UGANDA NATIONAL NGO FORUM

STRUCTURAL ADJUSTMENT PARTICIPATORY REVIEW INITIATIVES (SAPRI)

THE IMPACT OF PUBLIC EXPENDITURE MANAGEMENT UNDER SAPS ON BASIC SOCIAL SERVICES: HEALTH AND EDUCATION

FINAL REPORT

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Executive Summary

The premise by mainly government and the World Bank/International Monetary Fund (IMF) was that public expenditure reforms lead to the restoration of price stability and improvements in the cost effectiveness of the provision of Social Services. It was on this basis that the Government of Uganda embarked on public expenditure management by controlling certain expenditures and increasing financial resources to primary health care, water and sanitation as some of the priority areas. The government also introduced decentralisation as an institutional mechanism to support the implementation of some structural Adjustment Programme (SAPs).

Although an increase in public expenditure has been achieved, social indicators have remained poor, suggesting that social outcomes may not improve even in the face of further increases in social spending. Evidence of tracking studies demonstrated how, in spite of increased social spending in education, only 36% of non wage funds reached schools and as much as 70%-90% medical drugs supplies were diverted to personal use to compensate for the low salaries of medical staff.

Whereas the communities accord health issues high priority, they still have to contend with the recovery part of the operating costs. This is demonstrated in Uganda by a comparison of the level and quality of services offered by NGO facilities where patient fees are levied, with government ones where services are free. That not withstanding, the issue of costs haring needs to be revisited to accommodate the concerns of the poor in order to promote equity.

The UPPAP studies have established a link between poor health and poverty at individual, household and community level. Access to health care is still poor and the health infrastructure is inadequate in spite of the increased per capita recurrent budget allocation in real terms during 1986-1994.

Prior to the introduction of Universal Primary Education (UPE), prices of providing education service had risen substantially relative to the other prices by about 68%. At the time also there was no systematic increase in the share of education in recurrent budget until 1997 following the introduction of the Universal Primary Education (UPE) that substantially increased public spending especially on primary education. This was more a result of a political decision than a direct result of Structural Adjustment Policies.

Under UPE enrolment increased and so did teachers and textbooks but the system had a low retention of pupils especially for girls, in addition to a high age disparity in class. The teacher-pupil ratio still remains at 1: 100, the quality of education service provision remains poor. For example their device shows that after six years of school, 52% of the urban pupils and 97 % of the rural cannot read or write. Financial management at the school level is poor and there is no special provision for the other school costs 90% of which are born by the parents.

Policy dialogue in health and education should embrace participation from more stakeholders with a view to examine policy options that would increase the access of the poor and effective use of available resources. It is crucial to undertake analytical work to identify constraints to and experiences of segments of the population on any policy with a view to refining it based on country specific experiences.

ACKNOWLEDGEMENT

We acknowledge the insightful comments on the Report from staff of NGO Forum, members of its Steering Committee and participants to the various National Forums held during the study, David Wasike, Kevin Akoyi Makokha, Warren Nyamugasira, Ken Atim (Policy Analyst in the Prime Minister's office) and Judith Olupot who typed the corrections for the updated version.

ACRONYMS

DEOs	-	District Education Officers
DIS	-	District Inspectors of School
ESAF	-	Enhanced Structural Adjustment Facility
FPAU	-	Family Planning Association of Uganda
GDP	-	Gross Domestic Product
IGG	-	Inspector General of Government
IMF	-	International Monetary Fund
MC	-	Management Committee
MOES	-	Ministry of Education and Sports
MoH	-	Ministry of Health
MOLG	-	Ministry of Local Government
NGO	-	Non-Governmental Organisation
PAF	-	Poverty Action Fund
PAPSCA	-	Programme to Alleviate Poverty and Social Costs of Adjustment
PTA	-	Parents-Teachers Association
PHC	-	Primary Health Care
PHS	-	Primary Health Strategy
SAC	-	Structural Adjustment Credit
SAF	-	Structural Adjustment Facility
SAP	-	Structural Adjustment Programme
SAPRI	-	Structural Adjustment Participatory Review Initiative
TOR	-	Terms of Reference
UNFPA	-	United Nations Family Planning Association
UNDP	-	United Nations Development Programme
UPPAP	-	Uganda Participatory Poverty Assessment Programme
UPE	-	Universal Primary Education
URA	-	Uganda Revenue Authority

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1.0 INTRODUCTION

The goal of Structural Adjustment Programmes (SAPS) as regards fiscal operations was to reduce government expenditure as a major instrument for the control of inflation. From 1992, the government embarked on a process of expenditure control, where expenditures were kept within available revenue. The chief element of the public expenditure management is expenditure cut. Some of the specific policy measures under public expenditure management included operation of a cash budget while focusing the available funds on a few priority areas which in the case of Uganda were: primary health care, primary education, water and sanitation, agricultural extension and rural roads. It also included the divestiture of state owned enterprises, retrenchment of public sector employees, wage freeze, and reduction of subsidies. As a macroeconomic variable, public expenditure has a very pervasive impact on many sectors of the economy for example employment, wages, price level, access to health care, education, water housing and clothing.

Public expenditures have a very important role to play; the government's role must be guided by cost-effective criteria. It is essential that the government allocate its limited resources to those activities that provide the maximum social and economic rates of return. The government recognises that since the most single important asset owned by the poor is their labour, the central element of its poverty reducing public expenditure strategy should be to accord highest priority to developing their human capital. Human capital, more than any other factor, increases the income earning opportunities of the poor and contributes both to individual and national productivity. Accordingly during the past years, the government has attempted to foster such development in human capital by restructuring government expenditures in favour of the social sectors and rural infrastructure. Notwithstanding the severe resource constraints, the government must continue to ensure that these priority programs remain protected. Not only should more resources be channelled towards primary education and primary health care, but the efficiency of these expenditures should also be improved by ensuring that money is spent on high impact programs and that the combination of expenditures within and across sectors are optimal.

2.0 The Background and Context for Public Expenditure Reforms

The economic reforms implemented in Uganda since 1987 and the economic recovery that these reforms have generated, have justifiably attracted a great deal of attention among development practitioners and academics and Civil Society around the world. Uganda is regarded as a pioneer in implementing macroeconomic stabilisation and structural adjustment programmes in Sub-Saharan. First, because of the extent and consistency of its economic reform program, especially in the areas of fiscal policy, exchange rate reforms, trade
policy, and the use of debt relief to enhance public expenditure on basic social services. Second, because the reform program's success in achieving macroeconomic stability, boosting the economic growth rate, and reducing poverty.

These economic reforms followed a prolonged period of economic decline and civil strife that devastated human and physical capital and destroyed the economy's formal sectors, not least because this period witnessed significant erosion of much of the institutional framework that is required to support transactions in a modern economy.

It is an important goal of any country's economic development to improve the standard of living of the population. In a poor and resource-constrained country like Uganda where socio-economic indicators reveal extremely low levels of welfare as indicated in the table 1.

Table 1: Social Indicators

Poverty Lines **1990**				
Upper Poverty Line (Ush) 6,000 Head Count Index (%) 55 Lower Poverty Line (Ush) 3,000 Head Count Index (%) 19 NP Per Capital (US$)-1991			170	
	1965	**1970**	**1980**	**1990**
Gross Enrolment ratio				
Primary, Male	83	46	56	80
Primary, Female	50	30	43	63
Infant Mortality	119	109	116	117
Under 5 Mortality	-	-	-	180
Immunised for Measles	-	-	-	60
(%)	-	-	-	60
Immunised for DPT (%)				
Child Malnutrition (%)	-	-	-	45(stunting)
Prevalence (%)	-	-	-	2(Wasting)
Life Expectancy:				
Male (yrs.)	47	50	48	47
Female/Male Ratio	1.05	1.03	1.04	1.02
Total Fertility Rate	7.0	7.1	7.3	7.3

Source: Government of Uganda.

As one of the responses to the challenges, the government first provided a reasonable level of internal peace where previously large-scale violence existed. Second, it rescinded predatory taxation. Most notably, the government removed massive implicit taxation on exports by liberalising the foreign exchange rate and coffee marketing. Third, by ensuring fiscal discipline, the government provided a

currency whose value did not dramatically erode. While these three achievements may sound modest, attaining them was not easy.

Public Expenditures have a very important role to play and government's role must be guided by cost effective criteria. It is essential that the government allocates its limited resources to those activities that provide the maximum social and economic rate return. The Government recognises that since the most single important asset owned by the poor is their labour, the central elements of its poverty reducing public expenditure strategy should be to accord highest priority to developing their human capital. Human capital, more than any other factor increases the income earning opportunities of the poor and contributes both to the individual and national productivity. Accordingly, during the past years, the government has been attempting to foster such development in human capital by restructuring government expenditure in favour of the social sectors and rural infrastructure.

3.0 Support Mechanisms

Establishing affordable health care for all Ugandans has been a difficult target to be achieved within the SAP period. In order to reverse this situation, several policy measures have been taken, including decentralisation, which in Uganda officially commenced in 1993. The current status of decentralisation demonstrates impressive achievements as well as daunting remaining challenges. It is therefore worthwhile to examine whether decentralisation is leading to an intended policy outcome of improved health services to the population of Uganda.

4.0 Status of the Economy

Prior to implementation of SAP from 1986, the performance of the Uganda economy was characterised by high inflation running at an annual rate of 240 percent; earnings from coffee contributing 50% of tax and 70% of export earnings; limited scope of external borrowing resulting in reduced government spending; a large public sector with private sector predominantly subsistence; and public expenditure, exports and investment each estimated at 9% of GDP.

Since 1987, Uganda has implemented a series of structural adjustment policies with support of World Bank, IMF and other donors. These policies focused on rehabilitation of infrastructure; liberalising trade, payment systems, exchange rate, domestic prices and interest rates; removal of monopolies of marketing boards; restructuring the financial sector; civil service reform; privatisation and reforming public enterprises; and demobilisation of the army.

After some years of implementing SAP policies, fiscal crisis was experienced in 1990/91 resulting in dramatic increase in inflation and reduction in per capita

growth rate to 2 percent. To curb the fiscal crisis, the Government in 1992 embarked on expenditure cuts and control by keeping expenditures within available revenue (Cash Budget); and raising revenue through a combination of institutional changes such as establishing Uganda Revenue Authority outside the public sector and tax rate changes.

Social spending was protected during fiscal tightening through the introduction of 'core budget' in which social programs were given priority. The priority areas included primary education, primary health care, water and sanitation, agricultural research and extension, and roads. The increase of financial resources to the priority areas was often used as conditionality for tranche releases under SAP. Various donors pledged substantial amounts to help finance these key sectors of the economy.

5.0 General Observations

After many years of implementing SAP in Uganda, a number of contrasting and sometimes conflicting perceptions on SAPs and its impact have arisen. On the part of Government and the World Bank/IMF, the premise was that public expenditure reforms would lead to the restoration of price stability and improvement in the cost-effectiveness of the provision of social services.

On the other side, the Civil Society however noted that the freeze on the salaries and wages in the civil service and state-owned enterprises led to a decline in real wages of public service providers, a factor that is blamed for the poor social services. It is further argued that whereas Government is implementing a well-intentioned policy of Universal Primary Education (UPE), the quality has deteriorated remarkably with teacher to pupil ratio currently at 1:100, the school infrastructure has remained inadequate and the future prospects are not very clear. In the health sector the civil society acknowledges that whereas government is struggling to implement a Primary Health Strategy (PHS), it is built on a very weak health care system and is coming too late.

The burden of disease is still very high, compounded by poverty, a very low Doctor: Patient ratio of 1:24,000 and uncoordinated research. Only 54% of the population has access to safe water and the national coverage of latrines is only 60% that are unequally distributed. In addition decentralisation policy has only had a dismal impact, mainly due to poor remuneration and lack of proper structures of accountability at the district and beneficiary levels. Besides, impact has varied.

6.0 The Purpose

The overall purpose of the study was first, to assess the situation of basic social services, specifically health and education under the Structural Adjustment Programs (SAPs). The differentiated impact on various sectors of the population from resulting changes in social services, particularly low income groups such as women, the disabled and the poor are examined. The study deeply examined the impact of the decentralisation on the delivery of the services. In addition the trends in public expenditure during on health and education under SAPs are analysed in order to establish impact on various segments of the population; the flow and management of resources to local government; impact of user-fees in health
provision; and level of participation in policy formulation in health and education by various stakeholders and to makes some recommendations and the way forward.

6.1 Methodology

The required data on the impact of public expenditure management under SAPs on the basic social services; health and education were collected through detailed review of documentary sources from the Ministries of Health, Education and Sports, Finance Planning and Economic Planning, Local government, the World Bank and other Non-governmental Organisations (NGOs). Quantitative and qualitative surveys to seek views of decision-makers as well as those of people at the grassroots level were carried out.

Additional data on costs of various components of primary education including why so many children are not at school and views on cost-effective approaches to primary education were collected from head teachers (through questionnaires and interviews), teachers, parents, District Education Officers (DEOs) and District Inspectors of schools (DIS), Parent-Teachers Associations (PTA) and School Management Committee (MC) Chairmen and community opinion leaders (through interviews and focused discussions), and non-schooling youth (through interviews). The research was conducted in Kumi, Jinja, Apac, Luwero, Mbarara, Mubende and Kabale

6.1.2 Limitations of the Study

The flow of the research was interrupted when there was a change in researchers. This reduced the time for field visits and the number of people interviewed.

6.1.3 The Organisation of the Report

While this report notes Uganda's achievements where warranted, it provides an objective assessment of the reforms and identifies areas where policy mistakes were made, for example, where implementing reforms earlier might have generated higher rates of return and alleviated bottlenecks to private sector production.

The report points out where major weaknesses still exist, notably, the social cost as a result of policy implementation, corruption in the public sector, which raises the cost of doing business in Uganda and undermines the quality of public services, the poor enforcement of contracts, and the deficiencies in the physical infrastructure. The report also provides the pre SAP implementation period as juxtaposed to the SAP period when the Public Expenditure management was implemented. In addition this report documents the fact that the implementation of SAP in Uganda was not consistent during the period 1987-92. In 1986, government rejected market based reforms; and reforms were reluctantly implemented from 1987–92. Full ownership of the SAP programs by government were realised from 1992 onwards.

7.0 Implementation

In Uganda the implementation of SAPs was evolutionary with some results (outcomes) are realised much later after the reforms and complementary activities were undertaken. There was very limited participation outside government in the formulation of policies during the early years of SAP and only started to gain around 1995. Civil society started to effectively participate in SAP activities after introduction of Poverty Action Fund (PAF). Much more is yet to be achieved to widen out

participation. There has been an increase and improvement in coordination among donors, and changes in design and implementation of programmes following accumulation of experiences on how SAP works.

In addition a review of Uganda Participatory Poverty Assessment Programme (UPPAP) studies was done to incorporate the direct linkage between health and poverty. The same document also cites that poor nutrition leads to ill health. Health services therefore need to be seen as crucial to well being together with education, water, roads, credit and markets.

8.0 Findings of the Study

The objective of the study dictated data on costs incurred in providing social services (quantitative data) and on the quality of social services that are being provided (qualitative data), the costs of social services (i.e. recurrent expenditure and capital cost estimates).

Accessibility to health care was found to be limited to approximately 49% of the population living five kilometres away from the health facilities (Uganda, the Republic of, Ministry of Health, 1999, pg. 3). The government and private sectors- mission facilities, non-governmental organisations (NGOs), traditional practitioners-provide health services roughly equally.

The government is strong in immunization, hospital delivery, and reproductive health care including HIV/AIDS, while private providers account for a majority of curative care (Hutchinson, 1999a pg. 17). Yet, about half of the Ugandans do not seek medical treatment when they fall sick. It was estimated that the poor spent from one-quarter to one-half of what non-poor in 1999 spent on health care (Hutchinson, 1999 a pg.20).

Uganda not only has the lowest health indicators in the world, but a life expectancy of only 42. The status of the health units is such that only 1637 of the proposed 2078 health units are in use and even then only 59% of these are well maintained. There are 789 persons per bed and 12,500 persons per health facility. The ban on the recruitment on Public servants including health workers resulted in the doctor patient ratio of 1:24,000. Most of these doctors are in the urban centres. HIV/AIDS further exacerbated the health and nutrition problems in the country with an infected population of 10% in the rural areas and 8% in the urban areas.

8.1 Retrenchment

Reduction in the size of public sector by retrenching public servants and privatisation was achieved. However, the savings from the reduction of the number of civil servants were not translated into a rise of salaries to a living wage level. The retrenched were not retrained, nor were they given their packages as a lamp-sum. Public wages remain low compared to cost of living. As a result the social costs of adjustment of retrenched servants was significant.

Delays in payment of severance packages coupled with low pensions caused severe hardship to those retrenched. This had a gender dimension given that any loss of

family income meant that the women had of necessity to fill in that income gap by other means or cut family expenditure where extra income was hard to come by. The other issue that arose out of this is that families had to relocate since they had to move out of government housing or move into cheaper accommodation. This relocation had a direct impact on the education of the children and the family's access to health facilities and services.

8.1.1 Decentralisation

One measure to cope with staggering health situation was decentralization. This was an institutional mechanism put in place to support the implementation of SAPs. It was hoped to improve cost-effectiveness of public services by brining these services closer to the people. With the new Constitution of Uganda, promulgated in 1995, and the Local Government Act 1997, significant powers and functions have been devolved from the central to local governments. The survey results show that people generally value the L.C. as an essential institution, especially in rural areas[1]. The L.C. is a source of information as well as a mechanism to settle local disputes. They also consider that the L.C. is generally, although not conclusively, supportive of their needs. 67% of respondents in the seven surveyed districts answered that the L.C. is responding to the needs of ordinary people, while 30% responded negatively. This means that when local leadership is well organised and effective, the L.C. can be used as a promising local institution to link health service providers and recipients to create mutually satisfactory outcomes

Decentralisation has shown some results, which often contradict the original expectations of measure. Although it was anticipated that the local needs are going to be well matched by actions by local governments, the way in which the L.C. operates currently does not necessarily conform with this expectation. In fact, financial allocation by district authorities covering recurrent health costs has actually declined both in absolute and relative terms, after decentralisation was put in place. This reduction particularly applies to Primary Health Care (PHC). It is widely known that politicians prefer short-term results. Thus, they tend to be reluctant to support preventive healthcare activities such as PHC[2].

8.1.2 Expenditure on Health Care

The expenditure on health does demonstrate the preference for curative rather than preventive health care. This of cause still needs to be understood within a context where curative services are also suffering from severe shortage of funds. This unexpected reduction made the Ministry of Health (MoH) uneasy. Estimates of total of expenditures on health care in 1999 by type of service provider and source of funds are presented in Table 2.

[1] Uganda Participatory Poverty Assessment (UPPA) report confirms this based on the findings in other districts (Uganda, Republic of, 2000).

[2] PHC is difficult for them to understand partly because the concept is originated not within the country.

Table 2:TOTAL EXPENDITURES AND SOURCES OF HEATLTH CARE FUNDS 1999 SERVICE PROVIDERS

Source of Funds	MoH	Local Govt.	Urban Districts	Sub Total	Missions	Private Sector	Direct Donor Expenditure	Total
Government: Central Local	1504	50 127	117 254	1671 381	3	–	–	1674 381
Subtotal	1504	177	371	2052				2055
Missions: Monetary In kind					87 10			87 10
Foreign Donors	282			282			190	472
Private Sector Modern Traditional					420	2730 6310		3150 6310
Total	1786	177	371	2334	520	9040	190	12084

Source: Statistical Abstract 2000 UBOS June 2000

Total health care expenditures (public plus private and recurrent plus capital) are estimated to have been Ug Shs 12,084 (US$128) million or 1.8% of gross domestic product (GDP). Non-governmental capital expenditures are not available but are thought to have been small. Although data on household expenditure are also unavailable, in kind or monetary recurrent private expenditures on traditional and modern private care have been estimated at U Sh6310 million and U Sh2370 million respectively, or approximately 1.25% of estimated total private consumption expenditures.

The estimated proportion for Uganda is based on the proportion of total private consumption expenditures spent on health services in several other African countries (for example, in Rwanda, 0.8-2%, in Zambia 1-2% and 1.7 % in Zimbabwe). This may be underestimating the private health expenditures in Uganda however, given the partial collapse of government services and increased reliance on the NGO sector from 1972 to 1983. Including public and private expenditures, the total per capita expenditure of Ug shs 900 (Us$9.5) is lower than for most other countries in the region where estimates of total private and public expenditures.

8.1.3 Trends in Ministry of Health Expenditures

In normal terms annual Ministry of Health (MoH) total expenditure have increased from U Sh 128 million in 1972 to U Sh 2,348 million in 1999, but the nominal increase has hidden a large decline in the real value of health expenditures.

Deflated by a price index for gross domestic product and measured in 1986 shillings, total MoH expenditures in real terms have fallen by 85%, from U Sh 8,861 (US$93.8) million in 1972 to Ug Sh 2,348 (US$21.8) million in 1999. The decline results from a fall in the real value of both capital and recurrent expenditure. See table 3. The extent of the decline is emphasized when the effect of population growth in included;

from 1972 to 1999 real expenditure per capita fell by 87%, from U Sh 862 (US$9.2) to U Sh 135 (US$1.6).

Table 3: TRENDS IN GOVERNMENT HEALTH EXPENDITURE PER CAPITA 1982 PRICES

Fiscal Year	Millions of U Sh			US Dollars		
	Recurrent	Capital	Total	Recurrent	Capital	Total
1972	713	148	861	7.5	1.6	9.1
1973	647	79	726	6.8	.8	7.6
1974	488	27	515	5.2	.3	5.5
1975	399	9	408	4.2	.1	4.3
1976	514	23	537	5.4	.2	5.6
1977	379	87	467	4.0	.9	4.9
1978	360	76	435	3.8	.8	4.6
1979	135	17	153	1.4	.2	1.6
1980	79	15	95	.8	.2	1.0
1981	55	9	64	.6	.1	0.7
1982	111	22	132	1.4	.2	1.4
1983	133	31	133	1.4	.1	1.0
1984	118	36	98	1.3	.2	0.7
1985	123	22	146	1.2	0.1	1.6
1986	114	14	123	.8	0.2	1.8
1987	123	12	155	1.5	0.2	1.7
1988	134	16	134	1.3	0.3	1.6
Average						
1972-1978	500	64	564	5.3	.7	6.0
1981-1984	104	25	129	1.1	.3	1.4
1987-1999	134	21	46	1.3	.5	1.8

a_/Estimated actual expenditures.
b_/ Budgeted

The financial constraints facing the MoH reflect a general reduction in government revenue that started during the 1970s, was exacerbated by the civil disturbances of 1979, and has continued during the recovery period from 1980 to the present.

MoH expenditures as a percentage of total government budget and the declining proportion of the government budget going to health has been the declining expenditures as a percentage of GDP from 0.9% in 1972 to 0.3% in 1985, thus, central government support of health in Uganda is about one-half the 0.4% of GDP found on average in other low income countries included in the World Development Report. The current low level of the government health effort is a cause for concern in light of the fact that, prior to 1972, Government support of the health sector had been among the highest in Africa.

9.0 Recovery Program Expenditures and Donor Financing

The original recovery program included projects for the rehabilitation of Mulago Hospital Complex, rehabilitation of district hospitals, development of primary health care facilities, blood transfusion services and purchase of drugs. These five health projects totalled US$ 31.5 million (with US$ 6million of this being for recurrent drug

expenditures) or 29% of the social infrastructure funds and 5% of the total rehabilitation program, and were ranked number five in a list of twenty social infrastructure project for 1983/84, the first year of the plan, was US$ 12.6 million but actual expenditures totalled only US$ 5.3 million or 41% of planned. The primary reason for the funding shortfall has been a lack of donor support in the sector.

The revised recovery program places a greater emphasis on the rehabilitation of social services with the allocated funds now comprising 20% of the plan as compared with 16% in the original program. However, allocation to the health sector has not increased proportionately. Within the social infrastructure segment of the program, health projects now total US$37.5 million (if recurrent cost for drugs are included) or 15% of the total expenditures for health projects according to the revised recovery program, but as experience with the first program demonstrates, the intentions set forth in the recovery program are not meaningful unless supported by donor funding.

Table 4: FOREIGN ASSISTANCE IN HEALTH AND POPULATION a/1982 (US$ 000)

UNICEF	OTHER UN Agencies/	DENMARK	OTHER BILATERAL c/	MISSIONS d/	OTHER INTER-NATIONAL AGENCIES	TOTAL
Health 2026	-	1225	1349	1026	129	5755
Population	34	-	-	-	233	267
Total	34	1225	1349	1026	362	6022

a_/UNDP, Report on development Co-operation to Uganda, 1982. Donor reporting to the UNDP is incomplete and some assistance programs may be omitted. Mission assistance is estimated from extrapolation of incomplete data provided by the Catholic and Protestant co-ordinating agencies. The IPPF contribution is based on FPAU records. Mission and IPPF contributions in kind or time are included.
b_/UNFPA, c_/ Italy (650), Netherlands (699). d_/ includes local donations_/ Euro Action ACCORD (129), International Planned Parenthood Association (233).

9.1 Other Donor Support

Donor support in the health sector revolves around recovery activities. UNICEF, with expenditures of US$ 3Mmillion in FY83, is the largest donor in the health sector and provides approximately a third of donor funds.
UNICEF funds and technical assistance have played a major role in the provision of drugs and support for basic therapy and immunization. Bilateral support in health came from DANIDA (US$ 1.3 million), Italy (US$ 0.8 million) and the Netherlands (US$0.7 million); missions contributed US$ 2million.

10. 0 The Distribution of Health Services and Expenditures

Information on the geographical distribution of services in the seven districts surveyed is limited due to the collapse of the usage reporting system and the absence of monitoring and surveillance information.
A measure of the uneven distribution of government expenditures by districts was obtained by summing local expenditures, district-specific MoH expenditures and

allocation of central government expenditures in proportion to district facilities. NGO expenditures were added to government expenditures to get total district expenditures.

The results, summarised in table 5, suggest that distribution of expenditures is inequitable. In Kumi, which benefits from large regional and district hospitals as well as mission hospitals, the total per capita expenditure is U Sh 272 (US$2.88). At the other extreme, in Mbarara district, the annual expenditure per capita is U Sh101 (US$1.07). Excluding Kampala District and mission expenditures, government expenditures vary from U Sh123 (US$1.29) in Apac to U Sh 230 (US$ 3.10) in Luwero. The uneven distribution of services is further authenticated by the variation in the bed/population ratio from 3.1 per 100 Population in Luwero to 0.1 in Kabale as illustrated in Table 5.

Table 5: DISTRIBUTION OF HEALTH EXPENDITURES AND SERVICES FOR SEVEN DISTRICTS a/1998

Region and District	Expenditure Per capita (U Sh b_/)			Beds Per 1,000 Population		
	Government	NGO	Total	Government	NGO	Total
Eastern Kumi Jinja	156	115	271	1.18	1.61	2.78
Northern Apac	100	54	154	0.54	0.76	1.29
Southern Luwero	189	0	189	1.24	1.87	1.37
Western Mbarara Mubende Kabale	 128 186 105	 16 0 35	 144 186 140	 0.84 1.30 0.72	 0.23 0.06 0.49	 1.07 1.36 1.21

a/ excluding government expenditures in the four largest urban centres. With these expenditures included, total per capita expenditures in Kampala are 644; Jinja, 377; Masaka, 170; Mbale, 168; and the average is 203.

b/Estimated government expenditures have been allocated to districts in proportion to beds. District and town expenditures are from MOLG records. Data was available for only 22 districts.

10.1 Household Surveys

The study based on household surveys 1992/93 (Ablo and Renikka of World Bank) concluded as follows regarding public expenditure on health:

i. A significant number of people receive health services outside public, and thus not benefiting from the increase in public health spending during SAP. In 1990/96, 25% of lowest income reported receiving no medical attention either in public or private clinics. More patients reported are more likely to select private or non-governmental facility in seeking for medical care.

ii. Public spending in health is skewed towards curative services with preventive and public health measures receiving a small proportion. The poor have limited access to public facilities (hospitals) where much of the curative care is

provided. Moreover, it is in these facilities where cost-sharing requirements are most prohibitive to the detriment of the poor.

iii. Poor and the rich make equal use of outpatient health facilities implying that benefits from subsidies benefit the rich.

10.1.1 Interviews

In addition to the above findings, interviews with beneficiaries and other stakeholders during the study revealed the following:

i. Maternal services are limited for a majority of the rural women. However, immunisation coverage continues to improve and the poor benefit from these services.

ii. Health facilities serving the poor experience persistent and long periods of drug stock out, which subsequently acts as disincentive to access public health services. In the absence of public measures to curb stock shortages, cost-sharing funds were introduced to drug shortage gaps and provide additional resources for staff welfare and motivation in the face of low salaries/wages in most health facilities.

iii. Cost sharing works against the poor who rely on public health services.

iv. Recruitment of specialised health workers (i.e. laboratory technicians, Dental Assistants) as required at lower health facilities is problematic due to poor and low remuneration and other facilities offered in rural areas compared to urban areas. In addition, such specialised workers have access to private clinics in urban areas where they can receive additional pay during out of work time. They thus opt to work in urban areas.

v. Health indicators are generally poor partly because of skewed public expenditure towards curative medical care favouring the rich; inadequate maternal care services for the rural women population; and high cost of medical care.

An independent external evaluation of ESAF[3] in 1998, which included Uganda in the sample, also identified the following features of public spending in the health sector:

i. Per capita recurrent budget allocation to health sector rose in real terms during 1986 - 1994.

ii. Health sector benefited from both the strong growth in total recurrent expenditure and from the increasing share allocated.

iii. Rise in health expenditure was offset by the rise in price of health services; which increased more rapidly than average prices across the economy to about 65 percent. The rise was partly due to rising wages of workers in health sector and depreciation of exchange rate increasing cost of material inputs.

[3] External Evaluation of the ESAF by Dr.K.Botchwey, P.Collier, J.W.Gunning and K.Hamada for IMF. Uganda

iv. Performance in health sector showed change. Proportion of children receiving full immunization rose by 60% (from a coverage of 31% to one of 49%).

Direct measures of health status of the population were less satisfactory. The proportion of children malnourished on various measures showed no improvement.

10.1.2 Voices of the poor: The Cost Recovery

The usefulness of recovering part of operating costs directly from users is strongly demonstrated in Uganda by a comparison of the level and quality of services offered by NGO facilities where patient fees are levied, with government facilities, where services are offered free.

In many NGO facilities, fees constitute approximately 80% of revenues and allow continued replenishment of drugs and other supplies. Representative fees are Ush 50 per inpatient day, U Sh 50 per outpatient visit, U Sh500-1000 per consultation, and U Sh 200 -1000 per minor surgical procedure; full drug costs plus 25% (at joint medical stores subsidised prices) are charged. In Kumi, a female from Ngero argued:

If a patient has to go to the Kumi health centre, he/she must have 3,000/= ready in order to be availed the medical form. It takes someone the whole week to raise 200/= for a piece of soap. How then is it possible to raise 3,000/=?

This indicates that there are competing needs that one has prioritise and attend to in addition to health. Therefore although the user-charges may appear to be small, it is an additional burden to the already over-burdened income. As a result of being unable to pay, some people were reported to have resorted to self-treatment, traditional herbalists, traditional birth attendants and others to witchcraft. Women were perceived as more affected by the high costs of health care services; they were unable to access basic services like antenatal care leading to high chances of complications during childbirth.

It became clear during the interviews that apart from non-affordability, the system of user charges still had gaps. People did not seem to know which services they paid for and also did not appreciate the value for their money, as clearly put by one respondent from Apac:

One has to pay for medical care and drugs. Many die in the villages because they cannot afford to pay the user charges. Those who have some money pay, but get insufficient treatment. You can be given one panadol when you are very sick. You are asked to buy syringes yet you have paid admission fee. Sometimes you have to buy drugs from other clinics.

Another respondent in Kabale emphasised that: "*Previously people were not paying fees but now, before touching you one has to pay Ush 500 and the admission fee is Ush 200, forcing those with no money to remain at home with no treatment.*"

However, although the health costs were noted as constraints in accessing medical care for the poor, availability of private health units, drug shops, traditional birth attendants (TBAs) was appreciated because these enable the communities to access health services at any time. This is because these are located within villages and costs are sometimes negotiable, with possibilities for credit arrangements.

Communities still live far from health facilities. In some cases, the distances to the nearest health unit was 10-20 kms and the area has no public transport. This is made worse by the poor roads and lack of transport system, making it difficult for people to seek appropriate care promptly. Some of the roads become impassable during the rainy season. In Mubende , a participant in Kagando village had to say:

"We have many diseases these days. People are dying so much, but the difficulty especially in the rainy seasons is that rivers cannot allow us to cross and take patients to the health unit".

In Kabale, the most practical transport for patients was the *Ingobyi/Engozi* (stretcher for carrying the sick) and in communities where there were no health facilties nearby, patients were left to God's Mercy, as reported by one old man in Mukungu,

"When a person falls sick in the night, we only live by God's Mercy waiting for the morning to be carried to hospital."

10.1.3 Cost Effectiveness of Health services

From the point of view of long-term planning, the current physical facilities and associated recurrent cost problems imply that over a period the cost effectiveness of rehabilitation expenditure and recurrent cost support for facilities including district hospitals and health centres is likely to be as high as many primary health care activities. The unusually high return expected from increased expenditures on facilities stems from two sources:

- the current under utilisation of capital and fixed personnel expenditures from want of complementary operating funds; and
- the inadequate maintenance of existing facilities, which threatens the loss of capital in the future.

Under utilisation of government facilities is also partially related to poor maintenance and failure to provide minimum rehabilitation to war damaged equipment and buildings. Besides adding to the high cost through encouraging under utilisation, the poor physical state of facilities if continued will lead to even higher capital expenditures for rebuilding in future.

The physical infrastructure is still said to be inadequate. Congestion of patients is mentioned and in some cases has led to compromising privacy. Diagnostic equipment was reported to be largely lacking in most health units.

A woman in Luwero reported that:

"The health centres are not hygienic, services are poor and structures are poor and ill equipped".

There is lack of skilled human power in the health sector. For example Apac District had only 1 medical doctor located in the town centre, while the remaining areas only have sub-dispensaries run by nursing aides. To make it worse, even among trained/skilled health workers, there is a significant proportion that is poorly trained to handle and care for the sick. The majority of these are not likely to have had any chance for any form of continuing education, like refresher courses, training workshops and support supervision. A woman in Aneke, Apac lamented,

"In these health units, they do not look at the eyes of the sick children, not even listen to the beating heart. When you complain of stomach pain and diarrhoea, they do not test stool".

The communities recognise the poor staffing of the health units in their areas, and they would like to get qualified staff that would provide them with quality services.

Communities reported that drug supply was irregular, and when available got finished within a very short period. This was well brought out by one man from Agu in Kumi. Who said,

"When you want proper treatment in the government hospital, time the arrival of the vehicle, which brings drugs. By the second to third day, they will tell you the drugs are finished."

Most of the drugs are not there in the health clinics. Patients were asked to buy extra drugs from clinics as clearly brought out by a father of six in Bulambuti Jinja:

"When you take your children and your family members for treatment, first you give a registration fee before you are given a prescription of treatment for the disease you are suffering from. Then you are asked to go and buy drugs from a clinic, which is very expensive."

The attitude and conduct of the health personnel was said to discourage attendance at these units. They were reported to be indifferent with an *I-do-not care* attitude, rude, harsh, uncaring, and sometimes unavailable. Women reported that it was worse during delivery. Respect of privacy for women in labour is not observed, "*Even a sweeper is called to watch when one is delivering",* remarked a respondent.

It was reported that the health workers were requesting for under-table payments, outside the official user-fee. For example, it was reported that patients were often asked if they have come with their *"brother"*[4]*.* As a consequence, patients are often neglected and may die. Medical personnel were said to discriminate against patients in favour of those who were more likely to pay extra money. The relatively well off

[4] By "brother", health staff mean money

were reported to be offered more quality health care than the poor. This is a central issue of lack of equity. In this case *patients* with similar needs end up receiving different treatment. Obviously this practise discriminates strongly against the poor.

In the areas surveyed, the staff had not been paid for over a long period. Most of the local governments units were into arrears for salary payments, especially for their locally engaged staff, who were supposed to be paid from the locally generated revenue. As income from local revenue fell below their expectations, mainly due to poor payment of graduated tax and a cosh sharing revenue of only 5%, the staff salaries could not be met. Although districts have tried to pay arrears, there still remains a substantial amount in arrears. Fortunately the Ministries of Health, Finance and Public Services have started working on modalities of offsetting the arrears, although it has been a long process. The effect of such non-payment is loss of morale, poor performance, absenteeism, and corruption among other things.

11. 0 Implications, and policy recommendations

Most of the issues brought out by the study are not new but have become more acute in as a result of the reforms in public expenditure. The study also brings out the benefits and losses especially from the perspective of the communities largely representing the poor. The key observations are shown below:

11.1.0 Key Observations

Some of the key conclusions that can be made from the findings of the study include

- The communities accord health issues high priority.
- Poor health and inadequate health services are recognised to be major causes of poverty at individual, household and community level.
- Poor health is also recognised as an effect of poverty.
- Although the community appreciated that decentralisation had improved the quality of governance, there was need for more central government support, particularly in terms of capacity building in order for fruits of decentralisation to be realised.

The majority of the respondents were conversant with Primary Health Care (PHC) and what it entails though they were not fully aware of the various components of the PHC policies.

- The cost sharing policy is not well received by the people. It was clearly seen that the negative effects of cost sharing far out weigh the advantages. Some cannot afford to pay, while others who are able to pay are discouraged by the corruption and lack of transparency associated with cost sharing in Government health units.
- Access to health care is still poor; the health infrastructure is inadequate such that people have to travel long distances to reach a health unit if at all.
- The quality of health services is generally poor, more so in Government health facilities.
- Where the health facility is available, most often the range of services is limited.
- The attitudes of the health personnel in government facilities tend to be negative, leading to neglect and mistreatment of patients. This often results in people preferring to use alternative means of health care and hence poor utilisation of the government health facilities.

- Various international and local NGOs operating in the districts have elaborate plans in various fields including health, but most communities, had little or no information about operations of many development agencies.
- The role of churches and NGOs in the communities was highly appreciated as regards information flow and awareness. In addition to this, churches provide information and sensitisation on nutrition, hygiene, savings and income-generating activities, moral upbringing, HIV /AIDS, immunisation and cholera outbreak. This helps the communities to take appropriate measures and make strategies for development.
- Despite the constraint of cost, the availability of private health units, drug shops and traditional birth attendants was appreciated as they enabled the communities to access health services any time. This bridged the gap resulting from inadequate infrastructure.

11.1.1 Gender Dimensions

- It was common to find instances of women who have had to fore go their medication for the benefit of other members of the family.
- Under cost sharing women are increasingly unable to afford health services so a number of them self medicated at the risk of increasing their vulnerability.
- The use of exemptions and targeting as a pro-poor mechanism was not followed and when it was attempted, it was at the cost of quality care and services of especially women at delivery.
- Maternal services are limited for a majority of rural women so are the HIV/AIDS testing and counselling services.
- Poor rural infrastructure and distant health centres in the rural areas directly negates the antenatal, prenatal and post natal benefits that decentralised health services would have brought to women that have to rural women.

12. 0 Education Sector

12.1.0 Recurrent Unit Costs of Education

The database asked for covered the period 1986-1999, and so was obtained from two sources:

Head teachers provided data relating to costs to the school while parents supplied data that fall directly on the children. There were, however, weaknesses in the database procured, particularly in the filling of the question on costs by the head teachers that should be noted.

- A number of teachers lacked proper records. Therefore, some information sought could not be obtained. The reasons given for lack of proper records be obtained. The reasons given for lack of proper records was mainly insecurity/thuggery (i.e. records were destroyed) while other head teachers blamed their predecessors for not keeping records.
- The manner in which the questionnaires were filled showed inconsistencies in some aspects despite the fact that head teachers were given at least a week to fill them for instance, income and expenditure data for most schools could not balance. In some cases head teachers simply filled the source of income (i.e. government or parents) instead of the actual amount spent.

The results, therefore, on unit recurrent costs for the years 1991 and 1992 where most data was given are considered and presented in table 5

Table 6: Unit Costs of Recurrent Expenditure by Urban Vs Rural Schools in each Region

	CENTRAL	EASTERN	WESTERN
1991: Urban Rural	12,306 6,627	6,490 5,483	13,623 3,988
1992:Urban Rural	15,411 10,480	10,974 8,208	28,152 5,058

Note: Direct expenses on child are not included.

It is noted that the unit costs are rising from year to year at about more than 30 percent. It is also important to note that an increase in urban schools is generally higher than those in rural schools. The higher costs in the urban schools may be explained by the fact that the people who live in urban areas are affluent and know the benefits of investing in education. They are therefore willing to pay for the education of their children even under the trying economic situation.

Comparing the units across the regions, it is observed that the western region has the highest cost compared with the rest of the regions in the country. In terms of poverty, this pattern is not at all surprising. In terms of poverty, this generally poorer compared with the Western or Central region (World Bank, 1993c). Furthermore, the civil war between 1987 and 1992 in the Northern and Eastern regions exacerbated economic activities to the extent that people were on the run for their lives. Parents therefore did not have enough funds to pay for the education of their children.

Table 7: Contribution by government and Parents to unit costs of Individual components of Education

	1991				1992			
	Government		Parents		Government		Parents	
Individual Components	Unit cost	%	Unit cost	%	Unit cost	%	Unit cost	%
Salary Expenditure	7,333	65	3,071	35	9,646	67	4,727	33
Non-Salary Expenditure	2,195	26	6,262	74	4,320	36	7,828	64
Building Fund	264	5	5,229	95	560	6	8,079	94

From the above table it can be noted that for both 1991 and 1992 government contributed more towards the payment of teachers' basic salary (65 and 67 percent respectively), while parents contributed 35 and 33 percent towards teachers' salary topping up for 1991 and 1992.

On the other hand, the contribution of parents was more on non-salary items (74 and 64 percent for 1991 and 1992 respectively) the non-salary items included: instructional materials, welfare of teachers, school administration and extra-curricular activities, besides direct costs to the child for uniform, transport, extra-tuition (coaching) lunch, exercise books and extra textbooks. Parents contributed more (95 and 94 percent) than government (5 and 6 percent) towards the building fund for 1991 and 1992 respectively.

12.1.1 Universal Primary Education (UPE)

- It is important to note here that there was no systematic increase in share of education in recurrent budget until 1996 following the introduction of the Universal Primary Education (UPE), which substantially increased public spending especially on primary education. This was a political decision of the President of Uganda Mr. Yoweri Kaguta Museveni and not a SAP policy.

- Prices of providing education service rose substantially relative to other prices by about 68 percent before UPE.

- Available enrolment statistics for primary level show that for period 1987 to 1996, enrolment was stagnant at around 2.5 million then increasing to over 5 million after introduction of UPE. It however needs to be noted that whereas UPE registered high enrolment, there is low retention of pupils at school. A number of the pupils are either intimidated by the wide age disparity in the same class or failure to have uniform and then for the girls there are often domestic demands that draw them away form school.

- There ought to have been improvement in number of teachers, classroom and textbooks since 1997as a result of the additional public resources. However, the increases continue to be overwhelmed by upsurge of enrolled numbers following implementation of UPE. So that there is a teacher student ratio of 1: 100. In addition teachers were lost as a direct consequence of the ban on recruitment.

- Level of education service provision remained poor prior to 1997. Since 1997, primary education service provision has continued to be overwhelmed by the surge of students following the implementation of UPE.

- Studies carried out by the Uganda Examinations' Board (UNEB) in 1999 clearly revealed that after six years of primary education, 52% of the urban pupils and 97% of their rural counterparts could not read or write!

- Public spending on education prior to 1997 was inefficiently allocated and targeted: Government spending per student is skewed towards beneficiaries at the upper levels of education.

- Prior to 1997 poorest sections of the population benefited less than the richest, with disparities between the poor and rich worsening with increasing level of education. Burden of the cost of education was borne by parents to the detriment of poor. While UPE reduced this burden, it still exists between rural and urban schools, private and public schools and at secondary and tertiary levels of education. This has had a direct impact on standards and performance.

- UPE policy increased primary enrolment mainly from the poor segments of the population that had no access. However, the increase overwhelmed existing facilities such as classrooms, teachers and textbooks resulting in poor input/pupil indicators. There are studies that have shown that there is a marked drop out of the girls especially after seven years of primary education.

- The subject range has not changed. The ones taught in schools even after the introduction of UPE are not practical and applicable in the society in a manner that would reduce unemployment. Given therefore that a number of children drop out of school after seven years due to prohibitive costs of secondary school, and that there pupils have no numeracy and literacy skills, they are unlikely to add value to the communities they live in because they will not have the basic skills to generate compete in the job market.

- Since 1997, there has been significant increase in public resources to primary level education (receiving 70% of discretionary recurrent expenditure) allowing for procurement of classrooms, teachers and textbooks. There is now sustainable financing of these inputs in years to come to improve sector indicators. For instance, within next three years, student: classroom ratio will be 66. Student: teacher ratio is also falling yearly and so is the textbook: student ratios. These measures will of necessity take time to arrest the drop in quality of education and the production of pupils that are able to remain literate and numerate after seven years of limited transfer of those skills. The process of improving provision of essential inputs is being done as and when resources are available.

- Public sector secondary and tertiary education provision favours high-income groups and cost is a major constraint for the poor to access these levels of education.
- In 1997, much of the public spending on primary education did not reach the beneficiary. About 36% of resources reached schools. This has improved to about 70% in recent years as a result of decentralisation. There is also an improvement in transparency in resource disbursement to local governments.

12.1.2 Other Concerns

Other concerns in the education sector (also pertinent to health) reported during interviews, affecting service provision include:

- A number of the disadvantaged are still outside the formal education system even with UPE in place. There is no clear-cut policy on child mothers to ensure their re-admission into school after delivery. This destroys the future and confidence of these girls especially since there is no in-built counselling process to address the issue of stigmatisation.

- Financial management at school level (and also health facilities) needs urgent attention to increase the effectiveness of the increased resources and spending.

- Role of communities needs clear definition and dissemination (there have been many conflicting policy statements for example the introduction of UPE was done without removing the ban on recruitment in the public service and the Parent/Teacher's associations were rendered redundant). Clarity of their role will enhance effective implementation of UPE especially the role of parents.

- Audit function at local government is weak and needs strengthening.

- Decentralisation of education and health as required by law should be fully implemented, accompanied with appropriate resources and capacity building initiatives or else this runs the danger of merely decentralising the anomalies and deficiencies that characterised centralised service delivery.

- Review of pertinent policies with greater participation of stakeholders.

- Payroll management and procurement of inputs such as textbooks should be decentralised to improve effectiveness of resources.

- Teacher housing needs attention to enhance effectiveness and motivation of teachers in school.

- Cost of secondary and tertiary education is high and is significantly being borne by parents (through provision of many items). This limits access of poor sections of society.

Be that as it may, the amount of capitation appears a lot on paper but it is not adequate per student.

"It is too low to cover costs involved in the provision of quality primary education. Moreover, schools are not allowed to charge any money to cater for other school costs."

In addition to limited school cost, teacher's salaries are a disincentive because they are low. This is especially the case for teachers in the urban areas where the cost of living is high. As one official remarked,

"*We are constantly being accused of failing to have trained teachers…the problem is payroll management…People in the Ministry of public service are funny. Sometimes you make a deletion of teachers that have either absconded or died."*

Although increases in public expenditure have been achieved, social indicators remain poor, suggesting that social outcomes may not improve even in the face of further increases in social spending if issues of allocation within the sectors and efficiency are not addressed. Evidence of the tracking study in 1996/96 supports this view. The study showed that although social spending may have increased, only 36% of non-wage funds reached schools and as much as 70% - 90% of medical drug supplies were diverted to personal use to compensate for the low salaries of medical staff.

As one person observed,

"UPE is a good policy but it is too early to say it is a success. There is the problem of the poor whose children drop out because their parents have failed to or do not want to assume their responsibility of providing uniform, exercise books, and meals; leaving their children in rugs and hungry!"

Another significant finding on provision of health and education during the period, based on findings from a Tracking study of funds in health and education in 1996 showed that an increase in real per capita public resources devoted to health and education expenditures did not translate into improvements in the impact of social indicators. The latter depended on the effectiveness and efficiency of spending, including the share of resources devoted to primary education and basic health care. Evidence from the study showed that, at least in the period *1990-95*, public funding for social spending in Uganda did not reach the intended beneficiaries, and, hence, health and education outcomes did not increase as much as the increase in spending would have suggested (Ablo and Reinikka, 1998). From those observations therefore one simple deduction is that the benefits in education have been broad but they have not yet equipped individuals with the knowledge and skills that a majority of the rural poor can translate into economic benefits.

Another important issue highlighted by one respondent is that:

"The most of the costs are borne by parents who paid 90 percent. The government paid very little. *So why do they say that the education is free. We should believe in this kind of lies."*

According to the reports given by the headmasters, DEOs, parents, teachers and chairmen of PTA and management committees who were interviewed during the survey, there are other contributions, which were provided by parents in kind. For instance, parents can organise to make bricks, construct classrooms and teachers' houses on self-help basis. Certainly "*this hidden cost could be significant depending on the enthusiasm and interest of a given community in the development of education in the area"*

Coaching is private tuition where lessons are conducted either during holidays or before/after the officially stipulated school period. Pupils pay a fee for this service directly to the teacher concerned. The free ranges from Ush 5,000 per week to Ush 20,000 per term depending on the location of the school. Teachers arrange with the

pupils to conduct the exercise either at the teachers' home or any other convenient place during weekends or holidays at school early in the morning (say 7:00am to 8:00 am) before school opens or after school time at 5:00 pm.

However, parents who are against coaching said since teachers benefit directly (through coaching fee), they tend to concentrate more on coaching than in the officially stipulated time. This puts pupils who cannot afford coaching at the losing side. Also, in an attempt to demonstrate that coaching "works" (is effective), teachers sometimes set exams based mainly on the part that they taught during the private time.
Primary education. An average of 1.5 percent of GDP during 1989/90 – 1996/97 was spent on education, and since 1996/97 there has been an increase to 2.5 percent following the implementation of UPE. This was possible following increase in resources made available by the concerted efforts of donors in response to a political decision and an increase in domestic revenue.

12.1.3 Conclusions on Primary Education

In conclusion, public spending has substantially increased on education since 1997, particularly at primary level but not as a result of SAPs. There has been an allocation of over 30% of Government discretionary recurrent expenditure to education, out of which 70% is allocated to primary education.
There are six general conclusions that can be drawn from primary education study.

- Little or no schooling is provided to more than 46 percent of primary schooling age population. Several factors contributed to this high percentage of non-enrolment but one main is due to abject poverty prevailing in the households
- Disparities in access to education between male and female are reflected in gross enrolment rates. For example, the average female gross enrolment rate at the primary level still remains only 63 percent in contrast to 79 percent for boys. The reasons are:

    ⇒ The opportunity costs of educating girls are higher as compared to educating boys. The opportunity costs include lost chore time, children's foregone earnings, and (especially for girls) mothers' foregoing earnings. Because poor families rely more on each family member to contribute to the family's survival, the opportunity costs of educating children are higher for poor families.

    ⇒ Inhibitory cultural values especially those suppressing women and encouraging daughters' early marriage.

- The education system is exceedingly inefficient. Average repetition rate at the primary level is 16 percent and only 32 percent of all the children who enter P1 persist to completion of primary school cycle.
- The unit costs of financing primary education are increasing every year and the burden falls heavily to parents with the result of lower income group either not enrolling or withdrawing their children from school when financial burden becomes too great. Contribution of parents of the total funding required by the school.
- Qualitative weaknesses are widely reflected in poor student achievement in primary leaving examination (PLE). Only about 8 percent, on average, of the

candidates for PLE obtain division one and are guaranteed admission to a secondary school. Such problems of poor academic performance are usually attributed to the poor quality of teachers, inadequate textbooks and other instructional materials, language inadequacies and various extra-scholastic factors. Without additional resources, educational quality will continue to decline

- Fiscal capabilities are being stretched to the limits simply to maintain the educational status quo. For example, on the basis of the 1989/90 Household Budget Survey, parental financing of primary education was about 1.9 percent of GDP, whereas Central government expenditure on education was only 0.6 percent of GDP. This is because government revenue remains extremely low at only about 7 percent of GDP, reflecting weak tax administration and the loss of coffee-based revenues.

However, the little revenue that government collects is spent on defence than other sector taken individually. Government revenue allocation to defence alone has ranged between 2 and 4 percent of GDP.

13.0 Implications for the PEAP

The findings of the study go a long way to underscore the importance of health and education in the development of the country and specifically in poverty reduction. The study is an eye opener with respect to the areas that are lagging behind in the sectors and need urgent attention and merit consideration investment. The importance of sensitisation of the communities on government policies and strategies has been highlighted. Although, in the PEAP community awareness of the causes of ill health and education was reported to be low, in all districts in the study the communities were able to identify the commonest cause in the population. This implies that mere introduction of serves or programmes without adequate appropriate information to the people who are to use them may lead to inadequate utilisation and even encourage misconceptions.

Important feedback has been received through the study, which will help guide further development and review of the sector government policies and strategies. The need to involve the communities in policy development and implementation comes out clearly for better implementation of programmes. Government will have to devise a mechanism of integrating the people's feedback into policy, programmes, and action plans.

14.0 Comments on the Hypotheses of the Study

Based on the above findings, the four hypotheses are examined in the subsequent sections.

Hypothesis 1: As a result of public expenditure management reforms, expenditure on social services declined leading to poorer social services, particularly health and education at lower levels.

As a general remark, there were benefits and loses under this reform. The government was able to reduce its wage bill and subsidy. The investors were able to purchase the divested enterprises usually cheaply under a very favourable

investment climate. The World Bank and IMF were able to entrench their policies and donor involvement was enhanced.

The other side of that is that there were job losses and loss of income and hence a fall in the standard of living. The gender implication of this drop in the standard of living was the increased workload and the income gaps for women at the household. Especially when they had to step in and provide nursing services because they were not affordable as a result of the introduction of user-fees and the drop in income at the household level.
There was loss of the power to bargain by the industrial workers because they were not allowed to demonstrate or go on strike for better work conditions.

Public expenditure reforms increased expenditure on social services especially education and in particular primary education but this was not a result of SAP's. The increase in social spending has not fully translated into improvements in the outcomes in health and education for several reasons:

i. Part of the public funding did not reach the intended beneficiaries.

ii. Allocations within the sectors (apart from aggregate sector spending) and efficiency issues were not adequately addressed.

iii. Inputs essential for provision the social services were either not procured or available in quantities to promote provision of the social services. For instance, health workers would be available in a facility with no drugs and other essential equipment or vice-versa. Also teachers are not recruited in some areas because of a ban on recruitment and local constraints. The poor social services can thus be blamed to a whole range of factors even beyond the realm of SAP. (SAP intervention required a complete understanding and quick response to these factors to enhance the effectiveness of increase in resources for social services.)

Hypothesis 2: Policy reforms have not improved access to basic services for all sectors of the population that require them.

With the exception of UPE that was not a result of SAP, Policy reforms undertaken have made it possible for additional resources to be channelled for social services. However, the policy reforms have not gone into depth to address the underlying constraints that limit access of the poor and other segments of the population to social services. The perception at initial stages of SAP (1986-1996) was that once resources for provision of social services are available and policy reforms were acceptable to government, social indicators would improve. Recent studies (Tracking Study/and other evaluation reports) evidently show more is required beyond policy reforms. In addition, the policy reforms must be introduced to embrace the effective participation and acceptance of the civil society. This was not the case until most recently.

Hence, policy reforms introduced with effective participation of and acceptance by the civil society; and addressing underlying constraints to provision of social services can improve access of basic services to all sectors of the popular. Continuous

monitoring is essential to appreciate the constraints involved during the policy implementation.

Hypothesis 3: There in gender differential impact under SAPs.

Gender differential impact under SAP exists but not unique as it extends to a whole series of public interventions. This is attributed to many reasons:

i. Lack of clear understanding of gender issues in the area of public expenditure management. Allocation and programmes were not gender sensitive.

ii. While resources were available for maternal care but significant portion of rural women had limited access to maternal health services.

With increasing knowledge of gender issues, public expenditure management should take into account such issues in allocation and targeting of available resources to reduce gender differentials impact of public spending in general.

Hypothesis 4: Public expenditure management, which has been characterised by inadequate provision of development funds to districts, has resulted in poor financial management, decline and un-equitable distribution of social services.

There has been increase in the flow of recurrent expenditures to local governments. Some of the recurrent funds in form of conditional grants have been channelled to local governments to cater for development needs such as construction of schools and health facilities. Decentralisation of development funds has just started and thus expected to increase resources for development.

The main finding related to this hypothesis is that financial management is too weak at both local governments and central ministries to realise better public services. The absorption capacity of funds by districts varies and contributes in part to un-equitable provision of social services. Although funds are inadequate to cover the needs of districts, the quality and quantity of services obtained from available resources remain low because of inefficiencies, corruption and poor governance.

Public expenditure management only started to address financial management issues around 1996 through initiatives to strengthen Auditor General, introducing transparent mechanisms of budget management as well as improving procurement procedures in the public sector. The results of these initiatives are yet to be realised.

15.0 Way Forward.

i. Public spending in health sector should be restructured and skewed towards primary and preventive health care to increase access of the poor especially women.

ii. Policy dialogue in health and education should embrace participation from more stakeholders including civil society with focus on implementation constraints especially at local government levels; and examining policy options to increase access of the poor and effectiveness of available

resources. NGOs to monitor performance of the poor in the overall provision of services.

iii. The civil society should be strengthened to play effective role in promoting transparency, monitoring and public awareness in area of public expenditure management to enhance the effectiveness and efficiency of public expenditure.

iv. Public spending in secondary and tertiary levels of education needs urgent attention to increase the access of the poor. In particular, the cost sharing now in place needs urgent review to address difficulties experienced by the poor to access these levels of education.

v. Staffing at facility levels (schools and health centres) should be given attention and current constraints to staff recruitment in some areas be addressed to enhance effectiveness of complementary inputs already provided and take advantage of existing financial resources for more manpower.

vi. Maternal health care services deserve more attention to enhance access of the majority of the poor rural women and children.

vii. Overall allocation and management of public resources in education and health sectors be given attention for efficiency use to realise improvement in social indicators. Recent increases in public spending in primary education are reasonable to yield even better output and outcome results.

viii. Further implementation of decentralisation policy should focus availing more resources to local governments to meet their mandates but also enhancing efficiency and financial management of resources. Communities should be empowered on design, implementation and monitoring of programs in their localities.

ix. Revisit the issue of cost sharing to accommodate the concerns of the poor and promote equity.

x. Involve the civil society in many aspects of SAP including reviews.

xi. The effectiveness of SAP can be enhanced by addressing issues of governance, increase in public accountability, greater openness in budgetary management, efficiency use of resources, empowering civil society, curb corruption and continuously address the concerns of the poor especially the women, children, disabled, the rural population and the poor in urban areas as well increasing number of youth leaving school and not finding gainful employment. These categories are adversely affected in many respects.

xii. Undertake analytical work to identify constraints to and experiences of segments of the population on SAP. Encourage civil dialogue with a view to refining SAP based on country specific experiences.

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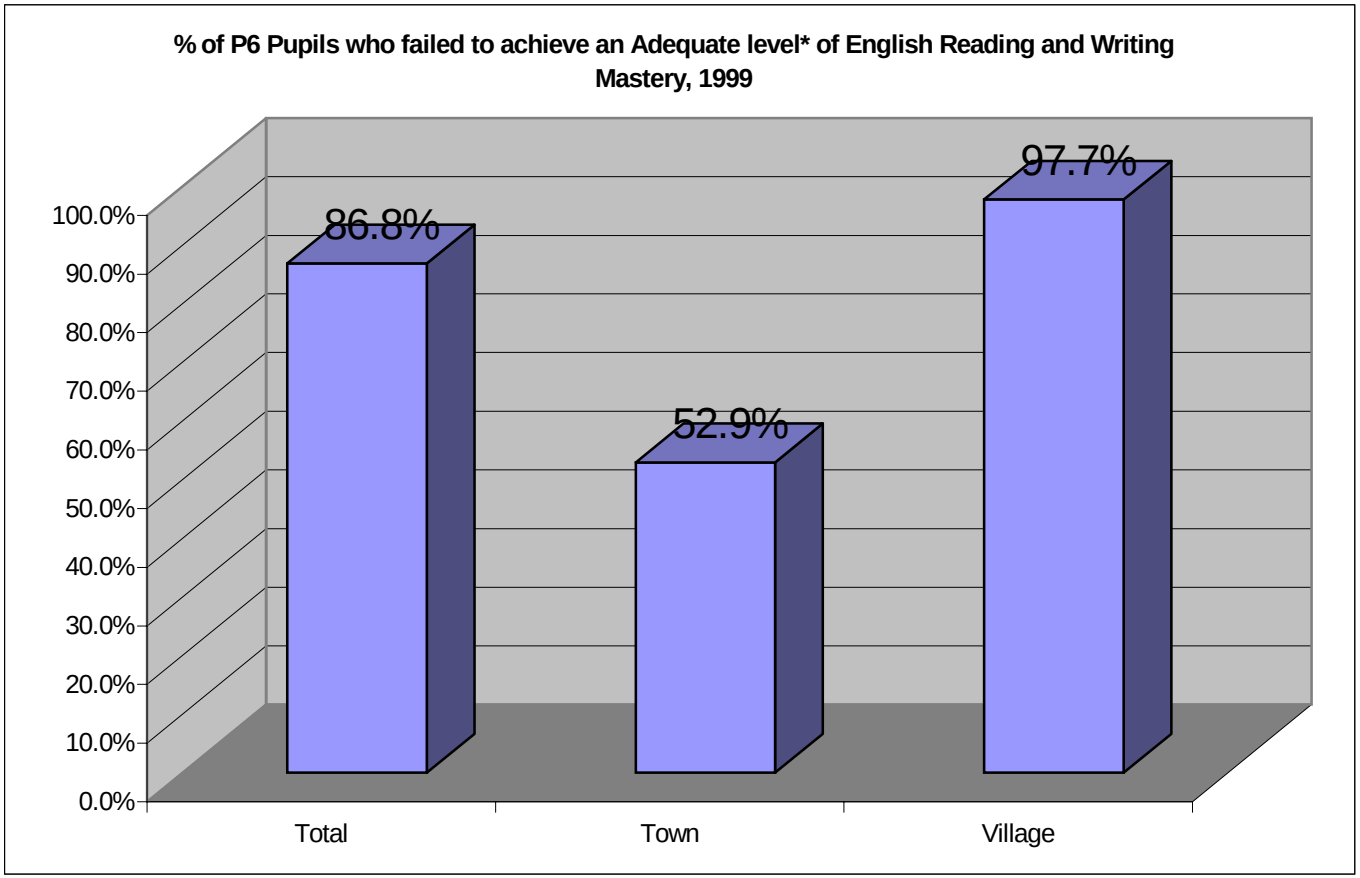
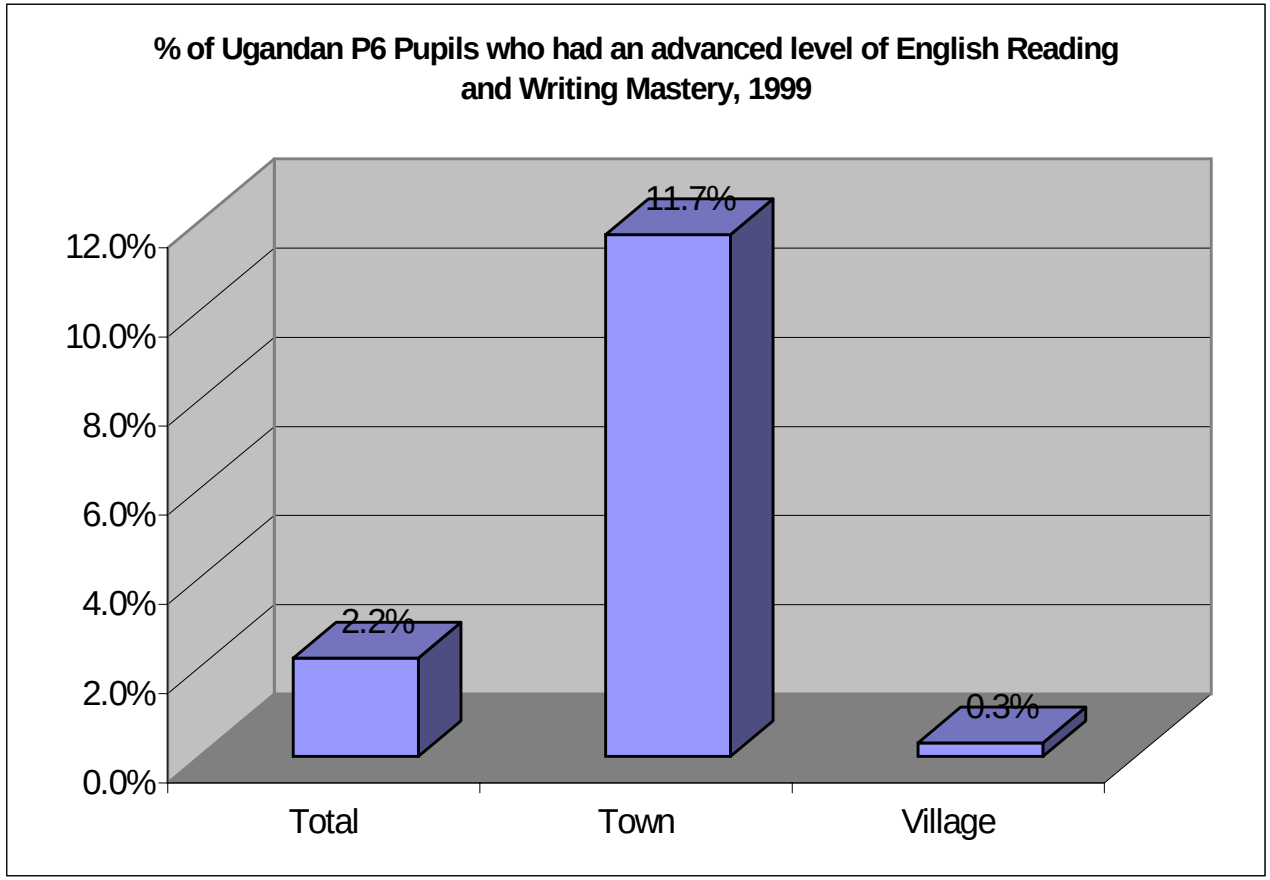
WHAT IS THE STATUS OF LITERACY IN UGANDA?



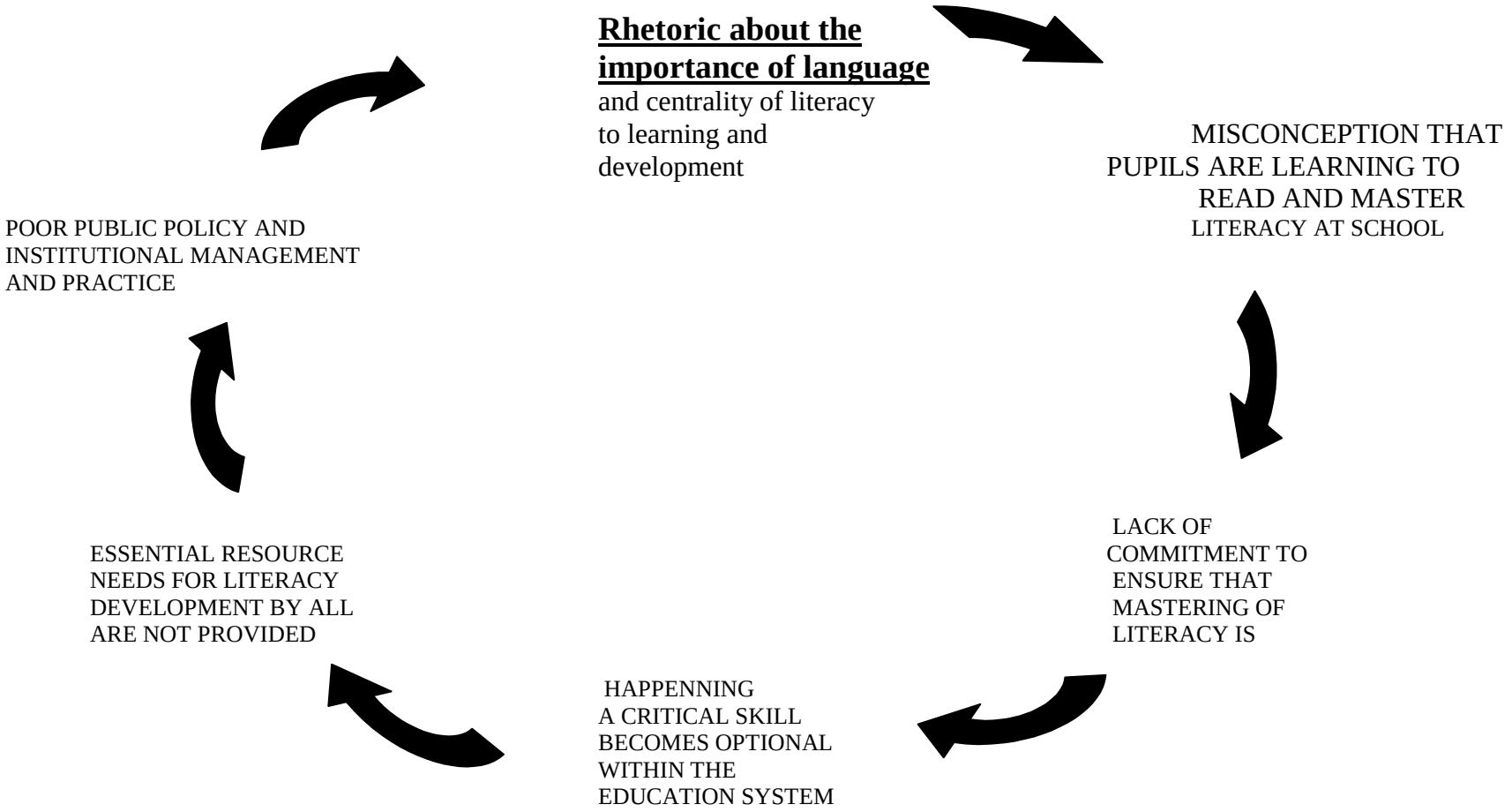
* Students who scored less than 36% on English reading and writing test
Source: UNEB, 1999



* Students who scored 64% and above on English reading and writing test
Source: UNEB, 1999

How do we explain the massive discrepancy between our expectations and what we see on the ground – **namely that the majority of children** cannot read by grade 6

Negative Cycle of Mastering Literacy at Primary School



Factors contributing to the misconception that mastering literacy is happening at school

- Existence of a language policy, open to multiple
  Interpretations, in a context of inadequate resources to
  Support its effective implementation.

- Curriculum development, pedagogy, and evaluation not
  Adequately based on relevant local research on language development, acquisition and mastery.
  - Absence of grade level reading norms to set minimum Standards for acceptable literacy levels.

  - Resource allocation concentrated on text books, without balancing the needs for non-text book reading materials which are fundamental to literacy practice and consolidation.

Impact of Negative Cycle on Education System

Severe limits on human capital accumulation and social – economic development

Education becomes much more expensive,
And a less worthwhile investment for government and parents