FINAL DRAFT

GFATM tracking study

Macroeconomics and sector background paper

UGANDA

Prepared for LSHTM
by Sally Lake

January 2004

CONTENTS

Acronyms……………………………………………………………………………………..…… iv
Acknowledgements……………………………………………………………………..………….. v
Summary of key issues and areas for Phase 2 tracking…………………..…………………… vi

1 INTRODUCTION 1

1.1 BACKGROUND TO THE STUDY 1
1.2 THE COUNTRY MACROECONOMIC AND SECTORAL FINANCING DESK STUDY 1
1.3 STRUCTURE OF THE DOCUMENT 3

2 THE MACROECONOMIC CONTEXT 4

2.1 OVERVIEW AND PAST PERFORMANCE 4
2.1.1 STRUCTURE OF THE ECONOMY 4
2.1.2 RECENT ECONOMIC PERFORMANCE AND PROSPECTS 4
2.1.3 FISCAL PERFORMANCE 6
2.2 POVERTY, PEAP AND THE PRSP 7
2.2.1 POVERTY IN UGANDA: AN OVERVIEW 7
2.2.2 POVERTY REDUCTION POLICIES AND STRATEGIES 8
2.2.3 THE POVERTY ACTION FUND (PAF) 9
2.2.4 THE PRSP, HEALTH AND HIV/AIDS 11
2.3 CURRENT ECONOMIC PROGRAMME 12
2.3.1 SUSTAINING ECONOMIC GROWTH 12
2.3.2 REDUCING THE FISCAL DEFICIT 13
2.4 EXTERNAL FINANCING 14
2.4.1 THE ENTEBBE PARTNERSHIP PRINCIPLES 14
2.4.2 BUDGET SUPPORT FOR POVERTY REDUCTION 15
2.4.3 OFFSETTING PROJECT EXPENDITURE WITHIN MTEF CEILINGS 16
2.5 ADMINISTRATIVE SETUP 16
2.5.1 ADMINISTRATIVE DECENTRALISATION 16
2.5.2 FISCAL DECENTRALISATION 17

3 THE GOVERNMENT PLANNING AND BUDGETING FRAMEWORK 18

3.1 THE FINANCIAL YEAR AND THE PLANNING PROCESS 18
3.1.1 AT CENTRAL LEVEL 18
3.1.2 AT DISTRICT LEVEL 19
3.2 THE MEDIUM TERM EXPENDITURE FRAMEWORK 20
3.3 FINANCIAL MANAGEMENT 20

4 HEALTH SECTOR CONTEXT 20

4.1 ADMINISTRATIVE SETUP 20
4.1.1 CENTRAL MOH 20
4.1.2 DISTRICTS AND HEALTH SUB-DISTRICTS 21
4.2 CURRENT HEALTH POLICIES AND STRATEGIES 22
4.2.1 THE UGANDA HEALTH SECTOR-WIDE APPROACH 22
4.2.2 HEALTH PLANNING AND BUDGETING 23

4.2.3 HEALTH FINANCING AND FINANCIAL MANAGEMENT 24
4.2.4 HSSP AND GFATM TARGET DISEASES 25
4.3 SECTORAL EXPENDITURE OVERVIEW 28
4.3.1 OVERALL HEALTH SPENDING 28
4.3.2 EXTERNAL FUNDING IN THE HEALTH SECTOR 29
4.3.3 PROJECT VERSUS PROGRAMME SUPPORT 30
4.3.4 EXTERNAL FINANCING FOR HIV/AIDS, MALARIA AND TUBERCULOSIS 31

5 GFATM AND SPECIFIC ISSUES FOR THE TRACKING STUDY 32

5.1 MACROECONOMIC ISSUES ARISING 33
5.2 SECTORAL ISSUES ARISING 34
5.2.1 GENERAL 34
5.2.2 HIV/AIDS 34
5.2.3 MALARIA 35
5.2.4 TUBERCULOSIS 36

6 ANNEXES 40

Annex A Terms of reference for the macroeconomic and sector background paper 40
Annex B PRSP MTEF projections for the health sector, 1999/00 – 2002/03 43
Annex C Uganda Medium Term Economic Framework and budget cycle 44
Annex D Overview of Health Sector Strategic Plan 45

List of tables

Table 1 GDP by sector 1998/99 – 2001/02 (at factor cost and constant 1997/98 prices)........4
Table 2 Percentage GDP growth by sector, 1998/99 – 2002/03..5
Table 3 Key macroeconomic indicators, FY 1998/99 – 2001/02..5
Table 4 Selected budgetary operations, FY2001/02 – 2002/03 (USh bn)...............................6
Table 5 PAF release performance, FY2001/02 (USh bn) 11
Table 6 Selected fiscal aggregates 2001/02 – 2005/06 (% GDP)...13
Table 7 Planning and budgeting cycle (health sector illustration) 19
Table 8 Health as % of GOU spending (including budget support).......................................28
Table 9 MTEF allocations to the health sector, 1999/00 – 2003/04 28
Table 10 Crude breakdown of FY2001/02 health sector funding by type 30
Table 11 Health donor project estimates for FY2002/03..31
Table 12 Approved funds for Uganda from GFATM, Rounds 1 and 2 (US$m)......................32
Table 13 Potential share of external procurement within GFATM TB proposal 37

List of figures

Figure 1 Health as % of GOU budget, original PRSP projections..12
Figure 2 MOH organogramme 21
Figure 3 Allocation of GOU health budget 1999/00 – 2003/04...29
Figure 4 Share of MOH project funding in MTEF total for FY2002/03, by source of estimates 31

List of boxes

Box 1 Ugandan PRPS quick guide to planning processes...18
Box 2 HSSP objectives 22

Acronyms

AIDS	acquired immuno-deficiency syndrome
BFP	Budget Framework Paper
CAO	Chief Administrative Officer
CMH	Commission on Macroeconomics and Health
DDHS	District Director of Health Services
DFID	Department for International Development (UK)
DHT	District Health Team
DOTS	directly observed treatment – short course
DP	development partners
FY	financial year (1 July to 30 June)
GDP	gross domestic product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HC	health centre
HDP	Health Development Partners
HIV	human immunodefiency virus
HPAC	Health Policy Advisory Committee
HSD	health sub-district
HSSP	Health Sector Strategic Plan
IFMS	integrated financial management system
IMF	International Monetary Fund
IMR	infant mortality rate
JRM	Joint Review Meeting
LC	local council
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review (of MOH HSSP)
PAF	Poverty Action Fund
PEAP	Poverty Eradication Action Plan
PER	Public Expenditure Review
PHCCG	Primary Health Care Conditional Grant
PNFP	private not-for-profit
PRGF	Poverty Reduction Growth Facility (IMF)
PRSC	Poverty Reduction Support Credit (World Bank)
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
SWAp	sector-wide approach
SWG	Sector Working Group
TB	tuberculosis
UPPAP	Uganda Participatory Poverty Assessment Process
USh	Uganda shillings
WB	World Bank

Acknowledgements

This draft paper was commissioned by a team from the Department of Public Health and Policy at the London School of Hygiene and Tropical Medicine as background to an 18-month tracking study of the Global Fund for AIDS, Tuberculosis and Malaria. The study is jointly funded by the Danish Agency for Development Assistance (DANIDA), the UK Department for International Development (DFID), Development Cooperation Ireland (DCI), and the Netherlands Directorate-General for International Cooperation (DGIS).

Assistance in sourcing documents from within Uganda was gratefully received from Samantha Smith (MOFPED), Rob Yates (MOH), Susan Fraser (DCI Kampala), and Ros Cooper and Angela Spilsbury (DFID Kampala), and through participation in the April 2003 Joint Review Meeting on behalf of Ireland Aid (Kampala).

Caveats

This document is the draft output of a desk-based study, and as such has been limited by the number and type of documents available to the consultant. Key documents which it has not been possible to obtain include the original Poverty Eradication Action Plan which provides the basis for the subsequent PRSP, and also the 2003 Poverty Status Report produced by the Ministry of Finance, Planning and Economic Development (MOFPED). In terms of sectoral documents, no specific policies or strategies for tuberculosis were obtained, so comments on the proposal are based on information from the overall HSSP and its Mid-Term Review report only.

Note: This draft report was essentially finalised in October 2003, and does not therefore take account of subsequent developments either in terms of country GFATM proposals and funding, or in the broader economic context. The health sector Public Expenditure Review has recently been finalised which should shed more light on sector financing, and findings thereof should be taken into account during Phase 2 of the study. Additional information and analysis will of course be included in any future update of this paper.

Summary of key issues and areas for Phase 2 tracking

Uganda's past economic performance has been impressive, with both a relatively high annual average rate of growth and low inflation. This in turn has acted as a trigger for increased aid flows, which have enabled a relatively rapid expansion of public sector activity, including allocations to the health sector. However, there are now signs that this is creating some strain on the economy, both through increased deficit funding of the budget which has led to rising interest payments, and through limited capacity to expand domestic supply in some non-tradable areas (eg construction) which is putting upward pressure on unit costs and therefore inflation.

A relatively strict fiscal stance has therefore been adopted by MOFPED, aimed at reducing the fiscal deficit from its current projected level of 11.3% to 9.5% over the coming 3 years. This necessitates a reduction in the growth of public expenditure in the economy, and therefore reduces the potential for the government budget to finance much needed expansion of the health sector in order for poverty reduction goals to be met.

At the same time, such macroeconomic policies need to be balanced against the acknowledged longer term benefits of additional investment in the social sectors including health, in terms of increased productivity and therefore growth.

Macroeconomic issues for follow-up

Key macroeconomic variables to be tracked over the remainder of the study include:

- **GDP growth – in real and per capita terms**

The growth rates cited in the GFATM proposals as the basis for a positive outlook on sustainability of sectoral resources have not been achieved in FY2002/03. Optimistic growth rates were also used in the Health Financing Strategy as the basis for a steady but slow closing of the gap between available resources and the (underestimated) costs of a health system which now apparently aims to deliver an increasing range of (relatively) high cost interventions as outlined in the GFATM proposals.

- **Domestic revenue performance as a % GDP**

The political concern of the Ugandan government regarding the proportion of the budget funded from abroad is likely to continue. Improved domestic revenue performance, rather than increasing external resource inflows, is being given a key role in determining the pace of public spending increases.

- **General budget support as a % of total revenues within the budget**
    - Budgeted cf actually disbursed
    - Loans cf grants

Linked to the above, the proportion of revenues coming from budget support will be important in the short term, both in terms of enabling the government to pursue its chosen growth path in terms of total public spending and inter-sectoral allocations, and in terms of the flexibility in use of those inter-sectoral allocations. The breakdown of grant and loan funding will indicate future interest and repayment commitments which take precedence over discretionary expenditure within the budget, and the divergence between budgeted and disbursed funds is an indicator of the extent to which the government is justified in maintaining a high level of

foreign reserves through which to even out lumpy flows, and cover for shortfalls in order to maintain planned spending levels.

Sector issues for follow-up

- **Timing and level of GFATM inflows**

Given the importance of predictability in aid management, monitoring of the timing of inflows of GFATM assistance in relation to plans and budgets, together with Uganda's capacity to absorb it effectively, will be important. Project funding is often one of the least predictable sources of government revenue, yet in the context of an MTEF which incorporates such funding into sectoral ceilings, an increased level of accuracy in this area will be critical in order not to reduce the potential for other funding to the sector.

- **Share of GFATM funding in sectoral MTEF**

With the intended incorporation of project funding into sectoral MTEF ceilings, the level of GFATM funding as a proportion of total sectoral funding should be monitored in order to ensure that the resources available to the sector are being used in the most efficient and equitable way to achieve stated objectives rather than being tailored to suit a broader international policy agenda.

- **Additionality**

Incorporation of project funding within sector MTEF ceilings means that ordinarily GFATM funding would not be additional. However a commitment has been made by MOFPED that an exception will be made, at least initially, that GFATM funding will not be offset against other funds to the health sector. This should be tracked to ensure that any earlier proposed growth path for sector funding is attained prior to the addition of GFATM. In addition, policy statements or changes in response to later proposals should be clearly documented in order to be able to track sector funding with and without GFATM funding over the period of the study.

- **Convergence between priority interventions and stated sectoral objectives**

Discussion in past JRMs has touched on the need to focus within the broad package of potential health services identified in the HSSP to identify critical interventions. As above, the extent to which GFATM-funded activities match such critical interventions should be monitored to ensure that the nature of the funding source is not being allowed to dictate spending in the sector in a sub-optimal manner.

- **Share of tradables in the GFATM-funded proposals**

More information is required with regard to the proposed breakdown of GFATM spending between tradables (eg drugs, vehicles) and non-tradables (eg allowances, in-country training costs) which might be expected to have differential impact on exchange rates.

One of the key issues to be monitored will be the sustainability of increased funding for key interventions included in the proposals. While the GFATM funds will undoubtedly contribute to scaling up some highly cost-effective interventions from which the poor can be expected to benefit, funding is limited at present to three years, with no guarantees that the Fund will be able to maintain its own (under-target) resource mobilisation efforts. In the context of the reduced growth in public expenditure for GOU as a whole, the extent to which future domestic and budget support resources can or will be channelled to these activities is

uncertain. However, this is likely to be an issue beyond the time frame of the Tracking Study.

1 Introduction

1.1 Background to the study

This paper forms part of a series of four country background papers undertaken as a desk study in order to support an 18-month Tracking Study which aims to report recipients' (governments and other country stakeholders) perspectives on the operationalisation of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) at the country level; and to make recommendations that will contribute to successful future GFATM implementation. The study is jointly funded by the UK Department for International Development (DFID), the Danish Agency for Development Assistance (DANIDA), Development Cooperation Ireland (DCI), and the Netherlands Directorate-General for International Cooperation (DGIS). The study is being undertaken by the London School of Hygiene and Tropical Medicine.

The objectives of the tracking study are as follows:

1. to synthesise government and other country stakeholders' perspectives on the country proposal preparation process, functioning of Country Coordinating Mechanisms, and implementation processes at the country level;
2. to identify lessons learned and make recommendations on the coordination of the Global Fund and other global health initiatives with existing country-level processes (Sector-Wide Approaches and Poverty Reduction Strategy Papers).

The study is being undertaken through a combination of methods, notably document review, in-country fieldwork, and separately commissioned desk studies on specific areas.

1.2 The country macroeconomic and sectoral financing desk study

The purpose of this background paper is to provide an overview of the macroeconomic and sectoral financing context for the second phase of the more detailed fieldwork, to review the planned inflows through GFATM in relation to aid levels and their potential macroeconomic impact, if any, and to propose areas related to economics and financing which might be tracked during Phase 2 of the main study. Terms of reference are attached at Annex A.

The need for a separate background paper on these issues has arisen in response to growing debate regarding potential trade-offs between the substantial and acknowledged need for an increase in investment in priority sectors such as health if the Millennium Development Goals and others are to be achieved, and the need for sound policies for macroeconomic stability and growth as a basis for long-term development. This debate has been most strongly articulated in Uganda to date, but is of increasing concern more generally among low income countries. In addition, there is some political concern within countries regarding the wisdom of an increasing share of the government budget and GDP coming from external resources, both in terms of predictability of revenue flows but also regarding national sovereignty with respect to the policy-making process.

In late 2002, DFID issued a policy paper summarising the macroeconomic effects of aid[1]. This was based in part on a paper commissioned on aid and monetary policy in Uganda in order to help clarify the position in which Uganda finds itself, ie of needing to trade off the availability and potentially productive use of additional external assistance to the country, with the adverse macroeconomic effects which such an inflow could produce[2]. These

[1] DFID (2002). *The macroeconomic effects of aid*. Policy paper. London: December 2002

[2] Adam C, *Uganda: Exchange rate management, monetary policy, and aid*. Paper prepared for the Bank of Uganda with DFID support. Revised version. Oxford: September 2001

primarily involve an appreciation of the exchange rate, resulting in a fall in the demand for exports and increase in imports. Other things being equal, this results in a contraction of the tradable sector of the economy in which it is generally assumed that there is greater long-term scope for productivity gains, and hence a lower long term average growth rate for the economy as a whole. This phenomenon is generally known as “Dutch disease”, after the macroeconomic effects seen following the discovery of natural gas of the Dutch coast.

There is a question mark, however, over this general assumption, with an alternative view suggesting that long term productivity can be enhanced by increased investment in the social sectors. Two key assumptions are necessary for the long term benefits of such investment to be delivered:

- that the increase in public spending on education and health should result in improved health and education outcomes;
- that these improved health and education outcomes should result in increased productivity.

The evidence from the WHO Commission on Macroeconomics and Health (CMH) supports this position, arguing that use of increased aid inflows to purchase non-tradable goods such as health care and education can and should translate into a healthier and more productive workforce, thereby mitigating, at least in part, the effect of such a contraction of the tradable sector of the economy. For example, the impact of girls’ education on future infant mortality rates (IMR) is well known, and lower IMR translates in turn to higher life expectancy and a longer productive life. Higher contraceptive prevalence rates result in smaller, healthier families. Nutritional interventions enhance learning capacity and thus productive potential in later life. In addition, a substantial proportion of aid flows to the health sector is used to purchase imported inputs (eg pharmaceuticals, vehicles) and is therefore exchange rate neutral. GFATM funded interventions could be expected to contribute to such productivity increases through extending life and reducing morbidity.

Unfortunately, the two impacts have different timeframes, with improved health outcomes being a longer term effect, while real exchange rate appreciation has an immediate effect. It is therefore generally recommended that some aid be focussed on measures aimed at improving private sector competitiveness through addressing supply side constraints. In addition, intervention in the financial markets is likely to be necessary in order to prevent domestic inflation due to sudden and excessive increases in the money supply. Such intervention might involve “sterilisation” of excess money through selling Government stocks, which in turn results in increased debt and higher interest rates, again crowding out the private sector. Success in this area therefore depends on the strength of individual country fiscal and monetary policy.

One key indicator of sound macroeconomic policy relates to the size of the fiscal deficit in relation to national income, or Gross Domestic Product (GDP), ie the gap between public expenditure and revenues. A distinction is sometimes made between the government deficit which excludes external grant funding, and the overall deficit which includes such grants. This document generally refers to the overall deficit. Any such gap between government incomes and expenditure clearly needs to be financed, with options including the printing of money, issuing of domestic debt, or borrowing from abroad.

There is general acceptance that reducing the fiscal deficit of a country is in itself a good thing, not least as it results in an increased proportion of the overall government resource envelope potentially available for priority poverty-reducing expenditures. Debt service, whether domestic or international, generally has first claim on public resources, and can often lead to a substantial reduction in the pool of funds for “discretionary expenditures”. There is generally less consensus regarding the relative, immediate priority to do so in low

income country governments with both a heavy burden of disease and substantial economic loss arising from HIV/AIDS, tuberculosis and malaria among other conditions.

The potentially large and supposedly additional inflows of funding through GFATM to low income countries has resulted in increased interest both in the broad macroeconomic debate outlined above, but also with respect to the relative advantages or disadvantages, and the potential impacts, within the health sector of different aid mechanisms. In a climate of increased moves towards either general or sectoral budget support, often through a health Sector-Wide Approach to the planning and financing of an agreed sectoral plan and more-or-less integrated package of health services at the operational level, GFATM funding threatens to re-introduce parallel systems and a vertical approach, with subsequent reversals in the efficiency of external support. These background papers therefore aim to explore these issues in the four study countries.

1.3 Structure of the document

The paper is structured as follows. Section 2 provides a snapshot of the current macroeconomic situation, describing the structure of the economy, recent economic developments, and the Poverty Eradication Action Plan and subsequent Poverty Reduction Strategy which currently govern overall macroeconomic policy and inter-sectoral allocation decisions. It goes on to outline agreed arrangements for managing external assistance in Uganda, focusing particularly on recent moves towards general budget support.

Section 3 describes the government budgetary framework, covering the planning and budgeting cycle, the Medium Term Economic Framework, and the current financial management arrangements. It should be noted at the outset that government documents define the budget in different ways which are not always clearly explained, with some definitions including donor-funded projects and others excluding them. Clarification is given as far as possible in the text.

Section 4 goes into more detail on health sector organisation, planning and financing, both generally and in relation to GFATM target disease-related activities. This section draws heavily on documentation provided at recent Health Sector six-monthly Joint Review Missions, in the absence of a recent Public Expenditure Report[3]. Overall trends in sector financing are reviewed, and the changing nature of external support is examined. Specific details of financing for activities relating to HIV/AIDS, tuberculosis and malaria are presented where available.

Section 5 pulls out issues specifically related to the GFATM proposals in the country, both in terms of potential levels of funding and the macroeconomic impact, and in terms of sectoral effects and their relationship to existing strategies. Following confusion regarding the original combined submission, three separate proposals (TB, malaria and HIV/AIDS) have currently been approved, with the HIV/AIDS proposal being the first to receive funding. In the context of tightly defined macroeconomic ceilings, debate about additionality of GFATM monies has perhaps been most pronounced in Uganda of the four countries in the study.

Section 6 summarises some key issues, and highlights specific areas for the second phase of the tracking study to follow up.

---

[3] A health sector Public Expenditure Review is being undertaken at the moment, and results may therefore feed into later revision of this document or the details of the areas for tracking in Phase 2 of the overall study.

2 The macroeconomic context

2.1 Overview and past performance

2.1.1 Structure of the economy

Uganda, although still one of the poorest countries in the world, is seen as having been relatively successful in its recent management of the economy. According to the World Bank, per capita Gross National Income was US$280 in 2001 (using the Atlas method), and the country ranked 147th in terms of the United Nations Development Programme (UNDP) Human Development Index (0.489 in 2001)[4].

The economy, as with many other countries in the sub-Saharan African region, is dominated by agriculture, both in terms of domestic production and as an exporter of primary agricultural produce. However, structural transformation over the past decade has seen a fall in the share of agriculture from 51% in 1991/92 to around 40% in the early 2000s. Over the same period, the share of industry has risen from 13 to 19% and of services from 36 to 39% (MOFPED 2002a). Table 1 shows the current and recent structure of the economy. Health is included within the Community Services sector.

Table 1 GDP by sector 1998/99 – 2001/02 (at factor cost and constant 1997/98 prices)[5]

Sector	1998/99		1999/00		2000/01		2001/02	
	Ush m	%	Ush m	%	Ush m	%	Ush m	%
Agriculture	3,068,757	41.7%	3,240,537	41.8%	3,389,548	41.2%	3,551,047	40.8%
o/w cash crops	*345,177*	*4.7%*	*370,100*	*4.8%*	*352,859*	*4.3%*	*364,764*	*4.2%*
food crops	*2,011,213*	*27.4%*	*2,133,907*	*27.5%*	*2,266,449*	*27.6%*	*2,371,729*	*27.3%*
Mining and quarrying	47,424	0.6%	49,697	0.6%	52,629	0.6%	56,714	0.7%
Manufacturing	712,550	9.7%	737,418	9.5%	802,759	9.8%	862,381	9.9%
Electricity and water	105,510	1.4%	114,655	1.5%	125,349	1.5%	133,429	1.5%
Construction	549,794	7.5%	557,956	7.2%	573,822	7.0%	609,623	7.0%
Commerce	906,243	12.3%	928,170	12.0%	986,009	12.0%	1,047,546	12.0%
Transport and communications	320,985	4.4%	344,639	4.4%	372,933	4.5%	410,044	4.7%
Community services	1,640,350	22.3%	1,780,319	23.0%	1,914,553	23.3%	2,031,319	23.3%
Total GDP	**7,351,613**		**7,753,391**		**8,217,602**		**8,702,103**	
Per capita GDP (USh)	348,765		358,721		371,300		384,827	

Source: adapted from MOFPED 2002b, Table 2.1

2.1.2 Recent economic performance and prospects

Recent economic performance in Uganda has been relatively strong. In recent years GDP growth has been sustained at around 6% per annum. Despite being below the required target growth path of 7.0% estimated to meet poverty reduction targets, this remains an indicator of solid performance in the face of poor international prices for coffee (Uganda's largest export), rising oil prices, and in-country problems caused by drought and pestilence. Table 2 shows GDP growth rates for the economy as a whole, by sector, and per head of population.

[4] The HDI is a composite index incorporating per capita GDP in purchasing power parity US dollars, life expectancy at birth, adult literacy rates, and educational enrolment rates.

[5] NB the original MOFPED table has an error in the summation of figures for 2001/02 which I have been unable to clarify. The table is not updated in the equivalent MOFPED publication for FY2003/04.

Table 2 Percentage GDP growth by sector, 1998/99 – 2002/03

Sector	1998/99	1999/00	2000/01	2001/02	2002/03
Agriculture	6.6%	5.2%	4.2%	5.8%	3.9%
o/w cash crops	*9.3%*	*7.0%*	*-4.9%*	*6.7%*	9.0%
food crops	*7.5%*	*5.9%*	*7.7%*	*6.2%*	2.2%
Mining and quarrying	14.5%	6.3%	10.1%	11.0%	11.5%
Manufacturing	14.2%	3.7%	8.8%	6.3%	6.6%
Electricity and water	5.3%	7.9%	8.3%	5.4%	3.9%
Construction	10.9%	7.3%	1.8%	7.8%	9.7%
Wholesale and retail trade	10.5%	1.8%	6.4%	7.6%	6.3%
Hotels & restaurants	7.3%	5.3%	6.1%	4.9%	7.3%
Transport and communications	6.9%	8.7%	9.7%	10.0%	9.7%
Community services	4.4%	8.5%	5.7%	5.8%	5.2%
Total GDP growth	**7.3%**	**5.9%**	**5.7%**	**6.0%**	**4.9%**
Per capita GDP growth	3.8%	2.4%	2.2%	2.5%	1.4%

Source: MOFPED 2003 (BTTB), Table 1.1
Note: Figures for FY2002/03 are projections at June 2003.

Growth in FY 2001/02 was spread fairly evenly across the agricultural, industry and service sectors, with particularly good performance in the construction and cash crop sub-sectors (MOFPED 2003c)[6]. The lower than projected growth in FY2002/03 is due to reduced food production due to climatic conditions, with growth in agricultural output estimated at 3.9% in FY2002/03 compared with 5.8% in FY2001/02. Nevertheless, Uganda's relatively high levels of growth have enabled positive per capita GDP growth, as shown in Table 2 above, although the publication of the recent census, with a higher than projected population growth (3.4% rather than 2.7% per annum between 1991 and 2002), has resulted in these figures being lower than previously estimated.

Macroeconomic stability has been largely achieved and maintained in Uganda, with inflation remaining below 5% for most of the late 1990s, as shown in Table 3 below. Foreign exchange reserves in the last couple of years have been slightly less than the target figure of 5 months of imports. This is attributed largely to the need to meet shortfalls in revenues due to delayed disbursements of budget support, itself due to constraints on the government side in meeting conditions in time. Projections for the end of the FY2002/03 indicate that reserves should reach 5.8 months of imports, ie on target.

Table 3 Key macroeconomic indicators, FY 1998/99 – 2001/02

Indicator	1998/99	1999/00	2000/01	2001/02*
Annual inflation (%)	0.2	5.8	4.5	5.0
Current account balance, excl grants (% GDP)	-14.8	-15.5	-16.6	-18.3
Overall deficit excluding grants (% GDP)	-6.0	-10.1	-11.0	-12.3
Reserves (months of imports)	4.9	5.0	4.4	4.7
Domestic revenue (% GDP)	12.4	12.0	11.7	13.0
Public expenditure (% GDP)	18.4	22.1	22.7	25.3

Source: MOFPED 2002a **(Sum BTTB/PRSP)**, Table 2.1, p16
Note: * Figures for 2001/02 are projections

No official figures for annual average exchange rates were found for the period in Table 3, and an estimated figure of US$ 1: USh 1,800 has been used in calculations throughout this document unless otherwise specified. However, the rate is reported to have depreciated by 10.3% between April 2002 and April 2003, from USh1,792 to USh 1,977 (MOFPED 2003b, p11).

[6] Hon. Minister of Finance. *Budget Speech*. 12 June 2003

2.1.3 Fiscal performance

Domestic revenues (including non-Uganda Revenue Authority (URA) revenues and repayments of loans by parastatals) are projected to reach USh 1,418bn for FY2002/03. Of these, URA revenues are expected to increase by 14.9% over the previous year, thereby achieving the target set for the year. However, non-tax revenues from line ministries and parastatal dividends have again under-performed, resulting in a projected overall domestic revenue shortfall of USh 14.3bn.

External revenues accrue from a number of sources of which budget support has become the most significant. Budget support in the Uganda context comprises grants and debt relief under the Highly Indebted Poor Countries initiative, and includes both general and sector-specific support[7]. According to the most recent MOFPED publication on the budget, budget support inflows totalled USh 398bn in FY2001/02, and are projected to reach USh492bn for FY2002/03 (MOFPED 2003x BTTB, Table 2.1, p28). A substantial increase was recorded in FY2001/02 over the previous year, largely due to the receipt of the first tranche of the World Bank Poverty Reduction Support Credit (PRSC). In FY2001/02, however, the total figure fell below budget estimates by USh 217bn, or 34%[8]. Unlike the shortfall in domestic revenues, however, this reduced inflow was offset by government borrowing and a reduction in Bank of Uganda reserves as it was largely due to a temporary delay in disbursement by donors. Notably, only one of two planned tranches of the PRSC was received within the financial year, and US$44m of EU money was withheld due to delays both on the GOU and EU sides. Such volatility and unpredictability of significant revenue sources clearly justify the GOU position on the need to maintain healthy foreign reserves. In FY2002/03, projected grants are expected to exceed approved budget due to currency depreciation against the original currencies, as shown in Table 4 below.

Table 4 Selected budgetary operations, FY2001/02 – 2002/03 (USh bn)

	2001/02 actual outturn	2002/03 approved budget	2002/03 projected outturn
Revenue and grants	**1,998.3**	**2,293.8**	**2,335.3**
Domestic revenue	1,253.8	1,432.6	1,418.3
Grants	744.6	861.2	917.0
of which: Budget support	*397.8*	*481.9*	*492.1*
Project support	*246.8*	*379.3*	*424.9*
Expenditure and lending	**2,583.1**	**2,735.9**	**2,741.0**
Current expenditure	1,429.9	1,537.5	1,592.9
Development expenditure	1,033.2	1,119.8	1,106.9
Net lending	4.9	-21.3	-14.1
Domestic arrears	115.2	50.0	55.3
Overall balance			
Excluding grants	-1,329.4	-1,303.3	-1,322.7
Including grants	-584.8	-442.1	-405.7
Grants as % revenues	*37.3%*	*37.5%*	*39.3%*
Budget support as % grants	*53.4%*	*56.0%*	*53.7%*
Grants as % expenditure	*28.8%*	*31.5%*	*33.5%*

Source: MOFPED 2003 BTTB, Table 2.1, p28

Note: There appears to be an error in the approved expenditure for FY2002/03.

Expenditure performance varied during FY2001/02 between sectors, and according to whether programmes were protected by the Poverty Action Fund (PAF) or otherwise[9]. The

[7] There is some lack of clarity in the labelling of loan funding as budget support according to different MOFPED documents.

[8] NB this percentage is in relation to the larger figure of budget support loans plus grants, which totalled USh739bn (MOFPED 2002x BPR, px).

[9] See Section 2.2.3 below for a description of the PAF, and more details of performance in FY2001/02.

annual Budget Performance Report (BPR) restricts itself to the budget excluding both externally-financed projects in the development budget and arrears[10]. The figures below are taken from that document, and are therefore somewhat lower than those reflected in Table 4 above. The BPR indicates that releases in FY2001/02 totalled USh 1,895 bn (excluding arrears payments), representing 98.8% performance relative to the budgeted level of such expenditure.

Overall wage performance was 100.7% of budget, with the slight over-expenditure in the total masking over-expenditure of 7.1% on the PAF wage bill, compensated for by under-expenditure on the non-PAF, non-statutory wage expenditures largely due to failure to fill approved positions central government votes (for example, in the MOH, approved positions within some referral hospitals, or in the ministry itself).

Non-wage recurrent expenditures also exceeded estimates, by 4.4%. Eighty percent of this over-expenditure was due to statutory votes, notably the Electoral and Parliamentary Commissions, with other institutions overspending including the Ministries of Defence and Internal Affairs, and State House. Over-expenditure in these areas contributed to a shortfall of up to 20% in releases to other central ministries. PAF non-wage recurrent release performance was 93.5%, due to under-release to some districts.

(Domestic) development expenditures absorbed the bulk of over-spend on wage and non-wage recurrent categories, with non-PAF development releases performing at roughly 70% of budget.

Total releases under PAF totalled USh 603bn, equivalent to 97% of budget estimates, although within this total there was a reduction in development expenditures to fund an over-expenditure on PAF wages.

By the end of FY2001/02, the expansionary fiscal policy had resulted in the fiscal deficit reaching 12.3% of GDP, as shown in Table 3 above. For FY2002/03, the deficit is projected to fall slightly to 11.3% of GDP, although this still represents a substantial increase since 1997/98 when the figure was 6.7%, and is discussed further in Section 2.3.2 below.

2.2 Poverty, PEAP and the PRSP

2.2.1 Poverty in Uganda: an overview

Poverty in Uganda is considered both in terms of low and variable level of income and consumption, but also in terms of physical insecurity, poor health, low educational levels, disempowerment, a heavy burden of work or unemployment, and social and/or geographical isolation.

Income levels continue to be low, with a large proportion of the population unable to meet the daily necessities of life. The relationship between low incomes and poor health and limited education are well known. The 2000 round of the Uganda National Household Survey estimated that about 7.7 million Ugandans, (ie 35% of the population) were unable to meet their basic needs. Although still high, this compares favourably with the figure of 44% reported in the 2000 PRSP. The PEAP target is to reduce the headcount of income poverty to 10% by 2017.

[10] There also appear to be slight discrepancies between the figures reported in the Budget Performance Report for FY2001/02 and the Background to the Budget paper for FY2003/04, notably for non-interest statutory payments.

Although the absolute level of poverty appears to be reducing, its distribution geographically is worsening, with an increasing number of poor in the North of the country, which is afflicted by conflict. An estimated 66% of the population in the North is considered poor. Cash crop farmers benefited most from the decrease in poverty, due to an increased share of the world coffee prices received by farmers, and this was reflected in a halving of poverty levels in the main coffee growing region, Central Uganda.

Other factors associated with poverty at the level of the household include rural residence, land shortage, low educational levels, limited access to markets, and being headed by a female widow or elderly person. Poverty also reflects features of the society more broadly, such as insecurity, the quality of public services, macroeconomic stability, health information, and the availability of productive employment.

Ill health was the most frequently cited cause of poverty in both the 1999 and 2002 rounds of the Uganda Participatory Poverty Assessment Process (UPPAP), although the proportion of communities identifying it as such fell from 67% to 50%. HIV/AIDS was mentioned as a separate cause in the 2002 round by 27% of communities, giving the disease a ranking of 8th most frequently cited cause, equal with the separate cause of death of a family member[11]. In addition, health services were targeted for one of the key messages in the second UPPAP report: *"Health services need more funding for drugs and staff and health facilities need better monitoring. Preventative health care deserves more attention."* (MOFPED 2002d, p ix).

2.2.2 Poverty reduction policies and strategies

Uganda was arguably the forerunner for the current series of Poverty Reduction Strategy Papers being developed throughout the continent, with an indigenous document, the Poverty Eradication Action Plan, produced in 1997. A revision and summary of this document, presented together with the Medium Term Expenditure Framework, was accepted by the World Bank as Uganda's first PRSP in 2000[12].

Strategic action for poverty eradication, as outlined in both the PEAP and PRSP, is based on four defined pillars:

- Creating a framework for economic growth and transformation;
- Good governance and security;
- Actions which directly increase the ability of the poor to raise their incomes; and
- Actions which directly improve the quality of life of the poor.

Combined, these aim to reduce absolute income poverty, to raise the educational achievement of Ugandans, to improve the health of the people, and to give voice to poor communities. Key elements under each pillar are summarised below.

Macroeconomic growth and transformation

Modelling has shown that Uganda is capable of GDP growth of 7% per annum over the longer term, but this requires specific action to create the necessary climate, particularly for private sector expansion. Four specific areas are indicated for action:

- The maintenance of macroeconomic stability and discipline;
- the setting of appropriate incentives in relation to economic openness, competition, and agricultural modernisation;
- the equitable and efficient collection and use of public resources, both through review of the progressiveness of different tax options, and by ensuring use of savings from debt

[11] MOFPED (2002d). *Deepening the understanding of poverty.* Second Participatory Poverty Assessment Report. Uganda Participatory Poverty Assessment Process. Kampala: December 2002

[12] MOFPED, *Uganda's Poverty Eradication Action Plan: Summary and main objectives*. Kampala: March 2000

relief and external aid for poverty-reducing activity, use of equalisation grants to level the playing field around the country; and
- the removal of constraints on private sector competitiveness, through development of infrastructure, commercial justice reform and strengthening of the financial sector.

Good governance and security
The second pillar of the PEAP/PRSP focuses on the need to ensure security and stability, through conflict resolution, particularly in the north and east of the country. In addition, the ongoing decentralisation process aims to strengthen democratisation, particularly at the village level. Improved public expenditure management is highlighted as a means of enhancing efficiency and transparency, with expected positive results for service delivery. A sector-wide approach to law and order includes costed reforms to the criminal justice sector. Improved mechanisms for disaster management and public information also fall under this pillar.

Raising the incomes of the poor
Given the importance of agriculture both in the economy as a whole, and as a source of livelihood for the majority of Ugandans, the Plan for the Modernisation of Agriculture is a key component of the third PEAP/PRSP pillar.

Improving the quality of life of the poor
The introduction of free primary education has been the single most important strategy under the fourth pillar of the PEAP/PRSP, with a substantial shift in budgetary resources to this end achieving dramatic increases in enrolment. Challenges remain in terms of ensuring adequate infrastructure, teaching materials and staff to maintain high levels of enrolment and improved educational outcomes. Efforts to improve health status focus on the delivery of a minimum package of services, while public interventions with some community contributions are tackling water and sanitation problems. Adult literacy and housing are also touched on.

2.2.3 The Poverty Action Fund (PAF)

The Poverty Action Fund was created by the Government of Uganda in 1998 as a mechanism for channelling savings accruing through debt relief under the HIPC initiative to five Programme Priority Areas identified in the PEAP. These are primary education, primary health care, water and sanitation, rural roads, and agricultural extension. These government funds are combined with donor contributions to the PAF, and together provide earmarked budgetary support to key social sectors. By early 2002, PAF budget lines accounted for 33% of the government budget, and were expected to increase further to 36% in FY2002/03 (MOFPED 2002b, p4).

Since its creation both the volume of funding to the social sectors, and the proportion flowing to local government, has substantially increased. In FY 2001/02, 72% of total PAF funding was budgeted for transfer to local government, with the actual releases reaching 74%. Strong accountability requirements for PAF funds have led to these being largely channelled to the districts through a number of sectoral Conditional Grants (CG).

PAF funding is fully integrated into the government budget, and subject to all existing processes of monitoring and audit. A committee, chaired by the Permanent Secretary/Secretary to the Treasury and attended by representatives from beneficiary line ministries, DPs, NGOs, civil society, districts and the media, meets quarterly to review cumulative progress with disbursement, expenditure, activities, and selected indicators specifically related to PAF funding. Five percent (5%) of PAF funding is retained at central level for accounting and audit, and a similar amount used for that purpose at district level.

PAF is widely acknowledged as having made a positive contribution towards poverty reduction in the country[13], by facilitating implementation of the Uganda PEAP/PRSP through a number of features:

- budget allocations have been reoriented towards pro-poor expenditure, through an increasing proportion of the budget being channelled as conditional grants to specific activities or sub-sectors, through the PAF;
- Improving the budget management function, by protecting PAF expenditures in the face of resource shortfalls, linking releases to accountability, increasing the transparency of resource allocation decisions, and providing funding for monitoring of PAF expenditures;
- Facilitating additional resource mobilisation, through increasing the confidence of development partners that budget support would be channelled to priority pro-poor sectors and activities; and
- Increasing funding for local governments, as the bulk of the conditional grants are transferred to districts and municipalities (Ndung'u and Williamson 2002).

The 2002 review of PAF was undertaken with a view to addressing the increasing concern that its continued existence was distorting overall public expenditure management through a partial interpretation of the PEAP, ie focusing on service delivery rather than the development of a sustainable environment in which continued allocations could be guaranteed, contrary to written guidelines[14]. In other words, PAF was felt to largely neglect pillars 1 and 2 of the PEAP as, for example, updated criteria for a programme to receive PAF funding included its identification within the PEAP, and a direct effect on poverty reduction through either increasing the ability of the poor to raise their incomes (Pillar 3) or improving quality of life of the poor (Pillar 4).

In addition, PAF has been criticised for having generated parallel structures and processes for budget preparation, implementation and review. Although these have resulted in greater budget discipline for part of the budget, in the context of revenue shortfalls and over-expenditure in areas such as Public Administration, pressure has increased on other potentially productive and poverty-reducing sectors and activities.

In line with the proposed reform of PAF, the level of protection has been slightly reduced in FY2002/03, from an effective rate of 95-100% to 90%. However, most PAF budget lines appear to have received an allocation in FY2001/02 of over 90%, with only the wage and development budgets at the central level failing to reach the 90% mark, as shown in Table 5 below.

[13] although it is explicitly recognised within a recent assessment that the impact of PAF alone cannot be easily separated from that of other parallel reforms such as introduction of the MTEF, development of SWAps, decentralisation etc (Ndung'u M and Williamson T (2002). *Financing poverty reduction in Uganda: A study reviewing the Poverty Action Fund*. Draft report. Kampala: April 2002 (p5).

[14] MOFPED (2002a). *Fighting poverty in Uganda: Poverty Action Fund - draft operational modalities.* Kampala: January 2002

Table 5 PAF release performance, FY2001/02 (USh bn)

	Approved budget	Budget releases	Performance
Wage	**197.0**	**210.9**	**107.1%**
Centre	1.3	0.9	66.9%
Local Govt	194.1	208.5	107.4%
Statutory	1.6	1.6	99.8%
Non-wage recurrent	**157.7**	**147.4**	**93.5%**
Centre	30.6	29.3	95.7%
Local Govt	122.1	113.2	92.7%
Statutory	5.0	4.9	98.9%
Development	**269.9**	**245.2**	**90.8%**
Centre	133.6	119.0	89.0%
Local Govt	136.3	126.2	92.6%
TOTAL	**624.6**	**603.5**	**96.6%**
Centre	165.6	149.2	90.1%
Local Govt	452.5	447.9	99.0%
Statutory	6.6	6.5	99.1%

Source: MOFPED 2002d, Table 4.4, p23
Note: Apparent errors in addition are reproduced from original source

2.2.4 The PRSP, Health and HIV/AIDS

As would be expected, both health and HIV/AIDS feature in the PEAP and PRSP, as improving the heath of the Ugandan people is one of the overall goals of poverty reduction in the country[15].

Generally, the low life expectancy of 42 years is due in large part to the AIDS epidemic, although recent progress has been made in reducing the incidence and consequently prevalence of HIV in the country, particularly in urban areas. The 2000 PEAP Executive Summary highlights HIV/AIDS as a cross-cutting issue, with the following objectives: to *"[i]ncorporate the response to AIDS into planning in all sectors; Uganda AIDS Commission plays a coordinating role here, and has developed the National Strategic Framework which is designed to integrate AIDS response into all sectors of public action. A proposal has been made for district-level funding specifically for AIDS-related activities."* (PEAP 2000, www.finance.go.ug)

Much emphasis has been given to the linkage between incomes and mortality, with the PRSP highlighting a strengthening of the relationship in recent years.

Health services are covered under the fourth pillar, improving actions to improve the quality of life of the poor. Very few details are given in the 2000 PRSP of specific policies to be followed, with reference made instead to the Health Sector Strategic Plan: *"Health care is being coordinated by the new health strategic plan. At the heart of this is the minimum health package. Service delivery is being improved by a number of mechanisms including better remuneration and training, better infrastructure, and better accountability to consumers through village health committees. The pro-poor implementation of cost-recovery will require the successful identification of targeting mechanisms, perhaps geographically based. AIDS and population growth raise cross-cutting issues."* (PRSP, p17)

Specific PEAP/PRSP monitoring indicators, selected from those defined for the sector as a whole, include immunisation rates for DPT3, per capita outpatient attendances at health facilities, and the proportion of health facilities staffed according to norms. In addition, HIV/AIDS prevalence is also monitored. The IDA/IMF Joint Staff Assessment of the 2000

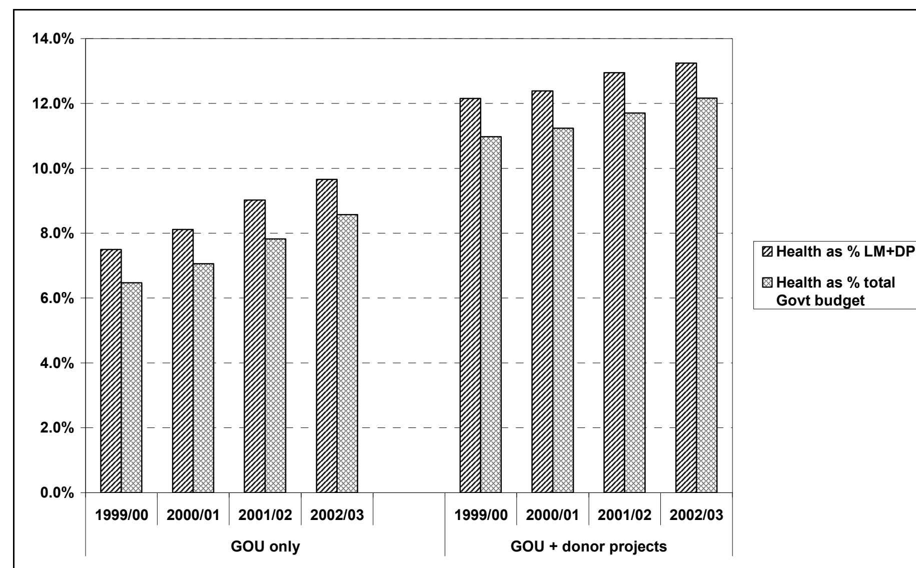
[15] Note: The emphasis varies according to different documents, and there are several versions. It has not been possible to access the original 1997 PEAP, and the Executive Summary of the 2000 revision on the web differs slightly from the PRSP version of 2000 which is a summary of the PEAP.

PRSP document refer to the following overall targets for health and HIV/AIDS for FY2004/05[16]:

- Reduction of infant mortality to 103 per 1000
- Reduction of HIV prevalence by 35%
- Reduction of stunting to 28%;
- And reduction in total fertility rates to 5.4 births per woman.

In terms of allocations, the MTEF estimates for 1999/2000 – 2002/03 which form part of the 2000 PRSP indicate a rising share of the government budget for health being allocated to health, as shown in Figure 1 below. A detailed breakdown by budget line is given in Annex B.

Figure 1 Health as % of GOU budget, original PRSP projections



Source: MOFPED 2000 (PRSP Annex Table 3)
Notes: LM = line ministries; DP = district programmes; GOU figures include budget support

Projected expenditure on HIV/AIDS is not as easily identified. Some is included within the health sector budget, through transfers to bodies such as the Uganda AIDS Commission, while other planned spending is incorporated in other sectors due to the multi-faceted approach to the epidemic.

2.3 Current economic programme

2.3.1 Sustaining economic growth

Economic growth for FY2002/03 has most recently been projected at 4.9% but the medium term objective is to return to a growth path of 7.0% per annum, the estimated level required to achieve the objective of reducing poverty to less than 10% by the year 2017. GOU has a long-term strategy to promote *"rapid and broad-based economic growth, led by a dynamic private sector"* which is dependent on medium term reduction in the fiscal deficit (see below).

[16] NB these are either not given (IMR) or not consistent (AIDS) with targets in the actual document, but may be taken from the PEAP.

Fiscal policy for the coming financial year is expected to concentrate on increasing domestic tax revenues, particularly from import taxes which are subject to widespread evasion at present. Further efforts will be made to improve the predictability of external resource inflows through budget support.

On the expenditure side, efforts will be made to reduce the persistent overspend in Public Administration, which is recognised as not contributing directly to poverty eradication goals. To assist the government in this area, the IMF Poverty Reduction and Growth Facility programme for FY2002/03 include a specific quantitative ceiling on over-expenditure by Public Administration, of USh20bn, compared with an actual figure of USh40bn in FY2001/02.

In addition, the new Public Finance and Accountability Bill is intended to reduce the incidence of supplementaries which distort expenditure programmes and reflect poor budgetary discipline. Parliamentary approval will henceforward be required prior to release of supplementary resources.

2.3.2 Reducing the fiscal deficit

Uganda places great emphasis within its macroeconomic policy on reducing the fiscal deficit, or public sector borrowing requirement, ie the difference between government expenditures and the revenues from domestic taxes and non-tax sources. The fiscal deficit as a percentage of GDP grew from 6.7% in 1997/98 to 12.3% in 2001/02, although it is expected to fall slightly for FY2002/03 (see Section 2.1.3). The position taken by the Ministry of Finance, Planning and Economic Development is that this is neither acceptable, nor a prudent strategy for the country to follow, and that the deficit should therefore be scaled back over the medium term. Very limited or zero growth in government expenditures is therefore planned for coming years, as shown in Table 6 below. Unlike the recent growth rate of 19% per annum, this is felt to be is consistent with the chosen deficit reduction strategy which aims to cut the fiscal deficit to 9.5% of GDP by 2005/06.

Table 6 Selected fiscal aggregates 2001/02 – 2005/06 (% GDP)

	2001/02	2002/03	2003/04	2004/05	2005/06
domestic revenues	12.3%	12.1%	12.7%	12.9%	13.0%
total expenditure	25.3%	23.7%	24.3%	23.1%	22.6%
GOU expenditure	19.7%	18.0%	18.1%	17.4%	17.0%
external projects	5.9%	5.6%	6.2%	5.8%	5.5%
Overall deficit before grants	-13.0%	-11.3%	-11.3%	-10.2%	-9.5%

This strategy is more restrictive than was envisaged even a year ago, when a 7% increase in expenditure was proposed[17], and is partly due to increased evidence regarding the inflationary consequences of public spending on (largely aid-financed) construction in recent years. Supply side constraints have resulted in unit costs being almost 70% higher than in 199798, pushing up costs for the private sector by around 7.2% per year (MOFPED 2003x BTTB, p39), demonstrating the potential effect of increasing demand for non-tradables in the economy as a result of external financing.

[17] Kassami C (2002). *Issues concerning the macroeconomic framework and the MTEF FY2003/04 - 2005/06.* Paper presented to the Budget Consultative Workshop, 28-29 October 2002. Kampala

As this strategy will clearly have consequences for spending ministries, two main reasons for this position were put forward by GOU at the October 2002 Budget Consultative Workshop in Kampala.

Firstly, increasing pressure on monetary management due to creation of excess liquidity in the domestic economy through aid-funded government expenditures. It is argued that the resulting increase in sales of Treasury Bills, and subsequently in interest rates, is crowding out lending to the private sector with longer term implications for growth. Interest costs (primarily domestic) have also risen substantially, with an analysis of the indicative MTEF ceilings given at the October 2002 budget workshop indicating that interest payments were the fastest growing element of expenditure, rising 42% between 2002/01 and 2003/04, ie a rise of USh61.4bn. Domestic interest payments alone were projected to increase by 80% from USh 73.6 bn to USh 132.7bn[18]. Given their prior claim on budgetary resources, this reduces the potential resource envelope to other sectors.

Secondly, the inability to fund government expenditures through domestic sources has led to increased vulnerability of the budget to reductions in external assistance, whether temporary or sustained. Despite various promises and international summit commitments (eg Abuja 2001), MOFPED point out that *"[t]he reality is that the donors cannot make any firm commitments as to the level of aid that they can give to Uganda for more than one or two years ahead, and moreover, their actual disbursements of aid often fall short of their pledges. Prudent budget management means that we should reduce our dependence on sources of finance that are inherently volatile and cannot be guaranteed over the medium term and increase the share of the budget which is funded from domestically generated revenues."* (Kassami 2002) In other words, the fiscal deficit must be reduced.

2.4 External financing

2.4.1 The Entebbe Partnership Principles

In order to strengthen the effectiveness of aid in achieving the targets of the PEAP/PRSP, government and partners agreed a number of principles to govern funding of the PEAP. Their agreement at a meeting in Entebbe in 2001 resulted in them being known as the Entebbe Partnership Principles. In addition to the shared principle that external funding would be sought and provided only for programmes within the PEAP, a number of commitments were made by both parties as summarised below.

GOU commitments included a continued and increased focus on poverty eradication, together with efforts to increase taxes, improve transparency, fight corruption and strengthen local government capacity. At the same time, GOU would assume full leadership in the donor-coordination process, strengthen monitoring and accountability, develop comprehensive, costed and prioritized sector wide programmes, further develop participation and co-ordination of all stakeholders, and strengthen the capacity to coordinate across Government.

On the part of development partners, agreement was made that they would:

- *"Jointly undertake analytical work, appraisals and reviews, set output/outcome indicators and develop uniform disbursement and accountability rules.*
- *Ensure all support is consistent with government priorities and is fully integrated into sector wide programs even when it is project funding outside the budget and discontinue individual, parallel country programs and stand-alone projects.*

[18]. MOFPED (2002e). *MTEF Ceilings Oct 2002* (Excel file)

.

- *Increase the level of delegation to country offices, and untied sector budget support, and progressively reduce tying of procurement and abolish topping up of individual project staff salaries."*[19]

Outstanding challenges include: the need to mobilise additional resources; ensuring the productive use of donor resources in order for benefits to outweigh the costs of managing the inflows; development of long-term macroeconomic and expenditure frameworks to reflect the PEAP targets as a means of stimulating debate on broad sectoral resource allocation and cost-effectiveness of alternative strategies of achieving the targets; and comprehensive civil service reform.

2.4.2 Budget support for poverty reduction

Budget support has become increasingly important within the GOU budget in recent years, providing an estimated 21% of total revenues in the projected budget outturn for FY2002/03 (as shown in Table 4 above), and a substantially higher proportion of the MTEF budget. One source estimates donor budget support to have increased from 2.6% of GDP in 1997/98 to 7.2% in 2001/02 (Bird 2002, p7).

It should of course be borne in mind that actual disbursement varies quite substantially however, and this is cited as one of the major reasons behind the decision to maintain strategic reserves at a relatively high level in order to minimise potential disruption to expenditures in the case of such resources not flowing as envisaged.

Budget support in Uganda comes from a number of different sources. The Poverty Reduction Growth Facility (PGRF) is provided by the International Monetary Fund as a concessionary loan, and was approved in September 2002 for a total of around $19m. Initially, Uganda drew US$2.1m, and following the first satisfactory review in June 2003, a further US$2.8m was made available. The PRGF loan carries an annual interest rate of 0.5% and is repayable over 10 years, with an initial 5½ year grace period on the principal[20].

World Bank budgetary support is currently channelled through the Poverty Reduction Support Credit (PRSC), formerly known as the Public Expenditure Reform Credit (PERC). WB support has in the past been reflected in estimates of budget support to PAF Health but such earmarking was not intended long-term. Although credits under the PSRC are to support PEAP/PRSP implementation and are programmed against clearly identified performance benchmarks, the proportion which is available to the health sector depends on broader GOU priorities and the relative availability of other funds to the sector[21]. The primary areas of support for the PRSC were identified in 2000 as: *"i) efficient and equitable use of public resources; and ii) improved service delivery through cross-cutting reforms, including measures to fight corruption and increase transparency"*[22].

The British and Irish Governments also provide general budget support, which in FY2001/02 amounted to a budgeted figure of US$35.4m. Actual disbursement was US$28.9m, with the shortfall due to delays in release of the Irish support while a report into the government's

---

[19] MOFPED 2002c, p27

[20] IMF (2003). *IMF completes the first review under Uganda's PRGF arrangements and approved US$2.8 million disbursement.* Press release 03/96. International Monetary Fund. Washington : 25 June 2003

[21] Although the April 2000 Aide-Memoire indicated that PERC funding would not be earmarked, the relatively small share going to the health sector (approximately 15.6%, based on total of $200m, and amounts as indicated in the draft 2000/01 Budget Framework Paper) prompted the MOH to request that it be protected through PAF.

[22] World Bank Pre-Appraisal Mission, *Uganda Poverty Reduction Support Credit Aide-memoire*, October 2000.

activities in the Congo was awaited. In addition, the Netherlands and Swedish governments provided (non-sector specific) general budget support to the Poverty Action Fund, disbursing $8.5m and $5.5m respectively (although the Swedish support was not included in the original budget) in FY2001/02. The European Union (EU), despite a planned contribution of $23.8m in Poverty Alleviation Budget Support to the PAF, failed to disburse due to delays both in the GOU submitting information to the EU, and delays in Brussels itself (MOFPED 2002c, pp 17-18).

2.4.3 Offsetting project expenditure within MTEF ceilings

Despite a relatively hard approach taken in the setting of sector ceilings within an overall budget constraint for the country, to date externally financed development allocations have been determined through a separate process. This has resulted in a softer overall budget constraint for sectors which have been able to increase their share of the budget through attracting additional project funding (Bird 2002, p7).

In order to increase both the transparency and the inclusivity of the budget, the decision has been taken with GOU to progressively incorporate donor project funding within MTEF ceilings for the different sectors with effect from FY2004/05[23]. This means that sectors benefiting from a higher proportion of donor project funding will in future receive less of the more flexible, GOU/budget support funding, given that donor projects frequently have greater restrictions regarding their use. One potential mechanism which is being proposed (and is generally accepted, at least within the health sector) to help mitigate the effects of this in the future, is that Sector Working Groups should play a greater role in assessing the desirability of any proposed project, in order to determine the extent to which it meets sectoral objectives.

Although often funding some of the direct costs of government operations, whether recurrent or capital, much donor project funding covers items such as technical assistance and administrative costs over which sectoral ministries may have limited control and which cannot always be said to be priority for the ministry concerned. This move will therefore necessitate the collection of more detailed information regarding the precise nature of donor project funding, in terms of levels and areas of expenditure (and potentially geographical coverage). This has been raised as an issue within the HSSP Mid-Term Review report, and was the subject of some discussion during the April 2003 JRM. It was agreed that Ministry of Finance should be requested to provide more detailed guidelines on this matter.

2.5 Administrative setup

2.5.1 Administrative decentralisation

The 1995 Constitution of Uganda and the 1997 Local Government Act together provide the policy framework for decentralisation in Uganda.

Under Uganda's decentralisation programme, districts are responsible for the planning, implementation and management of public services. **District local councils** were established under the 1993 Local Government Statute as a means of promoting more democratic, responsive and accountable government. Improved channels of communication between local government authorities and the populations they serve and to whom they are responsible is expected to facilitate locally appropriate decision-making and service delivery.

---

[23] K Muhakanizi, *The macroeconomic framework and MTEF: fiscal years 2003/04 – 2005./06.* MOFPED. Presentation at the Public Expenditure Review, 20 May 2003.

Each council is headed by a Local Council 5 (LC5) Chair who is the political head of the district, while the Chief Administrative Officer heads the civil service at the level.

At central level, the Ministry of Local Government coordinates activities related to local government. Sub-district level governments exist at LC3 (sub-county), LC2 (parish) and LC1 levels (village).

2.5.2 Fiscal decentralisation

Plans for strengthening fiscal decentralisation in Uganda have developed relatively fast over the past two years, beginning with an in-depth study both documenting the existing system of intergovernmental grants and transfers, and detailed proposals for streamlining the system at all levels[24]. The review of current procedures found that, at the time, there were 26 different transfer systems between central and local government, with 16 different CGs targeted at different sectors and sub-sectors. Many of these have their own planning and reporting requirements, and thus clearly create a substantial administrative burden on district staff, detracting from their ability to ensure effective and efficient service delivery[25]. In addition, such multiple and parallel funding systems are not conducive to clear accountability and transparency.

A further concern, highlighted throughout the initial report, is that the current system of financing district services runs contrary to the declared policy of decentralisation as articulated in the 1995 Constitution and the 1997 Local Government Act. Whereas these clearly refer to devolution, the effective result of the conditional grant system is closer to deconcentration, with line ministries transferring money to their respective local government departments, for spending in line with nationally determined priorities. There is concern that this has led to reduced ownership at the local government level, limited involvement of sub-district levels in planning and monitoring, and a resultant lack of commitment to operation and maintenance.

The District Development Project (DDP) piloted the devolution of discretionary development budget support to five districts, *"to test the anticipated Local Government Act and create a "policy experiment" for developing procedures for decentralised planning, financing and service delivery"* (Draft Strategy Paper (DSP)[26], Section 2.3). The subsequent Local Government Development Programme (LGDP) devolves development funding, through either a Local Development Grant (for those meeting minimum conditions) or a Capacity Building Grant (for those failing to meet the minimum conditions) to 31 districts and 13 municipalities. The minimum conditions are derived from existing local government legislation and financial regulations[27].

The fiscal decentralisation strategy has subsequently been further developed, and a pilot is planned for FY2003/04, starting at district level in 12 districts and 3 municipalities in FY2003/04, and subsequently moving to lower level governments in the pilot areas in FY2004/05 while the district level experience is scaled up. Under the pilot, expenditures at local government level will be classified according to whether they are Primary (equivalent to Poverty Action Fund (PAF) budget lines), Secondary, or Administrative. Local governments will initially be given the flexibility, within their recurrent budgets, to reallocate up to 10% between sectors, and within sectors between budget lines. This is subject to the proviso that

---

[24] A Batkin et al (2001), *Fiscal decentralisation in Uganda: the way forward.* Report prepared for the Government of Uganda/Donor sub-Group on Decentralisation. January 2001

[25] During a visit to Kabale district in March 2001, as part of the Joint Review Mission, the Chief Administrative Officer informed the team that he was currently managing 60 different accounts.

[26] MOFPED/MOLG, *Fiscal decentralisation in Uganda: draft strategy paper*, March 2001.

[27] The Local Government Act (1997) and the Local Government Finance and Accounting Regulations (1998).

the total spending on Primary/PAF budget lines across sectors does not change. Future flexibility will depend on assessment of performance in line with current Local Government Development Programme criteria.

In addition, a large increase in the LGDP grant in FY2003/04 is expected to benefit health (and other sectors) at the district level although the ex ante amount cannot be determined as allocations will be decided at local government level, and the initial amount falls under the Economic Functions and Other Social Services sector.

3 The Government planning and budgeting framework

As with other countries, Uganda has an interlinked planning framework combining means of achieving long and medium term policies and objectives, with processes for annual plans and budgets to operationalise these, nationally, geographically, and by sector. Box 1 below is reproduced from the PRSP and summarises these processes.

Box 1 Ugandan PRPS quick guide to planning processes

- **Vision 2025:** an overview of long term goals and aspirations by the year 2025
- **The PEAP:** the national planning framework on which to develop detailed sector strategies
- **Sector planning:** technical specification of sector priorities, disciplined by hard budget constraints
- **District planning:** implementation plans for sector strategies based on local priorities / needs
- **MTEF:** annual, rolling 3 year expenditure planning, setting out the medium term expenditure priorities and hard budget constraints against which sector plans can be developed and refined
- **District MTEF:** setting out the medium term expenditure priorities and hard budget constraints against which district plans can be developed and refined
- **Annual budget and district budgets:** annual implementation of the three year planning framework
- **Donor, NGO, private sector:** participating and sharing information / ideas in development sector plans and budgets
- **Participatory processes:** bottom-up participation of districts in the planning and monitoring process, as well as participatory poverty assessments, providing essential feedback on progress towards poverty eradiation goals

Source: MOFPED (2000), p4 (PRSP)

3.1 The financial year and the planning process

3.1.1 At central level

The financial year (FY) of the Government of Uganda (GOU) runs from July to June. The annual planning and budget cycle begins around October each year, lasting around nine months. The cycle generally begins with a Cabinet retreat to discuss the initial resource framework and identify key priorities, prior to the first MOFPED Budget Framework Paper (BFP) workshop in October where all spending ministries are informed of the new rules, provisional budget ceilings for the coming year (within the MTEF), and the timetable for the process. Sector Working Groups (SWG) are then convened which include key people in the relevant ministries, representatives of non-governmental organisations (NGOs) and Development Partners (DP).

Line ministries then convene a meeting with programme heads and senior managers to pass on the information regarding the time-frame, provisional ceilings, and to initiate the internal planning and budgeting process. The next stage of the process is production of a draft sectoral budget framework paper (BFP) by the SWG.

The BFP is then discussed at a second MOFPED workshop, which this time involves MOLG (usually scheduled for late November). A revised draft BFP and MTEF are then submitted to Cabinet for discussion during December/January. In February MOFPED issues a Budget Call Circular which contains more definitive sectoral budget ceilings. Revisions are again made within these amended ceilings, and resubmitted. In addition, a Public Expenditure Review meeting, linked to the Consultative Group process, takes place in May, at which amended ceilings are presented to partners, justified by GOU, and discussed. The final budget speech is read in June each year, prior to the start of the new financial year on 1 July.

3.1.2 At district level

At present there are separate medium-term planning processes at district level, covering a consolidated rolling district development plan which has traditionally covered a period of three years, and sectoral plans which, in the case of the district health sector strategic plan, cover a period of five years (2000/01- 2004/05). There is no inherent need for these to be separate as they both contribute to overall development goals of the Government Uganda. Harmonisation of the two processes, and of these plans with the MTEF, is currently under discussion. A summary of the main activities in the planning cycle is given in Table 7 below.

Table 7 Planning and budgeting cycle (health sector illustration)[28]

Timeframe	Central level	District level
July - September		♦ Health Sub-Districts (HSD) and DHMT to facilitate sub-counties to identify priorities and funding for coming year (July) ♦ HSDs prepare draft workplans inclusive of sub-county health activities with assistance from DDHS (Sept)
October	Spending ministries including MOH attend workshop convened by MOFPED to learn process, changes, and provisional ceilings for the coming financial year (FY).	
November	♦ Internal MOH/SWG meetings to inform departments of process and provisional ceilings; Draft budget framework paper (BFP) to be ready 24 November 2000 ♦ Second MOFPED workshop including MOLG (26-27 Nov)	First Local government budget framework paper (LGBFP) workshop; Comprehensive draft district health workplan ready for discussion at that workshop
December - January	Revised draft BFP and MTEF to be discussed by Cabinet	First regional LGBFP workshops
February	Budget Call Circular gives more definite budget ceilings	Draft workplan format for PHCCG to be submitted to MOH
March		Second regional LGBFP workshops; Discussion of health workplan and revision following comments
April - May		CAO signs MOU which is sent with workplan to MOH for approval (April)
June	Reading of national budget	

Sources: Primary Health Care Conditional Grant (PHCCG) guidelines[29]; communication with Health Planning Department staff; Hutchinson 1999

[28] NB this is based on 2000/01 and may have changed slightly.
[29] MOH, *District guidelines on the utilisation and management of grants for delivery of health services*, July 2000

3.2 The Medium Term Expenditure Framework

The term Medium Term Expenditure Framework in Uganda refers to a specific table setting out proposed three year budgets by sector, and for each sector by programme (see Annex B for the health sector example presented in the 2000 PRSP). The more detailed budgetary documents are referred to as Budget Framework Papers (see above), cover the three year period, and provide narrative as well as tables of allocation.

A medium term resource planning framework was initiated in Uganda in 1992 in response to economic crisis when inflation reached 100%, and to the inability of GOU to meeting counterpart funding commitments for externally funded projects. It was developed independently by MOFPED, and has subsequently incorporated other such initiatives, with strong Government leadership. Initially focusing on the overall macro-fiscal framework, and broad categories of spending (wages, non-wage recurrent, public investment programme etc), some sector analyses (including health) were introduced in 1995, encompassing all sectors in 1997, and the process was subsequently extended to local government in 2000 (Bird 2002).

3.3 Financial Management

In order to improve financial information and reporting systems, GOU is currently in the process of introducing an Integrated Financial Management System (IFMS), with support from the World Bank Economic and Finance Management Project II. The IFMS is eventually expected to cover all the major Government business processes, including budgeting, accounting and reporting, procurement, revenue, cash and debt management, and inventory control.

IFMS is expected to bundle all financial management functions into one suite of computer-based applications, and thence to assist GOU entities to initiate, spend and monitor their budgets, initiate and process their payments, and manage and report on their financial activities. IFMS has the potential to streamline all fiscal and financial management processes throughout Government and provide GOU with a modern budgeting and accounting system through which to undertake its national and public sector accounting and financial management.

As already referred to in Section 2.2.3, the PAF involves some additional procedures for financial management, with specific performance and expenditure formats used at both central and local government level.

4 Health sector context

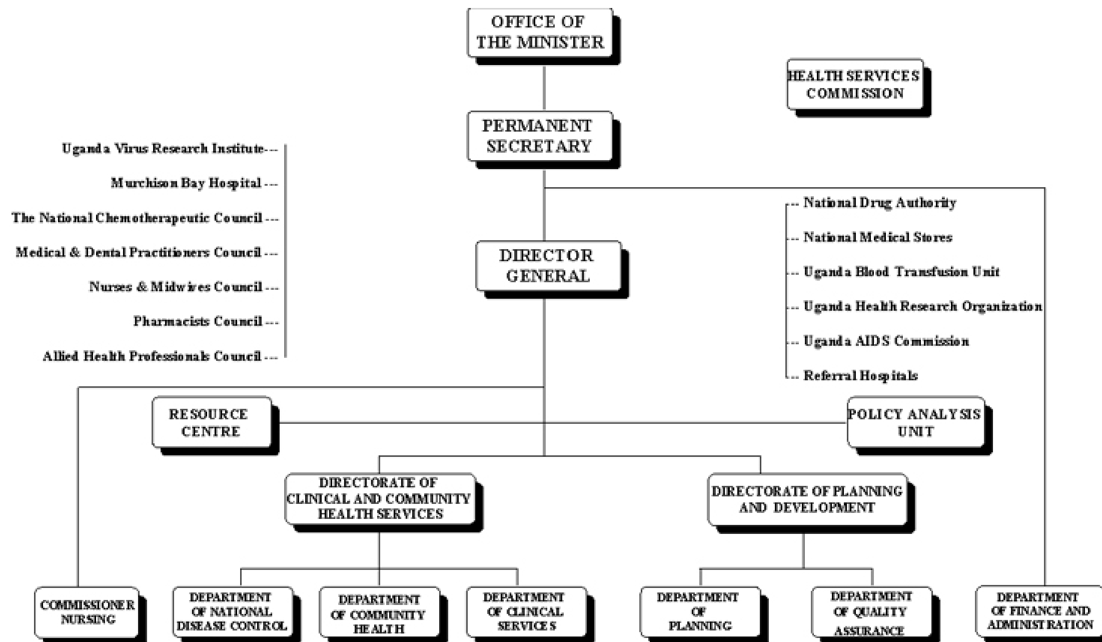
4.1 Administrative setup

4.1.1 Central MOH

The Ministry is headed by a Cabinet Minister, assisted by two Ministers of State. The Permanent Secretary is the overall accounting officer for the Ministry, and the Director-General of Health Services is the most senior technical officer. There are two directorates, of Clinical and Community Health Services, and of Planning and Development, under which sit a number of Commissioners and Assistant Commissioners in charge of various departments as shown in Figure 2 below.

Within the context of a decentralised system, as articulated through the Ugandan Constitution, the National Health Policy outlines the role and responsibilities of the central MOH as: policy formulation, standard-setting and quality assurance; resource mobilisation; capacity development and technical support; provision of nationally coordinated services (such as epidemic control); coordination of health research; and monitoring and evaluation of overall sector performance.

Figure 2 MOH organogramme



Source: www.health.gov.ug/

4.1.2 Districts and Health Sub-Districts

Responsibility within local government for health sector legislation, policy-making, planning, and supervision, together with co-ordination of the various health sector actors, falls to a District Health Committee within the District Council, chaired by the District Secretary for Health, and answerable to the Chief Administrative Officer of the district. The District Director of Health Services (DDHS) is employed by the District Council and serves as secretary to this committee. S/he, together with the District Health Management Team (DHMT), is responsible for planning and management of the sector and liaison with stakeholders within and outside the district, while service delivery is the responsibility of newly created Health Sub-Districts at the County level. The intention is to have all HSD headed by a medical officer in-charge, trained in management during a specially designed local short course. The creation of a level of the health system at county (LC4) level has caused some administrative problems as there is no official government structure at that level (see Section 2.5.1).

4.2 *Current health policies and strategies*

Policy within the health sector is guided by the overall policy framework of the Government of Uganda, ie the PEAP/PRSP, Vision 2025, the Entebbe Partnership Principles agreed in 2000 between GOU and development partners.

The National Health Policy (NHP) was approved by Cabinet in 1999, and on the basis of this, a five year Health Sector Strategic Plan (HSSP)[30] was developed through a participatory process involving government, development partners and other stakeholders. HSSP was launched in August 2000, with objectives as shown in Box 2 below. A Mid Term Review was undertaken between November 2002 and February 2003, the report of which was endorsed by the April 2003 Joint Review Mission, and implementation of HSSP is generally agreed to be on course. At the same time, the overall direction of the HSSP was accepted as an appropriate basis for continued activity over the remaining period of the plan, ie to the end of 2004/05.

Box 2 HSSP objectives

The stated objectives of the Uganda HSSP are to:

- *"relate the ongoing health sector reforms to health development*
- *provide a framework for three year rolling plans at all levels*
- *involve all stakeholders in health development*
- *exhibit a health sector strategic framework, with coherent goals, objectives and targets for the next five years*
- *indicate the level of investment in terms of costs required for achieving the policy objectives agreed upon by the Government of Uganda and its development partners*
- *articulate the essential linkages between the various levels of the national health care delivery system."*

(MOH 2000, p3)

HSSP is summarised in a logframe matrix, which is reproduced in Annex x. The five major programmatic outputs are:

1. minimum health care package implemented
2. health care delivery system strengthened
3. legal and regulatory framework strengthened and operational
4. integrated support systems strengthened and operations
5. policy, planning and information management system operational, and research and development implemented.

4.2.1 The Uganda health sector-wide approach

HSSP is seen as the joint Programme of Work for the sector-wide approach (SWAp) in Uganda. Donors in Uganda, (known as Health Development Partners HDP), signed up to the principles and policy priorities articulated therein, and the partnership was confirmed through the signing of a Memorandum of Understanding in August 2000[31]. According to the MOU, the objectives of such cooperation are *"to implement the National Health Policy and Health Sector Strategic Plan through a Sector-Wide Approach, which addresses the health sector as a whole in planning and management, and in resource mobilisation and allocation."* (MOH 2000x MOU).

[30] MOH (2000b). *Health Sector Strategic Plan 2000/01 – 2004/05*. Ministry of Health. Kampala: August 2000

[31] I have been unable to confirm to date whether everyone has now signed.

To date, Joint Review Meetings (JRM) have been held twice a year, involving a broad range of central and local government officials (from Health, Finance, Local Government, Public Service), development partners based within the country and from headquarter organisations, NGOs and civil society bodies. As laid out in the MOU, the April meeting was intended to review the draft plan of action for the coming financial year, in the context of the most recent budget estimates, while the October review is intended to assess performance over the previous financial year.

The recent Mid-Term Review of HSSP, undertaken between November 2002 and March 2003, resulted in agreement that this format would change for the remaining period of HSSP and into HSSP II, with a single detailed technical review in October to include visits to districts to review implementation progress, and to be preceded by a two day National Health Assembly. This latter forum is intended to develop broad national consensus on health development in the country, with particular attention paid to participation by civil society and local government. As a replacement to the April JRM, a one day meeting will in future be held in March/April to receive and review technical reports.

Another key SWAp coordinating structure is the Health Policy Advisory Committee (HPAC), which is chaired by the MOH and which to date has met at least monthly (although the intention is to change this to every two months from October 2003). Membership includes representatives of central government (including Finance and Local Government in addition to Health), development partners, and the private-not-for profit sector.

The HDP group have a separate forum, with a rotating chair, in order to reduce the transaction costs to government of dealing with a large potential number of partners. Issues are discussed between HDP members, and as far as possible, a common view presented in fora such as HPAC.

4.2.2 Health planning and budgeting

At the central level, the Health Planning Department (HPD) acts as secretariat for the planning and budget preparation process within the MOH. Headed by the Commissioner for Planning, the HPD is relatively well staffed[32] with highly qualified planners and health economists, several of whom trained initially as medical doctors. The planning process follows the general GOU budget cycle, described in Section 3.1, with the Sector Working Group taking responsibility for drafting the Budget Framework Paper to be submitted to MOFPED and on to Cabinet. An early version is presented for discussion at the October JRM of government and partners, with an updated version being discussed at the April JRM.

According to the MOU between the GOU (through the Ministry of Health) and partners, the draft annual workplan for Ministry departments and technical programmes within the headquarters is developed in line with the various estimates, and is subject to review by MOH and DP during the April Joint Review Meeting[33]. However, in practice this has not happened regularly, although draft workplans have been presented for discussion at a couple of October JRMs. The issue of strengthening the link between annual workplans and budgets at the central level was raised during the April 2003 JRM, but no conclusion reached.

The district level health planning process is relatively well-established in Uganda, having been introduced several years ago. Most HSD in-charges have now received specific training in financial management and accountability at the Uganda Management Institute. All districts produce annual health sector workplans based on bottom-up planning activities.

[32] compared to other countries in the sub-Saharan African region.
[33] Republic of Uganda, *Memorandum of Understanding (between GOU and DP)*, 2000

These are elaborated from their five year strategic plans (health sector) and 3 year district development plans, and incorporate health sub-districts (HSD), private not-for-profit (PNFP) health units, and some sub-county (HC 3) plans.

According to the PHCCG guidelines circulated to DHMTs and other implementation levels, the planning process at district level begins at the start of the financial year, in July. At this point the DHMT and HSD are expected to assist the lower levels (Health centre (HC) II and HC III) in identifying priorities for the coming year. In September, draft workplans are developed by HSD on the basis of lower level unit plans. These are then consolidated into a draft district health workplan that is presented for discussion at a local government BFP workshop in November. At this stage, first estimates of funding for districts is available in line with the sectoral MTEF, and revisions to the district plan can then be made.

4.2.3 Health financing and financial management

Financing of the health sector in Uganda is predominantly through the government budget (including donor budget support and projects). The cost of HSSP was re-calculated in 2002 at US$28 per capita. This compares with the WHO Commission on Macroeconomic and Health estimates of $38 for a low income country by 2015 (although the latter includes scaling up of antiretroviral treatment for AIDS to cover 65% of the population in need[34]). The figure also contrasts sharply with an estimated resource envelope of US$9 per capita from existing sources in FY2002/03. In response to this revised costing and the resulting gap, the HPD developed a long term Health Financing Strategy (HFS) document, supported by a subsequent Bigger Budget Paper which sets out the justification for the MOH's continuing lobby for additional resources from the GOU budget.

On the basis of an assessment of the potential of different financing mechanisms in meeting the resource requirements of the HSSP, the HFS concludes that a more expansionary approach to the overall budget by GOU and, within that, an increasing share allocated to health, is the only realistic option in the medium term, given the limited potential of users to contribute. The alternative is seen as a downward revision of expectations of the health sector's contribution to meeting PEAP/PRSP targets and the Millennium Development Goals. Further discussion of different types of external financing is given in Sections 4.3.2 and 5 below.

Cost-sharing was in place in government facilities until March 2001 when it was abolished by Presidential decree in advance of elections, as being contrary to the stated pro-poor policies articulated in the PEAP and PRSP. Although the MOH had been in the process of revising its policy, given the findings of the first Uganda Participatory Poverty Assessment Process (UPPAP) and other studies that financial barriers were indeed a hindrance to early accessing of essential health care, the nature and timing of the decision caused some problems, both in terms of removing a supplementary source of income with which to purchase necessary drugs and supplies, and in terms of reducing local ownership in health facility management through removal of the one relatively flexible source of funding.

At present, cost-sharing continues in the form of user fees at private wings of government hospitals, and there is some discussion around a phased introduction of social health insurance. Isolated community financing schemes exist, but are not widespread and a recent evaluation did not recommend scaling up.

The MOH has made substantial progress in recent years in strengthening the efficiency and equity of resource allocation within the sector, both through a progressive targeting of funds

---

[34] WHO (2001). *Macroeconomics and Health: investing in health for economic development*. Report of the Commission on Macroeconomics and Health. Geneva: 20 December 2001 (pp 51 – 55 and Table A2.A)

to the more cost-effective district and sub-district levels (see section 4.3.1 below), and through progressively moving towards an objective formula-based approach to geographical allocations. In FY2002/03 grants to districts were based on population, and incorporated health needs, poverty (using consumption figures) and the availability of project funding within a district. The changes were made in consultation with the Poverty Monitoring Assessment Unit within MOFPED and, although based in part on educated guesses by the regional health planners, are felt to have improved the pro-poor focus of allocations, with per capita allocations to high need districts considerably higher than for those with lower needs. Further review of such formulae is envisaged as part of the fiscal decentralisation process.

Financial management in the health sector generally follows government procedures as outlined in Section 3.3. Government funding flows from central government to line ministries or direct to local government, with releases published in the paper to ensure transparency. Various delays often occur in the banking and administrative systems before funds are available for eventual use, but substantial progress has been made in this area in the past two years. Progress and financial accountability reports are completed on a quarterly basis by Districts, and sent back to the MOH from where they are forwarded to MOFPED for review at the quarterly meetings.

Tracking studies on particular aspects of financial flows (or other identified "hotspots") are undertaken as an additional mechanism for examining bottlenecks and making recommendations for improving performance in specific areas. In recent years these have tackled the flow of funds from centre to district and on to final use, flows of drugs and supplies, and most recently for Programme 9, the centrally held PAF budget line for procurement of supplies and equipment for districts and health sub-districts.

4.2.4 HSSP and GFATM target diseases

The Uganda National Minimum Health Care Package (UNMHCP), ie the first programmatic output of HSSP, has 12 components, of which the first is Control of Communicable Diseases, specifically targeting action on malaria, HIV/AIDS and tuberculosis, ie the GFATM target diseases. Objectives specified in the HSSP are respectively:

- To prevent and control malaria morbidity and mortality;
- To prevent and control STD/HIV/AIDS transmission and mitigate the personal effects of AIDS;
- Control of TB through early diagnosis and treatment.

The technical programmes for each of the target diseases have their own strategies and plans, generally both for the medium term and on an annual basis. However, these are reflected in the overall central level sectoral plan (when it is produced) and report. Malaria and HIV/AIDS have been identified as "priorities" for review and report during successive JRMs during the first two years of HSSP implementation.

Malaria

Four malaria-specific targets are identified within HSSP for the plan period, clearly related to key strategies for tackling the disease:

- To increase from 30% to 60% the proportion of the population that receive effective treatment for malaria within 24 hours of onset of symptoms;
- Protection of 60% of pregnant women through intermittent presumptive treatment with sulphadoxine-pyrimethamine (SP);
- An increase from 5% to 50% in the proportion of under-fives protected by insecticide-treated materials; and
- A reduction in the hospital malaria case fatality rate from 5% to 3% (MOH 2000, p16).

These are repeated in the medium-term strategy[35], and are based on the targets set by the African heads of state in April 2000 in the 'Abuja Declaration' and the objectives of Roll Back Malaria (RBM) set out in 1998.

Principal intervention strategies identified in the strategic plan are case management, intermittent presumptive treatment during pregnancy, vector control, and epidemic prevention preparedness and response. These are to be supported by such enabling strategies as advocacy, information, education and communication (IEC) and social mobilization; human resource development; systems strengthening; technical support; surveillance and operational research; and management and supervision (MOH MCSP 2001, p6).

At national level, the Malaria Control Programme, which falls within the Department for National Disease Control of the MOH, provides technical support and policy guidance to the operational level. Due to the multiple funding sources for malaria-related activities, there is also a functioning Interagency Coordinating Committee for Malaria which comprises both government (MOH and others such as MOFPED, MOLG, Ministry of Education and Sports) and development partners.

Guiding principles articulated in the malaria strategic plan derive from both international (RBM) and national (PEAP, HSSP) agenda, and include: equity of access, a poverty focus and gender awareness; emphasis on country ownership of the entire process; building and strengthening partnerships; contribution to sectoral reform; and integration of malaria control activities into primary health care, and other socio-economic development activities (MOH 2001x MCSP, p18).

HIV/AIDS

HIV/AIDS-related activity in the country is also guided by a five year national strategic framework document, developed shortly after the HSSP[36]. In addition, a new overall national policy on HIV/AIDS is currently under draft[37], as is a policy regarding antiretroviral (ARV) treatment specifically[38].

The stated HSSP objective relating to HIV/AIDS (and sexually transmitted diseases (STD)) is *"to prevent and control STD/HIV/AIDS transmission and mitigate the personal effects of AIDS"*. A number of targets are identified for the plan period:

- To attain a 25% reduction in HIV sero-prevalence;
- Increase and sustain male condom use from 50% to 75% in rural areas, and sustain the rate in urban areas at/above the current rate of 80%;
- Increase female condom use to about 25% for both urban and rural areas;
- All health units (HC III and above) to provide HIV voluntary counselling and testing services;
- Reduce mother to child HIV transmission from the current 25-27% to 15%
- Achieve 100% HIV-free blood for transfusion at all levels;
- Effective management of STDs and opportunistic infections provided in all health units;
- Achieve 100% compliance of universal infection control procedures in all health units, both public and private;
- Provide counselling and psychosocial support to individuals and families affected by HIV;

[35] MOH (2001). *Malaria control strategic plan 2001/02 – 2004/05*. Draft. Malaria Control Programme, Ministry of Health. Kampala: October 2001

[36] UAC (2002). *National Strategic Framework for HIV/AIDS 2000/01 – 2005/06*. Uganda AIDS Commission. Kampala: March 2002

[37] UAC (2003). *An overarching HIV/AIDS policy for Uganda*. Draft. Uganda AIDS Commission. Kampala: January 2003

[38] MOH (2003). *Antiretroviral treatment policy for Uganda*. Draft. Ministry of Health. Kampala: April 2003

- Promote and participate in research to develop a vaccine and improve prevention and care of HIVAIDS (MOH HSSP, p16).

Stated objectives of the Strategic Framework document include: provision of a brief review of trends in HIV sero-prevalence; description of the efforts undertaken to prevent HIV infection and mitigate the adverse health and socio-economic effects of the epidemic in Uganda; provision of overall guidance for activities geared towards preventing the spread of HIV/AIDS and mitigating its effects; and to serve as the basis for the mobilisation of resources to implement the national AIDS Programme (UAC 2002, p1). The document includes reference to PEAP, Vision 2025, the National Health Policy and the Local Government Act of 1997, clearly situating HIV/AIDS-related activity within the broader national development policy context. Three specific goals are given for the framework, overlapping with and extending those of the HSSP objectives;

- Reduction of HIV prevalence by 25% by the year 2005/6;
- Mitigation of health and socio-economic effects of HIV/AIDS at individual, household and community levels;
- Strengthen the national capacity to respond to the epidemic.

Unfortunately, details are not available on the specific interventions and their relative contributions to these three goals[39]. However, the estimated total cost of the Strategic Framework was US$ 181,466,030 over five years. A subsequent update to include antiretroviral treatment resulted in an increase for the care and support component of US$ 5.8m[40].

The MTR report indicates that by the end of FY2001/02, 24 PMTCT centres and 32 VCT centres were operational, although this gives no indication of national coverage. Knowledge on HIV prevention was estimated at 90%, and both condom use and age at first intercourse were rising. All government health centres are apparently equipped to manage common sexually transmitted and opportunistic infections, although it is not clear to what extent the necessary drugs and supplies are in stock. Funding remained a major constraint to scaling up access to ARVs, although capacity for patient assessment and monitoring of treatment is largely restricted to higher level hospitals, and the national policy and guidelines are still not finalised.

Tuberculosis

Tuberculosis, though a public health priority, has not been a particular focus during the first half of the HSSP period, unlike HIV/AIDS and malaria, and progress with programme implementation has therefore been reported in annual sectoral reports rather than through the JRMs. Two targets were identified within HSSP for the plan period:

- To achieve 100% coverage with community-based Directly Observed Treatment – Short course (DOTS); and
- To achieve an increase in the TB treatment and cure rate from 60% to 80% (MOH 2000, pp16-17).

The MTR report indicates that 24 of the 56 districts are implementing DOTS, ie less than half, while the success rate has increased to only 63%. On a more positive note, the availability of drugs and diagnostics is reported to have increased.

---

[39] the version of the document I have is missing the detailed logframe.

[40] MOH (2002). *National Strategic Framework for Expansion of HIV/AIDS Care & Support in Uganda 2001/02-2005/06*, cited in A Alban (2003). *Analysis of planning, costing and cost-effectivenes of GFATM application for HIV interventions, Uganda*. Draft background paper prepared for LSHTM GFATM tracking study. Copenhagen: May 2003.

4.3 Sectoral expenditure overview

4.3.1 Overall health spending

As seen in Section 2.2.4, original projections for health spending under the PEAP/PRSP were for a 1% increase in the discretionary spending (defined as line ministry + district programme spending[41]) over the original MTEF period, from 12.2% to 13.2% (including donor project funding). Unfortunately it was not possible to access directly comparable figures for the actual share of the GOU budget going to health in the 1999/00 – 2001/02 period[42]. However, recent figures[43] indicate budget estimates for FY2002/03 of 13.7% and a projection for FY2003/04 of 14.0%, continuing a slow upward trend.

When donor projects are excluded, comparison of the original projections and estimates given in October 2002 for FY2002/03 also indicate that the sector has benefited beyond the initial aspirations, as shown in Table 8 below.

Table 8 Health as % of GOU spending (including budget support)

	PRSP 2002 projections				Estimates Oct 2002	
	1999/00	2000/01	2001/02	2002/03	2002/03	2003/04
Health as % LM+DP	7.5%	8.1%	9.0%	9.7%	11.2%	11.5%
Health as % total Govt budget	6.5%	7.1%	7.8%	8.6%	9.6%	9.7%

Source: MOFPED 2000; MOFPED 2002e
Note: The October 2002 figures represent budget estimates at the start of FY2002/03.

However, as pointed out in the recent MTR report, which referred to a figure of 9.6% in FY2002/03 (presumably GOU + budget support as % of total GOU), this still falls substantially below the Abuja target of 15%, and also the level of funding required to meet the PEAP targets through implementation of the HSSP.

More recent data show a less optimistic picture for the current year, with the steady increase in share of total government spending stagnating when Interest is excluded, and actually falling as a percentage of the total including Interest, as shown in Table 9 below.

Table 9 MTEF allocations to the health sector, 1999/00 – 2003/04

	1999/00	2000/01	2001/02	2002/03	2003/04
Health as % Total excluding Interest	7.0%	8.1%	9.6%	10.4%	10.4%
Health as % Total including Interest	6.5%	7.5%	8.9%	9.6%	9.4%

Source: MOFPED (2002d) for 1999/00 – 2001/02; MOFPED (2003d) for 2002/03; Muhakanizi (2003) for 2003/04 estimates
Note: All figures exclude donor project funding.

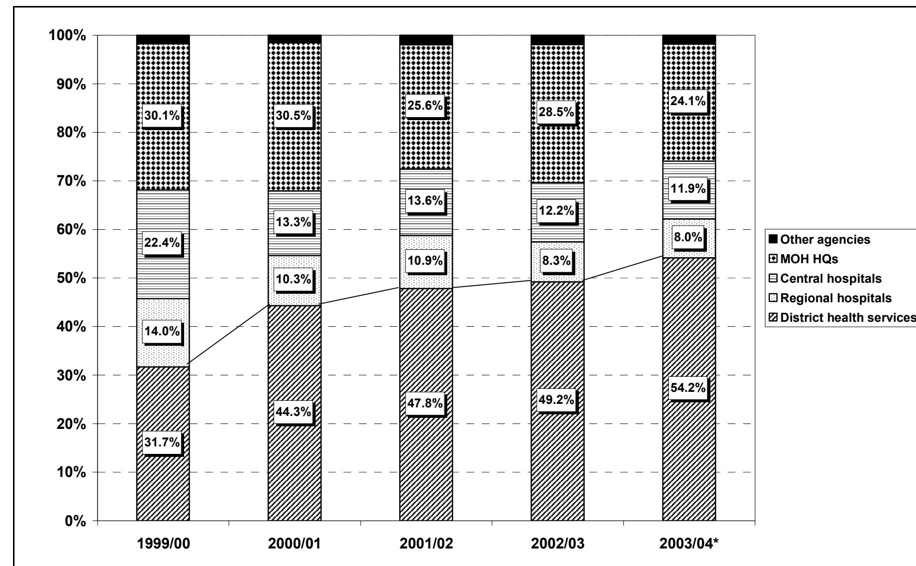
In terms of allocation within the sector, there has been a substantial shift towards the district level in support of the HSSP priority to implementation of the UNMHCP, and reflecting the increased focus in government policy more generally towards enhancing service delivery at the operation level. This is clearly shown in Figure 3 below.

District health services comprise government primary health care spending, subventions to PNFP institutions (largely faith-based organisations), and district hospitals, including the administrative and management costs of the district and sub-district health systems. The

[41] This many not be the selected definition by the GOU.
[42] The denominator for the share varies between documents, between discretionary and total. The PRSP tables show just line ministry and district programme.
[43] These figures are taken from the MTEF ceilings distributed at the Budget Workshop in October 2002 and have since been revised, so should not be taken as final.

share of the budget allocated to District Health Services has increased by over 70%, from 32% in FY1999/00 to a projected figure of 54% in FY2003/04. This figure underestimates total spending at this level as a proportion of MOH HQ spending is allocated to “Programme 9” which includes centrally procured drugs and supplies for distribution to health facilities throughout the country.

Figure 3 Allocation of GOU health budget 1999/00 – 2003/04



Source: adapted from MOH 2003x (MTR), p24
Note: Figures for FY2003/04 are projections

This shift towards the district level undoubtedly reflects both an improvement in efficiency, with more resources channelled to more a cost-effective level of the system, and in equity, as primary level facilities are more easily accessible to the population.

4.3.2 External funding in the health sector

External funding to the health sector comes in three main forms:

1. General budget support which is channelled through the overall budget and cannot be separated from GOU funding;
2. Sector budget support which is included within the Poverty Action Fund budget lines for health, and for which a total can in theory be identified through the contributions of the respective sector budget support partners (see Table 9 below), but which is again co-mingled with GOU funds (including HIPC debt relief) for the purposes of the MTEF; and
3. Project funding, which is (sometimes) reflected in the MTEF under a separate heading, “donor projects”.

These sources reflect those captured within the GOU budget and reporting systems. In addition, there is likely to be substantial off-budget support to various projects, through NGOs etc which is not captured, and which may not even be quantified. The MOH together with MOFPED are currently trying to improve mechanisms for identifying and incorporating such support into the routine budgetary systems.

Table 10 below represents a crude attempt to separate out domestic, HIPC and general budget support contributions to the health sector from earmarked sector budget support through PAF.

Table 10 Crude breakdown of FY2001/02 health sector funding by type

	USh bn	Source	US$ m	%
A. Budget				
MOH approved budget 2001/02	170.06	MOFPED 2002, Annex 1	97.2	
MOH PAF budget lines 2001/02	104.43	MOFPED 2002, Annex 2	59.7	
PAF as share of MOH				*61.4%*
Sector budget support (SBS) (budget)		MOFPED 2002, Table 3.3	19.2	
SBS as % PAF				*32.2%*
SBS as % MOH				*19.8%*
B. Actual				
MOH budget outturn 2001/02	162.89	MOFPED 2002, Annex 1	93.1	
MOH PAF releases 2001/02	105.21	MOFPED 2002, Annex 2	60.1	
PAF as share of MOH				*64.6%*
Sector budget support (outturn)		MOFPED 2002, Table 3.3	24.0	
SBS as % PAF				*39.9%*
SBS as % MOH				*25.8%*

Sources: MOFPED (2002d)
Notes: MOH budget figures exclude donor projects; Crude estimate of US$1: USh1,750 used as exchange rate for MOH budget figures; Sector budget support figures given in US dollars only in original source

The table shows that, in theory, earmarked sector budget support in FY2001/02 represented almost a third of budgeted and 40% of actual PAF spending in the sector, and almost a fifth of the total MOH budget (excluding donor projects) and a quarter of actual disbursements, and is therefore a significant source of funding to the sector[44].

4.3.3 Project versus programme support

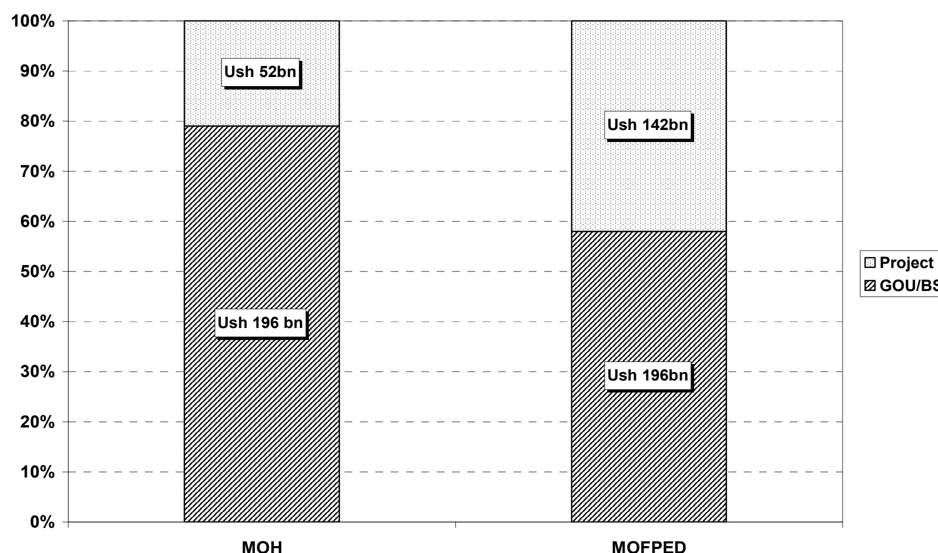
Uganda has seen a progressive move away from project aid and towards sector earmarked programme support, with budget support donors currently including Belgium, Denmark, European Union, Ireland, Netherlands, Sweden, United Kingdom, and the World Bank (MOH 2003, p54).

Difficulties in quantifying DP project support continue, particularly those projects implemented at the district level. Efforts have been made to incorporate these in annual district plans and budgets, as per planning guidelines, but have not yet borne much fruit although the picture varies very much between districts. The decision by MOFPED to increasingly incorporate project funding into sectoral ceilings, and to subsequently offset such funding against GOU/budget support allocations, will require much greater efforts to obtain more detailed information on DP funding and its breakdown between different types of expenditure. For example, commodities which are required as part of UNMHCP delivery, and which therefore substitute directly for GOU funding for drugs and supplies, should be considered differently to technical assistance. Based on figures presented at the October 2002 JRM, Figure 4 shows the share of project funding in the MOH total for the current

[44] Of course, fungibility between these sources of funding cannot be ruled out, as seen by the fact that the Norwegian sector budget support was in fact added to foreign exchange reserves as it had not been included in the original MTEF budget estimates. As these reserves were subsequently drawn down to compensate for shortfalls in general budget support, they could be assumed allocated to the health sector, thus demonstrating the futility of such an exercise.

financial year, indicating a large discrepancy between MOH and MOFPED estimates which remains to be clarified, but may be due to additional information within MOFPED regarding pipeline projects.

Figure 4 Share of MOH project funding in MTEF total for FY2002/03, by source of estimates



Source: Data presented at the October 2002 JRM.
Note: GOU/BS includes both general and sector budget support.

More recent figures project total health sector funding including projects for FY2002/03 at USh 311bn, or 11.5% of the budget outturn (including interest payments), which represents a slight fall from the MOFPED total of USh338bn shown in Figure 4. A projected increase to USh371bn in FY2003/04 (12.1% of the total projected budget) is largely attributed to the expected inflow of GFATM funding in FY2003/04 (MOFPED 2003, BTTB, Table 3.2, p46).

4.3.4 External financing for HIV/AIDS, Malaria and Tuberculosis

Although Uganda, like Tanzania, is in the process of developing a comprehensive database of external funding in the country, this is not yet at such an advanced stage to be able to provide a detailed breakdown of external spending on the three target diseases. However, limited information provided by the health sector desk officers within MOFPED indicates the projects listed in Table 11 as having been incorporated into their calculation of the health sector MTEF for FY2002/03 (as per Figure 4 above).

Table 11 Health donor project estimates for FY2002/03

Title	*FY 2002/03 Millions US$*
Uganda Blood Transfusion Services Phase 3	0.3867
Sexually Transmitted Infections Project	0.5900
AIDS Palliative Care Project	0.6440
Uganda AIDS Commission Secretariat	0.2780
Uganda HIV/AIDS Control Project	9.6000
MOH donor project funding for GFATM diseases (US$ millions)	**11.4987**
MOH donor project funding for GFATM diseases (% of total)	**15.0%**
Total MOH Donor Project Funding US$ (Millions)	***76.9***
Total MOH Donor Project Funding UShs (Billions)	***141.8***

Source: MOFPED data

As in other countries, the picture regarding total spending on HIV/AIDS activities is complicated by the fact that much takes place through government agencies other than the MOH, and through NGOs. For example, the Uganda AIDS Commission falls under the Office of the President, rather than within the health sector, although some spending on HIV/AIDS related activities is channelled through the Ministry. The National Health Accounts might include information on NGO spending (not only for HIV/AIDS but in the health sector more generally), but the original report has not been circulated, and an update is currently being undertaken. In addition, some districts have a more complete picture of funding for activities within their geographical remit, but no systematic attempt is undertaken by the MOH to collate this on a national basis. NGO funding therefore remains largely unquantified at this point.

Malaria and tuberculosis almost certainly also benefit from project funding, although it is not clearly identifiable in the MOFPED database. For example, UNICEF, DFID, and DCI are currently active in provision of drugs, training and research related to malaria, and WHO, World Bank and German Leprosy Relief Association are identified within the GFATM proposal as funding TB activities. Unfortunately no comprehensive up-to-date central level plan/budget document was available from which more details of the level, duration and allocation of more vertical project funding could be drawn[45].

5 GFATM and specific issues for the tracking study

Having submitted an original proposal during the first call in March 2002, in which activities tackling the three target diseases were combined, Uganda was requested to separate these, revise (to varying extents) and resubmit. Following this, approval was given in November 2002 for funding to the tune of US$36m for the first two years for HIV/AIDS, with a further US$15m scheduled for release in the third year subject to satisfactory review. The TB and malaria components are now approved, but grant agreements have not been signed to date due to pending clarification of some issues. Total approved funding according to the GFATM status report is shown in Table 12 below.

Table 12 Approved funds for Uganda from GFATM, Rounds 1 and 2 (US$m)

	Yrs 1 and 2	Lifetime budget
HIV/AIDS	36.3	51.9
Tuberculosis	6.8	9.1
Malaria	23.2	35.8
Total	**66.4**	**96.7**

Source: www.globalfundatm.org/files/grantstatusreport.xls @ 22 August 2003

The status report indicates that to date US$287,029 has been disbursed for the HIV/AIDS component.

A third round proposal is currently under preparation, and although details are not yet available, it is believed to include a substantial request for funding specifically to scale up access to ARV treatment in the country.

[45] NB the MOH may produce the annual plan as on some occasions in the past, in which case such information could be compiled at a later date.

5.1 Macroeconomic issues arising

Issues relating to the level and predictability of aid flows in general in relation to overall government budgets and to GDP, and the macroeconomic stability arguments arising therefrom, have been documented more in the case of Uganda than the other study countries, although others (eg Tanzania) are following suit in terms of assessing the macroeconomic impact of aid levels.

GFATM funding is grant funding, and as such has no impact on future debt service or principal repayments, and as such is to be preferred to loan funding. However, this will be to the extent that it can be used to provide general or sectoral budget support, which appears unlikely, or to free up other funding to ensure that other poverty reduction priorities are met.

The need for substantial foreign exchange reserves, to maintain a planned level of expenditure given initial budget support estimates, and/or to cover delayed disbursements of the same, has been amply demonstrated in the Ugandan context during FY2002/03. Similarly, the effect on the overall resource envelope available for discretionary (and thus priority poverty-related) expenditures of increased domestic interest payments is clear (Section 2.3.2) in the MTEF for FY2003/04.

As mentioned in Section 1.2, there is general acceptance that reducing the fiscal deficit of a country, highlighted by MOFPED as a policy priority for the medium term, is in itself a good thing. There is generally less consensus regarding the relative, immediate priorities for the Government of Uganda, with one recent paper on poverty reduction and public expenditure stating that *"..Uganda continues to adopt a cautious view of what can be afforded"*[46]. Contributions to the debate by the IMF[47] and other observers[48] suggest that any adverse macroeconomic effects of expanding the overall MTEF ceilings a) would be minimal; b) would be outweighed by the longer-term benefits to economic development; and c) could be in any case managed given Uganda's strong macroeconomic programme. The same paper, for example, goes on to state that: *"given the present and projected modest share of government spending, the clear evidence of weak public services acting as a drag on private sector investment, and the record of rapid sustained growth, it seems reasonable to assume that spending is not yet at a level where crowding out private sector activity needs to be a major concern."* (Foster and Mujimbi 2002, p13)

Any "Dutch disease" effect of aid will occur regardless of the type of funding modality used to channel the aid, ie through the government budget, private sector grants, or to finance tax cuts (DFID 2002, p3). It also depends highly on the extent to which the additional aid-financed consumption is targeted at non-tradable goods and services, and to which there is excess capacity within the economy.

---

[46] M Foster and P Mijumbi (2002). *How, when and why does poverty get budget priority? Poverty reduction strategy and public expenditure in Uganda*. Overseas Development Institute Working Paper 163. London: April 2002

[47] TC Dawson (2002), *Uganda and the IMF. The debate on aid flows to Uganda: the IMF's point of view*. Letter by the Director, External Relations Department, IMF. 7 June 2002

[48] For example, C Adam (2001). *Uganda: Exchange rate management, monetary policy, and aid*. Paper prepared for the Bank of Uganda with DfID support. Oxford: June 2001

5.2 Sectoral issues arising

5.2.1 General

One of the guiding principles of the GFATM has always been that funding of country proposals should be **additional** to existing resources, in order to enable scaling up of activity in affected countries, and it was on this basis that several development partners signed off on Uganda's GFATM country proposal. Despite responses initially offered by MOFPED during the October 2002 JRM to questions on this issue which were clear that it is not currently possible for such funds to be fully additional, due to the requirement to remain within MTEF ceilings, a compromise appears to have been reached, although there is still some lack of clarity on this issue. To date, it appears that the proportion of GFATM funding channelled through the public sector is to be treated as project funding for the duration of the funding. Funding to private sector/NGO activities will not be considered within the budget.

This is an issue that deserves further attention during the tracking study, as it remains to be seen how, with the planned incorporation of project funding into sectoral ceilings from FY2004/05, the overall share of the health sector MTEF will be affected. GFATM funds are essentially project funds, with their own financial management arrangements, and which are tied to a limited set of activities targeting only three diseases. Although these diseases are of concern to the Uganda MOH, if funds are not to prove 100% additional the implication is that they will in the future be displacing existing, more flexible GOU/budget support funding and may therefore be channelled towards less cost-effective and efficient activities, to the detriment of overall sectoral efficiency. This may compound the effect on lower level units that was seen following the abolition of user fees in 2001, further reducing the flexibility at the decentralised level on how available funds may be spent. The second UPPAP report refers to shortages of drugs and staff at health facilities, indicating constraints to access to effective health services, while acknowledging the increase in financial access brought about by the fee abolition.

In the absence of a more detailed costing of key interventions and support activities for the UNMHCP, it is difficult to state whether the existing balance of funding for specific diseases is appropriate or not.

5.2.2 HIV/AIDS

Although the current GFATM proposal does not include ARV therapy on a grand scale, it is intended to cover costs of preparatory activities to enable scaling up of ARV delivery. Such costs were presumably not included in the original costing on which the Health Financing Strategy is based, and therefore the target figure of US$28 per capita is likely to be under-estimated. Now that clarification has been received that it is possible to use GFATM funds for this particular intervention, and a third round proposal is under preparation, the cost implications of ARV treatment, the projected expansion path for scaling up access, and the specific trade-offs relating to such an intervention given the long-term nature of treatment, must be given explicit consideration in relation to the broader health sector financing requirements.

The issue of ARVs raises an additional concern regarding short-termism, and what might happen if and when the current "fashion" for global initiatives wears off, or if GFATM fails to generate the resources it is currently soliciting. Unlike some other interventions, ARVs are a lifetime commitment, and the consequences of non-compliance with treatment are increasingly documented, and are serious – both in terms of increasing general drug resistance, and of individual susceptibility. The step to substantially scale up access to ARVs should not be taken without serious analysis of financial sustainability of the strategy.

In addition, given the cost of ARV treatment, and the systems strengthening which will be required to enable wider access to and follow-up for ARV treatment at the peripheral level, there is an equity issue regarding potential recipients of such treatment. It appears likely that the rural and poorer sections of the population are less likely to benefit, at least in the short to medium term, and ARVs therefore have the potential to distort efforts made to date to concentrate scarce resources on those services from which the rural poor benefit most.

5.2.3 Malaria

The GFATM malaria proposal aims, as part of the Uganda Roll Back Malaria partnership, to enable the scaling up to national level of two key interventions which have been piloted in the last couple of years: "Home Based Management of Fever" using pre-packaged malaria treatment for children under five; and increased access of pregnant women and under-fives to insecticide-treated nets through a system of targeted subsidies (vouchers). In addition, the proposal aims to develop a rational approach to indoor residual spraying, concentrating on 11 epidemic-prone districts and selected institutional populations such as boarding school pupils. These are expected to contribute to the overall goal of the National Malaria Control Strategy: *"to control and prevent malaria morbidity and morality, minimise social effects and economic losses attributable to malaria in the country."*[49]

As such, the proposal is largely targeted at priority vulnerable groups, pregnant women and children, as stressed throughout the PRSP and HSSP, and is therefore consistent with broad development and sectoral policy priorities. Malaria represents a significant burden of disease in the country, and the selected interventions can be expected to impact upon mortality and morbidity (and resultant anaemia) among these groups. Anecdotal evidence was given at the April 2003 JRM that the introduction of HBMF in the pilot districts was already causing a reduction in outpatient attendances for fever. Scaling up to national level, albeit in a phased manner, will also extend coverage to previously under-served and generally poorer areas.

It is not possible to get a clear idea of the import component of the GFATM proposal (and therefore the extent to which the GFATM funding would potentially be exchange rate neutral) as several items are either not costed separately (eg vehicles, laboratory equipment) and it is also not clear whether they will be procured locally or from outside Uganda. The proposal specifies that Homapak, the pre-packaged drugs for under-fives, are locally available, which means that a substantial proportion of the drug and supply component will add directly to domestic consumption, and no indication is given of any potential capacity constraints in scaling up activity in this area. Other drugs and supplies (eg for intermittent presumptive treatment of pregnant women, ITNs, and insecticides both for the ITNs and for indoor residual spraying) are expected to be procured through regular channels using international competitive tendering.

The proposal specifically refers to the provision of support, whether direct or indirect, to the growth of the private sector in Uganda, through promotion of sales of ITNs. The private sector is seen as an engine of growth in Uganda, and this activity therefore has the potential to contribute to broader economic development in the country. No support to the domestic manufacturing of nets is envisaged, with all ITNs to be procured from abroad.

There are some concerns regarding the section on sustainability of the interventions (Section 4), where the proposal refers to political commitment being demonstrated by having signed the 2001 Abuja declaration on raising the budget share of health to 15%. However, at present, as shown in Section 4.3.1, the share of the government spending allocated to health is currently stagnant or falling, due to priority having been placed on defence, and to

[49] GFATM Malaria proposal, p3

persistent overspend in Public Administration. As mentioned in Section 4.2.3, implementation of the HSSP, excluding national scale-up of the proposed malaria interventions, was costed at US$28 in the 2002 HFS. This is already substantially beyond current resources, and while GFATM funding may provide the initial funds to scale up, there can be no guarantee at present that coverage can be maintained. There has been some discussion regarding focusing on key interventions within UNMHCP, and it is likely that HBMF and ITN promotion would be included, but this decision has not yet been taken.

5.2.4 Tuberculosis

The GFATM TB proposal covers a three year period from 2003 to 2005. The document refers to objectives of increasing the case detection rate for new smear-positive pulmonary TB to 70% and successful treatment of 85% of cases, over that period, and as such, differs slightly from those given in HSSP which refers to an increase in the treatment and cure rates from 60% to 80%. Eight specific objectives are given through which to achieve this, covering a range of activities from community mobilisation and communication strategies, through geographical expansion of community-based DOTS, to national level procurement and distribution of TB drugs and laboratory supplies. In addition, the proposal identifies integration of HIV/TB activities, through screening at VCT centres and intermittent presumptive treatment for HIV positive persons, as a key intervention.

Although no detailed TB strategies are identified within HSSP, it is likely that the proposed activities in the GFATM proposal are largely consistent with existing documents, given the type of activity foreseen. Notably, the GFATM funding is clearly targeted towards enabling the scale-up of CB-DOTS which is one of the stated objectives of the programme in the HSSP.

The manner in which some activities are described in the proposal do not take account of existing plans and activities which aim to strengthen general systems within the Ugandan health sector. For example:

- the planned procurement of motorcycles for 700 sub-counties does not make clear whether the identified need is based on general vehicle availability or specific availability of a vehicle for TB activities, and may therefore be contrary to the National Health Infrastructure Development and Maintenance Plan (although the transport component of that plan is still rather weak);
- In addition, if such motorcycles are to be seen as being specifically for use in relation to TB activities, this would be contrary to moves to integrate both supervision and transport management more generally;
- the emphasis given to TB data collection and analysis makes no mention of the existing systems for integrated disease surveillance or to the Health Management Information System;
- Actual procurement is intended through existing channels, although reference is made to the National TB and Leprosy Programme making bulk purchases rather than feeding in information to the proposed centralised procurement plan for drugs and supplies;
- No reference is made to the National In-Service Training Strategy which might be appropriate for some of the planned workshop training, for example for sub-county health workers on CB-DOTS, unspecified health workers on integrated HIV/TB activities, or nursing assistants in microscopy.

On the basis that imports have been identified as a lesser concern for the economy in terms of exchange rate appreciation and the crowding out of private sector activity, Table 12 below shows the potential extent of external procurement within the TB proposal. The inclusion of items in the table is based on original proposal pricing in US dollars, with the exception of operational research on access of TB patients to VCT. This is clearly just an assumption,

excludes binocular microscopes, although laptops and motorcycles would both presumably be available in country.

Table 13 shows that the bulk of the requested funding could in fact be received in kind, following external procurement, with a relatively small US$2m (22%) covering the remaining inputs which are largely for per diems, honoraria, stationery, fuel purchase, hall hire, and commissioning of communications materials (videos, jingles etc).

Table 13 Potential share of external procurement within GFATM TB proposal

Item	**Unit cost ($)**	**no**	**Total (US$)**
TB drugs	30	127,000	3,810,000
Lab equipment and supplies	13	52,000	676,000
X-ray units	20,000	20	400,000
Teaching microscopes	6,200	4	24,800
Motorcycles	3,000	700	2,100,000
Laptops	3,000	6	18,000
Antibiotics			40,000
Fluorescent microscope	5000	1	5,000
Total externally procured items			**7,073,800**
Total amount requested			9,058,224
Potential % external procurement			***78.1%***

Source: MOH (2002)

References:

Adam C (2001). *Uganda: Exchange rate management, monetary policy, and aid*. Paper prepared for the Bank of Uganda with DFID support. Revised version. Oxford: September 2001

Bird A (2002). *Design and implementation features of medium-term expenditure frameworks and their links to poverty reduction: Uganda country study.* Report prepared as part of a multi-country study funded by DFID and the European Commission.

Dawson TC (2002). *Uganda and the IMF. The debate on aid flows to Uganda: the IMF's point of view*. Letter by the Director, External Relations Department, IMF. 7 June 2002

Foster M and Mijumbi P (2002). *How, when and why does poverty get budget priority: Poverty Reduction Strategy and public expenditure in Uganda.* Overseas Development Institute Working Paper 163. London: April 2002

Hutchinson P (1999).

IDA/IMF (2002). *Uganda: Updated debt sustainability analysis and assessment of public external debt management capacity*. Washington: July 2002

Kassami CM (2002a). *Strategic issues in the Government-Donor partnership.* Paper presented at ?????

Kassami CM (2002b). *Issues concerning the macroeconomic framework and the MTEF FY 2003-04 – 2005/06*. Paper presented to the Budget Consultative workshop, October 28-29 2002, Kampala

MOFPED (2000). *Poverty Reduction Strategy Paper. Uganda's Poverty Eradication Action Plan: Summary and main objectives.* Kampala: 24 March 2000

MOFPED (2002a). *Fighting poverty in Uganda. Poverty Action Fund draft operational modalities*. Draft. Ministry of Finance, Plannign and Economic Development. Kampala: January 2002

MOFPED (2002b). *Summary of Background to the Budget 2001/02: Uganda Poverty Reduction Strategy Paper Progress Report 2002*. Ministry of Finance, Planning and Economic Development. Kampala: April 2002 (from MOFPED website www.finance.go.ug)

MOFPED (2002c). *Background To The Budget Financial year 2002/03: Enhancing production and exports for poverty reduction*. Ministry of Finance, Planning and Economic Development. Kampala: June 2002 (from MOFPED website www.finance.go.ug)

MOFPED (2002d). *Annual Budget Performance Report FY2001/02*. Ministry of Finance, Planning and Economic Development. Kampala: November 2002 (from MOFPED website www.finance.go.ug)

MOFPED (2002e). *MTEF Ceilings October 2002*. Excel file

MOFPED (2003a). *The Integrated Financial Management System.* From the website (www.finance.go.ug)

MOFPED (2003b). *Background to the budget: Financial year 2003/04*. Ministry of Finance, Planning and Economic Development. Kampala: June 2003

MOFPED (2003c). *Budget speech*. Delivered by Minister of Finance, Planning and Economic Development, Kampala: 12 June 2003

MOFPED (2003d). *Semi-annual Budget Performance Report FY2002/03: July – December 2002*. Kampala: May 2003

MOH (2000a). *District guidelines on the utilisation and management of grants for delivery of health services.* Ministry of Health. Kampala: July 2000

MOH (2000b). *Health Sector Strategic Plan 2000/01 – 2004/05*. Ministry of Health. Kampala: August 2000

MOH (2000c). Memorandum of Understanding.

MOH (2002a). *Health Financing Strategy*. Health Planning Department, Ministry of Health. Kampala:

MOH (2002b). *Bigger Budget Paper*. Health Planning Department, Ministry of Health. Kampala:

MOH (2003). *Health Sector Strategic Plan 2000/01 – 2004/05: Mid-Term Review Report.* Ministry of Health. Kampala: April 2003

Muhakanizi K (2003). *The macroeconomic framework and MTEF: Fiscal years 2003 /04 – 2005/06.* Presentation at the Public Expenditure Review, 20 May 2003.

Ndung'u M and Williamson T (2002). *Financing poverty reduction in Uganda: a study reviewing the Poverty Action Fund*. Draft Report prepared for the Ministry of Finance, Planning and Economic Development. Kampala: April 2002

Sachs J (2002). Letter to the Bishops.

6 Annexes

Annex A Terms of reference for the macroeconomic and sector background paper

General objectives:

- To summarise the macroeconomic and sectoral context (policy and performance) for each of the four countries
- To flag issues of concern relating to macroeconomics and financing for subsequent tracking during the country studies (both general and, where appropriate, country-specific), and to propose means of addressing these

Specific objectives:

a) To present general macroeconomic issues, as follows:

- To describe country Medium Term Expenditure Frameworks (MTEF), annual budget structures and the pattern of inter-sectoral allocations, in relation to stated country priorities.
- To synthesise available literature on the impact of aid on macroeconomic variables and performance, and to consider the level and planned use of GFATM inflows at the country level in relation to this information
- To review available information on country aid inflows in relation to the breakdown between general and sector budget support and project support, their inclusion within MTEF ceilings; and the level, time-scales and modalities of donor commitments to ongoing funding

b) To present health sector issues, as follows:

- To describe sectoral MTEF and annual budget allocations (to health and other HIV/AIDS activities), and to report recent budgetary performance, comparing planned and actual spending (from MTEF, Public Expenditure Reviews, sectoral budgets, National Health Accounts, etc)
- To summarise current country health policy priorities (particularly relating to HIV/AIDS, TB and malaria) – as reflected in written policy and strategy statements, and budgetary allocations, comparing these with plans and proposed use of GFATM funds
- To summarise current financial management (planning, budgeting, procurement, disbursement, accounting and reporting processes) in each country, in relation to SWAp development and the adoption of common (government) procedures
- To use this information as a baseline for future tracking of the extent to which GFATM processes are integrated with or set up in parallel to existing procedures
- To summarise trends in health sector financing by type: domestic/external, by level of care, across diseases/programmes (where available)
- Where information exists, to review country and sector performance in relation to evidence of absorption capacity (percentage of money released that was spent)
- To analyse existing GFATM proposals in terms of type of support (eg commodity versus systems strengthening; disease specific versus general), and allocations by level of care (e.g. tertiary versus primary or community level interventions)

c) To propose areas for future tracking, e.g.

- Balance of commodity support versus systems strengthening support
- Extent to which GFATM funding is in fact additional or has substituted for other sources of funding (at the country level, and/or by individual development partners)
- Shifts in the modalities of donor support (between budget, sector, project and GFATM support)
- Degree of integration and/or duplication of new with existing financial management and reporting systems
- GFATM funding as % of total sectoral funding (and implications for financial sustainability)
    - Generally, and for specific high value commodities such as ARVs
- Extent to which GFATM funding alters the intra-sectoral allocation of resources by:
    - level of care
    - geographical area (urban/rural, or more detailed)
    - disease/programme
    - type of input
    - general systems strengthening versus disease-specific activities

Methodology:

- Participation in meetings of tracking study team:
    - planning of phase 1 field work, January 2003
    - review of findings and planning of next phase of field work, mid 2003

- Desk review of general and available country-specific literature (to be provided, or access to it to be facilitated, by the funders). It should include:
    - General documentation on macroeconomic implications of aid – general and, if possible, sector specific
    - MTEF documentation, with external audit reports, where available
    - Indicative (e.g. 1 and 3 year) health sector basket funding commitments by partners – pooling donors and government
    - Overall general and health sector/HIV-AIDS budgets
    - Breakdown, where available, of non-pooled (e.g. project) support from major donors to health / HIV/AIDS activities
    - Existing and indicative future levels of commitment by donors to general budget support
    - GFATM applications (successful ones for each country, or most recent applications if approval still pending)
    - Key development agency policy documents (general, HIV/AIDS, health, country)
    - National Health Accounts reports
    - Public Expenditure Review reports
    - Sectoral policy documents
    - Current country HIV/AIDS, malaria and TB policies and strategies, where these priorities have been included in GFATM applications
    - Country Financial Accountability Assessments (where available)
    - Available audit reports

Outputs:

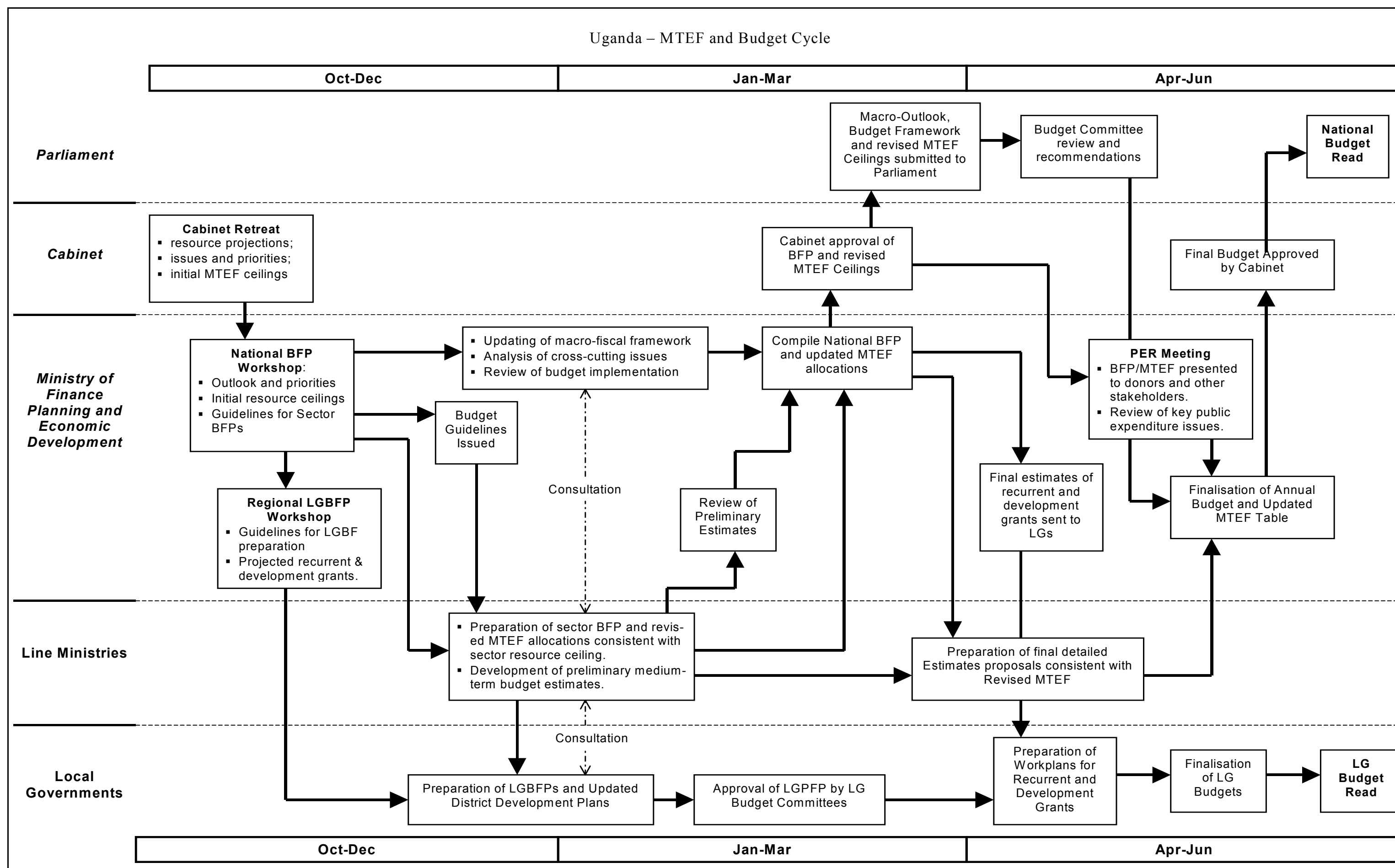
- Four country-specific reports, including recommendations for issues to be raised and data to be collected in the tracking study field work.

Annex B PRSP MTEF projections for the health sector, 1999/00 – 2002/03

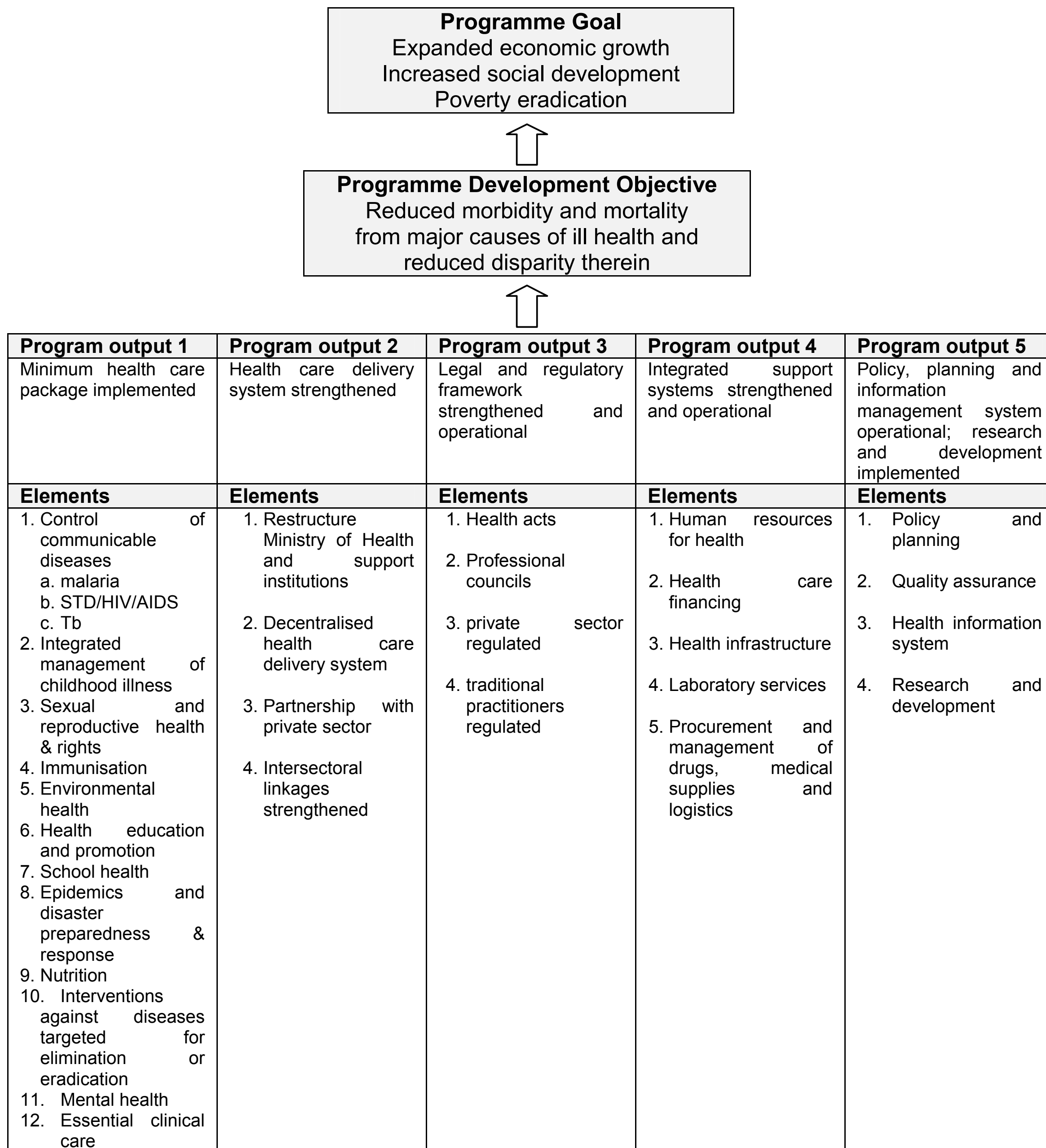
	1999/2000						2000/01					
	Wage	Non-W Rec	Dom devt	Donor project	Total GOU	Total	Wage	Non-W rec	Dom devt	Donor project	Total GOU	Total
MOH	2.51	8.63	12.02	99.62	23.16	122.78	2.64	8.03	10.54	108.39	21.21	129.60
Butabika hospital	0.53	0.99	0.15	-	1.67	1.67	0.56	0.94	0.06	-	1.56	1.56
Mulago hospital complex	5.23	6.00	1.95	15.05	13.18	28.23	5.50	5.46	0.92	16.38	11.88	28.26
Health Services Commission	0.13	0.53	0.10	-	0.76	0.76	0.13	0.47	0.04	-	0.64	0.64
District NGO hospitals/PHC	-	3.30	-	-	3.30	3.30	-	3.30	-	-	3.30	3.30
District PHC	7.36	5.00	-	-	12.36	12.36	7.73	27.03	-	-	34.76	34.76
District medical services	-	6.48	-	-	6.48	6.48	-	6.16	-	-	6.16	6.16
District health training schools	-	1.85	-	-	1.85	1.85	-	1.76	-	-	1.76	1.76
District referral hospitals	6.99	3.99	-	-	10.98	10.98	7.33	3.79	-	-	11.12	11.12
District lunch allowance	9.18	-	-	-	9.18	9.18	9.64	-	-	-	9.64	9.64
Health total	31.93	36.77	14.22	114.67	82.92	197.59	33.53	56.94	11.56	124.77	102.03	226.80
Total LM + DP	393.82	433.44	279.14	518.97	1,106.40	1,625.37	436.63	481.24	339.79	573.09	1,257.66	1,830.75
Health as % total LM + DP	*8.1%*	*8.5%*	*5.1%*	*22.1%*	*7.5%*	*12.2%*	*7.7%*	*11.8%*	*3.4%*	*21.8%*	*8.1%*	*12.4%*
Grand total (incl S, I, C)	**407.37**	**590.39**	**283.67**	**518.97**	**1281.43**	1,800.40	**450.84**	**653.85**	**341.51**	**573.09**	1,446.20	2,019.29
Health as % Grand Total	***7.8%***	***6.2%***	***5.0%***	***22.1%***	***6.5%***	***11.0%***	***7.4%***	***8.7%***	***3.4%***	***21.8%***	***7.1%***	***11.2%***

	2001/02						2002/03					
	Wage	Non-W Rec	Dom devt	Donor project	Total GOU	Total	Wage	Non-W rec	Dom devt	Donor project	Total GOU	Total
MOH	2.90	8.73	11.06	117.49	22.69	140.18	3.29	9.83	12.45	126.89	25.57	152.46
Butabika hospital	0.61	1.03	0.15	-	1.79	1.79	0.69	1.17	0.15	-	2.01	2.01
Mulago hospital complex	6.05	5.86	0.97	17.75	12.88	30.63	6.86	6.54	1.09	19.17	14.49	33.66
Health Services Commission	0.14	0.49	0.04	-	0.67	0.67	0.16	0.54	0.04	-	0.74	0.74
District NGO hospitals/PHC	-	3.63	-	-	3.63	3.63	-	4.12	-	-	4.12	4.12
District PHC	8.50	43.74	-	-	52.24	52.24	9.35	61.95	-	-	71.30	71.30
District medical services	-	6.77	-	-	6.77	6.77	-	7.69	-	-	7.69	7.69
District health training schools	-	1.93	-	-	1.93	1.93	-	2.19	-	-	2.19	2.19
District referral hospitals	8.07	4.17	-	-	12.24	12.24	8.88	4.73	-	-	13.61	13.61
District lunch allowance	10.60	-	-	-	10.60	10.60	11.66	-	-	-	11.66	11.66
Health total	36.87	76.35	12.22	135.24	125.44	260.68	40.89	98.76	13.73	146.06	153.38	299.44
Total LM + DP	485.00	541.06	364.21	623.19	1,390.27	2,013.46	547.51	627.46	412.60	673.04	1,587.57	2,260.61
Health as % total LM + DP	*7.6%*	*14.1%*	*3.4%*	*21.7%*	*9.0%*	*12.9%*	*7.5%*	*15.7%*	*3.3%*	*21.7%*	*9.7%*	*13.2%*
Grand total (incl S, I, C)	**500.59**	**736.67**	**366.02**	**623.19**	1,603.28	2,226.47	**565.2**	**809.33**	**414.63**	**673.04**	1,789.16	2,462.20
Health as % Grand Total	***7.4%***	***10.4%***	***3.3%***	***21.7%***	***7.8%***	***11.7%***	***7.2%***	***12.2%***	***3.3%***	***21.7%***	***8.6%***	***12.2%***

Annex C Uganda Medium Term Economic Framework and budget cycle



Annex D Overview of Health Sector Strategic Plan



Program output 1	Program output 2	Program output 3	Program output 4	Program output 5
Minimum health care package implemented	Health care delivery system strengthened	Legal and regulatory framework strengthened and operational	Integrated support systems strengthened and operational	Policy, planning and information management system operational; research and development implemented
Elements	**Elements**	**Elements**	**Elements**	**Elements**
1. Control of communicable diseases a. malaria b. STD/HIV/AIDS c. Tb 2. Integrated management of childhood illness 3. Sexual and reproductive health & rights 4. Immunisation 5. Environmental health 6. Health education and promotion 7. School health 8. Epidemics and disaster preparedness & response 9. Nutrition 10. Interventions against diseases targeted for elimination or eradication 11. Mental health 12. Essential clinical care	1. Restructure Ministry of Health and support institutions 2. Decentralised health care delivery system 3. Partnership with private sector 4. Intersectoral linkages strengthened	1. Health acts 2. Professional councils 3. private sector regulated 4. traditional practitioners regulated	1. Human resources for health 2. Health care financing 3. Health infrastructure 4. Laboratory services 5. Procurement and management of drugs, medical supplies and logistics	1. Policy and planning 2. Quality assurance 3. Health information system 4. Research and development