

SO8 SERVICES DELIVERY CONCEPT PAPER

I. BACKGROUND AND RATIONALE

A. Problem Statement

The Ugandan economy grew at an average annual rate of 6.7% during the decade of the 1990s, and the number of Ugandans living in poverty declined from 56% to 35% of the population. Unfortunately, progress against basic indicators of social wellbeing such as fertility, morbidity, mortality and educational performance did not match the rate of economic progress, and that economic progress will come to a standstill or even reverse itself unless key human capacity issues are more vigorously addressed.

Uganda's population is young and growing rapidly. Key cohorts in this youthful population include infants and children five years or less, school-aged children 6-14 years, adolescents 15-19, and young adults of 20 and above. With the child mortality rate at 152, survival is the main hurdle that young children face. Those who surmount this first hurdle enter a primary education system that has difficulty equipping them with the life skills they need to become responsible adults, even if they do complete their education. Most young people leave school at 16 or even younger, many of them already sexually active, some of them pregnant, others married, the majority only nominally literate, and many at risk of HIV infection. In order to sustain economic progress and make a difference in Ugandans' quality of life, it is necessary to focus on the basic human conditions that work against poverty reduction in the country: high morbidity and mortality, poor education quality, and high fertility.

USAID's hypothesis for the 2002-2007 planning period is that if there is to be "improved human capacity" (SO8), then a strategy to improve basic human conditions must address the holistic context in which they exist. The chosen strategy is thus integrated, bringing together health, population, nutrition, HIV/AIDS, and basic education interventions to achieve broader human capacity results. It also builds on recent sectoral experience and is two-tiered, addressing systems strengthening and service delivery, at the national and district levels. Importantly, it is targeted at Uganda's young population, by age cohort, based on experience that shows that youth are more likely to adopt behavioral change. Given past experience, this integrated, two-pronged, demographically targeted strategy is expected to yield significant results.

B. Prior USAID Involvement

USAID has contributed to improving human capacity in Uganda since the early 1970s. Under the 1997-2001 strategy, the focus was on increasing service utilization for reproductive, maternal and child health in targeted districts (SO4), and on improving quality and equity in basic education (SO3). Activities in the health sector focused primarily on service delivery, related to reproductive health and to address the HIV/AIDS pandemic. Activities in the basic education sector focused on strengthening systems to improve quality, notably in teacher professional development through the Teacher Development and Management System (TDMS). These investments have contributed to significant achievements: the contraceptive prevalence rate (all women, any method) increased from 4.9% in 1989 to 13.4% in 1995 and 20.1% in 2000; the rate of HIV prevalence has declined; and Uganda now has what is recognized as one of the best teacher preparation systems in Africa. In spite of these and similar achievements, as mentioned above, many critical social

indicators have been stagnant or declining. Moreover, there are significant regional and district disparities in health and education status. The new integrated, demographically targeted SO8 strategy will address problems from both the systems and services dimensions, at the national and district levels, in an effort to reverse these trends.

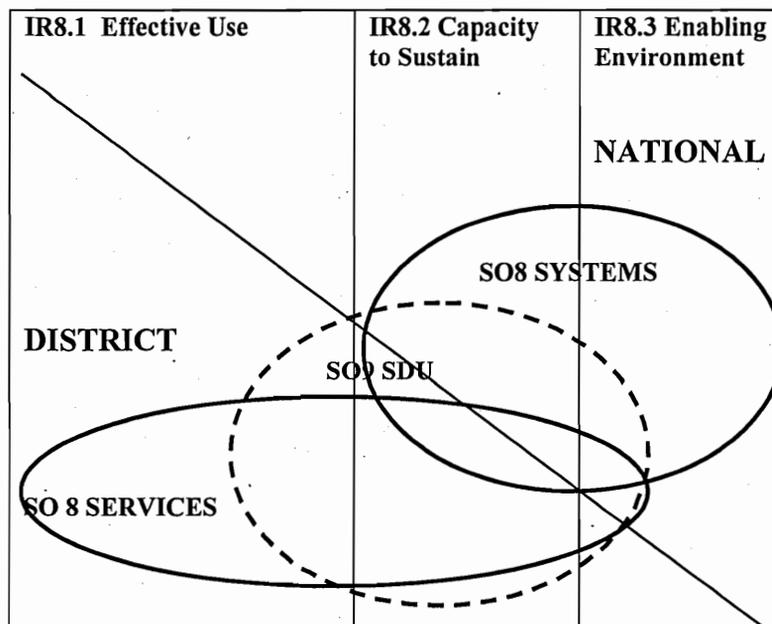
C. Conformance with GOU Policies and Other Partner Programs

The integrated USAID strategy will complement the Government's holistic Poverty Eradication Action Plan (PEAP) which aims to: directly increase the ability of the poor to raise incomes; and directly increase the quality of life of the poor. All activities fit within the Education Strategy Investment Plan (ESIP), Health Sector Strategic Plan (HSSP), and National HIV/AIDS strategy. Government input has been sought in consultative meetings at national, district, county and sub-county levels. In addition, USAID has worked closely with our donor partners to ensure coordination and collaboration. All future interventions will be closely coordinated with these actors and the numerous bilateral and international donors as well as agencies and NGOs involved in conflict prevention, mitigation and response in Uganda.

D. Conformance with USAID Strategy

The proposed activity is one of three core activities expected to achieve SO8 results of effective use, increased capacity to sustain, and strengthened enabling environment for social sector services during the 2002-2007 strategic period. The three core activities are: i) Service Delivery, which will be undertaken through three complementary implementing instruments/mechanisms focused at the district and sub-district levels on integrated services delivery, HIV/AIDS best practices, and social marketing; ii) Systems Strengthening, which will ultimately be comprised of one institutional contract after transition instruments have terminated; and iii) the SO9-managed Strengthening Ugandan Decentralization (SDU), which provides critical complementary support to both SO8-managed core activities. Figure 1 below shows the relative contribution to achievement of SO8's intermediate results (IR) by each of the three core activities.

Figure 1: SO8 Activities to Achieve Results



II. ACTIVITY DESCRIPTION

A. Overview

The strategic objective statement for SO8 is “Improved Human Capacity.” Human capacity is defined as: individuals’ ability to decrease vulnerability to poverty through improved health and education status. USAID will monitor achievement to assess if it is improving this capacity through four milestone (interim) indicators, with targets as follows: contraceptive prevalence rates (CPR) for modern methods will increase from 18% to 26%; immunization coverage among children (12-23 months) will increase from 38% to 47%; HIV prevalence among 15-24 year old antenatal clients will decrease by 5% annually, and average test scores for primary grades 3 and 6 pupils will increase by at least 10%.¹

The three intermediate results (IRs) that will contribute to achievement of SO8 are: 8.1, Effective use of social services; 8.2, Increased capacity to sustain social sector services; and 8.3, Strengthened enabling environment for social sector services. Preliminary indicators to measure their achievement are elaborated in the ISP, and targets will be finalized in the coming months. USAID plans to allocate an average of approximately \$30 million/year to achieve these results.² With reference to Figure 1, these funds will be divided among three core activities.

- The Services activity will utilize about 68% of total yearly funding over the strategic period, through three “core” instruments: the AIDS/HIV Integrated Model District Program (AIM) for HIV/AIDS prevention, care and support; Commercial Market Strategies (CMS) for social marketing of health and education products; and the new Integrated Services Cooperative Agreement (CA) focusing on increasing quality, access, availability, and use of social services by key demographic cohorts. The estimated cost of the Integrated Services Cooperative Agreement is approximately \$45 million over five years.
- The Systems activity will utilize about 14% of total funding, and will be implemented through one core instrument, a new Systems Strengthening contract.
- These four instruments will be complemented by the SO9-managed Strengthening Decentralization in Uganda (SDU) activity, which addresses district and sub-district level planning, budgeting, and monitoring from a service delivery and systems strengthening perspective. SO8 will continue to contribute about 2% of its annual funding to SDU, with increases possible as SDU gains experience and expands geographic coverage.

USAID will also continue annual procurement of contraceptive commodities and access to specialized technical staff to enhance USAID’s program oversight and management through Field Support to support all activities above. The contraceptive commodities are expected to account for approximately 6% of total funding, and USAID’s total oversight and management costs are expected to account for approximately 10% of yearly funding.

¹ These targets will be updated and revised over the next 6 months.

² The \$30 million/year represents an average of the low and high funding scenarios.

B. Tools & Tactics to Achieve Services Results

Given the deterioration in service statistics cited earlier, the Services activity will comprise the bulk (68%) of SO8's funding during the strategy period, or approximately \$20 million per year. The Services activity will support decentralized, sustainable social services delivery at district and sub-district levels, with its success facilitated by the capacity building and policy development that will be undertaken through the Systems activity. The ongoing AIDS/HIV Integrated Model District Program (AIM), including support to the AIDS Information Center (AIC) and The AIDS Support Organization (TASO), will deliver services with a budget of about \$8 million per year, while the CMS social marketing activities will deliver services with an estimated \$2.5 million annual budget. The new integrated Services Cooperative Agreement will have two main components: i) Promoting Use of Services; and ii) Incentive/Challenge Grants to Induce Change.

Promoting Use of Services. This component, comprising approximately 40% of the new activity (or about \$4 million per year for five years), will support integrated service delivery in four main areas:³

- Quality Improvement and Assurance. The implementing partners will increase the quality of services delivered at district and community levels by promoting the use of improved technical norms, protocols and standards. This sub-component will facilitate operations research, field testing, and harmonization of technical norms and standards, and will strengthen regulatory mechanisms for encouraging adherence to quality standards. Recipient organizations will identify Best Practices being developed and used in AIM and the Systems contracts to promote their application by community and district providers.
- Decentralized Planning, Budgeting and Monitoring. Working in close collaboration with AIM and SDU (SO9), recipient organizations will promote the use of improved planning, budgeting and monitoring in order to improve social sector delivery. This sub-component will place particular emphasis on fostering public-private partnerships to optimize social service coverage and quality in a given district.
- Public-Private Partnerships. This sub-component will build public-private partnerships by supporting district and sub-district level dialogue and strategy development between the two sectors. Among the issues that this dialogue will address will be the respective public-private roles in social service pricing, cost sharing and recovery, and the application of licensing, regulation norms and standards. District level supervision and inspection will be improved through government as well as peer associations. The sub-component will clearly benefit from the ongoing work of the CMS activity as well as the challenge grant component described below.
- Increasing Demand and Advocacy for Social Services. This sub-component will create, increase and sustain demand for social sector services through updated and innovative behavior change communication strategies (BCC). Multi-channel BCC efforts will increase knowledge of existing services and their benefits, and increase the desire/intent to use services as well as utilization of specific services by target populations. Further, the sub-component will strengthen Local Councils (LCs), Civil Society Organizations

³ Technical considerations within these four areas are laid out in greater detail in Technical Analyses that are available separately.

(CSOs) and Community Based Organizations (CBOs) to develop and implement advocacy agendas and action plans and hence their ability to influence district development plans and national policies and programming. Advocacy will also be strengthened by technical assistance and training provided to local media. For example, the activity would build the capacity of FM radio stations to deliver messages to rural populations.

Incentive/Challenge Grants to Induce Change. The second component of the new Services Cooperative Agreement, comprising about 60% of the new agreement (or about \$5 million per year for five years), will consist of challenge grants to public and private service providers. The primary objective of the grants would be improved quality, increased access, increased adoption of positive behavior change in specific geographic/demographic areas (IR 8.1), an enhanced role of the private sector in service delivery (IR 8.2.2), and increased community participation and advocacy (IR 8.3.1). Secondary objectives would include improved district and sub-district level planning, budgeting, management, and monitoring systems (IR 8.2.1).

The grants will be focused in selected districts in which SO8 has a primary focus (districts to be determined in future analysis and with government collaboration), but would also include a certain percentage of grant funding (e.g. 15% per year) for targets of opportunity outside the focus districts. The grants would also have specific demographic focus, e.g. orphans and vulnerable children, persons living with AIDS, youth, especially girls, and conflict-affected and internally displaced persons. Grants would be linked to provision of training and technical assistance in order to meet a minimum set of organization and administrative standards. However, service delivery would remain the primary focus of the grants and training of CSOs or providers would be kept to a minimum and appropriate share of the grant. Potential grant recipients would include communities, public providers, for-profit providers, NGOs, and faith-based organizations.

Broad illustrative examples of community based challenge grants would be a challenge given to a community or group of communities to achieve measurable results in increased immunization rates, increased girls' attendance and persistence in school, decreased teen pregnancy, or increased assisted deliveries. The challenge would be given to local governments working with Parent Teacher Associations (PTAs), Village Health Committees (VHCs), and public and private schools and health care providers. Grantees would be responsible for proposing the specific set of activities that would be undertaken to deliver these results. Incentive payments could be provided to grant recipients as results begin to be achieved.

Given the existence of numerous grants to districts (e.g. UPE capitation grants and PHC Grants), SO8 is still exploring if districts and public providers should receive challenge grants under the Services Cooperative Agreement. If it is determined they should, illustrative examples of challenge grants for public providers might relate to achievement of key district level targets. For example, an LC5 would propose to achieve a specific percentage of expenditures of the planned social services budget expended for intended purposes. The challenge grant would provide basic training and materials for planning, management, budgeting & monitoring, while the incentive grant would be provided if target was achieved. Alternatively, a proposed challenge grant might be for increased immunization rates in the district, with the challenge grant covering an aggressive IEC campaign and the incentive grant provided if targets were achieved.

Grants to for-profit providers might relate to quantity and/or quality of goods or services. A private school could be challenged to improve girls attendance and/or persistence rates in a private school, while private midwives could be challenged to increase ante- and post-natal care visits. For-profit providers would be assisted in linking up with business development and financial (loan) services available through CMS and/or SO7 partners. Challenge grants for NGO Providers might relate to improving institutional sustainability and/or increasing advocacy capability and achievements. For the latter, a challenge grant (plus training) might be given to develop a position paper and a strategy for a specific problem area. Incentive grants could be given as specific achievements are made.

The Services Activity will be characterized by close collaboration with SO9 at the district and sub-district levels. Areas of particular collaboration with Services will be: capacity building in decentralized planning and budgeting; and advocacy training for CSOs. It is expected that service delivery will be significantly improved by the district level training that is organized and conducted by SDU.

III. ACTIVITY MANAGEMENT

A. GOU and Other Key Partners

The lead Ministries for this activity are the Ministry of Health, Ministry of Education and Sports, Ministry of Local Government, and to a lesser extent the Ministry of Gender. They are each expected to name the respective Department of Planning as the lead contact for USAID at the national level. USAID and its implementing partners will use the existing Education Strategy Investment Plan (ESIP) and Health Sector Strategic Plan (HSSP) mechanisms, or work with GOU colleagues to establish one or more multi-ministry fora where activity progress can be monitored and issues of mutual interest can be addressed.

At the District level, the primary point of entry will be the LC5 in close consultation with the Social Services Committee Chair and District-level line ministry personnel. Again, USAID and its implementing partners will work with District-level colleagues to identify and conduct multi-agency fora to monitor activity progress and address issues of mutual concern.

Other key Ugandan and international partners include: Public Service; Ministry of Finance, Planning and Economic Development, Uganda AIDS Commission, TASO, AIC, Education Funding Agencies Group, and Health Development Partners. The SO8 team and its implementing partners will collaborate closely with them as necessary and appropriate to successful implementation of the activity.

B. USAID

Program funding under SO8 will continue to support a number of FSN-PSCs, Fellows, TAACS, and other management personnel and related expenses for the planning period. As stated above, these are estimated to comprise about 9% of total funding, with SO8's annual contribution to the Mission-wide monitoring & evaluation contract estimated at an additional 1% of total funding, for 10% total funding allocated toward management and oversight. USAID recently merged its more traditional health and education teams into the integrated human capacity SO8. The combined team is working on a new team charter that adjusts roles and relationships to meet the challenge of assuring continued high quality technical oversight while providing a coherent, integrated approach to achieving results. The team has planned a

series of exercises with a consultant over the next few weeks to more fully elaborate its charter, and will present a new team approach to activity management at that time. In order to assure complementarity of efforts to achieve SO8, USAID will foster an "SO8 implementing partners group" early in the planning period to meet periodically to foster coordination and avoid redundancy of efforts. Additionally, as mentioned above, the SO8 team will include in the Systems contract a requirement for the contractor to facilitate a coordinated annual planning process of the USAID contractors and recipients.⁴

C. Procurement Plan

The SO8 Transition Plan provides a detailed Procurement Plan for the next 12-24 months that demonstrates that SO8 will significantly reduce management units down from over 20 bilateral and field support activities to three (3) core instruments and the field support mechanisms. The timetable for obtaining assistance under the Services CA discussed herein follows:

- Draft Program Description completed "in-house" 30 November 2001;
- Technical reviews and revisions with USAID/W colleagues 1-15 December 2001;
- MAARD to CO by NLT 21 December 2001;
- CO issues Request for Applications o/a 15 January 2002 for 60 day period;
- Applications received o/a 15 March 2002;
- Technical reviews (with USAID/W technical member) completed and write-ups to CO on or about 15 April 2002);
- Request for clarifications issued 15 May 2002;
- Clarifications received, review begins 1 June 2002;
- Selection made, negotiations 15-21 June 2002; ;
- Award made o/a 21 June 2002;
- Activity begins July 2002

IV. BUDGET

The SO8 budget for the planning period demonstrating funding per activity per IR is attached.

⁴ The term "recipients" comprises individual agencies, joint efforts, lead-sub efforts, and/or consortia cooperative agreements contributing to SO8 with USAID financing.