



German Foundation for
World Population (DSW)

HEALTH SPENDING IN UGANDA

THE IMPACT OF CURRENT AID STRUCTURES AND AID EFFECTIVENESS



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INTRODUCTION AND METHODOLOGY

In recent years, the EU has been committed to reforming its external aid instruments according to aid effectiveness principles established by the Paris Declaration on Aid Effectiveness (2005), as well as the Accra Agenda for Action (2008). In particular, attention has been paid to increasing the “ownership” of developing countries’ Development Assistance¹.

Despite such positive efforts, key social sectors such as health have suffered significant decreases and gaps in EU funding in recent times. Official Development Assistance (ODA) spending in health worldwide decreased by USD 124 million between 2006 and 2007, mainly due to a decrease in European health ODA. Compared to total ODA disbursements, European donors contribute relatively less to health than other international donors. In 2007, the EU-15 and other European donors represented only 50% of health disbursements, while accounting for some 67% of global ODA².

In the light of such trends, there is a perceived need to reassess aid effectiveness principles against sector-specific funding for health. Action for Global Health (AfGH), a network of European health and development organisations, consequently decided to commission DSW Brussels to undertake six combined fact-finding and advocacy visits to developing countries in 2010 in order to assess the impact of current aid structures and aid effectiveness principles on health-spending in those countries.

The overall objective of these fact-finding visits is to bring evidence and experience from developing countries to support European advocacy for global health, by producing country-specific policy briefings and disseminating them to key decision-makers and organisations in Europe and in developing countries.

This country briefing aims to compile the main findings gathered during AfGH’s visit to Uganda in February 2010 and provide recommendations to policy makers and civil society. In the fact-finding visit to Uganda, AfGH was represented by DSW Brussels and TB Alert UK. During the visit, AfGH partners met with key stakeholders in the country, in particular, the Ugandan Ministry of Health (MoH) and the Ministry of Finance, Planning and Economic Development (MoFPED).

AfGH partners also interviewed key donors, Members of Parliament and civil society in the country, in particular:

DONORS INTERVIEWED

The Delegation of the European Union to Uganda (hereafter: EU Delegation), the German Embassy, DFID, WHO, World Bank, and USAID.

MEMBERS OF PARLIAMENT

MP of Chua Constituency, Member of Social Services Committee, Member of Planning and Development Coordination Office, and Member of Ugandan Parliamentary Forum on MDGs.

NGOs

ActionAid International (Uganda), Naguru Teenage Information and Health Center, DENIVA, Reproductive Health Uganda, Community Action For Development, and one other CSO³.

In all of these meetings, the discussions were focused on the status of health aid effectiveness in the country. The results of these interviews have been complemented with previous and subsequent desk work in order to provide a comprehensive perspective on the effectiveness of health aid (or lack thereof) in Uganda, based on the principles of the Paris Declaration and Accra Action Plan on aid effectiveness.

¹ For more information on Aid Effectiveness Principles, see: www.oecd.org/dataoecd/11/41/34428351.pdf

² DSW, EPF, EuroNGO. “Euromapping 2009: Mapping European Development Aid & Population Assistance”. 2009, Brussels, Belgium.

³ This organisation asked not to be named, in order to be able to express their views without jeopardising its relations with donors and the Ugandan Government.

SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

OWNERSHIP

- Through joint budget support groups, donors should advocate for an increase of domestic resources allocated to the health sector in order to meet the Abuja Declaration target of 15% of the annual budget allocated to the improvement of the health sector.
- The Government of Uganda (GoU) and European donors need to revise their NGO mapping systems and make additional efforts to ensure that a greater diversity of CSOs, including CBOs, are invited to participate in key decision-making and monitoring mechanisms, such as the HPAC, Mid- and End-Term reviews of the Country Strategy Paper, budget support and MDG contracting processes, as well as CSO capacity-building programmes in the framework of budget support.

ALIGNMENT

- Due to the GoU tendency towards macro-economic priority-setting, donors should, at least in the medium-term, continue to have mixed funding policies and recognise the role of CSOs in the health sector, particularly with regard to service delivery.
- EU donors need to engage in a dialogue with the IMF and the World Bank, by involving governments in developing countries, in order to promote policy coherence between government, EU and non-EU donor policies – specifically with regard to sector expenditure ceilings which are believed to burden developing countries' social sectors.

HARMONISATION AND DIVISION OF LABOUR

- All stakeholders need to ensure that the International Health Partnership (IHP+) process is brought forward and that CSOs and the parliament are involved at all stages of this process. The process should also be linked to existing budget support and MDG contracting mechanisms.

RESULTS-BASED MANAGEMENT

- If Uganda is to meet health MDG targets, European donors will need to use policy dialogue and joint assessment framework mechanisms in order to advocate for more results-based management of budget support – specifically with regard to MDG 5, where progress has proven to be slow.

MUTUAL ACCOUNTABILITY

- Joint monitoring mechanisms, such as the Joint Assessment Framework (JAF) in Uganda, should be used to remind governments of their obligations towards achieving the health MDGs and the necessity to take these considerations into account during the annual budget planning exercise.
- In this context, emphasis should also be put on health indicators jointly agreed upon for the variable tranche of budget support, as well as for MDG contracting. There is a need to closely monitor whether 21% of total EU commitment allocated to the variable tranche of budget support, together with variable tranches by other Joint Budget Support Framework Development Partners is enough of an incentive for the GoU to push for progress on MDG targets.

OWNERSHIP

OPERATIONAL DEVELOPMENT STRATEGIES

Uganda is a signatory of the Paris Declaration on Aid Effectiveness. The Poverty Eradication Action Plan (PEAP) has been the main framework guiding the overall country development since 1997 to date. As of the year 2000, the largest category of groups who were most affected by chronic poverty were those living in emergency settings and areas of conflict in the Northern and Eastern parts of Uganda⁴.

The New Development Plan 2009/10 - 2013/14 (NDP) focuses on growth, employment and prosperity. The Ugandan MoH is in the process of drafting the second Health Policy (NHP II) (2009-2018) and the third Health Sector Strategic Plan (HSSP III).

AID EFFECTIVENESS AND BUDGET SUPPORT IN UGANDA

In 1998, the Ugandan government (GoU) introduced the Poverty Action Fund (PAF) to ensure that additional debt relief to Heavily Indebted Poor Countries (HIPC) and donor direct budget support were channelled into specific PEAP priority programmes. This helped reorient allocations within sectors towards pro-poor expenditures, and increased funds channelled to local governments. Over time, the PAF has also contributed to the mobilisation of PAF sector-specific donor resources through budget support, which increased from USD 20 million in 1998/99 to over USD 130 million in 2001/02⁵. By providing donors with a level of comfort in terms of allocation, implementation and transparency, the PAF enabled the donors' shift from project to budget and Sector Wide Approach (SWAp) support, considered to be the only way to ensure country ownership in the long term. At present there are five development partners providing general budget support to Uganda, namely Norway, Ireland, United Kingdom, the European Commission and the World Bank. In addition Denmark, Belgium, Sweden, France and Italy provide sector budget support. All general budget support is in principle allocated to the PAF, which, despite its undeniable benefits, has also led Uganda to become heavily dependent on foreign aid inflows. Some⁶ fear that this has reduced the

incentive for increasing domestic revenues to social sectors.

BUDGET SUPPORT AND THE HEALTH SECTOR IN UGANDA

Since 2000, Uganda's Health Sector Strategic plan has benefited from direct donor support through joint SWAp support, accounting on average for 40% of Uganda's health sector resources. In the 2008/09 Financial Year, the total Government funding to the health sector was UGX (Ugandan Shilling) 628.46 billion (ca. EUR 226 million) of which UGX 375.38 (ca. EUR 135 million) was GoU funding and UGX 253.08 (ca. EUR 91 million) donor funding. The GoU funding increased by 35%, whilst donor project funding increased by 44%. Together, this contributed to an overall increase in funding of almost 51% on the previous year. For the 2009/10 Financial Year, the total resource envelope to the sector is UGX 636.9bn (ca. EUR 229 million) out of which UGX 377.9 billion (ca. EUR 136 million) constitutes the GoU contribution (excluding donor project funding)⁷.

However, there has not been any increase in terms of the health sector's proportional share within the annual budget, which stagnated at c. 10%. Approved budget estimates for 2010 indicate that the share of health sector allocations **within the total budget is 10.2%**, which represents a slight decrease compared with the previous year (2008/09: 10.7%), thus also lagging far behind the 15% target of the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, signed by the GoU in 2001.

Moreover, in order to deliver the minimum healthcare package, the health sector needs an estimated USD 40 per capita per annum⁸. In 2008/2009, the total public allocation to health per capita was USD 10.40, which, despite representing an increase in comparison with previous years, is still largely insufficient to meet the population's needs. On-budget health funding depends on allocations made by the MoFPED to the sector. On that basis, the MoH top management subsequently allocates funds to programmes within the sector.

4 An Overview of Chronic Poverty and Development Policy Uganda: http://www.chronicpoverty.org/uploads/publication_files/WP11_Okidi_Mugambe.pdf

5 "Pro-Poor Public Spending Reform – Lessons from Uganda's Virtual Poverty Fund". Sudharshan Canagarajah, World Bank and Tim Williamson - Centre for Aid and Public Expenditure at the Overseas Development Institute, London. http://siteresources.worldbank.org/INTPRS1/Resources/383606-1106667815039/PAF_PREMNote_0705.pdf

6 See previous footnote.

7 All figures have been taken from the MoFPED's national budget framework paper FY 2009/10 – FY 2013/2014. <http://www.finance.go.ug/docs/National%20BFP%20April%203%2017.30.pdf>

8 Source: Health Sector Strategic Plan III - 2010/11-2014/15

TOTAL BUDGETARY ALLOCATION AND PERFORMANCE OF THE SECTOR DURING HSSP II IN BILLION UGX

Fiscal Year	GoU Funding	Donor Project Funding	Total	Contribution of Donor Projects to the Total Sector Budget in the MTEF	Per Capita Expenditure (UGX)	Per Capita Expenditure (USD)	GoU Expenditure on Health as Percentage of Total GoU Expenditure	GoU Budget Performance
2004/05	219.56	254.85	474.41	54%	17,437	10	9.7%	92.8%
2005/06	229.86	268.38	498.24	54%	18,213	9.98	8.9%	95.7%
2006/07	242.63	139.23	381.86	36%	13,518	7.84	9.6%	95.6%
2007/08	277.36	141.12	418.48	34%	13,949	8.2	9.6%	98%
2008/09	375.38	253.08	628.46	40%	20,948	10.4	8.3%	98%

Source: Annual Health Sector Performance Report – Financial Year 2008/2009. November 2009

However, there is off budget funding to the sector not reflected in the Mid Term Expenditure Framework. The Development Partners and the budget sector working group are in the process of harmonising the donor funding to the sector including the off budget. The projected allocation for 2010/11 is UGX 748.5bn (ca. EUR 269.5 million) while that of FY 2011/12 is 853.9bn (ca. EUR 307.4 million) out of which 508.2bn (ca. EUR 182 million) and 610.4bn (ca. EUR 220 million) respectively is GoU contribution excluding donor project funding⁹. So far, most of this off-budget funding is allocated to the three communicable diseases, and does not contribute to health-system strengthening.

In general, the 10 top donors to the health sector in Uganda in recent years have been the following (source: OECD Database 2006-2008):

- 1 USAID
- 2 Global Fund
- 3 IDA
- 4 UK
- 5 Ireland
- 6 Sweden
- 7 AfDF
- 8 GAVI
- 9 Belgium
- 10 UNFPA

From the GoU funding, UGX 23.4 billion (ca. EUR 10 million) per year (on average) between 2008-2009 was earmarked budget support which had been contributed by donors as follows:

BUDGET SUPPORT FROM DONORS OVER THE LAST TWO YEARS OF HSSP II

Country	USD FY 2007/08 in Millions	USD FY 2008/09 in Millions
Belgium	2.80	2.19
Sweden	5.13	1.51
Norway	-	1.67
France	-	1.02
Denmark	3.72	6.92
Italy	0.03	1.45
TOTAL	11.67	14.76

Source: Annual Health Sector Performance Report – Financial Year 2008/2009. November 2009

⁹ Source: MoFPED. National budget framework paper FY 2009/10 – FY 2013/2014. <http://www.finance.go.ug/docs/National%20BFP%20April%203%2017.30.pdf>

DATA MANAGEMENT SYSTEMS

As pointed out by some of the European donors interviewed, improving the Ugandan data management system would also contribute to increasing ownership. Differences in the donor reporting systems used by entities within the GoU – e.g. the MoH, MoFPED, the Office of the Prime Minister and the Uganda Bureau of Statistics (UBOS) – as well as the different departments within the MoH, sometimes cause discrepancies according to the sources of data used and/or different cut-off points in time.

There are also reports about falsified data: For example, the health sector regularly undertakes inventories of health facilities to verify that the number of units and classification of units corresponds with reality. There have been concerns that some facilities and/or districts over report in order to receive more allocation for drug procurement. The European Union Delegation to Uganda (EC) recommends that data and information management are strengthened by using Civil Society Organisation (CSO) reports to verify data.

CIVIL SOCIETY, THE PARLIAMENT AND OWNERSHIP

Despite very positive developments towards civil society participation in Uganda in recent years, both the GoU and European donors in Uganda sometimes still neglect the fact that country ownership is meant to be exercised not only by the government, but also by the parliament and civil society.

CIVIL SOCIETY - PARTICIPATION

In the health sector, a number of important mechanisms have been established in order to ensure CSO participation. The Health Policy Advisory Committee (HPAC), for example, is composed of representatives from the MoH and key donors, meeting on a regular basis in order to provide policy guidance to the sector. CSOs and MPs are invited to each annual health sector review in order to contribute to the discussions on past performance and future targets and undertakings.

With regard to the elaboration process of the National Development Plan (NDP), several consultations with CSOs have already been undertaken within different sectoral committees, including the health sector committee at district and national levels. However, some CSOs claim that the discussion was dominated by a few powerful lobbying agencies. Moreover, no follow-up is usually made on whether and how recommendations given by CSOs are taken into account during the decision-making process.

With regard to the International Health Partnership (IHP+), very few CSOs seem either to have heard of it or are aware of civil society's role and the opportunities within this framework.

Moreover, despite the fact that thousands of CSOs have been registered in the last few years following the Non-Governmental Organisation (NGO)

Registration Amendment Act, ministry officials still tend to invite only a few well-known health CSO networks – mainly those working on communicable diseases such as HIV/AIDS and Malaria – to these consultation or information sessions and processes.

The most prominent CSO networks which regularly participate in these processes are: the Development Network of Indigenous Voluntary Associations (DENIVA – representing c. 700 organisations), the Ugandan National NGO Forum (c. 1,000 members), The Uganda Network of AIDS Service Organisations (UNASO – representing 1,600 organisations with 44 district networks), MARCIS (Malaria), the Public Health Alliance (PHA), and the Coalition for Health Promotion and Social Development in Uganda (HEPS Uganda).

Despite the apparent magnitude and outreach of some of these networks, a meeting with six widely-recognised CSOs and Community Based Organisations (CBOs) working in the sector of sexual and reproductive health revealed that although recognising the need to form or join coalitions and alliances in order to increase their capacities and advocacy abilities, many of these smaller organisations seem to shy away from membership. This may be related to a number of factors, such as, for example, high membership fees, political orientation, as well as the NGOs' own lack of institutional (and financial) capacities to fully engage in such networks.

Bearing in mind that, according to the MoH, these smaller CSOs and CBOs play a crucial role in the Ugandan health sector, often ensuring service delivery to the most vulnerable, there is a need for donors, as well as International NGOs, to increase their support for capacity-building and advocacy programmes targeting specifically smaller health CSOs and CBOs.

CIVIL SOCIETY - FUNDING FOR HEALTH CSOS

With regard to funding opportunities, health CSOs mention UN agencies (UNFPA, UNAIDS, UNICEF, UNIFEM) as well as USAID / PEPFAR and European bilateral aid (DFID, Denmark – DANIDA, Sweden – Sida) as being their main sources of funding. Pooled donor funding for civil society projects is also welcomed by CSOs – a prominent European initiative to be mentioned in that context is the Independent Development Fund, a grants management fund chaired by DANIDA, DFID, Sida, The Netherlands, the NGO Forum, DENIVA and the Human Rights Network Uganda¹⁰ open almost exclusively for proposals from national CSOs and CBOs; international NGOs can only apply as part of a consortium.

With regard to EU Delegation funding through thematic programme Calls for Proposals (for example, “Non-State Actors and Local Authorities in Development”; or “Investing in People”), health CBOs and CSOs consider them to be difficult to access. Key obstacles are said to be the competitiveness, complexity and length of procedures, as well as the digital divide and lack of proposal writing skills many organisations are affected by.

To increase understanding of EU funding mechanisms and rules, the EU Delegation usually organises an information session for CSOs upon publication of a Call for Proposals. According to the EU Delegation, 120 organisations had participated in the last information sessions.

The date of the information session, as well as all calls for proposals and their guidelines are usually published on the EU Delegation website (<http://www.deluga.ec.europa.eu/en/>), as well as at the following EuropeAid link:
<https://webgate.ec.europa.eu/europeaid/online-services/index.cfm?do=publi.welcome&userlanguage=en>

The EU Delegation therefore argues that “NGOs which are not able to properly find a link on the website, register on time for an information session and carefully read the guidelines are also likely to face major challenges with project implementation”. This argumentation shows the apparent advantage that INGOs and bigger National CSOs or Networks have when applying for EU funding, while smaller CSOs and CBOs, which – according to the MoH – “play a crucial role when it comes to health service

delivery to the most vulnerable”, often lack the necessary human and financial capacities to dedicate sufficient time to resource mobilisation. However, that does not necessarily mean that they do not have the capacities and expertise necessary to implement a health-project: Activities as disparate as project implementation and resource mobilisation each require specific skills and abilities. CSOs have a tendency to prioritise project management and implementation over resource mobilisation. Indeed, they rarely employ an expert exclusively responsible for mobilising funds. Donors should be taking these factors into account when evaluating project proposals. It is also a clear advantage to work with a variety of CSOs and CBOs, rather than exclusively focusing on those CSOs with the highest institutional and financial capacities – and running the risk that certain INGOs and National CSOs start taking EU funding for granted and neglect the presentation of quality proposals..

Aside from thematic funding, the EU Delegation to Uganda supports CSOs through multi-annual financing agreements in the framework of joint GoU/EU Programmes, such as the Civil Society Capacity Building Programme (9th EDF – 2005-2008), the Human Rights and Good Governance Programme (9th EDF – began in 2006, ongoing), “Support to Decentralisation” (began in 2006, ongoing) and the “Democratic governance and Accountability” Programme (10th EDF - began in 2009, ongoing). CSOs are selected on the basis of Calls for Proposals organised by the National Authorising Officer (NAO) within the Ministry of Finance, Planning and Economic Development.

¹⁰ www.idf.co.ug

EXAMPLES OF CSO HEALTH PROJECTS FINANCED BY THE EC IN RECENT YEARS

Project / Programme Title / NGO	Main Objectives	Total EU Funding	Timeline Start/End Dates	Contacts
NGO-CO-FINANCING				
Marie Stopes International (ONG-PVD/2006/119-508)	Securing a stronger future for poor and disadvantaged groups at high risk of mortality and morbidity in 18 districts in Uganda	€713,765.62	Start: 19 Dec 2006 End: 4 May 2010	Ms Katie Tong +44 207 034 2372
HEALTH NGO				
AMC (AMSTERDAM UNIVERSITY) (SANTE/2006/105-316)	Infectious diseases network for treatment and research in Africa	€4,889,689.00	Start: 28 Dec 2006 End: 29 Dec 2011	Ms Nadine G Parker +256 077251953
CUAMM (SANTE/2007/127-598)	Improving Access and Quality of Reproductive Health Services for Oyam District	€2,015,215.59	Start: Sep 2007 End: 30 Sep 2010	Mr. Peter Lechoro 0414 267 585 uganda@cuamm.org

Source: EU Delegation Uganda Website

This table seems to confirm that international NGOs, as opposed to national CSOs and CBOs, have comparative advantages with regard to accessing EU funding for health activities in Uganda. This could be related to their institutional and financial capacities and confirms the need for donors to support capacity-building activities specifically targeting National CSOs and CBOs. In general, some of the key challenges mentioned by CSOs/ CBOs in accessing funding for health activities are the following¹¹:

- Health funding is given less priority when compared to livelihoods and education.
- A disproportionate share of donor funding in Uganda is allocated to two communicable diseases (HIV/AIDS and Malaria), with an emphasis on treatment rather than prevention, whereas other health areas such as child health/survival and family planning/sexual and reproductive health rights (SRHR) are neglected.
- Funding for health needs for some of the vulnerable groups is inadequate.
- In the case of basket funding provided, for example, by the Uganda AIDS Commission (UAC) and the Civil Society Basket Fund, CSOs criticise that their disproportionately high administration costs decrease the funding available for programme and project implementation.
- High competition among CSOs for funding and lack of capacities of national CSOs and CBOs compared to international NGOs (INGOs) working in Uganda.
- Untimely disbursement of funds is one of the major challenges that affect the implementation plans for CSOs – especially critical when addressing urgent health issues (e.g. outbreaks).
- Calls for Proposals: Short deadlines and lack of preparation hinders successful submission of proposals.
- In the area of sexual and reproductive health, highly sensitive issues, such as abortion and sexual minorities, are consciously being neglected and under-funded.

¹¹ The views expressed by CSOs/ CBOs during interviews are their own and do not necessarily reflect the opinions held by Action For Global Health.

As a result of the CSO-meeting held in Kampala, CSOs and CBOs established the following recommendations¹²:

- The Government should increase CSO-involvement in policy making and budget allocation, have clear follow up processes and increase budget allocation for the health sector.
- Donors should provide more direct support to CSOs and local governments to implement health programmes.
- Populations at higher risk of chronic poverty and those most affected by health inequalities should be supported to access EC funds, with a strong emphasis on capacity development which is required to effectively implement health programmes in their rural communities.
- Donors should align their funding priorities not only with national, but also with local priorities and needs of the country so as to make funding relevant and more effective.
- Donors and the government need to make information on funding opportunities and budgeting more accessible to CSOs.
- Increased funding for advocacy/capacity-building is needed, but training should build on existing networks, activities and strengths.
- There is a need for national CSOs, CBOs and INGOs to join or form coalitions, to share information and to transfer knowledge rather than to compete for funding, as it is the only way to achieve CSO-ownership.



CSO Workshop on Health Aid Effectiveness Participants, Kampala, 15 Feb. 2010.

Photograph: DSW

¹² The recommendations are listed here as they reflect the views of the participants in the Joint CSO/CBO meeting which took place in Kampala, on 15 February 2010. The aim of the meeting was to establish a common CSO/CBO position on Health Aid Effectiveness, which was then used as an advocacy tool during the meetings with other stakeholders.

PARLIAMENT

According to the annual budget procedure in Uganda, the parliament has “the last word” with regard to the approval of the annual budget. Specifically, the Social Service Committee within the parliament has had a particular influence on the budget in the past – for example, further to a recommendation of the Committee, the budget has once been rejected by the parliament for neglecting to include a budget for sexual and reproductive rights.

However, as initial sector budget ceilings are set by the MoFPED, some members of parliament denounce a lack of transparency in the way allocations are made to different sectors by the MoFPED¹³. They claim that only part of the available budget is released, whereas the resulting supplementary budget is allocated throughout the year at the Ministry’s discretion. Moreover, when the budget is submitted to the parliament, the latter only has one month for scrutiny – which often leaves little time for presenting elaborate amendment proposals.

With the introduction of performance-based budgeting, votes now have to demonstrate what they achieve with the allocated funds in terms of physical outputs. This is a requirement which clearly affects social sectors such as health and education, which should not be judged exclusively on the basis of physical outputs, as a stagnation or reduction of sector allocations on these grounds is

likely to have a direct impact on the lives of the most vulnerable sections of the population. Rather than refusing to undertake further allocations to the health sector which are necessary to meet the population’s needs, the GoU should focus on establishing effective disciplinary systems for the mismanagement and misallocation of resources by government officials in order to help increasing the performance of the sector.

MPs are invited to the half-year budget workshop, where expenditure figures during the last two quarters are reviewed and discussed. Additionally, some committees undertake regular field assessment missions resulting in publicly accessible reports on the situation of the health sector at district level. In that context, MPs therefore play a crucial “watchdog” role, and opportunities should be created for MP’s whose constituencies experience disproportionate impacts of social and economic development policies in order for them to link their activities to those of CSOs. Some donors, such as the EU Delegation, DFID and USAID, have supported programmes to strengthen links between parliamentarians, CSOs and local governments to lay the foundations for good governance. The programme “LINKAGES”, for example, aimed at fostering new vertical and horizontal policy-making links between and among Parliament, selected local governments and civil society is co-financed by USAID and the Kingdom of the Netherlands.



Fact-finding team meets Hon. Okello-Okello, Ugandan Parliament.

Photograph: TB Alert

¹³ The statements Parliamentarians expressed during interviews are their own and do not necessarily reflect the opinions held by Action For Global Health.

ALIGNMENT

Key European donors, such as the EU Delegation to Uganda, are ensuring that their aid flows are aligned with national priorities through joint establishment of multi-annual country strategy papers and through budget support. The EU

Delegation's Country Strategy Paper 2008-2013, for example, focuses on the following, jointly agreed priorities, which match the priority sectors established by the MoFPED in its National Budget Framework Paper 2009/10:

National Indicative Programme	Budget Support EUR in Millions	Project Approach EUR in Millions	Total EUR in Millions	As Percentage of Total
BUDGET SUPPORT FOR ECONOMIC GROWTH AND POVERTY REDUCTION			186	42%
General Budget Support	175			
Institutional Support & Capacity Delopment		11		
FOCAL SECTOR 1: TRANSPORT INFRASTRUCTURE			172	39%
Institutional Support & Capacity Development		10		
Rehabilitation of Northern Corridor Route		122		
Sector Budget Support (Road Fund)	40			
FOCAL SECTOR 2: RURAL DEVELOPMENT			60	14%
Sector Support to Agriculture	15			
Rural Recovery and Forestry		30		
Karamoya Peace and Development		15		
NON FOCAL AREAS			21	5%
Support to Democratic Governance And Civil Society		12		
Technical Cooperation Facility		7		
Support to NAO		2		
GRAND TOTAL	230	209	439	
	52.5%	47.5%		100%

Source: EC Country Strategy Paper Uganda – 2008-2013

Alignment has also been a priority for major EU bilateral donors in Uganda: In 2007, the UK government signed a 10-year GBP 700 million (ca. EUR 1 bn in 2007) Development Partnership Agreement with the GoU and its country strategy paper is aligned with government priorities. A total of 14% of its GBP 71.1 million bilateral aid budget in 2008/9 was allocated to the health sector. It is also interesting to note that DFID is currently participating in the Partnership Policy Task Force, aimed at establishing an aid partnership policy in the framework of the National Development Plan. As both the MoH and civil society claim that donor grants coming into the country are not well documented and captured, DFID is advocating within the partnership policy framework the establishment of a virtual data system where all aid flows will have to be registered. To give another example for alignment of European Aid, the Danish Development Cooperation (DANIDA) allocated c. EUR 56 million in recent years to support the HSSP III process.

Non-European donors, such as USAID or Japan, are being criticised by the government for “undermining public financial systems” in Uganda, through their off-budget and project-based aid programmes, often managed through parallel implementation units. USAID, for example, donates up to USD 283 million to Uganda, with USD 190 million given to the health sector, mainly through off-budget and project-based aid programmes. The US approach is backed by many CSOs, welcoming the flexibility of USAID project funding mechanisms. The organisation will only channel programme funds through Ugandan banks in an agreement of joint oversight with the recipient districts in the North, arguing that this was the only way to ensure that beneficiaries – namely teachers and health workers – were reached, as there is no tracking system for budget support through national accounts. As an observer to the Joint Assessment Framework process (JAF) in Uganda, USAID has yet to be convinced by the efficiency of such mechanisms in ensuring that MDG targets are met, as only four out of eight indicators established by the joint budget support group were met during the past year. Moreover, USAID claims that reproductive health had largely been neglected by European donors due to budget support and poor prioritisation of this issue by the GoU. The government, on the other hand, upholds that USAID programmes undermine public financial management systems – for example, there is no audit mechanism in place to capture aid flows channelled directly to the district level. In the health sector, USAID largely focuses on the two most prevalent communicable diseases in Uganda – particularly on HIV/AIDS, providing for c. 80% of aid to HIV/AIDS in Uganda. Direct support is also

provided to National Medical Stores – another approach making USAID subject to criticism by the government, the latter arguing that funds should be channelled through the MoH.

Similarly, funds channelled through **global health initiatives** (e.g. the Global Fund to Fight AIDS, TB and Malaria) are seen as posing a potential threat to the efficiency of the health sector resource envelope, as they use Country Coordinating Mechanisms (CCMs) to disburse funds and their project-based approaches are not consistent with the systems approach used under the SWAp. Project-based pool-funding is criticised by the government, the parliament and civil society for its focus on three communicable diseases, while official reports show that non-communicable diseases are on the rise in Uganda and that the health sector’s highest need is to strengthen systems and increase health workforce, as well as to prevent medical stockouts.

However, **increased European alignment efforts may not necessarily have a positive impact on certain social sectors** if the government does not consider them to be a priority. In Uganda, further increases in the health sector resource envelope are constrained by a number of factors. These include the pledge by the government to pursue conservative management of the macroeconomy, with a firm cap on the fiscal deficit. Interviews held with different stakeholders during the fact-finding mission confirmed that health is still considered to be a “non-productive” sector, and will remain under-funded in comparison with high-priority sectors, such as energy, rural development, water and road infrastructure. Inefficient use and misallocation of resources by the MoH are also mentioned as being key factors preventing an increase of domestic health-sector resources.

In addition, **increased sector budget support may not necessarily result in increased health spending on the government’s side**: The MoFPED in Uganda claims that, due to macroeconomic constraints such as inflation rates and fiscal deficits, ODA allocated to the health sector in Uganda cannot be used if exceeding the Annual Expenditure ceilings committed by the government. Sector ceilings are set, based on a percentage share proposed by the MoFPED and approved by the cabinet in accordance with agreed national priorities and subject to the constraints set by non-discretionary expenditure. Large public expenditures financed through donor aid inflows are thought to destabilise the economy for a number of reasons – for example by raising demand, inflation and exchange rates, reducing the export competitiveness of the country and crowding out the private sector, thereby stifling private sector-led economic growth, the engine of development¹⁴. Therefore, according

14 Also see WHO/Caritas Report: http://www.who.int/rpc/evipnet/uganda_report%20Budget%20ceiling%20and%20health.pdf

to this policy, public expenditure must be highly restricted, particularly for social services. If the health sector obtained more funds through global initiatives, the health sector domestic budget would be cut proportionally.

Consequently, despite the fact that the former PEAP and the current NDP identify priority areas for poverty reduction and progress towards MDGs, the necessary budgetary allocations to attain these goals can only be made within the established spending limits. In other words, the need for additional resources to overcome the funding gap affecting the health sector in Uganda and to achieve the Abuja Declaration and health Millennium Development Goals (MDG) targets stands almost in direct conflict with the so-called “absorption capacity” of the economy¹⁵.

With regard to European ODA, this means that if donors were to shift their policies exclusively towards budget support, this could have a potentially negative impact on Uganda’s health sector and progress towards health MDGs. MPs, CSOs and even some representatives of the MoH and the MoFPED therefore recommend that donors should continue implementing mixed funding policies, including project-based support, technical assistance and direct support for CSO/CBOs, local governments and districts, specifically within the health sector, in order to ensure that the Ugandan population’s medium-term access to quality healthcare is not threatened by macroeconomic priority-setting.

Moreover, policy dialogue and joint budget support mechanisms should be used to remind the GoU of its commitments towards the health MDGs and Abuja Declaration targets, which should be taken into account at a very early stage of the budget procedure, i.e. when setting annual sector expenditure ceilings.

A NEED FOR POLICY COHERENCE IN DEVELOPMENT

Another conclusion that can be drawn from these findings is that lead European donors in Uganda should not only ensure that their own trade, migration and employment policies are coherent with their own development goals – they also need to engage in a dialogue with non-European institutions, such as the International Monetary Fund (IMF) and the World Bank in order to promote policy coherence between government, EU and non-EU donor policies, specifically with regard to

expenditure ceilings which are believed to be burdening the social sector.

For example, a recent report published by the IMF reveals that the institution is clearly supporting sector expenditure ceilings, by stating that “Establishing rules that put specific limits on spending and borrowing can strengthen fiscal credibility and discipline [...] While they impose some measure of inflexibility, sectoral expenditure ceilings can serve as helpful guidelines for policy-makers, and can prevent overspending on showcase projects”¹⁶.

Similarly, there is a need for greater coherence with regard to EU and non-EU policies both within and beyond development cooperation: The MoH in Uganda, for example, clearly regrets the fact that donor countries are hiring away public servants from the health sector due to both employment needs for their own in-country development programmes, as well as EU internal labour, health workforce recruitment and national immigration policies aimed at attracting skilled health personnel from developing countries and thus causing a major problem of “brain-drain” in those countries.

The Joint Assessment Framework Initiative, which has recently been launched by the GoU and some of the major donors in Uganda, including the World Bank and the EU Delegation, could potentially become a very important tool for this kind of dialogue (for more information, see “Results-based Management”).

UNTIED AID

European aid in Uganda is said to be largely untied – as opposed to non-European donors. A particular problem mentioned by MPs is the procurement, by certain donors, of international medicine supplies which are not needed in Uganda and create storage problems for National Medical Stores.

PREDICTABILITY OF FUNDS

The MoH have major concerns about disbursement of donor funds as some donors disburse only 75% of the total commitment. However, donors equally complain about disbursements versus commitments made by the national entities: According to some European donors, only 11% of fund allocations directly channelled from the Presidential Cabinet to National Medical Stores was actually spent last year.

15 Also see Eurodad report: http://www.eurodad.org/uploadedFiles/Whats_New/News/Eurodad%20Afrodad%20UgandaMDGsPRSPs.doc

16 IMF Working Paper. Budget Institutions and Fiscal Performance in Low-Income Countries. p. 13, March 2010

HARMONISATION AND DIVISION OF LABOUR

European Donors have effectively achieved a refocusing of their national programmes on two focal sectors, in addition to General Budget Support. It is worth mentioning that health was not chosen as a focal sector by the EU Delegation. According to a division of labour matrix established by the international donor community in 2009, the lead agencies with regard to health aid in Uganda from 2009-2011 will be Sweden, the US and Italy. The African Development Bank, the UK, the World Bank and Japan will remain actively engaged in the sector, whereas Denmark and Ireland are soon scheduled to be leaving the sector.

With regard to **shared analysis**, the OECD Survey in 2008 indicated that only 21% of missions are carried out jointly among donors in Uganda, whereas the target for 2010 was 40%. Various stakeholders on the ground confirmed that these figures have not significantly changed over the last two years. There is also a perception, on the government's and the MPs' side, of frequent

duplication of missions, particularly those emanating from Europe. However, not only donors, but also the European NGO community was criticised for duplication of certain activities – there is therefore a need for civil society to assess its own aid effectiveness as a prerequisite for successful advocacy in that field.

Uganda became a signatory of the International Health Partnership (IHP+) in 2009. Moreover, the country has very recently started taking steps towards developing a country compact. A country taskforce has been constituted and first drafts of the Terms of Reference are being discussed. The Draft New National Health Policy II and HSSP III also explicitly make mention of IHP+, which can be seen as a direct result of European donors' efforts (including DFID) to push the process forward. The IHP+ Country Compact is scheduled to be finalised by June 2010.

RESULTS-BASED MANAGEMENT

UGANDA'S PROGRESS TOWARDS HEALTH MDGs AND HEALTH SECTOR PERFORMANCE

In the context of increased budget support as the preferred aid modality of major European donors in Uganda, it is essential to analyse the government's own responsibility in ensuring results-based management of aid – particularly with regard to progress towards the health MDGs. While considerable progress has been made during recent years towards improvement of health outcomes, **MDG 4** and **MDG 5**¹⁷ remain a challenge. Some government officials see MDG targets not only as being imposed by international donors, but also as “unreachable and ill-adapted to local realities”. Lack of knowledge about MDG targets also remains a problem: According to the Ugandan Parliamentary Forum on MDGs, for example, only two years ago some 95% of MPs did not know about these targets. The forum also confirms that there is still a lot of progress to be made on the issue of link-ups between the MDGs.

Various factors explain the lack of progress towards the health MDGs, with the exception of **MDG 6**¹⁸. The Mid-Term Review of both HSSP I (2000/01-2004/05) and HSSP II (2005/06-2009/10) noted

that the health sector is still under-funded, that effective and efficient use of resources needs considerable improvement, and that health system constraints limit progress in coverage of quality health services. MPs claim that the government has not complied with its obligations under the Ugandan Health Policy, which stipulates that every parish in Uganda should have a health centre. The removal of user fees, despite being a policy, is said not yet to be a reality in Uganda. The following table discloses interesting data on the performance of the health sector over the past five years, showing that most of the HSSP II targets for 2008/09 were not attained and some of them even decreased on 2004/2005 levels. Whereas the MoH argues that higher budget allocations made to the health sector would have increased the level of performance, the MoF states that allocations to the sector were specifically reduced due to low sectoral performance. One donor supports this argument, stating that “without tackling the inefficiencies in the sector (health workers absenteeism, leakage of drugs - just to name the two biggest system challenges) any additional funds would be wasted as well and have no real impact at the end of the day”.

PERFORMANCE AGAINST THE 8 PEAP INDICATORS FOR THE HSSP II PERIOD (2005/06 - 2008/09)

Indicator	FY 2004/05	FY 2008/09	HSSP II Target 2008/09
Proportion of approved posts filled by trained health workers	68%	56%	55%
Proportion of health facilities without stockouts of 6 tracer medicines & supplies	35%	26%	35%
OPD utilisation in Govt. & PNFP Units	0.9	0.8	1.0
Percentage of deliveries taking place in health facilities (Govt. & PFNP)	38%	342%	35%
Couple Years of Protection (CYP)	234,259	549,594	380,000
DPT 3 / Pentavalent vaccine coverage	89%	85%	83%
Household latrine coverage	57%	67.4%	65%
National Average HIV Sero-Prevalence at ANC Surveillance sites (Age 15-24 years)	6.1%	6 - 7%	4.4%

Source: Annual Health Sector Performance Report – Financial Year 2008/2009. November 2009.

¹⁷ MDG 4: Reduce by two thirds the mortality rate among children under five. MDG 5: Reduce by three quarters the maternal mortality ratio.

¹⁸ MDG 6: Halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases.

With regard to MDG 5 targets and sexual and reproductive rights, progress is slow and the government itself admits that targets set for 2008/9 have not been attained, as confirmed by the following table:

SEXUAL REPRODUCTIVE HEALTH AND RIGHTS PROGRAMME FY 2008/09

Indicator	FY 2004/05	FY 2008/09	HSSP II Target 2008/09
Caesarean section rate per expected deliveries	4%	2.4	7%
Proportion of pregnant women receiving two doses of IPT	36%	44%	50%
Maternal Mortality ratio (per 100,000 live births)	505	435	354
Proportion of women attending ANC 4 times	42%	39%	50%
Proportion of health units with no stock-outs of Depo-Provera	50%	34%	60%

Source: Annual Health Sector Performance Report – Financial Year 2008/2009. November 2009.

The increase in ODA Uganda benefited from in recent years has not helped in that respect, as much of the external funding for sexual and reproductive health was re-allocated to HIV/AIDS programmes. The following table, indicating how aid is spent by sector, confirms this trend – a major part of aid flows is allocated to Sexually Transmitted Disease (STD) control including HIV/AIDS in Uganda:

AID FLOWS BREAKDOWN BY SUBSECTOR

Subgroup Name	2006 - 2008 USD Million Average
Population policy & admin. management	5.9
Basic health infrastructure	22.2
Medical services, training & research	12.3
Family planning	1.2
Reproductive healthcare	4.7
Infectious disease control	27.0
Basic healthcare	34.1
Health policy & admin. management	49.9
STD control including HIV/AIDS	205.2
Grand Total	362.5

Source: OECD Health Focus Charts – Disbursements average 2006-2008

However, the MoH has shown that it wishes to accelerate progress towards MDG 5 targets, by establishing a road map for maternal health for 2009/2010, foreseeing a total budget of c. EUR 7 million (UGX 20.28 billion).

Nevertheless, if Uganda is to meet health MDG targets, European donors will need to use policy dialogue and joint assessment framework mechanisms in order to advocate for more results-based management of budget support.

As argued above, rather than refusing to undertake further allocations to the health sector which are necessary to meet the population's needs, the GoU should focus on establishing effective disciplinary systems for the mismanagement and misallocation of resources by government officials in order to

help increasing the performance of the sector.

Moreover, direct, project-based aid to civil society will need to be maintained in the medium term, as it is so far the only way to ensure that the most vulnerable are reached in Uganda. According to the Parliament and the MoH, for example, CSOs play a vital role in service delivery within Uganda's largely deficient health sector, but they still depend almost entirely on external assistance. Even though the long-term goal should be to seek alternative (national/ private) sources of funding for these organisations, the health sector, and more importantly the most vulnerable within the Ugandan population, would – at present – be disproportionately affected if direct donor support decreased significantly.

MUTUAL ACCOUNTABILITY

POVERTY ACTION FUND ACCOUNTABILITY

According to the MoFPED, to enhance transparency, all releases of PAF resources are published regularly and are discussed at quarterly PAF meetings, chaired by the government. A large number of donor agencies have been represented. Officers from the relevant line ministries and district-level officials are invited to attend and report on implementation issues. Local and international NGOs are invited to attend in order to exchange information, discuss policy issues, and, where applicable, report on programme implementation and/or accountability issues. The media are also invited to these meetings in order to enhance accountability through sharing information with the public. Consequently, CSOs should be able to claim invitations to such meetings.

UGANDA'S JOINT ASSESSMENT FRAMEWORK (JAF)

Whereas the 2008 OECD survey had highlighted the absence of Joint Assessment Reviews, such a mechanism has now been established in Uganda: In October 2009, the government and a group of 11 development partners endorsed a new framework under which donors will fund activities of the government. The so-called Joint Assessment Framework (JAF) will determine direct budget support over the next three years. It takes effect this financial year 2009/2010. The 11 Joint Budget Support Development Partners include: the World Bank, the African Development Bank, the European Commission, the United Kingdom, Denmark, Sweden, Norway, Germany, Ireland, Belgium and the Netherlands. The World Bank is currently the permanent chair of the Joint Budget Support Framework Task Force while the Netherlands is currently the rotating co-chair.

Together, these donors contribute more than 80% of direct donor funding to Uganda. For the first time, development partners have agreed on one joint assessment framework with the GoU to support the improvement of these services in four critical sectors – education, health, water and roads.

The initiative is believed to improve the impact of Government spending and reduce transaction costs in the delivery of aid, thus making it more effective. The JAF provides a set of well-defined and shared targets and actions by which performance can be measured. The health sector performance indicators include a number of sexual and reproductive health-related indicators linked to MDG targets for 2010 and 2015, such as, for example, the contraceptive prevalence rate, as well as indicators to measure levels and distribution of qualified health workforce and absenteeism rates in the health sector. These have been derived from the GoU's own targets and reform commitments, as expressed in sectoral policy papers and the national budget framework.

Each October/November, the GoU's performance for the previous Ugandan Financial Year will be assessed, drawing on information from key sector review documents and national survey data. An assessment report will be prepared, shared and discussed with the GoU. The balance between met and unmet targets will determine overall performance. Budget support donors will use this assessment to individually determine what level of financial commitment to provide to the GoU in the form of budget support for the following year. These commitments will be announced each February, as part of the budget workshop where allocations for the next fiscal year are being discussed. Joint monitoring mechanisms, such as the JAF in Uganda, should be used to remind governments of their obligations towards achieving the health MDGs and the necessity to take these considerations into account during the annual budget planning exercise.

In this context, civil society networks and the Parliament should be strengthened, through information-sharing and advocacy capacity-building, in order to enable them to advocate for better health systems and increased domestic health resources. However, most health CSOs and CBOs interviewed during the fact-finding visit stated that they had not even heard about the JAF process.

MDG CONTRACTING – MORE ACCOUNTABILITY FOR PROGRESS ON MDGs?

Due to Uganda's good track record, the country became one of eight countries eligible for signing an MDG-Contract with the EU. The financial agreement, signed in May 2009, foresees the provision of EUR 175 million to the national budget over six fiscal years (2008/09 to 2013/14). The main aim of the MDG-Contract (MDG-C) as part of the Joint Budget Support Framework (JBSF) is to improve the efficiency and effectiveness of public spending for better service delivery. Activities planned in this framework include improvement in Public Financial Management systems (PFM) and follow up on grand corruption cases, as well as policy dialogue on reforms in the health and education sectors to address the key constraints in these sectors.

The MDG-C foresees an MDG-based variable tranche (EUR 36 million) which will be based on achieving jointly set targets for health and education. For the health sector these key indicators are:

- Number and proportion of children immunised with DPT3
- Number and proportion of deliveries in health facilities (health centres and hospitals)
- Proportion of health facilities without drug stockouts

The EU Delegation, together with the other Joint Budget Support Framework Development Partners discusses and agrees on targets for these indicators through existing sector dialogue structures, including HPAC and most importantly the annual health sector review. At the annual review Members of Parliament, civil society representatives, academics and private health providers also have an opportunity to participate in the formulation, implementation and assessment of the abovementioned key indicators, which are also important for disbursements under the MDG-Contract. However, as revealed during the fact-finding mission, both civil society and Parliament are still lacking information about this new aid modality, as well as the means available to them for getting involved.

There is a need to closely monitor whether 21% of total EU commitment allocated to the variable tranche of budget support, together with variable tranches by other Joint Budget Support Framework Development Partners is enough of an incentive for the GoU to push for progress on MDG targets.

RECOMMENDATIONS TO STAKEHOLDERS IN THE EU AND IN UGANDA

OWNERSHIP

- Through joint budget support groups, donors should advocate for an increase of domestic resources allocated to the health sector in order to meet the Abuja Declaration target of 15%.
- The GoU should increase involvement of CSOs and the national parliament in policy making, budget allocation and tracking systems, as a key element for true ownership.
- The GoU and European donors need to revise their NGO mapping systems and make additional efforts to ensure that a greater diversity of CSOs, including CBOs, are invited to participate in key decision-making and monitoring mechanisms, such as the HPAC, Mid- and End-Term reviews of the Country Strategy Paper, budget support and MDG contracting processes, as well as CSO capacity-building programmes in the framework of budget support.
- Clear follow up processes of CSO and parliamentary scrutiny need to be established.
- Donors and the government need to make information on funding opportunities and budgeting more accessible to smaller Health CSOs and CBOs, for example by directly inviting them to information sessions.
- Civil Society networks and the Parliament should be strengthened, through advocacy capacity-building, in order to enable them to advocate for better health systems and increased domestic health resources.
- National CSOs, CBOs and INGOs need to join or form coalitions, to share information and to transfer knowledge rather than to compete for funding, as it is the only way to achieve CSO- ownership. The government and donors should support coalition-building.

ALIGNMENT

- Due to the GoU tendency towards macro-economic priority-setting, donors should, at least in the medium-term, continue to have mixed funding policies and recognise the role of CSOs in the health sector, particularly with regard to service delivery.
- EU donors need to engage in a dialogue with the IMF and the World Bank, by involving governments in developing countries, in order to promote policy coherence between government, EU and non-EU donor policies – specifically with regard to sector expenditure ceilings which are believed to burden developing countries' social sectors.
- The predictability of ODA disbursements needs to be increased.

HARMONISATION AND DIVISION OF LABOUR

- Donors, as well as NGOs, need to focus on increasing shared analysis mechanisms and avoid duplication of missions.
- All stakeholders need to ensure that the IHP+ process is brought forward and that CSOs and the parliament are involved at all stages of this process. The process should also be linked to existing budget support and MDG contracting mechanisms.

RESULTS-BASED MANAGEMENT

- If Uganda is to meet health MDG targets, European donors will need to use policy dialogue and joint assessment framework mechanisms in order to advocate for more results-based management of budget support – specifically with regard to MDG 5, where progress has proven to be slow.
- Rather than refusing to undertake further allocations to the health sector which are necessary to meet the population's needs, the GoU should focus on establishing effective disciplinary systems for the mismanagement and misallocation of resources by government officials in order to help increase the performance of the sector.
- Direct, project-based aid to civil society will need to be maintained in the medium term, as it is so far the only way to ensure that the most vulnerable groups affected by health inequality are reached in Uganda – particularly in the health sector, due to CSOs important role in service delivery.

MUTUAL ACCOUNTABILITY

- Joint monitoring mechanisms, such as the JAF in Uganda, should be used to remind governments of their obligations towards achieving the health MDGs and the necessity to take these considerations into account during the annual budget planning exercise.
- In this context, emphasis should also be put on health indicators jointly agreed upon for the variable tranche of budget support, as well as for MDG contracting. There is a need to closely monitor whether 21% of total EU commitment allocated to the variable tranche of budget support, together with variable tranches by other Joint Budget Support Framework Development Partners is enough of an incentive for the GoU to push for progress on MDG targets.
- The EU Delegation to Uganda should ensure that both the Parliament and civil society in Uganda are involved in every stage, including the formulation, implementation and assessment of budget support and MDG contracts, in order for them to be able to make the government accountable for reaching the agreed targets.



Patients waiting in Ugandan Health Clinic.

Photograph: DSW

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LIST OF ACRONYMS

AfGH	Action for Global Health European NGO Network	INGO	International Non-Governmental Organisation
CBO	Community-based Organisation	JAF	Joint Assessment Framework
CSO	Civil Society Organisation	JBSF	Joint Budget Support Framework
DSW	Deutsche Stiftung Weltbevölkerung (German Foundation for World Population)	MDG	Millennium Development Goals
EC/ EU	Delegation of the European Union to Uganda	MoFPED	Ministry of Finance, Planning and Economic Development
Delegation		MoH	Ministry of Health
EDF	European Development Fund	MTEF	Mid-term Expenditure Framework
EU-15	15 EU Member States prior to the accession of 12 new members (2004 and 2007). EU-15: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom	NAO	National Authorising Officer
FY	Financial Year	NDP	National Development Plan
GBS	General Budget Support	NGO	Non-Governmental Organisation
GoU	Government of Uganda	NHP	National Health Policy
HIPC	Heavily Indebted Poor Countries	ODA	Official Development Assistance
HPAC	Health Policy Advisory Committee	PAF	Poverty Action Fund
HSSP	Health Sector Strategic Plan	PEAP	Poverty Eradication Action Plan
IHP+	International Health Partnership	SRHR	Sexual and Reproductive Health Rights
IMF	International Monetary Fund	STD	Sexually Transmitted Diseases
		SWAp	Sector-wide Approach
		UBOS	Ugandan Bureau Of Statistics
		UGX	Ugandan Shilling

Action for Global Health is a network of European health and development organisations advocating for the European Union and its Member States to play a stronger role to improve health in development countries. AfGH takes an integrated approach to health and advocates for the fulfilment of the right to health for all. One billion people around the world do not have access to any kind of health care and we passionately believe that Europe can do more to help change this. Europe is the world leader in terms of overall foreign aid spending, but it lags behind in the proportion that goes to health.

Our member organisations are a mix of development and health organisations, including experts on HIV, TB or sexual and reproductive health and rights, but together our work is organised around a broad approach to health. AfGH works to recognise the interlinkages of global health issues and targets with a focus on three specific needs: getting more money for health, making health care accessible to those that need it most and strengthening health systems to make them better equipped to cope with challenges and respond to peoples' needs.

In the light of the upcoming Fourth High Level Forum on Aid Effectiveness in South Korea in November 2011, Action for Global Health commissioned DSW Brussels to undertake six combined fact-finding and advocacy visits to developing countries in 2010 in order to assess the impact of current aid structures and aid effectiveness principles on health-spending in those countries. The overall objective of these fact-finding visits is to bring evidence and experience from developing countries to support European advocacy for global health, by producing country-specific policy briefings and disseminating them to key decision makers and organisations in Europe and in developing countries.

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