Technical approach paper

The Uganda health SWAp: new approaches for a more balanced aid architecture?

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The early years of the Uganda health SWAp are generally considered a success story, but its performance has declined in recent years. A number of factors, including decreased government health spending, changes in aid modalities used by development partners, weakening government leadership, and poor governance in the health sector can help to explain this decline in performance. Discussions between government and donors on how to reform SWAp processes have begun, and a number of initiatives have emerged in this respect.

The Uganda experience with the health SWAp offers useful insights into the present realities of the aid architecture for health, as well as lessons for the future. It shows that leadership capacity is fundamental to the success of SWAp processes. It also points to the need for a more balanced funding architecture, which should include global financing partnerships, support long term macroeconomic balance, and enable effective use of non-financial resources.

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Introduction

The early years of the Uganda health SWAp are generally considered a success story. However, its performance has subsequently declined. This paper examines the factors which contributed to this decline, and the current challenges faced by government and donors.

The lessons from the Uganda experience with the health SWAp also have wider relevance. They point to the need for a more balanced architecture of development assistance for health, a broader form of co-operation among government and all partners (including non-SWAp partners), as well as the crucial importance of leadership capacity at country level.

The origins of the Uganda health SWAp

From the early 1970s to the mid-1980s Uganda experienced a period of intermittent civil war. The country emerged from conflict with a vastly deteriorated public health situation, and a health sector in shambles. The resulting poverty and insecurity were compounded by lack of trained staff, decaying infrastructure and poor literacy levels. Nonetheless, Uganda subsequently managed a rapid and remarkable recovery, which is often quoted as a success story in economic growth and poverty reduction.

In the 1990s Uganda's pioneering Poverty Eradication Action Plan (PEAP), which received strong support from the World Bank, became a model for what was to become a global movement for poverty reduction policy and strategy. The PEAP is the overarching policy, with sector specific strategies contributing the overall plan. The current National Health Policy (NHP) was developed in the late 1990s as a result of the PEAP planning process, and benefited from improved co-operation between government and development partners.

Through much praised facilitation from WHO, and with strong political leadership from the Ministry of Health, development partners and government agreed on a health SWAp arrangement in 1999. The improved cooperation between government and development partners was also instrumental in the translation of the NHP into an operational plan – the Health Sector Strategic Plan I 2000-2005 (HSSP I) – which was launched in 2000, and followed by the HSSP II (2005-2010) in 2005.

Early successes

A range of stakeholders and expert observers tend to agree that the first three years of the Uganda health SWAp were very successful. The Memorandum of Understanding guiding the SWAp process included two particularly important features: 1) an obligation from the government to steadily increase the budget for health; and, 2) a commitment from development partners to increasingly use general or sector budget support as the principal aid modality. Both government and development partners strove to implement and deliver upon their commitments. The resource flow to the health sector improved considerably; more staff was hired and new infrastructure (predominantly in the primary health care domain) was developed.

Progress in achieving the targets outlined in the HSSP I was visible a few years after the launch of the SWAp. New outpatient attendance rose from 0.4 visits per capita a year in 2000 to 0.9 in 2004/05, and child immunisation showed similar sharp improvements. Inputs into the health system improved so much that it is reasonable to expect that the national Demographic and Health Survey, when published in 2007, will also show improvements in health outcomes.

Such was the success of the Uganda health SWAp that other African countries sent delegations to study it as part of their own efforts to build strong health sectors.

Current challenges

Unfortunately, the situation today is very different. Both government and donors face numerous challenges, which may be explained by a number of concomitant factors.

Reduction in government health spending
The increase in real term government spending for health has come to an end, and at present there is no

evidence that this policy will be reversed. In 2004/05 government spending on health as a percentage of government budget rose to 9.7%, but it has since declined to a projected level of 8.3% for 2007/08.[1] Consequently, adherence to the HSSP II is weaker because the plan is far from fully financed from the government budget. The underlying causes of the lowered priority accorded to health are not completely clear. The President of Uganda commented on the health sector during the 2005 Mid Term Review, pointing to a need to improve preventive care over curative care for cost efficiency (and other) reasons. During the budget discussions in 2005, Ministry of Finance, Planning and Economic Development (MoFPED) representatives gave several reasons for the lowered government support to the health sector: increasing project funding from donors, quality problems in health sector budget submissions and increasing needs in other sectors – predominantly the energy sector. This situation has subsequently created an increasing dependence on ad hoc, often project based, development assistance for health. The projects tend to reflect specific areas of interest amongst development partners, and only partially reflect the balance needed between different sub-sectors in the health strategic plan.

Changes in preferred aid modalities used by development partners

Budget support as a share of total health financing has rapidly declined. This is the result of stagnating budget support funding and a dramatic increase in project funding from development partners. In 2003/04 government made a greater contribution to health than the sum of development partners' project support. As table 1 shows, in 2004/05 government spent 219 billion Ugandan shillings (Ush) on health (partly financed with general and sector budget support from donors) – compared to almost Ush 255 billion on project/programme support from development partners. In 2005/06 the figures were respectively Ush 230 billion from government and Ush 507 billion to project oriented development partner contributions.[2] It is important to note that the sums of donor project financing are uncertain. Figures from Ministry of Health and Ministry of Finance tend to differ considerably in the budget discussions. The figures do not answer a fundamental question: have the increases in donor support led to decreases in government funding, or have decreases in government funding led to higher donor contributions? Probably both are true, but the dominant force is most likely that of dramatic increases in donor project funding through global health partnerships (GHPs).

Table 1: Key financial data for the Ugandan government health sector[3]

Fiscal year	**2004/05**	**2005/06**
Government expenditure (billion Ush)	219.56	229.88
Sum of donor projects public sector	254.85	507.26
Total health expenditure in public sector	474.41	737.14
Per capita expenditure in public sector (Ush)	17.437	29.946
Per capita expenditure (US$)	10	15
Government expenditure on health as % of total expenditure	9.7%	9.0%
Budget performance (expenditure as % of budget)	92.8%	95.7%
Annual budget increase	5.7	4.7

Weak government leadership

Government leadership has considerably weakened, and the mutual respect shown by development partners and government in the early days of the SWAp process is now less evident. Discussions in the 2006/07 budget process were at times confrontational, and donor statements in the Joint Reviews have become more outspoken and critical.

[1] Data from the Mid Term Expenditure Framework issued by the Ministry of Finance, Planning and Economic Development (MoFPED) during the budget process and presented during the Mid Term Review 2006.
[2] Data from the Annual Health Sector Performance Report 2005/06.
[3] Data from the Annual Health Sector Performance Report 2005/06 and from the 2007/08 budget process presented by the MoFPED.

Weak governance
There is also evidence of poor governance in the health sector, with increased corruption, poor co-ordination between ministries, and decreasing transparency. Notable examples are the Global Fund to Fight AIDS TB and Malaria fraud scandal exposed in 2005 and the embezzlement of funds from GAVI which led to the arrest of three former ministers of health.

Declining performance – some hypotheses

What caused the decline in performance of both government and development partners with respect to the health SWAp? It is not easy to pinpoint a single reason, but a number of hypotheses can be advanced.

1. The leadership decline hypothesis
The change in SWAp efficiency coincided with a change in political leadership in the Ministry of Health (MoH). The recently replaced leadership has been accused of involvement in major corruption scandals. When an experienced MoH director general left, there was a vacuum until a qualified successor was appointed on a permanent basis. After the General Elections in 2006 the political leadership in the MoH was replaced by a team with limited experience of central government. Leadership effectiveness and efficiency has been affected by these recent changes, and by other governance issues. For example there is some (albeit anecdotal) evidence that MoH leadership is challenged from State House and its complement of presidential advisors. This tends to further weaken the MoH and its operations within the agreed SWAp co-operation structures.

2. The aid instrument hypothesis
Major new funding initiatives, including two major global health partnerships (GHPs) have played an increasing role in Uganda over the last couple of years:

- The GAVI Alliance, which might rightly claim success in view of the rapid increases in immunisation coverage, has underlined the challenge of sustainability posed by the advent of such external initiatives. A certain lack of clarity around financing measles vaccination campaigns has illustrated the need for long term financial planning involving all parties – government, development partners and GHPs.

- The Global Fund to Fight AIDS, TB and Malaria (GFATM) has a more mixed record. On the one hand it has rapidly improved financing for antiretroviral and anti-malaria drugs. On the other hand, it has been at the centre of a damaging scandal, which had paralysing effects on policy makers, implementing agencies and on relations between the Ministry of Health, national stakeholders and development partners for more than a year.

- The President's Emergency Plan for AIDS Relief (PEPFAR) has broadened the involvement of civil society in the AIDS response and increased the availability of antiretroviral drugs and of resources for prevention. However, PEPFAR's strong emphasis on the abstinence component of the ABC[4] approach has created difficulties for other development partners who have been more supportive of the "B" and "C" elements, leading to fragmentation in Uganda's HIV prevention policy.

- Equally, the President's Malaria Initiative is an important source of finance, but in terms of policy development and implementation it functions separately from the country's established systems for malaria control. The approach clearly has sustainability implications, and poses a major challenge to the overall financial planning for the health sector, which will have to accommodate the cost to the sector when funding by the initiative expires. At present there is no room in the government budget for initiatives on this scale. For this, a marked increase in general budget support earmarked to the health sector would be required, but none of the budget support development partners have so far indicated that such an increase is viable or probable.

- These major funding initiatives are usually implemented through project support, which clashes with comprehensive policy implementation and planning frameworks such as the HSSP I and HSSP II. Duplication of ministerial efforts and an increased administrative burden for districts with weak district managerial capacity is an unavoidable consequence of this myriad of new parallel initiatives.

[4] "Abstain, Be faithful, use Condoms".

In turn, the demand for strong coordination and leadership from government increases. Furthermore, GHPs have very substantial resources in comparison with SWAp-financed government activities, and compete very successfully for key staff and other scarce resources. This creates not only imbalances to health sector funding in general, but also displacement of activities with less generous financing.

3. The macroeconomic imbalance hypothesis
Macroeconomists close to the Ministry of Finance have expressed concerns (both privately and in public) about the high level of development partner dependency and the influence that health spending from development partner sources might have on the short, medium and long term macroeconomic stability of the Ugandan economy. Among the risks are: appreciation of the Ugandan shilling, causing difficulties for exports; increased interest rates (and decreased volume) for private investments caused by the need to neutralise the inflow of foreign exchange; a resulting long term deceleration in GDP growth; and inflationary tendencies due to demand on key staff and key materials in the economy.

The combined effects of macroeconomic stability measures and the substantial influx of foreign exchange from the GHPs are discussed later. It is difficult to make a clear distinction between the "macroeconomic imbalance hypothesis" and a substitution effect, where the inflow of foreign support to the budget creates a situation in which the demand on internally raised resources can be diminished. A low tax share of GDP indicates that a substitution effect may be resulting from aid flows.

4. The flag-fading hypothesis
Development partners (both bilateral and multilateral) have the need to "show their flag" to their home constituencies in order to justify their presence and attract resources. But the SWAp approach tends to make the origin of financial resources less visible. SWAps may also cause concern among policy conscious HQ representatives because the health policy direction is influenced by a large group of development partners, and the profile of their particular country or organisation can be lost. At the receiving country level this might hinder efforts to secure compromise agreements and positions. If important development partners push in the direction of a more "flag-showing" approach, other development partners will feel they have sacrificed their individual positions for the sake of solidarity and common interest. It is worth noting that in Uganda donors have generally managed to discipline themselves when under pressure from home to show a sharper national identity. The "flag-fading problem" may be a specific HQ problem.

Analysis

Developments in Uganda during the period 1998-2006 do not point to a single explanation for the decline in the performance of the SWAp. Rather, it seems that all the four causal mechanisms described in the previous section have interacted with one another and contributed to weakening performance. However, there has been no comprehensive and systematic study of this subject, and of the mechanisms behind the ups and downs of the Uganda SWAp. A more thorough analysis would be of great interest, both to understand country specific processes and the broader enabling conditions for successful SWAps.

An initial observation is that leadership problems in the Ministry of Health have made the whole SWAp mechanism more vulnerable. They have reduced the space for acts of solidarity among SWAp partners for the sake of the common good, and allowed other powerful developments to influence the situation.

The entry of GHPs in the picture took place when the discussion about the macroeconomic impact of increased development assistance was particularly intense. GHP funds were seen as competing for resources within the fixed budget ceiling for health spending determined by the Medium Term Expenditure Framework. More resources from GFATM, PEPFAR, the President's Malaria Initiative and the GAVI Alliance thus tended to weaken the position of the Ministry of Health in the budget dialogue with the Ministry of Finance. Since the GHPs worked only within certain segments of the total health strategy, sub-sectors without earmarked development partner support were negatively affected.

The combination of macroeconomic concerns and dramatically increased project funding from GHPs pushed the health SWAp further away from the agreed policies. At the same time transaction costs increased, and the need for project negotiations and planning reduced the capacity for concerted and effective Ministry of Health leadership.

Thus, the global drive for increased financing of priority health interventions becomes a double-edged sword. On the one hand additional resources are much needed, but on the other hand their intervention focus and planning and financing modalities can undermine collective and comprehensive structures such as the SWAp. This is clearly not the intention of the development partners that fund these GHPs – they are in most cases active and committed SWAp partners and committed to the Paris Declaration on Aid Effectiveness. Many global health partners active in both "camps" seem to have had a rather schizophrenic health financing policy and health financing practice over the last couple of years. Globally, the GHPs are also taking these concerns into account, through for example efforts to pool funds and use government mechanisms.

The idea that a specific GHP might consider its contribution outside the macroeconomic framework is a new approach to health financing, based on the assumption that certain moneys impact on the macroeconomic situation, while others do not, depending on their origin and purpose. But such approach has little support from economic theory and practice.

Key lessons

A number of lessons can be drawn from the SWAp experience in Uganda.[5]

- The architecture of development partner funding needs more balance between project support and budget support – i.e. between predominantly vertical GHP funding and horizontal basket funding modalities and sector budget support. If vertical funding prevails, the SWAp will considerably be weakened as a mechanism to achieve concerted action, low transaction costs and strong government ownership. The argument for a balanced funding architecture is supported by macroeconomic considerations that limit total spending on health to avoid destabilisation.

- There is also a need for agreements on this "balance" between government and the whole group of development partners, and non-SWAp partners need to be included in this effort. Such agreements need to adopt a long-term time perspective to satisfy the needs of the Ministry of Finance in securing budgetary and allocative efficiency and macroeconomic stability. This is a precondition for balanced growth in health sector spending reflected both in the medium and long term macroeconomic frameworks. This balance also applies to non-financial resources, particularly with regard to trained health staff. Without such co-ordination, any imbalance will result in crowding out of essential activities, risking major harm to the realisation of common strategies and goals.

- The leadership weakness observed in Uganda is partly related to the high transaction costs caused by several independent planning and implementation mechanisms beside the SWAp process. Thus SWAp structures and processes may need to be revised and reformed to allow for broader co-operation between development partners and government, where GHPs and other separate bilateral initiatives are also given a voice and an obligation to act under a common umbrella.

- This broadened form of co-operation needs to consider ways of integrating projects (which have a limited time span and often a sub-sector focus) with the general health sector development framework supported by the SWAp partners. In order to be effective in macroeconomic discussions, such arrangements need to follow a time schedule that is harmonised with the government budget process. Arrangements of this type also need to include a facility for project assessment to ensure that:
  - they focus on priorities in the general health sector development framework;
  - they are not creating imbalances in resource utilisation (mainly staff); and
  - project funding and general/sector budget support combine into a balanced health financing architecture.

Recent SWAp reform initiatives

The problems experienced by the Uganda health SWAp have not gone unnoticed. They have opened new discussions between government and development partners on reforming SWAp processes and structures, based on the Paris Declaration on Aid Effectiveness. A number of initiatives in this respect have recently emerged.

[5] Based on the author's personal observations and experience in Uganda over many years.

Following the corruption scandal mentioned earlier, GFATM, local development partners and government have held discussions on improving Global Fund integration into SWAp processes. The example from Mozambique, where GFATM funds and the Country Coordination Mechanism are integrated in the common fund and SWAp, demonstrates that a "budget support approach" is possible.[6] The Ministry of Health has issued a policy statement in this regard to development partners. The GFATM is still waiting for confirmation that issues of monitoring and evaluation and position of non-governmental stakeholders are fully agreed before accepting the MoH proposal. Even so, the policy statement is clearly addressing some of the problems discussed in this paper.

The Ministry of Health and development partners have also agreed, in principle, on improved integration of Technical Assistance (TA) into routine Ministry processes and structures. How this agreement is going to be implemented is yet to be seen, especially since it may conflict with donor regulation on the use of aid for TA.

The process of rationalising and harmonising aid partnerships has been going on for some time. The Uganda Joint Assistance Strategy (UJAS), designed collaboratively by a number of development partners, ultimately aims to reduce transaction costs by diminishing the number of active partners in each aid sector. Government is examining the proposals that have been put forward.

The structures for co-operation between Ministry of Health and development partners have involved a very intricate and complex net of working groups and similar processes. Based on the Paris Declaration, efforts have been made to considerably reduce the number of groups and to sharpen their roles to avoid duplication. However, it remains to be seen how this will work in practice.

These initiatives are all promising, but the main problems remain. The common strategy – so important for a SWAp – at present exists only on paper, since the budget framework for health is far below the expected levels of government contribution. SWAp processes, also improved on paper, still suffer from leadership problems within government.

Conclusions

The Uganda health SWAp, with its early successes and later problems, offers valuable insights into the present realities and the immediate future of development assistance for health.

Its experience suggests that **a balanced architecture of aid for health** is needed which:

1. promotes active participation from global financing partnerships and other donors acting within the framework of common co-ordination structures and supports systems development;
2. supports long term macroeconomic balance and allocative efficiency, together with increased predictability both for project mode financing and budget support;
3. enables effective use of non-financial resources – particularly staff; and
4. is informed by financial planning frameworks (for the medium and longer term) with dependable data on donor finance, that integrate project funding in line with sector priorities .

The leadership capacity of the country is fundamental to the success of improved SWAp processes. Further studies into how the leadership factor is affected by, and also affects the effectiveness of development assistance for health, would be of great interest.

About the author

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[6] See "The Global Fund operating in a SWAp through a common fund: issues and lessons from Mozambique" (HLSP Institute, January 2007) www.hlspinstitute.org/projects/?mode=type&id=126874

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