Case study of a ‘successful’ sector-wide approach: the Uganda health sector SWAp

A lessons learned paper established in the frame of the SDC-STI SWAp Mandate 2003-4

By

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This paper and more papers on Uganda can be downloaded from:
http://www.sti.ch/scih/swap_country_uganda.htm
There is now a considerable literature detailing the successes, failures and lessons learned of ‘sector’ programmes. Since the advent of sector approaches such as Sector Programmes (SP), Sector Investment Programmes (SIP) and Sector-wide Approaches (SWAp) in the mid- to late-1990s, there is now quite a considerable literature available detailing the successes, failures and lessons learned (see http://www.sti.ch/scih/swap_references.htm). Most of this literature is in the form of documents written by or on behalf of aid agencies (commonly referred to as ‘grey’ literature), with limited academic publications in peer-reviewed journals.

However, some valuable recent experiences from countries with more ‘mature’ sector programmes are not readily available in summary form. In terms of in-depth country case studies, there have been some notable series of publications on issues related to donor coordination and sector programmes:

- The WHO series of the year 2000 (Uganda, Tanzania, Ghana, Mozambique, Cambodia and Vietnam)
- The special issue of the journal ‘Health Policy and Planning’ in 1999 (Bangladesh, Cambodia, Mozambique, Zambia and South Africa), and

However, many of these studies are now several years old and therefore do not reflect more recent experiences of these and other countries with donor coordination approaches and sector programmes. These studies generally reflected a snap-shot of these countries at one point in time, summarizing the successes so far and the challenges still remaining. They do not reflect the situation in countries with a ‘mature’ sector programme – that is, a sector programme that has overcome any initial teething problems and developed some kind of longer term stability and equilibrium.

From SDC’s point of view, it is interesting to learn what is going on in sector programmes in countries not supported by SDC in the health sector. Aid coordination via sector programmes or alternative mechanisms (e.g. PRSP) is one of the five key focus areas of the new SDC Health Policy (2003-2010). However, as all donors, SDC is still in a learning phase regarding sector programmes, and its support to sector programmes varies considerably between geographical departments. SDC recognizes that other countries’ experiences can offer a perspective to the countries where it is helping implement a sector programme, such as in Tanzania and Mozambique, and other countries where a sector programme is under discussion, such as Rwanda.

Therefore, the main aim of this paper is to describe the sector programme features in the health sector in Uganda, which is a

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1 These documents can be found, by country, at [www.sti.ch/scih/swap_country.htm](http://www.sti.ch/scih/swap_country.htm).
2 The only SDC Department actively supporting health SWAps is SOSA (Eastern and Southern Africa).
The aim of this paper is to understand some of the factors for success in the Uganda health sector ‘SWAp’.

SWAp that has received international acclaim for its design and execution. The paper seeks to understand why it is working, the critical factors for success, what did not work so well and why, and what lessons there may be for other countries. Furthermore, this paper lays the foundations for more in-depth country case studies on SWAp potential to be conducted by the Swiss Tropical Institute jointly with SDC.

Background to the health sector and the SWAp in Uganda

At the start of the sector-wide approach in Uganda in 2000, key issues faced by the health sector included (Brown, 2000):
- Poor health indicators, even by African standards.
- Serious shortage of funding to the sector.
- Weak health care organization and management, with especially low capacity at district level.
- Inadequate public-private partnerships.
- Inefficient allocation of resources at district level
- Disproportionately high national spending on tertiary care
- Disparities between different population groups and regions

In 2000, the SWAp marked the start of a major change in the way many donors provided their support to the health sector.

For a decade the Ugandan Ministry of Health (MOH) has been restructuring, key components of which have been decentralisation (since 1993) and the changed role of the central MoH—a decade ago when the Memorandum of Understanding was signed for the sector-wide approach (SWAp)). The SWAp marked the start of a major change in the way many donors provided their support to the health sector – now often using an unearmarked allocation via the budget of the Ministry of Finance, Planning and Economic Development (MoFPED). In the same year, the Health Sector Strategic Plan (HSSP) was implemented, which was prepared within the framework of the Poverty Eradication Action Plan. In 2003 a mid-term review of the HSSP was completed, reporting good progress in implementation.

Key lessons learned from the Uganda health sector SWAp

There are many topics that could be selected for review of lessons learned from Uganda. In the interests of space, and also for emphasis, some key elements of success have been selected for presentation and which provide valuable lessons for other countries undergoing or considering a SWAp.

SWAp lead up and launch

The lead up to the sector programme and the support at its launch are crucial factors for how a SWAp can set off in the right direction for long-term success. Important factors for success include

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3 Encompassing policy making, providing guidelines, training and capacity-building, monitoring the health sector, and the coordination of donors.
The lead up process to establishing the Memorandum of Understanding for the SWAp took several years of preparation, including evaluation and review, better SWAp understanding, consensus development, developing enabling conditions, and critical reflection.

The phasing of a SWAp can vary considerably between countries, depending on many local factors. Whether stakeholders waited until the right conditions existed before launching the SWAp, and whether there was wide participation in SWAp design. Also, the more lessons learned from other countries or sectors can be gathered and utilized in designing a SWAp, the more likely previous mistakes will be avoided.

In fact, the health sector in Uganda had very few lessons to learn from other countries or sectors, as the years 1999 and 2000 marked the start of health SWAps in several countries where they are now more mature. The series of WHO documents commissioned by the InterAgency Group on SWAps and Development Cooperation were available only in 2000, and Uganda was one of these countries reported. However, as Brown (2000) reports, the lead up process to establishing the Memorandum of Understanding took several years in the Ugandan health sector. Annex 1 shows in more detail the steps to reach the final MOU in 2000. The GOU, donors and stakeholders were reported to have been introduced to the concepts of the sector-wide approach as early as April 1997, with a review mission in September 1997. This long period of preparation allowed time for a considerable amount of reflection, as well as appropriate steps to be taken for the SWAp launch, including the HSSP and a high degree of consensus and support as evidenced by the large number of signatories of the MOU. It was no coincidence that the SWAp start date coincided with the first year of the HSSP implementation. Indeed one could argue that the HSSP is the embodiment of the SWAp. In parallel the PEAP and PAF gave further momentum to the processes, and a focus on the poor. All these factors together have increased donors confidence in the health sector, enabled leadership and ownership of the Government of Uganda, and given a necessary focus for activities financed by donors (through the Poverty Action Fund). Table 1 gives an overview of a typical phasing of a SWAp, with estimated timelines for each phase.

Table 1. Typical phasing of a SWAp

<table>
<thead>
<tr>
<th>PHASE</th>
<th>PERIOD</th>
<th>PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead up to SWAp</td>
<td>1-5+ years</td>
<td>Examine SWAp benefits</td>
</tr>
<tr>
<td>Laying foundations</td>
<td>1-2+ years</td>
<td>Health policy and plans</td>
</tr>
<tr>
<td>MOU</td>
<td>1 year</td>
<td>Agreement &amp; consensus</td>
</tr>
<tr>
<td>1st SWAp period</td>
<td>1-2 years</td>
<td>Initial actions with core donors</td>
</tr>
<tr>
<td>2nd SWAp period</td>
<td>1-2 years</td>
<td>Early lessons learned, and new donors on board</td>
</tr>
<tr>
<td>3rd SWAp period</td>
<td>3-4 years after MOU</td>
<td>Mature SWAp and outputs/ outcomes available</td>
</tr>
</tbody>
</table>

MOH structure and decentralisation

For example, a minimum level of donor consensus, and improving donor-Ministry of Health relations.

It could be argued that the PEAP process, which predates the SWAP, gave the health sector a good example to follow in terms of GOU leadership and improving coordination.
The decentralisation process in Uganda preceded the health SWAp by 7 years, but it wasn’t until the SWAp was implemented (along with the PRS) that the decentralised levels became more fully effective – with an increase in funds but also the leadership of the central MOH.

Under the SWAp, the MOH has redefined its role from one of service provider to that of policy making, providing guidelines, training and capacity-building, monitoring the health sector, and the coordination of donors. In other words, the main role of the central MOH is to support the decentralized levels in the implementation of the HSSP. It should be noted that the changes in the MOH since 2000 followed on from previous restructurings starting in 1993 when decentralization policy was first implemented. Since then the MOH has been under increasing pressure to become more effective and responsive to lower levels, and reduce expenditure at central level. This has meant that in theory SWAp funds become more decentralised – i.e. sent to the decentralized levels (except salaries). However, this was reported not to take place after the major 1995 MOH restructuring due to resistance from the centre to decentralize (Jeppsson et al 2003). In this restructuring the staff of the central MOH increased by 40% instead of decreasing. It was also reported that the decentralization of the responsibility for service delivery met with great resistance in the later restructuring lasting from 1997 to 1999. It was not until the operation of the PAF (a fund that must be spent on poverty-reduction activities), the requirement of the MOFPED for the MOH to reduce expenditure at central level, and various reviews concluding that the service delivery level needs to be strengthened, that sufficient resources have been decentralized since 2000 to give the increased power promised to the decentralized levels for so long.

These experiences in Uganda gives clear signals to other countries what are the difficulties in decentralizing the health sector (whether alone or in tandem with local government reform), especially in the context of a sector programme which tends to give the central level increased powers, even if their role has been redefined. For example, the importance of having a well functioning Ministry of Health structure, having rules that are enforced (such as spending requirements at decentralised levels), and a long-term commitment to decentralisation, are all factors that have helped the decentralised level cope with the implementation of a sector-wide approach.

There are a number of arguments why decentralization has been important for the success of the sector-wide approach in Uganda. With the re-centralising tendency of the SWAp, where negotiating power rests with the central MOH, there are very real threats that the centre sees this as an opportunity to take complete control over the activities of the decentralized levels. However, due to the decentralization achieved before 2000, this pressure was partially resisted in Uganda. This may be explained partly by the fact that decentralization was a devolution to local governments rather than merely a deconcentration to local offices of the MOH. Therefore the re-centralising tendency of the SWAp could effectively be resisted as local governments are now responsible for the health sector, thus reducing the interference possible from the central MOH. Second, the reforms were of such a great scale, with so many expectations, that the
A streamlined and well-functioning MOH institutional structure has also proved invaluable to the implementation of the SWAp.

Budget support provided by donors has given a degree of stability that allows for an integrated and considerably more effective MTEF and increased political commitment to the HSSP.

The fact that the budget support is provided through the Ministry of Finance means that the Government of Uganda has been able to take a stronger leadership role. MOH accountability has shifted away from donors and to the Ministry of Finance.

Central MOH needed effective decentralized levels to take responsibility for all activities to implement the HSSP. Another factor for the apparent success of the SWAp in Uganda has been the various Ministry of Health committees and bodies that exist, some of which are related to the SWAp. In general, there has been a clear delineation of responsibilities, clear communication and decision making channels, and well-structured mechanisms for consultation and participation in decision making as well as health sector monitoring. The various levels of these structures and links between them are described more fully in Annex 2.

The SWAp and health sector financing

The budget support from donors that often results from a sector-wide approach agreement, and the greater stability this financing mechanism brings a sector, allows for an integrated and considerably more effective MTEF. The sector programme in Uganda was nested within the HSSP, giving greater political commitment to the implementation of the HSSP. The amount of on-budget funds has also increased the resource envelope for the health sector over the last four years, due to donors moving their support from projects to budget support. The longer term commitment allows for longer-term government plans to be made, and the health sector is given assurances that its budget will increase year on year. Also, the PAF gives further assurances that donor funds are spent on priority items (related to poverty-reduction), through which donor funds have now been channeled.

Another interesting facet of the Ugandan health SWAp is the fact that, very soon after the MOU was signed, the donors moved to general budget support through the MOFPED, as opposed to sector support which is earmarked for the health sector. This has given a stronger role for the MOFPED, who have become increasingly strict about what the government budget (including donor funds) is spent on, and also has set sector budget ceilings based on its national development strategy and PRS (PEAP). This means that accountability has clearly shifted from donors to the MOFPED (parliament and civil society).

One policy change that has been heavily influenced and facilitated by the changes in modalities of health sector financing has been the abolition of user fees in 2001. Low health service use has often been argued, both internationally and nationally, to be partly explained by the imposition of user fees, especially on poor and vulnerable groups, and there is quite a body of evidence to support this argument. However, the decision to abol-

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6 Assuming funds promised by donors are forthcoming. Problems may arise when conditions for release are not met in full by the MOH, with the result that activities cannot be implemented as planned.
The SWAp has provided some conditions which has allowed MOH to abolish user fees on essential health services (more decentralised funds, increased efficiency), with generally very positive results.

Given this background, the MOH is Uganda was provided with a good opportunity to abolish user fees, in the context of the SWAp and with the poverty-reduction targets driving the agenda. The increased flow of funds to the health sector, the decentralisation of the fund distribution, and the guaranteed PAF funds, together gave an excellent opportunity for revenue losses from user fees to be covered from other sources. The result has been generally very positive. Experiences are now being presented that show improved access, increased use of services, and less work days lost due to sickness and lower health expenditures for the lowest two income quintiles. However, impacts are limited so far on illness reporting rates, use of preventive services and quality of service, and also drug stock-outs and reduced staff motivation have been reported. Therefore, while the longer term impacts need to be evaluated more fully, initial indications are that the population can benefit greatly from the abolition of user fees on essential care.

Supporting the transition to SWAp, HSSP implementation and M&E needs

The pre-conditions described above – wide support, a process of reflection, a national plan, etc – are important but not sufficient for SWAp success. Once the SWAp is launched, it has been clear from international experience that continued support of various kinds is needed from donors and other stakeholders, beyond the unearmarked budget support. The early phase of SWAp is not only a time when MOH is fragile due to structural changes and the temporary increased workload, but also considerable technical input is needed, and donor expectations for monitoring and evaluation increase instead of decrease. In Uganda, rather unusually, it was decided even before the SWAp launch (see Annex 1) to put in place a financing mechanism called the Partnership Fund, which it was intended would help MoH achieve its own plans and reform objectives, but also to help them meet donors requirements for monitoring and evaluation. Especially given the increasing power of the MOFPED, it is has become more and more difficult to gain financial support from the government budget for activities that are not related to service provision. These include, for example, development of central MOH capacity and technical studies, and also the joint review process, which by national standards are very costly processes.

The aim of the Health Sector Partnership Fund (PF) was ‘to provide a common and transparent mechanism for the different development partners to contribute towards the additional costs that government will have to confront in the process of undertaking the preparatory activities for the implementation of the health sector strategic plan through a sector wide approach’. Essentially, this meant supporting financially (a) technical assistance required by government but not provided for through other exist-
The Partnership Fund has been reported to have greatly facilitated implementation of the SWAp.

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A review of this Partnership Fund was conducted recently to determine whether the Fund has been utilised compared to its intended purpose and whether the Fund should continue (de Loor and Hutton, 2003). The review concluded that the Partnership Fund has served as an enabling instrument for the SWAp to work and to help it progress more rapidly. It is widely seen by stakeholders as answering major needs of the SWAp process and HSSP implementation in a timely fashion. Among its many benefits are:

- It has helped the health policy advisory committee to function (where donors also meet) and allowed joint decisions to be taken,
- It has given Ministry of Health a lead role in the twice yearly joint review missions,
- It has contributed to the monitoring and evaluation of the sector,
- It has provided Ministry of Health with a flexible and timely access to necessary technical assistance that has informed policy decisions and helped it meet its undertakings
- It can also be partially held responsible for the greatly improved collaboration between health sector partners.

Therefore, while the PF was recognized at its inception that it was a time-limited mechanism, its role in the success of the sector-wide approach has been important. While a Partnership Fund-type mechanism is not the only one for providing these types of support, it can be argued that it has benefits over bilaterally-agreed support mechanisms between donors and MOH, including: better coordination of activities, better and more participative decision-making, transfer of ownership to MOH, improving MOH leadership abilities, and improving government contracting and procurement mechanisms (to the extent they are used).

Future outlook
This section briefly concludes what are the main issues facing the health sector in Uganda, and how these may be resolved

Financial constraints: current projections of health sector expenditure are insufficient to meet needs, despite increased budget allocations expected over the coming years. However, the sector is able to absorb substantially more resources especially for drugs and supplies, and insufficient spending on this will clearly affect health outcomes. In the medium- to longer-term, the contributions of the majority of donors are not yet secured. Furthermore, the MOFPED sector ceilings limit how much additional donor funds would reach the health sector anyway, including increased funding from global health initiatives. These
budget ceilings are seen by the MOH and donors as a threat to rapidly improving health outcomes to meet internationally agreed targets. However, the MOH is in an ongoing dialogue with MOFPED for increasing the sector ceilings for health.

Merging Partnership Fund into government systems of financing, monitoring and procurement. While it is true that the PF does not use or support fully government mechanisms of procurement, the benefit of the PF mechanism has that it has given timely support to the senior management of the health sector, allowing plans to stay on track. However, at some point the PF mechanism currently used should give way to a fully government system, with funds for these needs coming from the MOH budget, procurement through the normal MOH channels, and monitoring through the MOH quarterly and annual reports. It is not yet clear whether improvements will be made first before the PF mechanism is terminated, or whether the termination of the PF will hasten the improvement in the GOU procurement procedures.

Role of donors. One possible logical conclusion of the current situation is that some donors leave the health sector altogether (in terms of their place around the policy table), in order to save on donors’ own costs in maintaining their presence in-country. Donors can justify this if they feel that the health sector has graduated to a level where donor engagement is necessary, as has already happened in many middle-income countries.

Donor projects that fall outside the HSSP. Due to non-alignment of donor and GOU priorities, projects are implemented that either fall outside the main core of the HSSP, or that, due to the flow of funds, distort the implementation of the HSSP. While the MOFPED allows a range of aid instruments, it explicitly asks that donor projects not supporting the government budget should at least be planned and coordinated with the GOU, and that they be directed at HSSP priorities. With the aid volumes associated with some of these global initiatives (e.g. GFATM, PEPFAR), this is becoming increasingly important. However, for various reasons this has not happened, and in the next few years it is the task of GOU (with donor acquiescence) to bring donor projects more fully in line with HSSP priorities.

Conclusions

It is recognized that no two health SWAps are the same when comparing the experiences of countries with more ‘mature’ health SWAps (Uganda, Tanzania, Ghana, Bangladesh). In other words, there is no blueprint for a SWAp, nor are experiences from one country directly transferable to any country,
This study has highlighted some important findings from the Uganda health SWAp:

- A SWAp should not be rushed into.

- A decentralised (or decentralising) health system or local government structure can increases the effectiveness of a SWAp.

- General budget support has many (potential) long-term developmental advantages.

- Donors should consider helping MOH implement the SWAp in other ways through temporary ‘slush’ funds.

- Donors should not expect immediate results from a SWAp. Long-term commitment of all partners is essential.

and for a variety of reasons. However, as the published literature has already shown, there are various factors and preconditions, with predictable consequences, that tend to be common across countries (Foster 2001, Baldwin 2001). This brief paper has not attempted to repeat these results. Instead, this study has described some experiences from the health sector SWAp in Uganda which may be useful for other countries to consider in their approach to the development and implementation of a SWAp. The essential conclusions of this study are:

- Sufficient time should be allowed in the lead up to a SWAp to ensure that the necessary relationships are developed, consensus reached, and plans discussed, so that the Memorandum of Understanding reflects realistic plans and real intentions as opposed to a wish list.

- A health sector strategic plan based on a sound national health policy, if developed in parallel with the lead up to the SWAp, can ensure that the initial phases of the SWAp, where enthusiasm is greatest, brings in real progress and sets the basis for longer term health gains.

- If a sector already has experience with decentralization, this serves as a way of resisting the strong (re)centralizing tendencies of the SWAp.

- Donors generally prefer some kind of earmarking of their funds, even if funds are fungible once they reach the Ministry of Finance as in the case of Uganda. General budget support, while resisted by health sector donors in other countries, has proved to strengthen government ownership and control over their budgeting process, and accountability to parliament.

- Other financing mechanisms are important for helping a line ministry to implement a SWAp, especially when sectors are strongly controlled by the Ministry of Finance. In Uganda, the Partnership Fund has played an important role in meeting donor M&E requirements and providing funds for additional technical assistance to the MOH.

- SWAps take time, and even when performance indicators do not improve after 23 years implementation, donors should recognize the scale of changes going on, and that recipient governments need donors’ continued commitments to the SWAp.

References
Annex 1. Steps towards reaching the MOU

April 1997    The concept of the sector-wide approach was introduced to GOU, donors and stakeholders.

September 1997    SIDA, WHO and DFID joint mission to review whether conditions were favourable for adopting a sector-wide approach

January 1998    GOU invited donors to support a health SWAp

September 1998    Health Sector Investment and Strategic Plan drafted

Oct-Nov 1998    Aide memoire signed outlining consensus on how the SWAp should be approached

December 1998    Consultative group meeting held to review programme development plans

April 1999    Joint MOH / donors workshop to develop programme goals and objectives, targets and indicators. Programme logframe drafted.

May 1999    GOU / donor consultative meeting held in Geneva – health policy was endorsed as the basis for the SWAp. Some donors (Ireland Aid, NORAD, DFID and SIDA) agreed to contribute to a Partnership Fund in order to support the SWAp development.

September 1999    National Health Policy finalized and approved by cabinet

October 1999    GOU / donor consultative meeting held in Kampala to review progress on preparation for the SWAp. Statement of Intent signed by some development partners present, and soft endorsement of revised strategic plan given by donors

November 1999    First joint mission (GOU and donors) to plan next steps. The meeting focused on: costing and financing; SWAp process; priority technical programmes; financial management including cost sharing; and procurement and drug management.

August 2000    MOU signed.

Taken from Brown (2000).
Annex 2. Decision making bodies in the Ugandan health sector

Diagram. Links between decision making bodies and health sector bodies.

* Indicates that a description is given below.

Diagram from de Loor and Hutton (2003).
MoH decision-making bodies and coordinating mechanisms

The Top Management Committee (TMC), chaired by the Minister of Health, is responsible for providing overall policy direction, making higher level policy decisions, approving policy proposals and giving general oversight to the health sector as a whole. The committee meets fortnightly, but no formal terms of reference exist. The TMC is made up of the 2 Ministers of State, the Permanent Secretary, the Director General, the 2 Directors of Health, the Directors of Mulago and Butabika National Referral Hospitals, and the Under Secretary (as secretary).

The Senior Management Committee (SMC), chaired by the Permanent Secretary, provides strategic leadership in overseeing policy development and planning, as well as oversight of technical programmes and assuring coordination of the activities and overall functioning of the Ministry. Intermediate management decisions are made at this level. SMC also examines and prepares the necessary position papers on matters to be referred to TMC. Again, no formal ToR exists. The SMC is made up of the Directors of the two directorates, the Under Secretary, all Commissioners and Assistant Commissioners.

The next level of the decision making hierarchy is the Sector Working Group (SWG) The SWG is chaired by the Permanent Secretary and consists of Ministry of Health, Ministry of Finance (MOFPED) who is the Secretary, and development partners. The SWG agrees budget priorities, approves projects, examines the Medium Term Expenditure Framework, and is in charge of the PEAP revision. However this group only meets very infrequently!

Working Groups (WGs) were set up to expedite the heavy preparatory workload called for by the HSSP. The WGs were drawn from the already existing Ministry of Health Departments and programmes with the co-option of Development partners and other stakeholders. Eight Working Groups were established: Human Resources, Health Infrastructure, Basic Package, Finance and Procurement, Supervision and Monitoring, Decentralisation, Research and Development and Public-Private Partnership in Health. The WGs are expected to work closely with each other and to report to HPAC regularly (see below). The WGs were instrumental in translating the various HSSP outputs into policies, plans and implementation activities. They have, to varying degrees, continued to play a significant role in addressing emerging issues/pieces of work in the respective areas of the HSSP. Working Groups tend to react to imminent Joint Review Missions rather than to their agreed schedules of work.

Quarterly progress meetings are a routine tool of the MoH to assess progress and performance against activities and objectives agreed at the previous meeting. The Health Policy Statement is an annual report from the Minister of Health that reports on health sector performance and sets out the priorities for the next fiscal year.

The National Health Assembly (NHA) is a Government of Uganda event, which is intended to provide an annual forum for developing broad national consensus on health development in Uganda, with particular attention to participation by civil society and local government. However, the cost of holding the National Assembly is considerable and no budget allocation exists in the Health Budget for convening the National Assembly. For this reason the NHA was not held during the period 2000-2002. The first NHA was held in November 2003, financed by donors through the Partnership Fund.

SWAp mechanisms for monitoring and evaluation

Health Policy Advisory Committee (HPAC). HPAC, initially called Health Policy Implementation Committee (HPIC), was formed during the preparation of the HSSP mainly to advise government and development partners on the implementation of the National Health Policy and the Health Sector Strategic Plan. Membership of HPAC is drawn from MoH, development partners, MoFPED, Ministry of Local Government, Ministry of Education and Sports and the Pri-
vate Not For Profit (PNFP) providers. HPAC meets regularly, initially (from 1999 to 2000) meeting weekly, and since 2000 it meets once a month. HPAC is the body administering and deciding use of funds of the Partnership Fund, which was set up originally to help move the SWAP forward with timely decisions and an additional pool of funds, thus providing the ‘oil for the cogs’ of HPAC and MOH Departments. It is important to note that both the SWG and HPAC are subordinate to the twice-yearly Joint Review Missions (see below).

There are various other groups and committees feeding into HPAC that are important to mention. The Health Development Partners Group (HDPG) meets monthly, with the overall purpose of coordinating development partners in Uganda. The group is open to all agencies listed in the MoU between the MoH and Development Partners (August 2000). The group’s aim is to strengthen the partnership between GoU and the HDPs to ensure more effective implementation of the HSSP and to reduce transaction costs for both agencies and Government. The HDPG choose one agency to be their coordinator for each GOU financial year. The coordinator chairs the monthly meetings and acts as a contact point between group members and MOH. Inter-Agency Coordinating Committees (ICCs) are important fora for those working in particular disease areas to coordinate their activities.

Since the beginning of the sector-wide approach in the health sector, Joint Review Missions (JRM)s have proven to be important events in which donors and development partners come together, progress in the health sector is reported, key areas are reviewed, and undertakings agreed for the next 6 month period (until the next JRM). The MoU stipulates that two Health Sector Joint Reviews Missions be held every year to review the implementation of the plan. The objective of the October/November JRM is to review the performance of the health sector during the previous financial year and financial envelope for the following year, and the objective of the March/April JRM is to agree on sector priorities, budget allocations and financing plan for the sector for the upcoming financial Year. All the JRM}s have been held as scheduled with very active participation of all stakeholders, often including several days of visits to districts which allows those not familiar with the terrain to see conditions and progress at this level. JRM}s have been proven to be very demanding in time, in preparation of documents, as well as expensive to organize. It has therefore been decided that from 2004, the April JRM will be replaced by a one-day meeting to review technical reports on selected areas. These technical reports will have been commissioned by the preceding October JRM.

The HSSP is built on an extensive range of log frames, which detail targets, verifiable indicators and means of verification for each output. These were jointly developed by GOU and development partners. The MoU stipulated that once a year an Annual Health Sector Performance Report should be published summarizing progress made against the defined targets. The report is written by MoH with the assistance of local consultants. Consultant costs and cost for printing are paid for by the Partnership Fund.

*Extracted from de Loor and Hutton (2003).*