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Report No: 53151-UG

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 85.7 MILLION INCLUDING SDR 19.8 MILLION IN PILOT CRW RESOURCES
(US$ 130 MILLION EQUIVALENT)

TO THE

REPUBLIC OF UGANDA

FOR A

UGANDA HEALTH SYSTEMS STRENGTHENING PROJECT

April 27, 2010

Human Development 1
Country Department AFCE1
Africa Region

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CURRENCY EQUIVALENTS
(Exchange Rate Effective as of March 31, 2010

Currency Unit = Uganda Shilling Shs.
Shs. 2085 = US$1
US$1 = SDR 0.6586

FISCAL YEAR
July 1 – June 30

ABBREVIATIONS AND ACRONYMS

ACT	Artemisinin-based Combination Treatment
AfDB	African Development Bank
AHSPR	Annual Health Sector Performance Report
ANC	Antenatal Care
APL	Adaptable Program Loan
BCC	Behavioral Chang Communication
CAS	Country Assistance Strategy
CFAA	Country Financial Accountability Assessment
CPI	Country Portfolio Index
CPR	Contraceptive Prevalence Rate
CSOs	Civil Society Organizations
DAH	Development Assistance for Health
DALYs	Disability Adjusted Life Years
DANIDA	Danish International Development Agency
DHS	Demographic and Health Survey
DHSP	District Health Services Pilot and Demonstration Project
DPT	Diphtheria, Pertussis and Tetanus
EmONC	Emergency Obstetric and Neonatal Care
EMP	Environmental Management Plan
ESAMI	Eastern and Southern Africa Management Institute
ESIA	Environmental and Social Impact Assessment
FINMAP	Financial Management Accountability Program
GFATM	Global Fund for AIDS Tuberculosis and Malaria
GAVI	Global Alliance for Vaccines and Immunization
GOU	Government of Uganda
GHs	General Hospitals
HCIV	Health Center Type Four
HCWMP	Health Care Waste management Plan
HGSAP	Health Governance Strategy and Action Plan
HMIS	Health Management Information System
HNP	Health Nutrition and Population
HPAC	Health Policy Advisory Committee
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
ICT	Information, Communication, and Technology
IDA	International Development Association
IEC	Information, Education, and Communication
IFMIS	Integrated Financial Management Information Systems
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Net
IUD	Intrauterine Contraceptive Device
IFMIS	Integrated Financial Management Information Systems
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Net
IUD	Intrauterine Contraceptive Device
LTIA	Long-Term Institutional Arrangements
LGMSDP	Local Govt. Management and Service Delivery Program
MDG	Millennium Development Goal
MIS	Management Information System
MMR	Maternal Mortality Rate
MOFPED	Ministry of Finance, Planning and Economic Planning
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSI - U	Marie Stopes International - Uganda
MTEF	Medium-Term Expenditure Framework
MVA	Manual Vacuum Aspiration
NACME	National Advisory Committee on Medical Equipment
NDP	National Development Plan
NMS	National Medical Stores
ORET	Development-Related Export Transactions Programme
PACE	Programme for Accessible health, Communication and Education
PDE	Procurement and Disposal Entity
PDO	Project Development Objective
PDU	Procurement and Disposal Unit
PEAP	Poverty Eradication Action Plan
PEFA	Public Expenditure and Financial Accountability
PEPFAR	USG President's Emergency Program For AIDS Relief
PER	Public Expenditure Review
PETS	Public Expenditure Tracking Survey
PMTCT	Preventing Mother-to-Child-Transmission of HIV
PNFP	Private-not-for-profit Providers
PPDA	Public Procurement and Disposal of Public Assets Act
PRSC/JBSO	Poverty Reduction Support Credit/Joint Budget Support Operation
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper
QER	Quality Enhancement Review
RBF	Result Based Financing
RHU	Reproductive Health Uganda
ROM	Results-Oriented Management
RRHs	Regional Referral Hospitals
SCM	Supply Chain Management
SIL	Sector Investment Loan
SoE	Statement of Expenditure
STIP	Sexually Transmitted Infections Project
SURE	Securing Uganda's Right to Essential Medicines
SWAp	Sector Wide Approach
TA	Technical Assistance
TB DOTs	Directly Observed Tuberculosis Treatment
TFR	Total Fertility Rate
TOR	Terms of Reference
UACP	Uganda AIDS Control Project
UBOS	Uganda Bureau of Statistics
UHSSP	Uganda Health systems Strengthening Project
UNFPA	United Nations Population Fund
UNMHCP	Uganda National Minimum Health Care Package
UJAS	Uganda Joint Assistance Strategy
UPSPEP	Uganda Public Sector Performance Enhancement Project
VHT	Village Health Teams
VOIP	Voice Over Internet Protocol

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UGANDA
Uganda Health Systems Strengthening Project

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UGANDA

UGANDA HEALTH SYSTEMS STRENGTHENING PROJECT

PROJECT APPRAISAL DOCUMENT

AFRICA

AFTHE

Date: April 27, 2010	Team Leader: Peter Okwero
Country Director: John McIntire	Sectors: Health (100%)
Sector Manager/Director: Eva Jarawan	Themes: Health system performance (100%)
Project ID: P115563	Environmental category: Partial Assessment
Lending Instrument: Specific Investment Loan	Joint IFC:
	Joint Level:

Project Financing Data

[ ] Loan [X] Credit [ ] Grant [ ] Guarantee [ ] Other:

For Loans/Credits/Others:
Total Bank financing (US$m.): 130.00
Proposed terms: Regular IDA: Repayable in 40 years including a grace period of 10 years.

Financing Plan (US$m)

Source	Local	Foreign	Total
BORROWER/RECIPIENT	14.31	0.00	14.31
International Development Association (IDA)	89.62	40.38	130.00
Total:	103.93	40.38	144.31

Borrower:
The Republic of Uganda

Responsible Agency:
Ministry of Health
Plot 6 Lourdel Road
P.O. Box 7272
Uganda
Tel: (256-41) 434-0874 Fax: (256-41) 434-0887
info@health.go.ug

Estimated disbursements (Bank FY/US$m)

FY	11	12	13	14	15				
Annual	2.90	47.40	34.40	29.50	15.80				
Cumulative	2.90	50.30	84.70	114.20	130.00				

Project implementation period: Start May 25, 2010 End: July 31, 2015

Expected effectiveness date: August 2, 2010 Expected closing date: July 31, 2015

Does the project depart from the CAS in content or other significant respects? ***Ref. PAD I.C.***	[ ]Yes [X] No
Does the project require any exceptions from Bank policies? ***Ref. PAD IV.G.*** Have these been approved by Bank management? Is approval for any policy exception sought from the Board?	[ ]Yes [X] No [ ]Yes [ ] No [ ]Yes [X] No
Does the project include any critical risks rated "substantial" or "high"? ***Ref. PAD III.E.***	[X]Yes [ ] No
Does the project meet the Regional criteria for readiness for implementation? ***Ref. PAD IV.G.***	[X]Yes [ ] No

Project development objective ***Ref. PAD II.C., Technical Annex 3***
The project development objective is to deliver the Uganda National Minimum Health Care Package (UNMHCP) to Ugandans, with a focus on maternal health, newborn care and family planning. This will be achieved through improving human resources for health; physical health infrastructure; and management, leadership and accountability for health service delivery.

Project description *[one-sentence summary of each component]* ***Ref. PAD II.D., Technical Annex 4***
The project comprises four components, namely: (a) improved health workforce development and management; (b) improved infrastructure of existing health facilities; (c) improved management, leadership, and accountability for health service delivery; and (d) improved maternal health, newborn care and family planning services. The choice of subcomponents and activities was guided by the need to both achieve results during the project's life span, and also promote reforms that would sustain service delivery in the long run, whilst complementing on-going efforts by other development partners.

Which safeguard policies are triggered, if any? ***Ref. PAD IV.F., Technical Annex 10***
The project includes renovation of health facilities and provision of health care, which may have potential adverse environmental impacts. As such, the project needs to comply with environmental assessment requirements under the Uganda National Environment Act (1995), National Environmental Impact Assessment Regulations 13/1998, other Ugandan environmental regulations, and the World Bank safeguard policy OP 4.01 on Environmental Assessment. The Environmental and Social Impact Assessment (ESIA) including the EMPs and the Health Care Waste Management Plan dated April 13, 2010 (HCWMP) have been disclosed at the country level and in the InfoShop. The ESIA suggests that there are no involuntary resettlement issues associated with this project and that OP 4.12 is not triggered.

Significant, non-standard conditions, **if any**, for:
Ref. PAD III.F.
Board presentation:
None

Loan/credit effectiveness:
(a) The Recipient has prepared the Annual Work Plan for the first year of Project implementation;
(b) The Recipient has recruited the Accounting, Procurement and Monitoring and Evaluation

Specialists; and

(c) The Recipient has adopted the Project Implementation Manual.

Covenants applicable to project implementation:

(a) The Project Implementation Manual will include the following: (i) an institutional set-up for the management of the Project, (ii) financial management and accounting procedures annexes; (iii) detailed arrangements for the overall carrying out of the Project; (iv) guidelines for the preparation of Annual Work Plans; (v) internal control systems to be followed during Project implementation; (vi) detailed guidelines and procedures for the implementation of the ESIA in connection with the carrying out of the Project; (vii) the guidelines for Project monitoring and evaluation; and (viii) guidelines for implementation of the Health Governance Strategy and Action Plan;

(b) By April 15 of each year, an annual work plan and budget (the Annual Work Plan) shall be developed, including: (i) the Project activities to be carried out during the next twelve months; (ii) the procurement plan and disbursement schedule; (iii) the annual budget for the Project; (iv) annual training plan; and (v) the amount of counterpart funds to be provided by the Recipient to carry out the Project activities during such period.

(c) The Project shall be carried out in accordance with the provisions of the Anticorruption Guidelines;

(d) The Project shall be carried out in accordance with a Health Governance Strategy and Action Plan, in form and substance satisfactory to the Association, including, inter alia: (i) anticorruption prevention measures; (ii) mechanisms to improve the impact of Project activities; and (iii) procedures to enhance the transparency of Project transactions;

(e) The external audit shall be carried out by the Auditor General of Uganda, within 6 months after the end of each fiscal year and include action plans to improve performance and/or correct any shortcomings and/or deficiencies;

(f) The Project shall be implemented in accordance with the provisions of the Health Care Waste Management Plan and the Environment Management Plan;

(g) Project progress reports shall be provided quarterly no later than forty-five days after the end of the period, and shall include progress on the Key Performance Indicators;

(h) Procurement audits of the project shall be carried out annually.

I. STRATEGIC CONTEXT AND RATIONALE

A. Country and sector issues

1. **Over the last two decades, Uganda has registered impressive economic performance.** Average GDP rate grew at an average of over 6 percent per annum and poverty levels were reduced from 44 percent to 31 percent between 1992 and 2005/06. Nonetheless, Uganda remains one of the least developed countries. GDP per capita in 2007 was estimated at US$320. In 2008 the population was estimated at 28 million people with a growth rate of 3.2 percent and a dependency ratio of 1.12, both among the highest in the world. Per capita income is estimated to have grown only by 0.6 percent per year in the past decade[1].

2. **The global economic crisis threatens short-term prospects.** In 2008/09, GDP grew at 7.1 percent, but growth rate is expected to decrease to 5 percent in 2009/10, falling short of projected performance in both years. At the outset of the global financial crisis, Uganda was shielded against the first round effects, with the exception of instability in the foreign exchange market. However, secondary effects later became apparent, with a slowdown in growth on account of reduced demand for Uganda's traditional exports, tighter liquidity conditions, and a resultant slowdown in economic activity. Both the current and capital account balances deteriorated, and the shortfall in fiscal revenue resulted in modest expenditure cuts, while inflationary pressures continued through 2008/09 and the first half of 2009/10. In the health sector, the increased prices for drugs and medical supplies have reduced availability of critical health commodities.

3. **Uganda has registered improvements in Health Nutrition and Population (HNP) outcomes, but the improvement in outcomes remains poor compared to other countries in the region**. The Maternal Mortality Rate (MMR) is estimated at 435 deaths per 100,000 live births[2], while the Infant Mortality Rate (IMR) is estimated at 76 deaths per 1,000 live births; stunting in children under five is estimated at 32 percent. Communicable diseases contribute over 50 percent of disability adjusted life years (DALYs) lost[3]. HIV prevalence dropped from 18 percent in the early 1990s to 6.4 percent, where it has remained since 2002. With the exception of Millennium Development Goal (MDG) 6 on combating communicable diseases, Uganda is unlikely to achieve MDGs 4 and 5 related to reducing child mortality and improving maternal mortality. In comparison with other African countries, Uganda has similar outcomes to Kenya and Tanzania in infant mortality, but is higher than both countries in mortality in children under 5 years. In maternal mortality, Uganda has slightly better outcomes than Kenya and Tanzania. The status of key HNP outcomes is outlined in Table A1-1 in Annex 1.

4. **While over 72 percent of the population resides within 5 kilometer radius of a health facility, this has not translated into effective utilization and coverage for key interventions**[4]. Interventions targeted at HIV/AIDS and Malaria Control Programs registered marked progress since 2004/05. Coverage of (a) children under five who receive effective treatment for fever within 24 hours increased from 60 to 71 percent; (b) pregnant women who receive intermittent preventive treatment (IPT) for malaria during pregnancy increased from 34 to 47 percent; and (c)

[1] As measured in US$.
[2] MMR for 2008 is 352 according to the latest Lancet paper.
[3] The last Burden of Disease study was in 2002.
[4] Health Sector Strategic Plan 2005/06 – 2009/10, Midterm Review Report, MOH, October 2008.

households with at least one insecticide treated bed net (ITN) increased from 15 to 42 percent between 2004/5 and 2008/9. It is estimated that 190,000 out of 350,000 eligible persons are receiving antiretroviral treatment. With the introduction of artemisinin-based combination treatment (ACTs), malaria, a leading cause of morbidity registered a 39.3 percent decline in the total outpatient cases. Utilization of other key services have stagnated or deteriorated and their coverage remains low. Outpatient utilization is estimated at 0.9 visits per capita, deliveries under skilled care at 41 percent, contraceptive prevalence rate (CPR) at 24 percent and percentage of women attending at least four antenatal care (ANC) visits at 58 percent. While the percentage of children under one year reported to have received three doses of diphtheria, pertussis and tetanus inoculations (DPT) is high (90 percent), the proportion of fully immunized children is low (46 percent). Similarly, while all districts report having adopted community based directly observed treatment of tuberculosis (TB DOTs), the proportion of TB cases reported remains low at 57.4 percent compared to the target of 70 percent. The TB cure rate is estimated at 75 percent against a target of 85 percent. Table A1-2 in Annex 1 illustrates the trends in major HNP indicators.

5. **The goal for health in Uganda is to reduce morbidity and mortality from the major causes of illness by delivering the Uganda National Minimum Health Care Package (UNMHCP).** [5] The package includes cost effective interventions which primarily target major communicable diseases, as well as maternal and child health. The objective is to improve access to, and utilization of, essential services, including basic surgical and obstetric care. These objectives are highlighted in the Poverty Eradication Action Plan (PEAP)[6] under Pillar 4 on improving human development. The plan's emphases are on mobilization and efficient utilization of funding; recruitment and better deployment of the health workforce; improvement in supply, distribution and rational use of essential drugs; and strengthening public private partnerships for improved health services.

6. **Uganda's health reforms are generally regarded as successful in terms of structural changes, although outcomes have been mixed.** Despite acknowledged underfunding, improvements were observed, especially during Health Sector Strategic Plan I (HSSP I), in programming of the Government portion of the budget; rationalization of financing of essential medicines and supplies through the Drug Credit Line;[7] partnership and financing of the private-not-for-profit providers (PNFPs); recruitment of qualified health workers in Government health facilities; and in the renovation and upgrading of primary health care facilities and provision of staff accommodation. Since 2004/05, bottlenecks have emerged which impede health system performance. These include the misalignment of external development assistance with national priorities and systems; weak procurement and supply chain management; generally weak management capacity; and issues related to recruitment, deployment, and management of the health workforce, especially in remote and hard to reach areas.[8] Compounding the low funding level is the limited allocation of discretionary funds and restricted availability of operational funds largely due to the earmarking of the budget through the wage bill, project support, and conditional grant transfers.

[5] National Health Policy (1999 – 2009) & Health Sector Strategic Plans (2000/01 -2004/05 and 2005/06 – 2009/10)
[6] Poverty Eradication Action Plan of 2000 and revised in 2004; the equivalent to the Poverty Reduction Strategy Paper (PRSP).
[7] According to the Essential Drug List of Uganda.
[8] Fiscal Space for Health in Uganda May 20, 2009 – Contribution to the 2008 Uganda Public Expenditure Review.

7. **Improving maternal health remains a challenge**. Major causes[9] of maternal deaths can be prevented if women deliver with the assistance of skilled health personnel and have access to quality emergency obstetric care. While the percentage of women who deliver with the assistance of doctors or nurse/midwives increased from 38 percent in 1988 to 42 percent in 2006 and the use of antenatal care increased from 87 to 94 percent in the same period, emergency obstetric and neonatal care (EmONC) is still not widely accessible. Health Centre IVs facilities were designed to provide comprehensive EmONC, but only 16 percent have functional theatres and 45 percent have a medical officer at the post.[10] Providing EmONC services does not necessarily mean that women will utilize them. According to the 2006 Demographic and Health Survey (DHS), 81 percent of women indicated they had difficulty accessing health services: 65 percent could not afford treatment; 54 percent indicated long distance to the health facilities; 49 percent have difficulty obtaining transport; and 46 percent were concerned that drugs are not available at the health facilities.

8. **The status of maternal health is a good predictor of the functioning of the health system**. The maternal health Millennium Development Goal is perhaps the one most dependent upon a well functioning health system (including the availability of facilities, medicines, supplies, staff, and a functioning referral system), so there are synergies in focusing on health systems strengthening and maternal/reproductive health in parallel.

9. **The total fertility rate (TFR) is the fifth highest in the world and has virtually remained unchanged for two decades (6.9 births per woman in 1988 versus 6.7 in 2006)**. The use of modern contraceptives among married women is low (24 percent), and Uganda has the highest unmet need for contraceptives in the world (41 percent). As a result, many women resort to induced abortions with an estimated 300,000 performed annually. The average desired family size of 5.0 (as opposed to TFR of 6.7) indicates that the need for family planning services in Uganda is high. Only 46 percent of public health facilities provide family planning services and there is limited availability of community based family planning services. The private sector is the major source of contraceptives as 43 percent of women obtain contraceptives from private sector, as opposed to 32 percent from public health facilities. The Government has prepared a Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (2006 – 2015), and a Reproductive Health Commodity Security Strategic Plan (2010/11 – 2014/15), which addresses these concerns in a systematic way, including appropriate emphasis on the use of existing private sector providers.

10. **Uganda is under considerable pressure to increase spending for health**. This is driven by the rapidly growing population and the need to adopt more effective health technologies and service standards to combat the high disease burden. Most hospitals in Uganda were built between 1930 and 1970 and no longer conform to current demands and service standards. Over the years, insufficient attention was paid to their maintenance; and the majority are dilapidated and in poor physical condition. Existing management systems for hospitals have become outdated and misaligned with current reforms underway in the country. Poor alignment of

[9] Hemorrhage, abortion complications, sepsis, obstructed labor and pregnancy induced hypertension.

[10] Uganda has a seven-tier public health care system: Health Center I (serves villages with a population of 1,000 or less); Health Center II (parishes with a population of 5,000); Health Center III (sub-countries with a population of 20,000); Health Center IV (counties with a population of 100,000); General Hospital (districts with a population of 500,000); Regional Referral Hospitals with a population of 500,000 population); and the National Referral Hospital.

various public sector reforms (procurement, decentralization, restructuring of line ministries and agencies, etc.) to health sector needs, coupled with proliferation of districts that lack resources and capacity to execute their mandates, have both complicated management of health service delivery and rendered the existing management, supervision mechanisms, and accountability frameworks ineffective. Abuse, waste, and inefficiency are recognized as major problems in the sector. In particular, absenteeism represents a major source of inefficiency and waste. The Global Fund for AIDS Tuberculosis and Malaria (GFATM) and Global Alliance for Vaccines and Immunization (GAVI) suspended their support in 2005 citing mismanagement of their grants. Although the suspensions have since been lifted, grant disbursements have not fully recovered.

11. **The Government recognizes the challenges and is committed to improving efficiency and effectiveness of public spending by strengthening the overall public financial management and procurement system.**[11] Starting in 2009/2010, implementing agencies receiving external funds were required to provide detailed work plans, including procurement plans, and ensure the availability of counterpart funds during the preparation of the Budget Framework Paper. The health sector, as a major recipient of external funds, is strengthening its institutional capacity to manage grants under GFATM in line with the newly developed framework for the management of development partner projects, the Long-Term Institutional Arrangements (LTIA).[12] The LTIA describes processes and measures to align programming and management of external funds to national processes and systems. The Government, with the support of partners under the Joint Budget Support Framework, is working on strengthening service delivery by addressing cross cutting constraints. The Joint Budget Support Framework brings together partners providing general budget support and is coordinated by the Ministry of Finance, Planning and Economic Development (MOFPED) and the Office of the Prime Minister. Public sector management has been singled out for improvement, with a focus on improving personnel management and accountability for service delivery. In the health sector, in particular, this will involve strengthening personnel management functions, rolling out implementation of Results-Oriented Management (ROM) and Client Charters and developing an incentive scheme to attract and retain health workers in remote and hard to reach areas. To address the bottlenecks in the sector, the Ministry of Health (MOH) has developed a *Master Plan for Accelerating Performance in the Health Sector* (April 2008). This plan underscores the need to address bottlenecks in health infrastructure, human resources for health, and essential medicines and supplies.

[11] The Republic of Uganda, Budget Speech, Financial Year 2009/10 and National Budget Framework Paper FY 2008/09 – 2012/13.

[12] Long Term Institutional Arrangements for Management and Coordination of Global Health Grants in Uganda; Operational Manual, August 2008.

B. Rationale for Bank involvement

12. **Health systems strengthening has generally received insufficient support from development partners**. The Government of Uganda (GOU) wishes to address these issues by strengthening the health system, specifically in the areas of improving existing health infrastructure, human resources for health and management of the health sector. In addition, it would like to improve the quality and availability of services for maternal and newborn care as well as family planning. These areas receive considerably less support from other development partners. The main sources of external funding to Uganda are from the Global Health Initiatives, GFATM, GAVI and USG President's Emergency Program For AIDS Relief (PEPFAR), and are directed to prevention of HIV/AIDS, malaria, tuberculosis, and other immunizable diseases. The Government views the World Bank as a key development partner able to mobilize the scale of funding needed to tackle health systems bottlenecks and to provide the necessary technical expertise.

13. **Health system bottlenecks require actions involving Government-wide engagement.** The World Bank is uniquely positioned to facilitate such a multisectoral response given the scope of its engagement with the GOU across sectors, as well as its experience and available expertise. The Bank already has a number of ongoing operations with a multisectoral reach, including the series of the Poverty Reduction Support Credit/Joint Budget Support Operation (PRSC/JBSO), the Uganda Public Sector Performance Enhancement Project (UPSPEP), and the Local Government Management and Service Delivery Program (LGMSDP). A key priority under the PRSC/JBSO is to improve service delivery. While support under the PRSC/JBSO arrangement will tackle broad policy reforms, the proposed project will complement these activities by deepening their implementation within the health sector. In addition, the project will strengthen laboratory infrastructure and services in the renovated health facilities, thereby complementing efforts of the proposed East Africa Public Health Laboratory Networking Project.[13] The project will focus on physical health infrastructure; human resources for health; and management, leadership, and accountability for health service delivery. These priority areas currently represent the chief constraints to effective health services delivery. By addressing them, the project will contribute towards improving service delivery at the frontline, and making providers accountable for services delivered to clients.

14. **The recent changes in the aid architecture for health have led to increased calls for the World Bank to concentrate on strengthening health systems**. The project is consistent with both the Bank-wide and Africa Region HNP Strategies,[14] which stress the Bank's comparative advantage in addressing health system bottlenecks. The specific actions selected under the project are therefore in line with the Bank's core competences.

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[13] This is a regional project with the aim of strengthening capacities for the diagnosis and surveillance of TB and other communicable diseases through the establishment of a network of efficient, high quality, and accessible public health laboratories. Proposed for joint submission to the Board with this project on May 25, 2010.

[14] The World Bank Strategy for Health, Nutrition, and Population Results, April 2007; and Improving Health, Nutrition, and Population Outcomes in Sub-Saharan Africa: The Role of the World Bank, December 2004.

15. **The Bank's current approach to support the health sector was prepared jointly with other partners providing budget support, and is elaborated in the Uganda Joint Assistance Strategy** (UJAS 2005-09). The UJAS is aligned to the Poverty Eradication Action Plan (PEAP), and although it did not explicitly provide for a separate investment operation for health outside the PRSC, the proposed project is consistent with both UJAS and PEAP objectives, and several of the health systems bottlenecks were earmarked for action. Improving health infrastructure, human resources for health, leadership, and management functions, will contribute to strengthening health service delivery. The Government recently approved a five-year National Development Plan (NDP) to replace the PEAP. The theme of the NDP is "growth, employment, and prosperity for socio-economic transformation". It underscores the importance of human capital formation and places emphasis on the expansion of the delivery of the essential health package and strengthening the existing health systems and leadership in the health sector. The project is included in the new Country Assistance Strategy (CAS) under preparation, which will be submitted to the Board on the same date as the project.

16. **The proposed operation also takes into account the impact of the global economic slowdown on the Ugandan health sector.** Secondary effects have now become apparent, with a slowdown in growth on account of reduced demand for Uganda's traditional exports. In 2009/10 the current account balance improved, but Foreign Direct Investment and other short-term foreign inflows have remained weak. The Ushs/US$ exchange rate, which depreciated by over 17 percent in 2008/09, is expected to depreciate more moderately by 4.6 percent in 2009/10. From 5.8 months of import cover recorded by end of 2007/08, the international reserve position is still a comfortable 5.6 months cover. However, a continued weakening in aggregate demand through 2009/10 is expected to reduce GDP growth to 5.6 percent, slow imports, reduce tax revenues, and support a further deceleration in inflation, from 14.2 percent year-on-year in 2008/09 to 7.0 percent by the end of 2009/10. In the health sector sustained inflationary pressures have led to increased prices of commodities, a majority of which are imported. To this end, supplementary resources provided under the Crisis Response Window will help the Government to counteract the negative effects of the crisis by sustaining current investment levels in the health sector and to ensure availability of health commodities under component four of the project on improving maternal health, newborn care and family planning.

C. Higher level objectives to which the project contributes

17. **The project contributes towards reduction of morbidity and mortality**. The project is designed to contribute to the achievement of the HSSP II objectives of reducing morbidity and mortality from major causes of ill-health, premature death and disparities therein. The project will also contribute towards the attainment of the goals and objectives of the new National Development Plan of improving growth and creating employment and prosperity for socio-economic development through improving human capital development.

18. **Maternal and child mortality remain high in Uganda, yet many of the causes are avoidable.** The project will therefore also help to make operational the 2006-2015 Uganda *Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity* and contribute to strengthening Uganda's national capacity to deliver maternal and child health services. In doing so, the project will contribute towards the achievement of MDGs 4 and 5

which aim to reduce child mortality and improve maternal health as outlined in the National Development Plan (NDP). page 254.

II. PROJECT DESCRIPTION

A. Lending instrument

19. The project will be financed through a Sector Investment Loan.

B. Program objective and Phases

20. Not Applicable

C. Project development objective and key indicators

21. **The project development objective (PDO) is to deliver the Uganda National Minimum Health Care Package (UNMHCP)[15] to Ugandans**, with a focus on maternal health, newborn care, and family planning. This will be achieved through improving human resources for health; physical health infrastructure; and management, leadership and accountability for health service delivery.

22. **The project will place emphasis on expanding coverage and improving the quality of maternal health and newborn care, and family planning services**. Maternity care, in particular, is influenced by the degree to which the health system is functioning. Hence, in addition to addressing major (cross-cutting) gaps in the achievement of the MDGs, a focus on maternity services should provide an additional indication of the success of the project's efforts at strengthening health systems.

23. **Achievement of the project development objective will be measured using the following key performance indicators (KPIs)[16]**:

(a) Deliveries taking place in Government and Private-not-for-Profit (PNFP) health facilities (%).
(b) Pregnant mothers attending at least four antenatal care (ANC) visits (%).
(c) Contraceptive Prevalence Rate (CPR) (%).
(d) People with access to basic package of health, nutrition or population services (number).
(e) Direct Project Beneficiaries (number) of which female (%)[17].

[15] The UNMHCP is a set of essential cost effective interventions identified to respond to the most important causes of disease burden in Uganda. The UNMHCP is organized around four clusters: (a) integrated maternal and child health services; (b) prevention and control of major communicable diseases; (c) prevention and control of non communicable diseases; and (d) crosscutting areas of health promotion, community health initiatives, environmental health, school health, as well as gender and health.

[16] Newborn care will be addressed through improved care during the ante natal period and delivery. In this regard no specific PDO indicator will be provided for newborn care. Instead the indicators on deliveries and ante natal care will cover newborn care.

[17] Defined as patient visits in renovated health facilities - out and in patient visits.

D. Project components

24. **The project comprises four components.** This include: (a) improved health workforce development and management; (b) improved infrastructure of existing health facilities; (c) improved management, leadership, and accountability for health service delivery; and (d) improved maternal health, newborn care, and family planning services. The choice of subcomponents and activities was guided by the need to both achieve results during the project's life span, and also to promote reforms that would sustain service delivery in the long run, while complementing ongoing efforts by other development partners. While some activities are being undertaken at the national level because of the need to address systemic sector-wide issues, the core set of interventions in each of the first three components will focus on a selected number of districts (see Annex 4 for the criteria used in selecting facilities/districts), with a view to rolling out these core interventions to other districts in the future. The project renovation interventions are primarily directed at public facilities, but will to a limited extent equip PNFP training institutions.

Component One: Improved health workforce development and management (US$5 million).

25. **The objective of this component is to improve development and management of the health workforce**. Emphasis will be placed on improving Human Resources for Health (HRH) to address maternal and neonatal care. The project will support: (a) consolidation of central level HRH functions at the MOH; (b) strengthening human resource management functions in the sector; (c) improving staff retention in remote and hard to reach areas; and (d) improvement in pre-service and in-service training. Specific aspects of HRH will also be addressed in other project components.

26. **Consolidate central level Human Resources for Health functions**. The Government intends to strengthen and consolidate central level HRH functions in MOH. Specific activities will include the funding of two long-term advisors, rolling out of an HRH Management Information System (MIS), and providing logistical support to the four professional councils.[18]

27. **Strengthen human resource management functions**. To minimize recruitment delays and reduce the high cost of advertisements, the project will support: creation of a Central Job Bureau in the MOH, short-term training of personnel officers (designated officers) including hospital administrators and other health managers in relevant areas of personnel management, and provide equipment and technical support for HRH MIS in selected districts[19], including hospitals.

28. **Improve staff retention in remote and hard to reach areas**. The Ministry of Public Service is in the process of developing an incentive-based framework to support recruitment and retention of personnel in hard to reach areas. The project will support the implementation of this framework and the motivation and retention strategy prepared by MOH. Also, since students from remote areas are likely to stay in their districts,[20] the project will provide scholarships for

[18] Medical and Dental Practitioners, Nurses and Midwives, Pharmacists and Allied Health Professionals Councils.
[19] WHO and USAID Capacity Project will support HRH MIS in other districts.
[20] MOH, Uganda Health Workforce Study: Satisfaction and Intent to Stay Among Current Health Workers, April 2009.

students from hard to reach areas who would be expected to return to the areas after their courses.

29. **Improve pre-service and in-service education.** This subcomponent will improve pre-service education for selected health cadres in short supply by providing scholarships for high priority cadres and teaching materials. For in-service training, the project will provide scholarships for postgraduate training in clinical disciplines with major vacancies; support the accreditation of courses for continuing professional development; and support the development of a system of internship and clinical mentorship for selected cadres.

Component Two: Improved infrastructure of existing health facilities (US$85 million).

30. **The objective of this component is to improve infrastructure of existing health facilities**. Emphasis will be placed on providing minimum quality standards of health care services, especially in the areas of maternal and child health, through (a) renovation of selected health facilities; (b) provision of medical equipment; (c) improved capacity for operations and maintenance; and (d) strengthening the referral system.

31. **Renovation of selected health facilities**. Under this subcomponent, the Government proposes to renovate 17 general hospitals (GHs)[21] and 27 Health Centers Type IV (HC IVs)[22] and upgrade two general hospitals into regional referral hospitals (RRHs)[23] (the proposed list of health facilities are listed in Annex 4, Page 42 in Table A4-1). The final list will be agreed after completion of studies on the detailed designs and cost of the works. The health facilities for renovation were selected based on remoteness of location; the state of dilapidation; proximity to major highways prone to road traffic accidents; catchment population; and the need to promote an effective referral system. The infrastructure works also will include construction of incinerators; provision of HIV/AIDS clinics and obstetric theatres; expansion of laboratory and delivery suites; completion of operating theatres; and the construction/completion of staff housing. Depending on identified needs, the project will connect health facilities to reliable sources of water, power, sewerage, transport, and Information Communication and Technology (ICT) services. The specific activities that will be carried out under this subcomponent include the following:

(a) Six GHs dating back to the 1930s will require fundamental replanning and replacement of some buildings to align them to the revised standards. This will involve construction of staff houses as the lack of housing is a major constraint to the recruitment and retention of key hospital staff.
(b) The two GHs selected for upgrading to RRHs are located in remote areas and are among the hospitals built before the 1950s.
(c) The GHs built between 1969 and 1973 will not require major replanning. Renovation works are anticipated to include re-roofing, replacement of water and sewerage systems,

[21] General hospitals have a capacity of 100 beds, serve a catchment population of about half a million people and are staffed by four to six medical officers.
[22] Health Centers Type IV are upgraded Health Centers started under HSSP 1 to bring emergency surgical and obstetric care closer to the communities. They are staffed by one or two a medical officers and serve a catchment population of 100,000 people.
[23] In addition to services provided by general hospitals, regional referral hospitals provide specialist services in surgery, pediatrics, obstetrics, internal medicine, and ophthalmology and serve a population of about two million people.

window replacement, and provision of solar lighting in the wards. Some additional works will include construction of incinerators, provision of HIV/AIDS clinics and obstetric theatres, as well as expanding space for the laboratories and the delivery suites.

(d) Work on HC IVs will involve completion of operating theatres and doctor's houses and construction of some additional staff housing. Patient privacy and improved infection control, especially for HIV/AIDS and TB patients, will be addressed during replanning.

32. **Provision of medical equipment**. The renovated facilities will be supplied with appropriate types of medical equipment, with priority given to essential medical equipment for diagnostics, surgery, and obstetric care.

33. **Improved operations and maintenance**. This subcomponent will strengthen capacity for proper operations (maintenance, repairs, and replacements) of health facility assets: buildings, medical equipment, and vehicles. The project will assist GOU to develop policies and procedures for procurement and maintenance of medical equipment; support existing policies for maintenance; review options for managing and financing Regional Medical Equipment workshops including exploring Public Private Partnership (PPP) options; and support implementation of an inventory system developed through the Danish International Development Agency (DANIDA).

34. **Improved referral system.** The project will provide ambulances depending on need to selected hospitals and a general purpose vehicle for each renovated health facility so that the ambulances are reserved for emergency transfers rather than general purpose use. In addition, the project will support MOH to develop policy guidelines on ambulances and a strategy for using ICT to improve referrals. The procurement of vehicles will be guided by the Government instructions on engine capacity. Activities under this subcomponent will be implemented under close collaboration with component four on reproductive health.

Component Three: Improved Leadership, Management, and Accountability for health service delivery (US$10 million).

35. **The objective of this component is to strengthen management, leadership, and accountability for health service delivery**. Priority will be placed on (a) implementing performance-based management approaches; (b) professionalizing and strengthening the management of hospitals; (c) developing and rolling out implementation of the hospital policy framework; and (d) procurement, logistics, and supply chain management (SCM).

36. **Performance-based management approaches**. The Ministry of Public Service has instituted Result-Oriented Management (ROM)[24] and Client Charters[25] as part of a comprehensive integrated performance management system aimed at improving performance monitoring for results and productivity in delivery of public services. The project will assist

[24] ROM is aimed at enhancing performance and accountability of implementing agencies, which are required to prepare annual performance plans that reflect their performance output targets as a basis for the appraisal of the performance of the agency and staff.

[25] Client Charters spell out the service standards and the commitment to service delivery that clients and stake holders should expect from an implementing agency. The Client Charters are intended to enhance transparency, performance, and accountability.

MOH in customizing and rolling out the implementation of ROM and Client Charters; strengthening Performance Appraisal and systems for Recognition, Reward, and Sanctions; and initiating application of Performance Contracts in the sector. Further, the project will support the scaling up of social accountability mechanisms like the citizens report card at community level for health service delivery.

37. **Hospital policy framework**. The project will support the new MOH hospital policy by assisting in the development and roll out of guidelines for developing individual hospital plans, reviewing options for management of RRHs and developing a rational financing mechanism for public hospitals. In addition, the project will support the MOH to develop a hospital accreditation system and internship policy to guide practical skills development for essential health cadres.

38. **Professional management of health facilities.** The Government has plans to professionalize the management of hospitals, and has requested Uganda Martyrs University, Nkozi[26] to develop a two-year Masters program in hospital management. The project will support MOH to implement this training program, as well as, programs to upgrade staff already in management positions.

39. **Procurement, logistics, and supply chain management**. Under this subcomponent, the project will build capacity in the pharmacy division to monitor activities of National Medical Stores (NMS); review relevant procurement regulations (Public Procurement and Disposal of Assets and Local Government Acts) to suggest amendments and develop guidelines where necessary; and provide complementary SCM support to selected districts in close collaboration with the new USAID-financed SURE project[27].

40. **Strengthening delivery of health services at the district level**. With the proliferation of districts, the Health Sub-district concept is no longer able to meet its original intended objectives in terms of appropriate supervision of health services.[28] The project will provide short-term TA to examine the options for addressing this by reviewing the viability of the Health Sub-district concept, the suitability and capacity of the regional hospitals, and the administrative and management capacity at the district level to support health service delivery.

41. **Project Management**. This subcomponent will support costs related to the operations and management of the project, including specific TA in the areas of project management, financial management, procurement, and other areas. Consistent with the use of government systems, these consultants will work as part of the relevant functional units.

Component Four: Improved maternal, newborn and family planning services (US$30 million).

42. **The objective of this component is to improve access to, and quality of, maternal health, newborn care, and family planning services**. This component will: a) expand and

[26] Uganda Martyrs University is already running courses in health services management.
[27] The USAID SURE project is supporting 45 districts in medicines logistics management.
[28] The subdistrict concept involved delineation of catchment areas and upgrading of selected health centers to provide emergency obstetric and surgical care. The health subdistrict was headed by a medical officer.

improve quality of reproductive health and newborn care; and b) increase the availability and demand for family planning services. While some activities under this component will be implemented on a national scale, others will be implemented in selected districts based on specific criteria. The project will finance key Emergency Obstetric and Neonatal Care (EmONC) equipment, contraceptives, and training and capacity building activities to expand coverage of maternal health, newborn care, and family planning services. Consistently with the objective of rapid disbursement of CRW resources, procurement of EmONC equipment and commodities, including contraceptives, under this component will be front-loaded. This should allow the buildup of buffer stocks which will guard against future stock-outs, allowing normal Government procurement of contraceptives to maintain adequate inventory levels.

43. **Expanding and improving quality of maternal and newborn care.** This subcomponent will: (a) finance development and dissemination of maternal and newborn care guidelines and protocols; (b) provide hands-on training and mentorship on Emergency Obstetric and Neonatal Care (EmONC); (c) provide basic and comprehensive EmONC lifesaving procedures and delivery services, including the purchase of major EmONC equipment, essential EmONC medicines and supplies; (d) augment the provision of post-abortion care through the purchase of manual vacuum aspiration kits and provision of related training; (e) strengthen the referral and communication system through the provision of protocols and guidelines, ambulances with basic resuscitation equipment, a boat ambulance for the Kalangala district[29], and ambulances (bicycle, motorcycle, or tricycle) for hard to reach communities to increase utilization of maternal and newborn care services[30]; and (f) expand and strengthen maternal and perinatal death reviews.

44. **Increasing the availability of and demand for family planning services.** This subcomponent will expand the provision of family planning services through: (a) expanding and improving the quality of facility-based family planning services; (b) expanding the provision of long-term and permanent methods (LTPM) through NGOs and private providers (e.g., midwives and private practitioners); (c) providing community-based distribution of family planning services; and (d) generating demand for services. The project will procure additional IUDs and implants to meet the needs of NGOs that are providing such services, and to make LTPM more accessible at the public facilities. The MoH will partner with these NGOs to provide hands-on training to nurses and clinical officers (for IUD and implant insertion and removal) and to medical doctors at the HCIV health facilities and hospitals (to perform female sterilization). Family planning equipment will be procured for the public health facilities, including mini-laparatomy kits, vasectomy kits, implant insertion and removal kits, and IUD insertion kits. The project will train and support community-based distributors to provide condoms and oral contraceptive pills and to refer and follow-up clients using injectable contraceptives, implants, or IUDs. The project will support the 2009-14 Uganda Reproductive Health Commodity Security Strategic Plan by filling gaps to ensure the continuous availability of the full range of contraceptives (taking into consideration contributions from USAID and the United Nations Population Fund [UNFPA]).

[29] Made up op small islands in Lake Victoria.

[30] The equipment will be procured as part of Component 2 for an estimated cost of $3.2 million in addition to the funding for this component.

E. Lessons learned and reflected in the project design

45. **Previous IDA Projects**. The project design benefitted from lessons learnt by the earlier IDA projects[31] other development partner projects in Uganda, and the Bank study on contracting for Primary Health Care in Uganda[32], which assessed performance-based contracting as a means of delivering primary health services through private not for profit health facilities. These lessons are consistent with findings from other countries.

46. **Project Development Objective (PDO) and Result Framework.** Both the DHSP and STIP had broad PDOs and weak monitoring frameworks. As a result, monitoring the achievement of the development objectives and implementation progress was less than satisfactory. Accordingly, efforts have been made to elaborate a realistic PDO for which the project can be accountable, and to develop a clear result framework with baseline data at the outset. In doing so, special attention was paid to existing capacity, with a premium placed on avoiding an overly complex project design.

47. **Focus on reforms for which there is already commitment**. Reform processes tend to be protracted, especially if they are too broad and commitment, and/or a champion, is absent. The project was specifically requested by the GOU (and hence there is clear ownership) and it has been designed on the basis of existing government programs, and to the extent possible, avoids introducing new reforms. The project will target selected areas of reform for which there is both Government-wide and development partner commitment, and ongoing complementary operations, especially in regard to reforms which require cross-sectoral actions.

48. **Ensure synergy and complementarity with other ongoing programs**. The World Bank is unique in Uganda because of the complementary operations which it has on the ground. These include the PRSC, UPSPEP, and LGMSDP. The project, in its design of Components 1 and 3, takes these operations into account and will deepen implementation of reforms under these programs in the health sector. While the other operations are focused on broad Government reforms, the project will deepen implementation of these reforms within the health sector.

49. **The benefit of analytical work.** The project design greatly benefits from analytical work in the sector. Prior to project preparation, the Bank and GOU undertook a study on realities of fiscal space for health in Uganda.[33] The Bank also undertook a study on governance and political economy of the health sector in Uganda.[34] These studies and those by the USAID-financed Capacity Project[35] have provided valuable input to Components 1 and 3, and were instrumental in helping GOU to look beyond health infrastructure challenges towards the major binding constraints affecting health sector performance.

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[31] Sexually Transmitted Infections Project (STIP), District Health Services Project (DHSP) and Uganda HIV/AIDS Control Project (UACP).
[32] Unpublished Report. World Bank. Contracting for Primary Health Care in Uganda, February 2007.
[33] Fiscal Space for Health In Uganda, May 2009.
[34] Final Draft Report; Governance and Political Economy Constraints for Development Effectiveness in Uganda's Health Sector; August 2009.
[35] MOH, Uganda Health Workforce Study: Satisfaction and Intent to Stay Among Current Health Workers, April 2009; Uganda Health Workforce Turnover Study, February 2009.

50. **Managing cost escalation.** This project involves considerable work on infrastructure. Experience from previous African Development Bank (AfDB) health infrastructure projects, as well as IDA's road projects, show that substantial cost escalation often occurs. To mitigate against this, the feasibility and architectural design studies (including costing) will be completed early so that adjustments can be made to the implementation plan before the contracting process begins. In addition, the financing of Component 2 will be capped at US$85 million.

51. **Building on successes of earlier projects.** To mitigate the logistical challenges of distributing medical equipment from the national level, the (IDA-funded) District Health Services Project and Dutch funded Development-Related Export Transactions Programme (ORET), both consigned medical equipment directly to health facilities. In addition, seven year maintenance contracts were included under ORET for expensive equipment. The Government has incorporated the lessons learned from these projects into the project design.

52. **Bonding staff and performance contracts.** Several attempts by Government and development partners to bond staff in the health sector proved ineffective in the past. Similarly, the performance-based bonus scheme experiment[36] did not have a discernible impact on the production of health care services provided by PNFP facilities. Instead, it appears that facility autonomy in financial decision making had a positive impact on health care production. Cognizant of this, the project will introduce scholarship schemes and focus on strengthening management functions at the health facility level, in line with responsibilities already devolved to the health facilities under the decentralized arrangement.

53. **Governance and Accountability.** In 2005, the GFATM and GAVI suspended their support to Uganda citing mismanagement of the grants. The Bank undertook a study on the governance and political economy of the Uganda health sector in August 2009 findings which that study have been incorporated into the design of the institutional, fiduciary, and monitoring arrangements. The report highlights challenges in areas of fiduciary management, sector stewardship, and proliferation of districts lacking sufficient capacity to implement their mandates. The issues are elaborated in Annexes 7, 8 and 11.

F. Alternatives considered and reasons for rejection

54. **Lending instruments.** The following two alternatives were considered: (a) an adaptable program loan (APL); or (b) a stand-alone sector investment lending (SIL) operation. While the value of ensuring long-term engagement and commitment to policy reforms in the sector could potentially be realized under an APL, this instrument was rejected mainly because of the absence of a current sector plan to anchor the operation over most of the period of project execution. GOU is currently in the process of developing a new health sector strategic plan and an overall National Development Plan. Once this plan is developed and approved, an APL instrument could be considered for any follow-on operation.

55. **Including a specific focus on nutrition.** In light of the significant problem of malnutrition in Uganda, the option of incorporating nutrition interventions into the project was explored. However, it was felt that since malnutrition is currently being addressed by GOU

[36] Unpublished Report, World Bank, Contracting for Primary Health Care in Uganda, February 2007.

(including some external assistance), and there are already a number of complexities in the project, adding another major area of focus beyond reproductive health was not feasible, although nutrition interventions related to maternal and child health may be explored in the future.

56. **Incorporating Results Based Financing (RBF) into the project interventions.** RBF was also considered as an option. It was felt that RBF should be explored once project implementation is more advanced, rather than incorporating this into the initial project design, since many of the project interventions in leadership, management, and human resources will help facilitate RBF. However, these elements need to be in place for RBF to work effectively, and thus a sequential approach was therefore felt to be the most appropriate.

III. IMPLEMENTATION

A. Partnership arrangements

57. **The project will be implemented under the Uganda health sector wide approach (SWAp) arrangement governed by the Memorandum of Understanding (MOU) between the GOU represented by the MOH and the development partners**. While the MOU is not a legal document, it reflects the commitment of all parties towards implementation of the Health Sector Investment Plan under principles which foster strong collaboration and partnership. In addition, the project will be implemented in a complementary manner to the USAID supported Capacity Project and Securing Uganda's Right to Essential Medicines (SURE) project, both of which are particularly relevant to the interventions included under this project.

B. Institutional and implementation arrangements

58. **The project will be implemented under the newly created framework for the management of the development partner projects, the Long-Term Institutional Arrangements (LTIA)**. This framework describes processes and measures to align and mainstream programming and management of development partner projects to national processes and systems, thus ensuring coordination and sustainability of programs. The PS of the MOH will serve as the "Accounting Officer" for the project, assuming overall responsibility for project funds. The PS will delegate the day-to-day management of the project to a Project Coordinator who will be a senior officer within the MOH and will be supported by Component Coordinators. These Coordinators are heads of departments/divisions directly involved in project implementation: Health Infrastructure; Human Resources for Health; Reproductive Health; Curative and Clinical services; Quality Assurance, Procurement and Finance. Component coordinators may appoint focal persons to lead implementation in their respective departments/sections.

59. **This project will be among the first to use the new framework**. A manual to make operational the LTIA was developed and endorsed by partners. In support of this approach, technical advisors/specialists will be provided under the project to assist with capacity building and other project implementation activities in, *inter alia*, Financial Management, Procurement, Monitoring and Evaluation, Human Resources for Health (HRH Policy Advisor and HRH Management System Strengthening Advisor), Health Infrastructure (Quantity Surveyor and

Architect) and Reproductive Health (RH Advisors). The Project Coordinator will be supported by a Deputy Project Coordinator and a Project Officer. Where consultants are recruited, they will be accountable and report to the respective heads of departments/component coordinators to which they are assigned. Coordination of policy issues arising from the implementation of this project will be through the respective Technical Working Groups. The Project Coordinator will be responsible for providing periodic reports to Senior Management and Top Management Committees as well as the Health Policy Advisory Committee (HPAC), where partners and Government meet together. This arrangement will ensure coordination and harmonization of policy proposals and decisions which affect the implementation of the project specifically and the health sector generally. The Permanent Secretary will ensure that all the above positions including focal persons are assigned to lead project implementation in their respective sections/departments. The structure for the institutional arrangement for the project, principles governing project institutional arrangements and the detailed job descriptions for the project coordinator, component coordinators, focal persons and suggested TAs are outlined in Annex 6, and elaborated in detail in the project implementation manual.

60. **The project will concentrate its activities in districts with facilities under renovation.** Implementation of activities under Components 1, 3, and 4 will be targeted to districts with health facilities under renovation to demonstrate the impact of a comprehensive health systems approach to improving service delivery. By clearly showing the success of the approach, the potential for further roll-out to other districts with either Bank or other development partner funds would be enhanced. In order to ensure local government ownership, districts will participate in all the phases of renovation. The districts will be expected to approve and certify the architectural designs and works under the project.

C. Monitoring and evaluation (M&E) of outcomes/results

61. **The results framework is informed by current advances in M&E thinking in the Bank, and is consistent with MOH's overall M&E framework.** The result framework focuses on accountability for results by placing a strong emphasis on intermediate outcomes. The data will be collected from a combination of sources such as the routinely collected health information systems and sample-based surveys, including beneficiary surveys to evaluate user satisfaction conducted by the Uganda Bureau of Statistics. The Department of Quality Assurance will have the primary responsibility for coordinating M&E activities under the project. An M&E specialist will be recruited to work in the Department of Quality Assurance. In support of the project objective, and consistent with the activities being financed, five outcome indicators and 16 intermediate indicators were selected for which the project will be held accountable. These, however, are not the only indicators that will be tracked by the project, or that will be needed to successfully demonstrate the results chain in support of the outcome indicators. The following IDA-15 indicators applicable to this project are included in the core set of project indicators: (a) Health personnel receiving training (number, in-service, pre-service); (b) Health facilities constructed, renovated, and/or equipped (number); (c) Pregnant women receiving antenatal care during a visit to health provider (number); (d) Direct Project Beneficiaries (number) of which female (%); and (e) People with access to a basic package of health, nutrition and population services (number). The indicator: patient visits in renovated health facilities - out and in patient visits – will be used as a proxy measure for Direct Project

Beneficiaries (number - female and male). The detailed description of the result framework including the matrix is in the Annex 3.

D. Sustainability

62. **The project will address health systems bottlenecks and improve effectiveness of the health sector**. By improving management of human resources for health and strengthening management functions in the sector, the project will directly contribute towards the sustainability of the sector. Emphasis on addressing system-wide constraints will ensure reproductive health activities become more sustainable. The financial impact of the project on Government's health spending will be felt mainly in terms of additional resources for maintenance of renovated facilities and repairs and replacements of medical equipment. These costs will require a commitment by Government if the project's benefits are to be sustained beyond the project's life span. The project is part of the broader Government program under the SWAp and it is included within the Government's Medium-Term Expenditure Framework (MTEF). Under the optimistic scenario, Government per capita health expenditure is projected to double between 2007 and 2015 (from UGShs 19,453 to UGShs 41,214), rising from 3.13 percent to 4.08 percent of GDP. Using projections based on a much more prudent scenario, per capita expenditure is anticipated to increase to UGShs 31,582. With this projected increase in health spending, Uganda should be able to absorb the recurrent costs into its budget. This will however depend on continued development partner support, Government commitment to health, and increased emphasis on reducing waste in health spending.

E. Critical risks and possible controversial aspects

63. The overall project risk rating is **substantial.**

64. **Provision of operational funds for maintenance**. The poor state of the physical health infrastructure is largely due to inadequate budgetary allocations towards operational costs, including maintenance. There is a risk that Government will continue to provide inadequate budgetary allocation for such costs. The MOH has agreed to create a credit line for medical equipment; establish a budget line under the hospital vote to finance replacement of basic medical equipment and undertake renovations and repairs of their assets; and include maintenance contracts during procurement of large ticket items. The Bank will continue working with Government to: (a) ensure that adequate budgetary allocations are made towards maintenance in the MTEF; (b) establish a viable maintenance program including making operational the credit fund/line for essential equipment for which Government and partners have already reached agreement; and (c) operate the new inventory system.

65. **Capacity to implement the project**. The MOH has previously relied on project implementation units to execute large development partner projects. For this project, it intends to use the newly developed framework for the management of development partner funded projects. To mitigate the risks associated with the move to the new implementation arrangements, a detailed assessment of the implementation as well as fiduciary arrangements was conducted, and agreement reached with the MOH to provide additional consultants who will have the dual roles of helping to carry the burden of project implementation and building

capacity within the MOH to effectively carry on such activities on an ongoing basis. In addition, the team will undertake rigorous monitoring of the project during implementation. Further, at the suggestion of the Quality Enhancement Review (QER) panel, the Bank team will pay specific attention to the civil works component through the following steps: (a) retaining the services of an independent architect to review the designs and costing when the report of the consultants contracted under the PPA is available and (b) conducting semi-annual internal audits as well as value-for-money audits under the project.

66. **Sustained interest for reform**. Project activities under Components 1 and 3 demand sustained commitment of Government, especially that of the Ministry of Public Service, towards reforms in areas of management of human resources for health and strengthening management of health facilities. These reforms may take time, resulting in a loss of interest by Government. In order to mitigate against this risk, the project will target a few selected areas of reform for which there is Government wide and development partner commitment, as well as complementary to ongoing Bank operations. For example, the team will engage in the PRSC process and continue to work with the UPSPEP team to build and maintain broad commitment to the agreed reforms especially with the Ministry of Public Service. Emphasis on Information, Education and Communications (IEC) and Behavioral Change Communications (BCC) in an effort to change the mindset will promote sustainable change regarding acceptance of RH services.

67. **Governance Challenges**. GAVI and GFATM both at one time suspended their grants to Uganda citing irregularities with the way the grant funds were being used. A detailed project implementation manual is being developed with the roles of key entities involved in the project implementation clearly defined. Measures to ensure effective oversight and fiduciary control have been considered, including appropriate covenants in the financing agreement, i.e., semiannual internal audits and value-for-money audits. Management of fiduciary risks will be built into the project design including: (a) prior review of large contracts; (b) random reviews of statements of expenditures (SOEs) during implementation; (c) financial management reporting linking performance to financial costs; (d) random audits of small executing entities; and (e) financial audits of all large executing agencies. During project implementation, FM (and procurement) will be given emphasis during supervision with respect to monitoring agreed mechanisms and conditions. In addition, a Health Governance Strategy and Action Plan has been agreed with Government. This will also be monitored during project implementation (Annex 11, Health Governance Strategy and Action Plan). Guidelines on preventing and combating Fraud and Corruption in projects financed by IBRD Loans and IDA Grants" dated October 15, 2006 shall apply to the project.

68. **National Elections**. National elections are scheduled for February 2011. This may result in attempts to exert political influence in established project decision making processes. Processes and principles promoting transparency in the project decision making were agreed during preparation and have been clearly elaborated in the project implementation manual. In addition, health facilities for renovation were ranked and selected in accordance to the agreed criteria at project preparation. Clear criteria, broad stakeholder involvement, and detailed documentation of decision making processes (including the selection of facilities for rehabilitation) should help to minimize political interference, by increasing the leverage of the project to argue in support of agreed activities/ interventions.

F. Loan/credit conditions and covenants

69. Credit Effectiveness:

(a) The Recipient has prepared a satisfactory Annual Work Plan for the first year of Project implementation.
(b) The Recipient has recruited the accounting, procurement and monitoring and evaluation specialists.
(c) The Recipient has adopted the Project Implementation Manual. The manual will include financial management, procurement, monitoring and evaluation annexes.

70. Project Execution:

(a) The Project Implementation Manual will include the following: (i) an institutional set-up for the management of the Project, (ii) financial management and accounting procedures annexes; (iii) detailed arrangements for the overall carrying out of the Project; (iv) guidelines for the preparation of Annual Work Plans; (v) internal control systems to be followed during Project implementation; (vi) detailed guidelines and procedures for the implementation of the ESIA in connection with the carrying out of the Project; (vii) the guidelines for Project monitoring and evaluation; and (viii) guidelines for implementation of the Health Governance Strategy and Action Plan;
(b) By April 15 of each year, an annual work plan and budget (the Annual Work Plan) shall be developed, including: (i) the Project activities to be carried out during the next twelve months; (ii) the procurement plan and disbursement schedule; (iii) the annual budget for the Project; (iv) annual training plan; and (v) the amount of counterpart funds to be provided by the Recipient to carry out the Project activities during such period.
(c) The Project shall be carried out in accordance with the provisions of the Anticorruption Guidelines;
(d) The Project shall be carried out in accordance with a Health Governance Strategy and Action Plan, in form and substance satisfactory to the Association, including, inter alia: (i) anticorruption prevention measures; (ii) mechanisms to improve the impact of Project activities; and (iii) procedures to enhance the transparency of Project transactions;
(e) The external audit shall be carried out by the Auditor General of Uganda, within 6 months after the end of each fiscal year and include action plans to improve performance and/or correct any shortcomings and/or deficiencies;
(f) The Project shall be implemented in accordance with the provisions of the Health Care Waste Management Plan and the Environment Management Plan;
(g) Project progress reports shall be provided quarterly no later than forty-five days after the end of the period, and shall include progress on the Key Performance Indicators;
(h) Procurement audits of the project shall be carried out annually.

IV. APPRAISAL SUMMARY

A. Economic and financial analyses (see Annex 9)

71. **Health status is a major determinant of individual wellbeing and a good indicator of a country's level of development, particularly for developing countries**. Public investment in health care is justified because of: (a) its public goods nature; (b) uncertainty surrounding illness (in terms of occurrence), severity, and cost of treatment; (c) asymmetry of information regarding medical interventions; and (d) the need to correct existing inequalities. The public sector will continue to play a significant role in Uganda for a number of reasons: the private health subsector is underdeveloped and poorly regulated; the population is largely rural; and there is a high burden of communicable diseases primarily affecting mothers and children for which cost-effective interventions exist. In addition, Uganda as a country is witnessing a rapid rise in household out-of-pocket expenditures on health and catastrophic illnesses.

72. **The project focuses on critical bottlenecks impeding sector performance**. In addition to health infrastructure, the project will focus on addressing critical health system bottlenecks, as they relate to, in particular, maternal, child health, and family planning services. These bottlenecks are responsible for significant waste in the sector. To mitigate contingent liabilities arising from health infrastructure related works, expansion of existing facilities and construction of new facilities will be discouraged.

73. **Uganda will continue to experience optimal growth prospects in the near and intermediate period**. The economy is anticipated to continue to grow by 6 to 7 percent per year in real terms for the next 5 to 7 years. Similarly, as previously noted, it is anticipated that health spending will double over the same period. On the basis of this projected growth, Uganda should be able to realize considerable spending in the sector. The impact of the increase, however, will critically depend on a number of factors: the sustainability of funding from global initiatives, the extent to which domestic resources can be mobilized to substitute funding from Global Health Initiatives if the latter become unavailable, and on the extent to which Uganda can improve efficiency of health spending and address drivers of increased health spending.

74. **The fiscal space study revealed significant waste in the health sector, primarily because of weak management of**: (a) human resources for health; (b) health facilities; (c) procurement and logistics; and (d) development assistance for health. The project will address gaps in some of the areas under Component 1 and 3 and contribute to reducing waste in the sector.

B. Technical

75. **The project aims to improve functionality of the existing health facilities**. The choice of project subcomponents and interventions has been guided by the need to address the most pressing health system bottlenecks and to improve functionality of existing health facilities, in particular to deliver maternal and child health services which represent a major source of disease burden in the population. Poor management of human resources for health, weak overall logistics management and inadequate management capacity at the health facility level are among the most pressing challenges.[37] While some project activities will have a national focus, project implementation will be targeted to the districts with health facilities under renovation, in order to maximize the synergistic impact of a comprehensive health systems approach to improving

[37] Fiscal Space for Health in Uganda. Contribution to the 2008 PER. May 2009

health service delivery. The selection of the preliminary list of health facilities for renovation was based on remoteness of location, state of dilapidation, proximity to the major highways prone to road traffic accidents, catchment population, and the need to promote an effective referral system.

76. **Uganda's high population growth rate is driven primarily by the high total fertility rate**. The total fertility and population growth rates are among the highest in the world and are putting a big strain on the capacity of Government to deliver social services, especially in areas of education, health care, and employment. Investing in reproductive health care, especially family planning will not only release the strain on Government budget for social services but also improve the health of mothers and children and the overall welfare of households.

C. Fiduciary

Procurement

77. **The national legislation on public procurement as laid out in the Public Procurement and Disposal of Public Assets Act (PPDA), 2003 is generally in line with the World Bank's Guidelines**. Some of the exceptional provisions are currently being addressed as part of the PRSC. The exceptions are listed in Annex 8 of the PAD. The major country procurement risks are the limited compliance with the Act, as indicated in PPDA's Audit Reports. This risk will be mitigated for the project by the IDA's monitoring through prior review and post review of contracts and supervision missions. Procurement for the proposed project would be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits," dated May 2004, revised October 2006, and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers," dated May 2004, revised October 2006.

78. **Procurement for the project will be implemented by MoH and NMS**. The key issues and risks concerning procurement for implementation of the project are: (i) staff capacity gaps in the MoH Procurement Disposal Unit (PDU), particularly the lack of experience of the PDU staff in IDA financed procurement management; (ii) inadequate staff numbers and technical skills mix in the Health Infrastructure Division to supervise consultants and contractors; (iii) the workload for the PDU, (iv) Inadequate procurement planning, (v) Inadequate procurement record keeping, and insufficient space in PDU and (vi) inefficiency in procurement processing partly attributed to lack of understanding of roles and responsibilities between user departments and PDU. The risk to project procurement management by MoH to project is **Substantial**. The details on the procurement arrangements are indicated in Annex 8.

79. **The corrective measures to mitigate the overall risk as agreed upon are**: (a) Recruit a Procurement Specialist to provide hands-on coaching, mentoring of PDU staff and User Departments, (b) PDU staff to attend courses in procurement of works and goods and selection of consultants at ESAMI, (c) PDU to delegate to user departments the micro-procurement function or to use framework contracts for common items, (d) MoH to establish an acceptable MIS for procurement tracking and an acceptable procurement filing and record keeping system, (e) MoH to recruit one Architect, one Quantity Surveyor and 5 Clerks of Works, (f) PDU to

prepare a procurement plan for the first 18 months in coordination with the user departments, and (f) Prepare Procurement Manual to clarify roles and responsibilities of staff. The procurement plan was agreed between the Borrower and the Project Team on April 1, 2010 and endorsed during the negotiations.

80. The results of the assessment indicate that the procurement management overall risk rating for the project is **Substantial.**

Financial Management

81. **The project's financial management transactions will be mainstreamed within the MOH with the Permanent Secretary as the overall accounting officer**. Daily operations will be handled by the Accounting Department headed by the Assistant Commissioner (Accounts). Due to the already existing work load, additional accounting staff will be recruited under the project. The GOU accounting policies and procedures documented in the Government's Treasury Accounting Instructions issued under the Public Finance and Accountability Act 2003 will be used for the project. This will be supplemented with additional guidance on Bank project requirements regarding external auditing and financial reporting, as documented in the Financing Agreement. Semiannual internal reviews will be carried out by the Internal Audit Department of the MOFPED, and at least two Value-for-Money audits will be commissioned by the Auditor-General during the life of the project. The funding for these activities will be provided through the project. The project's accounts will be handled using Navision accounting software pending configuration of the Integrated Financial Management Information Systems (IFMIS) currently being rolled out by the MOFPED to handle preparation of project accounts. The Ministry has adequate internal audit arrangements, and the internal auditors within the Ministry will include the project activities in their work plan. The project's financial statements will be audited by the Auditor General in accordance with statutory requirements, and Terms of Reference will be developed. The GOU will name at least three designated signatories for Withdrawal Applications and will name at least two individuals designated to act for the Accounting Officer, the Project Coordinator, and the Component Coordinators when absent. The GOU will further state a procedure in the project implementation manual that will automatically delegate authority to the Acting Accounting Officer, Project Coordinator and Component Coordinators as required.

82. **The results of the assessment indicate that the Financial Management overall risk rating for the project is substantial after mitigating measures**. Appropriate mitigating measures have been identified and incorporated in project design. Actions outlined in the Financial Management Action Plan will be undertaken by MOH to strengthen the financial management system. In order to ensure that the project is effectively implemented, MOH will ensure that appropriate staffing arrangements are maintained throughout the life of the project. In conclusion, the proposed financial management arrangements put in place by the project meet the Bank's minimum requirements for project financial management as per OP/BP 10/02 and therefore adequate to provide, with reasonable assurance, accurate and timely information on the status of the project required by IDA. The implementing entities are compliant with the Bank's financial management requirements and there are no overdue audit reports and interim financial reports from these entities.

D. Social

83. **The project will contribute towards improving service delivery at the frontline and making providers accountable for services delivered to the clients, as well as providing opportunity for both male and female users to provide feedback on the same services**. This will promote the social development outcomes of inclusion and cohesiveness for improved health services delivery. Further, the project activities include the rehabilitation of known existing general hospitals and HCIV health facilities including staff housing. However, the Environment and Social Impact Assessment (ESIA) undertaken in January 2010 that included visits to all sites has confirmed that there is no need for additional land for project activities, and MOH and the relevant facilities have acceptable proof of ownership of the available land and there are no disputes over this land. The ESIA suggests therefore that there are no involuntary resettlement issues associated with this project and that OP 4.12 is not triggered. Individuals, who are staff of the health facilities with non-health related activities like gardening on the facility land will be given notice and a date for their departure or relocation will be set prior to the start of civil works. Construction related social impacts have been covered under the site specific EMPs. It is agreed that employer rules affecting activities employees can exercise on their work premises are not subject to the Association's resettlement policy.

E. Environment

84. **The rehabilitation/expansion of basic health infrastructure and construction of staff houses and other facilities on the grounds of existing hospitals and health centers may have localized adverse environmental impacts associated with civil works**. To manage these, the project will have to comply with environmental assessment requirements under the Uganda National Environment Act (1995), National Environmental Impact Assessment Regulations 13/1998, other Ugandan environmental regulations, and the World Bank safeguard policy OP 4.01 on Environmental Assessment. Environmental due diligence for the major civil works was carried out through preparation of an Environmental and Social Impact Assessment (ESIA), which includes an Environmental Management Plan. There are no environmental or social issues which cannot be addressed through routine mitigation measures and good construction practices and funded within the overall level allocated for civil works activities.

85. **The project will enhance and expand provision of health services, thus contributing to increased generation of medical waste**. To manage the environmental aspects of medical waste management, the project will promote implementation of the National Health Care Waste Management Plan for 2009/2010 – 2011/2012 that was recently completed and disclosed. The project will also promote implementation of the existing injection safety policy. Following the HCWMP, the project will fund construction and use of suitable medical waste incinerators for the various levels of health facilities. The final selection of waste incineration technology was determined with environmental (air pollution) as well as operating (cost and sophistication) considerations in mind. It was agreed that the approved HCWMP (April 13, 2010) will apply to the project throughout the duration of the project, unless agreement is reached to adopt an updated or revised version of the HCWMP.

F. Safeguard policies

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP 4.01)	[x]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[x]
Pest Management (OP 4.09)	[ ]	[x]
Physical Cultural Resources (OP/BP 4.11)	[ ]	[x]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[x]
Indigenous Peoples (OP/BP 4.10)	[ ]	[x]
Forests (OP/BP 4.36)	[ ]	[x]
Safety of Dams (OP/BP 4.37)	[ ]	[x]
Projects in Disputed Areas (OP/BP 7.60)*	[ ]	[x]
Projects on International Waterways (OP/BP 7.50)	[ ]	[x]

G. Policy Exceptions and Readiness

86. **No policy exceptions are required**. The project implementation plan has been completed and a project operations manual is being prepared. Further, activities have started under the Project Preparation Advance to develop detailed environmental assessments for each facility and to conduct detailed architectural, engineering, and costing work. Once completed, this should allow the project to quickly move into tendering and implementation of the civil works, which represent a large proportion of total project costs.

* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas.

Annex 1: Country and Sector or Program Background

Uganda: Uganda Health Systems Strengthening Project

87. **Uganda has over the last two decades registered impressive economic performance.** GDP rate grew at an average of over 6 percent per annum and poverty levels were reduced from 44 percent to 31 percent from 1992 to 2005/06. Nonetheless, Uganda remains one of the least developed countries. GDP per capita in 2007 was estimated at US$320. In 2008 Uganda's population was estimated at 28 million people with a growth rate of 3.2 percent with a dependency ratio of 1.12, both among the highest in the world. Income per capita is estimated to have grown by 0.6 percent in US$ terms in the past decade.

88. **Uganda's HNP outcomes remain by and large poor**. MMR is estimated at 435 deaths per 100,000 live births, IMR at 76 deaths per 1,000 live births and stunting in children under five at 32 percent. HIV prevalence dropped from 18 percent in the early 1990s to 6.4 percent in 2002, where it has since remained. With the exception of MDG 6 on combating communicable diseases, Uganda is unlikely to achieve MDGs 4 and 5 related to reducing child mortality and improving maternal mortality. Communicable diseases contribute over 50 percent of disability adjusted life years (DALYs) lost. The status of HNP outcomes are exemplified in Table 1.

Table A1-1: Health Outcome Indicators 1989 – 2006.

	1989	1995	2000	2006
Infant mortality	119	97	88	76
Under five mortality	180	147	152	137
Infant Immunization Rate	31%	47%	38%	46.5%
Maternal mortality	523	506	505	435
Deliveries supervised by skilled health providers	38%	38%	38%	41%
Total Fertility Rate	7.3	6.9	6.9	6.7
Contraceptive Prevalence Rate	5%	15%	18%	23.7%
Stunted children (chronic malnutrition)	43%	38.8%	38%	32%

Source: Uganda Demographic Health Surveys 1989, 1995, 2000, and 2006

89. **Improved physical access to health facilities (72 percent of the population resides within 5 kilometer radius) is not resulting in high utilization and effective coverage of key interventions**. Interventions targeted to HIV/AIDS and Malaria Control Programs – programs receiving large inflows of funding from Global Health Initiatives - registered marked progress between 2004/05 and 2006/07. Coverage of (a) children under five who receive effective treatment for fever within 24 hours increased from 60 percent to 71 percent; (b) pregnant women who receive IPT increased from 34 percent to 42 percent; and (c) households with at least one ITN increased from 15 percent to 42 percent. To date, it is estimated 190,000 out of 350,000 eligible persons eligible are on antiretroviral treatment. With the introduction of ACTs, malaria, a leading cause of morbidity, registered a 39.3 percent decline in the total outpatient cases from 16.3 million cases in 2005 to 9.9 million cases in 2006. However, utilization of other key services have stagnated or deteriorated and their coverage remains low. Outpatient utilization is estimated at 0.9 visits per person, health facility deliveries at 32 percent, contraceptive prevalence rate at 24 percent and women attending 4 ANC visits at 58 percent. While the proportion of children under one year reported to have received DPT3 is high (90 percent), the

proportion of fully immunized children is low at 46 percent. Similarly, while all districts report adopting community based directly observed treatment of tuberculosis (TB DOTs), the proportion of TB cases reported remains low at 57.4 percent against the target of 70 percent. The TB cure rate is estimated at 75 percent against the target of 85%. Table 2 illustrates the trends in major HNP indicators.

Table A1-2: Trends in Health PEAP Indicators (2000/01 – 2008/09)

Indicator	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Target
Pop coverage 5 km Radius	57%	NA	NA	72%	72%	72%	NA	75%	NA	80%
Outpatient Utilization	0.43	0.60	0.72	0.79	0.9	0.9	0.9	0.9	0.8	0.9
DPT Vaccine Coverage	48%	63%	84.1%	83 %	89%	89%	87%	90%	85%	90%
Deliveries in Facilities	22.6%	19%	20.3 %	24.4 %	25%	29%	32%	40%	41%	60%
% Qualified Workers	40%	42%	56%	68%	68%	NA	68%	*51%	53%	85%
HIV- Prevalence	6.1%	6.5%	6.2%	NA	6.4%	NA	6.4%	7.4%	NA	5%
HCs without drug stock-outs	NA	NA	33%	40%	35%	27%	35%	28%	26%	60%
Latrine Coverage	NA	NA	55.6%	55.9%	57%	58%	58.5%	63%	64%	65%
Couple Years of Protection	NA	NA	210,839	212,089	234,259	309,757	357,021	361,080	549,594	325,407
Coverage IPT	8.6%	NA	20%	27%	34%	37%	42%	46%	47%	50%
Household with Nets	17.6%	NA	NA	15%	25.9%	34%	NA	NA	40%	70%
TB Cure Rate	50%	52%	60%	65%	67%	70.5%	NA	68.4%	75.1%	80%

Source: MOH. Annual Health Sector Performance Report 2006/07, 2007/08 and 2008/09.
* The staffing norms were changed.
DPT – includes pentavalent vaccine for children.
IPT – intermittent preventive treatment i.e., malaria prophylaxis treatment given to pregnant mothers to prevent malaria.
NA Not Available

90. **The goal for health in Uganda is to reduce morbidity and mortality from the major causes of illness by delivering the Uganda National Minimum Health Care Package (UNMHCP) to all Ugandans under a sector wide approach (SWAp).** Interventions are primarily targeted to major communicable diseases and mother and child health with the objective of improving access and utilization of essential services as well as basic surgical and obstetric care. This is captured in the Poverty Eradication Action Plan (PEAP), the equivalent to the Poverty Reduction Strategy Paper (PRSP) under Pillar 4 on improving human development. The main reforms were on mobilization and efficient utilization of funding; recruitment and better deployment of the health workforce; improvement in supply, distribution and rational use of essential drugs; and strengthening public private partnerships for health.

91. **Uganda has had a long track record with implementing health reforms.** These reforms however have not led to the desired improvements in health outcomes. The pace of reforms slowed down during the HSSP II period. During the HSSP I period, improvements were observed in programming of the Government portion of the budget, rationalization of financing of essential medicines and supplies through the Drug Credit Line, partnership and financing of the private-not-for-profit providers (PNFPs), recruitment of qualified health workers in

Government and PNFP health facilities and renovation and upgrading of primary health care facilities as well as provision of staff accommodation. However, several health systems bottlenecks have prevailed upon the health sector to impede its performance.

92. **Low Resource Base Coupled with Inefficiency and Pressure to Increase Spending.** Although cost-effective interventions exist for the majority of diseases affecting the population, Uganda is inadequately resourced to adopt and implement the interventions to scale.[38] Earmarking through the wage bill, project support, and conditional grant transfers has greatly limited allocation discretion and restricted availability of funds for operations. In face of low funding, Uganda is also under considerable pressure to increase spending for health, driven primarily by the rapidly growing population and the need to adopt more effective—but expensive—health technologies and service standards to combat the high disease burden. Uganda derives a large share of its health financing from external sources, a large portion of which are off-budget and skewed to a few programs, notably HIV/AIDS, which make it difficult to effectively program these resources. In addition, overall management of these funds is weak.

93. **Health Workforce.** The health workforce represents a major source of waste in the health sector and is characterized by low motivation, mal-distribution, high rates of attrition and absenteeism, and difficulties with attraction and retention of health workers in remote and hard to reach districts. Personnel management is especially poor and is characterized by delays in recruitment, payroll entry, confirmation, appraisals and promotion, and is associated with high staff turnover. Because of relatively better salaries in Government, the PNFP facilities are losing their staff to Government employment, depleting the PNFP subsector and undermining the entire health sector. Despite the challenges, studies by the USAID-financed Capacity Project reveal several opportunities: (a) few significant differences among health worker profiles in remote and non-remote areas; (b) greater job stability and intent to stay among public sector employees - over 53 percent having stayed in current organization at least 10 years; (c) desire mainly by PNFP health workers to migrate internally, but remain working in the sector; (d) low desire by nurses and allied health workers to leave the country (10 percent); and (e) a strong desire, particularly by health workers from the north, to serve their communities. The studies also reveal that physicians, especially PNFP physicians, were most likely to express desire to leave their jobs or migrate out of the country and that salary was a significant predictor in reducing odds of leaving.

94. **Health Infrastructure.** Hospitals in Uganda were built between 1930 and 1970 and no longer conform to current demands and service standards. Over the years, little attention was paid to their maintenance, and generally, the majority are dilapidated and in poor physical shape. Most Health Centers Type IV upgraded under the Health Subdistrict concept, which underpinned the sector reform agenda, remain incomplete and not fully functional. The current system for maintaining medical equipment through the Regional Medical Equipment workshops is not functioning adequately. In addition, existing management systems for hospitals have become outdated and misaligned to current reforms underway in the country. The referral system is poor and availability of equipment is low with only 50 percent of equipment estimated to be in good working condition. Staff accommodation is grossly inadequate. It is estimated that only 30

[38] Out of the estimated US$ 28 per capita, only about US$ 10 per capita is available to the public sector to finance its health program.

percent of eligible staff have institutional accommodation. The lack of accommodation is cited as a major reason for the inability to attract staff to remote areas, late coming and high rates of absenteeism. This has been recognized and with support of JICA, six hospitals were renovated and equipped in the last three years. In addition to revising the essential equipment list and maintenance policy and plan, plans are underway to establish a credit line for minor equipment.

95. **Inadequate availability of essential medicines and supplies is a major constraint.** Although Government established a drug credit line and developed a rolling three-year comprehensive procurement plan for medicines and supplies, coordination of the procurement of third party commodities and overall logistics management continues to be problematic across all levels. Drug shortages are common. In 2006/7, 65 percent of health facilities reported running out of one or more of the six tracer drugs. While this is partly because of a limited drug budget, it is believed that inadequate capacity for planning and management is also contributing to the shortages. Few districts are able to spend their drug budgetary allocations. In 2006/7, out of the US$ 2.40 per capita that was needed for essential drugs, only US$ 0.72 was made available for essential medicines and health supplies, excluding ARVs, vaccines, and ACTs.

96. **Impact of various Government reforms on the sector.** Uganda has undergone several public sector management reforms including procurement, decentralization, liberalization, etc. Poor alignment of the reforms to the health sector needs coupled with proliferation of districts that lack resources and the capacity to execute their mandates have complicated management of health service delivery and rendered the existing management and supervision mechanisms, as well as accountability frameworks, ineffectual. Although recognized, inter-sectoral collaboration has proved challenging in several areas including, sanitation, environmental health, and reproductive health.

97. **There is a growing understanding to improve efficiency of health spending and to address system bottlenecks**. Growth in health funding is projected to be modest and Uganda's opportunities for improving health service delivery will depend on improving value for money and efficiency of health spending. Government has committed to improving efficiency and effectiveness of public spending by strengthening overall public financial management and procurement. Starting 2009/2010, implementing agencies receiving external funds will provide detailed work plans, including procurement plans, and ensure availability of counterpart funds during the preparation of the Budget Framework Paper. The health sector, a major recipient of external funds, is strengthening institutional capacity to manage grants under the Global Fund for AIDS Tuberculosis and Malaria (GFATM) in line with the newly developed framework for the management of the development partner projects: Long-Term Institutional Arrangements (LTIA). The LTIA describes processes and measures to align programming and management of external funds to national processes and systems. The Government, with support of partners under the Joint Budget Support Framework, is working on strengthening service delivery. Public sector management has been singled out for improvement with a focus on improving the accountability framework for service delivery. In the health services, this will involve strengthening personnel management functions, rolling out implementation of Result Oriented Management (ROM) and Client Charters, and developing an incentive scheme to attract and retain health workers in remote and hard to reach areas, among others. The project will facilitate implementation of these Government-wide reforms in the sector. To address the key problems in

the sector, the MOH developed a Master Plan for Accelerating Performance in the Health Sector (April 2008). The plan underscores the need to address bottlenecks in health infrastructure, human resources for health, and essential medicines and supplies.

98. **Improving maternal health remains a challenge**. The major causes of maternal deaths (hemorrhage, abortion complications, sepsis, obstructed labor, and pregnancy induced hypertension) can be prevented if women deliver with the assistance of skilled health personnel and have access to quality emergency obstetric care. The percentage of women who deliver with the assistance of doctors or nurse/midwives increased from 38 percent in 1988 to 42 percent in 2006, while use of antenatal care increased from 87 percent to 94 percent in the same period. Emergency obstetric and neonatal care (EmONC) is not widely accessible. Health Centre IVs facilities are expected to provide comprehensive EmONC, but only 16 percent have functional theatres and 45 percent have a medical officer at post. Providing quality EmONC does not necessarily mean that women will access them. According to the 2006 DHS, 81 percent of women indicated they had difficulty accessing health services: 65 percent could not afford treatment; 54 percent indicated long distance to the health facilities; 49 percent have difficulty obtaining transport; and 46 percent were concerned that drugs are not available at the health facilities. The total fertility rate (TFR), the fifth highest in the world, has virtually remained unchanged in two decades (6.9 births per woman in 1988 versus 6.7 in 2006). The use of modern contraceptives among married women is low at 24 percent. Uganda has the highest unmet need for contraceptives in the world at 41 percent. As result, some women resort to induced abortions to achieve their fertility desires with about 297,000 induced abortions performed annually. The average desired family size of 5.0 (as opposed to TFR of 6.7) indicates that the potential need for family planning services in Uganda is high. Indeed, 65 percent of women of reproductive age not using contraceptives intend to use in future. The potential demand for family planning is not being met considering that only 46 percent of health facilities provide family planning services and community-based family planning services is virtually non-existent. Moreover, the private sector is the major source of contraceptives: 43 percent of women obtain contraceptives from private hospitals or clinics as opposed to 32 percent from Government hospitals or clinics. The Government has prepared a Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (2006 – 2015) and Reproductive Health Commodity Security Strategic Plan (2010/11 – 2014/15.

Annex 2: Major Related Projects Financed by the Bank and/or other Agencies

UGANDA: Uganda Health Systems Strengthening Project

Table A2-1: Major Health Related Projects in Uganda

Project/Program Title	Objectives	Coverage	Total Project Cost	Development partner Contribution
Ongoing projects				
AfDB. Support to the Health Sector Strategic Plan Project II	To improve access to quality Reproductive Health Services in South Western Uganda and expand Mental Health Services in Uganda	10 districts in SW Uganda for RH and 7 Regional Hospitals for mental health	UA 22.2 M	UA20 M
JICA: The Rehabilitation of Hospitals and Supply of Medical Equipment in the Central Region in Uganda	To upgrade and improve quality of health care services at selected health facilities through the refurbishment, expansion and the supply of equipment.	6 General Hospitals in Central Uganda		US$13.5 M
GAVI	Construct staff houses; train and equip 5,000 Village Health Teams in poorly performing districts; and train and equip 100 private health facilities to deliver immunization services	Countrywide	US$41.38 M	US$19 M
IDA: Uganda Public Service Performance Enhancement Project	Transform public service so that it is affordable, efficient and accountable in the use of public resources and improve policy, institutional and regulatory environments in targeted areas for sustainable growth and service delivery.	Ministry of Public Service		US$18.8 M
USAID: SURE Project	To strengthen logistics management for medicine	45 districts		US$45 M
USAID: STRIDES FP Project	Expand FP services	15 districts		US$ 50 M
Projects under preparation				
Belgium: Institutional Capacity Building Project	To strengthen the capacity for planning, management, and leadership in the health sector	MOH at the center, 2 regional hospitals and a few general hospitals and HC IVs		Euro 6.5 M
IDA: East Africa Public Health Laboratory Networking Project	To strengthen capacities for diagnosis and surveillance of TB and other communicable diseases by establishing a network of public health laboratories	Regional Project covering four countries: Uganda, Kenya, Tanzania and Rwanda		US$3.3 M (Uganda)

Annex 3: Results Framework and Monitoring

UGANDA: Uganda Health Systems Strengthening Project

A. Introduction

99. **The results framework for this project is informed by current advances in M&E thinking in the Bank and is consistent with the MOH's overall M&E framework.** The results framework focuses on accountability for results and places emphasis on intermediate outcomes. To avoid parallel data collection, the project will utilize the routine Health Management Information System (HMIS) and statistical records from the Uganda Bureau of Statistics (UBOS).

100. **A key principle underpinning the project design is to ensure that the systems investments are directly linked geographically to the infrastructure investments.** The selected districts where infrastructure related works will take place will also be targeted with interventions in other components (human resources, drugs distribution, etc.). The coordinated approach in improving buildings, equipment, human resources as well as availability of drugs is to ensure functionality of service delivery units, whether at hospitals or health centers.

101. **A large part of the project is devoted to financing infrastructure (civil works and equipment).** Such operations are usually *procurement heavy*. As such, there is a tendency to focus on tracking procurement (i.e., inputs) during supervision rather than the achievement of results (i.e., outcomes). For this reason, specific attention will be paid to tracking the outcomes/results that the project intends to achieve.

B. Monitoring and Evaluation Design

102. **Selection of Indicators.** The PDO is to deliver the Uganda National Minimum Health Care Package to Ugandans, with a focus on maternal health, newborn care and family planning. In support of this project objective, and consistent with the activities being financed, 5 key performance indicators and 16 intermediate outcome indicators were selected for which the project will be held accountable (Table A3-1). These, however, are not the only indicators that will be tracked in the project, or that will be needed to successfully demonstrate the results chain in support of the outcome indicators. As such, an additional set of project-level indicators (disaggregated by component) will be tracked by the project team.

103. **Consistency with Bank Core indicators.**[39] The following core indicators applicable to this project are included in the core set of project indicators: (a) Health personnel receiving training (number, in-service, pre-service); (b) Health facilities constructed, renovated, and/or equipped (number); (c) Pregnant women receiving antenatal care during a visit to health provider (number); (d) Direct Project Beneficiaries (number) of which female (%); and (e) People with access to a basic package of health, nutrition and population services (number). Patient visits in renovated health facilities (out and in patient visits) will be used as a proxy measure for (d) and (e) i.e., access and direct beneficiaries.

[39] OPCS. 2009. Core Sector Indicators and Definitions - Health. OPCS, World Bank, Washington, DC.

104. **Level of indicators.**[40] The indicators are a combination of output and outcome indicators. Specifically, the indicators are mainly Level III pertaining to capacity, and Level II pertaining to service delivery functioning, as per the agreed upon Africa Sector Results Chain for Health.

105. **Definition of indicators.** The denominator and numerator for each indicator have been clearly specified to ensure that definitions do not change over time. None of the project interventions target a specific target group; thus, there is no specific target group identified in the definition of the indicators.

106. **Disaggregation of data.** The infrastructural investments have a geographic focus, while many of the system-level investments (human resources and drug distribution) may have impacts beyond these geographic areas. For this reason, the indicators that have been identified will be associated with national averages, but will allow for district level disaggregation. This should allow for a closer link to be made with the district level activities.

107. **Data sources.** The data source for each of the indicators is clearly defined. Data sources are a combination of HMIS and sample-based surveys conducted by the UBOS. Further clarification on data quality, data collection methodologies, responsibility for data collection was done at appraisal.

108. **Attribution.** There are two ways to think about attribution: (a) attribution of a change in outcome relative to the inputs that the Bank financed; versus (b) attribution of a change in outcome relative to the program that the Bank supported (together with financing from Government, other development partners, etc.). The latter is the way that attribution will be considered in this project. While no formal impact evaluation has been envisaged for the project, informal efforts will be used to allow for the assessment of attribution (albeit imperfectly). For example: (a) data will be collected from the intervention districts as well as the non-intervention districts;[41] (b) strong efforts will be made to construct the results chain to link the inputs, outputs and intermediate outcomes with the project outcomes. The latter is also consistent with the point made in paragraph 103 that in addition to the core set of indicators, additional project-level indicators will also be collected.

109. **Baseline data.** To the extent possible, the proposed results framework uses existing indicators and data to measure the progress—not only for efficiency, but also to build on and strengthen existing data collection mechanisms. Baseline data are available for almost all indicators. Preliminary baseline data and targets were established for the following indicators: (a) people with access to a basic package of health, nutrition and population services (number), (b) Direct Project Beneficiaries (number) of which female (%) and (c) health workers receiving a salary within two months from reporting to work (%). These will be confirmed after the baseline survey in September 2010 using the project preparation advance.

[40] AFTHE. 2009. Results Chains for HNP.

[41] While these districts will not be formally treated as control districts because no formal matching is possible, it will be important to see how progress differs across these districts.

110. **Targets for the indicators.** The indicator targets and reporting arrangements were agreed upon and finalized at appraisal. Particular attention was given to the basis on which the targets were set as well as the realism and feasibility of their achievement.

C. Planning for Monitoring and Evaluation Implementation

111. **Data collection.** A key determinant of successful M&E implementation is the quality of data planning during the project preparation and the resources and responsibility for data collection and analysis.[42] To this end, a detailed data collection plan has been developed that identifies for each indicator:

(a) The source of the data or data collection mechanism;
(b) The frequency of the data collection;
(c) An assessment of the quality of the data collection mechanism;
(d) Where necessary, some comment on the concerns about data collection methodology especially where a non-standardized data collection mechanism is used;
(e) Responsibility for data collection and analysis (where an external source has been identified, the contact within the MOH is listed);
(f) Level and source of resources available for data collection.

112. **The methods of data collection include a combination of HMIS and surveys**. As far as possible, standardized data collection methods will be used. Most of the indicators will be collected annually, and any survey-based indicators will be collected at baseline, at mid-term and in the last year of project implementation. Where survey methods are being used, as in the case of CPR, a formal statistical sampling will be applied to ensure representativeness of the results.

113. **Primary responsibility of M&E**. The Department of Quality Assurance in the MOH will have the primary responsibility to coordinate M&E activities of the project. This will include: coordination of data collection processes, reviewing consultant reports or analytical products for M&E, and preparing periodic progress reports. An M&E specialist will be recruited to work in the Department of Quality Assurance.[43] This person will serve a quality assurance role for the project's M&E, and be expected to solicit expert opinion as necessary.

114. **Resources for M&E.** Costs related to M&E have been included in the costing of the project.

D. Planning for Monitoring & Evaluation Use

115. **The implementation of the M&E framework will be tracked during implementation, and will be a central part of project supervision**. In this regard, the mid-term review will provide an opportunity to assess fundamental M&E design issues, and make adjustments if necessary. There will be a strong results-orientation during supervision, with adequate attention devoted to progress on data collection, data quality and the actual use of data in tracking project

[42] Uribe-Vilar. 2009. *Assessment of M and E in HNP operations, 1997-2009*. Background Paper. HNP Evaluation. IEG. World Bank. Washington. DC.
[43] While this person may not have a dedicated responsibility for this role, agreements have been reached with the relevant authorities to second the identified individuals. This is fully consistent with the LTIA principles that the project is implementing, i.e., using the Government systems.

implementation in Aide Memoires. The M&E specialist will also be responsible for providing periodic and annual reports on the progress of M&E implementation and usage, as well as any design changes that may be proposed. One of the supervision's missions will coincide with the MOH's annual review meetings in October each year.

E. Country level M&E systems and capacity building strategies

116. **M&E capacity**. The majority of the project indicators are already being collected through the HMIS at the MOH and the UBOS. Data collection is therefore unlikely to pose a serious challenge. As previously noted, it was agreed at appraisal to recruit an M&E Specialist in the Quality Assurance Department to support the various teams to provide periodic reports on an *inter alia* basis.

Table A3-1: Results Framework

PDO – Project Development Objective and Outcomes	Project Outcome Indicators	Use of Project Outcome Information
To Deliver the Uganda National Minimum Health Care Package (UNMHCP) to Ugandans, with a focus on maternal health, newborn care, and family planning.	1. Deliveries taking place in Government and PNFP Health Facilities (%).[44] 2. Mothers attending at least 4 antenatal care (ANC) visits (%). 3. Contraceptive Prevalence Rate (%). 4. People with access to a basic package of health, nutrition and population services (number)[45]. 5. Direct Project Beneficiaries (number) of which female (%)[46].	To assess impact of the project in improving access and quality of health services.
Intermediate Outcomes by Project Component	**Intermediate Outcome Indicators**	**Use of Intermediate Outcome Monitoring**
Component 1: Improved Health Workforce Development and Management		
Improved availability of human resources for health *Improved Performance of the Health Workforce*	6. Health personnel receiving training (number).[47] 7. Approved positions filled by qualified health workers (%). [48] 8. Health workers receiving a salary within two months from reporting to work. (%).	To monitor capacity for personnel management to recruit and deploy health workers.
Component 2: Enhanced Existing Health Infrastructure		
Improved Availability of Health Infrastructure. *Improved Availability of Essential Equipment* *Improved Referrals of Patients*	9. Health facilities constructed, renovated and/or equipped (number).[49] 10. HC IV and Hospitals renovated according to agreed standards (Number). 11. H C IV and Hospitals with functioning minimum Essential Equipment (number)[50]	To monitor project progress towards improving functionality of physical health infrastructure. To monitor effectiveness of the

[44] This is a national-level indicator. The denominator for estimated pregnancies is 5 percent the estimated population size.
[45] Shall use a proxy indicator: patient visits in renovated health facilities – in and out patients (number)
[46] Shall use a proxy indicator: patient visits in renovated health facilities – in and out patients (number)
[47] Cadres are nurses, anesthetists and clinical officers.
[48] This indicator monitors approved positions by Government, which are funded according to their particular level.
[49] Government plans to renovate HC IV and Hospitals according to agreed standards
[50] Essential Equipment consists of: Theatre Equipment, Laboratory Equipment, Delivery Beds and Patient Beds in Maternity and Ward, per facility.

	12. HC IVs performing caesarian sections (number). 13. Health facilities with functional ambulances and communication systems (number).[51]	referral system and functionality of HC IVs.
Component 3: Improved Management and Accountability		
Improved Hospital Management	14. Hospitals with medical superintendents trained in health management/hospital administration (%).[52]	To assess project progress towards building management capacity to deliver health services.
Improved Responsiveness to Clients	15. Health Facilities with Client Charters (%).	To assess whether improvements in capacity are translating into improved service delivery.
Improved Procurement and Logistics Management for Medicines and Supplies	16. Health facilities without stock-outs of tracer medicines and supplies (%).[53] 17. Drug orders processed timely by NMS (%).[54]	To assess how responsive Health Facilities are towards their Clients.
Component 4: Improved maternal, newborn, and family planning services		
Expanding and improving quality of maternal and newborn care	18. Hospitals and HC IVs offering comprehensive emergency obstetric care (%). 19. HC IV facilities conducting maternal and perinatal death audits (%).	To monitor the project's progress in improving access to maternal and neonatal care services
Increasing the availability and demand for family planning services	20. Pregnant women receiving antenatal care during a visit to a health provider (number) 21. Couple years of protection (CYP).[55]	

[51] This measures the number of functional ambulances and general purpose vehicles in the sector per level of health facility.
[52] A qualified manager is defined as a manager with graduate or postgraduate training in health services management or hospital management and administration.
[53] This is measured on the basis of six tracer medicines/supplies i.e., the absence of any of the tracer medicines.
[54] NMS supplies for orders received on time reaching recipient district within 21 days of receiving order.
[55] This indicator measures the sum of Couple Year Protection by type of Family Planning commodity for all FP commodities dispensed or offered during the year.

Table A3-2: Arrangements for Results Monitoring

		Target Values					Data Collection and Reporting		
Project Outcome Indicators	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**YR5**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
1. Deliveries taking place in Government and PNFP Health Facilities (%).	34% (HMIS 08/09)	35%	37%	39%	42%	45%	Annual (AHSPR)	District HMIS reports	Resource Centre and RH Division, MOH
2. Mothers attending at least 4 ANC visits (%)	50%	58%	60%	62%	63%	65%	Annual (AHSPR)	Health Unit, HMIS reports	RH Division/ MoH
3. Contraceptive Prevalence Rate (%).	24% (UDHS, 2006)	24%	25%	28%	31%	35%	Annual	Panel Surveys	Uganda Bureau of Statistics (UBOS)
4. People with access to a basic package of health, nutrition and population services (number)*	0	40,000	50,000	55,000	65,000	70,000	Annual	District HMIS reports	MOH Resource Centre
5. Direct Project Beneficiaries (number) of which female (%)*	0	40,000	50,000	55,000	65,000	70,000	Annual	District HMIS reports	MOH Resource Centre
Intermediate Outcome Indicators									
6. Health personnel receiving training (number).	0	15	30	45	60	75	Annual Training School and Project Reports	HRMMIS	HRD
7. Approved positions filled by qualified health workers (%).	56%	60%	65%	70%	75%	80%	Annual (AHSPR)	HMIS	Resource Center and HRD
8. Health workers receiving a salary within two months from reporting to work (%)*.	0%	0%	5%	20%	20%	30%	Annual	Payroll MIS, (Pay change reports at the computer Services)	MoPS
9. Health facilities constructed, renovated and/or equipped (number). Cumulative.	0	0	10	20	35	46	Annual	Supervision and Inventory Reports	HID
10. H IV and Hospitals renovated according to agreed standards (Number).	RRH: 0 GH: 2 HCIV: 32	RRH: 0 GH: 2 HCIV: 32	RRH: 0 GH: 3 HCIV: 32	RRH: 2 GH: 3 HCIV: 32	RRH: 13 GH: 20 HCIV: 59	RRH: 13 GH: 20 HCIV: 59	Annual	Supervision and Inventory Reports	HID
11. HC IV and Hospitals with minimum Essential Equipment (number).	RRH: 0 GH: 2 HCIV: 117	RRH: 0 GH: 2 HCIV: 117	RRH: 0 GH: 2 HCIV: 117	RRH: 0 GH: 3 HCIV: 117	RRH: 13 GH: 20 HCIV: 144	RRH: 13 GH: 20 HCIV: 144	Annual	Supervision and Inventory Reports	HID

12. HC IVs performing caesarian sections (%)	14%	20%	30%	35%	40%	50%	Annual	Health Unit, HMIS reports	Resource Center
13. Facilities with functional ambulances and communication systems (%).	NRH: 75% RRH: 84.6% GH: 44.7% HC IV: 8.9%	NRH: 75% RRH: 84.6% GH: 44.7% HC IV: 8.9%	NRH: 75% RRH: 84.6% GH: 44.7% HC IV: 8.9%	NRH: 75% RRH: 100% GH: 80.9% HC IV: 6.3%	NRH: 75% RRH: 100% GH: 80.9% HC IV: 6.3%	NRH: 75% RRH: 100% GH: 80.9% HC IV: 6.3%	Annual	Supervision and Inventory Reports	HID
14. Hospitals with medical superintendents trained in health management/ hospital administration (%).	0	20%	40%	60%	80%	100%	Annual	HRH MIS	HRD
15. Health Facilities with Client Charters (%).	0	10%	30%	50%	70%	100%	Annual	Survey	HRD
16. Health facilities without stock-outs of tracer medicines and supplies (%).	26% (HMIS 08/09)	26%	30%	35%	40%	55%	Annual (AHSPR)	SCMIS	Pharmacy Division
17. Drug orders processed timely by NMS (%).	55%	60%	65%	70%	75%	80%	Quarterly	SCMIS[56]	NMS and MoH Pharmacy Division
18. Hospitals and HC IV offering comprehensive emergency obstetric care (%).	20% (combined)	25%	30%	35%	40%	50%	Bi-annual Third and final year of project.	Supervision and Inventory Reports Health facility survey	DHT RH Division/ MoH
19. Hospitals conducting maternal and perinatal death audits (%).	5%	6%	10%	15%	25%	40%	Annual	Supervision and Inventory Reports	RH Division/ MoH
20. Pregnant women receiving antenatal care during a visit to a health provider (number)	1,200,000[57]	1,230,000	1,250,000	1,300,000	1,350,000	1,400,000	Annual	District HMIS reports	RH Division/ MoH
21. Couple years of protection (CYP).	549,594	700 ('000s)	800 ('000s)	900 ('000s)	950 ('000s)	1,000 ('000s)	Annually	District HMIS reports	Resource Centre and RH Division, MOH

*Baseline and targets for: (a) people with access to a basic package of health, nutrition and population services (number), (b) Direct Project Beneficiaries (number) of which female (%) and (c) health workers receiving a salary within two months from reporting to work (%) will be confirmed after the baseline survey.

[56] Supply chain management information system.
[57] These are estimates. May be revised after baseline survey.

Annex 4: Detailed Project Description

UGANDA: Uganda Health Systems Strengthening Project

117. **The project comprises four components, namely**. (a) improved health workforce development and management; (b) improved infrastructure of existing health facilities; (c) improved management, leadership, and accountability for effective health service delivery; and (d) improved maternal health, newborn care, and family planning services. The choice of subcomponents and activities was guided by the need to both achieve results during the project's life span, and also promote reforms that would sustain service delivery in the long run, while complementing ongoing efforts by other development partners.

Component One: Improved health workforce development and management (US$5 million).

118. **The objective of this component is to improve development and productivity of the health workforce**. Under this component, the project will support: (a) consolidation of central level HRH functions at the MOH; (b) strengthening personnel management in the sector; (c) improve staff retention in remote and hard to reach areas, and (d) pre-service and in-service training. Specific aspects of HRH will also be addressed in other project components.

119. **Consolidate central level HRH functions**. The Government intends to consolidate central level HRH functions in the MOH. At the moment, these functions are housed in different sections of the Ministry and are poorly coordinated. The project will strengthen and consolidate HRH functions in HRM and HRD Divisions of the MOH to develop policies, oversee management of the health workforce in general, and to liaise with other Government agencies on personnel related matters. The project will place two long-term consultants (HRH Policy Advisor and HRH Management System Strengthening Advisor) in the newly created department, and will provide logistical support to the four professional councils. Councils will be assisted in assessing their capacities to discharge their mandates, through *inter alia*, the development of sound business plans. In addition to this, the project will also support the rolling out of the HRH MIS, which was developed with assistance from the USAID-financed Capacity Project. The HRH MIS is linked to the existing HMIS in the ministry, as well as those of other relevant Government agencies including the professional councils.

120. **Strengthen human resource management functions**. Personnel management in the sector is characterized by delays in recruitment, payroll entry, confirmation, appraisals and promotion, and is associated with high staff turnover largely on account of decentralized recruitments. To minimize recruitment delays and reduce high costs of advertisements, a Central Job Bureau will be created in the MOH. Districts and hospitals will be able to advertise staff openings with this Bureau, while job seekers (including recent graduates) will be able to register. This information will be relayed to the Health Service Commission and District Service Commissions on a regular basis, and made available to the general public. The project will provide short-term technical assistance to create the Central Job Bureau, and funding to furnish and equip the bureau on creation. At the district level, the project will build capacity for personnel management through training of designated officers including hospital administrators and other health managers in relevant areas of personnel management and provide equipment and technical support for HRH MIS. Each district will designate personnel officers or other

existing staff where personnel officers are in short supply to work for the health department. Other support will include support to the Health Service Commission and selected District Service Councils, with high vacancy rates, to recruit health workers.

121. **Improve staff retention in remote and hard to reach areas**. Staff turnover and vacancies are highest in remote and hard to reach areas, among lower level health facilities and the PNFPs. The Ministry of Public Service is in the process of developing an incentive-based framework to support recruitment and retention of personnel in hard to reach areas. This framework is underpinned by a motivation and retention strategy for health workers prepared by the MOH. The project will support the implementation of this framework. Several districts are implementing diverse retention schemes with varying degrees of success; these are under review by the Ministry of Public Service in order to come up with a Government wide policy for hard to reach/stay areas. In addition to documenting existing schemes, the project will assist to institutionalize mechanisms for routinely collecting data on the use and effectiveness of the schemes as part of the overall HRH MIS process. As previous attempts to bond staff after training has proved futile; the project will set up a scholarship scheme to support training of health workers to serve in remote areas. The MOH will prepare guidelines for managing the scholarship program in the project implementation manual.

122. **Improve pre-service and in-service education.** This subcomponent will improve pre-service education for selected health cadres in short supply. Both Government and not for profit (PNFP) training institutions will receive support to improve quality and the numbers of their graduates. Priority will be given to: laboratory technicians, radiology technicians, tutors, pharmacy technicians, and store keepers/logistics assistants for medicines through the provision of scholarships, as well as purchasing teaching materials including, anatomical models and charts, teaching videos and CDs, and other educational materials. For in-service training, the project will provide scholarships for postgraduate training in clinical disciplines where established, but vacant positions exist and support the accreditation of courses for continuing professional development. Since students from remote areas are likely to stay in their districts, the project will provide scholarships for students from hard to reach areas who would be expected to return to the areas after their courses. With liberalization of training, many private initiatives are involved in training health workers. The project will support the Government to develop a system of internship and clinical mentorship for selected cadres. In Health Center IVs, for example, newly graduated medical doctors will receive hands-on training, through mentorship programs, to ensure they can perform Caesarian deliveries, and manage EmONC.

Component Two: Improved infrastructure of existing health facilities (US$85 million).

123. **The objective of the component is to improve infrastructure of the existing health facilities in order to provide minimum standards of quality health care services, especially in the areas of maternal and child health, through**: (a) renovation of selected health facilities; (b) provision of medical equipment; (c) improved capacity for operations and maintenance; and (d) strengthening the referral system.

124. **Renovation of selected health facilities**. Poor maintenance has been the main cause for the poor status of both physical health infrastructure and medical equipment. The current system

for maintaining medical equipment through the Regional Medical Equipment workshops is not functioning adequately, with more than 50 percent of medical equipment in health facilities reported out of order. The MoH proposes to renovate 17 general hospitals (GHs) and 27 Health Centers Type IV (HC IVs), and to upgrade two general hospitals into regional referral hospitals (RRHs). See Table A4-1 below for the proposed list of facilities selected for renovation. Selection of the preliminary list of health facilities for renovation was based on remoteness of location, the state of dilapidation, proximity to the major highways prone to road traffic accidents, catchment population, and the need to promote an effective referral system. The final selection of health facilities and the works will be made after completion of feasibility and design studies currently underway. The choice of design will take into account the need for efficiency and the future recurrent cost implications of the investments and the contractors will be required to carefully plan the phasing of construction works in such a way that hospital operations are maintained throughout the construction period.[58] Specific activities that will be carried out under this subcomponent include the following:

(a) Six general hospitals dating back to the 1930s will require fundamental replanning and replacement of some buildings to align them to the revised standards and construction of staff houses as they were originally built without them. The lack of staff housing is a major constraint to the recruitment and retention of key hospital staff.
(b) The two GHs selected for upgrading to RRHs are located in remote areas and are among the hospitals built before the 1950s.
(c) The GHs built between 1969 and 1973 will not require major re-planning. Renovation works is anticipated to include re-roofing, replacement of water and sewerage systems, window replacement and provision of solar lighting in the wards. Some additional works will include construction of incinerators, provision of an HIV/AIDS clinic and obstetric theatre, as well as expanding space for the laboratory and the delivery suite.
(d) Work on HC IVs will involve completion of operating theatres and doctor's houses and construction of some additional staff houses. Patient privacy and improved infection control, especially for HIV/AIDS and TB patients will be addressed during re-planning. Depending on identified needs the project will connect health facilities to reliable sources of water, power, sewerage, transport, and ICT services.

[58] As previously noted the Government is using the Project Preparation Advance (PPA)[note: PPA not in acronym list] to prepare detailed architectural designs and costs the proposed works. The current cost estimates are based on market rates of similar works being undertaken by the Government and other partners.

Table A4-1: Proposed Renovation List of Selected General Hospitals and Health Centre IVs

Rank.	General Hospital	No.	HC Type IV
1	Moroto	1	Kasanda
2	Mubende	2	Kiganda
3	Mityana	3	Mwera
4	Masindi	4	Kyantungo
5	Kawolo	5	Bwijanga
6	Iganga	6	Buliisa
7	Bugiri	7	Kabuyanda
8	Anaka	8	Mwizi
9	Moyo	9	Buvuma
10	Kitgum	10	Ntenjeru-Kojja
11	Itojo	11	Bugono
12	Entebbe	12	Kiyunga
13	Kiryandongo	13	Buyinja
14	Nebbi	14	Nankoma
15	Apac	15	Padibe
16	Pallisa	16	Kitwe
17	Nakaseke	17	Rubare
18	Buwenge	18	Pakwach
19	Bukwo	19	Aboke
		20	Aduku
		21	Obongi
		22	Atyak
		23	Kibuku
		24	Budaka
		25	Ngoma
		26	Budondo
		27	Kikamuro

125. **Provision of medical equipment**. The renovated health facilities will be supplied with appropriate types of medical equipment in accordance with identified needs, based on the medical equipment policy and standard equipment list (disaggregated by level of facility). Priority will be given to essential medical equipment for diagnostics, surgery, and obstetric care. In addition, incineration facilities will be constructed or repaired where absent or out of order in accordance to NEMA recommendations. An assessment carried by NEMA and the MOH will guide the selection of the type of incinerators to be purchased and installed.

126. **Improved Operations and Maintenance**. This subcomponent will strengthen capacity for proper operations (maintenance, repairs and replacements) of health facility assets: buildings, medical equipment and vehicles. The MOH has agreed to create a credit line for medical equipment and establish a budget line for capital expenditure under the hospital vote. This should ensure that hospitals are able to both finance the replacement of basic medical equipment, and undertake renovations and repairs of their assets. Maintenance contracts will be provided for expensive and large ticket items (such as medical equipment and communication infrastructure). The project will enhance the MOH's capacity to replace and maintain medical equipment by: (a)

strengthening procurement capacity for medical equipment, especially with regard to specifications; (b) support policies for maintenance, including reducing the number of brands of medical equipment that health facilities can acquire; (c) explore the Public Private Partnership model, whereby health facilities can readily access private maintenance firms; (d) review options for managing and financing Regional Medical Equipment workshops; and (e) operate an inventory system developed through DANIDA.

127. **Improved referral system.** The project will provide ambulances on an as needed basis for selected hospitals, and a general purpose vehicle for each renovated health facility. This arrangement should ensure that ambulances are reserved for emergency transfers rather than general purpose use. There has been a marked expansion in ICT coverage in Uganda. Ambulances or specific persons, for example, will have phones that communities can call. Partnership with mobile phone companies will be explored to provide toll free numbers for communities to contact health personnel or request an ambulance. Ambulance drivers will be trained in the referral guidelines and will be required to keep log books on the use of ambulances. The MOH is in the process of determining where ambulances will be placed and how the operating and maintenance costs will be funded. In addition to this, the project will support the MOH to develop a strategy for using ICT (and possibly e-health) to improve referrals and roll out its implementation.

Component Three: Improved Leadership, Management, and Accountability for health service delivery (US$10 million).

128. **The objective of Component 3 is to strengthen management, leadership, and accountability for health service delivery**. Priority will be placed on (a) implementing performance based management approaches, (b) professionalizing and strengthening existing management of hospitals; (b) developing and rolling out implementation of the hospital policy framework; and (c) strengthening procurement, logistics and supply chain management.

129. **Hospital Policy Framework**. The MOH recently prepared a new hospital policy aimed at strengthening management of hospitals. A cabinet paper has been developed and a bill drafted on the organization and governance of tertiary hospitals. The cabinet paper sets out the Government's vision on granting autonomy to tertiary hospitals. The project will support the MOH to develop and roll out guidelines for developing individual hospital plans, hospital accreditation system, review options for autonomy of RRHs and develop a rational financing mechanism for public hospitals. As part of the hospital accreditation system, the project will support the MOH to develop a mentorship policy to guide practical skills development for essential health cadres.

130. **Performance based management approaches.** The Ministry of Public Service has instituted Result-Oriented Management (ROM) and Client Charters as part of a comprehensive integrated performance management system aimed at improving performance monitoring for results and productivity in the public service. The project will assist the MOH in customizing and rolling out the implementation of the ROM and Client Charters; strengthening Performance Appraisal and systems for Recognition, Reward, and Sanctions, and initiating application of Performance Contracts in the sector. Based on public service-wide guidelines, districts, hospitals

and unit managers will be required to develop institutional and individual plans for use during performance assessment and introduction of performance based contracts at MOH Headquarters, RRHs and Districts. Close collaboration with the Ministry of Public Service will be maintained during the process. In addition, the project will support the scaling up of social accountability mechanisms like the citizens' report cards at community level for health service delivery. Both service users and providers will get an opportunity to provide feedback on the performance of service points and agree on actionable plans to address identified constraints.

131. **Professional Management of Health Facilities.** The Government is planning to professionalize management of hospitals and has requested Uganda Martyrs University to develop a two-year Masters program in hospital management. The project will support the MOH to implement this training program, as well as upgrading programs for staff already in management positions. The Government has agreed to create positions for senior management cadre within the overall hospital establishment, with clearly defined competencies, qualifications, roles and abilities to fill these positions. The project will support the MOH to develop the plan for the transition and finance the actual training program of selected trainee managers. Two options are under consideration. In the first option, all staff holding positions of medical superintendents will take an initial introductory course, followed by a course-work component of the hospital management program offered through distance learning or part-time study. The staff will be given a maximum allowable time to complete the course and those who do not complete mandatory training within the stipulated time would be removed from their positions. In the second option, a select number of potential staff would undergo training on a full-time basis. As such, they will finish their training more quickly. It is anticipated that new candidates appointed to these positions would need to have the necessary management training qualifications. Hence persons without the required qualifications would be disqualified from holding these positions.

132. **Logistics and Supply Chain Management**. Under this subcomponent, the project will: (a) strengthen the capacity of the pharmacy division to coordinate procurement planning, monitor logistics and supply chain management and develop and monitor the performance agreement with the National Medical Stores; (b) review regulations (Public Procurement and Disposal of Assets and Local Government Acts) governing procurement of essential medicines and equipment, suggest relevant recommendations for amendments, and develop appropriate guidelines where necessary; and (c) provide complementary supply chain management support to selected districts including expanding/renovating storage facilities for medical supplies and pharmaceutical in the hospitals undergoing renovation. This support will be conducted in close collaboration with the new USAID-financed program that is also aimed at improving various aspects of supply chain management. Districts will be responsible for designating pharmacy assistants who will be trained in logistics management for medicines. This will ensure that they have the skills needed to coordinate the quantification and ordering of medicines and supplies. In addition, the project will procure distribution vehicles to improve capacity of the National Medical Stores.

133. **Strengthening delivery of health services at the district level.** The Health Subdistrict concept has encountered several challenges and is no longer able to meet its original intended objectives. With the proliferation of districts, most districts no longer have the requisite capacity

needed to manage health services delivery. The MOH is overstretched in its supervisory role and is increasingly relying on regional hospitals to supervise district programs. The project will provide support to review suitability and capacity of the regional hospitals in this regard. In addition, the project will review the viability of the Health Subdistrict concept as well as the administrative and management capacity at district level to support health services delivery. Arising from this, viable options for addressing current problems will be proposed.

134. **Project Management**. This subcomponent will support costs related to the operations and overall management of the project. While the details need to be discussed and agreed, this component will include specific technical assistance in the areas of project management, financial management, procurement, and other areas. Consistent with the LTIA, consultants (in areas such as Quantity Surveying, Architecture, M&E, Procurement, and Accountancy) will work as part of the relevant functional units. The numbers, duration, and duties of these consultants will be defined and elaborated in the project implementation manual. Apart from this, key activities under this subcomponent include: the collection of baseline data, coordination and implementation of the mid-term and end-of-project evaluation of all project components, and annual financial audits.

Component Four: Improved maternal, newborn, and family planning services (US$30 million)

135. **The objective of this component is to improve access to and quality of maternal health, newborn care, and family planning services**. Improved access to family planning services is an important factor in reducing the risk of complications in pregnancy and childbirth, including better birth spacing, delayed pregnancy in young women, and averting maternal deaths. This component will support: (a) expanding and improving quality of maternal health and newborn care, and (b) increasing the availability and demand for family planning services.

136. **Expanding and improving quality of maternal health and newborn care.** This subcomponent will draw on the lessons learned from the WHO supported Making Pregnancy Safer Initiative and the UNFPA supported Rural Extended Services and Care for Ultimate Emergency Relief (RESCUER) Project piloted in Soroti and Iganga districts respectively. It will involve: (a) disseminating maternal and newborn care guidelines and protocols; (b) providing hands-on training and mentorship on EmONC; (c) ensuring the provision of basic and comprehensive EmONC lifesaving procedures and delivery services; (d) augmenting the provision of post-abortion care; (e) strengthening the referral and communication system; and (f) expanding and strengthening maternal and perinatal death reviews.

137. **Maternal health and newborn care guidelines and protocols.** Guidelines and protocols will be adapted to improve and standardize maternal and newborn care. This will include the following: use of partograph, management of second and third stages of labor, neonatal resuscitation, newborn care (including early breastfeeding and Kangaroo Mother Care[59]), managing preterm/low birth weight babies, postnatal care, antibiotic treatment schemes, management of major obstetric complications (antepartum hemorrhage, postpartum hemorrhage,

[59] Technique to encourage new mothers to practice "skin-to-skin" contact with their newborns, especially pre-term babies, like a kangaroo mother keeps her baby in her pouch.

severe pre-eclampsia/eclampsia, sepsis, obstructed labor), post-abortion care, including use of manual vacuum aspiration (MVA) kits, and indications for Cesarean sections. Printed and laminated copies of guidelines and protocols will be disseminated to both public and private health facilities.

138. **Providing hands-on training and mentorship on EmONC.** Midwives, clinical officers, and medical officers will receive appropriate hands-on training based on developed protocols and guidelines. The Reproductive Health Division will determine the modes of training with workshops outside the work places of health personnel reduced to the minimum. UNFPA plans to constitute regional teams (comprising of an obstetrician, a midwife, and a public health nurse) to provide training and mentorship to health personnel at district hospitals and health centers. Given that in the past, commitment of regional teams have been patchy, the Kayunga District hospital currently has an arrangement whereby specialists visit the hospital on specific days of the month (at 140,000 Uganda Shillings, i.e., US$72 per day) to both attend to patients and train staff. This approach is working well, and could be scaled up, and used to supplement the efforts of regional teams. New graduate medical doctors will undergo mentorship prior to being posted to HC IVs to ensure that they can perform Cesarean deliveries, and anesthetist assistants will also be trained to work at Health Center IV.

139. **Provision of basic and comprehensive EmONC lifesaving procedures and delivery services.** Under this subcomponent, an attempt will be made to ensure that health centers and district hospitals are appropriately staffed; in particular, Health Centers should have midwives to perform delivery services and HC IVs should have medical officers who can perform Cesarean deliveries. Based on the maternal and neonatal assessment which will be conducted prior to project implementation, health facilities will be designated as Basic or Comprehensive EmONC. Considering that only 16 percent of Health Centers IV have surgical theatres, not all Health Centers IV will be able to provide comprehensive EmONC as expected. Major EmONC equipment and supplies (such as autoclave and general anesthetic equipment) and minor equipments (such as manual vacuum aspiration (MVA) kits) will be procured, an equipment maintenance plan developed, and training in equipment use provided under Components 2 and 3. Further, blood transfusion services will be strengthened to curb maternal deaths due to hemorrhage (antepartum, postpartum or abortion complications).

140. **Augmenting the provision of post-abortion care.** Post-abortion care (treatment of abortion complications with manual vacuum aspiration, post-abortion family planning counseling, and appropriate referral where necessary) deserves special attention since it requires both emergency care and family planning. Nearly 300,000 induced abortions are performed annually, with about 85,000 resulting in complications which require treatment. Medical doctors and midwives will be trained in the use of the MVA for managing abortion complications and MVA kits will be procured for use in HC IVs and hospitals.

141. **Strengthening the referral and communication system**. The referral system will be strengthened so that obstetric complications can be treated promptly and properly. This will involve a multipronged approach. Firstly, referral forms, protocols, and guidelines will be developed and disseminated to health facilities. Second, ambulances with basic resuscitation equipment (ambu bag, IV fluids and giving sets, oxygen cylinder, drugs, gloves, and cotton wool

equipments) will be procured under Component 1 of the project. Boat ambulance will be procured for the Kalangala district, which is made up of several islands. Additionally, bicycle, motorcycle, or tricycle ambulances will be procured and placed in hard to reach communities to increase utilization of maternal and neonatal services. Third, there will be a strong focus on IEC, as a means to further increase the utilization of services. Specifically, community-based health workers will register pregnant women in underserved and hard to reach communities, explain the benefits of giving birth with the assistance of skilled health personnel, and encourage pregnant women to deliver in health facilities.

142. **Expanding and strengthening maternal and perinatal death reviews.** Health Facility Maternal and Perinatal Death Auditing Committees have been established in about 20 hospitals to audit the reasons for deaths and to take steps to prevent similar deaths in these health facilities. The coverage of these reviews and recommendations of the committees are not always duly implemented. The project will support establishment of committees at all general hospitals.

143. **Increasing the availability and demand for family planning services.** This subcomponent will expand the provision of family planning services at the existing health facilities and in the communities. It will involve: (a) expanding and improving the quality of facility-based family planning services; (2) expanding the provision of long-term and permanent methods through NGOs; (c) providing community-based distribution of family planning services; and (d) generating demand for services.

144. **Expanding and improving the quality of facility-based family planning services.** Family planning protocols will be updated and disseminated to both public and private service providers. Family planning nurses will be provided with hands-on training on, *inter alia*, the insertion and removal of implants and IUDs and counseling so that clients can be provided with the information needed to make informed choices. The ongoing integration of family planning, ANC, postnatal care, and Preventing Mother-To-Child-Transmission of HIV (PMTCT) services will be augmented to increase the number of family planning clients. All pregnant women seeking ANC and PMTCT services will be offered individual family planning counseling and follow-up postnatal care. Further, pregnant women who want to undergo sterilization will be identified, and counseled so that the procedure can be performed immediately after delivery. This subcomponent will also support the 2009-2014 Uganda Reproductive Health Commodity Security Strategic Plan to ensure the continuous availability of the full range of contraceptives. Since the Government expects to increasingly provide more funding for contraceptives, this project will initially fill any annual funding gaps, as the Government gradually absorbs the cost of procuring contraceptives.

145. **Expanding the provision of long-term and permanent methods through NGOs.** Currently, NGOs such as Marie Stopes International - Uganda (MSIU), Programme for Accessible Health, Communication and Education (PACE), and Reproductive Health Uganda (RHU) have an arrangement with the Government to provide long-term and permanent methods (LTPM) at rural public facilities. The Government provides the contraceptives, while the NGOs use their own equipment and staff to provide LTPM services at public facilities. The main limitation in expanding LTPM is inadequate quantities of IUDs and implants. Cognizant of this, the project will procure additional IUDs and implants. Further, to make LTPM more accessible

at the public facilities, the MOH will partner with these NGOs to provide hands-on training to nurses and clinical officers (for IUD and implant insertion and removal) and to medical doctors at the HC IV facilities and hospitals (to perform female sterilization). In addition to this, family planning equipment will be procured for the public health facilities. This will include mini-laparatomy kits (for female sterilization), vasectomy kits, implant insertion and removal kits, and IUD insertion kits.

146. **To complement the facility-based services, community-based distribution of family planning services will be expanded to hard to reach and underserved communities**. Each selected health facility will identify and register community-based health workers who can provide outreach services in the communities. These community-based health workers (who could be a select group of the existing village health teams) will perform the following activities: individual family planning counseling so that clients can make informed choices; home delivery of condoms and pills; referral to the nearest family planning clinic (public or private) for LTPM; and follow-up of clients using injectable contraceptives, implants, or IUDs who have failed to go to the health facility for follow-up. Midwives at the health facilities will provide supportive supervision to the community-based health workers who are mapped to their respective facilities. The supervising midwife as well as the community-based health workers will be provided incentives contingent on: maintaining accurate and complete records signed or fingerprinted informed consent forms for LTPM, and the number of clients served.[60]

147. **Generating demand for services.** Appropriate and effective IEC and BCC materials will be developed and disseminated to both generate demand for family planning services, and dispel myths. The electronic and print media will be used to provide information on family planning services, including the available range of methods, and information on key RH issues such as the menstrual and ovulation cycle (only 16 percent of women, for example, know that the mid-menstrual cycle is the fertile period). In addition to this, community leaders and Village Health Teams (VHT) will also be encouraged to promote family planning delivery services and newborn care. IEC materials on RH, for example, have already been incorporated in the VHT handbook. This will be widely disseminated.

[60] The Government is still considering the kind of incentives that will be given to village health teams.

Annex 5: Project Costs

UGANDA: Uganda Health Systems Strengthening Project

Table A5-1: IDA Financing Table by Category (US$ million)

	Total Including Contingencies			
	IDA	Gov't	Total	Percent
Civil Works	57.32	12.59	69.91	48.5%
Goods	48.40	1.43	49.83	34.5%
TA	9.93		9.93	6.9%
Training	9.18		9.18	6.4%
Operating	5.17	0.29	5.46	3.8%
Grants				
Project Total	130.00	14.31	144.31	100.0%

Table A5-2: IDA Financing Table by Component (US$ million)

	Base Cost		
	IDA	Gov't	Total
1. Strengthen Human Resource Development and Management	4.87	0.04	4.91
2. Enhance Physical Functionality of Health Facilities	74.06	11.52	85.59
3. Strengthen Leadership and Management Systems	10.23	0.63	10.86
4. Reproductive Health	30.00		30.00
Total Base Cost	119.16	12.20	131.36
Physical Contingencies	4.82	1.06	5.87
Price Contingencies	6.02	1.06	7.08
Total Project Cost	130.00	14.31	144.31

Table A5-3: Foreign Exchange (US$ million)

	Local	Foreign	Total
1. Strengthen Human Resource Development and Management	4.52	0.39	4.91
2. Enhance Physical Functionality of Health Facilities	69.24	16.34	85.59
3. Strengthen Leadership and Management Systems	9.20	1.66	10.86
4. Reproductive Health	10.16	19.84	30.00
Total Baseline Costs	93.12	38.24	131.36
Physical Contingencies	5.87	0.00	5.87
Price Contingencies	6.10	0.98	7.08
Total Project Costs	105.09	39.22	144.31

Table A5-4: UHSSP Project Costs by Subcomponent (US$ million)

	Total Including Contingencies		
	IDA	Gov't	Total
1. Strengthen Human Resource Development and Management			
1.1 Consolidate central level HRH functions	1.70	0.04	1.74
1.2 Strengthening human resource management functions	0.74		0.74
1.3 Improve Staff Retention in Remote and Hard-to-Reach Areas	1.47		1.47
1.4 Strengthen Pre-service and in-service training of health workers	0.96		0.96
Component Total	4.87	0.04	4.91
2. Enhance Physical Functionality of Health Facilities			
2.1 Renovation of Selected Health Facilities	63.33	12.59	75.91
2.2 Provision of Medical Equipment	16.72		16.72
2.3 Improved Operations and Maintenance	0.19		0.19
2.4 Strengthen the referral system	4.66	1.05	5.71
2.5 Human Resource Related Issues			
Component Total	84.90	13.64	98.54
3. Strengthen Leadership and Management Systems			
3.1 Performance Based Management Approaches	1.19		1.19
3.2 Hospital Policy Framework	0.35		0.35
3.3 Professional Management of Health Facilities	1.17		1.17
3.4 Logistics and Supply Chain Management	3.86	0.21	4.07
3.5 Strengthen Delivery of Health Services at the District Level	0.21		0.21
3.6 Project Management	3.46	0.43	3.88
Component Total	10.23	0.63	10.86
4. Reproductive Health			
4.1 Expanding and improving quality of maternal and newborn care	9.65		9.65
4.2 Family Planning	20.35		20.35
Component Total	30.00		30.00
Total Costs	130.00	14.31	144.31

[1]Identifiable taxes and duties are US$ 14.3 million, and the total project cost, net of taxes, is US$130 million. Therefore, the share of project cost, net of taxes, is 9.9 percent.

Annex 6: Implementation Arrangements

UGANDA: Uganda Health Systems Strengthening Project

148. **The project will be implemented under the newly created framework for the management of the development partner projects, the Long-Term Institutional Arrangements (LTIA).** The LTIA describes processes and measures to align and mainstream programming and management of development partner projects to national processes and systems, thus ensuring coordination and sustainability of programs. The LTIA is consistent with the PEAP Partnership principles (2001) and Paris Declaration on harmonization and alignment of development partner support. A manual has been developed and endorsed by the partners. It describes principles on: (a) financing mechanisms; (b) planning and budgeting; (c) coordination at central, sector, and district levels; (d) program implementation, procurement, and financial management; and (e) program monitoring and evaluation.

149. **This project will be among the first to use the LTIA framework.** As the MOH mainstreams its various projects, there will inevitably be initial implementation problems. But by signing onto the LTIA, the World Bank, alongside other development partners will work together to assist GOU establish a system that will ensure effective capacity to program development assistance for health. It is acknowledged that specific interventions will be necessary to strengthen capacity within the LTIA in the short medium and long term.

150. ***Guiding Principles***. The following principles shall be the guiding principles for project implementation consistent with the mainstreaming strategy adopted by Government:

(a) The use of the Government structures and systems for project implementation;
(b) The project components will be assigned and managed by the relevant departments and/or divisions in the MOH;
(c) The project components will be supervised by component coordinators who shall be heads of departments or divisions whose departmental/divisional mandates are consistent with component activities;
(d) Where there are capacity gaps, the ministry will recruit TAs to assist the staff within the ministry. Such TAs would mentor and train the staff he/she has been attached to. The TA shall report to the relevant heads of department/division;

151. **The MOH will have overall responsibility for implementation, accounting for project funds and for coordinating project activities.** The PS of the MOH will serve as the "Accounting Officer" for the project, assuming overall responsibility for the execution of the project and ensuring that project resources are used for their intended purposes and accounted for. For proper coordination of execution of the project, the Permanent Secretary, MOH shall appoint a Project Coordinator whose position shall not be below that of a head of department in the MOH to provide overall coordination of project activities. The project coordinator will be supported by Component Coordinators, who are heads of departments/divisions directly involved in project implementation, and together with other relevant officials will constitute a Project Secretariat. The departments/divisions include: Health Infrastructure, Human Resources for Health, Reproductive Health, Curative and Clinical services, Quality Assurance, Procurement

and Finance. The component coordinators may appoint focal persons to manage specific project subcomponent activities in their relevant departments/divisions.

152. **Coordination of policy issues arising from the implementation of this project will be through the respective existing Technical Working Groups and respective departments/divisions for onward submission to Senior Management Committee of the MOH**. It will be the responsibility of the Project Coordinator to provide periodic reports to the Senior Management and Top Management Committees as well as the Health Policy Advisory Committee (HPAC), where partners and Government meet together. This arrangement will ensure coordination and harmonization of policy proposals and decisions which affect the implementation of the project specifically and the health sector generally. The project secretariat will be responsible for coordinating day-to-day implementation of the project, timely project reporting, fiduciary matters, and project monitoring and evaluation.

153. **Technical advisors/specialists will be provided under the project**. They will assist with capacity building and other project implementation activities, *inter alia*, Financial Management (Accountant), Procurement (Procurement Specialists); Monitoring and Evaluation (M&E Specialist); Human Resources for Health (HRH Policy Advisor and HRH Management System Strengthening Advisor); Health Infrastructure (Quantity Surveyor and Architect); and Reproductive Health (RH Advisors). The Project Coordinator will also be supported by a project officer. The consultants recruited under the project will be accountable and report to the respective heads of departments or divisions to which they are assigned.

154. **To ensure effectiveness of the project's institutional arrangements and smooth flow of communication between the Bank and Government, the following were agreed upon**:

(a) All official communication to the Bank on the project shall be under signature of the PS, MOH;
(b) All project decisions shall be made by the ministry through the PS, MOH, with advice from the project coordinator and component coordinators;
(c) Renewals of TAs contract shall be based on satisfactory performance assessment carried by the ministry and agreed upon between the ministry and the Bank; and
(d) Senior and top management of the ministry will be briefed by the project coordinator from time to time regarding the progress of project implementation to ensure transparency and ownership of project by ministry management.

155. **Project terms of reference.** The terms of reference for the key main positions in the project are included below. The terms of reference for the project secretariat, focal persons, and the job descriptions for the various consultants are elaborated in detail in the project implementation manual. Implementation arrangements regarding Financial Management, Procurement, and Monitoring and Evaluation are described in the respective Annexes.

156. **Permanent Secretary.** In addition to the normal duties of the PS, under the project the main functions of the PS will include:

(a) Main interlocutor between the Bank and Government on the project;
(b) Overall accounting officer, therefore answerable to Parliament and Bank on the project;

(c) Principal signatory to the project account;
(d) Responsible for all official communications to the Bank regarding the project;
(e) Providing policy guidance to the project within the context of the overall Health Sector Strategic Plan.

157. **Project Coordinator.** The project coordinator will:

(a) Be responsible for the successful implementation of the project and achievement of its objectives;
(b) Work closely with component coordinators to ensure timely implementation of component activities;
(c) Brief PS, MOH on project implementation and draw his/her attention to policy issues which might require attention at higher levels;
(d) Brief senior and top management on project implementation progress and emerging issues;
(e) Responsible for collation and production of timely reports as required by the Bank for submission to the Bank under signature of the Permanent Secretary, MOH;
(f) Liaise with other projects/programs within the health sector to ensure synergy and coordination;
(g) Review work plans from component coordinators and ensure that they are consistent with the project document and objectives;
(h) Review all requisitions for payments from component coordinators to ensure that all the necessary supporting documents are attached and then communicating to the PS, MOH to that effect, confirming with a loose minute that the payment is for activities within the project;
(i) Counter-sign vouchers and second signatory to project account;
(j) Holds regular project management meetings with component coordinators and project staff to review implementation progress, work plans, and budget;
(k) Liaise with the relevant departments of the ministry to ensure that the project is adequately budgeted for in the MTEF and the ministry budget;
(l) Reports to the PS, MOH;

158. **Component Coordinators.** The component coordinators will be responsible for:

(a) Day to day implementation of the project component;
(b) Preparation of the component work plan, budget and progress report;
(c) Initiation of all component activities;
(d) Preparation of Terms of Reference and specifications of tasks to be contracted under the component;
(e) Evaluations of technical proposal submitted from consultants/contractors for tasks to be performed under his/her component;
(f) Certification of works/services/goods provided under his/her components before payments can be made;
(g) Briefing the project coordinator and senior management about progress of implementation of the component activities;
(h) Keeping track of the component outputs and contribution to the KPI and PDO;

(i) Holding regular component coordination meetings with relevant component staff;
(j) Reports to the project coordinator.

Annex 7: Financial Management and Disbursement Arrangements

UGANDA: Uganda Health Systems Strengthening Project

Summary of Financial Management Assessment

159. The Bank undertook a financial management capacity assessment of the MOH in accordance with the Bank's Operation Policy/Bank Procedures 10.02 with respect to financial management, and the Financial Management Practices Manual issued by the Financial Management Sector Board on November 3, 2005.

160. The project's financial management transactions will be mainstreamed within the MOH with the Permanent Secretary as the overall accounting officer. Daily operations will be handled by the Accounting Department headed by an Assistant Commissioner. Due to the already existing work load, additional accounting staff will be recruited under the project. The GOU accounting policies and procedures documented in the Government's Treasury Accounting Instructions 2003, issued under the Public Finance and Accountability Act 2003, will be used for the project supplemented with additional guidance on Bank project requirements on external auditing and financial reporting as documented in the Financing Agreement. Fiduciary oversight will be provided through semi-annual internal audit reporting, Value-for-Money audits by the Auditor General and annual financial audits of the project accounts. The accounts will be handled using Navision accounting software pending configuration of the Integrated Financial Management Information Systems (IFMIS) to handle preparation of project accounts. The ministry has adequate internal audit arrangements and the internal auditors within the ministry will include the project activities in their work plan. The project's financial statements will be audited by the Auditor General in accordance with statutory requirements, and suitable Terms of Reference will be developed.

161. The results of the assessment indicate that the Financial Management overall risk rating for the project is **Substantial** after mitigating measures. Appropriate mitigating measures have been identified and incorporated into the project design. In conclusion, the proposed financial management arrangements put in place by the Program meet the Bank's minimum requirements for project financial management as per OP/BP 10/02 and therefore are adequate to provide, with reasonable assurance, accurate and timely information on the status of the project required by IDA.

Country issues

162. The Public Expenditure and Financial Accountability (PEFA) Report of November 2008 issued in June 2009 and the Country Financial Accountability Assessments (CFAA) of 2004 and 2008 show that GOU has made substantial progress in improving its Public Financial Management Systems but risks remain in terms of (a) quality and timeliness of in-year budget reports since budget reports only include information on budget releases and not actual expenditures; (b) stock and monitoring of expenditure payment arrears; (c) effectiveness of internal audit; (d) oversight of aggregate fiscal risk from other public sector entities; (e) effectiveness of measures for taxpayer registration and tax assessment; (f) legislative scrutiny of external audit reports; (g) effectiveness of payroll controls; and (h) effectiveness in collection of

tax payments. The GOU has prepared a Financial Management Accountability Program (FINMAP) to address the weaknesses in its Public Financial Management system. The FINMAP is supported by a number of development partners (Public Financial Management Development Partner Group) including the World Bank under the Local Government Management Service Delivery Project (LGMSD).

Risk Assessment and Mitigation

163. The objectives of the project's financial management system are to (a) ensure that funds are used only for their intended purposes in an efficient and economical way; (b) ensure that funds are properly managed and flow smoothly, adequately, regularly, and predictably in order to meet the objectives of the project; (c) enable the preparation of accurate and timely financial reports; and (d) enable project management to monitor the efficient implementation of the project; and to safeguard the project assets and resources. Furthermore, a strong financial management system should include the following necessary features: (a) adequate number and mix of skilled and experienced staff; (b) robust internal control system able to support orderly and efficient payments and procurement processes, and ensure proper recording and safeguarding of assets and resources; (c) an accounting system that can support the project's requests for funding and meet its reporting obligations to fund suppliers, contractors and other providers including the GOU, IDA, other development partners, and local communities; (d) a system capable of providing financial data to measure project performance; and (e) an independent, qualified auditor be appointed to review the Project's financial statements and internal controls.

164. The table below identifies the key risks that the project management may face in achieving these objectives and provides a basis for determining how management should address these risks.

Table A7-1: Financial Management Risks and Mitigation Measures

Risk	Risk Rating	Risk Mitigation measures incorporated into project design	Risk after Mitigation
Inherent Risk			
Country level: The 2008 PEFA reported weaknesses in Government PFM systems, i.e., weak enforcement of procurement and payroll rules and procedures.	**Substantial**	A Government led PFM Reform Program is under implementation which addresses issues of procurement and its related enforcement. Payroll and Pension reforms are being addressed through the UPSPEP program under Ministry of Public Service.	**Moderate**
Entity level: Annual statutory audits have highlighted various internal weaknesses of accountability, delayed payments to contractors resulting into penalties, un	**High**	An agreement has been reached to recruit staff where gaps have been observed. Professional and experienced staff in finance, accounting and procurement will be hired on contract for project implementation. The use of Direct payments to suppliers and contractors will be emphasized to avoid payment delays.	**Substantial**

Risk	Risk Rating	Risk Mitigation measures incorporated into project design	Risk after Mitigation
funded commitments and flawed procurement rules and procedures.			
Project level: Multiple construction sites involved and transactions controlled centrally at MOH. Inability to use funds efficiently and economically for purposes intended.	**High**	In-depth semiannual internal audit reviews will be carried out by the Inspectorate & Internal Audit department of MOFPED to provide independent internal verification of the transparency and soundness of key financial management tasks under the project, including procurement procedures, processing of payments and preparation of financial reports for Bank review. The Auditor General will conduct two Value-For-Money audits over the project duration to assess effectiveness and efficiency in the utilization of Credit proceeds. Fiduciary aspects of the project will be embedded with monitoring and evaluation so that there is a linkage between outputs that contribute to indicators and resources. Further, there shall be enhanced accounting and reporting given the proposed contract staff hired by the ministry. Independent external auditors shall be engaged to conduct annual audits. A detailed and comprehensive annual work plan and budget will be developed and shall be strictly followed to help monitor the rehabilitation and construction of selected hospitals and Health Centers (HCs).	**Substantial**
Overall inherent risk			**Substantial**
Control risk			
Budgeting: Some project elements may be estimated below cost due to frequent price escalations.	**Moderate**	Project budget plans to be prepared in sufficient detail which will be used as a management tool and the PPF advance has been requested with sufficient consultancy costs to ensure initial procurement process is done in advance before effectiveness. This will mitigate on cost estimates. The IFRs to be prepared will be used to monitor variance analysis with budget.	**Low**
Accounting and Information System. Inability for the Ministry to manage the Project Accounts with sound systems, which will slow down the project activities.	**Substantial**	The Assistant Commissioner (Accounts) & Senior Accountants in the ministry are qualified and experienced in Bank funded projects. They will oversee and be responsible for the outputs of the contracted staff. The ministry installed Navision Accounting system to process project accounting. The ministry will require renewing the license and uploading the latest version of the package for utilization by the project.	**Moderate**
Staffing at MOH may be	**Moderate**	MOH has agreed to hire a few technical staff to	**Low**

Risk	Risk Rating	Risk Mitigation measures incorporated into project design	Risk after Mitigation
stretched to implement the requisite control procedures as intended such as accounting and internal controls		complement their available personnel to efficiently implement the project. Finance, Accounting and Procurement are the critical areas to be focused on.	
Fund release and usage: especially delays in effecting payments to suppliers and contractors, funds for the project may not be used in an efficient and economical way and exclusively for purposes intended.	**Substantial**	The method of Direct Payments will be actively used other than DA replenishments. Major suppliers and contractors Communities will be paid directly through withdrawal application instructions to the Disbursing office. The agreed periodic internal audit reviews will ensure that payments are made for work done and where such payments have been made for no work done, appropriate measures will be taken for refund. Strictly adhere to the approved budget of the project will be observed.	**Moderate**
Internal control: Risk of influence peddling leading to contractors inflating prices for goods and civil works.	**High**	The Ministry PDU together with the ongoing internal audit reviews will play a leading role in mitigating this risk. The Internal Audit department will incorporate the project in their annual work plans with regular internal control reviews. Other Government law enforcement offices would be informed in case need arises.	**Substantial**
Reporting and Monitoring: financial information may be unreliable and submitted late.	**Moderate**	The experienced Principal & Senior Accountants at the ministry will primarily be responsible for financial reporting working together with technical staff contracted. The project will initially report through Statement of Expenditures (SOE) until such a time when they will have built sufficient capacity to use Report based IFRs.	**Low**
External Audit	**Moderate**	The Auditor General is primarily responsible for auditing all Government programs and projects. He may subcontract CPA firms, with the final report issued by the Auditor General with the ToR satisfactory to IDA.	**Low**
Overall control risk			**Moderate**
Overall Project Risk Rating			**Substantial**

H – High S – Substantial M – Modest L – Low

Strength and Weaknesses of the Management Unit

165. The assessment noted the following salient features as **strengths** for project financial management: (a) accounting policies and procedures will be based on the Treasury Accounting Instructions 2003, issued under the Public Finance & Accountability Act 2003; (b) qualified and experienced accounting personnel within the ministry; (c) adequate arrangements for budgeting

and for external and internal auditing; (d) adequate funds flow arrangements; and (e) while the IFMIS, which is the computerized accounting system for the ministry is not configured to be used for projects, the project's accounts will be prepared using an appropriate accounting package already in place.

166. The assessment identified salient **weaknesses** which would affect project financial management. Although experienced staff exist, they are not adequate for the purposes of this project financial management given they have to support other projects and continue with their routine work. The Auditor General's audit reports for 30 June 2006, 2007, and 2008 for the MOH identified accountability issues, which require the implementing entity to improve on its internal control systems. In order to mitigate this risk, the funds for this project will be ring fenced within the ministry and their use will be closely monitored by the Accounting Officer, Internal Audit Department of the MOFPED, Auditor General's Office and the Bank to ensure they are used for the purposes intended.

Institutional and Implementation Arrangements

167. There will be no Project Coordination Unit (PCU). The MOH shall coordinate project implementation and manage: (a) procurement, including purchases of goods, works, and consulting services; (b) project monitoring, reporting and evaluation; (c) contractual relationships with IDA and other Cofinanciers; and (d) financial management and record keeping, accounts and disbursements. The ministry will also constitute the operational link to the IDA and GOU on matters related to the implementation of the project. The MOH will manage the project as an autonomous project with a separate bank account and books of accounts. Finances and other resources realized for the activities of the project shall not be used to cater for other functions other than those budgeted for. The Permanent Secretary (PS) MOH will be the "Accounting Officer" for the project, assuming overall responsibility for accounting for the project funds.

Budgeting, Accounting and Staffing Arrangements

168. Government planning and budgeting procedures which are documented in the Government's Treasury Accounting Instructions 2003 are adequate and will be followed. There is a planning unit and a budget officer that is responsible for the budgeting process in the ministry. All other departments are involved in the budgeting process.

169. **Books of Accounts and List of Accounting Codes.** The ministry will maintain similar books of accounts to those for other IDA funded projects. A list of accounts codes (Chart of Accounts) for the project should be drawn upon finalization of the accounting computerization process. This should match with the classification of expenditures and sources and application of funds indicated in the Financing Agreement.

170. **Staffing Arrangements.** The MOH is staffed with qualified and experienced accounting personnel, but due to excess work load, the project's accounts will be prepared by a designated contract staff who will report to the Senior or Principal Accountant who in turn will report to the Assistant Commissioner and ultimately to the Permanent Secretary. The designated accountant

will be assisted by an accounts assistant. Otherwise the MOH has one Senior Accountant, several Accountants and accounts assistants. In order to ensure that the project is effectively implemented and funds put to their intended use recruitment of the project accountant will be a condition of effectiveness for this project.

171. **Information system.** The ministry is connected to the Integrated Financial Management System (IFMIS) but the Ministry will prepare the accounts for the project using its Navision Accounting software. The team in Ministry is conversant with preparing the accounts using this accounting software.

Internal Control and Internal Auditing

172. **Internal Controls and Financial Management Manual.** The existing Financial Management Manual in the Ministry is the Government's Treasury Accounting Instructions 2003 issued under the Public Finance and Accountability Act 2003. These procedures, however, fall short of project requirements on external auditing and financial reporting which will be documented in the Financing Agreement. Thus a section in the Project Implementation Manual (PIM) on Financial Management will describe the accounting system, i.e., major transaction cycles of the project.

173. **Internal Audit.** The ministry has qualified and experienced internal auditors, i.e., a Senior Internal Auditor and an Internal Auditor. The internal audit unit issues out reports on a quarterly basis based on their review of the internal control system of the ministry agreed to incorporate the Uganda Health Systems Strengthening Project into their internal audit work plan. The qualification and experience of the staff in the unit is adequate and their quality assurance is monitored by the MOFPED under the Commissioner Internal Audit. In this regard, the internal audit arrangements at the ministry are adequate.

Banking & Funds Flow Arrangements

174. The following bank accounts will be authorized by the MOFPED and maintained by the Ministry for purposes of implementing the project:

(a) **Designated Account (DA):** Denominated in US dollars where disbursements from the IDA will be deposited.
(b) **Project Account:** This will be denominated in local currency. Transfers from the Designated Account (for payment of transactions in local currency) will be deposited into account in accordance with project objectives.

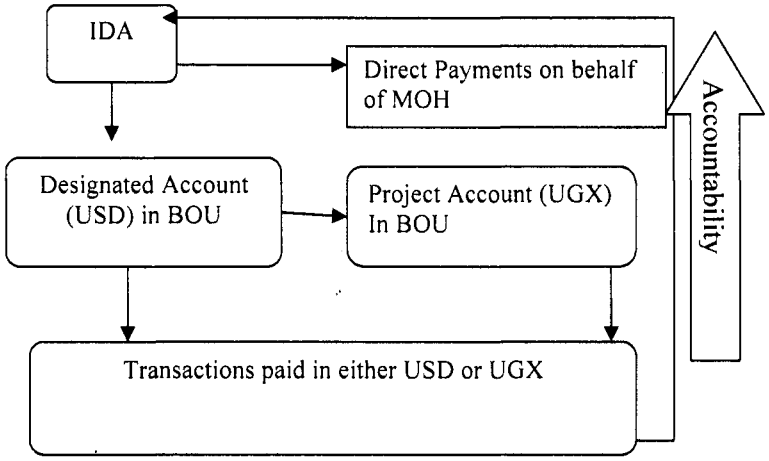
175. These bank accounts shall be opened at Bank of Uganda in accordance with the Financing Agreement. The signatories for the project accounts will be in accordance with the Treasury Accounting Instructions/ Public Finance and Accountability Act 2003.

176. **Disbursement Arrangements**. The MOH will receive disbursements into the Designated Account based on quarterly Interim Financial Reports (IFRs). Initial cash flow forecasts upon which the advance disbursement will be made from the IDA Credit should be prepared within

one month after the date of effectiveness. A duly authorized Withdrawal Application for the additional cash replenishment required into the Designated Account will be provided along with the IFRs. The withdrawal requests and IFRs should be submitted to the Bank within 45 days after the end of the quarterly calendar periods. The cash flow projections will be supported by work plans and procurement plans.

177. If ineligible expenditures are found to have been made from the Designated Account, the Borrower will be obligated to refund the same. If the Designated Account remains inactive for more than six months, the Borrower may be requested to refund to IDA amounts advanced to the Designated Account. IDA will have the right, as reflected in the Financing Agreement, to suspend disbursement of the Funds if reporting requirements are not complied with.

Figure A7-1. FUNDS FLOW CHART



Financial Reporting Arrangements

178. As per World Bank guidelines, the project will issue quarterly interim financial reports (IFRs) within 45 days after the end of each calendar quarter, which are designed to provide quality and timely information to the project management, MOH, the Bank and various stakeholders monitoring project performance and will be composed of the following:

(a) A statement of Sources and Uses of Funds for the reported quarter and cumulative period (from project inception) reconciled to opening and closing bank balances; and
(b) A statement of uses of funds (expenditure) by project activity/component comparing actual expenditure against the budget, with explanations for significant variances for both the quarter and cumulative period.
(c) In addition to the above reports, the Ministry will submit to the Bank the following information in order to support report-based disbursement, when systems are deemed satisfactory:

(i) Designated Account (DA) Activity Statement;
(ii) DA Bank Statements;

(iii)Summary Statement of DA Expenditures for Contracts subject to Prior Review;
(iv)Summary Statement of DA Expenditures for Contracts not subject to Prior Review.

179. The annual **financial statements** should be prepared in accordance with International Public Sector Accounting Standards (which *inter alia* includes the application of the cash basis of recognition of transactions) for external audit. The IDA Financing Agreement will require the submission of audited financial statements to the Bank within six months after the financial year end.

External Auditing Arrangements

180. The Auditor General is primarily responsible for the auditing of all Government projects. Usually, the audit may be subcontracted to a firm of private auditors, with the final report being issued by the Auditor General and submitted to the Bank within **six** months after the end of each GOU financial year, i.e., by 31 December. The private firms to be subcontracted should be acceptable to the Bank. In case the audit is subcontracted to a firm of private auditors, IDA funding may be used to pay the cost of the audit. The audits are done in accordance with International Standards on Auditing. Appropriate terms of reference for the external auditor should be developed by the Ministry and agreed with the Bank's Country Financial Management Specialist.

Financial Management Action Plan

181. The action plan below indicates the actions to be taken for the project to strengthen its financial management system and the dates that they are due to be completed by.

Table A7-2: Financial Management Action Plan

	Action	Date Due	Responsibility
1.	Production of formats of unaudited interim financial reports (IFRs) that will be used for the project and reaching agreement on them with IDA.	Agreed at PPF approval.	MOH and IDA
2	Recruitment of Project Accountant.	Before Effectiveness	MOH
3	Development of work plans and terms of reference for internal audits and Value-for-Money audits[61].	Not more than 6 month after effectiveness	MOH
4.	Improve on MOH internal control systems to ensure that the project's funds are used for purposes intended.	To be done during implementation.	MOH, Internal Audit Dept., Auditor General's Office and IDA

[61] A Department has been established in the Office of the Auditor General to conduct value-for-money audits. Generic ToRs already in existence will be adapted to the project.

Effectiveness Conditions and Financial Covenants

Effectiveness Conditions

182. The Recipient has recruited an Accountant.

183. Financial covenants are the standard ones as stated in the Financing Agreement Schedule 2, Section II (B) on Financial Management, Financial Reports and Audits and Section 4.09 of the General Conditions.

Supervision Plan and Conclusion

184. Supervision missions will be conducted at least twice every year based on the risk assessment of the project.

185. A description of the Ministry's financial management arrangements above assesses the mitigated financial management risk as **Substantial** which satisfies the Bank's minimum requirements under OP/BP10.02 with some improvements to be effected to the system to be adequate to provide, with reasonable assurance, accurate and timely accounts/information on the status of the Project as required by the Bank. The recommended improvements are detailed in the risk table and the Financial Management Action Plan above.

Annex 8: Procurement Arrangements

UGANDA: Uganda Health Systems Strengthening Project

A. Background

186. Procurement activities for the proposed project will be implemented by the MOH.

Applicable Guidelines

187. Procurement for the proposed project would be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits," dated May 2004, revised October 2006, and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers," dated May 2004, revised October 2006, and the provisions stipulated in the Legal Agreement. The various items under different expenditure categories are described in the Procurement Plan below. The procurement entities as well as contractors, suppliers, and consultants will observe the highest standard of ethics during procurement and execution of contracts financed under this project. The project will carry out implementation in accordance with the "Guidelines on preventing and combating Fraud and Corruption in projects financed by IBRD Loans and IDA Grants" dated October 15, 2006 (the Anti-Corruption Guidelines).

B. Applicable Procedures

Use of National Procurement System

188. Procurement in Uganda is governed by the Public Procurement and Disposal of Public Assets Act of 2003. The procedures in the PPDA act have been reviewed by the Bank and found to be acceptable, subject to the following exceptions which will not be applicable under this project:

(a) Negotiations with the best evaluated bidder. This practice is not appropriate, except for consulting services, contracts, and for goods and works under exceptional circumstances, and for contracts procured through direct contracting.
(b) The merit point system for bid evaluation. This shall not be applied for goods and works contracts procured on basis of competition (ICB, NCB or restricted tender).
(c) Prequalifying bidders and then inviting only a few on a rotational basis. For shopping procedures, the Procuring and Disposal Entity (PDE) will not be allowed to prequalify suppliers on an annual basis and invite only a few on a rotational basis. Where prequalification is conducted, all prequalified providers will be invited to submit bids. Common supplies like stationery and consumables will be aggregated and procured annually through framework contracts to enable implementing agencies to place orders for urgently needed supplies at short notice, at a competitive price.
(d) Application of Domestic Preference under NCB. Domestic Preference shall only be applied under ICB.
(e) Use of microprocurement. Microprocurement as defined in the PPDA Act will only apply for contracts estimated to cost the equivalent of US$150 or less.

(f) Selection of Consultants: The procedures for Selection of Consultants shall not apply as they treat the selection of Consultants like the procurement of goods and works. Only the Bank's guidelines shall apply for selection of all Consultants under the project.

189. Under the proposed project, procurement under ICB and selection of consultants using QCBS shall also (in addition to the World Bank guidelines) comply with the national approval system except where the two conflict when the World Bank guidelines will take precedence. Specifically, the Contracts Committees shall perform their oversight functions at each of the key procurement stages and contracts shall be subjected to the Solicitor General's clearance where applicable. Shopping shall follow the RFQ procedures as defined in the PPDA Act and attendant regulations with the exception of the rotation of bidders as indicated above. These procedures have been reviewed by the Bank and found to be satisfactory. In addition, no negotiations shall take place with respect to a quotation submitted by the supplier or contractor under shopping.

C. Solicitation Documents to be used

190. **Goods and Works.** The Bank's Standard Bidding Documents and Standard Form of Evaluation will be used for procurement of all contracts under International Competitive Bidding (ICB), and may also be used for procurement under National Competitive Bidding (NCB) with appropriate modifications. Alternatively, for NCB the standard tender documents for procurements of Supplies, Works and Non-Consultancy Services prepared and issued by the Public Procurement and Disposal of Assets Authority (PPDA) may be used subject to modifications to be agreed with the Bank for the SBDs for goods and works, such as the following:

(a) Only the "Technical Compliance Selection methodology" (award to the lowest evaluated responsive bidder) as defined in the Act shall be adopted. The rest of the methodologies shall not be used, even for NCB, for the procurement of goods, works and nonconsulting services.

(b) The following documentation or their equivalent shall not be treated as eligibility requirements: (i) tax clearance certificates; (ii) VAT registration certificates; and (iii) trading licenses. These may however be included as post qualification requirements, on which clarification/additional information can be sought during the evaluation.

(c) In accordance with para.1.14 (e) of the Procurement Guidelines each bidding document and contract financed out of the proceeds of the Financing shall provide that: (i) the bidders, suppliers, contractors, and subcontractors shall permit the Association, at its request, to inspect their accounts and records relating to the bid submission and performance of the contract, and to have said accounts and records audited by auditors appointed by the Association; and (ii) the deliberate and material violation by the bidder, supplier, contractor, or subcontractor, of such provision may amount to an obstructive practice as defined in paragraphs 1.14(a)(v) of the Procurement Guidelines.

191. **Consulting Services.** The Bank's Standard Request for Proposal document will be used in the selection of consulting firms. The PPDA procedures for selection of Consultants including bidding documents, evaluation forms, etc., shall not apply for this project.

D. Record Keeping

192. The PDU will be responsible for procurement record keeping and shall open a file for each contract that they enter into. The file should contain all documents relating to the procurement process in accordance with the requirements and as described in the PPDA Act.

E. Scope of Procurement under the Project

193. **Procurement activities to be financed by the Bank are:**

(a) **Procurement of Works.** Works to be procured under this project would include: civil works contracts for renovation of 2 Regional Referral Hospitals, 17 General Hospitals, and 27 Health Centers Type IV.

(b) **Procurement of Goods:** Goods to be procured under this project would include: medical equipment; ambulances and general purpose vehicles for hospitals; office equipment and furniture; and setting up and managing a VOIP/e-Health Communication system between the MoH Headquarters, Mulago, the 2 RRHs, the 17 GHs and 19 DHOs, etc.

(c) **Procurement of nonconsulting services.** Nonconsulting services will include, but not be limited to (i) servicing of office equipment; (ii) repair and maintenance of project vehicles; and (iii) services for Logistics and supplies contractor to pilot delivery of medicines and health supplies from JMS and NMS to 9 Districts for 1 year. The procurement of nonconsulting services shall follow the existing SBDs with appropriate modifications.

(d) **Selection of Consultants.** The consulting services from firms and individuals required for the project would comprise of contracts for: (i) design and preparation of bidding documents for rehabilitation of the health facilities (3 Lots); (ii) construction supervision of civil works (5 lots) for renovation of health facilities; (iv) technical assistant support to the MOH; and (v) studies agreed upon during implementation.

(e) **Operating Costs.** The project will finance costs of the implementing agency that directly relate to project implementation. The project's operating costs include expenditures for routine repair and maintenance of equipment and vehicles used for project implementation, fuel, communication costs, use of internet costs, stationery and other office supplies, consumables, travel *per diems*, accommodation expenses related to project implementation, workshop venues and materials, and costs of translation, printing, photocopying and advertising. Salary top-ups, meeting allowances, sitting allowances and honoraria to civil/public servants and contracted consultants shall not be financed by the project.

(f) **Training plan.** The project will formulate an annual training plan and budget which will be submitted to the Bank for its prior review and approval. The annual training plan will, *inter alia*, identify: (i) the training envisaged; (ii) the justification for the training, how it will lead to effective performance and implementation of the project and or sectors; (iii)

the personnel to be trained; (iv) the selection methods of institutions or individuals conducting such training; (v) the institutions which will conduct training, if already selected; (vi) the duration of proposed training; and (vii) the cost estimated cost of the training. Upon completion of training, the trainee shall be required to prepare and submit a report on the training received. Additionally the Uganda Health Systems Strengthening (UHSSP) Project Implementation Manual shall specify how candidates eligible for the graduate training shall be selected. These procedures shall ensure equal opportunity to all eligible participants.

F. Assessment of the agency's capacity to implement procurement[62]

194. **The Procurement Function.** The Project will be mainstreamed into MOH under the direct oversight of the Permanent Secretary (the Accounting Officer). The procurement function will be executed by the PDU. The PDU is headed by a Principal Procurement Officer who is supported by 3 Procurement Officers (1 Senior Procurement Officer, and 2 Procurement Officers); 1 Secretary; 1 Data Entry Clerk; and 1 Office attendant. Although the PDU procurement staff possess the basic qualifications and are conversant with procurement processing under the PPDA Act and regulations, none of them has experience in IDA financed procurement management. The review of contract records found that although the procedures followed in the preparation of documents, management of bidding process, bid evaluation, and contract award were carried out in compliance to the PPDA Act, the procedures were not always fully satisfactory. Key documents were found missing in the procurement files reviewed; the user departments reported routine instances of misplacement of their requisitions and delays in procurement processing; and space in the PDU was established to be insufficient for staff and storage of procurement files.

195. **The Contracts Committee.** MOH has a Contracts Committee in place as per procurement law. The Contract Committee meets at least weekly or as need arises. Due to poor procurement documentation, the Contracts Committee often returns procurement documents to PDU for revision leading to delays in the procurement cycle. To improve the quality of procurement documents prepared by PDU, it is recommended that MOH recruit a Procurement Specialist/s, with TOR acceptable to IDA for at least the first two years to handle procurement of contracts related to this project and provide hands-on coaching to PDU staff.

196. **The PDU.** Government has started to address the challenges in the PDU established during the procurement assessment. A data entry clerk was engaged to enter information from User Departments into the IFMIS and computers and a photocopier were purchased for the PDU. The PDU will be allocated new offices once the extension building under construction is completed in March 2011. PDU will adopt framework contracts for procurement of common use items, e.g., stationery, and delegate microprocurements (procurements under US$1,000) to user departments to free PDU staff to handle the other contracts.

197. **The Health Infrastructure Division (HID).** The Health Infrastructure Department is responsible for all health infrastructure related works, including medical equipment, in the sector

[62] The procurement assessment of the MOH to implement procurement for the project was carried out by Grace Munanura on July 20, 2009.

financed by Government and other development partners. Under the project, it will coordinate procurements on renovation of health facilities, medical equipment and vehicles, and supervise consultants and contractors financed by the project. In addition to two Electrical Engineers whose recruitment is underway, there are four Civil Engineers, two Medical Equipment Engineers and one Sanitary Engineer in the division. The Division is currently engaged in technical support to ongoing civil works carried in the Regional Referral hospitals; African Development Bank financed rehabilitation of 26 HC III's and 13 HC IVs, 5 Mental Units and remodeling of Mbarara Hospital; JICA financed renovation of hospitals. The Health Infrastructure Department will designate 2 Civil Engineers to the project and recruit an Architect and Quantity Surveyor to supplement skills in the Division for the implementation of the project. The MOH will also recruit 5 Clerks of Works with the responsibility of verifying onsite physical quality of the works by contractors. The National Advisory Committee on Medical Equipment (NACME) is a specialized committee in the MOH with representation from various ministries charged advising Government medical equipment. The committee has prepared the Medical Equipment Policy in three volumes: Volume 1 – Policy; Volume 2 – Guidelines, which contain a list of the different medical equipment required at the different levels of Health facilities; and Volume 3 – Specifications, which contain for the detailed technical specifications for the different medical equipment for each level of health facilities. In this regard, the MOH has adequate capacity to prepare technical specifications for medical equipment.

198. **National Medical Stores (NMS):** National Medical Stores is a Government parastatal agency with the mandate to procure and distribute essential medicines and supplies on behalf of the MOH. NMS will procure essential supplies and commodities under the project mainly under the component on maternal health, newborn care, and family planning. The PDU has one Head of Department and 3 Procurement Officers and has handled similar procurements before. It is currently processing a procurement of US$10 million for contraceptives and US$9 million for Maama kits[63]. Although the PDU staff lack IDA procurement experience, they are familiar with the kind of procurements to be handled under the project and procurement management under PPDA Act. The MOH will be responsible to prepare Technical Specifications under the project. The records reviewed indicate that procurement processing in NMS is in compliance to the PPDA Act. NMS will provide appropriate space for storage of procurement documentation. The risk to the project procurement management by NMS is **Moderate.**

199. The overall risk to project procurement management by MOH to project is **Substantial.**

[63] The Maama kit contains basic materials to facilitate clean and safe delivery and reduce the risk of deadly infection to the mother and her newborn baby i.e. sterile gloves, plastic sheets, cord ligature, razor blades, tetracycline, cotton, soap and sanitary pads.

200. The proposed corrective measures which have been agreed to mitigate the overall risk are indicated in the matrix below.

Table A8-1: Procurement Action Plan

Risk	Action	Completion Date	Responsible Entity
Inadequate capacity and procurement skills of PDU staff to handle IDA financed procurement management.	Recruit a Procurement Specialist/s to provide hands-on coaching, mentoring of PDU staff and User Departments.	By August 31, 2010	MOH
	PDU staff to attend ESAMI or GIMPA courses in: (i) procurement of works and goods (ii) selection of consultants	By twelve months after effectiveness	MOH
	Delegate to user departments micro-procurement function or use framework contracts for common items	Immediately	MOH
Inadequate procurement filing and record keeping system.	MOH to establish an acceptable MIS for procurement tracking as well as an acceptable procurement filing and record keeping system.	Within six months of effectiveness	MOH
Inadequate office space for PDU staff and procurement files.	At least make available an office space for the procurement specialist.	By August 31, 2010	MOH
Inadequate skills mix in HID to provide technical support to civil works contracts.	Recruit 1 Architect; 1 Quantity Surveyor and 5 Clerks of Works[64].	Within 3 months of effectiveness for the Architect and Quantity Surveyor; and within 12 months of effectiveness for Clerk of Works.	MOH
Inadequate procurement planning.	PDU to prepare a procurement plan for the first 18 months in coordination with the user departments.	By project negotiations	MOH
Lack of understanding of roles and responsibilities between user departments and PDU.	(i) Prepare Procurement Manual to clarify roles and responsibilities of staff; (ii) Train user departments in procurement and contract management.	By effectiveness By six months of effectiveness	MOH MOH

G. Procurement Plan

201. The Borrower, at appraisal, developed a procurement plan for project implementation which provides the basis for the procurement methods. This plan was agreed between the Borrower and the Project Team on April 1, 2010 and endorsed during negotiations, and is available at the MOH offices on Plot No. 6 Lourdel Road, Kampala. It will also be available in the project's database and in the Bank's external website. For each contract to be financed by the Credit, the different procurement methods, consultant selection methods, the need for prequalification, estimated costs, prior review requirements, and time frame are agreed between the Borrower and the Bank in the Procurement Plan. The Procurement Plan will be updated in

[64] Recruitment of the above staff have been initiated through the project preparation advance.

agreement with the Project Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

H. Frequency of Procurement Supervision

202. In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agencies has recommended at least one supervision mission annually mission to visit the field to carry out post review of procurement actions.

203. **Prior Review Threshold:** The prior review thresholds are as follows:

I. Procurement of Goods and Works

Expenditure Category	Contract Value (Threshold) US$	Procurement Method	Contracts Subject to Prior Review
1. Works	>=5,000,000	ICB	All Contracts
	< 5,000,000	NCB	Selected Contracts as indicated on Procurement Plan
	<100,000	Shopping	None
2. Goods	>=500,000	ICB	All Contracts
	<500,000	NCB	Selected Contracts as indicated on Procurement Plan
	<50.000	Shopping	None

II. Selection of Consultants

Expenditure Category	Contract Value (Threshold) US$	*Selection Method*	Contracts Subject to Prior Review
(a) Firms[65]	>=200,000	QCBS, QBS, LCS, FBS	All contracts
	<200,000	CQS, LCS, QBS, FBS	Selected Contracts as indicated on Procurement Plan
	All values	SSS	All contracts
(b) Individual	>=50,000	IC	All contracts
	All values	SSS	All contracts

[65] **Short list comprising entirely of national consultants**: Short list of consultants for services, estimated to cost less than US$200,000 equivalent per contract, may comprise entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

E. Details of the Procurement Arrangements Involving International Competition

1. Goods, Works, and Nonconsulting Services

Procurement Packages with Methods and Time Schedule

1	2	3	4	5	6	7	8	9
Ref. No.	**Contract (Description)**	**Estimated Cost ($ mill) –excludes local taxes**	**Procure ment Method**	**Pre-qualification (yes/no)**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
A) WORKS								
1	**Lot 1** Construction works at RRH -Mubende GHs - Nakaseke, Mityana and Itojo HCIVs - Kasanda, Kiganda, Ngoma, Mwera, Kyantungo Kikamulo, Kabuyanda, Mwizi, Kitwe, Rubare **Lot 2:** Construction works at GHs - Apac, Kiryandongo, Masindi, HCIVs -Aboke, Aduku, Bwijanga and Bullisa **Lot 3:** Construction works at GHs - Kitgum, Anaka, Moyo and Nebbi HCIVs - Padibe, Atyak, Obongi and Pakwach **Lot 4:** Construction works at GHs - Kawolo, Entebbe, Buwenge, Bugiri and Iganga HCIVs - Buvuma, Budondo, Ntenjeru-Kojja, Buyinja, Nankoma, Bugono and Kiyunga **Lot 5:** Construction works at RRH - Moroto GHs - Pallisa and Bukwo HCIVs - Kibuku and Budaka	60	ICB	No	Yes	Prior	28th Feb 2011	*Tendering process to commence after design and tender documents are ready in December 2010*
B) GOODS								
1	***Medical Equipment***							
1.1	***Procurement of Medical Equipment and Hospital Furniture not requiring installation*** ***Lot 1:*** *Diagnostic Kits and Instruments sets for 2RRH, 17GHs and 27 HCIVs.* ***Lot 2:*** Office Furniture (office Chairs, Desks, Book shelves, filling cabinets) for 2RRHs, 17GHs, 27HCIVs	4.7	ICB	No	No	Prior	28th Feb 2011	

1	2	3	4	5	6	7	8	9
Ref. No.	**Contract (Description)**	**Estimated Cost ($ mill) –excludes local taxes**	**Procurement Method**	**Pre-qualification (yes/no)**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
1 2	***Procurement of Medical Equipment requiring Pre-installation*** ***Lot 1:*** 2 No. X-ray -Fluoroscopy , 19 No. X-ray-Basic Radiology Services (BRS), 46 No. *Mobile X-ray, 46 No. Ultrasound machines* ***Lot 2:*** *Theatre Equipment, Laboratory equipment, Patient Monitors, Sterilizers, Infant Incubator* for 2RRHs, 17GHs, and 27HCIVs. ***Lot 3:*** Dental Equipment for 2RRH, 17GHs and 27HCIVs ***Lot 4:*** 50 sets of Solar Blood Bank and Solar Vaccine Fridges ***Lot 5:*** 46 No. *Generators, 19 No. Washing Machines, 57 No. Electric Boilers, 38 No. Dryers*	9.0	ICB	No	No	Prior	28th Jun 2012	Delivery of Items will coincide to the extent possible with the completion of Hospital civil works
1.3	***Procurement of Hospital Furniture*** Procure, Install and commission Hospital Furniture for **2RRH, 17GHs, and 27HCIVs** *(Includes: Hospital Beds, Bed side Lockers, Patient Screens, Examination Beds, Examination Mattresses, Hospital Chairs, Surgeons stool, cabinets, drip stands, Patient Stretchers and Trolleys, wheel Chairs)*	3 0	ICB	No	No	Prior	28th Feb 2011	
1 4	***Procurement of Reproductive Health Kits*** **Lot 1:** Procure Critical essential EmoNC equipment *(autoclave and general anesthetic equipment, newborn resuscitation equipment and Caesarian section sets for 94 health facilities, manual vacuum aspiration (MVA) kits-**200 sets**, and training mannequins for 13 RRHs)* **Lot 2:** Procure Family Planning Kits *(Inter Uterine devices (IUDs) and implants, mini-laparatomy kits, implant insertion and removal kits, and IUD insertion kits) - **2,480,000 sets*** **Lot 3:** Procure Kits for Community based workers *(Rain Coats, Water-proof bags, umbrella, gumboots - **12,600 sets)***	7.0	ICB	No	No	Prior	28th Feb 2011	
1.5	***Procurement of Reproductive Health Kits*** ***Lot 1 – Contraceptives*** Procure **2,480,000 sets** of Contraceptive supplies containing (*Oral Contraceptives, Injectables and Emergency Contraceptives)*	7.3	ICB	No	No	Prior	28th Feb 2011	

1	2	3	4	5	6	7	8	9
Ref. No.	**Contract (Description)**	**Estimated Cost ($ mill) –excludes local taxes**	**Procure ment Method**	**Pre-qualification (yes/no)**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
	Lot 2 Mama Kits Procure **4,960,000** Mama Kits containing the following: 1. Cotton wool (250 gms) 2. Surgical Gloves (4 pairs) 3. Mackintosh or polythene sheet (2 pieces) 4. Cord ligature 5. 1 piece of soap 6 1 piece of razor blade 7. 1 metre of cotton cloth for the baby)							
2	***Vehicles***							
2.1	***Procurement of 4WD Vehicles*** ***Lot 1:*** Procure 19No Ambulances ***Lot 2:*** Procure 2 No. Mobile Medical Equipment Workshops ***Lot 3:*** Procure 1 No. Minibus 14-seater vehicle, 54 No. 4WD-Double Cabin Pickup vehicles, *2No.-4WD Station wagons Vehicles* ***Lot 4:*** Procure 27 No. Motor Cycles ***Lot 5:*** Procure 27 No. Tricycle Motor Cycles Ambulances	4.565	ICB	No	No	Prior	30th Nov 2010	

B. Selection of Consultants

1. Short list comprising entirely of national consultants: Short list of consultants for services, estimated to cost less than $200,000 equivalent per contract, may comprise entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines

2. Consultancy Assignments with Selection Methods and Time Schedule

1	2	3	4	5	6	7
Ref. No.	**Description of Assignment**	**Estimated Cost (US$ mill)**	**Selection Method**	**Review by Bank (Prior / Post)**	**Expected Proposals Submission Date**	**Comments**
1	***Lot 1:*** Consultancy Services for Construction Supervision for Mubende RRH, Nakaseke, Mityana and Itojo GHs, Kasanda, Kiganda, Ngoma, Mwera, Kyantungo Kikamulo, Kabuyanda, Mwizi, Kitwe, Rubare HCIVs ***Lot 2:*** Consultancy Services for Construction Supervision for Apac, Kiryandongo and Masindi GHs, Aboke, Aduku, Bwijanga and Bullisa HCIVs.	4.616	QCBS	Prior	29th /03/2010	*This process initially budgeted under the Project Preparation Advance but included here due to changes in estimated cost of assignment*

1	2	3	4	5	6	7
Ref. No.	**Description of Assignment**	**Estimated Cost (US$ mill)**	**Selection Method**	**Review by Bank (Prior / Post)**	**Expected Proposals Submission Date**	**Comments**
	Lot 3: Consultancy Services for Construction Supervision for Kitgum, Anaka, Moyo and Nebbi GHs and Padibe, Atyak, Obongi and Pakwach HCIVs ***Lot 4:*** Consultancy Services for Construction Supervision for Kawolo, Entebbe, Buwenge, Bugiri and Iganga GHs, Buvuma, Budondo, Ntenjeru-Kojja, Buyinja, Nankoma, Bugono and Kiyunga HCIVs ***Lot 5:*** Consultancy Services for Construction Supervision for Moroto RRH, Pallisa and Bukwo GHs, Kibuku and Budaka HCIVs					

Abbreviations:

1. RRH: Regional Referral Hospital
2. GH: General Hospital
3. HCIV: Health Center IV
4. NMS: National Medical Stores
5. HRH: Human Resources for Health
6. EmoNC: Emergency Obstetrics and Neo-natal Care
7. MOH: MOH
8. BRS: Basic Radiology Services

Annex 9: Economic and Financial Analysis

UGANDA: Uganda Health Systems Strengthening Project

Introduction

204. **Economic analysis plays a significant role in informing the choice of project alternatives, design arrangements, and implementation strategies, and is often used to make judgments on how a proposed or existing project involves the efficient use of resources.** In the health sector, economic analyses commonly rely on four techniques, namely: cost-minimization analysis, cost-effectiveness analysis, cost-utility analysis, and cost-benefit analysis. Because of measurement challenges arising from difficulties in valuing incremental costs and the impacts of health interventions, rigorous economic analysis commonly performed in other sectors are seldom conducted in the health sector. This analysis assesses (a) economic rationale for investing in the health sector in Uganda; (b) economic justification for the selection of the project components and activities; (c) financial sustainability of the health sector; and (d) project sustainability. The analysis is mainly informed by the recent assessment of fiscal space for health in Uganda.

Economic rationale for investing in a health sector in Uganda

205. **Health status is a major determinant of individual wellbeing and a good marker of country's level of development, particularly for developing countries.** Health and health care carry special characteristics that give them a claim on public resources. The "public goods" nature and positive spillover effects of some elements of health care are among the reasons why societies prefer public intervention in the provision of health care. The uncertainty of illness in terms of occurrence, severity and cost of treatment together with asymmetry of information regarding medical interventions are also among some of the reasons used to justify investments of public resources into the health sector. Most countries are concerned about existing inequalities in health status and provision of health care, and justify the use of public resources to correct such inequalities on the principle of equity. The private health sector in Uganda is underdeveloped, poorly regulated, and consists predominantly of small clinics and drug shops offering basic curative care of sometimes doubtable quality. The population is largely rural (85 percent) with a big proportion living in abject poverty (31 percent) and unable to afford basic health care. Communicable diseases for which cost-effective interventions exist are the major cause of disease burden and mothers and children bear a disproportionate burden. In such a scenario, a network of public health facilities that offer curative care as well as coordinate preventive health care services serve as a safety net to the population, most especially to patients requiring hospitalization. It is vitally important to ensure these health facilities are properly staffed and managed and function adequately. While the private sector can deliver some of these services in the urban areas, Government intervention is required in regulation and ensuring services which are not provided by the private sector are made available in particular to the rural areas. Uganda is witnessing a rapid rise in household out-of-pocket expenditures on health, and the level of health spending is deemed catastrophic. Out-of-pocket health expenditures amounted to almost 9 percent of total household consumption expenditure and represented about 37.9 percent of total health spending in 2006. Detailed analysis of the national household survey data from 2006 indicates that, on average, almost 28 percent of sampled households faced health expenditures that could be deemed "catastrophic," defined as health expenditures in excess of 10 percent of total household consumption. In the absence of social health

insurance, as is the case in the context of Uganda, public provision will remain an important aspect of health care service delivery.

Economic justification for the selection of the project components and activities

206. **The project comprises three major components**: (a) improving functionality of existing physical health infrastructure; (b) improving health workforce development, management, retention, and productivity; and (c) strengthening leadership, management, and accountability for health service delivery.

207. **Waste in public spending is a problem in the health sector and occurs in a number of ways.** These include leakages of funds before reaching the designated spending entities, breach of Government financial and procurement regulations, weak execution of Government regulations especially in respect to application of sanctions and from direct abuse of public office. In fiscal 2005-06, approximately UGShs 36 billion, or 13 percent, of health sector spending was lost due to waste (A9-1). The greatest source of waste was from health worker absenteeism where approximately UGShs 26 billion was wasted because of a daily average 37 percent absenteeism. The same analysis reported additional waste of UGShs 6 billion as a result of leakage of PHC non-wage and NGO grant and an additional UGShs 2 billion from questionable expenditures and ghost workers. Though not comprehensive, this assessment of waste in the sector revealed significant waste in the management and performance of the health workforce, drug procurement and logistics management, general procurement in the sector and programming of development assistance for health. The project will support Government to improve performance of the sector by addressing weaknesses in some of these areas, in particular human resource management.

208. **While the Government was originally interested in improving functionality of the existing infrastructure, the project will focus on addressing critical health system bottlenecks responsible for significant waste in the sector**. The team will ensure that those areas not covered by the project are addressed either by Government or through other partners and programs. Efforts to strengthen drug supply chain management is expected to led by USAID through SURE project while efforts on improving programming of development assistance for health is being taken up through the MOFPED and will be followed through the PRSC. As for health infrastructure, priority will be placed on renovation of existing infrastructure with the aim of ensuring their functionality. In order to mitigate the contingent liabilities arising from health infrastructure related works, expansion of existing facilities and construction of new facilities will be discouraged.

209. **The benefits of investing in maternal and neonatal care in Uganda are obvious.** This is mainly because of the huge disproportionate burden of maternal and neonatal deaths in Uganda and the fact that there are affordable and cost effective interventions to prevent these avoidable deaths. Evidence from countries of similar economic development to Uganda suggests that improved coverage with a package of interventions directed to maternal and neonatal care is extremely cost-effective – US$82 – US$142 per DALY averted.[66] Although difficult to value, there are also significant benefits to invest in maternal care especially at the household level given the primary role that mothers play in the homes. In addition, the high fertility, high unmet need for family planning and the large number of

[66] Disease Control Priorities in Developing Countries, 2nd Edition – Disease Control Priorities Project.

induced abortions with attendant complications do provide strong economic rationale to invest in family planning.

Table A9-1: Calculations of waste in the health sector FY 2005-06

Problem Area	Source	UGShs Bn
PHC Non-Wage Grant leakages	PETS	3.0
NGO PHC Grant leakages	PETS	3.0
Questionable Expenditures	Auditor General's Reports	2.4
Ghost Workers	Payroll Clean-up Exercises	1.0
Health Worker Absenteeism	Chaudury, et. al.	26.0
Drug Leakages	NMS (Expiry)	1.3
Procurements		
Total waste		**36.7**
Total health expenditures		**285.0**
Percent of health expenditure wasted		**13%**

Source: Fiscal Source for Health in Uganda (2009)

Financial sustainability of the health sector

210. **Uganda's total health expenditure per capita is about US$25, of which 28.5 percent of total health spending is by external sources, 37.9 percent from out-of-pocket and the remainder (about 30 percent) from Government sources.** Government spending as a proportion of the overall budget is about 10 percent, 5 percent lower than the Abuja Declaration's 15 percent target. In nominal terms, the health sector budget as a percentage of the total Government budget grew from 7 percent in 1997-98 to 12 percent in fiscal 2002-03, and has remained fairly constant at this level. Estimates from 2000-06 suggest that the elasticity of Government health expenditure with respect to GDP when development partner funds are included is about 1.44 percent, and 0.95 percent excluding external grants. Hence, the extent of fiscal space for health derived from economic growth projections in Uganda is likely to critically depend on the sustainability of global funding or the extent to which domestic resources can be mobilized to substitute global funds if the latter become unavailable.

211. **The IMF projects economic growth in Uganda to continue to rise by 6 to 7 percent per year in real terms for at least the next 5 to 7 years, if not beyond.**[67] Assuming that Government health spending will continue to respond in the same way to growth as it has over 2000-06 these growth projections imply that Government per capita health expenditure would double between 2007 and 2015 (from UGShs 19,453 to UGShs 41,214), rising from 3.13 percent to 4.08 percent of GDP (scenario 1). If a more prudent approach is taken and the budget for health is kept constant as a share of GDP (Scenario II), then per capita health expenditure will also rise considerably (from UGShs 19,453 to UGShs 31.582). On the premise of the two scenarios Uganda should be able to realize considerable resources to the sector. The impact of the increase will however depend on the extent Uganda can improve efficiency of health spending and address drivers of increased health spending.

[67] IMF, *Uganda: Article IV Consultation* (Washington, DC: IMF, 2007).

Table A9-2: Fiscal Space for Health Projections Based on Economic Growth, 2007-15

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015
Real GDP growth rate	6.20%	6.50%	6.50%	6.80%	7.10%	6.00%	6.50%	6.50%	6.50%
Nominal GDP (billions)	19,307	21,374	23,715	26,102	28,813	31,430	34,667	38,238	42,177
Population (millions)	31.1	32.2	33.4	34.5	36	37.4	38.9	40.3	41.8
Scenario I: Elasticity of health budget to GDP is 1.44									
Government health expenditure (billions)	605	692	795	903	1,031	1,158	1,322	1,508	1,722
Government health expenditure (% of GDP)	3.13%	3.24%	3.35%	3.46%	3.58%	3.68%	3.81%	3.94%	4.08%
Government health expenditure per capita	19,453	21,473	23,814	26,171	28,661	30,953	33,993	37,400	41,214
Scenario II: Health budget is constant share of GDP (3.13%)									
Government health expenditure (billions)	604	669	742	817	902	984	1085	1197	1320
Government health expenditure (% of GDP)	3.13%	3.13%	3.13%	3.13%	3.13%	3.13%	3.13%	3.13%	3.13%
Government health expenditure per capita	19.431	20.777	22.224	23.681	25.051	26.304	27.894	29.698	31.582

Note: GDP growth and nominal GDP projections data are from IMF (2007)). Population projections are from HNPStats; Government health expenditure projections are derived from average elasticity of Government health spending with development partner funding. All figures in UGShs.

Project Sustainability

212. **By addressing the health system bottlenecks and strengthening management functions in the sector the project will be directly contributing towards the sustainability of the project.** The financial impact of the project on Government's health spending will be felt mainly in terms of additional resources for maintenance of renovated facilities and repairs and replacements of medical equipment. These costs will require commitment by Government if the project benefits are to be sustained beyond the project's life span. The project is part of the broader Government program under the SWAp and it is included within the Government MTEF. Considering the projected increase in health spending over the intermediate period, Uganda should be able to absorb the project costs into its budget. This will however depend on continued development partner support, the Government's commitment towards health and its emphasis on reducing waste in the health sector.

Annex 10: Safeguard Policy Issues

UGANDA: Uganda Health Systems Strengthening Project

213. **OP 4.01.** The project triggers OP 4.01 on Environmental Assessment due to renovation of existing hospitals and health centers. These include refurbishment or addition of specialized wards, construction of incinerators and staff housing, and connections to water, sewerage, and power facilities for the functionality of the health facilities. Key adverse environmental impacts are those associated with construction phase activities (e.g., noise, construction traffic, construction waste, visual impacts). Some potentially adverse impacts are associated with operation of hospitals and health centers (e.g., medical waste generation and disposal through incineration, waste water disposal, general waste disposal). Land acquisition for construction of health and ancillary facilities has not been a common occurrence. The project is not expected to have adverse cumulative or long-term impacts.

214. **ESIA.** To ensure compliance with environmental assessment requirements under the Uganda National Environment Act (1995), National Environmental Impact Assessment Regulations 13/1998, other Ugandan environmental regulations, and the World Bank safeguard policy OP 4.01 on Environmental Assessment, environmental due diligence for the major civil works has been carried out through preparation of an Environmental and Social Impact Assessment (ESIA), which includes an Environmental Management Plan. There are no environmental or social issues which cannot be addressed through routine mitigation measures and good construction practices and funded within the overall level of funding allocated for the civil works activities. The Environment and Social Impact Assessment (ESIA) undertaken in January 2010 that included visits to all sites has confirmed that there is no need for additional land for project activities, and MOH and the relevant facilities have acceptable proof of ownership of the available land and there are no disputes over this land. The ESIA therefore determined that there are no involuntary resettlement issues associated with this project and that OP 4.12 is not triggered. Individuals, who are staff of the health facilities with non-health related activities like gardening on the facility land will be given notice and a date for their departure or relocation will be set prior to the start of civil works.

215. **Consultations.** Local consultations were carried out through meetings and interviews as part of the ESIA preparation at each of the project sites. The consultations included the full spectrum of directly affected local stakeholders, were recorded by the ESIA team and factored into preparation of the ESMP. One of the main concerns that emerged from the consultations was access to health care during construction. The project will be implemented in such a way that provision of health care services will continue at the target facilities during the rehabilitation and construction works so outages of service will be minimized.

216. **HCWMP.** To manage environmental aspects of medical waste management, the project will promote implementation of the HCWMP for 2009/2010 to 2011/2012 that was recently completed and disclosed. The project will also promote implementation of the existing injection safety policy. The HCWMP outlines interventions for rationalizing, improving and monitoring medical waste management to strengthen safety and reduce environmental impacts. It includes capacity development and training measures. Following the HCWMP, the project will fund construction and use of suitable medical waste incinerators for the various levels of health facilities. Various incineration technologies were considered. The final selection of waste incineration technology was determined with environmental (air pollution) as well as operating (cost and sophistication) considerations in mind.

217. **Borrower Safeguards Capacity.** The borrower has substantial experience in hospital renovation and construction in compliance with Uganda's National Environmental Management Authority guidelines, and some experience with World Bank safeguards. Environmental compliance is the responsibility of the Environmental Health Division of the MOH which is charged with executing the environmental health plans under the overall policy guidance of the National Environmental Management Agency. Under the project, the division will work together with NEMA to strengthen efforts in handling all environment related issues, including those under civil works.

218. The MOH and the decentralized health service delivery points have some experience with the formulation and implementation of the Health Care Waste Management Plan. In addition the sector has a Uganda Safe Injection Policy. The challenge continues to be the weak health care waste management due to insufficient and inadequate equipment for handling of waste material, and the poor enforcement by the authorities.

219. **Legal covenants and funding.** Adherence to ESIA and HCWMP to IDA satisfaction will be anchored in the covenants of the financing agreement. Funding for the prescribed mitigation measures, including cost of mitigation measures associated with civil works and medical waste management will be integrated in other project costs and financed by IDA.

Annex 11: Health Governance Strategy and Action Plan

UGANDA: Uganda Health Systems Strengthening Project

A. Introduction

220. This Health Governance Strategy and Action Plan (HGSAP) names the key governance challenges and recommends reforms to meet those challenges. A number of the initiatives recommended are already covered under Components 2 and 3 of the UHSSP. The HGSAP draws on a governance diagnostic in the health sector to identify key project specific and overall sector wide steps that could be undertaken to address governance challenges in the sector. The governance diagnostic drew on the results of the assessment of human resources management practices in the health sector using the World Bank Actionable Governance Indicators, the Health Sector Public Expenditure Review (PER) and the draft report on Governance and Political Economy Constraints for Development Effectiveness in Uganda's Health Sector (August 2009]. These reports emphasize governance challenges relating to (a) ineffective policies regarding HR management leading to high vacancy rates and absenteeism; (b) mismanagement of resources leading to poor policy implementation, service delivery and grand corruption; (c) unclear definition of roles and manipulation of existing structures to serve a few members of the population; and (d) very limited citizen participation. The HGSAP provides actions to promote accountability for effective service delivery both at the centre in the MOH and at district level right down to the lower level health units.

B. Governance at the Country Level

221. At the Country level the GOU has pursued a combination of governance reforms. Among the key initiatives are: (a) creation of a legislative framework for public finance management; (b) service delivery arrangements under the sector wide approach (SWAp); (c) political, administrative, and fiscal decentralization to local governments; (d) public sector management reforms to regulate human resource recruitment, remuneration, and performance; and (e) regulatory institutions put in place to ensure compliance with national standards in several areas including drugs management. Overall progress has been mixed. At the Country level, Uganda has maintained a Country Portfolio Index (CPI) score of below 3.0 (2.5 in 2009 and 2.8 in 2008) putting it among the weak performers. Results from the third National Integrity Survey[68] (NIS III-2008) show that Government efforts have not yielded significant impact, and that corruption is perceived to be increasing. Institutions in the health sector, which hitherto were not reported to be corrupt, are now among the most highly corrupt public institutions. The results of the NIS III established that 43 percent of households regarded health workers as corrupt and that 54 percent of the respondents indicated having known of a case of corruption in the health sector. With regard to institutional effectiveness, the continued proliferation of districts has negatively impacted on service delivery, impeding reforms in public finance management including procurement because of limited capacity of the local governments, which are charged with the mandate of delivering social services. Coupled with this is the weak capacity of key public institutions charged with regulation. The elections scheduled for February 2011 are likely to lead to

[68] The NIS III is the most comprehensive survey that done in Uganda to look at governance and anticorruption in service delivery. It was led by the Office of the Inspector General of Government's office.

"political influence peddling" including creation of more new districts and further erosion of the regulatory capacity of some of key public institutions.

C. The Health Governance Strategy and Action Plan

222. The HGSAP complements the MOH's efforts to address some of the key challenges identified in the governance diagnostic and pursues a comprehensive approach to strengthening governance and accountability in the UHSSP and the health sector as a whole. The action plan presents a flexible design that will allow for (a) further development through annual governance and anticorruption work plans that the GOU and the Bank will agree upon based on the UHSSP's expected outcomes, and (b) the project to complement MOH and work with the entire health sector and ensure progress in health financing, internal systems reform and external accountability reforms. The HGSAP will focus on the following three areas: (a) health sector stewardship; (b) strengthened internal efficiency through mitigating risks related to resource management (financial and human); and (c) promotion of external accountability. The HGSAP complements standard fiduciary accountability measures discussed in detail under Annex 7 and 8 on financial management and procurement management respectively. For the HGSAP to create maximum impact at national, district and local levels, the project will identify appropriate heath governance structures to mainstream governance into the health sector and, most importantly, as a key underlying and component of new sector strategic plan under development that can be easily monitored.

D. Health Sector Stewardship

223. **Leadership Capacity Development.** To complement actions under Component 3 of the UHSSP, HGSAP proposes structured exchanges with a focus on health sector health leadership, regular regional face to face meetings, peer learning and formation of a local/subregional network for exchange between health reform programs in different landscapes. HGSAP proposes drawing upon expertise of the World Bank Institute to implement this action.

224. **Functional Communication Strategy.** The MOH will develop and implement a functional communication strategy in conformity to the Access to Information act and geared towards enhancing both user access and internal information flow. Implementation of the communication strategy will be led by the Permanent Secretary's Office in the MOH who will be supported by professional communication officers and equipped with modern communication channels or mechanisms.

E. Strengthened Internal Efficiency

Mitigating Financial and Procurement Risks

225. The HGSAP proposes to mitigate these risks by the following actions:

(a) Strengthened Budget and Procurement Management and Control. To enhance transparency and accountability and complement actions on extension of IFMIS detailed under Annex 7 and 8, the MOH under the HGSAP will publish procurement information and activities on the MOH website and visible public bulletin boards to inform suppliers and contractors of ongoing activities and update procurement procedures and regulations;

(b) Further as part of project implementation and planned capacity building interventions under Component 3, MOH will provide systematic training in public financial management and procurement targeting health staffs working in these areas at the MOH, districts, and subdistrict levels, as part of the overall training and capacity building interventions;
(c) Effective and Timely Disciplinary and Sanction Mechanisms. The Ministry will as a matter of procedure take disciplinary actions against noncompliance with budget and procurement regulations in a timely and fair manner in order to raise the bar on misuse of sector resources. This will be monitored as part of the implementation of the HGSAP.

Mitigating Health Personnel Risk

226. The following measures will be implemented under Component 2 to mitigate health personnel risks:

(a) Development and Piloting a sector specific incentive policy for Hard to Reach Areas;
(b) Establish a Job Bureau to Facilitate Recruitment and Rotation of Health Workers;
(c) Pilot Performance Contract and Performance Appraisal;
(d) Enforce Effective Disciplinary Actions.

F. Promote External Accountability

227. To promote external accountability, MOH and health service delivery institutions will:

(a) **Promote short route accountability service providers to citizens** through disclosure of information; development of a user complaints management system; participatory approach in health policy making and service provisioning; and public oversight in the context of the HSSP III.
(b) **Promote the use of Bulletin Boards to disclose information,** scale up community involvement and improve transparency. User Bulletin Boards will post information relating to the district disease burden, health budget, drug information, community outreach programs, health information, service standards under the Client Charter, and recourse processes.
(c) **Develop a User Complaint Management System** at the district level in which inputs and feedback from users will be fed into the decision making process of Health Facility Management Committees and follow-up actions identified and taken. Specific institutional arrangements at the district level shall be explored to manage complaints and provide timely feedback to the public. Indicators of system efficiency will be monitored and tracked as part of the HMIS.
(d) **Support a training program to strengthen capacity of health CSOs** that focuses on governance and tools for policy advocacy and constructive engagement with policy makers and health care providers to strengthen citizen participation in health policy development and service delivery. With regards to participation of local communities in service provisioning, the Village Health Team (VHT), a cornerstone of the HSSP II, will be strengthened. VHT activities will encompass community health education, assessment of user satisfaction through score cards, and channel the voice of local communities into Community Health Management Committees. Financing for VHT

to carry out these activities will be considered through leveraging its support to VHTs from other sources, including GAVI and CDD grant (IDA-LGMSDP).

(e) **Conduct user/client satisfaction surveys** on a regular basis in pilot districts. As part of the Monitoring and Evaluation component under the UHSSP Results Framework, an initial survey (User Score card) will be conducted to establish a baseline, after which additional surveys will be initiated to track progress.

G. Implementation Arrangements

228. **To ensure adequate implementation and monitoring of the proposed HGSAP, it will be mainstreamed into HSSP III.** For the strategy to have maximum impact at the national, district and local levels, an appropriate heath governance structure will be identified to mainstream governance into key health sector activities as envisaged under the HSSP III.

229. **The Minister of Health with the support of the Permanent Secretary will lead the implementation of the Health Sector Governance Strategy and Action Plan.** He/she will advocate the governance strategy among stakeholders inside and outside the health sector through an effective communication strategy to be developed and implemented as recommended by this strategy.

230. **Day-to-day implementation** of the health governance strategy shall be under the responsibility of the team that is responsible for implementing the Uganda Health System Strengthening Project.

Table A10-1: Health Governance Strategy and Action Plan – Monitoring Indicators

Governance Risk	Action	Key Milestones for Monitoring Indicator	Responsibility Center
1. Inadequate Health Stewardship and Leadership	i. Leadership capacity development for MOH top management •Peer Learning Workshops on various health policy issues in collaboration with WBI •Joint MOH-WB analytical and advisory activities on a Health financing Strategy and Health Service Delivery Structure Review; ii. Develop and implement a MOH communication strategy; iii. Orientation of political leadership.	• An approved training program with identified budget and source of financing to implement the program. • WPA that include such AAA. • A communication strategy approved by MOH, costed and under implementation.	MOH/World Bank UHSSP
2. Weak Internal Accountability			
a. Mitigating Financial and Procurement Risks	**National Level** • Expand the coverage of IFMIS • Develop an integrated procurement plan (IPP) for the health that include a procurement tracking system • Strengthen procurement oversight through (a) an independent audit of civil works; and (b) bi-annual procurement supervision that leads to an adoption of a procurement improvement plan. • Strengthen disciplinary and sanctions in case of noncompliance through assessments of resource management performance based on clear criteria on PFM standards.	• Timely transfer of PHC to districts in the first month of each quarter. • Procurement information and activities published on the MOH website and visible public bulletin boards informing suppliers and contractors of procurement activities installed. • IPP approved and a procurement tracking system introduced. • Clear disciplinary and sanction policy for noncompliance with PFM regulations and procedures adopted and implemented.	MOFPED / FINMAP MOH
	District Level • Expand the coverage of IFMIS to more districts. • Strengthen disciplinary and sanction actions through assessments of resource management performance based on clear criteria on PFM standards.	• IFMIS installed and utilized for processing health budget requests by DHOs. • Audit report recommended actions against mismanagement of health resources.	MOFPED, MOH, and DHOS

b.Mitigating risks related to health personnel	**National Level** • Develop and pilot an incentive policy for hard to reach areas. • Establish a job bureau to facilitate recruitment and rotation of health workers. • Pilot performance contracts for managers of health units (i.e.. hospitals and NMS). • Develop a capacity development program that includes not only a technical training plan but also a human resource plan outlining how staffs are used, managed, retained, and developed. • Conduct annually individual performance appraisal based on a concrete performance plan and results indicators agreed upfront with health workers.	• An incentive policy for hard to reach areas and action plan developed and tested in selected districts. • Performance contracts signed with managers of hospitals. • Individual performance appraisal incorporated as a part of a health unit's work plan or activities.	MOPS, MOH, MOFPED
	District Level • Conduct annual individual performance appraisal based on concrete results indicators agreed upfront with health workers. • Enforce effective disciplinary actions on poor performance and absenteeism.	• Individual performance appraisal is implemented by health units.	DHOs
3. Weak External Accountability	**National Level** • Install User Bulletin Boards to disclose information. • Implement user complaint management System. • Encourage citizen participation in health policy development and in service delivery. • Strengthen public oversight. • Support health consumer s' organization to voice citizens' complaints.	• User Bulletin Board installed and responsible personnel assigned. • Complaint management system is developed with clear procedures and loops for service providers to address consumers' inputs and feedbacks. • Budget identified and allocated for citizen participation.	MOH
	District Level • Install User Bulletin Boards to disclose information. • Implement user complaint management System. • Encourage citizen participation in health policy development and in service delivery. • Strengthen public oversight. • Use of Barazas[69] to highlight citizen's complaints.	• User Bulletin Board installed at health centers. • Minutes of Health Facility Management Committee addressing issues posed by consumers on User Bulletin Boards. • VHT budget allocated and fully executed. • Score cards are conducted regularly.	DHOs

[69] Public and open meetings

	Facility Level • Install User Bulletin Boards to disclose information. • Implement user complaint management System. • Encourage citizen participation in health policy development and in service delivery. • Strengthen public oversight.	Same indicators as those listed above under district level.	In charge for HCs

Annex 12: Project Preparation and Supervision

UGANDA: Uganda Health Systems Strengthening Project

Project Planning and Implementation

Stage	Planned	Actual
PCN review		February 9, 2009
Initial PID to PIC		April 14, 2009
Initial ISDS to PIC		August 4, 2009
Appraisal	March 15, 2010	March 17, 2010
Negotiations	March 29, 2010	April 15 – 16, 2010
Board/RVP approval	May 25, 2010	
Planned date of effectiveness	August 2, 2010	
Planned date of mid-term review	August 15, 2012	
Planned closing date	July 31, 2015	

Key institutions responsible for preparation of the project:
Ministry of Health
Ministry of Finance, Planning and Economic Development
Ministry of Public Service
Ministry of Education and Sports

Bank staff and consultants who worked on the project included:

Name	Title	Unit
Peter Okwero	Senior Health Specialist	AFTHE
Dominic Haazen	Lead Health Policy Specialist	AFTHE
Martin Fodor	Senior Environmental Specialist	AFTEN
Grace Munanura Nakuya	Procurement Specialist	AFTPC
Paul Kamuchwezi	Financial Management Specialist	AFTFM
Gayle Martin	Senior Health Economist	AFTHE
Martin Onyach-Olaa	Sr. Urban Development Specialist	AFTUW
Barbara Magezi	Public Sector Specialist	AFTPR
Anne Marie Bodo	ET Consultant Pharmacist	AFTHE
Gladys Alupo	Program Assistant	AFMUG
Martin Fodor	Sr. Environmental Specialist	AFTEN
Mary Bitekerezo	Sr. Social Development Specialist	AFTCS
Katherine Anne Tulenko	Public Health Specialist	AFTHE
Innocent Mulindwa	ET Consultant	AFTED
Samuel Lantei Mills	ET Consultant	HDNHE
Rianna Lisa Mohammed	Health Specialist	AFTHE
Harry Wiebe	Consultant Architect	AFTED
Luis M. Schwarz	Senior Finance Officer	LOAFC
Evarist F. Baimu	Counsel	LEGAF
Philip Beauregard	Senior Counsel	LEGAF
Hege Hope Wade	Operations Officer	AFMUG

Bank funds expended to date on project preparation:

Bank resources:	$148,966
Trust funds:	0
Total:	$148,966

Estimated Approval and Supervision costs:

Remaining costs to approval:	$50,000
Estimated annual supervision cost:	$110,000

Annex 13: Documents in the Project File

UGANDA: Uganda Health Systems Strengthening Project

(a) Health Sector Strategic Plan 2005/06 – 2009/10 Midterm Review Report, MOH, October 2008;
(b) National Health Policy (1999 – 2009) & Health Sector Strategic Plans (2000/01 - 2004/05 and 2005/06 – 2009/10);
(c) Poverty Eradication Action Plan of 2000 and revised in 2004;
(d) Fiscal Space for Health in Uganda May 20, 2009 – Contribution to the 2008 Uganda Public Expenditure Review;
(e) The Republic of Uganda, Budget Speech, Financial Year 2009/10 and National Budget Framework Paper FY 2008/09 – 2012/13;
(f) Long Term Institutional Arrangements for Management and Coordination of Global Health Grants in Uganda; Operational Manual, August 2008;
(g) The World Bank Strategy for Health, Nutrition, and Population Results, April 2007; and Improving Health, Nutrition, and Population Outcomes in Sub-Saharan Africa: The Role of the World Bank, December 2004;
(h) MOH, 2010-2015 Uganda Reproductive Health Commodity Security Strategic Plan;
(i) Unpublished Report, World Bank, Contracting for Primary Health Care in Uganda, February 2007;
(j) Final Draft Report; Governance and Political Economy Constraints for Development Effectiveness in Uganda's Health Sector; August 2009;
(k) MOH and Capacity project, Uganda Health Workforce Study: Satisfaction and Intent to Stay Among Current Health Workers, April 2009;
(l) MOH and Capacity Project, Uganda Health Workforce Turnover Study, February 2009;
(m) OPCS, 2009. Core Sector Indicators and Definitions - Health. OPCS, World Bank, Washington, DC;
(n) AFTHE, 2009. Results Chains for HNP;
(o) Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (2006 – 2015);
(p) Uganda Joint Assistance Strategy (UJAS 2005-2009).

Annex 14: Statement of Loans and Credits

UGANDA: Uganda Health Systems Strengthening Project

			Original Amount in US$ Millions						Difference between expected and actual disbursements	
Project ID	FY	Purpose	IBRD	IDA	SF	GEF	Cancel.	Undisb.	Orig.	Frm. Rev'd
P092837	2010	UG: Transport Sector Development Project	0.00	190.00	0.00	0.00	0.00	191.01	0.00	0.00
P112334	2009	UG: Energy for Rural Transformation APL2	0.00	75.00	0.00	0.00	0.00	74.89	5.90	0.00
P111633	2009	UG: SEC N-Uganda SAF (NUSAF2) (FY09)	0.00	100.00	0.00	0.00	0.00	87.32	-15.30	0.00
P110803	2009	UG: Post-Primary Educ & Trg APL-1 (FY09)	0.00	150.00	0.00	0.00	0.00	152.19	0.00	0.00
P090867	2008	UG: Local Govt Mgt Svc Del Pjt (FY08)	0.00	55.00	0.00	0.00	0.00	39.36	17.92	0.00
P078382	2008	UG: Kampala Inst & Infrast Dev Prj (FY08)	0.00	33.60	0.00	0.00	0.00	30.33	22.86	0.00
P110207	2008	UG: Program for Control of Avian Influ	0.00	10.00	0.00	0.00	0.00	9.48	5.00	0.00
P069208	2007	UG: Power Sector Dev. Project (FY07)	0.00	300.00	0.00	0.00	0.00	91.03	34.88	0.00
P086513	2006	UG. Millennium Science Init (FY06)	0.00	30.00	0.00	0.00	0.00	17.28	0.44	0.00
P050440	2006	UG: Pub Serv Perform Enhance (FY06)	0.00	70.00	0.00	0.00	51.21	17.60	57.88	1.60
P074079	2005	UG: Road Dev APL 3 (FY05)	0.00	107.60	0.00	0.00	0.00	10.27	2.73	3.63
P083809	2005	UG: Priv Sec Competitiveness 2	0.00	70.00	0.00	0.00	0.00	47.43	42.55	0.00
P079925	2004	UG: Natl Re Dev TAL (FY04)	0.00	30.00	0.00	0.00	0.00	8.46	1.36	-0.09
P065437	2003	UG: PAMSU SIL (FY03)	0.00	27.00	0.00	0.00	0.00	0.03	-3.45	0.00
P073089	2001	UG: EMCBP SIL 2 (FY01)	0.00	37.00	0.00	0.00	0.00	14.33	-3.21	7.29
P070627	2001	Regional Trade Fac. – Uganda	0.00	20.00	0.00	0.00	0.00	8.78	5.62	0.00
P050439	2001	UG: Priv & Utility Sec Reform (FY01)	0.00	48.50	0.00	0.00	12.14	8.53	17.22	11.72
		Total:	0.00	1,353.70	0.00	0.00	63.35	808.32	192.40	24.15

UGANDA
STATEMENT OF IFC's
Held and Disbursed Portfolio
In Millions of US Dollars

		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
1996	AEF Agro Mgmt	0.26	0.00	0.00	0.00	0.26	0.00	0.00	0.00
1992	AEF Clovergem	0.84	0.00	0.00	0.00	0.84	0.00	0.00	0.00
1999	AEF Gomba	0.45	0.00	0.00	0.00	0.45	0.00	0.00	0.00
1998	AEF White Nile	0.10	0.00	0.00	0.00	0.10	0.00	0.00	0.00
2005	DFCU	10.00	0.00	0.00	0.00	10.00	0.00	0.00	0.00
1998	Tilda Rice	0.48	0.00	0.00	0.00	0.48	0.00	0.00	0.00
2005	UMU	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total portfolio:	13.13	0.00	0.00	0.00	12.13	0.00	0.00	0.00

		Approvals Pending Commitment			
FY Approval	Company	Loan	Equity	Quasi	Partic.
2002	Bujagali	0.07	0.00	0.00	0.04
	Total pending commitment:	0.07	0.00	0.00	0.04

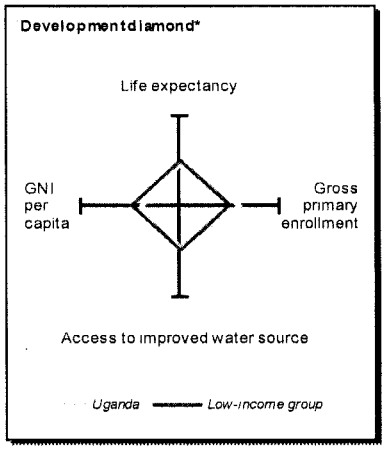
Annex 15: Country at a Glance

Uganda: Uganda Health Systems Strengthening Project

Uganda at a glance

12/9/09

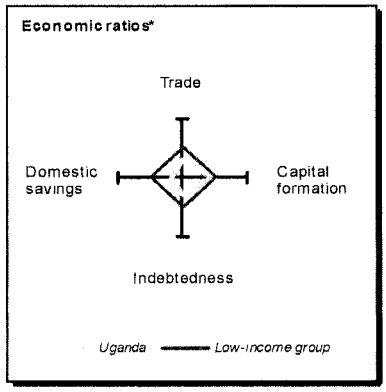
POVERTY and SOCIAL	Uganda	Sub-Saharan Africa	Low-income
2008			
Population, mid-year *(millions)*	31.7	818	973
GNI per capita *(Atlas method, US$)*	420	1,082	524
GNI *(Atlas method, US$ billions)*	13.3	885	510
Average annual growth, 2002-08			
Population *(%)*	3.3	2.5	2.1
Labor force *(%)*	3.4	2.8	2.7
Most recent estimate (latest year available, 2002-08)			
Poverty *(% of population below national poverty line)*	38	..	..
Urban population *(% of total population)*	13	36	29
Life expectancy at birth *(years)*	53	52	59
Infant mortality *(per 1,000 live births)*	85	89	78
Child malnutrition *(% of children under 5)*	16	27	28
Access to an improved water source *(% of population)*	64	58	67
Literacy *(% of population age 15+)*	74	62	64
Gross primary enrollment *(% of school-age population)*	117	98	98
Male	117	103	102
Female	118	93	95



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

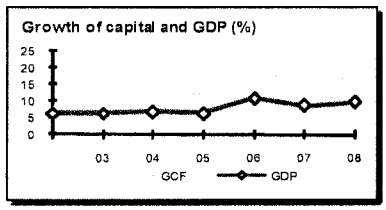
	1988	1998	2007	2008
GDP *(US$ billions)*	6.5	6.6	11.9	14.5
Gross capital formation/GDP	10.8	16.4	22.1	23.6
Exports of goods and services/GDP	7.6	9.6	16.7	15.6
Gross domestic savings/GDP	0.6	5.7	8.2	5.8
Gross national savings/GDP	1.6	6.1	13.8	12.0
Current account balance/GDP	-4.5	-11.6	..	..
Interest payments/GDP	0.7	0.5	0.1	0.1
Total debt/GDP	29.8	59.9	13.5	15.5
Total debt service/exports	62.2	22.7	2.4	2.3
Present value of debt/GDP	..	..	7.8	8.1
Present value of debt/exports	..	..	33.8	35.8

	1988-98	1998-08	2007	2008	2008-12
(average annual growth)					
GDP	6.9	7.1	8.6	9.5	5.7
GDP per capita	3.5	3.7	5.1	6.0	1.2
Exports of goods and services	13.0	11.3	12.2	7.3	12.1

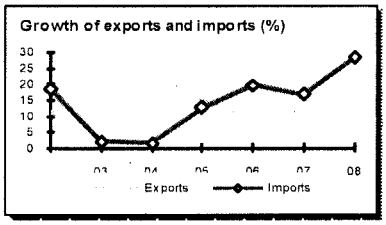


STRUCTURE of the ECONOMY

	1988	1998	2007	2008
(% of GDP)				
Agriculture	56.7	42.1	24.0	22.7
Industry	10.2	18.1	25.9	25.8
Manufacturing	5.8	9.1	7.7	7.6
Services	33.1	39.8	50.0	51.5
Household final consumption expenditure	91.3	81.4	78.9	82.4
General gov't final consumption expenditure	8.1	12.9	12.9	11.8
Imports of goods and services	17.8	20.4	30.6	33.4



	1988-98	1998-08	2007	2008
(average annual growth)				
Agriculture	3.7	2.4	-0.3	9.1
Industry	11.2	9.6	9.9	6.4
Manufacturing	13.0	6.7	4.3	8.1
Services	8.1	9.5	8.8	13.0
Household final consumption expenditure	6.4	6.9	10.3	15.8
General gov't final consumption expenditure	7.2	4.3	2.3	2.8
Gross capital formation	7.1	10.0	13.9	16.8
Imports of goods and services	7.6	9.4	16.7	28.1



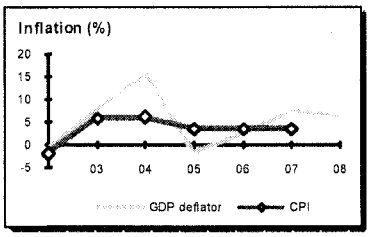
Note: 2008 data are preliminary estimates.

This table was produced from the Development Economics LDB database.

*The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

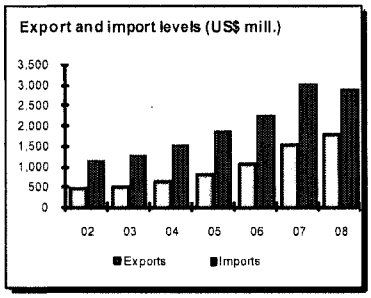
PRICES and GOVERNMENT FINANCE

	1988	1998	2007	2008
Domestic prices				
(% change)				
Consumer prices	188.5	5.8	3.5	..
Implicit GDP deflator	190.0	8.8	7.3	6.3
Government finance				
(% of GDP, includes current grants)				
Current revenue	5.8	10.6	12.6	13.0
Current budget balance	-0.6	1.0	1.1	1.4
Overall surplus/deficit	-5.6	-5.7	-5.1	-5.0



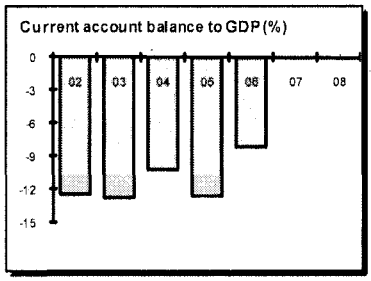
TRADE

	1988	1998	2007	2008
(US$ millions)				
Total exports (fob)	298	458	1,521	1,787
Coffee	286	269	229	297
Cotton	..	11	20	22
Manufactures	..	..	..	..
Total imports (cif)	545	966	3,027	2,912
Food	..	..	..	..
Fuel and energy	69	84	403	403
Capital goods	..	..	..	..
Export price index *(2000=100)*	138	127	135	163
Import price index *(2000=100)*	87	101	141	161
Terms of trade *(2000=100)*	158	125	96	102



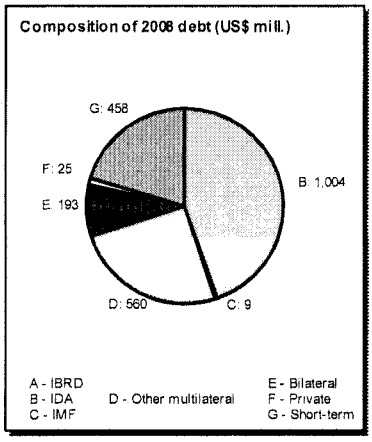
BALANCE of PAYMENTS

	1988	1998	2007	2008
(US$ millions)				
Exports of goods and services	324	634	1,998	2,259
Imports of goods and services	682	1,426	3,528	4,361
Resource balance	-358	-792	-1,530	-2,102
Net income	-57	-9	-224	-335
Net current transfers	120	37	..	..
Current account balance	-295	-764	..	..
Financing items (net)	343	898	..	..
Changes in net reserves	-48	-134	-682	-594
Memo:				
Reserves including gold *(US$ millions)*	57	750	2,080	2,673
Conversion rate *(DEC, local/US$)*	60.0	1,149.7	1,780.0	1,696.5



EXTERNAL DEBT and RESOURCE FLOWS

	1988	1998	2007	2008
(US$ millions)				
Total debt outstanding and disbursed	1,941	3,942	1,610	2,249
IBRD	44	0	0	0
IDA	585	1,947	840	1,004
Total debt service	202	153	65	74
IBRD	6	0	0	0
IDA	6	17	5	8
Composition of net resource flows				
Official grants	187	534	1,170	1,300
Official creditors	92	109	424	223
Private creditors	-1	-2	-1	-1
Foreign direct investment (net inflows)	5	210	733	788
Portfolio equity (net inflows)	0	0	-23	-32
World Bank program				
Commitments	135	184	425	521
Disbursements	74	113	374	172
Principal repayments	4	5	0	0
Net flows	70	108	374	172
Interest payments	8	12	5	7
Net transfers	62	95	368	165



Note: This table was produced from the Development Economics LDB database. 12/9/09

UGANDA

DISTRICT CAPITALS
NATIONAL CAPITAL
RIVERS
MAIN ROADS
RAILROADS
DISTRICT BOUNDARIES
INTERNATIONAL BOUNDARIES

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AUGUST 2008