REMARKS BY CIVIL SOCIETY ORGANISATIONS AT THE CLOSURE OF THE 9TH JOINT REVIEW MISSION

Thursday, October 30th 2008, Speke Resort - Munyonyo

- The Honourable Minister of State for Health
- His Excellency the Ambassador of the Kingdom of Belgium
- Other members of the Diplomatic Missions
- Hon. Members of Parliament
- Permanent Secretaries (MoH and other Ministries)
- Director General of Health Services
- Health Development Partners
- Other technical staffs from ministries
- District leaders
- Representatives of Civil Society Organisations

Ladies and Gentlemen,

I am glad to represent Civil Society Organisations in making these remarks at the closure of the 14th Joint Review Mission (JRM) of the health sector this October 30th 2008. I am Dr. Sam Orach, working for Uganda Catholic Medical Bureau, one of the Facility-based PNFP health networks.

Hon. Minister of State, once again CSOs appreciate being involved in the Joint Review Mission, which of recent has also included them on the joint district visits. Over these four days we have also listened to various presentations and participated in discussions.

CSOs appreciate the government leadership that has in the past made it possible for them to access resources that enabled them to reach communities with services that would otherwise have not been possible through government structures or health facilities. These have mainly been in relation but not limited to the Global Health Initiatives that have seen CSOs play an important role in the fight against especially HIV/AIDS. In that respect, however, we urge that steps be taken to overcome the remaining hurdles hampering further release of funds from The Global Fund to fight HIV/AIDS, TB and Malaria as we all appreciate the negative effects it has had on service delivery by both government and CSOs.

We also appreciate government support to the facility-based PNFPs that enabled them to not only improve on quality but also increase access as well as equity and efficiency in the provision of health services. Despite the hiccups that were experienced at the district level, we also appreciate the inclusion of PNFPs during the payment of the one-off hard-to-reach allowance to the northern districts affected by conflict.

We all appreciate that given the elastic nature of demand for health services and the return for money demonstrated by the PNFP health networks, continued and increased investment into the PNFP will benefit the population of this country. Like the non-facility based CSOs, the PNFPs have registered more donor funding in recent years

with a decline in the last financial year; but 80% of these are not fungible, being for HIV/AIDS services – and often received in kind. The effects of stagnation of support with fungible funding have been discussed. Increasing support to PNFP facilities is a strategic investment that we urge government to willingly undertake.

Hon. Minster of State, we appreciate all efforts of government, development partners, district leaders, health workers, various CSOs etc that yielded progress in some areas within the past year. However for two years running we are noting with great concern an overall stagnation in performance with respect to the HSSP II indicators. Government, Development Partners, CSOs, and communities need to jointly work even harder to improve performance of the sector for the remaining part of HSSP II as we leap into the HSSP III. While recognising that various factors affected performances of districts, we particularly want to thank districts that have demonstrated that even with the limited resources and sometimes in very difficult situations it is still possible to make achievements. On the other hand we urge government to actively respond to help remove or reduce the factors that impede the flow and utilisation of grants released from the centre to districts and especially to improve transfer of funds from district headquarters to health facilities. Districts (both public and PNFP facilities) need to receive more funding.

We note that CSOs are not only partners to government in formulating policies, mobilising resources and providing services but also represent users of the services. As users we are concerned that as the population grows and as unit cost of services increases and as the country undertakes to scale up important services, per capita funding to the health sector is not increasing in a proportionate manner. While government puts emphasis on production it is important to remind ourselves that labour is one of the key factors of production. No useful labour can be provided by a sick population. We therefore urge government to demonstrate that health is a top priority through allocative decisions that increase funding to the sector. Not only should funds increase, but they should be made to reach the districts, health facilities and service points in the communities.

We share the belief health workers, public or in PNFPs deserve good remuneration and better general conditions of services. But we also want to emphasize that no amount of money per se will replace the importance of commitment and adherence to professionalism. We have heard here of absenteeism in public health facilities reaching an alarming 50% of working time. We also know of non-functioning of some staff who are physically present at facilities. But we think all these are at the tip of an ice-berg. We think that there is also a fundamental problem of formation and guidance. Training of health workers now seems to be more academic than vocational in approach. We urge health training institutions to emphasise mentoring and counselling of trainees.

In addition, problems of leadership and management have been identified during the Mid-term Review (MTR) and this JRM. Related to that has been the debate about recentralisation of health workers as decentralisation is blamed for poor performance of the health sector. We suggest that a careful discernment be made on whether decentralisation has failed or government has failed decentralisation with respect to the health sector. We also suggest that lessons be drawn from other sectors. If decentralisation has worked for them there is need to learn why it has done so and not

for the health sector and what the implication will be if only the health sector is recentralised whether fully or partially. Observations from various countries also show that the private sector generally performs better because ownership and governance are closer to point of implementation with stronger management. Maybe these can also offer some lessons for us.

At the opening of this review we made recognition of the important responsibility government has as a steward of good policy and ensuring that this is properly supported and implemented. We observed how important it is for Uganda to enhance its partnership with CSOs and to strategically strengthen CSOs if we are to improve access, equity, quality and efficiency in the health sector. We were also informed about attempts to get the non-facility based CSOs improve on their coordination and inputs to the sector within the framework of public-private partnership for health. We once again want to observe that the ability and freedom of individuals and communities to play roles in planning, managing and securing health care for themselves or influence government decisions and processes are part of a democratic situation. We have seen that supporting this democratic process through providing support to facility-based CSOs and other funding to non-facility based CSOs working with communities has benefitted the health sector and the nation. While we support the Sector-Wide Approach (SWAp), the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action with regard to working under government leadership and ownership of programs, using existing government systems, ensuring mutual accountability, encouraging involvement of CSOs etc, we believe that both government and Development Partners need to discern how best these high level commitments can be translated into strong and effective Public-Private Partnership here on the ground to enable CSOs not only to play a watchdog role but be able to better complement government efforts in using available resources to increase equity and access to services.

Partnership, like marriage, can only be strong and useful if deliberately and wilfully nurtured for a purpose. CSOs commit to doing their best to nurture that partnership. But similar deliberate practical commitment is necessary from government and just as is support of other partners. Allow me urge once again that as we draw the new National Health Policy, HSSP III and the National Development Plan, strengthening Public Private Partnership for Health be taken as an important feature of these plans.

Also important is the need a clear framework for effective engagement of government with CSOs and other partners. Significant investment of effort will be needed to have the PPPH policy passed, disseminated and made operational on the ground.

We believe that the deliberations of these four days can bring new energy that will enable all of us pursue important decisions arrived at as we move towards the end of HSSP II.

We look forward to meeting here a year from now to receive reports of performances that give us all smiles and better hope for the future.

Once again I thank you and may God bless you all.