

**HIGH-LEVEL FORUM ON THE HEALTH MILLENIUM
DEVELOPMENT GOALS**

**HARMONIZATION AND MDGS:
A PERSPECTIVE FROM TANZANIA AND UGANDA**

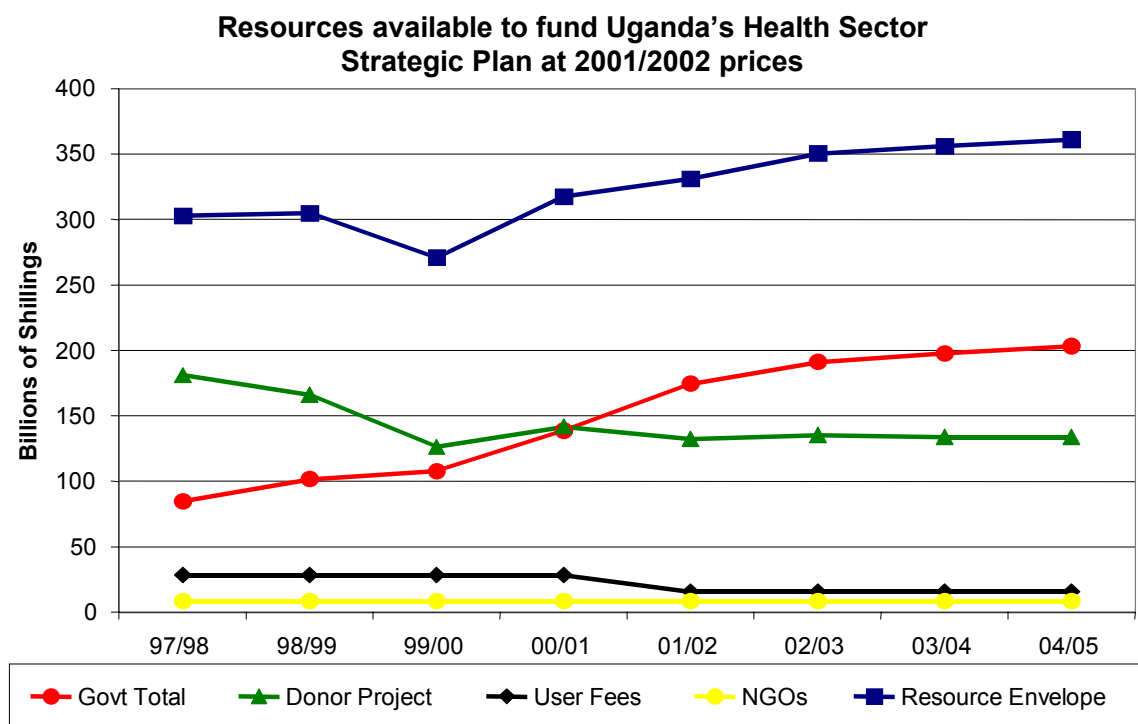


1. What has been the effect of increased harmonization?

In both Uganda and Tanzania, increased harmonization through the Sector-Wide Approach (SWAp) and increased budget support has increased the resources available to the health sector over the past five years. This has led to increased health sector outputs in both countries, but not yet to measurable outcomes in all health millennium development goals (MDGs).¹

Uganda

While the total resources available for the health sector have increased by only 15% in real terms over the past five years, the government budget for health, including budget support, has more than doubled in shilling terms. The allocation to the health sector has increased from 7.3% of the total government spending in financial year (FY) 1999/2000 (equivalent to US\$2.7 per capita) to 9.6% in FY 2002/2003. General and earmarked budget support for health currently amounts to US\$4.1 per capita. During a similar period, project aid shrank from about 60% to 36% of total resources for health. The Government abolished user fees in its health units in March 2001. Health units run by non-governmental organizations (NGOs), however, continue to charge fees and this accounts for 7% of the resource envelope. The shift from project aid to budget support and the concurrent abolition of user fees is illustrated in the graph below.



Source: Ministry of Health, Health Sector Performance Report, October 2003.

The increase in the health budget for the period under review has been modest: in absolute terms, only US\$1.4 per capita. The Ugandan Government's budget comes from two sources: domestic tax revenues and external aid (both general and earmarked). Because tax collection performance is poor, growth in domestic tax revenues has not kept pace with economic growth. It is increases in donor

¹ A notable exception is the HIV/AIDS MDG target, which Uganda has achieved: HIV prevalence is now at 6.2%, down from 18% in 1992.

support, therefore, that have largely funded the increase in the health budget, with a recent trend for some major donors to move away from projects to budget support.

Increased budget resources have been allocated more efficiently. For example, funding for primary health care (PHC) and districts has increased from 32% to 54% of the overall budget, while the central hospital budget decreased from 22% to 12%. They have also been used more efficiently, especially in supplying an improved mix of inputs such as staff, drugs and logistics).² And they will be allocated more equitably from 2003/2004 through a resource allocation formula that takes poverty into account. In addition, the decision to abolish user fees (which resulted in a sustained increase in outpatient attendance of 72%) has increased access to health services for the poor.

Uganda has sought additional resources for health through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which has pledged US\$97 million over the full lifetime of the project. This would be equivalent to an additional US\$1.3 per capita a year, if all resources are spent. However, only the HIV/AIDS grant agreement has been signed so far.³

The benefits of recent economic growth have been concentrated in certain groups, resulting in rising inequality. The richest 10% of the population have experienced a 20% increase in real consumption since 1997, and the poorest only 8%.⁴ The Economic Commission on Africa⁵ comments: "There remain vast regional disparities in the incidence of poverty [in Uganda], with a clear spatial pattern. The more affluent central crescent around Lake Victoria has made great strides in economic development, while the drier, more disadvantaged northern part of the country has fallen even further behind. Inequalities in socioeconomic development tend to be linked to inequalities in health." However, the MOH is trying to redress some of those inequalities by improving its resource allocation formula. From next year a poorer district will receive 51% more than Kampala per capita for its PHC budget.

Sector performance provides a mixed picture. From 1995 to 2000, infant and maternal mortality figures stagnated, whereas HIV prevalence rates improved. These statistics vary significantly from those required to achieve the country's own Poverty Eradication Action Plan (PEAP)⁶ and MDG targets.

Table 1: Some stagnating health indicators in the 1990s in Uganda

INDICATOR	1995	2000	PEAP TARGET (2005)	MDG TARGET (2015)
Infant mortality rate (deaths < 1 year per 1 000 live births)	81	88	68	41
Maternal mortality rate (deaths per 100 000 live births)	527	505	345	131

² Disentangling the effects of extra funds from those of efficiency gains is very difficult, but the MOH is convinced that increased output is a result of both.

³ Global Fund pledges for Uganda include: US\$36.3 million for HIV/AIDS (US\$51.9 million over the full lifetime of the budget; grant agreement signed) US\$23.2 million over two years for malaria (US\$ 35.8 million total budget; grant agreement not yet signed); US\$6.8 million over two years for TB (US\$ 9.1 million total budget; grant agreement not yet signed).

⁴ *International Monetary Fund/International Development Association Poverty Reduction Strategy Paper Annual Progress Report*, Joint Staff Assessment prepared by staff of the IMF and IDA, 9 March 2001.

⁵ *Economic Report on Africa 2003 – Accelerating the Pace of Development*, UN Economic Commission for Africa.

⁶ In effect Uganda's Poverty Reduction Strategy Paper (PRSP).

However, since 2000, health sector outputs have improved significantly, reflecting better access to and use of the Minimum Health Care Package by the Ugandan population. A number of PEAP indicators, including the HIV/AIDS MDG and proxy indicators for child mortality MDGs, selected to assess performance of the health sector, have shown marked improvement (see Table 2 below). However, the performance of the indicator for maternal health services remains disappointing.

Table 2: Some improving PEAP indicators

No.	PEAP performance indicator	Baseline value (99/00)	2000/01	2001/02	2002/03
1	Out Patient Department utilization (Total Government of Uganda and PNFP)	0.4	0.43	0.60	0.72
2	DPT 3 vaccine coverage (< 1 year)	41%	48%	63%	84%
3	Proportion of approved posts filled with trained health staff	33%	40%	42%	53%
4	Deliveries in health units	25.2%	22.6%	19%	20.3%
5	Urban/rural HIV seroprevalence (national average)	6.8%	6.1%	6.2%	6.2%

Tanzania

Tanzania presents a somewhat similar picture. The health sector's share of the national budget increased from 7.5% in FY 2000/2001 to 8.7% in FY 2002/2003. This is equivalent to a rise from US\$3.4 per capita in FY 1998/1999 (US\$2.4 from domestic resources plus US\$1.0 in donor aid), to US\$5.9 spent per capita in FY 2000/2001, to US\$6.6 per capita budgeted for FY 2002/2003 (US\$3.6 from domestic resources plus US\$3.0 in donor aid per capita). Within the SWAp, support for the health sector budget is channelled partly through the President's Office Regional and Local Government for district support, and partly through the MOH central basket. The UK Department for International Development (DFID), a long-term partner to the SWAp basket, has now moved to general budget support. Although general and earmarked budget support has increased over the past years, off-budget funds (project aid) have remained important. They still contribute 40% of external resources but, this is falling.

Overall allocations to the health sector have been increasing in real terms and have become more efficient, with the largest rise being for PHC and preventive services. This signifies a movement in recurrent expenditure away from secondary and tertiary hospitals towards district health services (from 50% to 60% over the period under review); away from regional administration to local government; and reducing the share of salary costs from 65% to 50%, while increasing the share of "Other Charges",⁷ which is considered a priority in the Poverty Reduction Strategy Paper (PRSP). Both domestic and donor resources have increased,⁸ but the main source of extra funds was the Tanzanian Government's grants to district councils. Foreign aid was 53% and 56% of the total health sector budget respectively in FY 1999/2000 and FY 2001/2002. The recently adopted resource allocation formula, which includes poverty and under-five mortality criteria, will allow resources to be allocated more equitably from FY 2003/2004.

⁷ "Other charges" refers to non-salary items in the recurrent budget, including drugs, supplies and other operational expenditures.

⁸ Some stakeholders consider the rise in domestic resources for health too modest. Allocations to local government authorities of the Tanzanian Government's subventions to health have stagnated in FY 2002/2003 despite "Other Charges" subventions being identified as a priority item in the PRSP.

Additional resources are sought through different channels. The Global Fund has pledged US\$5.2 million over the full budget lifetime, equivalent to US\$0.27 per capita a year in mainland Tanzania during the first two years.⁹

In terms of health sector performance, outpatient attendance has been maintained at 0.9 visits per capita a year. Coverage of the diphtheria-pertussis-tetanus vaccine DPT3 has increased to 83% and the proportion of fully immunized children below the age of two has increased from 74% to 79%. The proportion of births attended by trained personnel increased from 50% to 80%. The Integrated Management of Childhood Illness and Roll Back Malaria strategies have been introduced and coverage progressively extended.¹⁰ Health-financing strategies such as the Social Insurance and Community Health Funds have been rolled out further and policies on user charges have been maintained. According to the MOH, the introduction of financing strategies has improved the accessibility of quality services, because drugs are now available at all times. There is no recent evidence on whether progress towards the health MDGs is “on track”.

2. Has increased harmonization led to any tangible improvements?

Different ways of governments and their development partners doing business together have resulted in many positive changes, but this depends very much on local leadership. This perception is very much the same in Tanzania and Uganda, among government and other stakeholders.

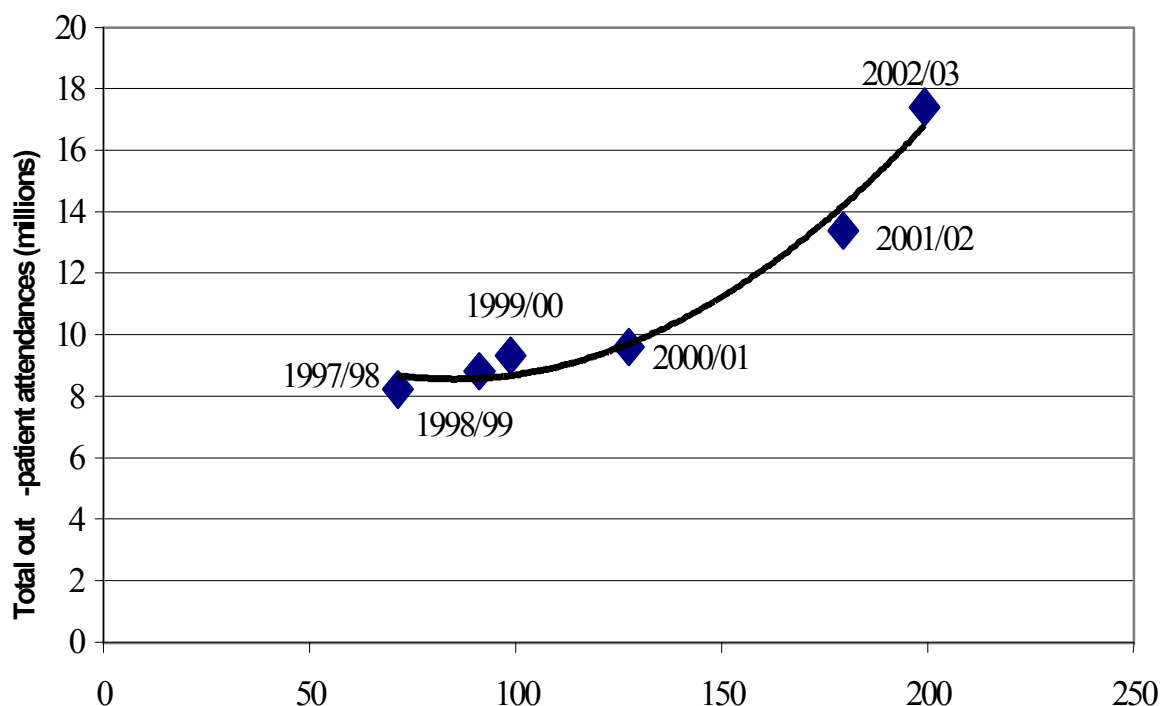
Tangible improvements in output have been documented (see section 1). Improvements in outcome (as measured by the MDG targets) need more time to materialize and may need focused cross-sectoral interventions (to address, for example, maternal mortality, child mortality, malaria prevalence) as well as broader socioeconomic development (to address child mortality, for example). SWAp and other harmonization efforts have improved efficiency and equity in resource allocation, as illustrated in section 1. The increase in outpatient attendance in Uganda that resulted from abolishing fees would not have been sustained if the supply side had not injected more resources (increased drug supplies; ring fencing of district drug budgets; employment of 2 700 additional health workers, etc.). This was made possible by increased budget support (both general and earmarked). New approaches to resource allocation between districts, based on poverty criteria, are another concrete example of governments and partners working together in Tanzania and Uganda. Sector plans have improved. The resources available and the way they are allocated to sector priorities are better known. Ministries of health have become more vocal and knowledgeable in defending their sector budget to ministries of finance, through prioritized sector plans, Medium-Term Expenditure Frameworks, Public Expenditure Reports and PRSPs. This new way of doing business together is much appreciated by both governments and development partners.

While most people agree that significant improvements have been made, major stakeholders say that policy dialogue should be more cross-sectoral and more oriented towards results.

⁹ Global Fund in Tanzania Mainland: HIV/AIDS: US\$5.4 million over two years (the same over the full lifetime of the budget; grant agreement signed). Malaria: US\$11.96 million over two years (US\$19.8 million total budget; grant agreement signed). Tanzania Zanzibar: Malaria: US\$781 000 over two years (US\$1.2 million total budget; grant agreement signed). HIV/AIDS: US\$1.2 million over two years (US\$2.3 million total budget; grant agreement signed).

¹⁰ Source: PRSP Review 2002, March 2003.

**Government funding and outputs:
improving performance in the Ugandan health sector**



Source: MOH, Three Years of Implementation of the Uganda Health Sector Strategic Plan, Flyer 2003.

3. What is the preferred mode for donor aid?

Governments (ministries of health, ministries of finance) in both Uganda and Tanzania strongly prefer budget support to project aid because it makes critical resources more available for the nationally defined priorities in poverty reduction. Moreover, budget support is more flexible, more equitable and can be decentralized to the level where the needs are greatest and the action must be taken. UN organizations and most development partners (e.g. DFID, the Danish International Development Agency (Danida), World Bank) agree that budget support has added value. However, some bilateral donors, while they support overall national policy directions, maintain project support for other reasons. For example, in FY 2003 USAID provided just under US\$42 million to Uganda for health-related activities, financed entirely as project support. All projects are said to follow the principles and priorities of the PEAP and Health Sector Strategic Plan (HSSP). USAID has stringent internal reporting requirements which make it difficult for the agency to provide basket funding, but staff also expressed the view that budget support is “inefficient” and lacks transparency.

The methods of budget support differ between Uganda (mainly general budget support) and Tanzania (mainly sector-specific budget support, but now also partly general budget support). However, health sector budgets have increased significantly in both countries. Most stakeholders who favour budget support propose that about 80-90% of donor aid should be channelled in this way. The remainder should be “projectized” with the specific aim of sustaining and guiding the implementation of national health sector plans: developing sector strategies, ensuring that resources are used in the most cost-effective way, testing innovative strategies, covering specific expertise, supporting change. UN organizations (UNICEF, WHO, and the United Nations Development Programme) see it as their specific mandate to provide this projectized support, given their technical know-how and expertise. Some bilateral agencies that contribute to SWAs and budget support (e.g. Danida, DFID) also want

to continue financing specific technical or strategic support through earmarked funding. The partnership fund in Uganda has been used for this. Danida in Tanzania, in addition to supporting the health sector budget, provides earmarked support to, for example, the Health Sector Reform Secretariat. Projectized support to selected central-level activities or units may also help build the capacity to support district services.

Uganda has a Poverty Action Fund (PAF) tool, in place across all priority sectors, which defines the priority budget lines that fall under the PAF in each sector. For health, these are district PHC, district hospitals, NGO hospitals and selected central budget items coordinated by National Service Delivery, such as drugs. This tool helps to prioritize poverty alleviation and MDG goals within the budget and ensures that aid is channelled to those priorities. In Tanzania, the MOH remains somewhat reluctant to move from sector budget to general budget support, because it fears that its budget may be reduced if the Ministry of Finance (MOF) does not give it sufficient priority. The MOH in Uganda, which favours general budget support, is concerned that negotiations with the Ministry of Finance, Planning and Economic Development (MFPED) are failing to deliver the appropriate budget shares intended by the donors.

While most observers agree that increased budget support has improved some outputs, national policy dialogue and the implementation of reforms should be more oriented towards results. In Tanzania, the SWAp has focused mainly on systems building, policy development and process. As the MOH in Tanzania put it: "We have to move from a reform phase to a service implementation phase." In Uganda, the SWAp is the coordinating mechanism for delivering the minimum health care package and is seen as part of wider health systems reforms. In general, both countries state that health system development is needed but insufficient. A targeted, prioritized and multisectoral approach is required to achieve specific results.

Other forms of aid relate to global initiatives. Both Tanzania and Uganda (ministries of health, ministries of finance and main stakeholders) strongly prefer Global Fund money to be allocated through budget support and to use existing systems, rather than to set up parallel management, accounting and procurement systems.¹¹ Both countries have effective systems in place. They are trusted and used by major development partners, so it is hoped that over time GFATM money will be channelled through them. In the case of Uganda, where sector policy is coherent, the MOH argues that budget support facilitates policy coherence. However, the Global Fund remains off budget and several donors continue project support. This suggests that not all development partners and global initiatives accept budget support as the main and most effective financing mode. Project aid also remains a major mode of financing the health sector in Tanzania.

Both Uganda and Tanzania agree that managing all the different flows of funds and a large number of uncoordinated projects remains problematic, but recent trends have been positive. Basket mechanisms and budget support have increased, and projects are better aligned in support of national sector plans.¹²

4. Is reliable information on health outcomes available to measure performance?

Both Uganda and Tanzania use specific indicators to measure sector performance. Tanzanian Health Sector Performance Indicators explicitly include all health MDGs, which are also part of the PRSP. District performance is assessed annually by an independent body.¹³ However, the reliability of

¹¹ The Ugandan MOH currently negotiates the use of government procurement procedures for the Global Fund.

¹² The Ugandan MOH has recently "shelved" a US\$15 million project proposal, where transaction costs were considered to be out of balance (mainly high technical assistance costs).

¹³ National Institute for Medical Research, Dar es Salaam.

systemic data provided through health management information systems (HMIS) is a major problem. While HMIS can provide facility-based proxy indicators, population-based indicators such as child mortality rate, maternal mortality rate and nutrition can be addressed only through demographic health surveys or a representative sample of sentinel survey sites.

In Uganda, with the exception of malaria and other diseases (TB), all health MDGs are reflected in the PEAP, at least as proxy indicators.¹⁴ Quantitative targets are set nationally and, according to the MFPED, there is a need to scale down quantitative targets to more “achievable” levels. The Annual Health Sector Performance report presents information on all health MDGs. District performance is monitored annually through District League Tables, which include management and service indicators, including some proxy indicators for selected MDGs (EPI, deliveries, sanitation). Quarterly supervisory visits support district performance. Uganda produces a high quality and comprehensive annual sector performance report which could serve as an example for other countries.

5. What is the best tool for setting national sector targets such as MDGs?

There is a general consensus among both government and development partners that health MDGs should not be addressed in isolation from the overall MDGs, or outside the national macroeconomic planning framework. The main reference for targeting and achieving MDGs, including health MDGs, is the PRSP in Tanzania and the PEAP in Uganda. It is generally understood that PRSPs drive the agenda more than the MDGs, but that MDGs are part of, or “mainstreamed” in, the PRSP and the sector plans.

“MDGs should be mainstreamed in PRSPs and national sector strategic plans, but local ownership is essential and country plans should be supported rather than global agendas. In other words, how can we support national plans in order to achieve the MDGs and not the other way round?”

In Tanzania, the PRSP gives the MOF the final say on allocation of resources between sectors. Development partners claim that harmonization efforts have done little to increase domestic resources for the health sector and that, although development partners participate in the discussions, their influence on resource allocation between sectors is limited. On the other hand, the MOF would not like development partners to become too influential.

In Uganda, the PEAP (using the PAF) is an effective mechanism for allocating budget resources to priorities across sectors. It suits the MFPED because it gives the ministry the final word, but it also provides the MOH with a powerful allocation mechanism. For example, of the budget increase in FY 2003/2004, 90% must be allocated to the agreed health PAF lines. The PAF tool in Uganda could be an example for other countries embarking on budget support.

According to the MFPED in Uganda, the presence of different PEAP and MDG goals has led to different interpretations of their overall purpose among various stakeholders. While goals overlap (e.g. child mortality), some quantitative targets of MDGs (such as reduction of child mortality by two-thirds in 2015) are more ambitious than those set out in the PEAP, and vice versa. The time horizon is also different for the two sets of goals. However, MDGs can play a useful role. They have already been embraced by certain sectors such as health, can enrich the list of poverty monitoring indicators and allow international comparisons. The challenge for the next PEAP and HSSP revision is therefore to combine them and make them compatible with all MDGs.

¹⁴ Maternal and child mortality MDGs are not reflected as such in the Ugandan PEAP but proxy indicators are included (see Table 2).

“Most MDGs are more a political than a technical responsibility. We are just considering these high levels of mortality as something normal. Change will only occur if national political leaders start to take mortality seriously and are willing to do something about it. Uganda has shown that this is possible in the HIV/AIDS crisis.”

6. The costs of reaching the health MDGs

While it may be useful to know that achieving health MDGs in Uganda or Tanzania may cost between US\$30 and US\$40 per capita a year, any detailed costing of MDGs should take into account local constraints and opportunities and is best done at country level. Costing of health MDGs is complex, because it should also take into account the effects of other sector interventions, cross-sectoral impact of HIV/AIDS, etc. Many query the need for detailed disease-specific costing exercises, because they carry the risk of promoting attempts to reach health MDGs in isolation from overall development MDGs.

In Uganda, the MOH estimates that it will need to capture 15% of the national budget if it is to achieve the goals set in Vision 2017. The MOH recosted the HSSP and estimated that it would take US\$28 per capita to fund the plan by 2010/2011. There is no explicit link between this figure and the MDGs, because the HSSP is more geared towards the PEAP goals (where proxy indicators for the MDGs are integrated). However, the estimated US\$28 per capita is close to the first rough estimates by the Millennium Project for reaching the health MDGs in Uganda.

“Global funding for reaching MDGs is a fallacy. Get back to earth and have the next high-level forum in a developing country to see the reality.”

7. Can the health MDGs be achieved with the resources currently available?

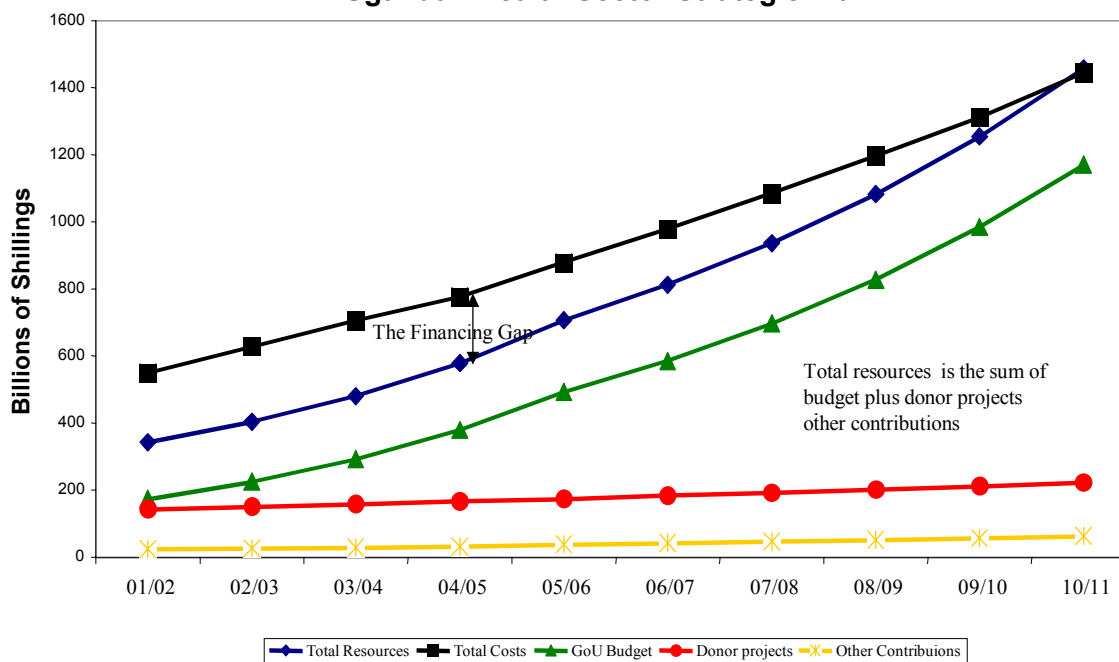
All partners agree that more funds are needed to achieve the goals of sector reform strategies and health MDGs. Uganda has calculated that it needs about US\$28 per capita a year¹⁵ to implement the priority strategies of the HSSP. The increase in resources should be progressive and comprehensive, i.e. it should cover all essential system inputs such as financial and human resources, capacity and skills, and logistics.

As a first step, Tanzania requires US\$9.0 per capita (compared to US\$6.6 per capita in FY 2003/2004) to implement the first phase of its new strategic health plan. No local cost estimates exist yet for a longer time horizon, but the finances needed in the medium term are likely to be close to those in Uganda.

Both government and development partners agree that scope remains to improve the efficiency of resource use. But most state that increased efficiency may result in only marginal benefits (increased outputs of 10-20%) and not in the significant changes required substantially to reduce maternal and child mortality. To achieve the MDGs, resources must be increased substantially, but this will not be sufficient if it results only in “doing more of what we do now”. To achieve some of the targets, “we have to do things differently and better”. This will involve building health systems, scaling up interventions that have been proved to work, and avoiding the mistakes of the past. To reduce maternal mortality rates, there is a clear need to improve access to emergency obstetric services delivered by technically competent staff. Reducing child and maternal mortality requires well-targeted multisectoral interventions.

¹⁵ This calculation did not include costing for a comprehensive anti-retroviral (ARV) programme.

Closing the financing gap for the Ugandan Health Sector Strategic Plan



8. How to scale up resources if concerns about macroeconomic stability are deemed more important than socioeconomic development?

Better health leads to better socioeconomic development but surprisingly, high rates of maternal and child mortality are now being accepted almost as “normal” at national and global levels. HIV/AIDS and maternal and child mortality are more a political than a health sector responsibility. Politicians should take them seriously and attempt to address them. More resources should be allocated to deal with them. Moreover, communities should be sensitized to hold their leaders to account. Uganda is a great example of how HIV/AIDS prevalence has tumbled down, among other reasons because of political support at the highest level and well-targeted actions. But how can resources be scaled up significantly if macroeconomic stability is thought to be incompatible with a larger health budget? According to the MOH of Uganda, this is the **single most important issue** that has to be solved if there is a serious intention to achieve significant progress towards the MDGs.

In Uganda, the MFPED has publicly stated that from FY 2003/2004, budget ceilings will be calculated taking all project aid into account. Although the MFPED has always stated that, for example, Global Fund money would be additional, additionality may be hard to prove. In other words, if the sector accepts more “earmarked” project aid, it will lose out on more flexible budget resources. While the total available to the health sector may remain stable, resources would be earmarked for specific projects which may not be in line with poverty reduction or MDG goals.

The MFPED and some World Bank and International Monetary Fund (IMF) macroeconomists stress that increasing aid can distort exchange rates, undermining export competitiveness and thus, also, economic growth. This is argued in the MFPED’s report on “Uganda’s progress in attaining the PEAP targets in the context of MDGs, May 2003”. The report states that there are three major constraints—resource constraint, absorptive capacity and crowding out of private sector activities. The presence of multiple constraints, it says, implies two trade-offs: between development and macroeconomic objectives, and between the MDG goals themselves. Full implementation of the PEAP would require an increase of 63% in government spending, while achieving the MDGs would be far more expensive. The report acknowledges that social sector interventions boost human resource capabilities through improved health and educational attainment; but it takes time to develop human capital. According to the authors, long-term development objectives may be at odds with short-term macroeconomic objectives, mainly because they crowd out the tradables sector. Second, sustained efforts to achieve

costly sector goals may have macroeconomic and budgetary consequences that make it more difficult to attain other goals, notably a reduction in the number of poor people. According to the authors, the main focus should therefore be on increasing efficiency and effectiveness of current government spending. This viewpoint often prioritizes economic growth above attaining the MDGs or even dismisses the relevance of the MDGs. For example, health officials in Uganda report different World Bank economists as saying: “developing countries like Uganda cannot achieve the MDGs”, and “MDGs are the aspirations of UN agencies which cannot be achieved.”

Not all macroeconomists (including the IMF) agree that this view should prevail. According to an IMF source, “Uganda does not have to refuse aid for health or any other poverty-eradication programmes in order to adhere to IMF-imposed guidelines.[...] Indeed, IMF staff have suggested restructuring public spending so as to accommodate higher expenditures for important social and economic sectors. The amounts of aid and increases in health spending currently under discussion in Uganda would have minimal macroeconomic impact.”¹⁶ There is also a strong argument that increasing expenditure on imported commodities does not harm the macroeconomy.

The same IMF source states: “In the specific case of Uganda, given that the aid flows in question are to be used for top priority spending such as imports of life-saving drugs and other essential medical supplies, we do not see any adverse effects on the macro economy. Moreover, even if these aid flows placed pressure on the exchange rate and the competitiveness of the economy, these effects could be minimized through monetary and exchange rate policies.”

As the MOH and many development partners state: “How many more deaths can we just accept for the sake of private sector development or the value of local currency?” and “Is there no way to handle the trade-off between macroeconomic and social objectives in a more flexible way, by allowing progressively more short- to medium-term investment in social sectors, while dealing with the macroeconomic objectives in a longer-term perspective?”

“Increasing resources for reaching MDGs should focus on increasing local resource availability by reducing or rescheduling debt payments, and by reviewing barriers to fair trade, rather than by only increasing grants and loans.”

9. What are the main bottlenecks in achieving the health MDGs?

- (a) For the MOHs of both Uganda and Tanzania, the most important issue is the lack of appropriate levels of financial resources, affecting the capacity of the supply side to scale up needed interventions. This affects both the public and private sectors: in Uganda, for example, about 30 to 35% of health services are provided by faith-based NGOs. This means a need for more resources over a longer time. The unpredictability of the resources available over the medium term will inhibit governments from introducing any fundamental changes that they cannot sustain (e.g. pay reforms; training and attracting significantly more skilled staff; contracting private sector providers; etc.). Ensuring predictability means a “Memorandum of Agreement for a period of 15 years” and “independent monitoring systems”. The experience of the Global Alliance for Vaccine and Immunization (GAVI) shows how scaling up may be unsustainable if financial support cannot be maintained. Countries may be unable to afford the costly vaccines introduced and paid for under GAVI, after GAVI stops its support.¹⁷

¹⁶ IMF website: <http://www.imf.org/external/np/vc/2002/060702.htm>

¹⁷ The assumption was that market prices for the vaccines concerned would drop significantly and that countries would be able to support their purchase in the post-GAVI period. This, however, has not been the case.

For Uganda in particular, the capping of the health sector budget, with project aid included, in the projected Medium-Term Expenditure Framework is a major constraint to scaling up activities. Project aid in Tanzania continues to be perceived as additional to the budget (including budget support and basket funds), but the MOH faces a similar constraint in convincing the MOF to allocate more budgetary resources to health.

- (b) Second (and directly linked with the limited resources) is the problem of human resources (both quantitative and qualitative). This is related to issues such as low pay levels, difficulties in retaining staff in public service, brain drain,¹⁸ staff motivation and rewards for performance, pre-service and in-service training,¹⁹ and the impact of HIV/AIDS. Human resource development (HRD) is closely linked with the broader civil service reforms, which tend to lag behind. Tanzania has adopted a more flexible and increasingly decentralized approach to human resource (HR) management (e.g. District Councils becoming more responsible for HR matters in the near future and defending their case with the Civil Service Department). This seems more effective than the centralized and rather inflexible approach to HR management in Uganda, where all power lies with the Ministry of Public Service (MOPS). For example, Uganda's MOH cannot introduce allowances for midwives in disadvantaged districts without the agreement of the MOPS. Also in Uganda, the Ministry of Education (MOE) is responsible for training schools, but does not consider them to be a priority. Both Tanzania and Uganda stress the need for more investment in pre-service training, which has been chronically underfunded.²⁰ In Uganda, because pre-service training of medical staff remains under the MOE, it is not reflected in the PRSP priorities, although long-term sustainability cannot be achieved without appropriate output and quality of pre-service training. Surprisingly, the Tanzanian and Ugandan PRSPs do not address HRD in any systematic way, although both countries agree that HRD is the second most important issue in scaling up service output.

"If the international community is committed to supporting developing countries in making progress towards reaching the MDGs, it should invest in human resources development (including largely underfunded pre-service training) and be willing to pay part of the human resource cost."

- (c) Third, efficiency gains can be made when implementing the reforms at district level. In Tanzania, it is claimed that the slow process of implementing decentralization through the Ministry of Regional and Local Government has limited improvements in the quality of service delivery. In Uganda, some partners consider the Ministry of Local Government to be a rather weak implementor of the reforms and insufficiently pro-active in the health debate. Decentralization, both in Uganda and Tanzania, has yet to achieve more effective service delivery, with participation from local communities and "space" for the voices of the poor to play a part in reducing poverty and attaining MDGs. Effective decentralization requires the appropriate mechanisms and local capacity for accountability and for monitoring change and the performance of both public and private providers.
- (d) Lastly, a significant weakness in planning for health MDGs in both Uganda and Tanzania is the lack of a holistic cross-sectoral view on priority interventions that improve health. PRSPs remain a juxtaposition of sector priorities and strategies, viewed through individual sector spectacles; they do not take a holistic approach combining, for example, health, education and human resource issues. Health is seen too much as a health sector responsibility, and health-related issues that should primarily be addressed by other sectors are generally underfunded. Competence in

¹⁸ In 2002, 132 Tanzanian doctors left the country looking for greener pastures (Survey on Migration of Tanzanian Health Workers within and outside Africa, 2003). Brain drain of medical doctors is estimated as up to 30% of graduates in Uganda.

¹⁹ The annual intake of student medical doctors is too low to achieve the national health targets and donor agencies need to support in-service training. These issues were highlighted in the October 2003 Opening Address by the President of Tanzania at the 38th Scientific Conference and Annual General Meeting of the Medical Association.

²⁰ Investment of both government and donor funds through the government budget.

multisectoral approaches seems limited, but Uganda provides an interesting example of “best practice”. Following the disappointing child and maternal mortality figures in the 2000 Demographic Health Survey, the MFPED in Uganda set up a task force on infant and maternal mortality which produced its recommendations in 2003. It confirms that activities geared towards reducing mortality should be essentially multisectoral; that inadequate policy implementation, rather than inadequate policies, is an issue; and that mortality reduction will require substantial investment of resources in the social sectors. The task force has identified critical actions to be taken by several sectors. It remains to be seen whether these recommendations will be supported by appropriate levels of funding in the next PEAP review, given the ceilings set by the MFPED.

“Take a holistic view to development and poverty rather than focusing on health only. Do not limit health to health sector strategies. Build institutional capacity in multisectoral analysis and implementation.”

In Uganda, some macroeconomists state that the health sector has no more capacity to scale up, as all systems (public service and NGOs) are stretched to maximum capacity. Increased funding, they say, will lead mainly to increased unit costs, not increased output. This view is not shared by the MOH, which argues that the existing human resources and infrastructure have the capacity to dispense more drugs and supplies immediately. Moreover, there is strong justification for investment in additional capacity to increase coverage to previously underserved populations. This will result in further increases in output without driving up unit costs.

Most development partners agree that substantially more financial resources are needed for health. They need to be introduced progressively and taking into account local absorptive capacity, but their use should be well focused and targeted to cost-effective interventions. However, the need for additional resources must be addressed across sectors, and not for health alone.

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