Document of
The World Bank

Report No.: 35796

PROJECT PERFORMANCE ASSESSMENT REPORT

UGANDA

DISTRICT HEALTH SERVICES PILOT AND DEMONSTRATION PROJECT (CREDIT 2679-UG)

April 3, 2006

Sector, Thematic and Global Evaluation Division
Independent Evaluation Group

Currency Equivalents (annual averages)
Currency Unit = Uganda Shilling (Ush)

(as of December 28, 1994)	(as of January 6, 2006
US$1.00 = Us.940.0	US$1.00 = Us.1821.0
1.00 Ush = US$ .00106	1.00 Ush = US$ .00055

Abbreviations and Acronyms

ANC	Antenatal Care
BOD	Burden of Disease
CBO	Community-Based Organization
CHW	Community-Based Health Workers
CSO	Civil Society Organization
DFID	Department for International Development, United Kingdom
EHP	Essential Health Package
ICR	Implementation Completion Report
IEG	Independent Evaluation Group
KfW	Kreditanstadt fur Wiederaufbau
M&E	Monitoring and Evaluation
MOFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
NGO	Non Government Organization
ODA	Overseas Development Administration, United Kingdom
PNFP	Private Not for Profit
PPAR	Project Performance Assessment Report
SWAP	Sector-Wide Approach
TBAs	Traditional Birth Attendants
UDHS	Uganda Demographic and Health Survey
WDR	World Development Report

Fiscal Year

Government: July 1 – June 30

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IEG Mission: Enhancing development effectiveness through excellence and independence in evaluation.

About this Report

The Independent Evaluation Group assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEG annually assesses about 25 percent of the Bank's lending operations. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons. The projects, topics, and analytical approaches selected for assessment support larger evaluation studies.

A Project Performance Assessment Report (PPAR) is based on a review of the Implementation Completion Report (a self-evaluation by the responsible Bank department) and fieldwork conducted by OED. To prepare PPARs, IEG staff examine project files and other documents, interview operational staff, and in most cases visit the borrowing country for onsite discussions with project staff and beneficiaries. The PPAR thereby seeks to validate and augment the information provided in the ICR, as well as examine issues of special interest to broader IEG studies.

Each PPAR is subject to a peer review process and IEG management approval. Once cleared internally, the PPAR is reviewed by the responsible Bank department and amended as necessary. The completed PPAR is then sent to the borrower for review; the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

About the IEG Rating System

The time-tested evaluation methods used by IEG are suited to the broad range of the World Bank's work. The methods offer both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. IEG evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (more information is available on the IEG website: http://worldbank.org/oed/eta-mainpage.html).

Relevance of Objectives: The extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). *Possible ratings:* High, Substantial, Modest, Negligible.

Efficacy: The extent to which the project's objectives were achieved, or expected to be achieved, taking into account their relative importance. *Possible ratings:* High, Substantial, Modest, Negligible.

Efficiency: The extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. *Possible ratings:* High, Substantial, Modest, Negligible. This rating is not generally applied to adjustment operations.

Sustainability: The resilience to risk of net benefits flows over time. *Possible ratings:* Highly Likely, Likely, Unlikely, Highly Unlikely, Not Evaluable.

Institutional Development Impact: The extent to which a project improves the ability of a country or region to make more efficient, equitable and sustainable use of its human, financial, and natural resources through: (a) better definition, stability, transparency, enforceability, and predictability of institutional arrangements and/or (b) better alignment of the mission and capacity of an organization with its mandate, which derives from these institutional arrangements. Institutional Development Impact includes both intended and unintended effects of a project. *Possible ratings:* High, Substantial, Modest, Negligible.

Outcome: The extent to which the project's major relevant objectives were achieved, or are expected to be achieved, efficiently. *Possible ratings:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry and supported implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of the project). *Possible ratings:* Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower assumed ownership and responsibility to ensure quality of preparation and implementation, and complied with covenants and agreements, towards the achievement of development objectives and sustainability. Possible ratings: Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Contents

This report was prepared by Denise Vaillancourt, who assessed the project in February 2005. Pilar Barquero and Rose W. Gachina provided administrative support.

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Principal Ratings

	*ICR**	*ICR Review***	*PPAR****
Outcome	Unsatisfactory	Unsatisfactory	Moderately Unsatisfactory
Sustainability	Likely	Likely	Likely
Institutional Development Impact	High	Modest	Substantial
Bank Performance	Unsatisfactory	Unsatisfactory	Unsatisfactory
Borrower Performance	Satisfactory	Satisfactory	Satisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible operational division of the Bank. Ratings represent a consensus by the task team and management, drawn from a field-based assessment, carried out in partnership with the Borrower.
** The ICR Review is a desk assessment of the ICR carried out by IEG. Its ratings are based on a review of the project design document and the ICR. ICR Review ratings are validated by an IEG Panel Review and take into consideration comments and factual corrections from Bank operations staff and management.
*** The PPAR ratings are based on an independent field assessment carried out by IEG, which are validated by (technical) peer and Panel reviews, and which take into consideration comments and factual corrections from Bank operations and the Borrower.

Key Staff Responsible

Project	*Task Manager/Leader*	*Division Chief/ Sector Director*	*Country Director*
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Preface

This is the Project Performance Assessment Report (PPAR) for the District Health Services Pilot and Demonstration Project (DHSP) in Uganda. This project was financed through IDA Credit No. 2679 in the amount of US$45.0 million equivalent (30.9 Million SDR) with a planned government contribution of US$6.9 million, and projected cofinancing by KfW (US$ 9 million), SIDA (US$7.0 million), ODA/DFID (US$2.2 million) and DANIDA (US$5.0 million). The credit was approved on February 7, 1995, became effective on July 17, 1995 and closed on the originally scheduled closing date of December 31, 2002. The credit was 98 percent disbursed.

The findings of this assessment are based on an Independent Evaluation Group (IEG) mission to Uganda carried out in February 2005. This mission assessed two completed IDA-financed projects: (a) the Uganda Sexually Transmitted Infections Project (Credit No. 2603) on which a PPAR is already published (World Bank, June 2005) and used as input to an evaluation of the World Bank's assistance for HIV/AIDS control (World Bank, 2005); and (b) the DHSP, which is the subject of this report. The mission met in Kampala with authorities and staff of the Ministry of Health and the Uganda AIDS Commission; other public sector agencies implementing health and HIV/AIDS activities; selected NGOs carrying out health and HIV/AIDS activities and other representatives of civil society; and bilateral and international partners. The mission also visited selected facilities, institutions and community-based projects in the districts of Mukono, Soroti, and Ntungamo, interviewing public sector and civil society actors and beneficiaries. Key documentary sources consulted include: (a) World Bank project files; (b) project-related reporting and evaluation; and (c) epidemiological data, studies and research on health and HIV/AIDS, much of it generated in Uganda.

This PPAR will contribute to a planned IEG evaluation of the development effectiveness of World Bank's assistance to health sector development. In light of that purpose, relatively more material has been presented in this enhanced PPAR than is the IEG standard.

This report draws heavily on the technical reports and inputs of team members, Sebastian O. Baine and Simon Kasasa, both of the Institute of Public Health, Makerere University. The IEG team gratefully acknowledges all those who made time for interviews and provided documents and information.

Following standard IEG procedures, copies of the draft PPAR were sent to the relevant government officials and agencies for their review and feedback. However, no formal response was received.

Summary

The main objective of the District Health Services Pilot and Demonstration Project (DHSP) was to test, on a pilot basis, and demonstrate the feasibility of delivering an essential health services package (EHP) to district populations within a prudent financial policy framework, through an integrated program of policy, institutional and financial improvements in order to improve efficiency and equity in the provision of health services. Specific objectives were to: (a) mobilize more resources for the health sector; (b) improve efficiency in their use; (c) decentralize health services; (d) restore the functional capacity and improve the efficiency of essential existing government facilities; and (e) facilitate a greater role for the non-governmental sector. Project implementation was constrained by inadequate Government counterpart financing, weak procurement capacity, and delays in the support of district activities due to bottlenecks in disbursements to districts and to an underestimation of capacity constraints during project design.

Uganda's high burden of disease is largely attributable to preventable diseases. Once considered to be one of the best in Africa in its earliest years of independence, Uganda's health system was devastated by the civil conflict that occurred in the 1970s and 1980s, and suffered as well from relative neglect by government. In the early 1990s the Ministry of Health (MoH) launched a reform of the health sector, which aimed to place due emphasis on prevention and promotion, mobilize additional resources, build managerial capacity, promote community participation, strengthen private/public partnerships, and decentralize the health sector.

Prior to the DHSP, the First Health Project (Credit 1934), approved in FY88, supported the rehabilitation of health infrastructure and the provision of basic health services, including support to HIV/AIDS. Donor support focused on rehabilitation of infrastructure, but was largely uncoordinated. The initial design of an IDA-financed follow-on operation included support to health sector reform and to the fight against HIV/AIDS, but was later split into (a) the Sexually Transmitted Infections Project, approved on April 12, 1994, on which a PPAR has already been issued (World Bank, 2005); and (b) the DHSP, which is the subject of this review.

Pilot and Demonstration. The potential for learning under this project was undermined by the decisions first in 1996 to merge the pilot and demonstration phases, and then in 1998 to extend project support from the 16 pilot/demonstration districts to all 56 districts in Uganda, without the benefit of evaluating each phase, and fine-tuning sector reform before its nationwide application. Political pressures to expand project support rapidly to all districts during a post-conflict period were formidable. While the fostering of a learning process through pilot and demonstration phases was negligible, some learning did occur, nevertheless. First, about thirty studies were undertaken on various aspects of sector reform, although they were not organized for maximum learning, nor were the study results fully exploited. Second, the experience of implementing reforms supported under this project constituted a learning process in and of itself, albeit limited and largely undocumented.

Mobilization of resources. Total per capita expenditure on health more than doubled during the life of the project from an estimated US$7.74 in 1992/93 to about $18.31 in

2000/01. However, the level of per capita spending stagnated over the last few years of the project, and falls short of the estimated US$28 per capita needed to deliver basic services to Uganda's population. Government expenditure did not increase sufficiently to compensate for the 2001 Presidential decision to abolish users' fees. The project failed to mobilize private resources through experimentation in health insurance and other risk pooling schemes.

Efficiency in Resource Utilization. Project support has been instrumental in effecting improvements in the efficient allocation and utilization of health sector resources, but the financing of EHP delivery to Uganda's population is still inadequate and spending patterns are still inequitable. During the life of the project health sector financing was increasingly allocated away from central-level MoH and referral hospitals in favor of district health services and primary health care and this favorable trend has continued after the project's closing. Health services are still chronically underfinanced and the cost-effectiveness of service provision has not been evaluated.

Decentralization. Project support to health sector decentralization has culminated in a new organizational structure for MoH and redefined roles and responsibilities for central and decentralized levels of MoH. Project support has contributed to strengthened capacity at central and district levels to take on their newly assigned roles in a decentralized system, but there remain some issues of accountability in the management and use of financial resources and in the achievement of results.

Essential Health Services. The project provided substantial assistance to the design and delivery of the essential health package aimed at addressing Uganda's disease burden, initially in 13 pilot/demonstration districts and ultimately extended to all districts. Key indicators on the delivery of the EHP show mixed trends. While physical access improved somewhat, disparities persisted (urban-rural, regional, district and income), and chronic shortages of drugs, human resources and recurrent financing undermined service quality. Key performance indicators in maternal and child services remained virtually unchanged except for a notable decline in immunization rates.

Partnerships with the non-governmental sector. The project facilitated a greater role for private not-for-profit agencies, both by ensuring that they benefited from support provided to districts, and by using them as contractual agents to carry out district-level services and activities. Project experience did, however, reveal some reticence in assigning significant roles to NGOs and the for-profit sector. Project support to community-level health was limited and fell short of its potential.

Health Outcomes. The overarching goal of improving health status was not achieved. Key health indicators did not essentially change over the life of the project and inequities in health status persist. However, it is important to note that (a) health sector investment is but one of many determinants of health status; and (b) the counterfactual of no project might have resulted in a deteriorization of health status.

Ratings. The outcome of the DHSP is rated *moderately unsatisfactory*, overall, based on three project ratings of *substantial* relevance, *modest* efficacy, and *modest* efficiency. Institutional development is rated as *substantial*; and sustainability is rated as *likely*. The

Bank's performance was *unsatisfactory* because the pilot approach was insufficiently developed and inappropriate to Ugandas's post conflict situation; and inadequate attention was paid to monitoring and evaluation. The Borrower's performance was *satisfactory*.

Lessons

- Pilot and demonstration approaches to reform implementation will not automatically generate or document a learning process, nor will such approaches necessarily lead to a fine-tuning of reforms in light of experience, if they are not well prepared and if they are not fully understood and owned by Government and other stakeholders. Important ingredients to a successful pilot include: the definition of the learning agenda; the definition of the pilot process, including the use of evaluation for scaling-up; a clear and coherent monitoring and evaluation framework, including indicators, tools and methodologies; the availability of essential inputs; a realistic timetable; and strong social and political commitment.

- The absence of a clear and coherent results framework (clearly stated objectives, well-chosen indicators and a well-defined results chain, linking inputs, outputs, outcomes and impact) is likely to cause confusion among national stakeholders and compromise national understanding and commitment, especially when the project is complex and is supporting far-reaching reforms.

- Thoughtful project design, adequate implementation, and timely monitoring and evaluation are necessary, but not sufficient for project success. Adequate attention must also be given to assessing the political feasibility of projects.

- Bank support of the health sector has implications that extend far beyond the health sector alone. It can point the way toward successful decentralization, mobilize public resources, influence improved efficiencies in public expenditure, and encourage public private partnerships.

Vinod Thomas
Director-General
Evaluation

1. Background and Context

1.1 As of 2003 Uganda had a population of about 25.3 million, growing at an annual rate of 2.7 percent (World Bank World Development Indicators 2005), of which more than one third was living below the poverty line (MoFPED 2005). Uganda's human development indicators have lagged behind its good economic performance in the 1990s, a remaining consequence of political and economic turmoil of the 1970s and early 1980s.

1.2 After independence in 1962 and throughout the 1960s Uganda showed great potential as one of the strongest economies in Sub-Sharan Africa. However, its performance was set back considerably during the subsequent periods of military rule (1971-79) and civil war 1980-85). In 1987 the new National Resistance Movement (NRM) government under the leadership of President Yoweri Kaguta Museveni launched a recovery program to restore financial stability, create conditions for rapid and sustained growth and develop human capital. It also embarked on policy and institutional reform to deregulate the economy, eliminate direct state involvement in all but essential public services, and improve institutional efficiency. These efforts put Uganda on a path of recovery, but progress was slow through the early 1990s.

1.3 In 1996 Museveni was elected as Head of State in the first Presidential election under the new Constitution ratified in 1995. This new government sought to enhance the poverty focus of national development objectives and policies. To this end it set out to maximize growth, increase domestic resource mobilization, improve public sector management (through decentralization,[1] civil service reform and efficient allocation and use of resources), promote private sector development, and protect the environment. Substantial progress in social and economic development has been made in the 1990s, including: economic growth averaging 6.5 percent per year since 1992, some improvement in quality and access of basic social services and a noticeable fall in income poverty. However, income poverty has recently risen from 34 percent in 2000 to 38 percent in 2003, inequality has increased,[2] and conflict persists in the north. Government's most recent Poverty Eradication Action Plan (PEAP 2004/5 – 2007/8) cites four core challenges: the restoration of security and improving regional equity; sustainable growth in the incomes of the poor; human development; and using public resources transparently and efficiently to eradicate poverty.

1.4 The existence of formal civil society organizations (CSOs) dates back to colonial rule, during which time they were established to promote economic and social interests of various groups and to resist colonial oppression and exploitation.[3] Colonial-era CSOs also included welfare and charitable organizations such as national branches of the Red Cross Society, the Salvation Army, and other European-based organizations. However, during the dictatorships of Idi Amin and Milton Obote (1966-86), associational life in Uganda was severely repressed.

1. Decentralization law ratified in 1993.

2. The Gini coefficient rose from 0.35 in 1997/98 to 0.43 in 2003. (Source: Ministry of Finance, Planning and Economic Development, 2005).

3. This section drawn from Thue and others, July 2002.

1.5 The establishment of the NRM Government in 1986 enabled a revival and rapid growth of CSOs. As of 2002 there were over 2000 registered NGOs in Uganda, and many more (unregistered) community-based organizations (CBOs) and other informal groups. NGOs and CBOs represent a broad and diverse range of constituencies, motivations, roles and mandates, encompassing: promotion of group interests, service delivery, advocacy, community development, culture and religion, networking and information dissemination. They are increasingly consulted in policy formulation and in monitoring public expenditure at the district level, but need to further develop capacities in these areas. Additionally, they are heavily concentrated in and around Kampala.

1.6 In 1997 the Government of Uganda prepared a first draft of a Poverty Eradication Action Plan (PEAP), which was revised in 2000 to cover the period 2000-2003. This document, which guides public action to eradicate poverty, was the first Poverty Reduction Strategy Paper (PRSP) to be approved by the World Bank and IMF in May 2000. A second PEAP covering the period 2004/5 – 2007/8 was issued by Government in 2004.

Health Sector[4]

1.7 Health indicators in the early 1990s revealed very high infant, child and maternal mortality rates, high fertility, and high levels of malnutrition.[5] Uganda's high disease burden is documented in a 1995 Burden of Disease (BOD) Cost-Effectiveness study, which found that over three quarters of life years lost from premature death were due mainly to preventable diseases. Some sixty percent of the total national disease burden is attributable to prenatal and maternal conditions, malaria, acute respiratory tract infections, AIDS and diarrhea. Non-communicable diseases (hypertension, diabetes, cancer, mental illness, and chronic heart disease) are increasing in occurrence.

1.8 Once considered to be one of the best in Africa in its earliest years of independence, Uganda's health system was devastated by the civil conflict that occurred in the 1970s through 1986, and suffered as well from relative neglect by government which did not provide sufficient financial support for its functioning and rebuilding. As a consequence, private not-for-profit (PNFP) and for-profit (PFP) facilities developed during this period to compensate in part for the gap in services. After the conflict in the

Box 1. Highlights of Health Sector Reform Envisaged in MoH 1992 Strategy and 1993-95 Plan

- Reorient health services away from curative care to prevention and promotion by reallocating resources towards primary health care
- Mobilize additional resources to finance the health sector
- Strengthen planning, management and coordination of services at various levels
- Renovate and consolidate existing facilities and services
- Promote community participation in the development and management of health services
- Strengthen private/public partnership
- Decentralize health services delivery to the districts as part of the government's overall decentralization strategy
- Enable the sector to participate in ongoing government-wide reforms such as civil service reform and liberation of the economy.

Source: World Bank 2004

4. This section drawn from World Bank 2004.

5. Infant mortality rate: 88 per 1000 live births; under-five mortality rate: 150 per 1000 live births; maternal mortality; 523 per 100,000 live births; fertility: 6.9 children per woman of child bearing age. Infant mortality rate: 88 per 1000 live births; under-five mortality rate: 150 per 1000 live births; maternal mortality; 523 per 100,000 live births; fertility: 6.9 children per woman of child bearing age.

late 1980s donor support focused on the rehabilitation of health infrastructure, but this was largely uncoordinated by MoH. In the early 1990s MoH attempted to launch a reform of the health sector, as articulated in its White (strategy) Paper on Health (1992) and its Three Year Plan (1993-95). (see Box 1)

World Bank Support for Health through 1995

1.9 *Country Assistance Strategy*. The primary objective of the Bank's strategy for Uganda in the 1990s was to reduce poverty through efforts to: maximize labor-intensive economic growth, strengthen economic and social infrastructure, support human resource development, enhance the provision of public services, and measure effectively changes in poverty over time (World Bank 1995). Among the highest priorities of this strategy were improvements in health and education. Support to health sector development emphasized primary and preventive care, decentralization, and HIV/AIDS. While lending for health and HIV/AIDS was initially conceived under one project design in the early 1990s, it was decided to split them into two separate operations to accelerate the availability of financing for HIV/AIDS, which was considered urgent.[6]

Box 2. Highlights of the 1993 World Development Report, "Investing in Health" (WDR 1993)

WDR 1993 recommended a threefold approach to health sector development: (1) foster an economic environment that will enable households to improve their own health; (2) redirect government spending away from specialized care and towards such low-cost and highly effective activities such as immunization, programs to combat micronutrient deficiencies and control of treatment of infectious diseases, contained in an "Essential Health Package" (EHP); and (3) encourage greater diversity and competition in the provision of health services by decentralizing government services, fostering greater involvement by non-governmental and other private organizations, promoting competitive procurement and regulating insurance markets. The report asserted that countries could reduce their burden of disease by 25 percent by adopting the packages of public health measures and essential clinical care included in the EHP.

Source: World Bank, World Development Report 1993.

1.10 *Non-Lending Support*. In 1993 a social sector strategy was published, which covered education, health and population. The report highlighted the high morbidity and mortality, largely attributable to preventable diseases, and the inadequate availability and inefficient allocation of financial resources for health. It called for more resources to finance needed investments in health and pointed to ways in which resources could be more efficiently allocated for greater impact on health system performance and health status: favoring more preventive and promotional activities, and community health. Also in 1993 the World Bank published the World Development Report "Investing in Health,[7]" which was seminal in its influence of health investments. (See Box 2)

1.11 *Lending*. The First Health Project (approved by the Board in June 1988, declared effective in January 19889, and closed in March 1996) essentially contributed to Government's efforts to rehabilitate health infrastructure that had deteriorated in the wake of years of conflict. The Program for Alleviation of Poverty and the Social Costs of Adjustment

6. A health and HIV/AIDS operation was initially identified as the Community Health and AIDS Project (CHAP) in the early 1990s, but later split into (a) the Sexually Transmitted Infections Project, approved on April 12, 1994 (see Project Performance Assessment Report (PPAR) on this project published in 2005); and (b) the District Health Services Pilot and Demonstration Project, approved on February 7, 1995 and the subject of this review.

7. Include full reference.

(PAPSCA) (1990-1995) was the first Bank operation in Uganda which supported substantial involvement of NGOs in social service delivery and pointed to the important role of NGOs in the implementation and facilitation of social support.

1.12 *Donor Support* at the time of project design (early 1990s) was devoted primarily to the construction and rehabilitation of health infrastructure and the provision of essential inputs for service delivery and (increasingly) to the fight against HIV/AIDS. At that time donors were working in parallel and uncoordinated, although two (Austria and Swedish SIDA) did cofinance the first IDA-financed Health Project in Uganda.

2. Objectives and Design

2.1 The District Health Services Pilot and Demonstration Project (DHSP) was financed through an IDA credit of US$45.0 million equivalent,[8] approved on February 7, 1995 and declared effective on July 17, 1995, and a planned government contribution of US$6.9 million. In addition, anticipated cofinancing brought the total estimated project cost to US$75.1 million, including Swedish SIDA (US$7.0 million), DANIDA (US$5.0 million), KfW (US$9.0 million) and ODA (US$2.2 million equivalent).

2.2 **Objectives**.[9] In support of the CAS objectives of human resources development and poverty reduction, the overarching goal of the DHSP was to improve the health status of the populations in the project districts (World Bank, 1994 and World Bank, 1995). The main objective of the project was to test, on a pilot basis, and demonstrate the feasibility of delivering an essential health services package to district populations within a prudent financial policy framework, through an integrated program of policy, institutional and financial improvements in order to improve efficiency and equity in the provision of health services. Specific objectives of the project[10] were to: (a) mobilize more resources for the health sector (for improved sustainability), both through increases in public financing and through alternative/additional financing mechanisms; (b) improve efficiency in the use of these resources, reallocating expenditures towards the EHP; (c) support the implementation of national decentralization policy in the health sector (including capacity building at central and decentralized levels of MoH); (d) restore the functional capacity and improve the efficiency of essential existing government facilities; and (e) facilitate a greater role for NGOs, the private sector and communities (experimentation w/ contracting out).

8. All US$ amounts represent the US$ equivalent of SDRs or other currencies.

9. Statements of the goal, main objective, and specific objectives of the DHSP are found in various sections of the Staff Appraisal Report (World Bank, 1994) and are linked to the hierarchy of the Bank's overall objectives in Uganda in the Bank's 1995 Country Assistance Strategy (World Bank, 1995). Their presentation in the SAR is unsystematic and no outcome or impact indicators were established during the design stage. As a part of this PPAR exercise, an assessment of the various iterations of goals, objectives and expected outcomes was undertaken to create a more systematic presentation of the hierarchy of objectives that would serve as the framework for evaluating project performance. Annex C, Table C-1 presents the worksheet that documents (a) the sources of the various statements of project goals and objectives and (b) how they were distilled into the statement of objectives presented in this paragraph.

10. Itemized in a project-specific matrix in Government's Letter of Sector Development Policy and also articulated in project objectives and benefits sections of the SAR (see also Annex C, Table C-1).

2.3 **Components**. In support of these objectives the proposed project would (a) pilot and test/demonstrate new sector policies and strategies which would facilitate the implementation of essential health services; (b) strengthen management and planning capacity at district levels so that they would be prepared to provide essential health services; and (c) restructure the MoH so as to build its capacity to provide health policy leadership and to support the Government's decentralization policy. Project components (with estimated costs at appraisal) are briefly presented below.

2.4 **Pilot Activities (US$8.2 million)**. This component was intended to support the implementation of an essential package of cost-effective health services in three pilot districts (Soroti, Mukono and Masindi), which had (among other districts) carried out a burden of disease analysis and prepared action plans. At the design stage, drawing on the results of the burden of disease analysis and cost-effective analysis carried out in Uganda, MoH decided that the cost-effective package of services (encompassing public health, preventive and curative activities), would be comprised of: malaria control; maternal and child health, family planning and immunization services; hygiene, water and sanitation interventions; nutrition; tuberculosis and STI control;[11] treatment of other common diseases and health problems; and surveillance/treatment of special health problems.[12] This component was designed to support delivery of this essential package of health services (EHP), achieving a coverage of 60 percent of district populations (from a baseline of 20 percent), through the financing of critical inputs (drugs, equipment, supplies, rehabilitation works) and activities (training/capacity building, supervision costs, social mobilization, maintenance, operational research and monitoring and evaluation). It was also tailored to support learning in the following areas: innovative health financing; contracting out of repair, maintenance and rehabilitation; contracting out of health services; motivational remuneration of health workers; assessment of changes in health status attributed to essential health package. The pilot phase would be concluded with an assessment of the delivery, management and impact of the EHP in the three pilot districts and in three other districts that were also receiving support to deliver the EHP.[13]

2.5 **Demonstration Activities (US$19.1 million)**. This component was intended to continue support for the pilot districts and extend support to an additional seven districts for the delivery of the EHP, which would have been fine-tuned in light of lessons learned under the pilot phase. Coverage was also anticipated to increase from a notional 20 percent to 60 percent of district populations. It also aimed to continue and deepen the learning process on the five topics slated for the pilot phase and extend it to other topics, including community-based health and quality monitoring and assurance. Districts were to be selected to participate in the demonstration phase based on their satisfaction of a number of criteria, which would ensure that they would: (a) be decentralized by the central government, (b) have a health policy and implementation plans satisfactory to IDA, (c) volunteer for inclusion in

11. While an integral part of the essential package of services, the project would not provide direct support to this component, as it was considered to be fully financed. One source of financing was the IDA credit, approved on April 12, 1994, for a Sexually Transmitted Infections Project (STIP).

12. Guinea worm, schistosomiasis, trypanosomiasis, onchocerciasis and meningitis.

13. Gulu, Kabale and Tororo districts received support to deliver the EHP with funding from the first IDA-financed health project (reference) and Swedish SIDA.

the project on an annual basis; and (d) use other donor assistance in the framework of the EHP.

2.6 **Capacity Building for District Health Administrations (US$36.7 million)**. This component was designed to be nationwide in its coverage, but phased in its approach. In the context of an ongoing process of decentralization, it aimed to support strengthening of districts' capacities for health management and administration through training and on-the-job advice and assistance in planning, programming, supervision, monitoring and evaluation, financial management and financial reporting. To this end, computers, equipment, logistical support and some rehabilitation were also envisaged. The component also envisaged support to study and nurture innovations, including the development of private health units, increased autonomy of selected public facilities, improved effectiveness of training in Government institutions, contracting out of services, and new health financing mechanisms. In addition, this component aimed to strengthen the public health capacity of the National Resistance Army.

2.7 **Restructuring and Capacity Building of MoH (US$8.0 million)**. This component sought to reorient the structure of central-level MoH to accommodate ongoing health sector reforms, particularly health sector decentralization and the integration of health programs and services. A plan to consolidate and restructure MoH to this end was to be developed and implement with project support. This component also sought to strengthen the Health Planning and Inspection Department through the provision of study tours, training, short-term technical assistance, and software systems for management and information. It was also designed to support the relocation and full establishment of all MoH departments in Kampala, which had been scattered between Kampala and Entebbe. To this end, the project provided for the rehabilitation, furnishing and equipping of existing buildings in Kampala, with no new construction envisaged.

2.8 **Project Organization and Management, including monitoring and evaluation (US$3.1 million)**. The project aimed to support the costs of a Project Coordinating Unit (PCU) (shared with the IDA-financed Sexually Transmitted Infections project[14]), including salaries, office, furniture, equipment, vehicles, supplies, technical assistance, supervision, mission travel and other operating costs. This component also provided for a project launch workshop and funds for the preparation of a follow-on project. Implementation arrangements and monitoring and evaluation are described briefly below.

2.9 **Implementation Arrangements.** The project was placed under the overall responsibility of the MoH, with the Permanent Secretary (PS) serving as Project Director in charge of coordination and implementation oversight. A PCU, headed by a senior Public Health Specialist reporting directly to the PS, was given responsibility for day-to-day management and coordination of the project. Staffing of the PCU was to include a small professional staff (an administrator, three accountants, a procurement specialist, an engineer) and support staff. The Project Coordinator would serve as Secretary to a Project Steering Committee, established during the project design stage to act as an advisory body during implementation. This Committee was chaired by the PS/MoH, with representation from other departments in MoH, National Medical Stores, Ministries of Public Service, Local

14. Credit No. 2603, approved on April 12, 1994 (World Bank 2005).

Government (Decentralization Secretariat), Finance and Economic Planning, Justice and Constitutional Affairs, and selected local authorities. It was supposed to meet on a quarterly basis with the flexibility to invite wider participation from districts, NGOs and other interested parties on an ad hoc basis.

2.10 *At the central level*, MoH was to be involved in project management, oversight and implementation on a number of fronts. The PS was assigned responsibility for the implementation of capacity building activities at central and district levels. Given the strong focus of this project on district-level support and implementation, two district support teams drawn from the Health Planning Department staff were responsible for frequent travel to districts for close supervision and on-the-job training and support, both technical and managerial in nature, in close collaboration with the PCU. The Health Planning and Inspection Departments were given responsibility to carry out pilot activities and studies envisaged during the pilot and demonstration phases. In respect of their normal responsibilities, the Director General of Health Services and other technical staff of the MoH were supposed to provide technical support to the districts in line with the demands of the project and their comparative advantages.

2.11 *At the district level*, the district medical officer (DMO) was responsible for coordinating and implementing the EHP in their respective districts, assuming lead responsibility for planning, implementing and monitoring district-level activities supported under the project. They were expected to: undertake annual exercises to review and report on implementation of previous plans and to prepare plans and targets for the coming year in light of past performance, carry out supervision activities, manage district health teams, and reach out to communities, district authorities, NGOs and other local level partners and stakeholders in the achievement of project objectives. The districts were also encouraged to contract out health services and outreach activities as well as non-health support services to non-public local level actors, where feasible.

2.12 Project funds were supposed to be advanced to districts on a quarterly basis, based on funding requirements of their annual plans which were to be reviewed and approved by the central level (PS). Initial disbursements would be deposited into accounts to be opened by each district and subsequent disbursements would be made quarterly, on the basis of statement of expenses and reports submitted to MoH/PCU. The DMO would thus be accountable for the proper use of financial resources and of goods and services received under the project. Reporting responsibilities would encompass both financial and plan implementation aspects.

2.13 Monitoring and Evaluation activities planned under the project are discussed in Chapter 4.

3. Implementation and Costs

Implementation Experience

3.1 The project was approved on February 7, 1995, and declared effective on July 17, 1995. It was implemented over a period of seven and one half years, closing on December 31, 2002, as planned.

3.2 **Counterpart financing and legal covenants**. The Government did not fully meet its counterpart obligations, a problem generic to virtually all projects in the Bank's portfolio for Uganda. While a decision taken during the mid-term review to reduce the counterpart from 10 percent to 5 percent of total project costs helped alleviate financial constraints, the timely release of Government funds remained problematic. Still other financial pressures undermined smooth project implementation, most notably: (a) delays in the payment of taxes on goods imported with project funding, which caused MoH to pay substantial amounts in interest and demurrage charges and incurred major delays in the release of these goods essential to implementation; and (b) shortfalls and delays in the payment of health providers' salaries. The majority of legal covenants were fully met by Government. A condition of disbursement, banning expenditure on the demonstration phase until completion of the pilot phase, was not met. No violation of project safeguards was reported or observed.

3.3 **Procurement** for civil works and medical equipment was delayed by some three years. The mid-term review raised a number of underlying reasons for such delays: (a) confusion over the role of the Central Tender Board and consequent delays in bid evaluation approval; (b) breach of confidentiality in the tendering process; (c) inadequate capacity for procurement at the PCO, including lack of familiarity with IDA procedures; and (d) the absence of a viable procurement plan at the project's outset. Considerable procurement responsibility was decentralized to district tender boards, which met very rarely as districts often lacked funds to pay tender board allowances. District-level procurement was thus also delayed, or, in some cases, did not take place at all. Delays in the purchase of equipment and goods: (a) undermined project software efforts, especially service delivery, training and supervision; (b) inflated their costs; and (c) tied up project funds. Inadequate capacity to document fully the needs and technical specifications resulted in some acquired equipment being inappropriate (e.g., electrical equipment ordered for health centers without electricity). Informants at central and district levels noted that while procurement capacity has improved through the experience of project implementation, it is still in need of further improvement.

3.4 **Financial Management**. External audits and periodic supervision of districts by the PCO and the Bank have confirmed that overall the Government respected the exigencies of financial management and accounting required by IDA. However, as was the case for the Sexually Transmitted Disease Project,[15] the decentralized nature of the project design was innovative and thus caused complications and delays as central and district capacity was slowly built through experience. Other bottlenecks to the smooth flow of funds to districts included: delays in submitting district financial accounting reports, on which basis they would receive a follow-on tranche of financial support, turnover of the district accounting

15. World Bank, Operations Evaluation Department. 2005.

staff, the (initial) small size of the Special Account, and the closure in 1999 of the commercial Bank holding the Special Account.[16] The PCO exerted considerable and sustained effort to improve financial flows to districts and to further develop district financial management and accounting capacity, including the provision of technical assistance,[17] training and guidelines, and frequent and supportive supervision. A special World Bank disbursement mission culminated in a tripling of the initial amount (US$750,000) of the Special Account. A good indicator of growing district capacity for financial management is an increase in districts' capacity to absorb all financial resources, from 78 percent in 95/96 to 96 percent in 01/02 (Konde-Lule, et. al).

3.5 **Disbursements** were slow initially due to issues cited above, notably: (a) major delays in procurement; (b) the inadequate size of the Special Account; (c) and delays in submission of districts financial reports, which are required both for a replenishment of the Special Account and for an authorization to release the next tranche of funds. The disbursement lag ultimately disappeared as district absorptive capacity improved and procurement was carried out. During the last years of the project disbursements to districts had to be scaled down as remaining project funds became fully committed.

3.6 **Role of Civil Society Organizations/Subcontracting**. The initial project design envisaged an identification at the district level of services and activities that could be contracted out and award of contracts to the most qualified bidder through a competitive process. In practice, however, districts chose to involve reputable NGOs already active in the health sector[18] in the annual health planning exercises and to program jointly with them their continued (and/or expanded) support to district health sector goals in line with their capacities and comparative advantages. NGOs were also invited to submit technical proposals for financing. It is reported that district-level contracts with NGOs supported under DHSP covered a range of services and activities encompassing the delivery of health services and a number of support services, including: supervision, training, transport operation and maintenance, construction and social marketing. Informants from both central and district levels noted that partnerships with NGOs were modest, compared with those developed (by those same districts) under the STIP project. Discussions with informants revealed that the notion of complementarity was more accepted for HIV/AIDS activities, while the notion of competition was still an underlying factor in districts relative reluctance to contract out health sector activities. Neither the DHSP nor the STIP evaluated the NGO/CBO activities they supported, nor were they systematic even in monitoring activities or financial accountabilities of NGOs. By the end of the project NGOs received some 12 percent of district funding, falling short of the project goal of 30 percent. This shortfall notwithstanding, a range of informants confirmed that World Bank's support and encouragement of partnerships with NGOs under DHSP and STIP were instrumental in

16. The closing of the International Credit Bank right after replenishment of the Special Account had been authorized by IDA caused a considerable amount of project financing to be unavailable for a period of time.

17. SIDA provided a full-time technical assistant to the PCO to support capacity building of district-level accountants in financial management and accounting. All districts visited and central level staff expressed profound appreciation for his dedication and availability, which culminated in improved district capacity.

18. District-level informants noted that NGOs were solicited on the basis of: their location and target groups (with a view to improving coverage and equity); implementation experience and capacity; the nature and sustainability of their activities; their technical capacity; and their transparency.

influencing the formal adoption of this practice in the context of a new health policy. See also Annex D for more detail on support to NGOs.

3.7 **Project management and oversight**. The Project Steering committee didn't function, as planned. It met very infrequently and its role was not fully understood by its members. This issue was resolved towards the end of the project when the Department of Planning was sufficiently strengthened to assume responsibility for oversight and coordination of implementation.

3.8 **Risks**. Three of the four main risks identified during project design did come to pass. *First*, the implementation capacity of the central MoH and of district-level institutions was weak vis-à-vis the sweeping reforms proposed (especially decentralization), but mitigation efforts such as annual planning and reviews and quarterly monitoring and close, supportive supervision were effective in slowly building such capacity. *Second*, inadequate skills and compensation of health personnel did limit the capacity to improve the quality and coverage of essential health services. Solutions to this issue (recruitment and payment of adequate salaries/salary arrears) were, however, beyond the mandate of the project (or MoH) to address. *Third*, the starting point of inequitable financial and other support to public vs. NGO services within a district were mitigated by project support to district plans, which was holistic in its inclusion of NGOs to benefit from essential inputs and processes (drugs, equipment, supportive supervision, training, support of other activities and operational costs). While the risk of conservative elements in government and civil society blocking or slowing the process of reform did not come to pass, an unanticipated political risk did emerge. Against the backdrop of a post-conflict situation and a strong emphasis on equity, the notion of a pilot approach was never fully accepted. Instead, there was a strong drive for immediately distributing the resources of this health project equitably across all districts.

Planned vs. Actual Inputs/Activities by Component

3.9 Annex D provides a detailed inventory of planned vs. actual project support by component. Project inputs are also discussed in Chapter 4 in relation to the sub-objective(s) they were supporting. Actual project support differed from planned support in three fundamental ways. *First*, the pilot and demonstration phases were merged and project support was extended nationwide without first evaluating pilot/demonstration experience, as had been planned. *Second*, actual civil works cost almost double the initial estimates. *Third*, monitoring and evaluation was not implemented as planned.

3.10 ***Merging of Pilot and Demonstration Components and Extension of Project Support to all Districts***: During a supervision mission in November 1996, more than a year after effectiveness and some two years prior to the mid-term review, a joint (Bank and Borrower) decision to merge the pilot and demonstration phases was taken, prompted largely by the delays in project startup (especially procurement), on the one hand, and the short timeframe for the pilot operation on the other (internal supervision reporting). As a consequence, project support was extended to an additional seven districts[19] without the

19. A redrawing of administrative districts during project implementation increased the total number of districts from 39 to 56 and the total number of districts to be covered under this project (from 13 to 16) as follows: pilot districts (3 to 4); pre-pilot districts (3 to 4); demonstration districts (7 to 8).

benefit of an evaluation of an initial pilot phase. Subsequently, during a 1998 supervision mission, it was agreed to extend the project benefits to all districts (internal supervision reporting). While some operational research and studies were undertaken (itemized in Annex C.), the project ultimately did not assess, as originally intended, the effectiveness and lessons of implementing sweeping reforms in a few pilot and (subsequently) demonstration districts before expanding them nationwide. Table 1 below provides an overview of the planned vs. actual approach for the pilot and demonstration phases.

Table 1. Planned vs. Actual Approach for Pilot and Demonstration Phases

Pre-Pilot Phase Districts	Pilot Districts	Evaluation of Pilot	Demonstration Districts	Evaluation of Demonstration Phase
Planned (total number of districts at design stage: 39)				
3 districts: Gulu, Kabale, Tororo	3 districts: Soroti, Mukono, Masindi	To assess the delivery, management and impact of the essential health package delivered in 6 (pilot and pre-pilot) districts	Incorporation of an additional 7 districts (not specified at appraisal) for a total of 13 districts, which will implement the findings of the first phase assessment	To document the demonstration phase experience and lessons in all 13 districts (pre-pilot, pilot and additional districts in demonstration phase)
Actual (total number of districts at completion stage: 56)				
3 districts: Gulu, Kabale, Tororo were supported under the First Health operation with IDA and SIDA financing	A decision to combine pilot and demonstration phases was taken during a supervision mission in 1996. Thus the evaluation of the pilot phase was not undertaken. This consolidated pilot/demonstration phase supported 16 districts as follows: (4) Pre-pilot phase districts: Gulu, Kabale, Tororo, Busia (4) districts originally slated for pilot phase: Soroti, Katakwi, Mukono, Masindi (8) additional districts slated for demonstration phase: Apac, Iganga, Bugiri, Kamuli, Kiboga, Lira, Mubende, Rukungiri,			Some analyses/reviews of isolated pilot schemes on a range of topics, carried out in different localities, were undertaken, along with a few feasibility studies on other innovations. However, the consolidated pilot/demonstration phase was not evaluated. Nevertheless, in 1998 a supervision mission determined that "…the benefits of the pilots should now be expanded to all districts."

3.11 ***Planned vs. Actual Construction***. The project financed a total of about 150 works at the district level, including (a) the rehabilitation of 125 health units (more than double what was planned), three local-level UPDF health units, and three district hospitals; and (b) the construction of nine district health offices and eight district drug stores (Annex D, Tables D3-D6). A range of informants indicated that there was considerable pressure to undertake more works than initially planned because of the post-conflict situation, which had left the health infrastructure in shambles and placed national equity as a high priority. There were also reports of strong lobbying by district politicians to increase civil works support in their respective localities. Some 40 percent of completed health unit rehabilitations are located in districts other than those originally slated to pilot test and demonstrate reforms in service delivery (Annex D, Tables D3-D6). At the central level, the project financed the construction of a new building to house the Ministry of Health, as opposed to the original plan to rehabilitate an existing building for this purpose. The actual cost of civil works for central and district levels combined (about $23 million)[20] was almost twice the original estimate (about $12 million).[21]

3.12 ***Shortcomings in the Implementation of Monitoring and Evaluation (M&E)***. These are discussed in detail in Chapter 4.

20. Konde-Lule, 2002.

21. World Bank, 1994.

Planned Versus Actual Costs and Financing[22]

3.13 The total project cost is estimated to be about US$60.0 million or 80 percent of the appraisal estimate (US$75.1 million). The actual costs of each component were somewhat different than originally planned.

Table 2. Planned vs. Actual Costs by Component (US$ million equivalent)

Component	Planned[23]	Actual[24]	Actual as % of Planned
Pilot and Demonstration Activities	27.3	12.0	44%
Capacity Building for Districts	36.7	32.0	87%
Capacity Building for MoH (including project management and M&E)	11.1	16.0	144%
Total	**75.1**	**60.0**	**80%**

3.14 The IDA credit (US$45.0 million) and SIDA grant (US$7.0 million) were almost fully utilized, disbursing at 98 and 99 percent, respectively. The US$9.0 million KfW grant was fully utilized. The financing shortfall of US$15 million was largely attributable to two financiers (ODA/DFID and DANIDA) withdrawing from formal cofinancing arrangements[25] and the reduction of Government counterpart obligations (Annex E, Table E-1). In addition, a reduction in available IDA financing (as expressed in US$) is attributable to the lower value of the dollar in relation to the SDR, compared with appraisal estimates.

4. Monitoring and Evaluation

Design

4.1 Monitoring and Evaluation (M&E) activities planned under the project were meant to determine the impact and cost-effectiveness of health programs and to draw lessons for improved management and service delivery. While a few process indicators were defined during project design, the definition of indicators for assessing project outcome and impact was postponed into the first six months of implementation. An evaluation of the one-year pilot experience was planned to assess the costs and progress of district plan implementation, the cost-effectiveness of interventions and the impact of activities on health indicators, with a view to fine-tuning interventions for the demonstration phase. Baseline studies for pilot and demonstration districts would be conducted prior to credit effectiveness to (a) document health status and disease burden indicators and expenditure on different health packages; and (b) assess managerial capacity. Plans to monitor the delivery of EHP would rely on the (new) health management information system and sentinel surveys, as needed. Costs and

22. This section summarizes planned vs. actual cost data by project component, cost category and source of financing. See Annex E for relevant tables.

23. World Bank Staff Appraisal Report, 1994.

24. Actual costs were derived from three sources: (a) Government's final evaluation report (which shows final expenditures by cost category totaling an estimated US$58.39 million); (b) World Bank 2003 (which shows final costs by component totaling an estimated US$65.3); and (c) actual financing received reported in original currency amounts by the World Bank Loan Department, and other sources (see Annex E). Calculations included adjustments of appraisal (1994) exchange rates used by World Bank 2003 (US$1 = 940 U sh), instead of mid-2003 exchange rate (US$1 = 1992 U Sh).

25. Although these two partners initially indicated a willingness to cofinance the project, no firm assurances were received in this regard. In the end, both decided to channel their funding through separate parallel projects.

financing of delivery of different EHPs in different settings would also be tracked over time. In addition, the project provided for the M&E of NGO participation, assessing both process and substance.

4.2 As a complement to these activities, research and in-depth studies were envisaged, to explore ways and means of enhancing health status and health care delivery. Potential topics for deeper analysis included: cost and impact of EHP; alternative approaches for health impact assessment; cost recovery schemes; and other studies defined under each component.

4.3 Districts would be responsible for monitoring and reporting on their plan implementation, while the PCU would be responsible for M&E oversight, and analysis and compilation of findings. Implementation reviews would be carried out on a semi-annual basis, with every other review serving as a more in-depth annual review. Mid-term and final evaluations were also envisaged. The estimated cost of M&E was US$1.2 million, or 2 percent of the total project cost.

Implementation

4.4 The assessment of project outputs and outcomes has been seriously undermined by a number of factors inherent in the weak design and implementation of monitoring and evaluation. Project objectives were not clearly articulated, an impediment also noted by many informants involved in project management and implementation. Indicators were not specified until well after the mid-term review. Informants report that their many attempts to establish such indicators were unsuccessful due both to the complexity of the project design and to lack of guidance from the Bank. The final evaluation report of the Government shows the indicators finally selected to evaluate the project, but these do not capture the learning/experimentation inherent in the project design (Annex C, Table C-2). Neither do research and studies undertaken facilitate or document learning and experimentation. While districts did not carry out evaluations of the impact of their activities, they did undertake quarterly reviews of their activities against those planned and used these as vehicles for improved planning as well as for justifying a subsequent trance of financial support. All pilot and demonstration districts carried out baseline studies documenting their burden of disease, but changes in health status were not systematically tracked at the district level. NGO activities were not evaluated. M&E was officially the responsibility of the Health Planning Department/MoH, but in practice it was assumed by the PCO because of the overall weak capacity of the former. While the project in its initial years concentrated on 13 pilot and demonstration districts, for the most part data on relevant trends are only available at the national level.

5. Outputs and Outcomes by Objective

5.1 Notwithstanding weaknesses in M&E design and implementation discussed in Chapter 4, this chapter draws on project and other available information and data to assess whether or to what extent project objectives have been achieved, and the extent to which changes documented can be attributed to project support (itemized in Annex D). A results matrix (Annex F) and other data and graphics (Annex G) provide more detail on outcomes discussed below.

Main Objective: Test and demonstrate the feasibility of delivering the EHP

5.2 ***The fostering of a learning process through pilot and demonstration phases that would ultimately fine-tune policy for nationwide application was negligible. The potential for learning under this project was undermined by the decisions first to merge the pilot and demonstration phases (in 1996) and then to extend project support to all districts (in 1998) without the benefit of evaluating each phase***. These decisions were taken both because the launch of the pilot phase was delayed by procurement and other initial implementation issues (Chapter 3) and because the political pressure to expand project support rapidly to all districts during a post-conflict period was formidable.[26] Planned evaluations, originally intended to enhance the understanding of modalities and relative effectiveness of various reforms to be tested, demonstrated and refined during the pilot and demonstration phases, were not undertaken. Nevertheless, some learning did occur during project implementation, with caveats.

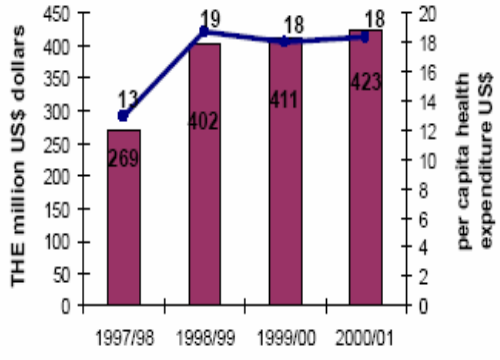
5.3 *First*, some thirty studies were carried out to collect and document various pieces of information and experience, covering a range of topics, including: health costs and financing, private health sector development, training, supervision, management, contracting out of key services, utilization rates, quality of care, and community health. Annex D, Table D-2 itemizes these studies and Annex F reflects the findings and use of study results by project objective, where such information was available. However, there was no systematic framework for the planning, design, coordination and implementation of these studies that would have addressed more deliberately and systematically the learning intended under the pilot and demonstration phases, nor were the results and use of these studies assessed by the Borrower in the final evaluation of this project.[27] *Second*, many informants from both central and district levels noted that the experience of implementing reforms supported under this project (decentralization, delivery of an essential package of services, partnerships with the non-governmental sector) constituted a learning process in and of itself. However, the learning which did occur through practical experience was ad hoc in nature, and much of it remained undocumented and underexploited.

26. A wide range of informants, spanning nationals (policymakers, managers, technical staff at central and decentralized levels), Bank staff and other partners, attested to this fact.

27. The final evaluation conducted by the World Bank does attempt to do this and provided a useful reference for this analysis.

Subobjective #1: Mobilize more resources for the health sector

Figure 1. Uganda Total Health Expenditure—1998/99 to 2000/01



Source: Uganda National Health Accounts 2002

5.4 ***Total per capita expenditure on health more than doubled during the life of the project from an estimated US$7.74 in 1992/93[28] to about $18.31 in 2000/01[29]. This upward trend is attributable to increases both in public spending (from $2.83 to $8.35 per capita) and in private spending (from $4.91 to $9.96 per capita).*** While the increase in per capita expenditure during the 1990s is significant, the level of per capita spending stagnated over the last few years of the project, and falls far short of the estimated US$28 per capita needed to deliver basic services to Uganda's population (MoH Health Financing Strategy, 2002) (See Figure 1).

5.5 Increases in public and private expenditure can be attributed only in part to project support, which fell short of its potential: there is still considerable scope and need for further increases in both public and private financing.

5.6 *Public spending*. While central government expenditure increased by almost half between 1994/95 and 2000/01 (from 91 billion shillings to 134 billion shillings), the trend of government spending on health is very modest in terms of its share of total government expenditure (from 8.0% in 1994/95 to 8.6% in 2000/01).[30] As a proportion of total health expenditure, central government's share has remained low ranging between 17 and 18 percent during the last few years of the project (1998/99 – 2000/01), well below the donor's share of 27 to 28 percent and households' share (ranging from 41 to 46 percent). The (modest) increase that did occur can be attributed in part and indirectly to project support,[31] especially: its encouragement and facilitation of donor collaboration and co-financing, its success in increasing the absorptive capacity of health districts (planning and financial management capacity and contracting with non-governmental sector – see paras. 5.14), its financing of the burden of disease and EHP studies which highlighted both the need for incremental financing for health and the potential for enhanced cost-effectiveness in the use of these resources, and its support of the production of key policy and strategic documents that have facilitated a SWAp approach (see para 5.15).

28. Ministry of Health Letter of Sector Development Policy, 1994.

29. Ministry of Health Annual Health Performance Report, 2003/04.

30. During the life of the project health's share of total government expenditure actually decreased to 6.5% in 1999/2000 and slowly increased over subsequent years (Annex G, Figure G.4).

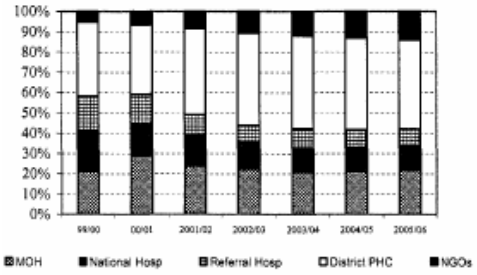
31. Increases in public spending are also attributable to the PRSP/PEAP process, which has highlighted the importance of improving health sector performance and health indicators and to the creation of a Poverty Action Fund for financing key components of the PEAP, including the support of primary health care. (Republic of Uganda 1998). The BOD/EHP work helped shape the health chapter of the PEAP; and the project's inputs to strengthen district capacity facilitated the use and accountability of these funds.

5.7 *Out of pocket expenditure*. The project provided considerable support to implement cost recovery in public facilities, including the provision of guidelines and tools on the collection and reinvestment of user fees, training of health workers and committee members, logistical support for records keeping, and a consultative process for policy development. Out-of-pocket expenditure as a share of all health expenditure actually decreased in the latter years of the project from US$8.67 (or 46 percent of all health expenditures in 1998/99) to US$7.41 (or 41 percent in 2000/01). In 2001, user fees were abolished by the Head of State as a means of addressing inequities in service access. This decision did not reduce household expenditure on health services (delivered by private and public services combined), but it did have a positive effect on the share of spending across the different income quintiles, with the poor paying about half and the better off paying almost double what they were paying previously (Annex G, Figure G.5). Government financing was never increased sufficiently after the decision to abolish user fees to compensate for (a) the consequent loss in income for the health facilities and low service quality; and (b) the increased utilization of free services.

5.8 *Health Insurance/Other Private Financing*. The project financed a number of studies to explore the feasibility of alternative/additional private financing mechanisms, including: a new health financing system proposal, a review of the health services cost-sharing scheme, a review of financial flows to the health sector, a health insurance feasibility study, exploration of drug revolving funds, income generation and prepayment schemes. Findings emanating from these studies pointed to issues and challenges. Insurance was found to be economically feasible, but not politically or financially viable. Drug revolving funds were found not to be feasible at the district level due to inefficient management and use of drugs. Operational research concluded that directly supporting income generation (to incite an increase in private health spending) is not the role or comparative advantage of the health sector. While two prepayment schemes at the hospital level were initially successful, it was concluded that more analysis and pilots were needed before firm conclusions could be drawn. Studies and experimentation carried out with project assistance did not culminate in increased private financing. Private firms expenditure on health actually decreased from US$0.10 per capita in 1998/99 to US$0.6 per capita in 2000/01. The fostering of risk pooling mechanisms under the project to generate more resources for health was very timid and modest at best, and remains a critical activity for closing the health financing gap.

Subobjective #2: Improve efficiency in the use of sector resources

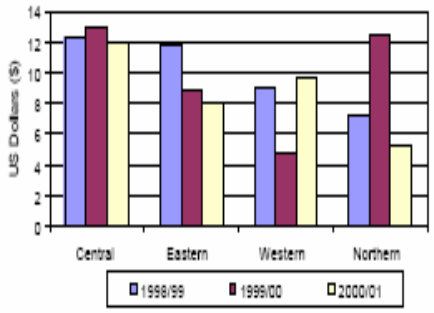
Figure 2. Share of Recurrent spending by level



Source: the MTEF from MOFPED

5.9 ***Project support has been instrumental in effecting improvements in the efficient allocation and utilization of health sector resources, but the financing of EHP delivery to Uganda's population is still inadequate and spending patterns are still inequitable.*** Assessment of the burden of disease and of the cost-effectiveness of health care interventions carried out with project support in the 13 pilot/demonstration districts identified the top 10 diseases that were the main cause of morbidity and mortality[32] and assessed the costs and financing of a package of basic, cost-effective interventions for addressing this health burden, the bulk of which would be delivered through the primary health care facilities (the EHP). While a number of informants stated that they already knew what the priority diseases were prior to the undertaking of this assessment, virtually all interviewed acknowledged that the EHP became the basis for the planning and prioritization of activities and for the allocation of resources. During the life of the project health sector financing was increasingly allocated away from central-level MoH and national and regional hospitals in favor of district health services and primary health care and this trend has continued after the project's closing. Total public resources for health (government and donors combined) is allocated increasingly to district services (from 32% in 1999/2000 to 54 percent in 2003/04), with allocations to MoH HQ, national and regional hospitals all declining (Annex G, Tables G.6 and G.7). This same trend is evident in patterns of recurrent spending (Figure 2**).** While this is indeed a very positive trend, it has thus far been inadequate to cover essential needs at the district level to enable the delivery of the EHP to the population. Health services are chronically underfinanced, as evidenced by inadequate transport, service access (poor state of infrastructure and inadequate staffing), and an unreliable supply of drugs and other essential materials. The cost-effectiveness of service provision has not been evaluated.

Figure 3. Per Capita Health Expenditure by Region, 1998/99- 2000/01



Source: the MTEF from MOFPED

5.10 Despite higher government spending in the poorer regions to compensate for lower private spending, regional inequities in total per capita spending persist, ranging in 2001 from about US$12 in the Central Region to about $5 in the Northern Region. (Figure 3).

5.11 ***The project provided support to analyze health personnel performance issues and to improve technical training, but these investments were not enough to address the fundamental human resources issues plaguing the health sector: inadequate numbers, skills, skills mix and distribution***. The project financed

32. Itemize top 10 diseases.

a study to review staff motivation mechanisms for rural health units in the Kabale district. Recommendations to improve staff motivation included: (a) their prompt payment; (b) performance-based rewards; (c) co-ownership of motorcycles/bicycles; (d) provision of housing; (e) prompt and appropriate personnel action. While low staff motivation was (and is still) considered to be a chronic problem, this project did not pursue ways and means of addressing it, given that the Ministry of Public Service had the responsibility for taking this on in the context of Civil Service Reform. The project also supported efforts to improve the effectiveness of training in public institutions. It supported the drafting of the training policy for the MoH, financed the construction and rehabilitation of a number of structures in various medical training institutions, provided scholastic materials, supported tutor training in Mulago and Butabika hospitals and improvements to training curricula for laboratory technicians, nurses and medical assistants. The outcome of these supports to improving training effectiveness was never evaluated, and government restructuring in the interim has placed all training institutions under the direct responsibility of the Ministry of Education. While there was scope for reallocating staff more equitably during the project, even though they were in short supply, inequities in their distribution persist (Annex G, Table G.10). Of the 870 HC IIs in the country, some 65 have no clinical staff, while 85 have 5 or more clinical staff (Annex G, Table G.11).

Subobjective #3: Support health sector decentralization

5.12 ***Project support to health sector decentralization has culminated in a new organizational structure for MoH and redefined roles and responsibilities for central and decentralized levels of MoH. The new structure and roles are commensurate with national decentralization policy and supportive of an intensified focus on the integration, quality and coverage of a cost-effective package of basic health services.*** The project supported a process of reviewing and refining the structure of MoH. As specified in the National Health Policy, core functions of central-level MoH now include: policy formulation, setting standards and quality assurance, resource mobilization, capacity development and technical support of districts, coordination, monitoring and evaluation. The new organigramme of MoH (shown in Annex G, Figure G.11) clusters three departments into a health services directorate, responsible, respectively for: disease control, community health and clinical services, thus encompassing prevention, public health, community health as well as clinical/curative services. The (other) main directorate (Planning and Development) brings together three strategic functions, each with its own department: planning, quality assurance,[33] and finance. This Planning and Development Directorate is responsible for strategy formulation, sector coordination and the provision of support and oversight to districts in their plan formulation and implementation. Uganda's national health policy also specifies that the health districts have first-line responsibility for planning and policy implementation within their jurisdictions. Their organization provides for local-level leadership and interaction with political leaders and civil society in the planning, implementation and monitoring of health sector activity, and it puts district hospitals under the authority of district health administration.

33. A newly created department.

5.13 ***Project support has contributed to strengthened capacity at central and district levels to take on their newly assigned roles in a decentralized system, but there remain some issues of accountability in the management and use of financial resources and in the achievement of results***. At *the central level*, the project has financed analytic work to review and streamline staffing in light of new roles and responsibilities. MoH staffing was downsized from over 400 staff to about 220 recommended posts. As of the project's end, 151 or 78% of these posts were effectively filled, 78 posts remained to be filled and 54 staff slated for retrenchment were still working in MoH (Konde-Lule et al. 2002). A number of informants commented that the goal of 220 posts may have underestimated staffing needs. The project supported Master's level training for technical and managerial staff in public health, health economics and health management and administration, allowing many of the newly defined MoH posts to be filled with fully qualified staff. The construction, equipment, and furnishing of a new MoH HQ building made it possible for all departments to be housed in one building in Kampala, rather than spread across two cities (Entebge and Kampala) and many more buildings. Informants have noted how this input has contributed to enhanced efficiency of inter-departmental communication, coordination and collaboration. Thanks to project-financed production of technical guidelines, two-thirds of MoH technical units (15 of 22) had technical guidelines by the end of the project. Two departments in particular benefited from project support: (a) the Planning Department, the weakest in the Ministry at the project's outset; and (b) the Quality Assurance Department, a newly created department responsible for setting quality standards and overseeing their application.

5.14 At *the district level* the project financed master's level training (public health, health economics, health management) for many district medical officers so that by the end of the project most DMOs held Master's degrees. The project supported the construction, equipment and furnishing of 9 district medical offices. All districts received computers, office equipment and other support to facilitate district management, including the establishment of a health management information system. The project financed inputs for strengthening of financial management capacity, including: guidelines, management tools, technical support, training and close pedagogical supervision of district accountants.[34] By the end of the project 77 percent of district health teams were trained in management (short of 100% target, but significant increase over the baseline of 35 percent). Thanks to intensive pedagogical support provided by central MoH and the PCO, health was the first sector to effectively decentralize. Before any other sector, health led the way in developing regular work plans at district level, which were approved by district councils in accordance w/ decentralization policy. However, there remain important goals for consolidating gains made in health sector decentralization. These include transparency in district financial management and accountability; district accountability for local-level results; adequate supervision; equity within and across districts; and meaningful public participation in health.

5.15 ***Project support has culminated in a policy and strategic framework for health sector development that has facilitated the transition to a Sector-wide approach***. Significant products generated with DHSP support include: the 1999 National Health Policy,

34. An important portion of district health accountants trained and functional left their jobs to pursue other opportunities which their (newly developed) skills qualified them for. Within the public sector some transferred to other districts and/or to different sectors. Others found employment in the private sector. While investment in such capacity was not totally lost, it did cause disruption to the districts that lost these skills to others.

2000/01 – 2004/05 (first) Health Sector Strategic Plan (HSSP), both of which are articulated around the principle of a cost-effective package of essential care to address the disease priorities of Uganda (CHP); a National Nutrition policy; and a Health Financing Strategy. This coherent policy framework, developed thru a participatory process involving donors and a broad range of stakeholders, provided the groundwork for moving towards a sector-wide approach.

Subobjective #4: Restore functionality and improve efficiency of public services

5.16 ***The project provided substantial assistance to the design and delivery of the essential health package aimed at addressing nine of the 10 diseases with the highest burden,[35] initially in 13 pilot/demonstration districts and ultimately extended to all districts***. Financial support was largely channeled directly to the districts and accounted for about 40 percent of their total expenditures for implementing their health plans (net of salaries, hospital costs and drugs) (Konde-Lule, 2002). The project rehabilitated, furnished and equipped over 110 primary health units, two thirds of which were in pilot/demonstration districts. It rehabilitated and equipped three district-level military health units[36] and provided them with logistical support and training to strengthen health education, immunization and outreach. It also supported the rehabilitation of the Soroti district hospital, rehabilitated the sewer system of Mpigi district hospital, and provided essential materials and supplies to district facilities necessary for the delivery of the EHP (vitamins, bed nets, wells, IEC materials and services). As a complement to the DANIDA-financed Uganda Essential Drugs Program, the project financed the construction of 8 district drug stores, the training of drug store assistants, the regional supervision of pharmacies, health education about drug use and a study to assess districts' drugs needs. In addition, the project provided extensive support to the technical training and continuing education of health personnel on the delivery of the EHP. Training on EHP delivery was also provided to community volunteers (traditional birth attendants and community health workers). The impact of service delivery training was never evaluated. A number of studies supported under the project assessed service quality and demand-side aspects of services.[37]

5.17 ***Key indicators on the delivery of the EHP show mixed trends. Improvement has been slow and modest, at best, and current performance levels are still inadequate to effect any notable improvement in health status***. Prior to the issuance of the HSSP, which provides baseline data from about 1999/2000, with updates for the subsequent years, performance trends in health service delivery are scarce. Trends detected during the life of the project and during the few years thereafter can be attributable at least in part to the significant resources and inputs provided by the project.

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35. The ten diseases with the highest burden of morbidity and mortality are: malaria, diarrhea, pneumonia, maternal conditions, AIDS, injury, measles, tuberculosis, neonatal conditions and cardiovascular disease. This project supported all elements of the EHP except for those addressing STDs/HIV/AIDS, for which a standalone IDA operation (Sexually Transmitted Infections Project) was approved in 1995 and implemented in parallel with this project (see reference on STIP PPAR).

36. Masindi, Tororo, Mubende districts.

37. "Assessment of the Quality of Immunization Services in Mukono District" (1997), Assessment of the Quality of Care in Mukono District" (1997), "Factors Affecting Utilization of Maternal, Child Health and Family Planning Services in Uganda" (July 1997); "Health Care Seeking Behavior for STIs among Adolescents in Rakai District" (1998); "Assessment of People's Knowledge, Attitudes and Behavior with regard to Malaria" (no date specified).

5.18 *General Indicators*. Between the late 1990s and 2000 the share of the population living within 5 km of a health facility increased from 49 percent to 57 percent (project target was to achieve a 60 percent coverage), although disparities in geographical access persisted (urban-rural, regional, district and income). In 1999/00 70 percent of district facilities experienced stockouts of chloroquine, oral rehydration salts, cotrimoxazole and measles vaccines. Stockouts were only slightly reduced to 67 percent of district facilities by 2002/03 and to 60 percent by 2003/04[38] for primary health care units (HC II, III, and IV). Despite the training provided under the project, health service personnel were not providing a minimum quality of care. In 2000/01, 42 percent of women 15-49 interviewed (DHS) cited the negative attitude of health providers as a constraint to their access to health services. Another indicator of the inadequate quality of health personnel is the fact that only 53 percent of approved posts were filled with adequately trained staff as of 2002/03. While this is up from the low levels in 1999/2000 (33 percent), it is still far below what is needed to ensure a minimum quality of care. Utilization rates (number of new visits per person per year) declined in public facilities during 1995–2000 (Humphrey et al 2000), but are noted to have risen from 0.40 in FY1999/2000 to 0.79 in FY03/04. (World Bank 2004). This rise is attributable in significant part to the abolition of user fees in public units (except for private wings of hospitals) which took effect in March 2001 and to decreased fees in some PNFP units. However, utilization patterns show that people in all income quintiles still are willing to pay for services of quality. Almost 70 percent of the top income quintile abandoned the public sector facilities and more than 40 percent of the lowest quintile also use private providers, despite the availability of free public services. This is yet another indicator that quality in public facilities is not adequate.

5.19 *Reproductive Health Service Indicators*. As shown in Table 3, during the project life the low modern CPR almost doubled and total wanted fertility declined slightly. However, family planning services are failing to meet the growing need. No improvement was made in the very low level of assisted deliveries. While utilization of antenatal care (ANC) is very high, critical components of these services are not routinely provided, as evidenced by the lower rates of tetanus immunization and malaria prophylaxis among pregnant women. The data provided in Table 3 mask stark inequities in the demand and utilization of reproductive health services. Ugandan women in the lowest income quintiles, those living in remote rural areas, and those with no education have much lower levels of knowledge of and access to these services than their richer, urban-dwelling, educated counterparts (Annex G). Decline in immunization rates and inequities in access are attributable by some to decentralization, which was undermined by inadequate financial and

Table 3. Trends in Reproductive Health Service Indicators, 1995 and 2000

Indicator	1995	2000
Modern CPR	7.8%	18.2%
Total wanted fertility	5.6	5.3
Unmet need for family planning	29.0	34.6
% deliveries supervised by skilled health providers	38	38
% pregnant women using ANC services (at least one visit)	89	93
% coverage of tetanus immunization of pregnant women	80	70
% pregnant women receiving malaria prophylaxis		33

Source: UDHS, 1995 and 2000/01

38. "Annual Health Sector Performance Report," 2003-04.

human resources, in experience of local level, and new opportunities for local level corruption and political intervention (Okuonzi 2000).

Table 4. Trends in Child Health Service Indicators

Indicator	1995	2000	2003*
Prevalence of fever in children under 5 (having fever during 2 preceding weeks)	46%	44%	
Prevalence of diarrhea in children under 5	24%	20%	
% mothers who know about oral rehydration salts (ORS)		90%	
% mothers who use ORS		11%	
% care givers who know that bed nets help prevent malaria			38%
% children under 5 sleeping under a bed net	n.a.	7%	20%
% children under 5 sleeping under an insecticide-treated bed net	n.a.	5%	10%
% children 12-23 months who received DPT3	61%	46%	

Sources: * 1995 UDHS, ** 2000/01 DHS, *** UNICEF 2003

5.20 *Child Health Service Indicators*. As shown in Table 4, during the life of the project DPT3 immunization actually declined. There also is an important gap between knowledge and practice for home-based care and prevention. While ORS is widely known among mothers as a means of treating diarrhea, only 11 percent actually use it on their sick child. The level of knowledge of mothers about the benefit of bed nets is low, but an even smaller proportion of mothers reported that their children sleep under the nets. These trends (supplemented by other data presented in Annex F) show that child health services are inadequate for achieving needed improvements in infant and child mortality. As is the case for reproductive health services, richer, urban, better educated segments of Uganda's population benefit disproportionately from child health services.

5.21 ***The project supported efforts to accord financial and managerial autonomy to public tertiary and regional hospitals, but only financial autonomy was granted by the end of the project.*** The project financed a study on "How to Make National Hospitals Autonomous," as well as study tours to Africa and Latin America which provided exposure to well-functioning autonomous hospitals. Training of health committees, equipment, supplies were provided to Mulago and three other hospitals to explore and text various options for autonomy. While a phased approach was envisaged, starting with national hospitals and subsequently extending to regional hospitals, a decision was later taken Ministry of Finance to grant financial autonomy to all referral hospitals at once. Mulago Hospital did not achieve managerial autonomy by the end of the project. Mulago's full autonomy, once achieved, is expected to provide lessons and guidance for others. National Medical Stores now fully autonomous.

Subobjective #5: Facilitate a greater role for the non-governmental sector

5.22 ***The project facilitated a greater role for PNFPs[39] both by ensuring that they benefited from support provided to districts and by using them as contractual agents to carry out district-level services and activities. Project experience did, however, reveal some reticence in contracting significant roles for NGOs.*** By design, NGOs were involved in

39. There is a range of PNFP agencies which carry out health activity, those that are facility-based and those that are not. Of the 2731 health facilities inventoried in 2004, 600 (or one-fifth) are PNFP. Their share of total health facilities is especially remarkable at the hospital level, where they make up 42 percent of all hospitals in Uganda (MoH Health Facility Inventory, 2002).

project activities at the district level. They participated in annual exercises to review the performance of previous district health plans and to prepare the plans for the forthcoming year. They were invited to benefit from training provided under the project, and were covered by the various supervisions which were carried out during the life of the project. They received a portion of goods provided under the project (drugs, medical and lab supplies and equipment, other supplies and materials. Some NGO health units were repaired or expanded with project assistance (Kamuli and Vira Maria hospitals and a faith-based facility in Soroti were cited as examples, among others). With the benefit of guidelines and technical assistance, districts used project financing to contract out services to NGOs. Some NGOs were contracted to perform specific tasks and/or deliver specific services, while others received grants for small projects. As is the case for the Sexually-Transmitted Infections Project (World Bank, 2005), records of project-financed contracting with NGOs were incomplete at central and district levels, which made impossible the compilation and analysis of data (in terms of numbers of contracts, geographic area of intervention, nature of intervention, costs, duration). Available data indicate that contracting with PNFPs did increase over the life of the project. The proportion of district health expenditure which financed contracted services in the pilot/demonstration districts increased from 6 to 12 percent, but fell far short of the project target of 30%. Government subsidies to NGO health facilities increased from 5% of the total recurrent expenditures to 11% and are expected to grow to 14 % in the next 3 years, based on MTEF projections. As financing agents, facility-based and non-facility based PNFPs made up a full one third (34 percent) of all financial transfers in 2000/01, up from 26 percent in 1998/99 (MoH National Health Accounts).

5.23 Interviews and documentation reveal some reticence in contracting NGOs to take over government services. The project envisaged experimentation in contracting out of district hospitals and health centers to NGOs in Kamuli and Kampala districts. Despite the presence of a PNFP hospital that would have been capable of being contracted as a district hospital, Kamuli district opted to build a new public district hospital. The project financed a strategic health plan for Kampala, which envisaged the contracting out to PNFPs of health services provision, given their strong presence. However, contracting out of health centers was never carried out. While the design document specifies that monitoring of NGO participation would be contracted out to an independent agency that would assess the nature and effectiveness of the framework for NGO participation and the effectiveness of NGO performance, this was not carried out.

5.24 ***The project's efforts to encourage private health sector development fell short of original plans, and did not culminate in any noticeable change***. The project financed a study to identify barriers to private health sector development and to recommend ways to overcome them. One decision emanating from this study was the opening up of private practice to categories of health workers such as registered nurses, previously not allowed to do so. The main support envisaged under the project was the provision of grants (maximum of US$25,000) to already established private health units in underserved areas for the purchase of equipment to enable them to better serve the primary health care needs of their clients. No grants were ever made under this component. Fears of creating artificial demand for services were cited as the main reason for inaction. A few informants noted that inaction might also have been attributable to reticence on the part of public sector actors, who were feeling the pressure to use the project funds to support the enormous agenda of improving public services.

5.25 ***Project support to community-level health was limited and fell short of the community mobilization necessary to equip communities with the knowledge, support and means to take a more proactive role in managing their own health more effectively***. The project supported the training and provision of kits to community-based health workers (CHW) and traditional birth attendants (TBAs) (quantities not available), and provided guidelines, logistical and other support for their supervision. It also supported a number of studies on community health.[40] In addition, some outreach and mobilization activities were carried out, focusing on malaria control, water and sanitation, and maternal and child health. Community participation in the planning, management and oversight of local health activity is still weak.

5.26 ***The overarching goal of improving health status was not achieved. Key health indicators did not essentially change over the life of the project and inequities in health status persist***. However, it is important to note that (a) there are many determinants of health status (and inequities therein) that are beyond the mandate of the health sector to effect directly (water supply, sanitation, food security, income, education, place of residence, conflict situations, to name a few); and (b) the counterfactual of this project needs to be considered (it is very possible that health status might have been worse in the absence of this project, which was by far the most important source of external financing for district health services in the country.

5.27 Between 1995 and 2000 infant, child and maternal mortality have remained unacceptably high. By the same token, no improvements were registered during this same period in total fertility or in child nutrition indicators (See Table 5). These aggregate health indicators mask important inequities. As is the case for access to health services and use of health services, groups with secondary education, urban residence and/or higher incomes have health outcomes that are considerably better than the average for Uganda and several times higher than those of the most vulnerable groups. (i.e., those with no education, rural residence and/or in the lower income quintiles) (Annex G).

Table 5. Trends in Health Indicators, 1995-2000

Indicator	1995	**2000**
Infant mortality (per 1000 live births)	81	88
Under five mortality (per 1000 live births)	147	151
Maternal mortality (per 100,000 live births)	527	504
Total fertility rate	6.9	6.9
% children underweight (-2 SD)	25	23
% children stunted (-2 SD)	38	39
% children wasted (-2 SD)	5.3	4.0

Source: UDHS 1995 and 2000/01

6. Ratings

6.1 **Outcome**. The outcome of the District Health Services Pilot and Demonstration Project is rated *moderately unsatisfactory*. This rating is derived from ratings of relevance, efficacy and efficiency of the main project objective and its subobjectives, summarized in Table 6 and discussed below.

40. "Evaluation of the Performance of Community Health Care Delivery in Hoima District" (1998); "Community-Based AIDS Home Care" (1998); "Sanitation in Primary Schools in Mpigi District" (1998).

Table 6. Summary IEG Ratings by Objective

Project Objectives/Subobjectives	Relevance	Efficacy	Efficiency	Outcome
Test and demonstrate feasibility of an essential health services package to district populations for improved efficiency and equity in service delivery	Modest	Negligible	Negligible	Highly Unsatisfactory
Mobilize more resources for the health sector	Substantial	Modest	Negligible	Unsatisfactory
Improve efficiency in the use of sector resources	Substantial	Substantial	Modest	Moderately Satisfactory
Support implementation of national decentralization policy in the health sector	Substantial	Substantial	Modest	Moderately Satisfactory
Restore functional capacity and improve efficiency of essential existing public facilities/services	Substantial	Modest	Negligible	Unsatisfactory
Facilitate a greater role for NGOs, the private sector and communities.	Substantial	Modest	Modest	Moderately Unsatisfactory
Overall project rating	**Substantial**	**Modest**	**Modest**	**Moderately Unsatisfactory**

6.2 The overall **relevance** of the project is *substantial*. For the most part project *objectives* are supportive of Government and World Bank development objectives for Uganda which are appropriate to Uganda's health sector challenges. Two of the five pillars of action articulated in Uganda's second Poverty Eradication Action Plan (PEAP) (2004/05 – 2007/08) are human development and good governance.[41] Under the human development pillar the PEAP seeks to improve the equity, coverage, quality and effectiveness of basic health services to improve health outcomes. It places emphasis on prevention and promotion and on enhanced multi-sectoral action to this end. The good governance pillar aims at improving the efficiency, transparency and accountability of public resource use for enhanced impact, decentralizing essential services, and strengthening partnerships with the non-governmental sector, both to enhance participation and to expand limited public sector capacity. The Uganda Joint Assistance Strategy[42] supports the PEAP, but will focus on certain areas judged to be especially important for achieving results, and all of which are relevant to the project's objectives: (a) strengthening the budget process and public sector management; (b) promoting private sector development; (c) strengthening governance; (d) improving health outcomes; and (e) fostering social and economic development of the north.

6.3 The project objective to test and demonstrate EHP delivery is relevant to national and World Bank development objectives of improved efficiency in health service delivery. However, the relevance of this project objective was (and still is) considered by government to be at odds with its drive to support an equitable process of health sector development, a process whereby all health districts would benefit from available financial and technical assistance at the same time, rather than in sequence.

41. Uganda's PEAP is composed of five pillars for supporting poverty reduction: (1) economic management; (2) enhancing production, competitiveness and incomes; (3) security, conflict resolution and disaster management; (4) governance; and (5) human development.

42. Full citation of this document, with dates Dec 14, 2005, for Board Presentation Tuesday, January 17, 2006. This is a first-time Joint Assistance Strategy of seven of Uganda's development partners – African Development Bank, Germany, the Netherlands, Norway, Sweden, The United Kingdom's Department for International Development, and the World Bank Group.

6.4 The project *design* was relevant to MoH policy and strategy, which sought to implement far-reaching reforms (decentralization, resource allocation, partnerships with civil society) as a means of improving service delivery and health status. The design also incorporated the new thinking, approaches and tools emanating from WDR 1993 for improving the cost-effectiveness of investments in health. Yet at the same time these two aspects of the project design (its pilot nature and analytic work to determine the BOD/EHP) were never entirely clear to many responsible for project oversight, management and implementation.[43] This confusion was further undermined by the project's weak results framework (unclear objectives, [44] absence of indicators until well after the MTR, inadequacy of indicators finally chosen, poor articulation of learning agenda, tools and processes, ill-defined operational research), which was further weakened when the pilot and demonstration phases (and their evaluations) were eliminated and cost-effectiveness studies of service delivery were never undertaken.

6.5 Overall project **efficacy** is *modest*. The project failed to test and demonstrate the delivery of the EHP to populations in selected districts and to evaluate experience with a view to fine-tuning reform and improving efficiency and equity in service delivery. While the PEAP process is the main force for giving the health sector a more prominent position in government's budget allocation, the project also contributed, indirectly, to the mobilization of more public resources: highlighting the financing gap and potential cost-effectiveness of service provision through BOD analysis and EHP preparation; developing and strengthening sector absorptive capacity, especially at the district level; mobilizing project co-financing; and supporting the development of a coherent policy and strategic framework that facilitated a SWAp approach. Project efforts to strengthen cost recovery mechanisms did not culminate in increased income for health facilities through this financing source because of the abolition in 2001 of cost recovery in public health facilities. The project was ineffective in mobilizing more resources through health insurance and other private financing schemes. Total health expenditure (public and private combined) falls short of what is needed to deliver the EHP to Uganda's population, and government's contribution to health expenditure remains modest and was not increased to compensate for the resources lost when cost recovery was abolished. The project was successful in its efforts to achieve a more efficient allocation of financial resources. Budgets and expenditures have been reoriented away from hospitals and central level administration towards primary care facilities and district administration, although there is still considerable scope for improved efficiencies, and levels of financing at the district level are still inadequate. Project investment in human resources management and training was modest in scope and did not culminate in improved allocation and utilization of this scarce resource.

6.6 Thanks to the project's support health was one of the first sectors to amend its structure and to reassign roles and responsibilities commensurate with national decentralization policy. Within a new organigramme, central level MoH role is focused on policy formulation, coordination, regulation and oversight, and districts assume primary responsibility for policy implementation. Project capacity building in planning, financial

43. Interviews with central and district level managers and technical staff.

44. Project coordinator said that it took more than half of the project implementation for people to understand what this project was all about. BOD/EHP/WDR 93 deceptively simple. Underlying institutional, financial and social changes not immediately evident.

management, supervision and monitoring enabled the health sector to be the first to prepare and implement local level action plans with the involvement of local authorities and civil society. Despite extensive investment in district level health services, there has been little improvement in health service delivery. Chronic shortages of drugs, qualified health personnel and other essential inputs have undermined quality. Increases in utilization rates in public facilities are largely attributable to the new policy of free services and many clients frequent non-public facilities, which charge fees, but which are perceived to provide better quality services. Except for slight improvements in contraceptive use and ANC attendance, performance indicators for key maternal and child health services have remained stagnant[45] or even slightly deteriorated.[46] And there is a persistent gap between knowledge and practice of healthy behavior and self-care. Finally, the project underachieved with regard to its facilitation of more important roles for NGOs, the private sector and communities. While some contracting with NGOs was carried out by some districts, the level of district expenditure fell far short the objective. No grants were provided to private sector practices to encourage them to deliver essential health services in underserved areas. Efforts to strengthen and support communities' capacities to participate in local level planning and management, to carry out public health activities and to improve safe behavior and home health care fell far short of the potential.

6.7 The overall **efficiency** of this project is *modest*. Although it was a fundamental objective of the project, the learning that took place under this project was inefficient. Despite major reforms and the pilot/demonstration design, (a) the learning objectives were not framed, (b) there was no evaluation of experimentation/experience on a small-scale before extending project benefits to the whole country, (c) research was ad hoc and somewhat supply-driven; and (d) no cost-effectiveness studies were undertaken.

6.8 Support to decentralization was somewhat efficient. District capacity building was grounded in practical experience, supported by: guidelines, training, and pedagogical supervision. Turnover of staff, especially accounting staff, did undermine the efficiency of district strengthening. Inefficiencies in reporting and accountabilities, both on the financial resources and on results, are being corrected with ongoing supervision and refinements to guidelines and systems. The BoD and EHP concepts have provided a new framework which has prompted more efficient allocation of financial resources in favor of front-line priority services. There is still scope for correcting inequities in per capita spending.

6.9 Support to EHP delivery was inefficient on a number of fronts. Political pressure to extend project benefits nationwide caused project resources to be stretched across all districts. While the original design was to focus investments in service delivery on about one third of Uganda's districts, the project's actual support to services was ultimately extended to all districts.[47] This fact, combined with the US$... million worth of expected cofinancing that fell through, culminated in an underfunding of EHP delivery. Numerous informants and reports document the consequences of this decision: (a) investments in infrastructure were carried out in many more districts than planned, compromising both the costs and quality of

45. E.g., deliveries attended by a skilled health worker.

46. E.g., percent of children 12-23 months who receive DPT3 vaccination; percent of pregnant women immunized against tetanus.

47. Numerous informants recalled the informal name of this project as "the National Treasury for Health."

originally planned works; (b) disbursements to districts to finance their annual health plans peaked in 1997/98 and were reduced thereafter, at a time when district action plans and absorptive capacity were improving annually. The paucity of qualified health service delivery staff is yet another factor in the inefficient delivery of the EHP. There is still a misunderstanding among some about planning and resource allocation for EHP delivery; and there is still scope for inefficiencies in allocation within the EHP. Two examples noted were (1) misunderstanding about formula for allocation of resources;[48] and (2) an apparent imbalance in the allocation of resources within EHP that favors curative over preventive and promotional activities. Underlying these inefficiencies is the project's failure to assess the cost-effectiveness of the delivery of the EHP.

6.10 The EHP could have been delivered more efficiently with better coverage had the support to the non-governmental sector been more successful. Contracting the district hospital function to a functioning PNFP hospital in Kamuli would have been much more efficient than the choice to construct and operate a new public hospital for this purpose. Contracting out service delivery to the numerous private facilities in Kampala (both for-profit and not-for profit) would also have improved efficiencies in service delivery. Finally, inadequate emphasis on nurturing the critical role of communities, households and individuals in the management of their own health is a lost, low-cost opportunity for improving health status.

6.11 The **institutional development** achieved under the project is rated as *substantial*. The reorganization of central-level MoH provided for a better alignment of its staff and services with national decentralization policy. Its new mandate of policy formulation, coordination and oversight and provision of technical backstopping to districts is well accommodated by the establishment and strengthening of a Policy Unit and a Directorate of Planning and Development that houses 3 departments in charge, respectively, of planning, quality assurance and finance and administration. The new structure is also well aligned with MoH policy to integrate health services. A Directorate of Clinical and Community Health Services houses three departments in charge of, respectively: disease control, community health and clinical services. Districts have been strengthened to assume their newly assigned, primary responsibility of health policy implementation at the local level. The financing of master's level training in relevant health sector disciplines, both technical and managerial, have permitted the filling of more key (central and district) positions with suitably qualified staff. The provision of guidelines, on-the-job training, technical assistance and supervision have helped build capacities and establish procedures in this newly decentralized organization for district-level strategic planning, implementation and monitoring of performance and financial management, as well as for central-level oversight and backstopping of districts'efforts.

6.12 The project strengthened institutional capacity for policy formulation and strategic sector management. With a coherent policy and strategic framework in place and with growing experience in eliciting and coordinating partnerships with donors, the MoH was by the end of the project capable of the leadership, vision and coordination skills required for a viable SWAp arrangement. In particular, the Planning Department was extremely weak at the project outset, but during the course of the project was considerably strengthened in this

48. Disease that has x% burden should get x% of the resources.

regard. Institutional development was less than desired with regard to the strengthening and nurturing of partnerships with civil society.

6.13 Project **sustainability** is *likely*. While initially they were not well understood by some and resisted by others, the notions of the BOD and EHP are firmly imbedded in national policy and strategy. As such, it forms the basis for sector planning, resource mobilization and goals of sector efficiency.[49] However, the current level of sector financing (US$18 per capita) falls short of needs for delivering this package (US$28 per capita). Recent trends show that government financing is still inadequate (despite modest increases over the years); and the gap is not likely to be met, especially given the abolition of user fees, which had been an important source of financing of public facilities. In the context of the PEAP and the SWAp there is considerable momentum for further increasing public (government and donor) financing. Even if some increase in public spending were achieved, financial sustainability will also depend on a more vigorous and successful pursuit of alternative financing sources through health insurance and other risk pooling schemes. Two other factors will ensure the sustainability of project investments: (a) the mobilization of adequate numbers and skills levels of health personnel and their appropriate allocation and remuneration; and (b) the constant availability of essential drugs, vaccines, and other commodities necessary for EHP delivery. Finally, partnerships with PNFPs and the private sector will only be consolidated and sustained with the stronger support and conviction of health authorities, both central-level and decentralized, about their role and potential to contribute to health sector objectives, rather than being perceived as competitors for scarce funding.

6.14 Prospects for the sustainability of the restructured MoH and certain critical functions are strong. The quality assurance function and staff were transformed from a temporary, project status into full-fledged department. Staff became civil servants and the costs of running this department were fully assumed by Government. Personnel who were trained in the health management information system also were given civil service status in recognition of the importance of this function in all districts.

6.15 **Bank Performance**. The Bank's performance during preparation was *unsatisfactory*. Quality at entry was mixed, at best. Among the strong points of the project design are: (a) its consistency with Government policy and Bank strategy; (b) its technical quality and attention to cost-effectiveness of the investment (drawing on new BOD, EHP tools of the WDR 1993); (c) its support to MoH restructuring and institution building; and (d) its success in mobilizing co-financing and collaboration among donors. However, the design was weakened by a number of factors. The project's objectives lacked clarity and indicators were inappropriate. Government ownership was mixed: it strongly supported this large source of financing for implementing its health sector reform program, yet it did not fully understand, or agree with, the pilot nature of the design, under which selected districts would benefit from the bulk of project support for health services, as opposed to nationwide coverage.[50] The Bank did not appear to be listening to the client regarding its strong discomfort with the pilot approach.

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49. EHP is now referred to as the Uganda Minimum Health Care Package (UMHCP) in the most recent policy and strategic documents.

50. The political feasibility of a pilot approach in a post-conflict country was not assessed in the risk analysis undertaken during the design stage.

Neither was there strong ownership of the methodology and rationale of calculating the burden of disease and defining the EHP.[51] The specific learning objectives of the pilot and demonstration phases were never fully framed, nor were studies/operational research deliberately designed to address learning objectives systematically. The design supported health as one means of achieving poverty reduction in Uganda, but it did not address inequities in service provision or in health status. Delays in project start-up revealed that the project was not ready for implementation upon effectiveness. Particular areas of weakness in this regard were inadequate capacity in the areas of: procurement, and financial management at both central and district levels.

6.16 The Bank's performance during implementation was also mixed, but *unsatisfactory* overall. Two supervision missions per year were carried out throughout the project's life. A decision towards the end of the project to hire a health expert to task manage this project from the field considerably enhanced the Bank's presence and ability to supervise the project more closely. Two features of the Bank's supervision of this project were particularly positive and appreciated by the Borrower. First, the Bank provided reliable the support and appropriate guidance throughout the life of the project to address and resolve issues constraining smooth implementation. One example is the special mission carried out by the disbursement analyst to unblock the flow of funds to the districts. Second, the Bank supervision missions served as a catalyst for donor coordination. Concerted efforts by the Bank's team enabled the missions to be joint in nature, including most major donors, thus facilitating a coordination and communication among donors as well as between donors and Government, a precursor to the SWAp approach which was adopted toward the end of the project.

6.17 The Bank's supervision support was deficient with regard to its focus on the development objectives. The learning objective was neglected. Because of political pressure in a resource-poor, post-conflict country, the Bank agreed to extend the project support to all districts. However, it did so without clarifying/revising the learning objective. Learning could have been more effectively achieved had it been better framed and supervised and had monitoring and evaluation been adequately revised and implemented. The Bank was not clear or rigorous in its provision of guidance and supervision of operational research and monitoring and evaluation. Informants noted that Bank missions did not include adequate monitoring and evaluation expertise, and that, furthermore, turnover in mission members made for conflicting and inconclusive advice on M&E. Internal supervision reporting was not sufficiently rigorous. Achievement of development objectives was rated satisfactory throughout the project, with the exception of one report (June 1997); and monitoring and evaluation was rated satisfactory throughout with one exception (December 1999 report). Neither did the Bank seize the occasion of the mid-term review to refocus efforts on the redefinition and monitoring of the project's development objectives.[52]

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51. These were described as unnecessary and complicated, whose rationale was not well understood. They were not accepted by a considerable number of stakeholders and not well applied. (Okuonzi 2000 and many respondents).

52. In its Aide-Memoire to Government on the MTR the Bank restated the original project objective (to pilot test and demonstrate EHP delivery) despite the decision that same year to extend Project benefits to all districts (not recorded in the A- M). Furthermore, rather than using the MTR as a vehicle for establishing outcome indicators, the A-M recommends that the PCO "finalize its indicators… and begin monitoring DHSP's performance.

6.18 **Borrower performance** was *satisfactory* overall. During the preparation process it provided a good framework within which the project was developed (health policy and plan for 1993-96 and White [strategy] Paper on Health, and Letter of Sector Development Policy, 1994). It assumed leadership in facilitating a participatory approach to project preparation, including donors, local authorities and civil society, and it was active in raising project cofinancing from other donors. However, interviews with many government informants made it clear that (a) there was never a strong consensus on the pilot/demonstration approach and (b) nor was there a full understanding/appreciation of the methodology and rationale for calculating the BOD and defining the EHP. Rather it was seen by many as Bank-driven and a conditionality for IDA financing.

6.19 During implementation government commitment to the project objectives was mixed. While it strongly supported the specific objectives of its health sector policy, its understanding of and commitment to the pilot and demonstration learning objectives became weaker in the wake of mounting political pressure to spread the benefits of the project nationwide. Even after its counterpart obligation was reduced, Government failed to meet its financial obligations, both in terms of amount and timing of these contributions. Over and above its counterpart obligations, Government allocations of its public budget for health have grown in actual amounts, but remained stable during the life of the project in terms of health's share of the total public budget. While resources and political commitment were modest, the MoH did provide an enabling policy and strategic framework, and gradually assumed leadership in the implementation of this project.

6.20 The implementing agency (Ministry of Health) and the PCO were *satisfactory* in their overall performance with some caveats. Despite weak capacity at the project's outset, the MoH Planning Department and the PCO put together district support teams that would travel to the field often to work with districts in support of their intensive training and start-up activities, related to planning and financial management. Districts have noted that this was highly useful and appreciated. Good monitoring and evaluation were plagued by lack of guidance (from the Bank) on the choice of indicators, and by inadequate M&E capacity within MoH. Delays in procurement and disbursements caused major setbacks in project start-up and implementation in the early years, but in the end the project managed to close as scheduled.

7. Findings and Lessons

Lessons Emanating from Pilot/Demonstration Approach

7.1 ***Pilot and demonstration approaches to reform implementation will not automatically generate or document a learning process, nor will such approaches necessarily lead to a fine-tuning of reforms in light of experience, if they are not well prepared and if they are not fully understood and owned by Government and other stakeholders.*** At the end of this project little knowledge about the "modalities and relative effectiveness of various reforms"[53] has been generated. Key questions remain unanswered.

53. Taken from statement of project objective.

How can resources be mobilized through health insurance and other risk pooling schemes? What is the current cost-effectiveness of EHP delivery? How should resources be more efficiently allocated across various services within the EHP, and across curative, preventive and promotional activities? The experience gained under this project provides much insight about critical factors that can undermine the success of a pilot and demonstration operation.

7.2 *A pilot operation will not reach its full potential for learning if the learning agenda is not well defined*. The learning agenda was not fully articulated in the project design documents, nor was it fully appreciated by those responsible for implementing it. A high level official of MoH was of the opinion that there was no reason for a pilot, since Uganda knew where they were and where they wanted to go in the health sector. Studies and research that were undertaken were primarily ad hoc (topic and geographical region) and supply-driven in nature. They provided thus an incomplete, fragmented framework, at best, for learning.

7.3 *Nor will a pilot operation reach its full potential if its process is not well defined.* The design document noted that the pilot would take one year and would be evaluated before moving on to the demonstration phase. However, it does not propose terms of reference for the evaluation, nor does it explain the process for its use in designing/launching the subsequent phase (process for discussion of findings, assimilation of lessons, fine-tuning of reforms, wider application of lessons, establishment of a new agenda for addressing new/unanswered questions). Furthermore, the criteria for moving from the pilot to the demonstration phase, specified in the development credit agreement as a condition of disbursement, required only that: 60 percent of funds for the pilot be disbursed, financial reports of pilot districts be satisfactory and management training for district health teams be completed. No conditions were specified for completion of an evaluation or for documentation and wider application of lessons.

7.4 *The absence of a clear and coherent monitoring and evaluation framework, including the specification of indicators and a menu of tools and methodologies, will undermine the learning potential of a pilot operation.* The logframe for the pilot was weak at best, with unclear objectives and the absence of indicators reflective of a learning agenda. Informants noted that operational research was largely supply-driven and neither planned nor properly budgeted for at the outset. Research carried out was thus neither systematic nor deliberately oriented around key questions. During the project design and implementation it was reported that there was no real interest or motivation among MoH officials for carrying out operational research. Rather, it was considered by most to be academic and irrelevant, especially given the urgency of upgrading health services nationwide in a post-conflict country.

7.5 *Pilots cannot be effectively launched when critical operational inputs are not in place*. Critical inputs required for pilot and demonstration phases were not defined at the outset. This both delayed the launch of the pilot phase and compromised the ability to test different innovations and hypotheses. Among essential elements not defined or provided for at the outset are: critical technical and managerial capacity (staff, skills, tools, systems, processes), infrastructure, equipment, drugs, other essential supplies, vehicles. Furthermore these inputs were provided late and their quality/availability throughout the project was inadequate.

7.6 *Pilot operations need a realistic, reasonably long timetable to ensure proper design and readiness for implementation.* The design envisaged a one-year implementation plan for the pilot phase, which turned out to be a serious underestimate.

7.7 *A pilot approach to health service delivery may not be appropriate in countries in desperate need of basic health care across the entire country, especially countries in a post-conflict situation.* Throughout project implementation there was tension between the needed time and technical requirements of the pilot and demonstration phases in selected districts and the political pressures to spread the benefits of project nationwide. Informants noted that the pilot/demonstration approach was not politically feasible, as people were dying in all districts, health investments were urgently needed in all districts. Under these circumstances the spending of project resources on a selected few districts and on studies was uncomfortable and strongly resisted. Striving for equity was (and still is) such a priority in MoH that one official noted that under any circumstances, if money for health sector is a constraint then MoH's response should be to scale down planned interventions and cover the whole country with some support, even if inadequate. The Bank failed to convince MoH of the benefits of a pilot approach, which can contribute to improved health services and health status in the whole country. More fundamentally, the Bank failed to assess the social and political context of Uganda which was not amenable to a pilot design. And it failed to adjust the project in a way that might have provided a better balance between learning and coverage, without overextending project resources.

Other Lessons

7.8 ***The absence of a clear and coherent results framework (clearly stated objectives, well-chosen indicators and a well defined results chain, linking inputs, outputs, outcomes and impact) is likely to cause confusion among national stakeholders and compromise national understanding and commitment, especially when the project is complex and is supporting far-reaching reforms.*** By the same token the absence of a clear plan and system for monitoring and evaluation and the failure to carry out critical evaluation and cost-effectiveness studies have undermined opportunities for learning and improvement.

7.9 ***Thoughtful project design, adequate implementation, and timely monitoring and evaluation are necessary, but not sufficient for project success. Inadequate attention to assessing the political feasibility of project objectives and components can undermine project success.***

7.10 ***Bank support of the health sector has implications that extend far beyond the health sector alone. It can point the way toward successful decentralization, mobilize public resources, influence improved efficiencies in public expenditure and encourage public-private partnerships.*** Not only was health the first sector to decentralize planning, implementation, and financial management of decentralized funds, it provided a reference and experience on which many other sectors drew as they attempted to decentralize. The World Development Report 1993 provided a new vision and a new set of tools for improving the cost-effectiveness of health sector investment. Now the EHP is at the core of Uganda's health policy and strategy, and provides the basis on which (increasingly more efficient) resource allocation decisions are made. Observed successful public-private collaborations

seemed to flourish where they shared common (district) objectives to which they were both contributing, in line with their comparative advantage.

7.11 ***Inequities in health services access and utilization and in health status will not change if they are not overtly targeted.*** Project objectives and indicators were not sufficiently targeted to vulnerable groups (rural populations, those with no education, women), whose access to services and knowledge of self care left them disadvantaged and consequently with poorer health status than the country norms). Over the life of the project inequities in knowledge, access and health status persisted.

Challenges and Future Directions

7.12 MoH has made great strides since the closing of this project in consolidating a SWAp approach, whose features are an improved vision of sector goals and targets and improved coordination among its multiple partners. Its Health Sector Development Plans are rising to the challenges implicit in these lessons. Inequities in service access and in health status are receiving more attention in annual plans, human resources issues are highlighted as crucial to improved service quality and availability, monitoring and evaluation have become more routine and more rigorous, as well as more decentralized. Efforts to achieve a stronger results focus are underway. The lessons emanating from DHSP also point to opportunities for further strengthening efforts on the following fronts: reconciling the need (and strong political pressure) to improve coverage with the need to improve the quality and viability of existing services; strengthening overall government support and commitment to health through the provision of financing and other support needed to improve service access and quality; underpinning a learning process to document and enhance cost-effectiveness of service delivery; stepping up efforts to mobilize resources through experimentation/promotion of health insurance and risk pooling schemes; improving accountabilities through greater rigor and transparency; and more proactive contracting with the non-governmental sector for service provision and other components of health sector development.

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Annex A. Basic Data Sheet

DISTRICT HEALTH SERVICES PILOT AND DEMONSTRATION PROJECT (CR. 2679-UG)

Key Project Data

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project cost (US$ Million)	75.10	65.26	87%
Loan Amount (Millions of SDR)	30.90	30.13	98%
Cancellation (Millions of SDR)		0.77	

Project Dates

	Original	*Actual*
Board approval	02/07/1995	02/07/1995
Signing	09/30/1996	09/30/1996
Effectiveness	07/17/1995	07/17/1995
Closing date	12/31/2002	12/31/2002

Staff Inputs (staff weeks)

	Actual/Latest Estimate	
	N° Staff weeks	*USUS('000)*
Identification/Preparation	163.60	105.00
Appraisal/Negotiations	71.00	62.80
Supervision	790.60	998.00
ICR	21.00	75.00
Total	1046.62	1240.80

Mission Data

	Date (month/year)	No. of persons	Specializations represented	Performance rating	
				Implementation progress	Development Objective
Identification/ Preparation	11/1993	8	1 Sr. Public Health Specialists, 1 Operation Officer, 1 Economist, 1 Field Manager – ODA, 2 USAID, 2 Representative from SIDA		
Appraisal/ Negotiation	5/1994	14	1 Sr. Public Health Specialists, 2 Operation Officer, 3 Economist, 1 Staff Assistant, 5 Representatives (ODA, USAID, SIDA, DANIDA), 2 Peer Reviewers		
Supervision	10/26/1995	8	2 Operation Officer, 1 Sr. Economist, 1 Representative – ODA, 1 Task Manager, 2 Representative from SIDA, 1 Implementation Specialist	S	S
	04/26/1996	6	2 Operation Officer, 1 Sr. Economist, 1 Representative – ODA, 1 Task Manager, 1 Implementation Specialist	S	S
	11/08/1996	7	2 Operation Officer, 1 Sr. Health Economist, 1 Representative – ODA, 1 Task Team Leader, 1 Consultant, 1 Disbursement Analyst	U	S
	05/29/1997	8	3 Public Health Specialists, 2 Economist, 1 Team Leader, 1 Communications, 1 Implementation Specialist	U	U
	11/14/1997	12	3 Public Health Specialist, 1 Operation Officer, 4 Economist, 1 Team Leader, 1 Health Program Officer, 1 STD Advisor, 1 Implementation Specialist	S	S
	05/28/1998	9	1 Team Leader, 1 Public Health Specialist, 1 Health Specialist, 1 Implementation Specialist, 1 Procurement Specialist, 1 Program Officer, 1 Sr. Health Advisor, 1 Public Health Specialist, 1 Sociologist	S	S
	04/30/1999	8	1 Public Health Specialist, 1 Mission Leader, 1 Sr. Health Specialist, 1 Health Specialist, 1 Health Economist, 1 Consultant, 1 Sr. Health Advisor, 1 Procurement Specialist	S	S
	11/05/1999	15	1 Team Leader, 3 Health Specialists, 1 Procurement Specialist, 1 Consultant, 1 Malaria Specialist, 1 Health Economist, 1 SIDA, Regional Adviser, 2 SIDA Consultant, 1 USAID, Tech. Adviser, 1 Macroeconomist, 1 Macroeconomist-Uganda, 1 Financial Mgt. Specialist	S	S
	04/18/2000	7	1 Mission Leader, 1 Pr. Health Specialist, 1 Health Specialist, 1 Sr. Procurement Specialist, 1 Financial Mgt., 2 Pharmaceuticals Specialist	S	S
	10/27/2000	4	1 Team Leader, 1 Lead Health Specialist, 1 Health Specialist, 1 Sr. Procurement Specialist	S	S
	03/21/2001	2	1 Team Leader, 1 Health Specialist	S	S
	11/21/2001	4	1 Team Leader, 1 Team Member, 1 Procurement Specialist, 1 Member Financial Mgt.	S	S
	06/2002	3	1 Sr. Health Specialist, 1 Team Leader, 1 Procurement Analyst		
ICR	01/2003	3	1 Team Leader, 1 Health Specialist, 1 Public Health Specialist		S

Annex B. Persons and Organizations Consulted

Uganda

Kampala

Uganda AIDS Commission
Dr. David Kihumuro Apuuli, Director General
Dr. Lucy N. Korukiko

Former Staff of STIP/Project Coordination Office
Dr. Peter Nsubuga, Coordinator (current Coordinator of Uganda HIV/AIDS Control [MAP] Project)
David Kaweesa-Kisitu, Monitoring and Evaluation Expert (current member of MAP team)
G. Awo
Enginyu S.S.B. Wanda, Procurement (former Procurement Officer, STIP)
Julius A. Byenkya, Implementation Officer (former Implementation Officer, STIP)
Ekaru, Procurement staff

Ministry of Public Health
Mohammed S. Kezaala, Permanent Secretary
Director of Health Planning
Dr. Francis Runumi Mwesigyl, Commissioner Health Services Planning
Dr. Mwebesa, Assistant Commissioner, Health Services (Quality Assurance)
Elizabeth Madraa, Programme Manager, STD/AIDS Control Programme
Vastha Kibirige, Coordinator Condom Unit, STD/AIDS Control Programme
Saul Onyango, Coordinator Care and Support (including PMTCT), STD/AIDS Control Programme
Dr. Wilford Kirungi, Epidemiologist, STD/AIDS Control Programme
Sam Enginyi, Senior Health Education Officer and IEC Coordinator, STD/AIDS Control Programme

Other Public Sector Agencies/Actors
Dr. Musinguzi Ambrose, UPDF (Military)
Captain Richard Rwanyonga, UPDF (Military)
Dr. Sam Agatre Okuonzi, Secretary General, National Council for Children, Ministry of Gender, Labor and Social Development (former Coordinator of DHSP)
Dr. Barungi Thaddeus Cos, Director Police Medical Services
Mr. Bazirakye Kaguta Didacus, Project Administrator, Police Component, HIV/AIDS/STIP, Uganda Police
Dr. Michael Kyonmya, Director, Prisons Medical Services
Dr. D. Nyabwana, Prisons Medical Services
Mbabazi Frances, Project Field Officer, HIV/AIDS/STIP, Uganda Police
Gertrude Kitone, Field Officer, Slum Aid Project

Dr. Josephine Kasolo, Director, Women's Crisis Centre
Rogers Kasirye, Director, Uganda Youth Development Link (UYDEL)
Dr. Eugene Kinyanda, Volunteer, UYDEL

Non-Governmental Sector/Civil Society

Christine Namayanja, Program Director, Marie Stokes International (MSI-Uganda)
Charles Goria, Sales Manager, Marie Stokes International (MSI-Uganda)
Edward Zzimbe, Marketing Manager, Marie Stokes International (MSI-Uganda)
Dr. Sam Orach, Uganda Catholic Secretariat
Dr. Hitimana, Executive Director, AIDS Information Centre
Jonathan Mubangizi, Records Officer, AIDS Information Centre
Dr. Benon Biryahwaho, Uganda Virus Research Institute
Romano Ojambo-Ochieng, Project Coordinator, ATGWU-URWU HIV/AIDS Programme

Bilateral and International Partners

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District of Mukono

Public Sector

Dr. Ellys K. Tumushabe, District Director of Health Services
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Non-Governmental Sector

Reuben Mubiru Kaggwa, Program Coordinator, Kyetume Community Based Health Care Program
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District of Soroti

Public Sector

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District of Ntungamo

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Annex C. Project Objectives and Indicators

Table C-1: Worksheet on DHSP Objectives

SAR "The Project Chapter, " Project Objectives subsection	**Key Policies and Institutional Measures under DHSP Action Plan (Government's Letter of Health Sector Policy, Ministry of Health, 1994)**	**SAR "Benefits and Risks" Chapter, paras 4.1 – 4.3**	**PPAR's Consolidation of Expected Outcomes/Specific Objectives**
Overarching development objective/Goal:			
The ultimate objective of IDA's involvement in Uganda's health sector and in the improvement of the health status of its people, is to contribute to overall economic productivity by enhancing the human capital of the population.		The project will help reduce the burden of disease and thus improve the health status of the populations in the project districts.	**In support of the CAS objectives of human resources development and poverty reduction, the overarching goal of the DHSP was to improve the health status of the populations in the project districts.** ***Note: 1995*** *World Bank Country Assistance Strategy* *Goal: to reduce poverty (p. 23)* *Development objectives: (1) to maximize economic growth; (2) to develop Uganda's human capital (p. 23)* *Health sector objective of health portfolio (DHSP and STIP): to improve the health status of the population in support of human resources development (p. 22); improvements in health and education are among the highest priorities in IDA's assistance strategy in Uganda (p. 13)*
Overall project objective:			
To pilot-test and demonstrate the feasibility of delivering an essential health services package to district populations, within a prudent financial policy framework for the sector in order to improve the efficiency and equity in the provision of health services.		• To test and implement, at the district level, sustainable models for delivery of essential health services to district populations. • (The Project) …will also serve as a vital pilot project for effective decentralization, thus contributing through an evolving learning exercise to institution and capacity building, and overall sustainability.	**To pilot-test and demonstrate the feasibility of delivering an essential health services package to district populations, within a prudent financial policy framework for the sector in order to improve the efficiency and equity in the provision of health services.**
Specific objectives:			
Support cost recovery and budgetary policies that will enable the health care system to move toward long-term	• Increase budget allocation/share of budget to the health sector each year • Support and develop	• Improving the sustainability of health services through cost recovery and insurance schemes.	**Mobilize more resources for the health sector (for improved sustainability), both through increases in public financing and through**

sustainability	alternative/additional financing mechanisms for health (cost recovery, health insurance)	• Encourage district health administrations to collect user chargers • Slow but steady movement in the direction of long-term (financial) sustainability	**alternative/additional financing mechanisms**
Support Government efforts to reorder priorities within the existing health care system by reallocating financial and human resources toward ensuring the provision of the EHP for all Uganda's citizens.	Reallocate sector resources to the most cost-effective interventions	The project will help reallocate Government expenditure toward essential public health and preventive services.	**Improve efficiency in the use of these resources, reallocating expenditures towards the EHP**
• Support the Government's strategy of decentralizing health services • Consolidate and improve management with increased local accountability	• Effectively implement the decentralization program in the health sector. • Build capacity in the health sector in support of a decentralized system.	• The capacity of the central MoH to develop and implement policy would have been greatly strengthened. • Institutionalized practice of developing annual implementation plans that address national and district health priorities.	**Support the implementation of national decentralization policy in the health sector (including capacity building at central and decentralized levels of MoH)**
Increase the efficiency of the existing health infrastructure and institutions	Restore the functional capacity and improve the efficiency of existing government facilities	• The policy reforms, outlined in the Letter of Sector Policy, would have a substantial impact on the effectiveness and efficiency of Government health service delivery. • Help improve access to health services and the utilization of government health facilities. • Improve the efficiency of services through institutional autonomy	**Restore the functional capacity and improve the efficiency of essential existing government facilities**
Experimentation with contracting out (to non-governmental entities) and voucher schemes	Facilitate a greater role for NGOs, the private sector and communities	• Improve the efficiency of services through contracting out. • Encourage district health administrations to contract with NGOs for services	**Facilitate a greater role for NGOs, the private sector and communities (experimentation with contracting out)**

Table C2. Indicators Selected By MOH after Mid-Term Review

Project Component	Sub-Component	Index activities of aspects	Indicators
Pilot and Demonstration	• Defining essential package	• Absorption capacity	1. % expenditure of district health budget
	• New financing mechanisms	• Application of EHP	2. % expenditure on EHP
	• Insurance for formal workers	• Contracting	3. % district annual expenditure
	• Contracting	• New financing mechanisms	4. % total health unit financing constituted by user fee collection
	• Greater hospital autonomy		
	• Options for paying health workers		
	• Update laws and regulations		
	• Pit latrine promotions		
	• Improve effectiveness of training		
District capacity building	• Strengthening health administration	• Strengthening health administration	5. % DHTs trained in management
	• Health planning	• Rehabilitation and equipment of health units	6. % of district health offices equipped
	• Training	• HMIS	7. Number of health units equipped/rehabilitated
	• HMIS	• Financial Decentralization	8. % health units/districts
	• Rehabilitation and equipment of health units		9. % un-earmarked funds
	• Quality assurance		
	• Support to UPDF		
	• Support to IPH		
	• Financial management		
Restructuring and capacity building of MOH	• Restructuring	• MOH staffing levels and relevant skills	10. % staff with the required skills and knowledge for the post they hold
	• Capacity building	• Availability of quality standards	11. % depts../units with technical guidelines
	• Relocation of MOH Hqs		
	• Policy leadership		

Source: Konde-Lule, 2002

Annex D. Planned vs. Actual Project Support by Component/Subcomponent

Table D1. Planned vs Actual Support

Planned	Implemented?	Comments
Part A: Pilot Activities		
Support to the delivery of EHP in 3 pilot districts (Soroti, Mukono, Masindi) and extension of support to 3 additional (pre-pilot) districts which had launched EHP under IDA financing of the first health operation and SIDA financing (Gulu, Kabale and Tororo)	Partially	Financial support to pre-pilot and pilot districts started in 94/95 and 95/96, respectively. During project implementation Soroti was divided into two districts (Katakwi and Soroti) and Tororo was divided into two districts (Busia and Tororo), increasing the total number of pilot and pre-pilot districts to four each. District plan interventions were based on burden of disease studies, which identified 10 diseases with highest burden: malaria, diarrhea, pneumonia, maternal conditions, AIDS, injury, measles, TB, neonatal conditions, cardiovascular disease. The definition of a cost-effective EHP evolved slightly during the course of project implementation, to better respond to the disease priorities. DHSP funded delivery of the following services: maternal and child health, family planning, immunization; integrated management of childhood illness, environmental health, health education, vector control, school health, TB and leprosy control. (See Annex …, Table … for the definition of the EHP at project design and at project completion.) (blue) DHSP has been the main source of funding of district delivery of EHP at about 40% of total expenditures at district level, net of salaries, hospital costs & drugs. (ICR)
Rehabilitation of buildings	Yes	Pilot districts: construction of 3 district health offices and two drug stores; rehabilitation of 15 health units and one (Soroti) district hospital. Pre-pilot districts: rehabilitation of 16 health units. (See Annex …, Table … for detailed itemization.)
Provision of furniture and equipment	Yes	(planned vs. by disb cat)
Provision of essential materials and supplies (drugs, vitamins, bednets, wells, IEC materials and services…)	Yes	Supported baseline study to assess drugs needs in districts. Procurement of essential drugs supplemented Uganda Essential Drugs Program (DANIDA-financed). (ICR)
Training/continuing education of health service delivery staff	Yes	This was a central focus of DHSP, focused on the delivery of EHP
Training/support of community-based health workers, and provision of TBA kits	Yes	TBAs, CHWs
Short-term technical assistance	Yes	One-year technical to support streamlining malaria control activities
Supervision	Yes	Provision of guidelines, logistics, funding of supervision costs
Community outreach/mobilization activities to extend public health activities	Partially	Malaria, water and sanitation, etc.
Support for strengthened drugs and stores management	Partially	Stores construction, training of store assistants, regular supervision of pharmacies, health education about rational drug use. Study on Drugs Needs Assessment in Districts (June 1997)
Support of a learning process		
Studies/operational research in the following areas: • Innovative health financing	Partially	Studies: Health Insurance Feasibility Study by Harvard University (no date specified) (proposes 3 types of insurance: (a) mutual funds for large firms and civil servants; (b) voluntary health plans for rural/informal sector; (c) savings on health care prepayments. Insurance found to be economically feasible, but not politically or financially viable: ICR); Study to Propose a New Health Financing System in Uganda (August 1996); Review of Financial Management System and Procedures of the health services cost-sharing scheme (September 1997); Review of Financial Flows to Health Sector (September 2000). (Konde-Lule) Studies found drug revolving funds are n ot feasible at district level. Inefficient management and use of drugs remain issues. Provision to districts of guidelines for cost recovery and training of health workers and community leaders. Operational research on income generation for improved private expenditure on health showed mixed results and concluded that directly supporting income generation is not the role or comparative advantage of the health sector. Two prepayment schemes at hospital level (Tororo and

Planned	Implemented?	Comments
		Kisi) were initially successful, but pilots needed to be expanded and studied in more depth before drawing conclusions.
• Contracting out of repair, maintenance and rehabilitation	Partially	Construction, cleaning, grounds maintenance, purchase of bednets, printing, service of computers, etc. (Konde-Lule) Support included guidelines for contracting and comparative prices. (ICR)
• Contracting out of health services/health activities	Partially	
• Motivational remuneration of health workers	Partially	Study: Review of staff motivation mechanisms of rural health units in Kabale district (1996) (Konde-Lule) Recommended: (a) prompt payment; (b) performance-based rewards; (c) co-ownership of motorcycles/bicycles; (d) housing; (e) prompt and appropriate personnel action. Motivation is critical, but is the responsibility of Ministry of Public Service (in charge of Civil Service Reform), not Health. (ICR)
Monitoring and evaluation:		
• Assessment of changes in health status attributed to the EHP	no	Study: Assessment of Burden of Disease and Cost-Effectiveness of Health Care Interventions (March 1996) (identified top ten diseases, and assessed costs and financing of needed interventions for 13 pilot/demonstration districts); District-level baselines were carried out at the project's outset (Report of findings from baseline studies in Soroti, Mukono, Masindi – 1995), but changes in the health status were not routinely tracked at the district level during the course of the project. Study: Protein-Energy-Malnutrition among Children under five Years: Jinja District (1998)
• Assessment of the delivery, management and impact of the EHP in the six (pilot and pre-pilot) districts after first year before moving on to demonstration phase.	no	In 1997 (some two years after the start of implementation) a decision was made to combine the pilot and demonstration phases without first evaluating the pilot phase.
Part B. Demonstration Activities		
Support to the delivery of EHP in 7 additional districts (for a total of 10), which would have been fine-tuned in light of studies and evaluation carried out during the pilot phase	Partially	Seven additional districts were included in the demonstration phase and started getting financial support in 96/97 (Apac, Iganga, Kamuli, Kiboga, Lira, Mubende, Rukungiri). With Apac being divided into two districts, the total number of incremental districts increased from seven to eight.
Rehabilitation of buildings	Yes	Construction of 3 DMOs and drug stores (Bugiri, Iganga, Rukungiri); rehabilitation of about 40 health units.
Provision of furniture and equipment	Yes	
Provision of essential materials and supplies (drugs, vitamins, bednets, wells…)	Yes	
Training/continuing education of health service delivery staff	Yes	With a focus on EHP
Training/support of community-based health workers	Yes	
Short-term technical assistance	Yes	
Supervision	Yes	
Community outreach/mobilization activities to extend public health activities	Yes	Sensitization and training of many community groups in the rational use of anti-malarial drugs and environmental control of malaria, including bednets.
Support of a learning process		
Continuation of studies/operational research in the following areas:		Above text on pilot phase applies here, as pilot and demonstration phases were consolidated into one.
• Innovative health financing	Partially	
• Contracting out of repair, maintenance and rehabilitation	Partially	
• Contracting out of health services/health activities	Partially	
• Motivational remuneration of health workers	Partially	
Extension of studies/operational research to additional areas:		

Planned	Implemented?	Comments
• Community-based health	Partially	Supported community-based mechanisms for sale and maintenance of impregnated bednets. After initial difficulties (prohibitive costs and lack of clear strategy), nets are now lower costs because they have been granted exemption from taxes. Studies: Evaluation of the Performance of Community Health Care Delivery in Hoima District (1998); Community-Based AIDS Home C are (1998); Sanitation in Primary Schools in Mpigi District (1998)
• Quality monitoring and assurance	Partially	Study: Assessment of the Quality of Immunization Services in Mukono District (May 1997); Assessment of the Quality of Care in Mukono District (1997).
Monitoring and evaluation:		
• Assessment of changes in health status attributed to the EHP	Very partially	Assessment of Burden of Disease and Cost-Effectiveness of Health Interventions (in each pilot and demonstration district). Studies: Factors Affecting Utilization of Maternal, Child, and Family Planning Services in Uganda (July 1997); Health Care Seeking Behaviors for STI among Adolescents in Rakai District (1998); Assessment of People's Knowledge, Attitudes and Behaviors with regard to Malaria (no date; not available in PCO)
• Annual reviews of district-level activities to assess EHP coverage, management and impact.	Very Partially	Study: Cost Analysis of Kabarole District Health system (1997)
Part C: Capacity Building for District Health Administrations		
Phased approach to nationwide coverage: 15 districts in year 1; 30 districts in year 2; (all) 39 districts by Year 3		Phasing of remaining districts not included in pilot/demonstration phase was carried out as follows: Group 1 (6 districts) received support for 3 years (1997-2000) : Arua, Hoima, Kasesse, Kisoro, Mbale, Mpigi. Group 2 (remaining districts) received support for 2 years (1998-2000)
Strengthening district capacity for health administration and management in the context of decentralization		Studies: Review of Management Structure of District Health Services (July 1998); Proposal for Structure and Establishment of Health Services Commission (no date; not available in PCO).
Training and on-the-job advice and assistance in planning, programming, supervision, monitoring and evaluation.	Yes	Training in supervision, planning, budgeting information systems and financial management. District health management information system coordinators and assistants were trained and their positions have been institutionalized. Master's degrees for many district directors in public health and management. Supported Advanced Diploma in Health Services Management offered at Makerere University for 30 middle managers (hospital administrators and district health team members) over a two year period (1998 and 1999). Health is first sector to develop local level plans, supervision is now institutionalized at the district and subdistrict levels. Financial management and financial autonomy guidelines developed and mainstreamed in all districts. Absorptive capacity for district health funds from all sources increased from 78% to 96% during 97/98 – 01/02 (data on pilot/demonstration districts only).
Development of capacities in financial management and financial reporting	Yes	
Provision of computers, equipment, logistical support and some rehabilitation	Yes	Provision of computers, office equipment other support for full establishment of health management information system and for overall management. Provision of pickup truck for each DHO. Construction of 3 DMOs & drug stores (Jinja, Kibale, Mpigi); rehabilitation of 40+ health units (Arua, Hoima, Junja, Kampala, Kayunga, Kibale, Masaka, Mayuge, Mbale, Mpigi/Wakiso); rehabilitation of sewerage system at Mpigi district hospital.
Technical training	Yes	Training of health personnel for improved delivery of the EHP. (ICR) All district health teams received training in early detection of malaria, management of severe malaria, planning malaria control programs, epidemic management, supplies management. (Konde-Lule et. al)
Support to NGOs and private health units to provide essential (public health and preventive) services (e.g., school health, reproductive health, community-based net sales and maintenance, community support for water and sanitation initiatives)		Services contracted out: supervision, training, transport operation and maintenance, construction and social marketing. Limited service delivery contracted out to NGOs, CBOs and private firms.
Training and supervision of NGO staff	Yes	NGOs and CBOs were trained in community needs assessment and management; many NGOs had their staff trained in environmental control of malaria.
Provision of supplies and equipment	Yes	Some NGO health units were repaired or expanded and many were provided with drugs and medical and laboratory equipment, among them Kamuli Hospital and Vira Maria Hospital..

Planned	Implemented?	Comments
Annual reviews of all NGO activities supported under the project in the context of district action plans	Partially	
Contracting of NGOs at the district level	Yes	Some NGOs were contracted to perform specific tasks and others received grants for small projects.
Encouragement of private health unit development		
Study to review regulatory, procedural and statutory barriers and to establish minimum standards	Yes	"Barriers to Private Health Sector Development in Uganda" identified barriers and made recommendations to overcome them, with some already adopted (e.g., opening up private practice to categories of health workers such as registered nurses, previously not allowed to do so)
Grants (maximum of US$25,000) to already established private health units in underserved areas for purchase of equipment	No	It was feared that grants might create artificial demand vs. satisfy unmet need.
Testing greater autonomy for selected Government health units		Study: How to Make National Hospitals Autonomou
Mulago (national hospital) and 3 other hospitals to test concept of self-governing trusts (training of health committees, provision of equipment and supplies)	Partially	Financing of hospital autonomy study (no date available; not available at PCO) and support to drafting policy that will affect national (Mulago and Butabika) hospitals. Nine regional hospitals will also become autonomous. MoH had planned a phased autonomy of referral hospitals, starting with national, and subsequently extending to regional hospitals. However, MinFin granted financial autonomy to all referral hospitals at once. Project financed study tours to Africa and Latin America. Mulago achieved financial autonomy by the end of the project, but not managerial autonomy. Mulago's full autonomy, once achieved, will provide lessons and guidance for others. National Medical Stores is now fully autonomous.
Involvement of capable NGOs in the supervision of nearby public health units and community-based activities (costs of supervision based on presentation of management plan and indicators)	Partially	
Measures to improve the effectiveness of training in public institutions	Yes	Supported: drafting of the training policy of MoH, provision of scholastic materials; supported tutor training in Mulago and Butabika hospitals
Testing mechanisms for improving staff motivation by giving training institutions authority to pay staff incentives in: nursing schools in Kabale and Lira, and laboratory assistant school in Jinja	Yes	Studies: Review of Staff Motivation Mechanisms of Rural Health Units in Kabale District (1996); How to Improve Effectiveness of Training in Government Health Institutions in Uganda (March 1997) Human resources development policy draft for health sector emanated from this work, but government restructuring has since placed all training institutions under the direct responsibility of the Ministry of Education.
Charging fees to students through fellowships to no more than 50% of students based on need		
Rehabilitation and equipment of training schools to increase feasibility of student charges and improve training effectiveness	Yes	Constructed and rehabilitated many structures in various medical training institutions, including those in Jinja
Curricula reform w/ emphasis on primary health care and public health, including a review of entry requirements and career paths	Yes	Efforts to improve training syllabuses for Laboratory Technologists, Nurses and Medical Assistants
Delegation of training responsibility to district level	Partially	
Financial and administration autonomy to training institutions supported under the project	Partially	
Contracting out services & supplies to be completed no later than end of first year of the project, culminating in plan and recommendations to be submitted for IDA review		
Study on contracting out of selected hospital services	Yes	Study to develop methods of contracting out hospital services and supplies (February 1997)
Encouragement of districts contracting out in-service training, management and supervision of health units to NGOs/private providers	Partially	

Planned	Implemented?	Comments
Training course for health information clerks contracted out to private training institutions		
Experimentation contracting out district hospitals & health centers to NGOs in Kamuli and Kampala districts	No	Study: Strategic Health Plan for Kampala: 1997-2002 (October 1996); Kamuli district opted to build its own (public) district hospital. (Konde-Lule) Contracting out of health centers in Kampala was not carried out. (Bank supervision reporting)
Study on feasibility of contracting out blood transfusion services		
Establishment of new funding mechanisms: implementation of guidelines on user fee levels, their collection and reinvestment	Partially	User fees were abolished in 2001. Private hospital wings are still available for those who can afford it.
Training of health management committees and health facility staff	Yes	Development of guidelines for user fees initiative; training of health workers and committee members in the management of fees initiative
Provision of equipment and supplies (safes, receipt books…)	Yes	Logistical support for records keeping; vehicles/allowances for supervision
Inter and intra district workshops to review collective experience	Yes	Support of consultative process on the development of a policy on users fees, which was approved by Cabinet (and later abolished by decision of the President in 2001).
Development and testing of new financing initiatives and exemption mechanisms		Contributed to the development of health insurance through funding of a feasibility study conducted by Harvard University.
Review and updating of health statutes and regulations to align w/ decentralization and new health policies		
Support to the process	Yes	Document review for all policies and laws (August 1996); opinion gathering from various stakeholders using questionnaires; compiling opinions and presenting a report in a consensus workshop; compilation of a final report. A new "Health Services Act was submitted to the Cabinet for approval.
Workshops to discuss proposed changes	Yes	
Strengthening the Public Health Directorate of the National Resistance Army (NRA)		
Continue support under 1st health project to integrate health education into all its health services and to strengthen public health capacity	Yes	Rehabilitation of three district-level UPDF Health units (Masindi, Tororo, Mubende districts); equipment vehicles and motorcycles; advanced training in Public Health to four professional staff; training for over 100 vaccinators and 50 health educators
Part D: Restructuring and Capacity Building for Central MoH		
Strengthening of policy-making role of MoH: support to Health Planning and Inspection Department (funds and software for health systems development; capacity building in planning, budgeting, monitoring, studies, study tours; training; short-term TA; introduction of quality assurance; health management information system)	Yes	Training of top MoH management officials in policy development; training of many MoH staff in health economics, policy and planning; full participation of DHSP staff in policy-making processes in MoH; formulation of guidelines/policies for malaria control, IMCI, family planning, epidemic management, nutrition policy, performance standards for hospitals and hygiene education guidelines for environmental health promotion. This culminated in the SWAP policy, which was supported through: consultative processes, joint reviews; consensus workshops and staff training.
		Institutionalization of Quality Assurance pilot department as full-fledged department and functional program through training, guidelines, logistical support; Study: Development of Effective Mechanisms of Supervision of Health Services (August 1997);
Support to the movement of MoH to Kampala (rehabilitation, furnishing, equipment of existing buildings – new construction not envisaged)	Yes	A new building for MoH headquarters in Kampala was constructed to house all key departments.
Enhanced policies	Yes	Significant support to the development of a national nutrition policy (Study: Review of Nutrition Situation in Uganda [no date available]; development of key policies/guidelines for newly restructured MoH departments.
Restructuring of MoH	Yes	Study: Review of Structure of Ministry of Health (March 1998); Size of MoH staff was reduced from over 400 to 220, of which about 150 posts were effectively filled and 70 still vacant by the project's end. In addition, 54 extra staff continued to work at MoH.
Other	Yes	Studies: Inventory of Health Services in Uganda (1997); National Health Accounts (June 2000); Review of Financial Flows to the Health Sector (September 2000), all of which were supportive of a transition to a sector-wide approach.

Table D2. Studies Conducted with DHSP Support

	Title of Study	Date of Report	Report Available at PCO
1.	Identify barriers to the Private Health Sector Development in Uganda	Dec-96	Yes
2.	Assess people's knowledge, attitude and behaviors with regard to malaria		
3.	Study to Improve Effectiveness of Training in Government Health Institutions in Uganda	Mar-97	Yes
4.	Develop an effective mechanism of supervision of health services	Aug-97	Yes
5.	Propose a new health financing system in Uganda	Aug-96	Yes
6.	Study on Factors affecting Utilization of Maternal, Child and Family Planning Services in Uganda	Jul-97	
7.	Review the management structure of district health services	Jul-98	Yes
8.	Drug Needs Assessment in Districts	Jun-97	Yes
9.	Propose the structure an establishment of health services		
10.	Propose a strategic health plan for Kampala 1997-2002	Oct-96	Yes
11.	Review and update health laws and regulations	Aug-96	Yes
12.	Review the structure of the Ministry of Health	Mar-98	Yes
13.	Assess the burden of disease and cost-effectiveness of health care interventions	Mar-96	Yes
14.	Develop methods of contracting out Hospital services and supplies	Feb-97	Yes
15.	National Health Accounts	Jun-00	Yes
16.	Determine how to make national hospitals autonomous		
17.	Review of staff motivation mechanisms of rural health units in Kabala District	1996	Yes
18.	Evaluation of the performance of community Health Care Delivery in Hoima District	1998	Yes
19.	Report of findings from Baseline Studies in the Districts of Soroti, Mukono and Masindi	1995	Yes
20.	Sanitation in Primary Schools in Mpigi District	1998	Yes
21.	Study of Community-Based AIDS Home Care	1998	Yes
22.	Protein-Energy-Malnutrition among Children under five years; Jinja District	1998	Yes
23.	Review of the Nutrition situation and strategy in Uganda, and to propose a strategic nutrition policy and plan		
24.	Cost analysis of Kabarole District Health System	Jun-97	Yes
25.	Assessment of Quality of Immunization Services in Mukono District	1998	Yes
26.	Review of Financial Management System and Procedures of the health services cost-sharing scheme	May-97	Yes
27.	Health Care Seeking Behaviors for STI among Adolescents in Rakai District	1998	Yes
28.	Assess the quality of care in Mukono District	1997	Yes
29.	Inventory of Health Services in Uganda	1997	Yes
30.	Review of Financial flows to the Health sector	Sep-00	Yes

Source: Konde-Lule

Table D3. IDA financed District-Level Civil Works by Category of District

District	DMO Office	Drug Store	Health Unit	UPDF Health Unit	District Hospital
Pre-pilot districts					
Busia			Rehab (2)		
Gulu			Rehab (6)		
Kabale			Rehab (5)		
Tororo			Rehab (3)	Rehab (1)	
Subtotal pre-pilot districts	**0**	**0**	**16**	**1**	
Pilot districts					
Katakwi	Constr (1)	Constr (1)	Rehab (4)		
Masindi	Constr (1)	Constr (1)		Rehab (1)	
Mukono			Rehab (6)		
Soroti	Constr (1)		Rehab (4)		Rehab (1)
Subtotal pilot districts	**3**	**2**	**14**	**1**	**1**
Demonstration districts					
Apac					
Bugiri	Constr (1)	Constr (1)			
Iganga	Constr (1)	Constr (1)	Rehab (9)		
Kamuli					
Kiboga					
Lira			Rehab (9)		
Mubende				Rehab (1)	
Rukungiri	Constr (1)	Constr (1)	Rehab (6)		
Subtotal demonstration districts	**3**	**3**	**24**	**1**	
Other districts					
Arua			Rehab (11)		
Hoima			Rehab (10)		
Jinja	Constr (1)	Constr (1)			Emergency Rehab (1)
Kibale	Constr (1)	Constr (1)	Rehab (3)		
Mayuge			Rehab (1)		
Mbale			Rehab (3)		
Mpigi/Wakiso	Constr (1)	Constr (1)	Rehab (8)		Rehab (1) (sewerage system)
Subtotal other districts	**3**	**3**	**36**	**0**	**2**
Grand Total	**9**	**8**	**90**	**3**	**3**

Table D4. District-Level Civil Works

District	DMO Office	Drug Store	Health Unit	UPDF Health Unit	District Hospital
Masindi	Constr (1)	Constr (1)		Rehab (1)	
Kabale			Rehab (5)		
Rukungiri	Constr (1)	Constr (1)	Rehab (6)		
Kibale	Constr (1)	Constr (1)	Rehab (3)		
Hoima			Rehab (10)		
Mukono			Rehab (6)		
Tororo			Rehab (3)	Rehab (1)	
Busia			Rehab (2)		
Soroti	Constr (1)		Rehab (4)		Rehab (1)
Lira			Rehab (9)		
Gulu			Rehab (6)		
Arua			Rehab (11)		
Mbale			Rehab (3)		
Mayuge			Rehab (1)		
Iganga	Constr (1)	Constr (1)	Rehab (9)		
Mpigi/Wakiso	Constr (1)	Constr (1)	Rehab (8)		Rehab (1) (sewerage system)
Mubende				Rehab (1)	
Bugiri	Constr (1)	Constr (1)			
Katakwi	Constr (1)	Constr (1)	Rehab (4)		
Jinja	Constr (1)	Constr (1)			Emergency Rehab (1)

Table D5. KfW-Financed Civil Works: Rehabilitation of Health Units by Category of Districts

District Category	Location of Health Unit Rehabilitated
Pre-pilot districts	
Tororo (1)	Kitongo
Subtotal pre-pilot districts	1
Pilot districts	
Masindi (7)	Bulisa
	Ibuje
	Ikoba
	Kijunjubwa
	Kimengo
	Kyatiri
	Masindi Port
Mukono (1)	Bulopa
Subtotal pilot districts	**8**
Demonstration districts	
Apac (3)	Alito
	Cawente
	Nabieso
Kamuli (3)	Balawoli
	Buyende
	Namwiwa
Kiboga (5)	Kiyuni
	Kikonda
	Kyantungo
	Kyankwanzi
	Lwamata
Mubende (4)	Bukuya
	Malangala
	Musozi
	Nabingola
Subtotal demonstration districts	**15**
Other districts	
Jinja (1)	Buwenge
Kampala (1)	Buyinja
Kayunga (1)	Kikandwa
Masaka (1)	Banda
Other /unidentified (7)	Agulurude
	Bumoli
	Buluguyi
	Iwemba
	Kakaire
	Muterere
	Nankome
Subtotal other districts	**11**
Grand Total	**35**

Table D6. Pilot and Demonstration Districts: planned vs. actual

Project Design Stage	**End of Project**	**Rehabilitation Works**	
		IDA-financed	**KfW-financed**
Pilot and Demonstration Districts			
Pre-pilot Phase: (3)	***(4)***		
Gulu	Gulu	X	
Kabale	Kabale	X	
Tororo	Busia	X	
	Tororo	X	X
Pilot Phase: (3)	***(4)***		
Masindi	Masindi	X	X
Mukono	Mukono	X	X
Soroti	Katakwi	X	
	Soroti	X	
Demonstration Phase: (7)			
Apac	Apac		X
Iganga	Bugiri	X	
	Iganga	X	
Kamuli	Kamuli		X
Kiboga	Kiboga		X
Lira	Lira	X	
Mubende	Mubende	X	X
Rukungiri	Rukungiri	X	
Subtotal Original Districts: (13)	***(16)***		
Other districts receiving rehabilitation/reconstruction support under DHSP			
	Arua	X	
	Hoima	X	
	Jinja	X	X
	Kampala		X
	Kayunga		X
	Kibale	X	
	Masaka		X
	Mayuge	X	
	Mbale	X	
	Mpigi/Wakiso	X	
Subtotal other districts (not specified at design stage)	***(10 +)***		

Annex E. Project Costs and Financing

Table E.1. Planned Versus Actual Project Financing (US$ million equivalent)

Financier	Planned[54]	Actual
IDA	45.0	40.51[55]
SIDA	7.0	6.97[56]
KfW	9.0[57]	9.00[58]
ODA/DFID	2.2	--[59]
DANIDA	5.0	--
Government of Uganda	6.9	3.50[60]
Total	75.1	59.98

54. Source: Staff Appraisal Report.

55. Source: World Bank Loan Department/Disbursement Data as of Closing Date: December 31, 2002.

56. Ibid.

57. KfW financing to support: reconstruction/rehabilitation of basic health facilities (5.8 million DM); rehabilitation of schools for health personnel in Fort Portal & Jinja (0.7 million DM); consultant oversight services (1.8 million DM); medical equipment (1.9 million DM); and contingencies (2.3 million DM). Source: Financing Agreement between German Financial Coorporation and Ugandan Government, October 12, 1995.

58. Konde-Lule, et. al., (Uganda Final Evaluation Report).

59. Source: Government and IDA final evaluation reports.

60. During the course of project implementation (around the mid-term review) Government's contribution was reduced from 10 percent to 5 percent of total project cost due to GoU's budgetary shortfall.

Table E.2. Planned vs. Actual Costs by Component (US$ million)

Component	Appraisal Estimate[61]	Actual Costs by Component[62]
Pilot and Demonstration Activities	27.3	13.02
Of which:		
Pilot Activities:	(8.2)	-
Demonstration Activities:	(19.1)	-
Capacity Building for Districts	36.7	34.88
Capacity Building for MoH	8.0	17.36
Project Management/Oversight	3.1	
Of which:		
Monitoring & Evaluation	(1.2)	
Support to PCO	(1.9)	
Total	75.1	65.26[63]

Table E.3. Planned vs. Actual Use of IDA Credit by Disbursement Category

(millions of SDR)

Disbursement Category	Initial Allocation	Final Allocation (by DCA Amendment)	Actual Disbursements	Actual as % of Initial Allocation
(1) Civil Works				
(a) for Part A* of the Project	1.51	0.74	0.41	27%
(b) for Part B** of the Project	6.86	11.84	11.08	162%
(2) Equipment, Materials and Furniture				
(a) for Part A* of the Project	2.40	1.40	0.96	40%
(b) for Part B** of the Project	4.80	3.80	4.73	99%
(c) other	0.69	0.00	0.00	0%
(3) Medical Supplies, Drugs				
(a) for Part A* of the Project	0.55	0.30	0.11	20%
(b) for Part B** of the project	1.03	0.42	0.29	28%
(c) other	0.14	0.00	0.00	0%
(4) Training	3.43	5.85	7.73	225%
(5) Technical Assistance, Consultants' Services, Studies and Research	3.10	3.10	2.48	80%
(6) Incremental Recurrent Expenditures	3.29	2.68	2.45	75%
(7) Unallocated	3.10	0.00	0.00	--
Reconciliation of Special Account			-0.11	
Total	30.90	30.13	30.13	98%

Amount cancelled: 0.77 million, or 2.5 percent of original credit amount

Source: World Bank Loan Department, December 2005

Note: Part A: Pilot Activities; Part B: Demonstration Activities

61. Source: Staff Appraisal Report, Table 3.2.

62. World Bank 2003 (Implementation Completion Report).

63. This estimate for total actual project cost does not match exactly the estimate of total actual financing ($59.98 million) cited in Table … above. Differences are likely attributable to timing and basis of calculating exchange rates of the different financial contributions, as well as to changes in exchange rates over the life of the project between Ugandan shillings and the various currencies. The mission was unable to access data through the project office to reconcile these differences.

Table E.4. Planned vs. Actual Use of Swedish Grant No. 20052 by Disbursement Category

(millions of Swedish Kronor)

Disbursement Category	Initial Allocation (Source: 9/30/96 Grant Agreement)	Final Allocation (Source: World Bank Loan Department)	Actual Disbursements	Actual as % of Initial Allocation
(1) Civil Works				
(a) for Part A of the Project	2.00	8.95	8.95	447%
(b) for Part B of the Project	5.00	0.00	0.00	0%
(2) Training	33.00	21.40	22.11	67%
(3) Vehicles	10.00	11.95	12.60	126%
Equipment, Materials, Furniture	0.00	3.98	3.98	Not initially foreseen as SIDA expenditure
Medical Supplies, Drugs	0.00	0.29	0.29	Not initially foreseen as SIDA expenditure
Technical Assistance, Consultants, Studies	0.00	5.71	5.72	Not initially foreseen as SIDA expenditure
Incremental Operating Costs	0.00	8.00	8.18	Not initially foreseen as SIDA expenditure
Reconciliation of SIDA Special Account	--		-1.55	--
Total	50.00	60.28	60.28	121%

Source: World Bank Loan Department, December 2005

Note: Part A: Pilot Activities; Part B: Demonstration Activities

Annex F. Project Outcomes by Objectives and Targets (Results Matrix)

Goal/Objective/subobjective	**Baseline data**	**Targets** ***(Indicators chosen after MTR [and not at outset] to monitor and evaluate project/source: Konde-Lulet et al. 2002)***	**Actual Achievements**
Goal: Improve health status of the Ugandan population (source: World Bank, 2004)			
Maternal mortality rate (deaths per 100,000 live births)	527 (1995 DHS) (523 in 1994 - World Bank, 2004)		504 (2000/01 DHS) (505 in 2004 – World Bank 2004)
Infant mortality rate (per 1000 live births)	81.3 (1995 DHS) 100 (World Bank, 2004)		88 (2000/01 DHS) 101 in 2000 (World Bank, 2004)
Under-five mortality rate (per 1000 live births)	147 150 (World Bank, 2004)		151 (152 World Bank 2004)
Total fertility rate	6.9 (1995 DHS)		6.9 (2000/01 DHS)
% children underweight (-2 SD)	23 (1988 DHS); 25 (1995 DHS)		22.5 (2000/01 DHS)
% children stunted (-2 SD)	442 (1988 DHS); 38 (1995 DHS)		38.6 (2000/01 DHS)
% children wasted (-2 SD)	1.9 (1988 DHS); 5.3 (1995)		4.0 (2000/01 DHS)
General Objective: Pilot test (in 3 districts) and demonstrate (in 10 districts) the feasibility of delivering an essential health services package to district populations			
To learn from pilot and demonstration phases and to finetune policy and practice for nationwide application of reform		• Pilot test delivery of EHP in three districts. • Enhanced understanding of the modalities and relative effectiveness of various reforms through the evaluation of experience in six (pre-pilot and pilot) districts after one year to inform the launch of a demonstration phase covering an additional 7 districts. • Enhanced understanding of the modalities and relative effectiveness of various reforms through the evaluation of demonstration experience to inform nationwide application of reforms	***Negligible.*** Project support was extended to the demonstration districts in 1996 without evaluating the experience of the pilot and pre-pilot districts. Project support was subsequently extended in 1998 to all 56 districts without evaluating the experience of the combined pilot and demonstration phases. Envisaged demonstration of how to improve essential service delivery did not happen as all necessary components were not in place (human resources, infrastructure, management systems). While some learning did occur through implementation experience and through the conduct of studies and research, learning opportunities were still not as fully exploited and documented, as they might have been. This being said, many reforms initiatives started/supported under the project are now part of HSSP.
Specific Objectives 1 – 5:			
1: Mobilize more resources for the health			***Modestly achieved.***

Goal/Objective/subobjective	**Baseline data**	**Targets** ***(Indicators chosen after MTR [and not at outset] to monitor and evaluate project/source: Konde-Lulet et al. 2002)***	**Actual Achievements**
sector			Increase in government health expenditure still represents a small share of total government expenditure and a modest increase (in per capita terms) and does not make up for loss of income to the health sector due to the abolition of user fees, nor does it cover the cost of increased service demand/utilization. Out of pocket expenditure was not reduced with the (unanticipated) abolition of user fees. But the burden of payment was shifted more to the richer segments of the population. Limited studies and operational research on risk pooling and other innovative financing mechanisms. Financing strategy needs to be expanded to encourage development of health insurance schemes and other options for risk pooling.
• ***Increase total per capita spending on health(public and private sources combined)***	$7.73 in 92/93 (MoH Policy Letter)		$18.31 in 2000/01 (MoH National Health Accounts, 2004), or about 60% of needs (US$28 to deliver essential health package in Uganda, as calculated in MoH Financing Policy, 2002)
Specific data on public spending:			
• ***Public per capita spending on health (all public sources)***	$2.83 in 92/93		$8.35 in 00/01 (MoH National Health Accounts, 2004)
• ***Central government per capita expenditure***	$3.15 in 98/99 (MoH National Health Accounts)		$3.28 in 00/01 (MoH National Health Accounts, 2004)
• ***Central government health expenditure***	91 billion shillings (about 2.0% of GDP) in 92/93 (MoH Policy Letter, 1994)		134 billion shillings in 2000/01 (MoH National Health Accounts, 2004) Per capita expenditures financed by donors in 2002/03: $3.30 (World Bank, 2004)
• ***Government spending on health as a share of total government expenditure***	8.0% in 94/95 (MoH National Health Accounts, 2004)		6.5% in 99/00; 7.4% in 2000/01; 8.6% in 2001/02; 9.0% in 2003/03 (World Bank, 2004 and MOFPED 2003)
• ***Government spending on health as a share of total health expenditure***	17% in 98/00 (MoH National Health Accounts, 2004)		18% in 00/01 (MoH National Health Accounts, 2004)
Specific data on private spending/alternative financing mechanisms::			
• ***Private per capita spending on health (all private sources)***	$4.91in 92/93(MoH Policy Letter, 1994)		$9.96 in 00/01 (MoH National Health Accounts, 2004)
• ***Out-of-pocket payments per***	$8.67 in 98/99 (MoH		$7.41 in 00/01 (MoH National Health Accounts, 2004)

Goal/Objective/subobjective	Baseline data	Targets *(Indicators chosen after MTR [and not at outset] to monitor and evaluate project/source: Konde-Lulet et al. 2002)*	Actual Achievements
capita	National Health Accounts, 2004)		
• ***Out-of-pocket payments as % of total health expenditure***	46% in 98/99 (MoH National Health Accounts, 2004)		41% in 00/01 (MoH National Health Accounts, 2004) While out-of-pocket expenditure continued to increase even after the 2001 decision to abolish user fees was taken, spending patterns across income quintiles changed significantly with the two poorest quintiles reducing their expenditures by 50% and the highest quintile almost doubling its expenditure.
• ***Expenditure on health by private firms***	US$0.10 per capita (or 0.5% of total health expenditure) in 98/99 (MoH National Health Accounts, 2004)		US$0.06 per capita (or 0.03% of total health expenditure) in 2000/01 (MoH National Health Accounts
2: Improve efficiency in the use of health sector resources, reallocating financial and human resources toward the most cost-effective public health and clinical interventions (EHP)		.	***Modestly achieved.*** Health sector financial resources have been shifted increasingly to the support of EHP delivery, and to lower level health facilities (vs. hospitals). There is still scope, however, to further improve resource allocation within the range of EHP (for example, the financing of drugs and other essential supplies, and greater support of household and community care). DHSP introduced the concept of EHP, which is the basis for (a more rational) planning and resource allocation, which emphasizes primary health care.
financial resources			
• ***% government budget allocated to drugs and medical supplies as % of government budget***	59% in 98/99 (Ministry of Finance)		54% in 00/01 (Ministry of Finance)
• ***% government budget allocated to districts***	32% in 99/00 (Ministry of Finance)		48% in 01/02 (Ministry of Finance); with trend continuing in 02/03 (49%); attributable to significant increases in primary health care conditional grants
• ***% government budget allocated to regional hospitals***	14% in 99/00 (Ministry of Finance)		11% in 01/02 (Ministry of Finance) with trend continuing in 02/03 (8%)
• ***% government budget allocated***	22% in 99/00 (Ministry of		14% in 01/02 (Ministry of Finance), with downward trend

Goal/Objective/subobjective	Baseline data	Targets *(Indicators chosen after MTR [and not at outset] to monitor and evaluate project/source: Konde-Lulet et al. 2002)*	Actual Achievements
to central hospitals	Finance)		continuing in 02/03 (12%)
• ***MoH HQ***	30% in 99/00 (Ministry of Finance)		26% in 01/02 (Ministry of Finance), with slight increase in 02/03 (28%)
• ***Regional equity in spending***			Public (government and donor) expenditure was allocated increasingly in favor of poorest/most vulnerable regions with lower out-of-pocket spending (Northern region), but this did not adequately offset high out-of-pocket spending in Central and Eastern regions, which in 2001 still had higher per capita expenditure ($12 and $8, respectively) than the Northern regions (about $5). Per capita expenditure in the Western region was brought up to almost $10.
• ***District budget***	40 billion shillings in 98/99 (NHA)		57 billion shillings in 00/01 (NHA)
• ***District health expenditure devoted to EHP***	33% (1995/96)	***80%***	62% in 98/99 (Konde-Lule et al., Table 10))
• ***MoH HQ expenditure as share of total health expenditure***	34% in 98/99 (NHA)		42% in 00/01 (NHA) includes funds for centrally-procured goods (drugs, supplies, equipment) and services destined for districts
• ***National Referral Hospital expenditure as share of total health expenditure***	20% in 98/99 (NHA)		12% in 00/01 (NHA)
• ***Regional Hospitals***	8% in 98/99 (NHA)		8% in 00/01 (NHA)
• ***Health districts***	37% in 98/99		38% in 00/01
			A (reasonable) 60 percent of the health recurrent budget is used on non-wage expenditures (2003), but there is scope for improvements in allocative efficiency, particularly for drugs and other essential inputs for better service delivery (World Bank, 2004).
• ***human resources***	82% of Medical Officers and 79% of registered nurses are in hospitals.	Redeployment of qualified staff to difficult areas	No data available on redeployment of staff. Available data (MoH Annual Health Sector Performance Report, 2003-04) show continued staffing gaps and inequitable distribution of human resources both across and within regions in Government facilities. Staffing of district (excluding non-medical staff) averages 86%, ranging across districts from a low of 40% to a high of 265% (MoH 2003-04)

Goal/Objective/subobjective	**Baseline data**	**Targets** ***(Indicators chosen after MTR [and not at outset] to monitor and evaluate project/source: Konde-Lulet et al. 2002)***	**Actual Achievements**
Staffing of district level facilities	No baseline available		• HC IIs are 85% staffed w/ clinical personnel
	No baseline available		• HC IIIs are 94% staffed
	No baseline available		• HC IVs are 117% staffed
	No baseline available		• District hospitals are 96% staffed
	No baseline available		• Across HC IIs, staffing varies from 65 facilities that have no clinical staff to 44 facilities that have at least 6 clinical staff.
# physicians/100,000 population	4.1 in 1991 (MoH and WHO)		4.7 in 2003 (WHO 2003 statistics and World Bank, 2004)
			There is a particularly severe shortage of nurses in Uganda. Nurses per 100,000 population: 5.6 (compared with 108.0 for Kenya, 85.2 for Tanzania and 73.4 average for Subsaharan Africa). Actual staffing of nurses in district health facilities is at 48% of requirements as defined by minimum staffing standards. Some nursing positions are being filled by surpluses in midwife and nursing assistant staff. (MoH 2003-04)
		Establish a capability to measure the cost-effectiveness of interventions	
3: Support the implementation of national decentralization policy in the health sector			
• ***through strengthened capacity at district level***		Delegation of recurrent expenditure authority to the districts: 7/93 for 13 initial districts; 7/94 for an additional 14; 7/95 for the remaining 12 Strengthen budgeting accounting HIS, planning and supervision in DHA Increased local accountability	Vast majority of district staff trained (especially Accounting Officers) left health sector or district. Many deployed in district but outside of health sector, so lost investment to health. Financial management guidelines adopted and fully institutionalized by all districts (Konde-Lule). Implementation of national health policy now primarily the responsibility of the district. DHSP staff positions and activities institutionalized
Increased district absorptive capacity: expenditure as a percentage of all district health financing available	60% in 1995 (Konde-Lule)		78% in 97/98; 96% in 01/02 (for pilot/demonstration districts) (Konde-Lule, Table 7) Rate of absorbing DHSP funds for pilot/demonstration

Goal/Objective/subobjective	**Baseline data**	**Targets** ***(Indicators chosen after MTR [and not at outset] to monitor and evaluate project/source: Konde-Lulet et al. 2002)***	**Actual Achievements**
			districts increased from 80% in 1995/96 to 88 % in 1998/99. (Konde-Lule, Table 8)
% district health teams trained in management (output)	35% in 1995 (Londe-Lule)	100%	77% in 1999 (Konde-Lule)
			Supervision now a regular activity that is performed by district and sub-district levels. Health sector first to develop regular work plans at district level, approved by district councils in accordance w/ decentralization policy.
% district health offices equipped (input)	32% in 1995 (Konde-Lule)	100%	100% by 1999 (Konde-Lule)
			Proportion of health units submitting monthly HMIS returns to the (pilot/demonstration) DDHS increased from 66% (of 8 districts reporting) in 1995 to 95% (of 12 districts reporting). Timeliness of submisison has also significantly improved (Konde-Lule)
		District hospitals to be brought under authority of district health administrations by 95/96	Achieved
• ***through strengthened capacity at central level***			
		Move MoH HQ to suitable facilities in Kampala	Achieved
		New streamlined structure/role for central MoH	1999 National Health Policy redefines core functions of MoH as policy/advisory/regulatory and assigns districts the primary responsibility for policy implementation. 22 technical units organized into 6 departments.
			Quality assurance raised to departmental level and institutionalized. Health planning department supported both for strengthening policy/planning skills and processes and for enhanced assistance and follow-up to districts.
Increase % staff with the required skills and knowledge for the post they hold			MoH staffing was downsized from over 400 staff to about 220 recommended posts. As of the project's end 151 or 78% of these posts were effectively filled. 78 posts remained to be filled and 54 staff slated for retrenchment were still working in MoH. Comments that 220 may have underestimated staffing needs.
Increase # departments/units with technical guidelines	One third of MoH units in 1995 (Konde-Lule)		Two thirds of MoH technical units (15 of 22) had technical guidelines by the end of the project.

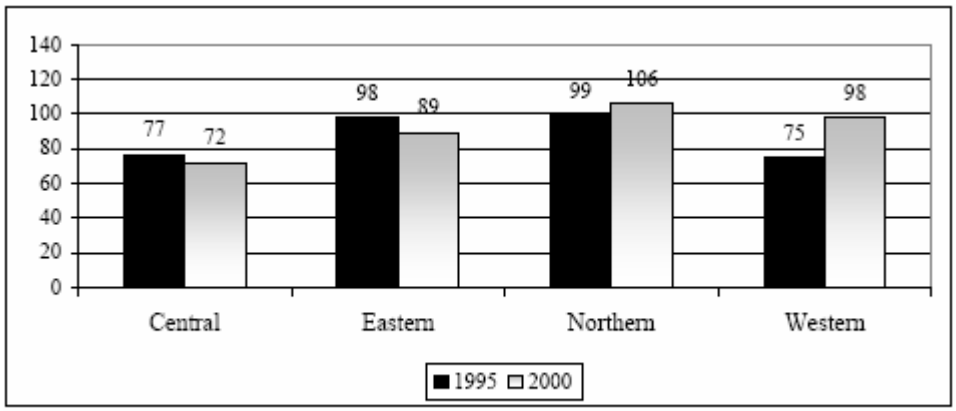
Goal/Objective/subobjective	**Baseline data**	**Targets** ***(Indicators chosen after MTR [and not at outset] to monitor and evaluate project/source: Konde-Lulet et al. 2002)***	**Actual Achievements**
Policy/plan formulation			Significant products generated with DSHP support both built and are a demonstration of enhanced capacity, including: 1999 National Health Policy, 2000/01 – 2004/05 (first) Health Sector Strategic Plan (HSSP), both of which are articulated around the principle of a cost-effective package of essential care to address the disease priorities of Uganda (EHP); a National Nutrition Policy. This coherent policy framework, developed through a participatory process involving donors and a broad range of stakeholders, provide the groundwork for moving towards a sector-wide approach. Government has a strengthened capacity for developing and managing partnerships with donors and NGOs.
4: Restore the functional capacity and improve the efficiency of essential existing government facilities/services			Service delivery and utilization are less than satisfactory. Project-supported reforms are not sufficient to create the required capacity for service delivery. Many aspects of human resources development were beyond the mandate of the project. Persistent shortages of critical inputs: human resources, medical equipment, physical structures and some aspects of management skills/systems. Inequality persists with regard to access and use of health services (World Bank, 2004)
expanded coverage of EHP in pilot districts		Integration of all health programs (except TB and AIDS) under the district medical officer (including immunization, control of diarrhea disease, malaria, others) Increase EHP coverage from 20 to 60 percent of (pilot and demonstration) district populations	There is little information on how the district health services coordinate and plan multi-sectorally w/in the overall district services (water and sanitation, agriculture, communication and transport, education).
• % population living w/in 5 km of a health facility	49 in late 1990s (World Bank, 2004)		57 in 2000 (World Bank, 2004) (but with persistent disparities in geographical access: urban-rural, regional, district and income)
• % currently married women with unmet need for family planning	29.0 (1995 DHS)		34.6 (2000/01 DHS)
• Contraceptive prevalence rate (modern methods)	7.8 (1995 DHS)		18.2 (2000/01 DHS)
• % live births receiving assistance	2.8 (1988 DHS)		3.8 (2000/01 DHS)

Goal/Objective/subobjective	**Baseline data**	**Targets** ***(Indicators chosen after MTR [and not at outset] to monitor and evaluate project/source: Konde-Lulet et al. 2002)***	**Actual Achievements**
at delivery from a trained health professional			38 percent births attended by health professionals (WB 2004); deliveries taking place at health facilities modestly improved from 20% previous year to 24.4% in 2003/04 (MoH, October 204): 25.2% in 1999/00 Deliveries spvsd by skilled h wkrs 38% 2000 (same as 38% in 1995) (MoH
• % live births receiving antenatal care from a trained health professional	11.1 (1988 DHS)		9.4 (2000/01 DHS) 93 percent utilization of ANC services (WB 2004)
Utilization of outpatient services (visits per person year)	0.64 in 1995 (Konde-Lule)	0.80	0.68 (all districts, 1999) (Konde-Lule); 0.79 in 2003/04 . Utilization went up noticeably after user fees were abolished in March 2001.
Percentage of infants who have completed DPT dosage (DPT III)	72% in 1990 (1990 DHS) 51% in 1995 (1995 DHS)	80%	46% in 2000 (2000/01 DHS); 85% coverage of DPT3/HepBHib reported in 2003/04 (MoH, October 2004)
• % children fully immunized			36.7 (2000/01 DHS)
• % children with diarrhea who received ORS or RHS	15.0 (1988 DHS)		43.2 (2000/01 DHS)
Improved quality			Evlauation of public sector health personnel clinical practices found that despite training in IMCI, trained personnel did not perform any better than untrained personnel on some critical guidelines. Attributed to problems in supervision. Lack of effective supervision an indication that mechanisms for technical accountability for service provision need to be strengthened. DHS 2000/01: • 34% pregnant women took antimalarial prophylactic treatment • 69% received tetanus immunization, despite 93% attendance for ANC Another study: 26% pregnant women informed about danger signs of complications and 2/3 had blood pressure measured despite multiple visits to providers. Quality better in PNFP and private: cleanliness, waiting times, hours, behavior of health personnel, patient satisfaction
			53 percent of primary health care posts filled by trained staff when applying the 1999 staffing norms (Annual Health

Goal/Objective/subobjective	**Baseline data**	**Targets** ***(Indicators chosen after MTR [and not at outset] to monitor and evaluate project/source: Konde-Lulet et al. 2002)***	**Actual Achievements**
			Sector Performance Report/World Bank, 2004)
• render selected hospitals autonomous		Render Mulago Hospital autonomus and limited to tertiary care	ISR: Autonomy for Mulago and other referral hospitals has been granted. Beginning 01/02 the regional hospitals became self accounting.
• Availability of essential materials and drugs			Average stock-out rate for all essential drugs: 30 percent in government facilities; 16 percent in PNFP facilities
			Current network of public health facilities is inadequate to provide health care to the population, warranting improved partnerships with profit and not-for profit private health sector.
•			
5. Facilitate a greater role for the non-governmental sector			
Increase contracting/Annual (district) expenditure on contracted services as a percentage of total district budget	5.7% in 1995 (4 of 13 pilot/demonstration districts were practicing some form of contracting) (Konde-Lule)	30%	12% in 1998/99. 12 of 16 pilot/demonstration districts were contracting out some of their services. (Konde-Lule). The Medium-Term Expenditure Framework projects that this would continue to grow to 14 percent in the next three years (World Bank, 2004).
• NGOs		Major role for NGO/private sector in provision of primary and secondary services in Kampala; involving NGO hospitals in spn of Government health units; supporting NGOs to provide some services; contracting NGOs to take over govt services; designating some NGO hospitals as district hospitals	NGOs are more involved in health sector planning and implementation. They have benefited from project support to districts, including: facility renovation, equipment, supplies, drugs, training and supervision.
• Private sector			Need for coordinated partnership with private providers.
• Communities			

Annex G. Other Relevant Data and Trends

Figure G. 1. Infant Mortality by Region, 1995-2000 (per 1000 births)



Source: UDHS (1995, 2000/01).

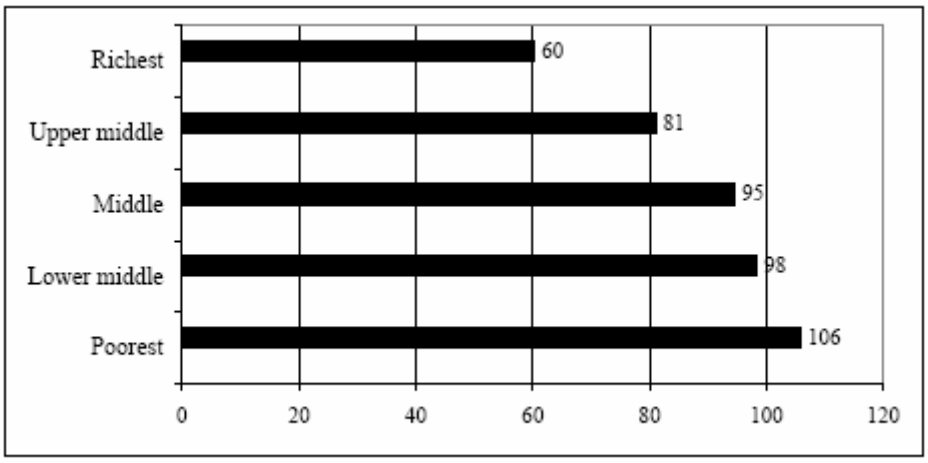
Table G.1. Mean number of children and fertility by quintile, Uganda

Income/Wealth Quintile	Children below 15	Children below 5	Total Fertility Rate
Poorest 20%	3.49	1.06	8.5
2nd Quintile	3.30	1.07	8.2
3rd Quintile	2.81	0.98	7.5
4th Quintile	2.33	0.80	6.3
Richest 20%	1.72	0.56	4.1

Note: Consumption quintile for distribution of children; wealth quintile for total fertility rate.

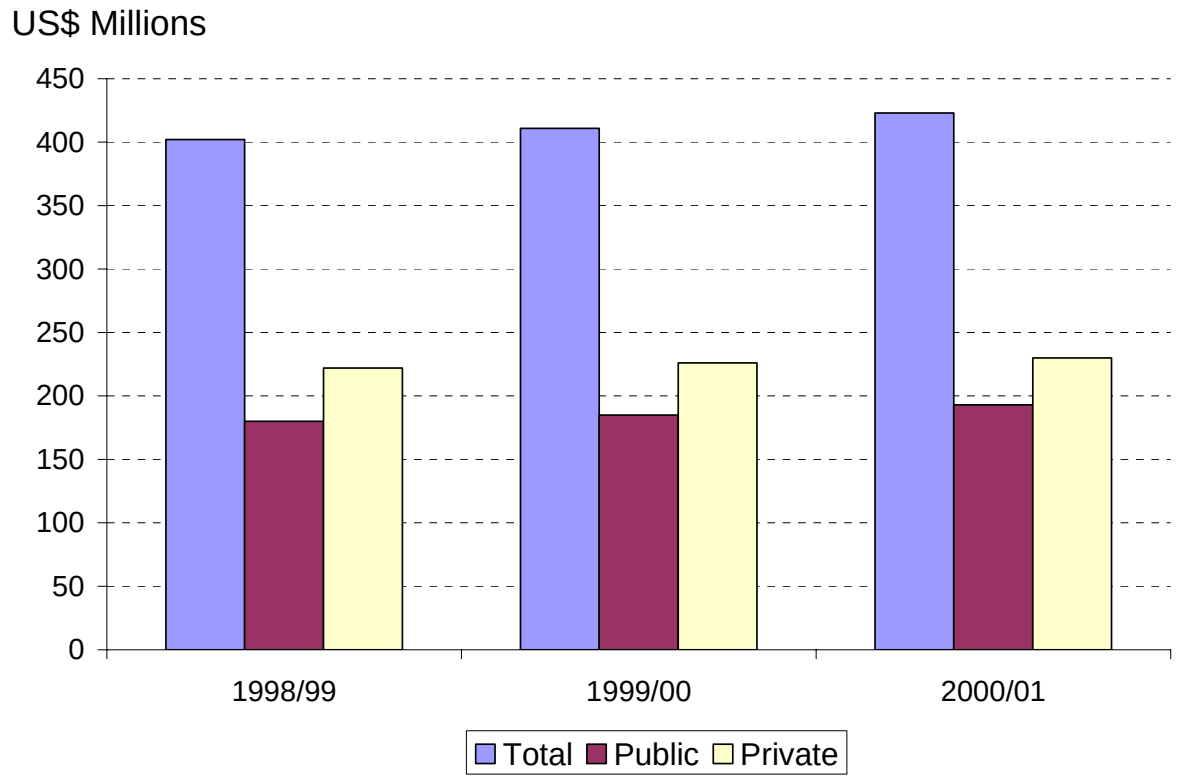
Sources: MFPED calculations based on UNHS (1999/2000). UDHS (2000/01)

Figure G. 2. Infant Mortality by Wealth Index Quintile (per 1000 births)



Source: UDHS 2000/2001.

Figure G. 3. Total Health Expenditure, 1998/99 – 2000/01



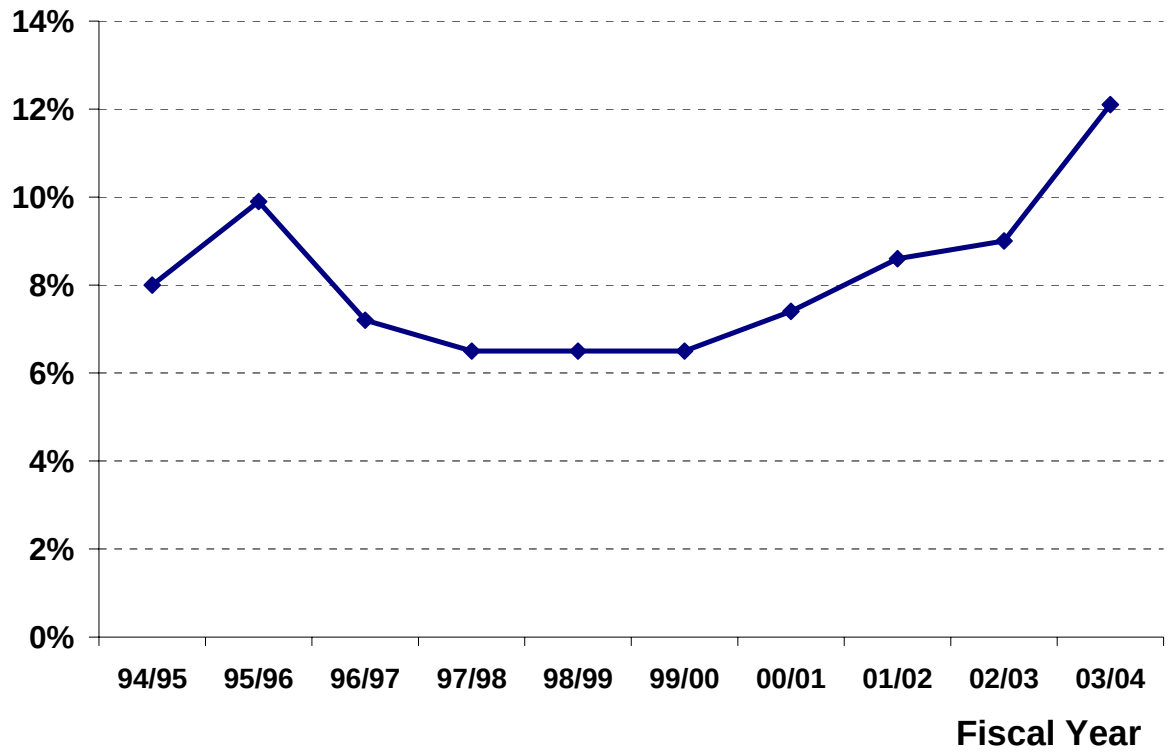
Source: National Health Accounts Study

Table G.2. Per Capita Expenditure by Financing Source

	1990/91		1992/93		1998/99		1999/00		2000/01	
Entity	US$ per capita	%	US$ per capita	%	US$ per capita	%	US$ per capita	%	US$ per capita	%
Central Government					3.15	16.9	3.04	16.5	3.28	17.9
Local Government					0.04	0.2	0.03	0.2	0.03	0.2
Parastatal					0.02	0.1	0.02	0.1	0.03	0.1
Donors					5.16	27.6	5.22	28.3	5.01	27.4
Subtotal public	3.00		2.83		8.37	44.8	8.31	45.1	8.35	45.6
Private firms					0.10	0.5	0.07	0.4	0.06	0.3
Households					8.67	46.4	8.27	44.9	7.41	40.5
Not for profit					1.54	8.3	1.78	9.7	2.50	13.6
Subtotal private	3.18		4.91		10.31	55.2	10.12	54.9	9.96	54.4
Total	6.18		7.73		18.68	100.0	18.43	100.0	18.31	100.0

Source: National Health Accounts Study

Figure G. 4. Public Spending on Health as a proportion of Total Government Expenditure



Source: World Bank 2004 and MOFPED 2003

Table G.3. Contribution from the public financing sources

	1998/99		1999/00		2000/01	
	bn.UgShs	%	Bn.UgShs	%	Bn. UgShs	%
Donors	151.42	61.66	176.13	62.84	203.83	59.99
Central Govt	92.42	37.64	102.46	36.55	133.65	39.34
Local Govt	1.17	0.48	1.09	0.39	1.24	0.37
Parastatals	0.57	0.23	0.62	0.22	1.03	0.30
Total	246		280		340	

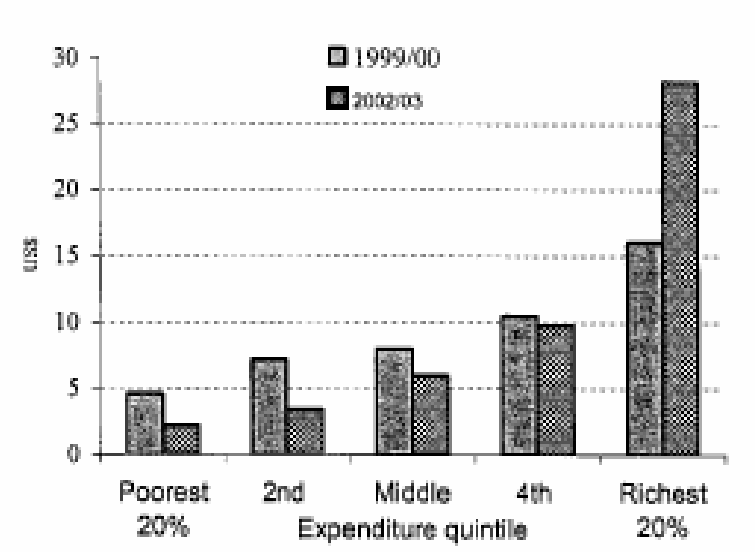
Source: National Health Accounts Study

Table G.4. Contributions from private financing sources

	1998/99		1999/00		2000/01	
	bn.UgShs	%	Bn.UgShs	%	Bn. UgShs	%
Private firms	2.82	0.93	2.43	0.71	2.33	0.58
Households	254.47	84.09	278.97	81.70	301.54	74.37
Not for Profit	45.33	14.98	60.06	17.59	101.59	25.06
Total	302.62		341.46		405.46	

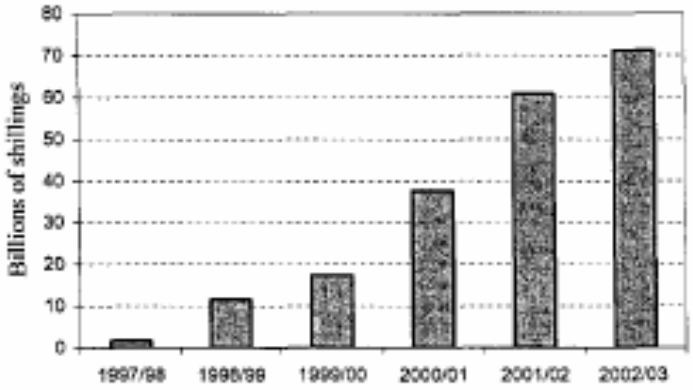
Source: National Health Accounts Study

Figure G.5. Out-of-pocket health spending per capita



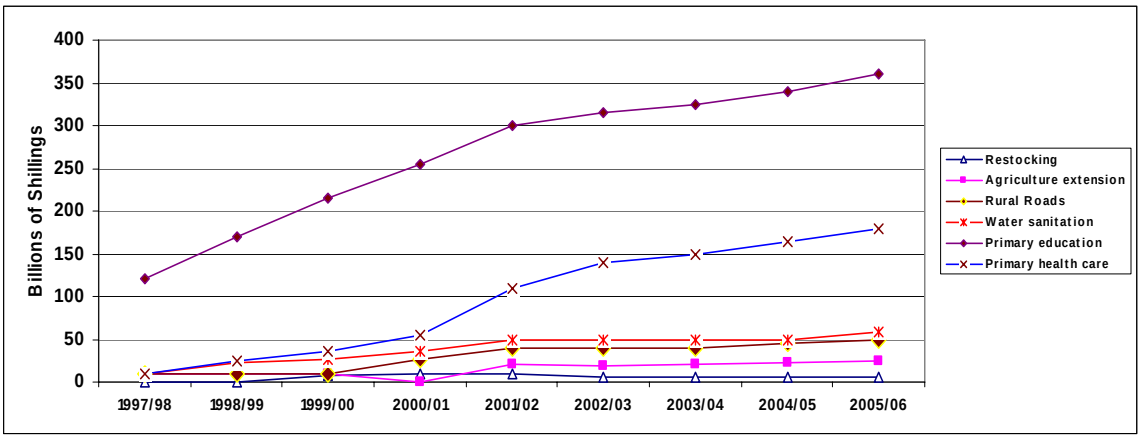
Source: Uganda Household Expenditure Survey, 1999 and 2002/2003

Figure G.6. District Primary Health Care Conditional Grant Funding



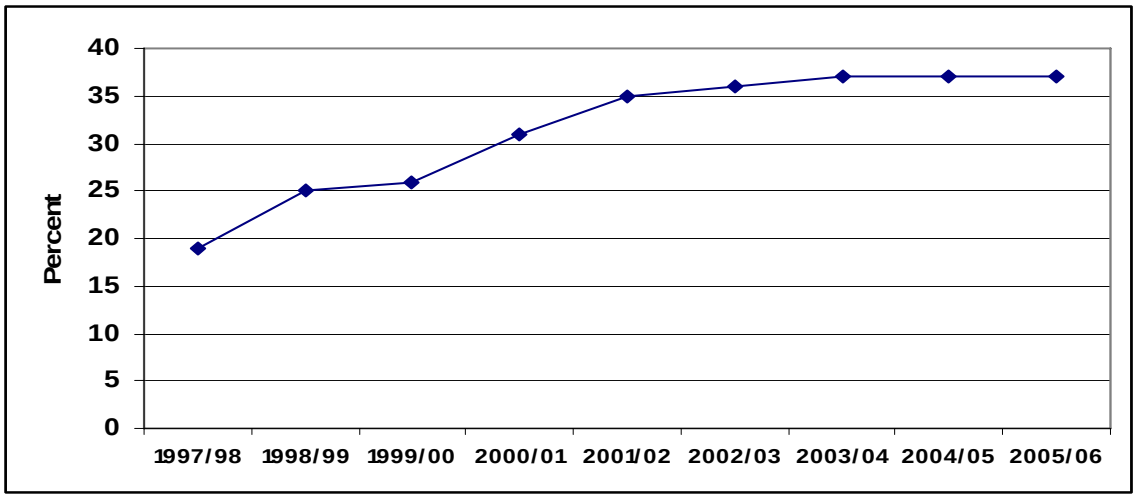
Source: MOH Database

Figure G.7. Trend of PAF Expenditure



Source: PRSP and resource allocation file

Figure G.8. PAF Expenditure as % of GoU Budget



Source: PRSP and resource allocation file

Table G.5. Central Government Development Transfers to Local Governments for FY 2003/04 (UShs. 000)

Region/ Grant	Northern		Southern		Eastern		Central		Total	
	Amount	%ge	Amount	%ge	Amount	%ge	Amount	%ge	Amount	%ge
Rural Water	6,308,598	15.9	7,952,305	17.3	8,575,418	18.9	7,038,674	16.9	29,874,995	17.2
LGDP	14,728,198	37.2	15,600,698	33.8	14,862,559	32.7	19,858,763	47.0	65,050,218	37.5
PHC	1,379,885	3.5	2,788,613	6.0	2,292,936	5.0	2,742,365	6.5	9,203,799	5.3
SFG	15,511,989	39.1	16,974,313	36.8	16,615,156	36.6	10,676,896	25.3	59,778,354	34.5
NAADS	1,694,096	4.3	2,777,944	6.0	3,088,915	6.8	1,915,203	4.5	9,476,158	5.5
TOTAL	39,622,766	22.9	46,093,873	26.6	45,434,984	26.2	42,231,901	24.4	173,383,524	100.0

Source: Budget Speech 2003/04 & Draft Estimates of Revenue and Expenditures 2003/04

Table G.6. Allocation of GoU Budget 1999/2000 – 2003/2004

	1999/2000		2000/2001		2001/2002		2002/2003		2003/2004 (3)	
	/= bn	%	/= bn	%	/= bn	%	/= bn	%	/= bn	%
District services	25.3	32	50.6	44	81.3	48	96.4	49	115.4	54
Of which District PHC PNFPs	*15.5*	*19*	*37.6*	*33*	*60.9*	*36*	*71.1*	*36*	*84.7*	*40*
Dist Hosps (1)	*3.3*	*4*	*6.7*	*6*	*11.6*	*7*	*16.6*	*8*	*19.7*	*9*
	6.5	*8*	*6.3*	*6*	*8.9*	*5*	*8.7*	*4*	*11.0*	*5*
Regional hospitals	11.2	14	11.8	10	18.6	11	16.2	8	17.1	8
Central Hospitals	17.9	22	15.2	13	23.2	14	23.9	12	25.4	12
MoH HQ (2)	24.0	30	34.8	30	43.6	26	55.8	28	51.3	24
Of which										
MoH HQ							13.54			
Program 9	nil		13.23	11.5	20.83	12.2	21.10	10.7	19.10	8.9
Counterpart funds							9.78			
Dist. Infra. Support							8.15			
Other Agencies	1.4	2	1.8	2	3.3	2	3.7	2	3.9	2
Total	79.9	100	114.2	100	170.1	100	196.0	100	213.0	100

Key to Table 2.5:
(1) Wages included under District PHC Funds
(2) Includes National Service Delivery Programmes from 2000/2001
(3) Projections

Table G.7. Health Sector Allocations in Percentages

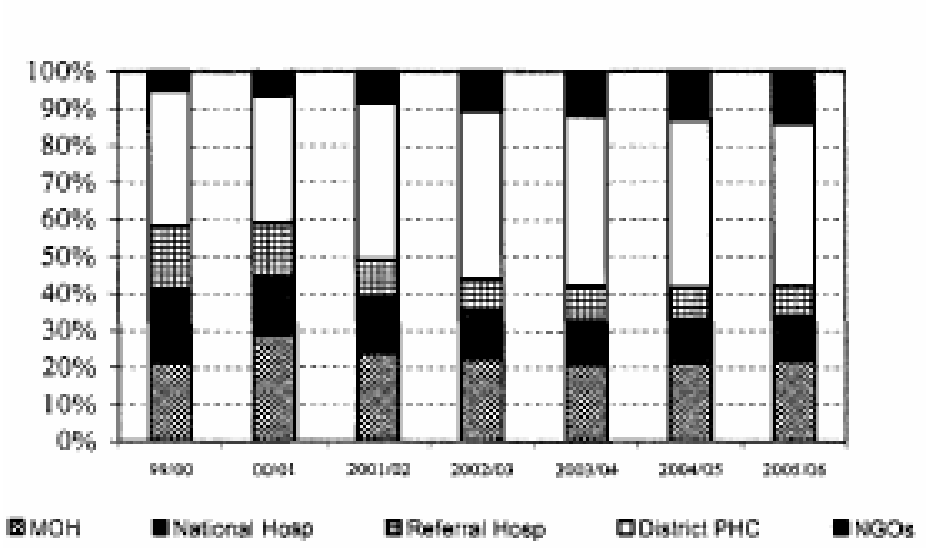
Budget Area	1999/00	2000/01	2001/02	2002/03	2003/04
District Services (PHC)	32	44	48	49	54
MOH HQs	30	30	26	28	24
National Hospitals	22	13	14	12	12
Regional Hospitals	14	10	11	8	8
Other agencies	2	2	2	2	2
Total	100	100	100	100	100

Source: Health Policy Statement 2003

Table G.8. Health Expenditure by Cost Category

	1998/99	1999/00	2000/01
Wages and allowances	14%	15%	15%
Drugs and medical supplies	59%	58%	54%
Other recurrent expenditure	13%	14%	18%
Capital expenditure	14%	13%	13%
Total	100%	100%	100%

Figure G.9. Share of Recurrent spending by level



Source: the MTEF from MOFPED

Figure G.10. District Health Services Expenditure to Providers

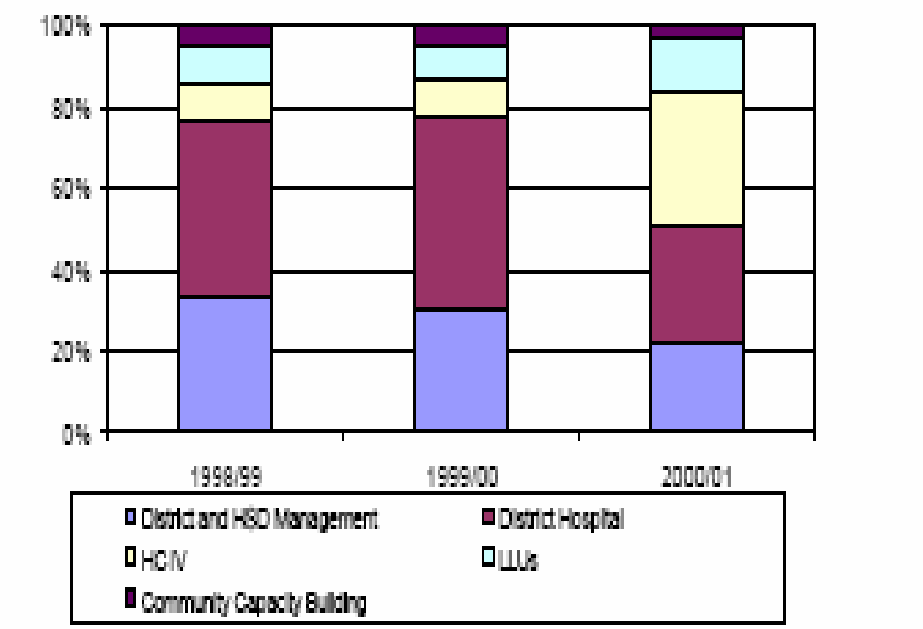


Table G.9. Proportion of district health expenditures on the EHP

District	1995/96	1998/99
Apac	6%	47%
Gulu	NA	65%
Iganga	19%	48%
Bugiri	NA	19%
Kabale	26%	68%
Kamuli	29%	67%
Kiboga	19%	70%
Lira	38%	69%
Masindi	31%	66%
Mubende	10%	56%
Mukono	53%	57%
Rukungiri	7%	57%
Soroti	18%	81%
Katakwi	NA	80%
Tororo	2%	67%
Busia	NA	70%
Average	33%	62%

N/A: Not applicable

Table G.10. Analysis of Actual Number of Clinical Staff and Minimum Staffing Norms – All Districts, GoU only.

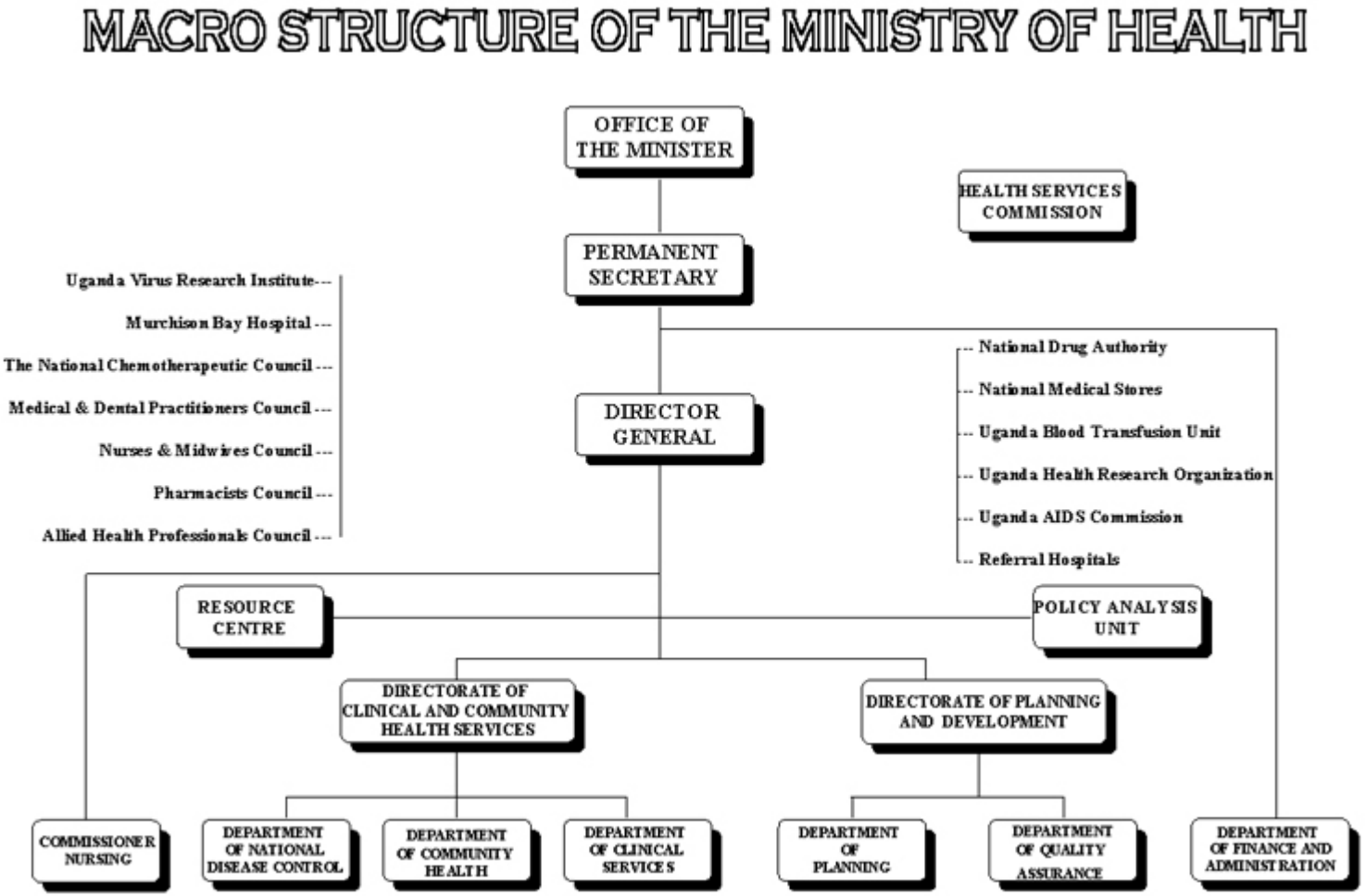
Categories/ Services	Level HC II		No. 870	Level H III		No. 714	Level HC IV		No. 152	Level Hosp. (GHP)		No. 38	TOTAL		
Clinical Staff	Act	Norm	Gap	Act	Norm	Gap	Act	Norm	Gap	Act	Norm	Gap	Act	Norm	Gap
Clinical	110		110	552	714	-162	356	456	-100	301	304	-3	1319	1474	-155
Medical	5		5	22		22	142	152	-10	139	152	-13	308	304	4
Midwifery	236		236	659		659	313	152	161	427	646	-219	1635	798	837
Nursing	472	870	-398	677	2142	-1465	451	608	-157	942	1634	-692	2542	5254	-2712
Nursing Assistant	1406	1740	-334	1444	714	730	520	152	368	795		795	4165	2606	1559
Total	2229	2610	-381	3354	3570	-216	1782	1520	262	2604	2736	-132	9969	10436	-467
			85%			94%			117%			95%			96%

Source" Annual Health Sector Performance Report 2003-04

Table G.11. Distribution of Clinical Staff in HC IIs (GoU)

Number of Clinical Staff per HCII	Number of HC IIs	HC IIs with Nursing Assistants only
0	65	
1	173	113 (1 Nusing Assistant)
2	231	94 (2 Nursing Assistants)
3	207	39 (3 Nursing Assistants)
4	109	4 (4 Nursing Assistants)
5	41	1
6 and above	44	4
Total	870	255

Figure G.11


MACRO STRUCTURE OF THE MINISTRY OF HEALTH
OFFICE OF THE MINISTER
HEALTH SERVICES COMMISSION
PERMANENT SECRETARY
Uganda Virus Research Institute
Murchison Bay Hospital
The National Chemotherapeutic Council
Medical & Dental Practitioners Council
Nurses & Midwives Council
Pharmacists Council
Allied Health Professionals Council
DIRECTOR GENERAL
National Drug Authority
National Medical Stores
Uganda Blood Transfusion Unit
Uganda Health Research Organization
Uganda AIDS Commission
Referral Hospitals
RESOURCE CENTRE
POLICY ANALYSIS UNIT
DIRECTORATE OF CLINICAL AND COMMUNITY HEALTH SERVICES
DIRECTORATE OF PLANNING AND DEVELOPMENT
COMMISSIONER NURSING
DEPARTMENT OF NATIONAL DISEASE CONTROL
DEPARTMENT OF COMMUNITY HEALTH
DEPARTMENT OF CLINICAL SERVICES
DEPARTMENT OF PLANNING
DEPARTMENT OF QUALITY ASSURANCE
DEPARTMENT OF FINANCE AND ADMINISTRATION