IHP+ 2016 MONITORING ROUND

COUNTRY REPORT

COUNTRY	Uganda
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1 Process of the 2016 IHP+ Monitoring Round

In Uganda, IHP+ Monitoring was facilitated by a country consultant working in collaboration with the IHP+ Focal Person in the Ministry of Health (MOH) and with inputs from the Ministry of Finance (MOFPED). Development Partners (DPs) were invited to participate via the MOH IHP+ Focal Person and the Health DP Group, for which WHO is currently the lead; 11 of the 18 DPs active in the health sector participated in this round of monitoring. A total of 20 CSOs and eight private sector organisations also participated. The 11 DPs were supportive but the response was relatively slow, due to pressure of work and a sense that they are asked to report similar information to different actors, and a considerable amount of time was spent on follow up. CSOs were responsive, in large part due to the fact that the country consultant has good links with this sector. Convening and engaging the private sector was more challenging, mainly because of the lack of a joint platform or structure that brings private sector organisations together. The MOH IHP+ Focal Person was very responsive and supportive; WHO also played an important role in facilitating engagement with other health DPs.

2 Commitment to establish strong health sector strategies which are jointly assessed and strengthen mutual accountability

2.1 EDC Practice 1: Partners support a single national health strategy

Uganda has a National Health Strategic Plan 2015/16-2019/20 which was jointly developed and assessed by the MOH in collaboration with other key ministries, DPs, CSOs and the private sector including but not limited to: Ministries of Local Government, Energy, Water and Environment, Gender, Labour and Social Development, Works, Finance; Belgium, DFID, USG, Italy, JICA, SIDA, KOICA, China, Netherlands; medical bureaus, UNASO; PHPs, Uganda Health Care Federation; communities and politicians. DP support is well aligned with national priorities. However, there is a need for a solid sector plan, improved coordination of DPs, more efficient operationalisation of Technical Working Groups (TWGs), and better sharing of information in order to identify and prioritise funding gaps. The compact is an opportunity to strengthen joint reviews and move to one plan and budget.

2.2 EDC Practice 5: Mutual accountability is strengthened

Uganda has an M&E plan for monitoring implementation of the national strategic plan and DPs use it. There are opportunities for dialogue and joint review as well as a signed compact. Around 45% of DPs that participated in this round use an M&E framework that is based on the national framework; the others have agency or programme specific frameworks or different frameworks that are agreed with MOH. Most DPs use indicators derived from the national

M&E framework; some use additional indicators required by their headquarters or that are activity or programme specific. Constraints relate to weaknesses in the HMIS (availability, quality, completeness and timeliness of data and capacity of M&E staff). Although some DPs are supporting capacity development, there is scope for joint investment to further strengthen the national M&E system. A key issue to be addressed is how best to ensure that DPs with separate M&E frameworks link to the national framework.

Other processes and mechanisms in place for mutual accountability include the Joint Annual Review (JAR), quarterly sector performance reviews, monthly Health Policy Advisory Committee (HPAC) meetings, monthly health DP meetings, and TWGs; the MOFPED, DPs, CSOs and the private sector participate in these mechanisms. Suggestions for strengthening mutual accountability processes include: stronger MOH coordination; strengthening joint action plans; improving the M&E framework; regular monitoring and meetings to ensure partners are held to account to their commitments and to ensure that recommendations and actions to improve mutual accountability are followed up.

3 Commitment to improve the financing, predictability and financial management of the health sector

3.1 Practice 2a/b: Health development cooperation is more predictable

According to the MOH, DPs disbursed 98% of funds allocated against the approved annual budget for the health sector for FY 2014/15. Although the figures do not show over-disbursement, DPs allocated additional funds to address disease outbreaks. DPs' figures indicate that 74% of funds were disbursed against the approved annual budget for the same FY (note that this excludes DFID, Sweden and USAID).

The proportion of DPs using national budget executing, reporting and auditing procedures was 96%, 93% and 92% respectively (again this excludes some DPs). Some DPs reported under-disbursement and one reported significant delays in disbursements; reasons include concerns about lack of transparency in government procurement, corruption, the Anti-homosexuality Bill, absorptive capacity and failure to meet performance targets.

Uganda has an MTEF in place (see www.budget.go.ug). Only 36% of participating DPs report that they shared indicative forward expenditure or implementation plans for the next 3 years with MOH or MOFPED; four DPs provided plans for 1 year and three provided plans for 2 years. Some DPs use the AMP system, the health sector resource mapping database, to communicate planned expenditure. Reasons for not communicating forward expenditure plans include: new grants not yet finalised, bilateral discussion and agreement with MOFPED, plans shared through other mechanisms, e.g. the MOFPED Aid Liaison Office or the GFATM CCM, and support not provided through government. Generally all the information exists but it is not found in one place or communicated through one channel. Opportunities to improve information flow include: better use of existing platforms, e.g. DP meetings, and better communication with the Aid Liaison Office.

3.2 Practice 2c: Health aid is on budget

The MOH reports that the national health sector budget reflects contributions from individual DPs. (Some areas are substantially underfunded: these include ARVs, ACTs, lab reagents and PHC non-wage grants for lower level health facilities.) Of the 11 participating DPs, seven reported that their health sector contribution is included in the national budget (five do not

provide budget support). Information on resources provided is available to government but through a range of channels. However, government and DP perspectives about the proportion of DP funds that are reported on budget differ.

Constraints identified by DPs include: concerns about the PFM system, fiduciary risk, transparency and accountability, and different budget cycles. Opportunities to improve the situation include: use of a common platform for sharing information, greater transparency and increased involvement in the sector budget working group including joint planning.

4 Commitment to establish, use and strengthen country systems

4.1 Practice 3: PFM systems are used and strengthened

Uganda has an ongoing reform programme with a results-based financing framework, a proposed National Health Insurance programme and a revised PPDA ACT as well as a Public Finance Management Act. The biggest obstacle is limited technical capacity to implement. Government respondents noted that some DPs continue to use their own financial systems and procedures and highlighted the need for a harmonised framework that can be used by all.

Only four DPs reported that they use the national PFM system. Of those that do not, reasons include: they do not provide budget support; they have their own systems and procedures, e.g. GFATM; they have concerns about transparency and accountability. Most DPs consider that sufficient support is provided for PFM systems strengthening and several are funding this.

The basket fund for the health sector, adopted by the MOH and MOFPED, represents the best opportunity for improvement; it is expected to increase support to the sector, strengthen the SWAp and improve alignment. As part of the Global Financing Facility, the MOH, with DPs, has also developed a Health Financing Strategy and an Investment Case for maternal, adolescent and child health services, and these will also provide opportunities to align strategies and investments through the national system. In addition, Uganda is preparing for a PFM assessment; this is an important opportunity for identifying gaps in the system that DPs can engage with government around action.

There is a need to take forward plans to strengthen the PFM system, to ensure that there is a common vision of an effective system, so that DPs can use it, to better coordinate PFM-related capacity building and systems strengthening support, and to identify the best way to improve coordination with DPs that cannot use national systems.

4.2 Practice 4: Procurement systems are used and strengthened

Uganda has a national procurement and supply plan for the health sector which allows for global and regional procurement mechanisms to be used; the government has no problem with procurement done through international channels or parallel systems. Government respondents identified the need to harmonise and strengthen national laws, in particular the PPDA Act, and to strengthen procurement systems.

Only three DPs report that they use the national procurement system; reasons for using parallel systems include DP national rules and regulations, efficiency, and transparency. Almost all DPs, 10 of 11, also report that they do not use joint or harmonised procurement systems; most use their own procurement systems or use agencies such as WHO or UNICEF. Five DPs noted that they sometimes prefer global or regional procurement to achieve economies of

scale or for specific items e.g. vehicles and vaccines. Despite concerns about the national procurement system, most DPs consider that support to strengthen national procurement and supply systems is adequate and several of them are funding this.

Options suggested for improving harmonisation of procurement systems include: more effective DP overview and coordination of procurement needs; agreement among DPs to harmonise procurement systems for key products, although some noted that it will be difficult to accommodate different systems; and reform of and significant improvement in national forecasting, procurement and logistics. Given constraints that some DPs face in using national procurement systems, the focus should be on ensuring that there is effective coordination and collaboration on procurement, to avoid duplication and gaps and to ensure maximum efficiency and economies of scale.

4.3 Practice 6: Technical support is coordinated and SSC and TrC supports learning

According to the MOH, there is currently no national health sector TA plan, but one is being developed that addresses increased capacity for the public and private sectors and civil society. Many DPs provide TA, and most TA includes an element of national capacity building. DPs highlighted the lack of a national TA plan to align with, reporting that, consequently, there is some duplication of effort in provision of TA, as well as a lack of transparency and information sharing among DPs and technical agencies about who is doing what. The recently introduced GFATM ITP Platform is a useful tool to track TA provision and to ensure that this aligns with the needs of the country.

DPs suggested that MOH needs to provide strong leadership and a platform for coordination and alignment of TA and that DPs need to more transparent and better at sharing information about TA provision. Development of a TA plan will provide an opportunity to strengthen DP alignment and coordination of TA.

Almost all DPs report that they agree TORs with recipient institutions and that they report on TA to these institutions. However, while government concurs that national institutions are involved in development of TORs, respondents noted that they do not always receive TA reports and that there is a lack of mechanisms to monitor performance of TA. Only half of DPs report that their rules and regulations about TA provision are publically available. Responses regarding involvement of recipient institutions in selection of TA providers vary: some DPs involve recipients, while others do the selection themselves.

MOH benefits from SSC and TrC through the community cooperation strategies of DPs and UN bodies, but highlighted the need for a clear plan to use SSC and TrC for TA and capacity building. Seven of the 11 participating DPs support SSC and/or TrC, mainly through capacity building, regional meetings and TA. DPs suggested that the effectiveness of these approaches could be enhanced through identifying countries with good practices and supporting cross-country learning, and improving coordination and harmonisation.

5 Commitment to create an enabling environment for CSOs and the PS to participate in health sector development cooperation

5.1 Practice 7: Engagement of CSOs

CSOs are represented in the HPAC, the highest policy organ of the MOH, as well as on the national committees and TWGs. CSOs are consulted through TWGs and during joint planning, budgeting and reviews; thematic TWGs constituted on an ad hoc basis always have CSO representation. CSOs receive information from MOH through the HMIS, during TWG meetings and reviews. CSO inclusion could be improved through more involvement at local government level. Most DPs in Uganda engage CSOs during consultation, planning, implementation and evaluation.

Government provides financial resources, training and TA to CSOs. DPs support CSOs to enable them to carry out a watchdog role, advocacy and to participate in technical committees, joint planning, supervision and evaluation. DPs provide resources and TA support to CSOs to build their capacity in governance, management, and financial management and sustainability. All support to CSOs also has to be aligned to existing legal frameworks, so any activities deemed to be outside these frameworks are difficult to promote or support.

The main constraints are CSO coordination and information sharing. CSOs need to be better at generating evidence to demonstrate their contribution and improving their coordination and partnerships. Government is increasingly aware of the benefits of CSOs and this is an opportunity that CSOs need to harness.

5.2 Practice 8: Engagement of the PS

Uganda has a PPPH policy, and a PPPH framework and implementation guidelines are being jointly developed. Government engages the private sector and provides information to the sector through the HPAC, CCM and TWGs. However only about 20% of private sector service delivery data is captured by government, and there is a need to improve private sector reporting including through alignment with the government system.

Most DPs report that they consult private sector organisations, such as the medical bureaus and professional organizations, and the Private Sector Foundation Uganda. Some DPs provide financial and technical support to private sector organisations, e.g. USAID support to private sector health providers through access to finance and World Bank support to professional associations to develop business plans.

A key challenge is that the Public Private Partnership Unit (PPPU) in the MOH is not well established and actions identified are not always well implemented. The weakness of the Unit, together with lack of a recognised structure for private sector representation, is a constraint to effective engagement with the sector. There is scope to strengthen private sector participation through strengthening the MOH PPPU, establishing clear private sector structures that government and DPs can engage with, improving understanding of the interests and incentives of the sector, and increasing its engagement in policy making and technical forums.

6 Other observations

There is a general commitment of all actors to work together but this commitment is affected by genuine weaknesses in the system and sometimes just lack of trust in the system. This can be solved by increased documentation and leadership by MOH and Ministry of finance. The discrepancies are mostly due to poor information sharing. Therefore capacity building at the Ministry of Finance AID Liason office is critical for increased transparency and accountability.

7 Discussion of findings

The draft report was presented to the MoH technical Working Group Meeting during the Month of April 2017 and the following was agreed as the most critical issues to be focused on by the different actors;

EDC 1 (Health sector plan)	Stick to the compact. Operationalize the HSD compact. Improve HMIS Data All DP should Support what is in the Strategic plan (Single National Health Strategy). MOH should take leadership and demand for adherence to this
EDC 2 (Predictability of funding)	To improve predictability strengthen the AID Liaison Office at Min of Finance with staff and equipment to capture and maintain funding Data but details of disbursement be communicated to line Ministry/MOH as well. Have a focal person at MOH in the Planning department. Current staff have other commitments. USG and CDC funding most problematic
EDC 3 (PFM systems)	GOU and MOH address transparency and accountability concerns expressed by donors. Support and Implement gaps identified through the PFM assessment. Special attention to gaps in PPDA and Public Finance management Act, fast track proposed Health Insurance Bill and results based framework. All capacity building be coordinated by AID Liason Office Min. of Finance
EDC 4 (Procurement and supply systems)	Most DPs don't use national procurement system. Sight weaknesses in GOU systems and need for economies of scale. Action; Short term MOH focus on effective coordination to avoid duplication. But Need a unified Procurement plan for Uganda – Gou to take leadership. Rather than weaken the system by not using it – DPs need to use and strengthen national system.
EDC 5 (Mutual accountability)	Stick to the WHO principle of 3 ones; 1 plan, 1 implementation, 1 M&E. All should be guided by the NDP, sector strategic plan. DPs need to be accountable for commitments made.
EDC 6 (Technical support and SSC)	No TA plan for Ug. DDs need to be transparent in selection of TA. Need national plan and learn best practices from other Countries. MOH should take leadership
EDC 7 (CSO engagement)	CSO need more capacity building to generate own data and for sef coordination; Locally founded CSOs need affirmative action in DPs and Moh consultative processes which tend to be dominated by international NGOs with local chapters; Need of pooled resources for CSOs, Address operating legal environment: Public management Act 2013, NGO Act 2016, and Penal code that limit rights of sexual minorities

EDC 8 (Private sector engagement)	Most Private sector not aware of PPPH policy, Feel left out. Need more MoH leadership, implement PPPh policy fairly, increase PPPH awareness

Annex 1: list of DPs that were invited and those that participated

Nr	List of DPs active in the health sector	DPs invited to participate in 5th IHP+ Monitoring Round	DPs that participated
1	Embassy of Sweden	X	X
2	UNFPA	X	X
3	WHO	X	X
4	USAID	X	X
5	UNICEF	X	X
6	Belgian Embassy	SAME AS BTC	
7	JICA	X	X
8	BTC	X	X
9	World Bank	X	X
10	CDC	X	
11	DFID	X	X
12	KOICA	X	
13	French Embassy	X	
14	UNHCR	X	
15	EU	X	
16	Clinton Health Services	X	
17	German Embassy	X	
18	WFP	X	
19	Embassy of Netherlands	X	
20	GAVI 4	X	X
21	GLOBAL FUND	X	X

Annex 2: list of participating CSOs

Nr	List of CSOs active in the health sector	CSO participated in online survey	CSO participated in focus group discussion
1	POMU		X
2	UYP		X
3	HEPS-UGANDA	X	X
4	UGANET		X
5	KADFO+	X	X
6	Medicine Transparency		X
7	UHSPA		X

8	SALT	X	
9	MAFOC	X	
10	ACODEV	X	
11	Uganda Protestant Medical Bureau	X	
12	Uganda Healthcare Federation	X	
13	Uganda Debt Network	X	
14	Community Integrated Development Initiatives	X	
15	Mbale Area federation of communities	X	
16	Naguru Youth Health Network	X	
17	Vjana Na children Foundation Uganda	X	
18	Young Mother Support Group	X	
19	Uganda Young Positives	X	
20	PEER TO Peer Uganda	X	

Annex 3: list of participating private sector organisations

Nr	**List of private sector active in the health sector**	**Private sector organisation participated in focus group discussion**
1	Uganda Health Care Federation	X
2	Uganda National Association of private Hospitals	X
3	Makerere School of Public Health	X
4	Uganda Private Midwives Association	X
5	PlanWise Ug limited	X
6	Social Scientist/Public health/Phiona	X
7	Uganda Medical Association	
8	Uganda dental Association	
9	Uganda Private Medical Practitioners association	
10	Federation of Private Health Professional Association	
11	Uganda Nurses and Midwives Union	
12	Uganda Insurance Association	
13	Uganda national Association o Private Hospitals	
14	Uganda Medical and Dental practitioners Association	
15	Uganda protestant Medical Bureau	
16	Uganda Catholic Medical bureau	
17	Uganda national Association of private	

	Hospitals	
18	Uganda Pharmaceutical Manufacturers' Association	
19	Uganda Pharmaceutical Distributors Association	
20	Pharmaceutical society of Uganda	