitment of partners to participate in the sector M&E plan rather than running parallel systems and funding additional activities.
- Use M&E to support the strengthening of mutual accountability that is being implemented under IHP+, to monitor Government and partner commitments. For example, the performance of funding agencies against their budgeted commitments to the health sector and analysis of how far their support matched plan priorities could be included in the annual health sector report (as in past Annual Health Sector Reports).

3. Annexes

4.1 Terms of Reference

Joint assessment of Uganda's Health Sector Strategic Plan (HSSIP)

Terms of reference for the joint mission 24 June - 2 July 2010

Background

Uganda signed the International Health Partnership+ (IHP+) Global Compact in February 2009. At the heart of IHP+ is a commitment to get better health results by increasing support for national health strategies and plans in a well-coordinated way. There is also a strong emphasis on mutual accountability for results.

Uganda is developing its new Health Sector Strategic Plan (HSSIP). In parallel it plans to revise its existing Memorandum of Understanding with health development partners. The MOH requested support from IHP+/HHA to carry out a joint assessment of the new HSSIP.

Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy, that is accepted by multiple stakeholders, and can be used as the basis for technical and financial support. Joint assessment is not a new idea, but there are several reasons for renewed interest in the approach. There is strong consensus that sustainable development requires harmonized support to national processes. In health, the increased number of international actors in recent years has led to a resurgence of efforts to get more partners to support a single national health strategy. The presumed benefits of joint assessment include enhanced quality of national strategies and greater partner confidence in those strategies, thereby securing more predictable and better aligned funding. The inclusion of more partners in a joint assessment is also expected to reduce transaction costs associated with multiple separate assessment and reporting processes.

An IHP+ inter-agency working group has developed a draft joint assessment tool, and associated guidelines. These were reviewed in a number of countries and by international agencies in 2009. The draft tool and guidelines were endorsed by IHP+ partners at a steering group meeting in July 2009. At that meeting, there was broad agreement that the draft tool, while complex, is 'good enough' and that it is important to move without delay to roll-out of joint assessment with a few interested countries. This was considered the best way to improve the tool and develop practical joint assessment processes. Any revisions will happen after the initial roll-out.

In Uganda, the main perceived added value of joint assessment of HSSIP is to create an opportunity for strategic discussion and thus strengthen the plan. Related expectations are that the assessment will increase confidence in the plan; help to get more partners on-plan and on-budget, and reduce at least some of the burden of separate appraisals / proposal preparations. The independent element is desired in order to provide a fresh, systematic perspective on the plan.

Status of HSSIP development

The MOH indicates that with HSSIP it has deliberately decided to follow HSSPII quite closely, but with more attention to organisational issues and efficiency. There is a new National Development Plan to refer to. A medium term expenditure framework, 3 year financial projections and joint budget support framework exist. Two aspects are being worked on: an updated costing of the agreed Minimum Service Standards, and agreement on how implementation of HSSIP will be monitored. A draft went out for consultation with senior management, district authorities and CSOs in February. The HSSIP Technical Working Groups met 15-19 March and reviewed the status of the plan. A Technical Review Meeting in late April decided to reschedule the joint assessment of HSSIP to the last week of June. HSSIP should go to Cabinet in June 2010.

The MOH has created an 'IHP+ taskforce'. This is chaired by Dr Francis Runumi, acting Director Planning, MOH. Christine Tashobya acts as taskforce secretariat. The taskforce is liaising closely with the HSSIP taskforce.
The timing of this joint assessment mission allows for an in depth review on an advanced but not final draft of HSSIP.

Joint assessment mission objectives

- To make a joint assessment of HSSIP using the JANS Tool and accompanying Guidelines as the guiding framework [5]
- To present and discuss the analysis of strengths and weaknesses of HSSIP with senior policy makers and other stakeholders, and possible courses of action on specific issues.

Specifically it will produce an assessment profile of the strengths and weaknesses of five sets of attributes:

1. The situation analysis, coherence of strategic plan with that analysis
2. The process through which the national plans and strategies have been developed; alignment with national development frameworks, multi-sectoral strategies
3. Adequacy of financing projections and strategies; financing and auditing arrangements
4. Implementation and management arrangements, including for procurement
5. Results, monitoring, review mechanisms

It is not the task of the joint assessment team to make any recommendation for funding. However, individual funding agencies will be able to use the assessment to inform their decisions, and in some cases use this instead of carrying out separate missions.

Joint assessment team responsibilities and reporting arrangements

Responsibilities and tasks

- Prior to the mission, to divide up 'desk review' work, and review HSSIP and associated relevant documents, such as evaluations and reviews of HSSPII; reports on financing of the sector; health system health system performance; health and health service needs; disease specific strategies pertaining to diseases of major importance, e.g. HIV/AIDS, malaria, TB as well as other key public health areas such as reproductive and child health; budgets, expenditure frameworks, actual expenditure records and audits; existing assessments of procurement and financial management systems; documents pertaining to decentralisation; notes from multi-stakeholder meetings and forums.
- To agree on a preliminary set of key issues to be discussed in greater depth during the in-country mission
- When in country, to conduct interviews with key informants, including some at district level

[5] http://www.internationalhealthpartnership.net/CMS_files/documents/joint_assessment_guidelines_EN.pdf

- To produce a profile of the strengths and weaknesses of HSSIP
- To discuss findings with stakeholders in Uganda, and subsequent actions
- To agree how to capture lessons learned, on the process and the tool, in collaboration with the IHP+ consultant responsible for documenting lessons across countries

Local logistic support - for document compilation, mission schedule organization and transport etc will be provided by MOH and WHO.

Reporting arrangements

The team leader of the joint assessment team will prepare and present the team's profile of strengths and weaknesses to HPAC, and share with IHP+ core team at the end of the mission. The Team Leader in collaboration with the whole team will prepare a report.

The Health Policy Advisory Committee (HPAC) will be responsible for deciding on follow up actions and communicating these to all interested parties.

Team composition

The assessment team consists of a mix of international and national experts, whose collective skill-mix addresses the main dimensions of the strategic plan, and includes people with substantial knowledge of the Uganda health system.

a) Local members

Members will primarily be drawn from MOH and development partners on the IHP+ and HSSIP taskforces, with other relevant personnel invited if deemed necessary.

b) Independent members and broad areas of expertise

Leo Deville: team leader; HERA

Finn Schleimann: health systems; health system performance assessment; public administration and decentralisation, World Bank

Lola Dare: health policy & systems development, including civil society engagement. independent consultant

Maria Francisco: public health expert, USAID

Rajan Durairaj: health system financing, WHO

Iraj Talai: financial management and procurement; independent consultant

Veronica Walford: M&E; documentation of lessons from JANS; health economist; independent consultant

Individual responsibilities

The prime purpose of this mission is to support national policy makers in strengthening HSSIP. However, joint assessment is of key interest to many IHP+ partners, and it will have high visibility and attention. The

independent element is critical to its credibility. Team members are expected to focus exclusively on this task, and not undertake other work during the mission.

Team leader: Leo Deville

- Overall, to guide and oversee the team's work.
- To work with the IHP+ taskforce to agree the agenda / schedule for the mission.
- To chair any preparatory team conference calls prior to the mission.
- To identify and allocate tasks to team members before and during the mission.
- To produce and present the report.

Other team members

- To carry out tasks as assigned by the team leader, including document review, analysis, interviews and written summaries of findings.
- To share information and work in a collaborative manner.

4.2 List of national counterparts

Uganda JANS June-July 2010
Uganda JANS - Division of Labour for Local Counterparts

No.	Attribute (as in the JANS tool)	Name of Officer	Constituency/Competency		Contact
1	**Situation Analysis & Programming**	Urlika Hertel	HDPs	0772 707 103	ulrika.hertel@foreign.ministry.se
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		Joshua Musinguzi	MoH/Dx Control		jmusinguzi@infocom.co.ug
2	**Process**	Sandra Kiapi	CSO	0752 774 597	maliamaks@gmail.com
		Timothy Musila	MoH/Health Systems, PPPH	0782 567 140	timothymusila@yahoo.co.uk
3	**Finance & Audit**	Luc Geysels? Peter Ogwal?	HDP		
		Rogers Enyaku/Tom Aliti	MoH/Health Financing	0772 602 281(Rogers)	rogersenyaku@yahoo.com
4	**Implementation & Management**	Juliet Bataringaya	HDP	0772 440 381	bataringayaj@ug.afro.who.int;
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		Isaac Kadowa	MoH/Health Systems	0772 468 777	kadisaac@yahoo.com
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		Joshua Musinguzi	MoH/Dx Control		jmusinguzi@infocom.co.ug
5	**Results, Monitoring & Review**	Wilfred Ochan	HDP	0777 912 212	ochan@unfpa.org
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		Rachel Seruyange	MoH/EPI& Health Systems	0772 410 407	seruyanger@yahoo.com

4.3 List of persons met

List of Persons met

Surname	Other names	Position	Agency	Email	
Aliti	Candia Tom	Prin Fin Officer	Ministry of Health	aliti68@yahoo.com	Phone
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Bornemisza	Olga	JANS Consultant	Global Fund - HSS		
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4.4 Programme of the JANS (first phase)

Date	Activity
Monday June 21,2010	Arrival of first members of team
Tuesday June 22, 2010	Travel to and work in Kamuli
Wednesday June 23, 2010	Work in Jinja
	Arrival of rest of team
Thursday June 24, 2010	10.00 am: Preparatory Meeting with Local Team Golf Course Hotel
	2.30 pm: Meeting with PS Office of the PM
Friday June 25, 2010	9.00 am: Briefing meeting with Senior Management Committee (SMC) & Health Policy Action Committee (HPAC) Golf Course Hotel
	2.00 pm: Meeting with Uganda AIDS Commission
Saturday June 26,2010	Team at work - this involves document reading, meeting with stakeholders, discussions within team and report writing;
Sunday June 27, 2010	
	Meeting with CSO representatives 10-12
Monday June 28,2010	9.00 am: Meeting with Top Management Committee (TMC) of MoH
	11.00 am: Meeting with Health Development Partners, Swedish Embassy, Lumumba Av.
	2.00 pm: Meeting with Catholic, Protestant and Muslim Medical Bureax at UCMB Nsambya
	2.30 pm: Meeting with Health Financing/Fin.Mngt MoH Officials
Tuesday June 29, 2010	10.00 am: Meeting with PS/ST at MoFPED
	2.00 pm: Meeting with CSOs at UCMB Nsambya
	2.00 pm: Meeeting with Deputy Secretary to Treasury at MoFPED
	2.00 pm: Meeting with Ministry of Local Government Officials Workers House Level 2
	2.30 pm: Meeting with Health Systems Working Groups
	4.30 pm: Meeting of Mission & Local Counterparts on Attribute 1&5
Wednesday June 30, 2010	8.00 am: Meeting USAID on Fin. Mngt & Channeling resources
	9.00 am: Meeting with Resource Centre MoH
	10.00 am: Meeting with Chairman National Planning Authority
	11.00 am: Meeting with PHPs at Fairway Hotel

	2.00 pm: Meeting with Ministry of Public Service
	2.30 pm: Meeting with Basic Working Group Clusters
Thursday July 1, 2010	8.30 am: Meeting with Finance & Budget MoH
	10.00 am: Team Debriefs Senior Management Committee & Heath Policy Action Committee (HPAC)
	2.30 pm: Meeting with Ministry of Education & Sport
Friday July 2, 2010	9:00am Team debriefs Acting PS, MoH
	10:00am Team debriefs Minister and top management committee
Saturday July 3, 2010	Team Departs

4.5 Annex on financial management

Financial Management System Assessment Report

As per Terms of Reference issued on June 10, 2010, I participated in the Uganda JANS mission which took place from June 24 – July 2, 2010. The Objective of my mission was to carry out an assessment of the financial management system, as part of a JANS exercise and under the direction of the mission leader. The scope of work consisted of an assessment stipulated in the sections pertaining to financial management in the JANS guidelines. It included the review of the country back ground documents (CFAA, PEFA indicators, PFMP, etc.) and the document to define the scope of FM work possible during the mission, and to carry out an assessment of the MOH Financial management capacity and systems as well as the related sections of the HSSIP .

Meetings were held, mainly with the MOH officials and ample material was made available to the mission. However, due to busy end of FY period and new FY budget processing schedule the mission wasn't afforded the opportunity to meet with the officials from the Ministry of Finance, Planning and Economic Development (MOFPED- eg. : Planning, the Accountant General and Treasury, IFMS staff, Internal Audit), Inspectorate General, Auditor General's Office, National Medical Stores management, or other relevant officials. This report is therefore influenced by the lack of interaction with the aforementioned officials and paucity of information related to finance, financial management, and Audit in the HSSIP itself.

The report mainly covers the Country circumstances, and discusses briefly the information available on the Health sector and MOH situation and PFM as practiced in the sector. It elaborates on the systems and capacity of the MOH as regards the overall financial management, budgeting, budget execution, recording and reporting, internal and external controls and audits, and procurement. The report includes suggestions for next steps and for strengthening of the capacity and mitigating measures to contain fiduciary risks.

Executive Summary

Uganda has been a pioneer in Public Financial Management (PFM) reforms in Africa and in implementing measures that are now common PFM features. The legal and institutional framework and PFM policies are well developed and are, with few exceptions, complete and comparable to internationally recognized models. The national regulations taken as a whole are substantially adequate as designed. In practice however, the application of those is problematic, mainly due to disregard by officials and to inaction to curb such disregards. Some recent measures, such as the creation of audit committees or recent actions on high profile corruption cases are in the right direction. Their pursuit and further deployment are appropriate actions and if sustained, they will demonstrate the resolve and commitment of the government.

The Budget process in Uganda is orderly and transparent. There is an elaborate multi-year and annual planning and budgeting system, by sector. The actual budget out-turns have until recently been fairly close to the approved budgets. Furthermore, the information is widely available to public and the recent revision to the budget classification has increased the transparency of the budget.

The Integrated Financial Management System (IFMS) is functioning well and has in-built mechanisms for commitment control. All this lend credibility to the budget, enhance transparency, improves predictability, and provides tools for better control over the budget execution.

However, the budget is not approved by the parliament before the start of each Fiscal year; the in-year adjustments and supplementary budgets are used to rather align budget with execution; quarterly releases to sectors are sometimes delayed; and domestic arrears continue to rise. The latter indicates bypassing of the system. These reduce confidence in the budget itself and in practices. Furthermore, large variances between

budget as approved and as executed have been reported, reflecting in part the impact of late releases on planning and difficulties of the sectors in execution in a short period of time.

In general, there have been frequent unexplained changes in the medium-term Expenditure Framework (MTEF) estimates from year to year and within year. Between the MTEF and budget preparation, sectoral ceilings have changed, forcing the spending entities to plan only one year ahead of time and then execute on a quarterly or shorter timeframe. These indicate a substantial risk that general budget support from DPs, intended to increase the support for the health sector not have a one-to-one incremental impact on overall health sector resources.

The Internal Controls are well designed but, according to audit reports, they are ignored or violated with impunity. The recent strengthening of the internal audit, although a welcome enhancement, is still not enough and more capacity and different scope of audit is necessary. The biggest concerns in fiduciary risk and wastage are the payroll and procurement. No information is available about the actions taken on the last payroll audit findings and procurement is not monitored adequately.

The function of public sector external audit is vested in the Auditor General (AG), supported by his office (OAG). The independence of AG has recently been enhanced; the audit methodology used by the OAG is adequate and reports are of relative good quality. Given the volume of work and time pressure and weaknesses of the auditees, the AG sub-contracts part of its work to private auditors. This is a normal practice, provided that adequate scrutiny for selection of auditors is done, that TORS are clear, and that supervision and quality assurance is in place.

The AG reports are discussed at the Public Accounts Committee (PAC) of the parliament but have not received the needed attention by the plenary sessions of the parliament, at the end of accountability chain. At present the PAC reports for 2001/2002 and latter years still await the parliamentary debate. Another area of concern is the long outstanding and unresolved issues raised by the AG and inaction by the sectors, including the MOH, and MOFPED.

Procurement policies and procedures are also adequate, with some unacceptable exceptions. Procurement is decentralized in Uganda. Some 200 plus procurement entities are charged with this task. The procurement entities have major delays in reporting to the regulator and some totally ignore this obligation without fear of action from the regulator.

In practice, there is widespread belief that the lack of respect for the rules and collusion is entrenched in Uganda. An area of weakness identified by the mission is the lack of clarity on responsibility and inadequacy of contract management.

Corruption remains a concern in Uganda. With a small deterioration in 2009, Uganda score of the Corruption Perception Index of 2.5 placed it at the 130th place together with Nigeria, Mozambique, and Mauritania in Africa. Furthermore, Uganda's relatively positive 2009 CPIA average score of 3.3 for Public Sector Management and Institutions is overshadowed by its score of 2.5 for Transparency, Accountability, and Corruption in the Public Sector; worse than the IDA average score.

With regard to the Health Sector and the sector ministry, the financial accountability and transparency strengths and weaknesses reported and observed are fairly consistent with assessment of the country. In summary, the main financial management and fiduciary problems emanate, not from inadequacy of the formal rules and regulations and the systems design, but more from violations and lack of compliance and lack of subsequent sanctions or remedies (eg. appropriate training) and from shortage of qualified staff.

The HSSIP document, in a succinct manner, refers to the appropriate national finance and Accounting regulations as well as the procurement act. It also refers to the negotiated agreements between the sector and the local government.

The Plan recognizes the capacity and systemic issues and dresses a list of items that needs to be addressed in order to improve the financial management, accountability, and transparency. There are some misconceptions in the plan. For example, it refers to the audit department ability to provide assurances and value for money analysis while that department is part of per-audit and has only four staff members without such capacity or mandate. As to the audit arrangements, it stipulates that the final accounts are annually submitted to the Office of the Auditor General without any elaboration as to how the sector will improve the quality of the financial reports or the timelines of the submissions.

There is no detail discussion on the modalities as how the work is organized within the sector or will be modified to ensure full transparency and accountability at all levels, or on linkages between the strategic plan, MTEF, annual plans and annual budgets. For example the payroll and drugs and medical supplies which form a large part of the expenditures in the sector have been regularly identified as areas of wastage and mismanagement. The plan should at the minimum elaborate on the strategy and ways to curb wastage and mismanagement. Although the HSSIP is for the sector as a whole, there is no discussion on performance and strategy of other important operators such as the agencies responsible for procurement of drugs and supplies, nor is there any suggestion as how to improve on VfM findings.

Clarity and transparency in allocations of resources, availability of funds on time, and compliance with rules have been other identified issues that have hindered the implementation and performance. There is no discussion or plans presented for those, or ways to improve the fairness in vertical and horizontal allocations of resources and fund availability, and for ensuring that plans, regulations, and instructions are complied with.

Some positive actions are underway such as creation of the Audit Committee and more systematic review of audit reports. However, the rest of the items are only listed in HSSIP which need to be planned for further. For example, the acknowledgment that the FM needs more staff and capacity building at all levels, should be complemented with plans, timetable, and cost estimates.

Given the fact that the HSSIP plan has not been costed and did not include substantive sections on finance and audits, and due to the unavailability of MOFPED and other important actors, this report is somewhat limited and a follow-up assessment is recommended. In the meantime and moving forward, the revised plan would benefit from a time-bound action plan with all mission-critical functions covered, implementation targets and persons responsible identified to carry them forward, and estimated cost for such actions. The revised plan should at the minimum include the following:

- Demonstration as how the annual plans and budgets will link to the strategic plan and to the MTEF, costed plan, and explicit assumptions together with scenario/sensitivity analysis;
- Description of arrangements within the sector for planning and execution of financial transactions and procurement, and for internal controls over such transactions, and perhaps setting levels of authority (limits) based on risk;
- Clarification of the Internal Audit function, scope, and arrangements for ensuring that internal controls are effective and the compliance improves at all levels;
- Enhanced external audit with plans that the financial statements are produced and delivered to the AG on time for his audits; that (with agreement from the GA) the OAG is responsible to carry out financial and compliance audits on time, and AG ensures that independent Value for Money and procurement audits are done routinely under his responsibility, based on agreed TORs and based on International standards for audit;
- Measures to improve the sector reporting, particularly from the lowest levels which will substantially improve the image of the sector; and
- Enhancement of the archiving and record keeping for ease of access and for audit trail.

Background

An overall analysis of strengths and weaknesses of Public Financial Management, or sector finance, financial management, and procurement is substantially missing in the HSSIP. Furthermore, some assumptions are stated in general terms and at very high level, and some that are specific (eg. per capita spending), are dispersed in different chapters and are sometimes inconsistent. Unless issues hindering proper budget execution, adequate financial performance, and timely and complete reporting and accountability at all levels are identified and well articulated, development of a strategy and plan for improvement will not be possible or convincing.

The overall PFM in Uganda has been extensively studied and some invaluable reforms are underway. Given the above, and since the Plan has not been costed yet, the assessment of the attribute 3 will be more general and limited at this time. The mission has therefore made a limited assessment based on prior country knowledge, the available literature such as diagnostic work, interviews, and observations during a brief walk through, offers recommendations as how to improve the plan and draw a strategic plan from a health sector FM situation analysis that should be carried out. The following assessment is drawing from the country PFM and how it impacts the Health sector. The report attempts to offer some suggestions for improvement of the plan and the fiduciary and accountability framework for the health sector.

Some relevant information considered for the analysis is:

- Para page ix PFMPR2008 expresses that "The Sector is not compiling and producing the quarterly financial information from the lower levels of service delivery (primary health clinics)". Furthermore the tracking survey dates back to 2005/2006, and the last Value for Money (VfM) report painted a bleak picture at the lower levels. Although the health sector is far more complex than education sector, taking example on the education sector for simplification, some aggregate reports could be produced to help better understand the performance.
- Summary of PEFA indicators relevant to budget expenditure management, indicating strengths and weaknesses or stagnation across the government (no sector or sub-national analysis or scoring available) is as follows:

Strengths:			
Credibility of the Budget		2005	2008
PI-1	Aggregate expenditure out-turn compared to original approved budget	B	B*
Comprehensiveness and Transparency of Budget			
PI-5	Classification of the budget	B	A
PI-6	Comprehensiveness of information included in the budget documentation	B	A
PI-10	Public access to key fiscal information	B	B
Predictability and controls in budget Execution			
PI-20	Effectiveness of Internal controls for non-salary expenditures	D+	C
PI-21	Effectiveness of Internal Audit	D	C+

Accounting, Recording, and Reporting			
PI-22	Timeliness and regularity of accounts reconciliation	C+	B
PI-23	Availability of information on resources received by service delivery units*	B	B**
PI-24	Quality and timeliness of in-year budget reports	D	C+
Weaknesses:			
Credibility of the Budget			
PI-2	Composition of expenditure out-turn compared to original approved budget	C	C
PI-4	Stock and monitoring of expenditure payment arrears	D	D+
Comprehensiveness and Transparency			
PI-7	Extent of unreported government operations	C	D+
PI-8	Transparency of Inter-governmental Fiscal Relation	C	D+
Policy-based Budgeting			
PI-12	Multi-year perspective in fiscal planning, expenditure policy and budgeting	B	C+
Predictability and Control in Budget Execution			
PI-16	Predictability in the availability of funds for commitment of expenditures	C+	C+
PI-18	Effectiveness of Payroll controls	D+	D+
PI-19	Competition, value for money and controls in procurement	C	D+
Accounting, Recording, and Reporting			
PI-25	Quality and timeliness of annual financial statements	B+	C+
External Scrutiny and Audit			
PI-26	Scope Nature and follow-up of External Audit	C+	C+
PI-27	Legislative scrutiny of the Annual Budget law	C+	C+
PI-28	Legislative scrutiny of External Audit reports	D+	D+
Donor Practices			
D-1	Predictability of Direct budget support	C+	D
D-2	Financial Information provided by donors for Budget, reporting on projects, program Aid	D+	C
D-3	Proportion of Aid that is managed by use of national procedures	C	D

Source: PFMPR, June 14, 2009.
*There was a significant deterioration of overall budget credibility.
**The indicator PI-23 for the Health Sector is below the rest of the government (would rate D+ or C).

- Supplementary budgets are used to revise budgets in line with actual expenditures, but widespread under spending of budgets outweighs these. This practice reduces confidence in the budget as

statements of intent by the government. This needs to be checked at the Health sector to learn exactly the relevance and level of variances (rated C at all sectors level).

- The biggest omission in the fiscal reports is the donor-funded project expenditure (about 25% of the total expenditure in 2007/8) which prevents full sectoral analysis.
- Little transparency with regard to the formula for transfers of conditional grants to higher-level local governments. An Underlying set of formula exists but unpredictable vertical allocations make the subsequent horizontal allocations also variable. Inter-sectoral shifts and political interventions add to the unpredictability of receipts by Local Governments (rated D+).
- There are frequent unexplained changes in the MTEF estimates from year to year and within the year. Between MTEF and budget preparations, sectoral ceilings may change, thus weakening the link to the PEAP. In practice, the sector working groups effectively plan only one year ahead. Furthermore, it is difficult to reconcile the MTEF and the PIP.
- Cash-flow forecasts are updated quarterly (good practice) but in-year adjustments are frequent and delays in releases interfere with action/execution plans.
- There are no regular Payroll reconciliations and there are substantial delays in including/excluding incoming /outgoing staff. Audit follow-ups are not transparent; CPIA and TI scores are low and have deteriorated in most recent year; the budget for the health sector has been reduced by more than 10% this year.

Institutional and legal framework

With some exceptions, the Institutional and Legal framework in Uganda are complete and follows the Westminster (Anglo-Saxon) model. The national regulations taken as a whole are therefore substantially adequate as designed. The practice and application of those is however problematic, that due to lack of some accompanying measures. The financial accountability and transparency shortcomings observed in the health sector and in Uganda, in general, emanate not from inadequacy of the formal rules and regulations and the design as much as they are from lack of compliance and from not holding erring officials to account with subsequent sanctions or remedies (such as appropriate training). The Regulations however, fall somewhat short of international good practices in some areas in terms of Internal and External audit, and procurement procedures.

Budgeting and budget execution

The upstream Budget exercise seems adequate and transparent. The transparency has improved with the recent changes to the budget classification and comprehensiveness of information has improved. The new classification is consistent with the GFS recommended by IMF. Also, the availability of information is enhanced and budget is posted on the MOFPED website. The transparency in inter-governmental fiscal relation, on the other hand has deteriorated and so has the extent of unreported government operations.

In general, and as the Public Financial Management Performance (PFMP) of June 2009 reports, there are frequent unexplained changes in the medium-term Expenditure Framework (MTEF) estimates from year to year and within year. Between the MTEF and budget preparation, sectoral ceilings can change, forcing the later entities plan only one year ahead of time and then due to other constraints mentioned above, execute on a quarterly or even shorter timeframe. These indicate a substantial risk that general budget support from DPs, intended to increase the support for the health sector not have a one-to-one incremental impact on health sector resources. In fact, this year's overall budget allocation has reportedly decreased by one hundred billion shilling (from some 700 to 600 billion or 15%).

The budget execution is therefore uneven, depending on sector and in-year changes to the ceilings. Adjustments to the allocations are less transparent and reduce credibility of the budget. Some by-pass the IFMS and create commitments outside the system, contributing to the domestic arrears which is contrary to budgetary discipline, but perhaps a consequence of unpredictability of resources and inability to plan and execute within the system in the short permissible timeframe.

Accounting and reporting

The introduction of the economic and administrative classifications and the new chart of accounts used since 2004/2005, together with the Medium-term budget and expenditure frameworks has brought Uganda up to the international standards as regards the government budgeting and accounts classification for accountability. The more recent addition of the "vote functions" complements the output orientation of the budget and should help the management to monitor the results. It is however reported that the MDAs are formulating the outputs as services without measurable targets. It would be very helpful to the sectoral management to use this feature appropriately for better information and decision making. At the MOH, several people still maintain some 50 vote books manually. These could be computerized at a small cost and used as a good management monitoring tool. Alternatively, and because of the complexities of the health sector, a sector-specific auxiliary accounting could be put in place to replace those vote books and to complement the economic and administrative classifications for more appropriate management information.

The IFMS is in place at central and many districts, including at MOH HQ. The further deployment of the system is the responsibility of the MOFPED. Once the deployment is completed, the timeliness of quarterly and annual reporting would improve and any delay in quarterly budget releases caused by late submission for reports would disappear.

There are two issues related to the accounting and reporting that merit elaboration:

a) The national classification which is mandatory for the national accounts does not lend itself well to sector specific and management needs for analysis and for steering a sector such as the health. The health sector, like many other sectors, needs an auxiliary accounting system with different classifications in order to analyze the revenues/resources and expenditures and to link the inputs to outputs and outcomes; and
b) The reporting from the lower levels (health clinics) is absent which damages the reputation of the sector. It will be extremely important to establish adequate accountability and reporting mechanisms to compile quarterly information regarding the reception and use of resources at all levels.

Governance and accountability run through the system vertically, horizontally, from top down, with the tone at the top and bottom up, with the rights of people and the final accountability demanded by the people.

At the lowest level the social accountability can be enhanced by establishing a reporting mechanism and monitoring by the beneficiaries. In many countries the reports are publicly posted on the bulletin boards at the premises of each provider of public service which gives a regular update of resources received and the usage made. This reporting is complemented by a quarterly reporting of the same information upwards which is compiled at the District and national level for the management.

In recent years, even smallest units in many countries have been using the website to produce and publish financial and other information. Beneficiaries or their representatives have been able to scrutinize such information and, using the text messaging, have been reporting abuse and misuses of resources, thus holding civil servants to account.

Well strategized and executed public information campaign can help inform the people of their rights to the type of services and to educate them as how to demand such services and report anomalies and provide feedback. Taking action on such reports and on the auditors findings is critical and a meaningful way to improving accountability and compliance.

The MOH has reportedly a draft "Patient bill of Right" which, when issued, would be a very positive first step towards enhancing accountability at the grass root.

Internal controls

Establishment of internal controls and their enforcement are the responsibility of the management. When those internal controls break down, the management has the obligation to take remedial action and establish additional mitigating measures against the risk of re-occurrence.

While a good internal audit service exists, the size is too small (only 4 people) and the scope of work does not address the widespread non compliance and by passing of controls. In this regard we suggest that the Internal Audit (IA) function and performance be analyzed and, in light of strengths and weaknesses a revamped IA be established with adequate capacity to function more in line with identified problems. This needs a well articulated and resourced strategy.

Several assessments have rated the financial inherent risk (due to the environment) as substantial or high. The Auditor General's reports also have raised several accountability and transparency issues. Some positive actions, such as creation of the Audit committee, are underway but the rest of items referred to are not planned for. For example, despite the acknowledgment that the FM needs more staff and capacity building at all levels, there is no plan for that and the tables only show additional medical staff and training for them (table##).

Flow of funds and resource/assets management

While each spending entity has a bank account at the central bank, the normal funds flow is through the treasury and quarterly budget releases. This is normally a good practice and in line with the principle of single treasury account. Yet, there have been reports of other bank accounts and overdrafts maintained by some budget entities.

In practice, the quarterly Cash-flow estimates by the sector ministries and quarterly releases by the MOFPED have been uneven. Some of the problems such as commitment outside the system or underperformances could be attributed to the late releases and unpredictability. In general a quarterly release does not allow a longer term planning and execution of plans.

Interestingly, the MOH has informed the mission that not only the quarterly releases have become regular and in full, the budget execution has been at 94% and 96% for the districts and MOH respectively. This needs to be validated, as it doesn't reconcile with the increase in arrears and other indicators observed.

There is a high risk of in-year reprioritization and diversion of resources towards other government priorities. This is reflected in several PEFA indicators and analyses.

External audit arrangements for the sector

The function of public sector external audit is vested in the Auditor General (AG), supported by his office (OAG). The independence of AG and OAG from the executive has recently been enhanced by allowing direct budget discussions with the PAC and direct charge to the Government revenue account without need for negotiations with the MOFPED.

The audit methodology used by the OAG is adequate and consistent with the INTOSAI guidelines. Given the volume of work and weaknesses of the auditees, the AG sub-contracts part of its work to private auditors. This is a normal practice, provided adequate scrutiny for selection of auditors is done, TORS are clear, and supervision and quality assurance is in place.

The AG reports are discussed at the Public Accounts Committee (PAC) of the parliament and then PAC forwards the report together with its own for debate at plenary sessions. An area of concern in relation to external scrutiny is that these reports do not receive the needed attention at the end of accountability chain. At present the PAC reports for 2001/2002 and later years still await the parliamentary debate. Another area of concern is the long outstanding and unresolved issues raised by the AG and inaction by the sectors and MOFPED.

Although the quality of audit is good, the audit reports are issued late, mainly due to the late submission of financial statement to the AG and to difficulties encountered at the audited entities. Some remarks made in past years' audits remain unresolved and unanswered. Unfortunately despite the legal requirements, the parliament has not debated the audit reports and the reports from the PAC, nor is there other means to impose remedies to the auditors' findings and the reports each year repeat the same unresolved issues.

In future, the financial audit should continue to be carried out by the AG and the timeliness of submission of financial reports should improve. The procurement and value-for-money audit should be carried-out by independent auditors under the supervision and responsibility of the GA, until such time that the OAG capacity improves.

Procurement

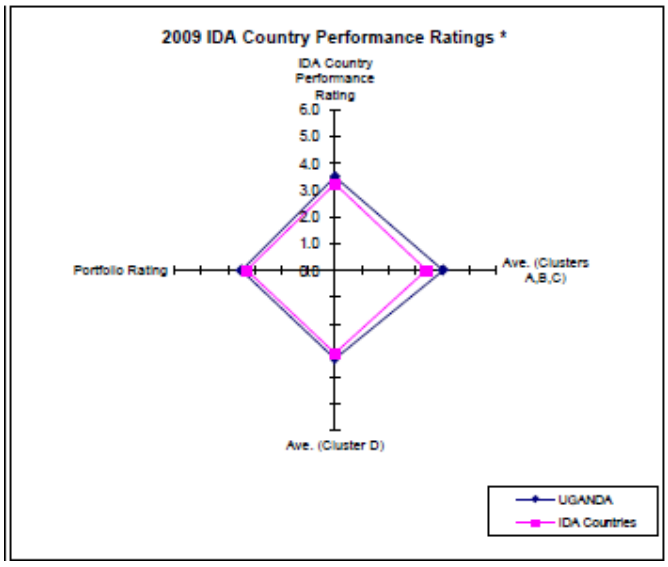
Procurement is decentralized in Uganda. Some 200+ procurement entities are charged with the procurement and disposal of public assets and have the obligation to report to the Regulator. The Public Procurement and Disposal of Assets Authority (PPDA) is the central regulatory body in charge of monitoring and regulating the function. The procurement entities have major delays in reporting to the regulator and some totally ignore this obligation. No action has so far been taken by the regulator.

Procurement policies, regulations and guidelines in effect are fairly comprehensive and, with some exceptions, compare with acceptable procurement practices acceptable by Development Partners. Among exceptions is the use of scoring method for the procurement of goods and the preferential treatment of National bidders in National Competitive Bidding (NCB). These have been identified by the World Bank as deviations from recommended methods (GF rules are silent). The National Medical Stores' procurement guidelines also allow annual prequalification and short listing by rotation which is an unfair practice. Such permissibility heightens the risk of abuse and requires close monitoring and scrutiny.

In practice, there is widespread belief that the lack of respect for the rules and departure from them, collusion among officials and bidders/suppliers, and/or existence of cartels among contractors is systemic and entrenched in Uganda. An area of weakness identified by the mission is the lack of clarity on responsibility and inadequacy of contract management.

Governance and Anti-corruption

Corruption remains a concern in Uganda. For 2009, Uganda scored 2.5 on the Transparency International (IT) Corruption Perception Index, ranking 130th together with several other counties in Africa, including Nigeria, Mozambique, and Mauritania. This is a slight deterioration from the previous year's poor rating. On CPIA score, Uganda's average score of 3.3 for cluster D indicators (public sector management and institutions) is better than that of IDA Countries for 2009. However, it's 2.5 score for Transparency, Accountability, and Corruption in the Public Sector (indicator 16), is lower than 2.9 for IDA average.



Comments on the HSSIP

Even the most conservative financial target of $12/capcit (or 15% of the total government budget) indicates an ambitious plan. No clear methodology is offered for prioritization, should the resources not materialize at the expected level, nor is a thorough analysis of the implementation capacity available. Recent reviews of the Ministry and sub-national bodies point to management weaknesses and shortage of qualified staff and high level of absenteeism. The last VfM audit painted a deplorable picture at public service delivery points. There is no information pointing to any change in work plans or the way staff is deployed, or if they will operate differently to increase productivity.

There is no detail discussion on the details and modalities as to how the work is/will be organized within the sector to ensure full financial transparency and accountability at all levels, clear linkages between the strategic plan, MTEF, annual plans and annual budgets, fairness in vertical and horizontal allocations of resources, and for ensuring that plans, regulations, and instructions are complied with.

Moving forward, the revised plan should include a time-bound action plan with all mission critical areas covered and targets and persons responsible to carry them forward. The revised plan should at the minimum also include details of the following:

- The manner in which the annual plans and budgets link to the strategic plan or to the MTEF;
- The arrangements within the ministry for internal controls;
- Internal Audit and arrangements for ensuring that internal controls are effective and compliance is improved; and
- Records and documents are better archived for ease of access and for audit trail.

There is also lack of clarity as to how the capacity is going to be built or the statutory instruments and guidelines referred to will be produced. In general simple to understand and user friendly small manuals specific to each function are more helpful in understanding and complying with the rules and regulations than large “all-inclusive” documents.

A good situation analysis on finance and audit should include review and understanding of /the reasons for :

- variation analysis between budgets as approved at the beginning of the year and adjustments in-year with the executed budget;
- Total sector analysis of the resources and expenditures -- not only government resources and on budget DPs —e.g. Include the household spending and off budget resources (in table page 26)

There are several ways to do economic and financial analysis:

The Plan needs to include scenarios and sensitivity analysis of assumptions, particularly the ones that are outside the Ministry's control. Also, output /outcome analysis are useful for different level of resources (incremental analysis; one or more methods). Each part of strategy can be analyzed as "least cost" or "Cost-Effectiveness" analysis. Also sometimes "with" and "without" analysis (what deterioration if no additional funding is forthcoming) can help enforce the arguments for resources.

Time-bound action plan

Although a long list of activities (yet not comprehensive enough given the PEFA and other reports) to be undertaken is given and some indicators for monitoring are selected, a well organized time bound action plan with each item being linked to the issue to be addressed, the inputs necessary, the cost of inputs, the responsibilities, and intermediary indicators for progress monitoring will help implementation and to monitor progress. A matrix such as the following can be added:

Subject	Issue	Inputs	Estimated cost per unit	responsibility	Monitoring
1.Financial reporting	1.1 Late/incomplete submission of periodic financial reports	1.1.1 Training of financial staff during the first year 1.1.2 TA for support to produce reports where delays occur 1.1.3 ….	1000 staff* $500=500000 18months* 10,000= 180,000 24months*3,000= 720,000 …..	???	
2. Internal Controls	2.1 Processes are lengthy 2.2	2.1.1 TA to undertake a study of the IC and suggest streamlining	2.1.1.1 1 month* 0 =0 (same TA as above can do this no additional cost)	Team of selected accounting officers under guidance of the audit committee	TA start by 4/2011 Report to the audit committee by 5/2011 Decision by audit committee May 2011 Implementation start July 2011
3. ….					