

**USAID/Uganda
Social Sector SO Development**

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November 6-16, 2000

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1.0 Purpose of Visit and Methodology

USAID/Uganda is in the process of developing a new Integrated Strategic Plan (ISP) for the period 2002-2007. In the Mission's current strategy there are separate Strategic Objectives (SOs) in education (SO3) and health (SO4) and both programs have achieved some impressive and significant results. The Government of Uganda's (GOU) new Poverty Eradication Action Plan (PEAP) has integrated education and health into one of four PEAP goals "to increase the quality of life of poor populations of Uganda."

As part of the new ISP process, the Mission developed a Concept Paper, which proposed the development of a Social Sector SO that would merge the education and health SOs. Not only are there important linkages within both sectors, but the Mission maintains a social sector approach would better align Mission supported programs with GOU priorities and make best use of synergies and resources to achieve greater impact in both sectors. The Concept Paper was reviewed in USAID/Washington and suggestions were provided to the Mission to guide them in final strategy preparation. The ISP is scheduled for submission to USAID/W in February 2001.

To assess the feasibility of integrating the education and health SOs into one Social Sector SO, the Mission requested the assistance of a two-person team consisting of a USAID Education Officer and an Expert/Consultant Health Specialist. The purpose of this assignment was to analyze the feasibility and desirability of this integrated approach, propose options on integrating or combining the two sectors, and make recommendations on how best to package the results, taking into consideration past accomplishments and future needs. The team was asked to

- Review background materials and meet with donors, government officials and contractors working in education and health
- Review strategy documents and reports such as the Grimm trip report, the USAID/Uganda Concept Paper, and the USAID/W guidance cable
- Meet with the Mission education and health SO team members and senior Mission management for guidance on how to proceed, and
- Develop a 4 to 5 page paper outlining an option(s) for integrating education and health into one Social Sector SO.

Rather than drafting a short Social Sector strategy paper as proposed in the original scope of work, the team agreed to prepare a more extensive document that explored at least two options for combining and/or integrating these two sectors. Each option included an initial draft Results Framework along with a definition of the problem, results, and possible indicators. The team briefed the Mission on highlights of each option and outlined recommendations to consider in finalizing the ISP Social Sector SO.

Health and education are complex sectors and the GOU has developed detailed sector strategies for each one. The Mission also has a large portfolio of health and education activities and there are a number of donors providing support to these sectors. Unfortunately, within the time frame of this visit, the team was not able to carry out a

comprehensive review of each sector, meet with key donor and government officials, or adequately identify all constraints and future needs. While options for integrating these two sectors were analyzed and a draft results framework was developed, this report represents a “work in progress” based on limited discussions, a cursory review of the program, and thinking through ways to integrate efforts. It is by no means meant to be a final document. Our intent is to help move the Mission forward in developing the conceptual framework for a new Social Sector SO within the new ISP.

2.0 USAID Uganda’s Integrated Approach to Health/Education

In October 2000, USAID/Uganda submitted a Concept Paper for a six-year Integrated Strategic Plan (2002-2007) for review by USAID/W. The Concept Paper argued that it was critical to realign the Mission goal to directly reflect the development vision of the GOU, as articulated in its Poverty Eradication Action Plan (PEAP). The Concept Paper proposed a new goal for the new strategy to assist *the GOU to reduce mass poverty* and outlined an adjustment to its program by consolidating its six Strategic Objectives (SOs) into three SOs. Under the proposed realignment, the economic growth and environmental SOs would be combined into *Environmentally Sustainable and Diversified Economic Growth (SO7)*; the democratic initiative SO would be combined with a conflict resolution Special Objective to form *Democracy, Good Governance and Conflict Mitigation (SO9)*, and the health and education SOs would be combined to form *Improved Social Service Delivery (SO8)*.

The USAID/W guidance cable reporting the results of the Concept Paper review congratulated the Mission for a well-thought out and articulated paper and authorized the Mission to prepare an Integrated Strategic Plan (ISP). But a number of issues were also raised during the review. There was concern about the proposed merger of SOs and while USAID/W noted agreement with the importance of synergy between sectors, they also stressed the importance of maintaining the integrity of SO statements and goals. The Mission was asked to review Agency experience with combining SOs, especially in the Africa Region and was advised that “should the Mission ultimately decide to combine all or some of their current SOs, it should provide full justification for such action in the final ISP.” The guidance cable also asked the Mission to modify its goal statement to include the private sector and civil society, more clearly articulate its concept of poverty reduction, and outline a plan for monitoring progress.

Shortly after the Concept Paper review Curt Grimm, from the Africa Bureau’s Development Planning Office, visited Uganda to assist the Mission in further conceptual development of the ISP, specifically the proposed plan to integrate or combine all SOs. His trip report pointed out some important theoretical and practical elements of sectorial integration, including the notion that

- Combining SOs does not necessarily result in SO integration
- An authentically integrated framework takes a lot of time to develop and could include a higher SO level result that may be beyond the manageable interests of the Mission

- Based on the USAID/Mali experience, it will be important to develop integrated implementation actions and performance monitoring
- For integration to work, technical teams need to operate in a truly collaborative manner, and
- The integration of the health and education SOs is likely to be the toughest for the Mission to develop and they should remain flexible about whether to integrate or not.

The technical team of Evans and Kennedy, mindful of the Concept Paper guidance cable and Grimm's observations, took as our task to assist the Mission in examining the feasibility of integrating the health and education SOs and to provide our best professional judgement on what an integrated health/education SO would look like. The team found the task difficult despite hours examining different alternative frameworks. However we were able to come up with a potential model that has two variations.

The following sections include a review of the education and health sectors, which includes USAID achievements, lessons learned and future program needs. The education section also contains a longer descriptive analysis of the current status and salient issues of education in Uganda. These two sections are followed by a discussion on integration where the team presents arguments for integrating along with the challenges the Mission will encounter. A short discussion on options follows with a presentation of the team's preferred approach for development of a Social Sector SO. A narrative draft Results Framework for this option is included in the report. The last section is the team's recommendations on what is needed to complete work in development of a Social Sector SO for the ISP.

3.0 Education-USAID Achievements, Lessons Learned, and Future Program Needs

3.1 Education Status in Uganda.

In December 1996, President Museveni announced a bold new initiative to achieve universal primary education (UPE) in Uganda. The UPE initiative abolished all school tuition fees for up to four children (two of whom should be girls) from each family and all PTA fees (except for urban schools). There were no restrictions on the number of orphans who could attend school free of fees. These measures were taken because research had shown that parents were financing about 60 percent of the direct costs of education and that the fees were a significant burden for many households in a country where the per capita income is only \$300. Moreover, the AIDS epidemic left many young children as orphans who were barely surviving and not attending school.

The impact of the UPE initiative on the demand for education was extraordinary. In 1996, the number of children enrolled in primary schools was about 3.1 million. In 1997, the first year of the UPE initiative, the number of children enrolled increased to 5.2 million, a one-year increase of almost 70 percent. Girls represented 2.3 million or 45 percent of the enrollment. Many of the children in the huge bulge in enrollments were overage whose

families could not afford schooling. The current year (2000) enrollment is believed to be 6.8 million, of who X percent are girls.

The explosion of enrollments since 1997 has placed an enormous strain on an education system that already provided uneven quality of services. There are several indicators, which clearly show the strain on the system. For example, **the current primary school pupil-teacher ratio is estimated to be 70:1, the current pupil-classroom ratio is 99:1, and the current pupil-textbook ratio is 6:1.** Until more classrooms can be built, more teachers hired and trained, and more instructional materials produced and distributed (factors discussed in more detail below), the short-run effect of higher enrollments has been to spread the inputs available to primary schools thinly, resulting in a diminution of quality (learning achievement) and high dropout and repetition rates.

The children most affected by the dilution of school inputs have been those in the youngest grades. Uganda has an official policy, which establishes staff ceilings in schools. In practice this means that the early grades have the largest numbers of children (the average number of children in the first two grades is 110 per class). It clearly is not possible for even the most experienced teacher to help 100 or more six- to eight-year old children learn the literacy, numeracy and other basic skills necessary to succeed in later grades. And, the early grades are the age when children should be given the closest attention so as to put them on the path to self-sufficient learning. Moreover, the widespread practice of assigning the least experienced teachers to the early grades probably results in very poor learning in most Ugandan early grades.

Although evidence on learning achievement in Uganda is scarce, the evidence that does exist suggests that learning achievement declined dramatically after the launching of the UPE initiative. Comparable tests administered in 1996 and 1999 show that **satisfactory test scores in mathematics declined from 48 percent to 31 percent, while scores on English declined from 92 percent to 56 percent. On the reading test, only 11 percent of children achieved a satisfactory result in 1999.** Not surprisingly, in these situations of low learning and overcrowded conditions, many students become demoralized and either repeat grades or dropout of school. Despite a policy of automatic promotion, repetition rates are 8 percent in grade one and 11 percent in grade two. Given current dropout and repetition rates, only about a quarter of those children enrolled in the first grade will complete primary school in the required seven years and only about 35 percent will ever complete primary school.

In recognition of the challenges imposed by the UPE initiative, in 1998 the Government of Uganda (GOU), with assistance from Dfid and USAID, initiated broad consultations with external donors and other major stakeholders in the development of an investment and policy framework for education addressing a number of issues, including access, quality, equity, private/public sector partnerships, policy making, and decentralized institutional capacity, especially at the district-level. Out of these consultations, a rolling plan emerged with twice-yearly reviews between the Ministry of Education and Sports (MOES), the donors and other stakeholders called the Education Strategic Investment

Plan (ESIP). The ESIP framework set out a number of strategic policy objectives to be achieved by 2002/2003, including

- Education would receive at least 31 percent of the total recurrent budget in *actual* expenditures and that primary education's share of the education recurrent budget would reach 69 percent
- Universal enrollment of primary age children
- Transition rate from primary to secondary school of at least 65 percent
- Availability of skill training opportunities for all other primary school graduates, and
- Increase of the participation of females, disadvantaged groups, and children of special educational needs.

Over the last five years, Uganda has had mixed success in achieving the ESIP objectives. First, in the area of educational finance, the GOU is making a good effort to finance primary education and achieve the ESIP objectives. Education's share of the total government budget has fluctuated between 21 and 27 percent and education's share of the recurrent government spending has been about 30 percent or slightly below the ESIP target. Nearly a third of this spending is financed from donor projects, implying that public investment in education in Uganda is heavily dependent on foreign sources and vulnerable to unexpected declines in donor support. Primary education's share of the education recurrent budget is slightly less than the ESIP target but, if one factors a portion of the allocation to the central Ministry as an allocation for primary education, then the ESIP target is met.

In the area of enrollment of primary age children, the GOU is on track to achieve the target with a net primary enrollment rate of 93 percent. While the gap between boys and girl's enrollment rates has decreased, girls still have lower attendance and higher dropout rates than boys. The gender gap is troubling because girls' education has profound development impacts on a variety of areas but especially on the social sectors like family health, nutrition and family planning and on future generation educational levels.

It does not appear that the GOU will achieve the other ambitious ESIP objectives. Despite an average annual increase in secondary enrollments of nearly 30 percent over the last three years, fewer than 45 percent of those who complete primary school continue formal education or training and fewer than 15 percent of those eligible are enrolled in technical/vocational education and training. Faced with the UPE bulge, which will increase primary school graduates by 2.5 times in 2004 and limited scope in the budget, the Government will not be able to expand access to post-primary education in the near future.

3.2 Challenges and Salient Issues.

Despite the GOU success in expanding access to primary education, there are a host of problems that should be addressed by the GOU in the coming five years. Foremost are the issues of quality and equity of primary education. As noted earlier, the poor quality

and equity of primary education in Uganda is related to a number of factors, outlined below.

Inadequate Classroom Capacity. In 1999, the stock of 41,000 classrooms yielded a pupil-classroom ratio of 146:1. To achieve the ESIP target pupil-classroom target of 55:1 by 2005, it will be necessary to increase the stock of classrooms to 125,000, or an additional 74,000 classrooms. With the assistance of the Dfid, the World Bank and others, about 9,000 classrooms are being built per year and, while that number might be increased in the future, it appears unlikely the ESIP target for classroom construction will be met. Moreover, even if the pupil-classroom target of 55:1 were met, that class size is generally regarded as too high to significantly improve conditions for pupil learning.

Inadequate Supply of Teachers. Currently, about 90,000 teachers are employed by the GOU. To achieve the ESIP pupil-teacher target of 40:1 by 2005, the government must employ about 173,000 teachers. The current supply of teachers for the two-year pre-service programs is about 9,000 teachers per year. With the high teacher attrition rate of 9 percent per year (about 8,100 teachers), the system is barely making headway to reduce class size and improve educational quality. Moreover, the reluctance of many teachers to serve in remote areas has exacerbated the problems of teacher supply. One bright spot in this equation has been USAID's support for the Teacher Development and Management System (TDMS), which has upgraded the skills of approximately 10,000 untrained teachers. The TDMS is a cascade training system linking 18 core primary teacher-training colleges (PTCs) with schools, which are resource centers, and through the resource centers to schools. There are another 27 PTCs which are not core PTCs. The network of PTCs and resource centers provides opportunities for continuous professional development for teachers, management training for head teachers and community outreach activities in a variety of areas in support of primary education. The TDMS is a real strength and a key element in improving teacher training and the quality of education in Uganda.

Inadequate Instructional Materials. In 1999, the estimated ratio of pupils to books ranged from a best of 11:1 in English to a low of 18:1 in science. The procurement of additional books in 2000 will increase the stock of books to 5:1 for English and 8:1 in science so the GOU is moving in the right direction toward the ESIP target ratio for the four "core" subjects (English, mathematics, social studies, science) of 3:1 by 2003. The annual recurrent expenditures from the GOU and from direct donor support for supplying textbooks (about US\$15 million) appears to be adequate to achieve the ESIP targets. USAID's efforts to decentralize the purchasing and distribution of instructional materials has been especially helpful in increasing the supply of textbooks and instructional materials but problems persist in the effective classroom utilization of these materials.

Curriculum Reform. The primary curriculum for the core subjects has been recently revised and circulated to schools but without adequate guidance to teachers and schools. Moreover, Government plans to add six new subjects (Kiswahili, production skills, agriculture, religious education, local languages, and performing arts and physical education) to the primary school curriculum. The cost of textbooks and instructional

materials for these new subjects plus the significant costs of retraining teachers will greatly impact the quality of education in Uganda, especially since a more diversified curriculum may reduce the time spent on core literacy and numeracy skills.

School Management. In Uganda, over 45 District Education Offices (DEOs) and Municipal Education Officers (MEOs) are responsible, in conjunction with communities, for the delivery of primary and secondary education. The role of MOES has shifted to one of policymaking, investment management and quality assurance. In practice, DEOs and MEOs are responsible for monitoring and supporting primary schools within their area, while secondary education is centrally managed. A variety of grants from the central government and the Poverty Action Fund to DEOs provide about 72 percent of all government resources to the districts.

At the school level, head teachers work with school finance committees in the financial administration of the schools, while parents and teachers are encouraged to help and oversee the management of the schools. Even though the devolution of responsibility for primary education has been hailed as a model for social sector decentralization in Uganda and Africa, much more work needs to be done to make the system function better. Currently, there is a lack of clarity between the DEOs and local school councils on roles and responsibilities. The capacity to plan and account for expenditure is weak, especially at the district and school level. There are uncertain relationships and weak planning processes between the TDMS system and the DEOs, which tend to ignore the needs of schools and communities. Concerns have been raised that the number of conditional grants is negatively impacting service delivery and there are issues around decentralization and the recruitment and deployment of teachers.

Malnutrition and Health. Malnutrition and poor health is widespread among primary school pupils, especially those from poorer communities. Worms, vitamin deficiency (especially vitamin A), malaria, poor hygiene and malnutrition all inhibit effective learning through either reduced cognitive ability or reduced concentration. The lack of separate latrines and the availability of water reduce participation in schools, especially among female adolescents.

HIV/AIDS. The role of education in the prevention and mitigation of HIV/AIDS and the impact of HIV/AIDS on the delivery of educational services have not received much attention in Uganda. The MOES has recently developed a HIV/AIDS plan for the period 2001-2006 which will, among other things, promote policy guidelines relevant to HIV/AIDS in the education sector, strengthening HIV/AIDS education in all educational institutions, incorporate HIV/AIDS and other reproductive health issues into the curriculum for all levels of education, promote teacher training in HIV/AIDS and reproductive health, and promote HIV/AIDS education, counseling, and health care services at all educational levels. It is not clear what, if any, assistance the MOES will need to implement this plan.

Early Childhood Development. The Government recognizes the importance of early childhood development as an intervention to improve readiness of children for primary

school, to reduce dropout and repetition and thus achieve UPE goals. Nevertheless, pre-primary education, like many other countries, is largely a private business in Uganda. Currently, there is no control over the quality of the curriculum, teaching methods facilities and quality of teachers. Moreover, expansion is constrained by a lack of trained teachers, especially in rural areas. The MOES has a new policy and curriculum in draft but much work needs to be done to implement and disseminate the policy and curriculum.

Access to Post-Primary Education. As noted earlier, the Government will be faced with a huge bulge of children seeking access to post-primary education in 2004. Given the limited budgets and donor support, it does not appear that GOU will not be able to expand the post-primary system as it is currently structured. There is, however, an important opportunity to work with the GOU to develop policy, models and options that explore

- Broad policy goals, objectives and strategies available to the GOU to expand secondary education
- Options for increasing equitable access to post-primary opportunities, especially for girls, the poor and rural residents
- Options for strategic, cost-effective expansion of secondary education
- Options for increased efficiency and cost-effectiveness in secondary education
- Options for workforce development and improved relevance in post-primary education, and
- Options for safeguarding quality in secondary education in the face of enormous demands on the system.

3.3 USAID/Uganda's Achievements in Education

Over the last eight years, USAID/Uganda has worked in education under the Strategic Objective (SO) of "Quality basic education for an increased percentage of Ugandan children." Activities and Intermediate Results (IRs) have focused on

- Increasing the availability of primary schooling
- Improving the quality of instruction
- Improving support for girls' participation in primary schooling
- Financial support to the education sector, and
- Improving technical efficiency and institutional capacity.

When measured using the performance indicators in the Mission's Results Framework, USAID/Uganda has made remarkable progress in the implementation of its education SO with all of its performance targets met or exceeded. For example, completion rates at grade 4 and grade 7 have increased dramatically from 1994-1996 to 82 percent and 37 percent, respectively, while there has been an enormous increase in the gross enrollment due to the UPE initiative, all suggesting substantial success in the sector. Moreover, even for those IRs where there is no reported data, it is clear that the Mission has made great progress. For example

- The policy dialogue partnership with the GOU has yielded huge dividends insofar as the GOU has maintained the ESIP financial targets for education and primary education and instructional materials and textbooks, once a GOU monopoly, have been converted to a competitive market, eliminating much inefficiency and corruption
- More than 8,000 untrained teachers, 15,000 trained teachers, 400 teacher trainers, and 400 head-teachers have been better trained under the TDMS system and as a result have improved their use of instructional materials, and received better support from supervisors
- A national plan for girls education was developed and implemented with assistance from UNICEF and USAID and pilot programs to enhance girls' persistence and achievement have been put in place, and
- The technical efficiency and institutional capacity of the education sector has been vastly improved through the decentralization of financial and administrative management of primary education to the district and school level.

These successes in the performance indicators, however, mask enormous and daunting challenges ahead for the education sector. Even some of the apparent successes are two-edged swords. On one hand, the dramatic increase in completion rates at grade 4 and grade 7 and in the gross enrollment rate suggest substantial success in the sector. On the other hand, the official policy of automatic pass coupled with the huge pupil-teacher, pupil-classroom, and pupil-textbook ratios and the evidence of declining learning achievement, suggest that the increase in completion rates mask a serious decline in the quality of education in Uganda. Moreover, it appears that girls continue to be disadvantaged in the Ugandan education system, which has profound developmental impacts on all sectors in which USAID works. As a result, it seems clear that any USAID effort in the education sector in Uganda should focus on improving the quality and equity of education, especially for girls.

3.4 Lessons Learned in Education

In nearly any development effort there are a series of issues that must be addressed before the problem is solved. In education, the first-generation development issue is usually access to basic education. Most developing countries emerging out of colonialism inherit an education system that provides a good education for a limited number of the elite and upper classes and the task is to broaden educational opportunities, often at the expense of educational quality. The second-generation problem then becomes re-establishing some quality in the education system. Once the quality issues are solved, tertiary-generation problems emerge such as equity, relevance, and efficiency. Often all of these problems are present at the same time.

Uganda appears to be struggling with all of the problems (access, quality, equity, relevance, and efficiency) but the GOU is a good development partner. They are making an extraordinary effort to finance primary education reform and they are attracting a good amount of donor support as a result. Moreover, USAID/Uganda, along with the World

Bank and Dfid, has been instrumental in assisting Uganda develop a sound educational policy and to implement programs, like the TDMS system, that have made substantial impacts and enabled the GOU to move ahead in its education reform. USAID's presence as a strong development partner as Uganda addresses its second-generation educational development issues has merit on technical and political grounds. Moreover, **the enormous and complex challenges remaining in the education sector suggest that the Mission should not abandon education as a strategic objective or subsume education under a social sector strategic objective. If the Mission subsumes education under a Social Sector SO, a real possibility exists that the Mission may miss an opportunity to ratify and re-enforce its achievements and/or support new GOU policy initiatives.**

Some of the key lessons learned in the education sector are

- The GOU is a good development partner in the educator sector and USAID should seize the opportunity to move ahead to address the second-generation issues while the GOU is committed to the problem
- Although the Mission has accomplished a great deal in the education sector, much more needs to be done to re-enforce the gains made to date
- Education reform is inherently a long-term task and it may be seen as irresponsible to reduce emphasis on the sector after only eight years
- The inadequate stock of classrooms and textbooks that currently hamper the system appear to be addressed by other donors but the inadequate supply of teachers is not being adequately addressed
- Teacher training is a comparative advantage of USAID through its special knowledge of and involvement with TDMS and TDMS is a major channel of quality improvement and intervention in the school and in the classroom
- Policy analysis has been an area of major success for USAID and the other donors are anxious that USAID maintain a place at the table, especially given the policy issues surrounding the burgeoning problem in secondary education
- Although Uganda has made good strides in decentralizing the education system, the reform is incomplete and decentralization of school systems is another area of comparative advantage for USAID, and
- Equity, especially for girls, is a persistent problem in Uganda and USAID has worldwide experience in supporting girls' education and institutional resources to draw on in the Africa Bureau and G/WID.

3.5 Future Program Needs in Education

There are a number of factors to be considered when outlining a strategy for USAID/Uganda. USAID/Uganda recognizes that it has had many successes but there are numerous issues remaining in the education sector. The Mission wants to build on its successes and utilize its comparative advantage in the design of its new six-year strategy in the education sector. Given the large donor presence in Uganda (more than \$80 million annually) and USAID resources planned at \$7-8 million per year, the Mission feels its comparative advantage is not in budgetary support for the GOU's ESIP initiative. Instead the Mission believes that it can more effectively use its grant funds to support policy

analysis, research and pilot programs to address the many issues facing the education sector. Finally, the Mission is interested in maximizing the synergies between the health and education sectors. Based on these factors, the ESIP successes, Mission discussions with Ministry staff, and this analysis, this report suggests the following areas for focus

- Improving the quality of basic education services, especially for girls
- Improving efficiency in teacher training
- Improving performance of teachers in the classroom
- Improving decentralized educational services
- Improving implementation of girls' education
- Improving pupil health, and
- Improving policy analysis, especially for unexplored areas like secondary education, post-primary education, and early childhood education.

4.0 Health- Achievements, Lessons Learned and Future Program Needs

4.1 USAID/Uganda's Achievements in Health

USAID has contributed to significant health achievements in Uganda over the past 10 years and one of the most important has been the contribution toward reducing the country's HIV/AIDS and adult sero-prevalence from 30% at some sites to 9.5%. Another major achievement has been the increase in contraceptive prevalence rates from 12% in 1995 to nearly 20% in 1997 in the 12 districts where USAID is providing support.

4.2 Lessons Learned in Health

- The USAID-supported DISH I/II projects have made important contributions to improving access to quality reproductive health services in Uganda however impact has been limited to work in 12 districts, which only reach 30% of the country's population. While facilitating wider adoption of DISH strategies beyond the 12 districts is a priority within the current agreement, DISH has only just begun to share their approaches and tools with the MOH to be adapted for scale up beyond the DISH districts.
- The DISH program can not be replicated in other districts without substantial outside technical and financial support. However there are a number of DISH models, tools and lessons learned that can (and should) be shared, scaled up, and adapted to the needs of other districts and service providers. Some of these include the HMIS system, logistics management systems, tools for monitoring of basic standards of quality, the sentinel surveillance system for monitoring and evaluation, human resource approaches to preparing district health teams such as distance learning, on-the-job training, and integrated reproductive and child health training modules programs for health workers.
- The USAID-funded social marketing program (CMS) is national in scope and 50% of product sales are in non DISH districts, except for family planning

products which are exclusively sold in DISH districts. The CMS approach shows great promise for having a major impact through utilization of the private sector to reach clients with important products and services. The CMS product line includes condoms (3 million/year), Injectiplan (275,000 vials/year), pilplan (675,000 cycles), and other newer products such as a pilot launch of mosquito nets in four districts, Vikela (emergency contraception) Clear Seven (treatment for GC, clamidia STI), and clean delivery kits. Future possibilities include expanding the "kit concept" to include a malaria treatment kit for various age groups, expanding their sales reach to more rural areas, and working with commercial sex workers and truckers.

- In July 2000 a pilot study carried out by DISH showed an increase in adolescents utilizing health services when services were made user friendly, service providers were trained in how to deal with the special needs of youth, and integrated services were made accessible to adolescents. Once the final report is completed and disseminated, this DISH approach to adolescent reproductive health should be developed and expanded, including to non-DISH districts.
- Decentralization has both positive and negative effects on the delivery of health services. While districts have been given the authority and responsibility for health, they are not yet adequately prepared to handle the program responsibilities to plan, implement and be accountable for services.
- Knowledge and skills development does not necessarily result in behavior change and additional emphasis is needed to change the attitudes of service providers and local communities. For example, behavior change and advocacy to support and adopt important health practices are a priority, especially for children and young adults. Messages such as the benefits of spacing births three years, benefits of delaying second births, and the importance of childhood immunization are some of the messages needed .
- Vertical or parallel programs (such as EPI) can have a negative impact on decentralized services if they are not adequately integrated within local health plans accompanied by technical assistance and resources.
- Community ownership and transparency are key to the sustainability of programs.

4.3 Future Program Needs in Health

- There are still one million Ugandans living with HIV/AIDS and as a result of HIV/AIDS, average life expectancy has declined to 43 years. Approximately 1.7 million children under the age of 18 have lost one or more parent to AIDS and this is expected to double over the next 10 years.

- Uganda continues with an extremely high fertility rate (6.8 children per woman), low contraceptive use (10%) and a high unmet need for services (29%).
- Malnutrition and micro-nutrient deficiency remain serious health problems (1/3 of children under 5 are stunted, 25% are underweight for their age, 5% are wasted, and Vitamin A deficiency and anemia are issues).
- Preventable diseases account for 75% of the national disease burden and outbreaks of such diseases as measles are a direct result of low immunization coverage (only 38% of children are fully immunized).
- Malaria is one of the largest causes of morbidity and mortality in Uganda and only 30% of the population receive effective treatment for malaria within 24 hours of the onset of symptoms. It is especially serious for pregnant women and children under five.
- Low/poor access to quality health care continues as a major problem and 51% of the population still live more than 5km from a health unit. Only 42.7% of parishes have any type of health facility and there are wide variations between rural and urban areas. (Health Facility Inventory 2000)
- (MOH 1999) The recent inventory of human resources in public health facilities indicated that only 34% of established positions were filled by qualified staff. The remainder were filled by untrained nursing aides or remained vacant.
- Adolescents have some overwhelming social needs that are unique and require distinct and special responses. For example, high teenage pregnancies contribute to 43% of the MMR and age at sexual debut is decreasing, and there is limited community participation in health and education along with a lack of knowledge on healthy practice and services to meet the specific need of youth such as safe sex, HIV/AIDS, counseling and youth friendly services, and life skills. Also young children, especially girls, experience high absenteeism and drop out rates in school, due in part to poor health and nutrition, unhealthy school conditions, and lack of special sanitary facilities for girls.
- The MOH needs to improve the management capacity of district health teams to include program planning, budgeting and financial accountability at district and sub-district levels.
- A functional logistics management system for drugs and other supplies (including contraceptives) does not exist and this is inhibiting the delivery of quality services at all levels of the health care system.

- (1996 Baseline Service Delivery Survey) The public sector provides a major share of the health care services and efforts are needed to better coordinate and understand the important role of all sectors in providing health services within districts. The government provides 43% of all health services, the private sector 35% and traditional doctors/healers nine percent.
- Those using the public sector vary greatly by type of service. For example, the government provides 60% of all immunizations and 50% of the family planning services, yet for curative care provides only 20-25% of the services. Clients in need of curative services are more likely to use private and NGO health care providers and even more likely to choose self-medication over government health care. (Hutchinson 1999)
- In the Hutchinson study the importance of quality as a major determining factor of whether or not to use government services is demonstrated. The study showed factors such as availability of antibiotics, presence of a functioning cold chain, numbers of support staff, and whether a facility is non-governmental (e.g. quality indicators) significantly increase the likelihood that poor clients will seek curative services.
- This same study showed that for preventive services, female education levels, income, and quality of care indicators (mentioned above) are significant determinants that affect use. Price, income and distance are not generally as important in use of preventive services.
- Exciting possibilities exist to expand support to the private sector in Uganda. Some of the current activities should be assessed and a determination made on whether they can be expanded or scaled up. Potential activities include
 - Expanding the social marketing product line, including the "kit concept"
 - Privatizing the CMS program through the creation of a local foundation
 - Exploring innovative health insurance schemes
 - Increasing support to private practitioners beyond the Midwives Association to include local community based organizations (CBOs).

5.0 Proposed Integration of the Health and Education Strategic Objectives

Some of the arguments for integrating both sectors into one strategic objective include

- Both contribute to the achievement of the one of Uganda's PEAP goals "increasing the quality of life of the poor".
- In the 1998 Uganda Participatory Poverty Assessment, ill health was cited as the most frequent case and reason for poverty. The health sector plays a key role in poverty eradication and overall socio-economic development in Uganda.

- There are many synergistic and cross cutting issues in both sectors such as HIV/AIDS, adolescent pregnancies, school drop outs especially among girls, discrimination against girls in schools, the need to understand and adopt healthy practices such as safe sex, and improve health conditions in schools to facilitate learning.
- This may result in a more efficient use of a reduced workforce and optimal use of human and financial resources on the part of the Mission.
- It will provide USAID with the opportunity to promote inter-sectoral linkages within the education and health sectors (which at present do not exist) and to provide leadership by developing multi-sectoral responses to priority and somewhat complex social sector problems.
- It will provide a more comprehensive response to the needs of the districts as they already function under integrated structures. A Social Sector SO could make better use of limited resources, encourage integration of programs based on needs, and foster important community-based linkages within the public and private sectors.
- In May 2000 the GOU decided to scale-up the HIV/AIDS response by mainstreaming the delivery of cost-effective interventions into all poverty eradication strategies and programs. This was done in order to more rapidly reduce HIV prevalence and mitigate the health and socio-economic effects of HIV/AIDS at the individual, household and community levels including health, education and other sectoral programs.
- It provides the ability to jointly fund certain results (health education in schools)

However at the same time, some of the real challenges the Mission faces in trying to develop a Social Sector SO include

- It would require a completely new SO design and, as noted by Curt Grimm, the SO results would have to be at a very high level.
- At present, there is very little inter-sectoral integration as the GOU SWAP and ESIP approaches are consuming most of the time and effort of the education and health sectors. There is very little joint planning at present.
- There would be the fear of losing education and HIV/AIDS in a larger integrated SO.
- The needs of each sector have similarities but at the same time each sector is complex and has very different needs and priorities.

- The apparent Mission workforce efficiencies resulting from combining health and education may not materialize and might actually increase the workload on an already harried staff.

5.1 Combined Approach

The team looked at possible approaches to combining these two sectors under a Social Sector SO. The first was strictly combining the two sectors under one SO and having an IR that deals exclusively with health and another with education. This would be putting two relatively separate sectors under one SO with perhaps a little overlap at lower IR levels in areas such as health education. In other words, each program remains relatively intact. The team concluded that this approach doesn't make much sense as it raises the SO to a higher level which may be difficult to achieve. Also if the intent is to only combine the two sectors under one SO, it would make better sense to have two separate SOs.

5.2 Integrated Cohort Model

The second approach, and the one proposed by the Mission, is where the entire SO would be integrated with IRs based on cohorts (0-5 years, 6-15 years, over 15 years). This approach has one IR focused on under 5s, another on adolescents, and the last on adults. While a logical case can be made for this type of approach (for example there are priority and synergistic needs of youth), discrete program results based on priority needs of the each sector do not logically or neatly fit under these cohorts.

Some of the priority program needs such as strengthening the capacity of districts, or improving quality in the delivery of a package of integrated health services do not easily lend themselves to this approach. For example there is a need to improve integrated health services including child health services. The cohort approach would divide services under cohorts according to age, which wouldn't make a lot of sense. The only area where health and education activities and needs intersect in this model is under the youth cohort. Therefore unless the Mission expects to move into areas such as early childhood development, post primary education, vocational training, or adult literacy programs, there aren't a lot of education activities that would contribute to the needs of the other two cohorts. In summary, while conceptually logical, the integrated cohort approach doesn't match the needs of the program (except for youth) and doesn't seem to be the best approach to integrating the education and health sectors.

5.3 Combined and Partial Integrated Cohort Approach

After the analysis of the above two approaches, the team developed an approach that included some combined IRs, and an integrated IRs that uses the youth cohort approach.

The features of this approach include

- Except for HIV/AIDS, it integrates the majority of health activities under one Intermediate Result.
- It highlights the need to strengthen the capacity of the districts and sub-districts through a separate Intermediate Result (IR2.1) that can easily link to the activities in the Mission's separate decentralization SO.
- Given the magnitude of the problem and the Mission's planned response, there is a separate IR for HIV/AIDS which addresses prevention and treatment, yet provides the opportunity to include these activities within the Mission's social sector SO.
- It includes an innovative new higher level IR focused on the special needs of youth, especially girls and has a completely integrated IR, which deals exclusively with joint health and education activities.
- This youth IR has a specific lower level IR, which focuses on the continuing needs of the education sector and builds upon USAID/Uganda's current program achievements. The education activities are clearly visible in this IR (IR3.2)

The team developed two variations on this model, one that is more integrated (with a health IR, an HIV/AIDS IR and a youth IR), and one that is less integrated but elevates the education IR to a higher level in the framework. Draft frameworks for these two variations can be found at the end of this report. The first more integrated option is presented below.

SO 8: IMPROVED DELIVERY OF GENDER-SENSITIVE SOCIAL SECTOR SERVICES

Possible Indicators: TFR, IMR, MMR, and Reduced rate of HIV/AIDS infection

IR1 Increase Access to Quality, Sustainable Integrated Health Services (IHS)

Integrated Health Services include Family Planning/Reproductive Health, HIV/AIDS/STI, Tuberculosis and Other Opportunistic Infections, IMCI, Immunization, Malaria.

Possible Indicators: CPR, Birth Spacing of three years, Reduced Incidence of Malaria,

IR1.1 Improve District and Sub-District Capacity to Deliver Integrated Health Services

Possible Indicators: CYP

IR1.1.1 Expanded Delivery of Quality Integrated Health Services

- Implement quality standards for IHS delivery
- Deliver a package of critical IHS services
- Provide adequate supervision and oversight

- Install in-service education systems for health personnel (DISH Training Information and Monitoring System)
- Increase capacity to develop behavior change strategies and implement IEC activities
- Create multi-sectoral partnerships/linkages with the other sectors, private sector and communities to improve coordination and deliver IHS

IR1.1.2 Program Planning Systems Functional
 -Improve financial and planning skills and accountability
 -Establish monitoring and evaluation systems (HMIS, program and financial)

IR.1.1.3 Operational Integrated Health Commodities, Supplies and Distribution Systems
 -Install drug, supplies and logistics management systems
 -Drug procurement functioning with little stock outs

IR1.2 Increase Role of the Private Sector in Integrated Health Services
 Possible Indicators include CYP

IR1.2.1 Increase Commercial Distribution of Integrated Health Service Products
 Possible Indicators: sales reaching percentage of target groups
 -Expand IHS product line using “kit” approach
 -Increase national coverage of CMS to rural areas
 -Reach special groups such as commercial sex workers/truckers

IR1.2.2 Integrated Health Service Payment Schemes Tested and Implemented
 -Test and scale up pilot insurance and HMO schemes

IR1.2.3 Expanded Private Sector Quality Integrated Health Services Provided
 -Expand CBO’s in delivery of IHS information and services
 -Support private practitioners (UPMA and others) to deliver IHS

IR1.2.4 Partnerships with Public Sector and Communities Strengthened

IR1.3 Advocate for and Establish Quality Integrated Health Services

- IR1.3.1 Scale up of Integrated Health Best Practices**
-Scale-up lessons learned (HIV/AIDS, DISH, EPI, etc)
-Create continuous quality improvements through research and pilots
- IR1.3.2 Systems for Quality Standards and Improvements Functioning**
-Develop national standards for delivery of IHS
-Set up systems (sentinel surveillance) to monitor program progress
-Set up and institute system to reward excellence in providing quality services
-Create health care financing schemes to sustain programs (with equity)
-Strengthen authority and capacity to provide standards and oversight (Council for Nurse Midwives, Council for Private Practitioners, National Drug Authority, etc)
- IR1.3.3 Strong Advocacy for Integrated Health Programs**
-Advocate for improved IHS policies, commitment, and support.

IR2 Increase the Capacity of the GOU to Expand Access to Quality HIV/AIDS Prevention and Care programs

Indicator: MTCT, HIV prevalence in pregnant women

- IR2.1 Scale up Model District HIV/AIDS Programs**
-Upgrade skills of health care providers
-Community and school based education
-TASO counseling and outpatient clinical care
-Improve/Expand Children/Orphans affected by HIV/AIDS
-Increase access to VCT and expand AIC programs (from 22 to 45 districts)
-Set up HIV/AIDS surveillance system with the MOH
- IR2.2 Increase Capacity of the Private Sector and CBOs in HIV/AIDS**
-Capacity building of community based organizations to carry out HIV/AIDS work
-Social marketing of condoms
- IR2.3 Strengthen HIV/AIDS Prevention Programs**
-Targeted programs for adolescents, sex workers and street children
-Promote behavior change and safe sex practices

- Promote fewer sexual contacts with non-regular partners
- Increase demand for STI services
- Set up affordable preventive therapy for TB and other opportunistic infections
- Anonymous HIV counseling and testing

IR3 Increase Capacity to Address the Special Needs of Youth, with a Focus on Girls

IR3.1 Adoption of Healthy Practices Among Youth

- Youth friendly health and education services
- Young married couples counseling and education
- Life Skills training (safe sex, family planning, HIV/AIDS)
- Treat nutritional deficiencies and health problems at schools
 - Immunizations
 - community-based and financed school feeding for at-risk children
 - vitamin A
 - de-worming
- Change pupil's health behaviors through school-based programs (HIV/AIDS, personal hygiene, nutrition)
 - curriculum units developed and disseminated
 - social marketing
 - supplies (condoms, vitamins, de-worming, immunizations)
 - peer education programs
 - integrate life skills program
- Strengthen capacity and resolve of school governing bodies to improve pupil's health
 - social marketing
 - community-based and financed improvements of school conditions such as latrines and/or clean water
- Improve health conditions for girls
 - MOES/MOH Task Force to implement integrated, prioritized girls' education/health program
 - strengthen district capacity to plan, manage and implement girls' education
 - support girl's school-based interventions at selected disadvantaged districts
 - establish a MOES senior teacher-counselor system
 - disseminate gender sensitization and health materials to schools

IR3.2 Improve the Quality of Basic Education Services

IR 3.2.1 Improve Efficiency in Teacher Training

- Improve integration of pre- and in-service training
- Improve delivery of professional development courses and materials

- Improve capacity of Teacher Training at Kyambogo (ITEK)
 - Improve teacher training curriculum
 - Improve PTC student assessment
 - Computer-assisted teacher training curriculum and materials

IR 3.2.2 Improve Teachers' Performance in Classroom

- Improve supervision of teachers
- Upgrade districts without Core PTCs to Core PTCs and extend services to schools
- Scale up selected classroom-based quality/equity interventions
- Disseminate classroom-based materials

IR 3.2.3 Reinforce Decentralized Education Services

- Strengthen organizational development, management and implementation between various levels of local government (PTCs, DEOs)
- Develop professional development training models for district/school level managers
- Assist districts to develop and implement girls' education and health programs

IR 3.2.4 Improve Implementation of Girls' Education Programs

- Mainstream gender issues into MOES policies, strategies, education services and operations
- Support development of district level girls' education action plans selected districts
- Integrate life-skill program into teacher training, school curriculum
- Establish senior teacher counselor system
- Disseminate gender sensitization materials to teachers/schools
- Pilot test alternative schooling models for hard-to-reach girls

6.0 Recommendations

Our task was to assess the feasibility of integrating the education and health Strategic Objectives into one social sector Strategic Objective. Our analysis suggests that it is feasible to integrate the two sectors but that it may not be desirable, especially given the enormous and complex issues facing both sectors. Moreover, even if it is feasible to conceptually cluster the education and health sectors into an integrated social sector SO, the task is going to take a great deal of analytical effort and time. As a result, we offer the following recommendations for the Missions' consideration:

- **Additional analytical studies** or information is needed to clearly define possible areas of intervention for the Social Sector SO. At a minimum these include a quick and dirty private sector study in health, an extensive review of current activities and

future priorities in health, and a more in-depth review of strategies and responses for dealing with improved teacher training.

- **The Mali experience** in the development and implementation of their integrated youth Strategic Objective should be studied (to ideally include someone taking a trip to observe the program) to learn how both sectors were integrated and determine why integration has been difficult there.
- **DISH II needs to immediately develop a scale-up strategy** and begin transferring skills and experiences to other districts. This will probably require a realignment of their current program activities. Also, the development of a local behaviour change and communications NGO (planned to be developed by DISH II) is an urgent and immediate priority need
- **Move cautiously.** Once the Mission has a more developed framework (with problem statements, possible indicators and general descriptions of activities) bring donors, local stakeholders, (GOU and private sector), contractors (technical experts) and USAID/W experts from the Africa Bureau and Global to review, validate and refine your strategic approach before finalizing it.
- **Streamline performance monitoring.** The current health performance monitoring plan collects extensive information and it is doubtful all can be directly attributed to the USAID program. While there is a temptation to collect a lot data, it also takes an inordinate amount of time to monitor. In developing the new ISP care should be taken to only include indicators that can be directly attributed to results achievement attributed to the program and those that will clearly measure progress towards result achievement.
- **Be flexible!** If it becomes too complicated to meaningfully integrate these two sectors, you can always design a responsive SO for each sector. This would not require “going back to the drawing board” but rather splitting the two off and highlighting synergistic IRs and activities. In this scenario the Mission could also consider developing a Special Strategic Objective (SpO) for those synergistic activities between health and education.
- **Involve the Africa and Global Bureaus** in the development of this combined SO. You are trying to do something in an area where USAID doesn't have much experience. As you go along, you need to continually get guidance and advice from those that will be reviewing your ISP in USAID/Washington.

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