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discussion

SWAps and Civil Society

The role of Civil Society Organisations in Uganda's Health Sector Programme

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CSOs and SWAps in Uganda

The Role of Civil Society Organisations in Uganda's Health Sector Programme

A Report to
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By
Stein-Erik Kruse
Centre for Health and
Social Development (HeSo)

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Acronyms

CSO – Civil society organisation
DC – District Councils
DENIVA – Development of National Indigenous Voluntary Associations
FB-PNFP – Facility-based Private not-for Profit
FHRI – Foundation for Human Rights Initiative
GoU – Government of Uganda
HIPC – Heavily Indebted Poor Countries Initiative
HPAC – Health Policy Advisory Committee
HSSP – Health Sector Strategic Plan
HURINET – Human Rights Network
LC – Local Council
MoH – Ministry of Health
MTEF – Mid Term Expenditure Framework
NHP – National Health Plan
NHP – National Health Policy
NRM – National Resistance Movement
NUDIPU – National Union of Disabled Persons in Uganda
PAF – Poverty Action Fund
PEAP – Poverty Eradication Action Plan
PFPH – Private for Profit Health Services
PPP – Public Private Partnership
PRSP – Poverty Reduction Strategy Paper
PPPH –Public Private Partnership in Health
SWAp – Sector Wide Approach
UCMB – Uganda Catholic Medical Bureau
UDN – Uganda Debt Network
UMMB – Uganda Muslim Medical Bureau
UPM – Uganda Protestant Medical Bureau
UCBHCA – Uganda Community Based Health Care Association

1. INTRODUCTION

1.1. Background and Objectives

This report about the health sector and civil society in Uganda is part of a broader study "SWAps and Civil Society" initiated by NORAD Oslo. The study seeks to explore the roles played by civil society organisations (CSOs) in sector wide approaches (SWAps) - with a focus on health and education programmes supported by NORAD. The background, purpose and study design are presented in the report "SWAps and CSOs. The Role of Civil Society in Sector Wide Approaches".

This study brings together and illustrates several important issues and new trends in Norwegian development cooperation. NORAD's strategy for poverty reduction advocates new forms of cooperation – sector and budget support instead of project support . NORAD has also developed new guidelines for funding civil society organisations – both Norwegian based NGOs and local CSOs.

The first generation SWAps focused almost exclusively on improving the effectiveness of Government and public sector while the involvement of CSOs was given little attention by both the countries themselves and their development partners. Lately, there has been more involvement of civil society – not least as a parallel trend to the involvement of civil society in PRSP processes at country level.

But there has been – both in Norway and internationally limited knowledge about what roles CSOs have played in sector programmes, their level of involvement and what the results are of their participation. There is both a need to understand better the features of current involvement, but also the potentials for what roles CSOs could and should play. Not least because international development cooperation policy has moved towards more partnerships among governments, donors, private sector and civil society in achieving sustainable development.

To begin the study, it was necessary to explore the field - collect available information, define some key concepts and identify and formulate relevant questions. We are now in the second phase with analysis and testing of hypotheses from the desk study in four countries: the health sectors in Malawi, Mozambique and Uganda and the education sector in Zambia. This is the report of the case study from Uganda which was carried out in April 2003. A synthesis report with findings for all the case studies will be prepared at the end.

The entry point for the study is civil society organisations in NORAD partner countries and their interactions with national SWAps - and not the Norwegian CSOs as such.

The objectives of the country studies are[1]:

(a) To review the roles of civil society organisations in selected sector programmes – in particular in relation to roles played by CSOs, analysis of opportunities and constraints and results achieved.

[1] See Mandate Annex 1.

(b) Provide advise and recommendations to NORAD, Embassies and Norwegian NGOs on how to improve the interaction between social sector SWAps and civil society.

The next chapter (Chapter 2 and 3) presents the country context - the socio-economic situation and the health challenges and policy response. The characteristics of CSOs in the country are presented and analysed in Chapter 4. Chapter 5 builds on the description and analysis in the previous chapters and seeks to respond and discuss in summary form the questions and hypotheses in the mandate.

We are most of the time using the broad term "civil society organisation" (CSO) in this report, which in Uganda includes NGOs, faith based and community organisations, media, labour organisations and traditional formal and informal organisations. NGO is the most common category and is used for the development-oriented organisations.

1.2. Methods of Work

The study approach and methods are presented and discussed in the background document. A number of roles CSOs could play in SWAps are portrayed: as contributors to policy discussion and formulation, advocates and lobbyists, service deliverers (operators), monitors (watchdogs) of people's rights and particular interests, innovators introducing new concepts and initiatives and finally as financiers.

Based on a review of literature and interviews of key informants in NORAD and among Norwegian NGOs key questions were formulated and for each question assumptions or hypotheses were proposed. The assumptions were intended to reflect "common wisdom" about CSOs and SWAps - what was taken for granted and thought to be true. Questions and hypotheses are presented in Annex 1.

The case studies serve as the empirical testing ground for the assumptions. The individual country programmes should help us to find out to what extent the assumptions could be confirmed, partly confirmed or rejected. Following such an approach, we would be in a better position to describe and explain the roles CSOs actually play in SWAps.

In Uganda key documents relating to the health sector programme and the roles of CSOs were reviewed. We met with key representatives from Government (Ministry of Health and Ministry of Finance), multi- and bilateral donors to the health sector and national and international CSOs. At the end of the visit, findings were discussed with key informants and later presented in a draft report which was circulated to NORAD and stakeholders in Uganda.

The testing of hypotheses through case studies were found useful and relevant, but was no guarantee of "objectivity". The process of verification was open for subjective interpretation, but in most cases clear patterns emerged after several interviews. In some cases representatives from Government and organisations presented opposing views and we have tried to reflect both in the report.

2. COUNTRY CONTEXT

Uganda had a projected population in 2000 of 23 millions[2]. There has been relative peace since 1986 when the National Resistance Movement took power, though there are still guerrilla movements in the North and on the border with DR of Congo.

2.1. The Economy

Uganda is one of the poorest countries in the world and is still struggling to recover from years of civil strife. The average annual economic growth over the last decade has been around 6.5%. In 1998/99, the macro-economic performance was generally better than programmed as real GDP growth was 7.8% and inflation was contained at acceptable levels (8%)[3].

Government budget deficits are reduced through external resources. In 1999/00, 34% of total Government expenditure was either grants or loans. The last year's external resources have increased due to strong support to the poverty reduction strategy, mainly through increased budget support and sector programme support. Tied project aid has decreased proportionately.

2.2. Poverty

Uganda has experienced reduction in poverty in recent years as the nationwide incidence of poverty fell from 56% in 1992/93 to 44 % in 1996/97[4]. Significant disparities in incidence of poverty exist between urban and rural areas and among regions and although there has been general decrease of poverty for all income classes.

Despite the improved macro-economic management, poverty still persists at a high level and demonstrates that good macro-economy is a necessary condition, but not sufficient for effective poverty eradication. Challenges with regards to political and security challenges are also important, as are access to services such as education and health. Insecurity persists in Northern and Western parts of the country. The Uganda National Integrity Survey established that more than half the public think corruption has become worse the last years.

2.3. Poverty Reduction Strategies

There have been several initiatives to strengthen the planning process in Uganda in recent years. The Vision 2025[5], a result of a major consultative process, gives an overview of long-term goals and aspirations by 2025. The Poverty Eradication Action Plan (PEAP) has guided formulation of Government policy since its inception in 1997. It has functioned as a national planning framework to guide medium term sector plans, district plans and the budget process.

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[2] Background information from HeSo (2001) "Providing a core set of health interventions for the poor – a systemic approach.
[3] The Republic of Uganda: Vision 2025. Prosperous People, Harmonious Nation, Beautiful Country. A Strategic Framework for National Development. Main Document March 1999. Selected Economic Indicators.
[4] Poverty Reduction Paper (PRSP) Uganda's Poverty Eradication Action Plan Summary and Main Objectives MoFPED March 24, 2000
[5] The Republic of Uganda: Vision 2025. Prosperous People, Harmonious Nation,, Beautiful Country. A Strategic Framework for National Development. Main Document March 1999.

It has later been revised as a precondition for debt relief under the enhanced HIPC Initiative and serves now as the country's Poverty Reduction Strategy Paper[6]. The revised PEAP also serves as Uganda's Comprehensive Development Framework and has four major lines of action:

- Creating a framework for economic growth and transformation.
- Ensuring good governance and security.
- Directly increasing the ability of the poor to raise their income.
- Directly increasing the quality of life of the poor.

Improving the health of the Ugandan population is a priority objective for the GoU poverty reduction strategy. The PEAP links its targets and strategies directly to the Health Sector Strategic Plan (HSSP) and the minimum health package. The HSSP sets the ambitious targets of reducing child mortality from 147 to 103 per thousand, maternal mortality from 506 to 354 per 100 000, to reduce HIV prevalence by 35%, reducing total fertility rate to 5.4 and reducing stunting to 28% by 2004/2005.

The first Poverty Eradication Action Plan (PEAP) of 1997 was a result of work by a national task force. It was developed through wide consultation with stakeholders, including civil society and has since gone through several subsequent revisions, specifically to incorporate the "voices of the poor" through a participatory poverty assessment process.

The 1995 Constitution of Uganda has guided the process of developing public-private partnerships and facilitated the involvement of civil society in policy processes. The Poverty Eradication Action Plan (PEAP) encourages partnerships between the public and private sector with increased focus on poverty eradication. The National Health Policy sets out as an objective to make the private sector a major partner in Uganda's national health development and supporting its participation in all aspects of the National Health Programme (NHP 1999). This is further outlined in the Health Sector Strategic Plan (HSSP).

2.4. Public Sector Reform and Decentralisation

Public sector reforms in Uganda include reorganisation and restructuring of the civil service, economic recovery programmes, privatisation, army demobilisation and constitutional reforms along with decentralisation.

Decentralisation in Uganda goes as far back as during the civil war when the National Resistance Movement (NRM) introduced a system of elected local councils in the areas that it was controlling. The political decentralisation was followed by administrative decentralisation introduced through the Local Government Statute in 1993.

The 1995 Constitution consolidated the local government system further and the RCs were renamed Local Councils (LCs). The 1997 Local Government Act details the responsibilities of each tier of the government. All political and administrative authority has been transferred to local government authority. They are mandated to

[6] Poverty Reduction Paper (PRSP) Uganda's Poverty Eradication Action Plan Summary and Main Objectives MoFPED March 24, 2000

levy taxes, pass plans and budgets, to deliver public services and even make laws. Line ministries formulate policies and guidelines, provide technical support, set standards and inspect services.

In line with this, the national poverty dialogue, goals and policies continue to be coordinated at central level while the local governments increasingly implement the antipoverty programmes. Correspondingly, total financial grants from central to local level are rising.

Financial Decentralisation

The financial decentralisation has been carried out in phases. From the financial year 1993/94 the District Council became the main budgetary unit. Initially, the central Government provided financial support to the local governments through a system of earmarked votes decided by the MOF. Since 1997, this was replaced by block grants in a phased way, which has enabled the districts to change priorities between different sectors. In practice, it appeared that the health sector in general was not a priority and the amount of funds allocated for primary health care became less than before the institution of block grants. A conditional grant was therefore established to assure a minimum level of PHC financing.

Table 1: Sources of funds at district level

Type of income source	For what	Comments
Conditional grant	PHC For PHC units and HSD units and PHC in hospitals including Community Health Department. Also for wages for those not receiving from unconditional grants	Funds come from Poverty Action Fund (PAF).
	NGO	Lower units NGOs i.e. Level 4 and below
Unconditional grant	"Block grant" 90% salaries, other permanent expenses for health service	
Local revenues district	All sectors	Taxes collected may be retained by the districts and sub-counties
Vertical programmes	Bilateral donors, UN agencies, Development Banks	Differs from district to district. Generally poorly distributed throughout the country
User fees	Collected at facility level	100% kept at facility level
Local Government Development Programme funds (LGDP) (Grant for infrastructure development – included health)	Infrastructure development	Started to decentralise development budget in 1999/2000 for primary school classrooms, which is continued in 2000/2001. Next financial year intends to build on this by increasing transfers to LGDP.
Equalisation grant	For least developed districts, based on the degree to which a local government unit is lagging behind the national average standard for a particular service. (National standards still not set?)	Implemented only in 2000/2001 and provided to 10 districts based on recommendation by local government finance commission. Was provided for already in the 1993 and 1997 LG legislation.

Source: HeSo (2001) "Providing a core set of health interventions for the poor – a systemic approach.

As funds to the districts have increasingly become tied to conditions and the unconditional grant is mostly used for salaries, the discretionary powers of the councils have diminished. Ministry of Finance plans in the future to introduce a system with minimum ceilings for sectors allowing more flexibility for districts.

Human Resource Management under Decentralisation
Changes are underway, but the Health Service Commission is still responsible for the recruitment and appointment of Headquarters staff, Referral Hospitals and staff seconded to the NGO hospitals. The district work force is the responsibility of the District Service Commission, which is mandated to employ, discipline and dismiss staff. Health staffs previously employed by the central ministries have been transferred to the districts.

2 .5. Medium Term Expenditure Framework

A critical element of the planning framework is the medium term expenditure framework (MTEF). The MTEF is intended to guide all public expenditure including use of donor funds.

Transfer to districts has increased through all types of sources. Although the unconditional grant has increased considerably from 1997/98 to 1999/2000 (21%), the major increase is linked to the conditional grant that has grown by more than 70%. The conditional grant represents approximately ¾ of the total transfers. The educational sector received ¾ of the conditional grant while the health sector has received approximately 17%, water and agriculture less than 2% and roads 4,6%.

It is interesting to note that there was a major change in government policy and priority in connection with the debt relief initiatives and the preparation of PEAP. Before 1996 there was no clear priority for social sector investments. The process leading to PEAP highlighted issues with regards to poverty and together with the conditionalities linked to debt relief the government policies changed.

The Poverty Action Fund
The budget process in Uganda has been reformed to enable resources to be concentrated on Government priorities. The Poverty Action Fund (PAF) was established as a framework for identifying and ensuring the reallocation of expenditures to programmes and activities that are directly poverty oriented in the budget. The PAF was initially created from resources saved in the HIPC debt relief initiative. It has since been able to attract additional donor funding (Geofffrey 2002).

Since the share of total public expenditure committed to PAF is protected in the budgetary process and has been progressively expanding, this means that poverty reduction outcomes to some extent are secured within the Government budget process.

Decentralisation and Local Participation
It is an open question to what extent decentralisation has provided sufficient space for the marginalised sections of the community, such as the poor and civil society to participate in local development.

A more participatory and inclusive process is constrained by the acute shortage of qualified personnel at district level in health, education and other sectors. The "democratic" and "participatory" ideal of listening and integrating the "poor's" voices in poverty reduction programmes often overwhelm strained local government capacities (Geoffrey 2002). The Ugandan Participatory Poverty Assessment Project

(APPAP) has helped inform Uganda's poverty reduction strategies, but almost exclusively at central level.

The decentralisation policy in Uganda has been hailed as one of the most progressive in Africa, but it is doubtful how effective LCs in Uganda can claim to represent competing interests in society – including civil society organisations. The future dilemma is how the Government will reconcile its commitment to democratic decentralisation while maintaining a poverty focus and support through NGOs along the lines of the PEAP at the same time.

The overall prospects for the CSOs in engendering political empowerment and participation and encouraging the long-term development of a democratic society in Uganda has been considered as poor, despite their good performance in service provision and poverty alleviation. Most NGOs found themselves exercising self-censorship, preferring the more prudent apolitical and non-confrontational roles, because Ugandans seemed reluctant to embrace those organisations that would antagonize the regime (Geoffrey 2002).

3.0. THE HEALTH CONTEXT

Until the 1970s, the health sector in Uganda was considered to be one of the best in Africa. Efforts after Independence to reform a heavily curative health system and improve primary level care succeeded to a large extent.

Churches established hospitals and health centres – often in remote and marginal areas. At Independence in 1962, the Government was responsible for 27 hospitals and up till 1970 22 new rural hospitals were constructed. This trend was disrupted during Amin's regime in the 1970's and accelerated in the early 1980's (Birungi et.al.). There was decline in Government expenditure on health care delivery and poor management, planning and control in the public sector. Medicines and other supplies became irregular at public health facilities resulting in proliferation of private profit-oriented health care providers.

It is now estimated that 79% of curative care in Uganda is provided by the private sector. In addition, access to health care services is predominantly dependent on private spending, which accounts for 58% of the health care expenditure (Birungi 2001). Despite the significant role played by the private sector, it has remained isolated from district/national planning until recently.

Though the gap may be narrowing, participatory poverty assessments in Uganda have suggested that users have a preference for NGO health facilities, when they have a choice. Though formal charges are higher, patients visiting an NGO facility face fewer uncertainties over illegal fees and over whether the facility will be open, staffed and with drugs available. NGOs pay their staff less, yet appear to achieve higher utilisation and better quality services.

NGO facilities are increasingly integrated within the public funded health system. An NGO facility is delegated funds from GOU for their general operations and, in addition, some NGO facilities have been designated as the lead facility within their

sub district, and receive PHC conditional grant funds-through the local authorities – even if they in some cases have been reluctant to release them to NGOs.

3.1. Health Status Indicators

While the macro-economic performance is relatively encouraging for Uganda, the social and health indicators are still lagging behind. The lack of progress is partly due to the HIV/AIDS epidemic, which poses a major challenge not only to the health system, but also to national resources in general. While the HIV sero-prevalence in urban areas has declined, it has now stabilised and increased in rural areas. It will therefore continue to hit the traditionally labour intensive agricultural systems. Life expectancy at birth is now projected to 42 years while it was 48 years in 1991.

Declining steadily after 1985, the infant mortality rate (IMR) levelled off in the 1990s and has stagnated around 97 per 1000 live births. Under-five mortality rates stands at 147 per 1000 live births and estimated maternal mortality rates (MMR) at 506 per 100 000 live births. Only 44% of Uganda's children between 12 and 24 months are fully immunised compared to 88% in 1990.

3.2. The Private Health Sector

The major stakeholders are the Government and the non-Government sectors.

Private sector encompasses:

- The Private Not-for-Profit (PNFP) health care providers, which include the religious based health services and non-governmental organisations (NGOs).
- Private for Profit service providers.
- Traditional Medicine Practitioners.
- Traditional Midwifery Practitioners (TBA).
- Other local service providers.

The private sector is estimated to be taking about 60% of the workload of rendering services to the population. The PNFPPs operate 26% of dispensaries and 45% of hospitals, (the Roman Catholic Church with 13% of lower units and 26% of hospitals). There is a general decline in the utilisation of PNFPP units, which may be attributed to a combination of several factors: the increased stability in the country leading to improved Government services, liberation of the private for profit sector and increased pressure for cost-recovery through user-fees. Lately, the improved salaries and working conditions in public sector has lead to a massive loss of qualified staff to the public sector, which then has improved its quality.

At national level there are three important umbrella organisations for the PNFPPs: Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), and Uganda Moslem Medical Bureau (UMMB) collaborating closely with the MOH and donors. In addition, there is also the Uganda Community Based Health Care Association (UCBHCA).

There used to be a system for grant in aid to NGO hospitals during the 70's representing about 10% of the annual income for a hospital. The remaining income came from patient's fees and donations. A similar system was reintroduced in the late 90's with the new health sector programme.

As mentioned, there is a preference for private health facilities. Quality of services is a major incentive for seeking treatment in private health facilities for all clients – irrespective of income. The public sector was, however, regarded as having higher quality expertise and equipment than the private sector – for instance for surgery. While the perception of quality in private clinics was favourable, it is limited to a few variables such as availability of drugs, client care and little time of waiting.

Most private health practitioners are employed by Government (dual employment). Health practitioners are not always clear of where they are full time employed and only part-time.

During the Presidential campaign (2001), president Museveni pledged the scrapping of cost sharing in all government health units. He argued that the policy was a deterrent to most poor people in accessing health units. Consequently, the user charges were removed in all Government health units. However, most public health units have run short of drugs. So in real terms, patient has to pay for drugs – even if it is not called user charges.

3.3 Health Policy Framework

Uganda adopted the Primary Health Care Strategy early, but any gains were wiped out by events. In 1987, the Health Policy Review Commission identified major constraints in the health system and the need to establish a clear policy and plan as well as for strengthening capacity at all levels. In 1993, a new Three Year Health Plan was adopted followed by a White Paper on Health Policy approved by the Cabinet in November 1993.

In 1997, the country initiated a process to develop a new Health Policy and Strategic Plan. Both have been developed as a collaborative undertaking between the MOH and related ministries, the development partners and civil society. The National Health Policy was endorsed late 1999[7], while the Health Sector Strategic Plan 2000/01 – 2004/05 in the first half of 2001[8]. The policy states that Primary Health Care shall remain the basic philosophy and that a Minimum Health Care Package will form the primary focus of the health care delivery system.

3.4. SWAps in Uganda

SWAps aim to strengthen the capacity of national institutions to manage the policy making process, as well as to strengthen the ownership and systems of accountability. SWAps also seek to enhance donor coordination at the policy level, to simplify management and reporting procedures and increase the overall effectiveness of aid.

In Uganda, SWAps have been developed for a number of sectors. These include Education Sector Investment Plan (ESIP), Programme for Modernisation of Agriculture (PMA), Health Sector Support Programme (HSSP) and the Road Sector Programme (RSP). These SWAps constitute sector programmes elaborated by the line ministries in cooperation with the donor community and provide a framework for implementing the PEAP objectives.

[7] The Republic of Uganda/MOH: National Health Policy September 1999.
[8] The Republic of Uganda/MOH: Health Sector Strategic Plan 2000/01 – 2004/05

Efforts to establish a Sector Wide Approach in health have been going on since 1997 and finally after nearly four years the first three donors agreed to release funds to a joint account as budgetary support at the Joint Government and Donor Mission in October 2000. The Health Policy and the Health Sector Strategic Plan (HSSP) form the basis for the implementation and a lot of work and consultations have gone into developing these.

3.5. Public Private Partnership in Health

The process of developing a policy on collaboration with the private sector dates back to 1987, when the Health Policy Review Commission Report recommended integrating the private sector into the national health care system. A Government White Paper on health policy followed in 1993, which also strongly recommended an increased role for the private sector in service delivery. However, the policy did not immediately gain high political support.

A new Minister of Health appointed a health sector NGO Panel representing an important step for increased involvement from civil society. A desk has been established in MOH to coordinate the activities of the private sector. A working group has also developed a policy for Public Private Partnership (Policy for Partnership with Facility-Based Private Not-For Profit Health Providers). The objectives are to promote the recognition and value of the private sector in health development and define an institutional framework within which to coordinate, implement, monitor, evaluate and enrich the partnership.

The document is positively endorsing the need for the private health sector in Uganda and laying out principles for partnership instead of talking of regulation and control. At the national level, studies on the role of the private sector have been conducted and analysis is being finalised (Annual Health Sector Performance Report 2000/2001).

The MoH through the NGO Panel organised a series of consultative meetings mostly with representatives of NGOs at national level. The meetings were dominated by representatives from MoH and religious health institutions with limited participation from other actors, such as private for profit providers, traditional healers and informal providers and district level organisations. In addition, major professional organisations, such as the Uganda Medical Association (UMA) were not consulted.

Some stakeholders participated in reviewing - not only the draft health policy, but also the draft Health Services Act, 1998. Since 1996, almost 20 draft policy documents have been produced and reviewed, to an extent that a number of MoH officials were concerned that the consultation and feedback process became responsible for delaying the finalisation of the policy. However, the feedback seems to have been important and useful criticism has been drawn from the private sector (Birungi 2001).

Consultations are perceived as important by partners involved, but questions about definitions and semantics took up considerable time in meetings. Concerns and fear were raised by private stakeholders of the use of the word “integration” in the policy document, which to them carried signals of being “swallowed up” by the Government. They would have preferred terms as “harmonisation” or “collaboration” rather than “integration”. In reality, the problems refer more to memories of recent

history than semantics. There were problems in the past when the Government took over the schools founded by religious orders without any consultations.

It has also been argued that the issue of what is public and private needs to be more clearly defined. The non-for profit NGOs do not want to be put in the same group as the private practitioners. They state that although the private set up is private, the PNFP render services without making a profit, is socially oriented and responds to a common good of people.

The stakeholders have been concerned about the lack of institutional framework for integration. The Executive Secretary for the Protestant Medical bureau observed*: "We have been collaborating on the basis of a gentleman's understanding, but what will happen if a Government that does not support integration comes into power?*" (Biringu 2001). This will change with the formalisation of the new Public Private Policy.

The Public Private Sector Policy Document
A draft policy for partnership with the private sector has been developed. The initiative was an undertaking of the MOH in the joint Review Mission April 2001 and was followed up through a Steering Committee. The draft has been discussed in three regional workshops.

The first part of the document provides the general policy framework for the private health sector as a whole. Part two follows the framework presented in part one, expanding and adapting it to the specific requirements of the partnership with the Facility Based PNFP providers. The drafting of the specific policies for the non-facility based NGOs, the private practitioners and the traditional health practitioners are not yet completed.

The policy for partnership with the private health sector aims to:

- Promote recognition and value of the role and contribution of the private sector in health development.
- Define an institutional framework within which to coordinate, implement, monitor, evaluate and enrich the partnership.
- Guide further development of the specific policies for partnership with the different private sub sectors.
- Provide policy makers and other stakeholders in health with guidelines for identifying and addressing partnership concerns when taking policy decisions.

Sector Working Groups
Various working groups appointed by the Health Policy Advisory Committee (HPAC) facilitated the process of the SWAp. The Public Private Partnership in Health Working Group was one such group. The main stakeholders were categorised as: Private Not For Profit (PNFP), the Private Health Practitioners (PHP) and the Traditional and Complementary Medicine Practitioners.

The working group has been sub-divided into three groups:

(a) Facility based Private nor for Profit (FB-PNFP)
This group operates from health facilities. The majority are faith based health care organisations existing under three umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB). As the fourth comes the Uganda Community Based Health Care Association (UCBHCA). The Bureaux together represent close to 80% of the 490 PNFP health units while the rest fall under the other humanitarian organisations and Community Based Health Care Organisations.

The FB-PNFP presently represents nearly 30% of the health care facilities in Uganda. Facilities are owned by their respective churches/denominations. 80% belongs to faith based organisations and the rest to other humanitarian organisations like African Humanitarian Action, Family Planning Association of Uganda, Uganda Red Cross, etc.

The partnership with the facility based NGOs is most advanced simply because they are well organised and the Medical Bureaux are allowed to speak on behalf of their members. Their participation in policy discussion and formulation has been extensive. They are represented in the Health Advisory Committee (HPAC), Health Sector Working Group and they participate at the GoU/DP Joint Review Missions. The process of joint monitoring and evaluation has also started at central level. Participation at district level is lagging behind, but is improving.

The Government support to this group has continued through secondment of personnel, provision of supplies and financial support. The Government allocations to the FB-PNFP sector are presented in the following table. The Government subsidies have increased from Ug. Shs 1 bn in 1997/98 to Ug. Shs 11.8 Bn for 2001/2002. This represents a growth from 4% to 30% of their budgets. The income from user fees represents about 50 % of total income for the health facilities and 20% from private donations.

Government allocations to the FB-PNFP Sector(Bn. Ug.Shs.).

Level	97/98	98/99	99/00	00/01	01/02	02/03
Hospitals	1	1	2.2	4.4	7.4	
Lower level units	-	0.7	2.2		3.0	
Health training schools			1.1	2.3	0.4	
Medical Bureaux					0.15	0.10
Seconded doctors salaries					0.86	0.86
Total	1	1.7	3.3	6.7	11.81	16.7

Source: PPPH Desk Office Report 2002

(b) Non Facility Based Private not for Profit (NFB-PNFP)
The non-facility based organisations working in the health sector are commonly referred to as international and national NGOs involved in health. Their contribution ranges from social awareness and advocacy to more specific aspects of service delivery.

The level of collaboration between this group and the Government has been much weaker than with the facility based NGOs, but MOH has provided support to for

instance organisations like: Mildmay International, TASO, Uganda Community Based Association of Uganda, Family Planning Association of Uganda, Uganda Red Cross for special programmes.

The consultative meetings have led to the drafting of a position paper on partnership also with the NBF-PNFP, which was presented at the 6th GoU/DP Joint Review Mission in April 2002.

Non-facility based NGOs are mostly funded by development partners. The allocations of Government grants to NFB-PNFP sector are as follows (in Bn. Ug. Shs.):

Government allocations to the NFB-PNFP (Bn.Ug.Shs.)

Organisation	**2001/2001**	**2001/2002**	**2002/2003**
AIDS Palliative Care and Training (Mildmay International)	0.63	0.1	
TASO	0.10	0.15	
FBAU	0.05	0.05	
UCBHCA	0.15	0.05	
Uganda Red Cross		0.05	
UCBHCFA		0.05	
Total	0.93	0.45	

Source: PPPH Desk Office Report 2002

(c) Private Health Practitioners (PHP)
There has been an incremental privatisation of the public health care system and proliferation of private-oriented health care providers, including licensed and non-licensed private clinics, drug shops, home providers, etc. This group comprises all cadres of health professionals who provide health services outside the Government and PNFPs. Government's partnership with this sector is least developed.

(d) Traditional and Complementary Medicine (T&CM)
This group is also known as the Task Force on Traditional and Complementary Medicine and includes all types of traditional healers. This group has registered considerable growth in the last decade. Progress in the partnership with this sector has been hampered by the lack of legal and institutional framework within which they can collaborate with the public sector.

Assessment of the Public Private Mix
A review of the public private mix (Birungi et.al. 2001) concludes that Uganda has tried to evolve a policy based on consensus, but that a framework for integration is still missing. The policy process proved to be tortuous and the mix was interpreted differently. Policy addresses inadequately the institutional and legal issues that are apparently critical for deriving a sustainable public/private mix. Despite the significant role played by the private sector, it remained isolated from the national planning process until recently. A similar assessment today would most likely yield a more positive result.

Two pending issues are still discussed and disputed between Government and the NGOs: the fact that facility based NGOs still charge user fees while the same is formally abolished in Government health facilities and the problem of transparency about income and expenditures among NGOs.

The latter refer to a concern in MOH that all NGOs should be more open about all its sources of income and total expenditures. They claim that certain organisations try to hide such data in order to avoid cuts in subsidies in years where external donations increase. All the facility based NGOs supported principles of transparency and expressed willingness to share all financial information. So this problem could be resolved through better communication and clear procedures and requirements from MOH.

The first issue is more difficult. Hospitals and health centres run by the facility based NGOs are currently funded through a mix: roughly 30% from MOH, 20% from donations and 50% from user fees. The potential for increasing private donations is limited (churches and small groups in Europe). If the Government grant is not increasing – the only remaining source of income is user fees. No user fees - mean no health facilities – or a dramatic reduction in number and scale of activities.

There is positive evidence that increased Government subsidies have led to reduction in user fees and increase in utilisation. The facility based NGOs could, however, have been more creative in designing a more differentiated fee structure: with exemptions for the very poor, low fees for certain diseases and maybe a minimum package of services that should be offered free of charge for all.

It seems that the facility based NGOs are quite protective of their health centres and hospitals. They still fear that the Government could nationalise their health facilities. This is not likely to happen in the current political and financial environment, but the NGOs remember Uganda's recent history and the rapid changes in political regimes. The Government cannot afford to take over private health facilities, but they could - would the faith-based organisations be against any nationalisation process? Churches and the four medical bureaux need to discuss future strategies and attitudes towards increased Government responsibility for health care in Uganda and their own role in this process.

4. CIVIL SOCIETY IN UGANDA

4.1. Organisational Characteristics

Rapid Proliferation of CSOs
In the post-1986 period, the country has witnessed a rapid proliferation of CSOs, particularly in the form of NGOs, organisations set up in support of development efforts, including playing the roles as intermediary organisations between community based organisations (CBOs) and foreign NGOs, or in support of advocacy initiatives. There is an absence of reliable basic statistics about civil society in Uganda, but more than 3500 NGOs are registered as compared to 1000 in 1994. It is, however, believed that less than 500 of these have sufficient capacity to be development partners. There are also many unregistered community based organisations and other informal groups.

A NGO Sector study is underway to identify and create better understanding of the major roles, nature and quality of services offered by NGOs.

Its preliminary findings were:

- Several NGOs are not registered at national and district level.
- Many NGOs have nomadic tendencies.
- There are many "phantom NGOs".
- There is a high level of infant mortality among NGOs.

When this report was almost finalised, we received a copy of the draft report (Barr et.al 2003). The stated purpose was to investigate the current state of the NGO sector and to examine the relationship between NGO and the national and local governments. Findings from the report are included in subsequent chapters.

Categories of CSOs
CSOs can be categorised on the basis of their membership, their geographical dispersion, motivations and values, roles, activates and functions. The recent NORAD study on civil society in Uganda (Thue 2002) uses the following categories:
(a) membership based and occupational organisations, (b) development support and service delivery organisations, (c) community based organisations, (d) advocacy groups, (e) cultural and religious organisations, (f) umbrella organisations/network and (g) media. In addition, there are a number of umbrella- or network organisations.

The NORAD study found that indigenous NGOs are largely characterised by local membership – predominantly urban and localised, high level of financial dependence-mainly from external sources and none from the Government, limited human recourse and skills, poor sustainability and a preoccupation with service delivery roles as opposed to advocacy work. Given the country's political history, the majority of NGOs in Uganda have a short life history – coinciding with the life of the Movement itself.

The new NGO sector study found that faith-based organisations are by far the largest category of NGOs, followed by those involved in community development. Unlike NGOs in other countries which focus on a small number of key services, most survey NGOs in Uganda seem to adopt a holistic approach. What they do appear to be driven

by the specific needs of their target group and by the resources available to the NGOs. Put differently, NGOs basic approaches to talk to communities. Identify their most pressing needs and seek to address them. Very few define themselves around a specific social service. Most resist – even resent – being providers of a specific service.

In terms of geographical coverage, close to half of the surveyed NGOs operate in one district only. Three quarters of surveyed NGOs operate in four districts or less. Only 7 operate nationwide.

Community Based Organisations
CBOs operate mostly as self-help groups at village level. Some of them are indigenous and traditional with functions long recognised by the communities (like burial societies). Some are introduced and induced by outsiders. Next largest in coverage are the small NGOs which operate at parish level and are formed by public or faith inspired individuals who want to help those less fortunate. Sometimes these small NGOs have developed from self-help groups. External donors mostly fund larger NGOs operating at district level.

International NGOs
Several international NGOs operate in Uganda. Most are engaged in service delivery and are spread out in the country. Unlike their local counterparts they are more secure in their funding and have sufficient capacities to engage the Government in policy processes.

Human Rights Organisations
There are several human rights NGOs in Uganda (NCG 1999), like: The Federation of Women's Lawyers (FIDA), The Foundation for Human Rights Initiative (FHRI), the Legal Aid Project (LAP), the Public Defenders Association of Uganda, the Human Rights Network (HURINET), Human Rights and Peace Centre (HURIPEC), African Centre for Treatment of Torture Victims (ACTV), the Uganda Human Rights Education and Documentation Centre and Amnesty International.

In an evaluation of those organisations, it was found they are developing in a positive way with increased professionalism, although they still have a long way to go to attain capacity in their work. They need also to be more vocal on human rights abuses and to improve their national reach (NCG 1999).

National Networks
A number of thematic networks have been established which have increased the collective voice of NGOs and the impact of advocacy:

- CSO Poverty Task Force
- Water and Environmental Sanitation NGO Coordination Task Force
- NGO Forum with NUDIPU on disability
- NGO Forum with HURINET on human rights
- VECO Uganda and OXFAM on food security
- Anti-Corruption Coalition Union
- Food Rights Alliance
- The Referendum 2000 CSO Consortium

In addition, there are two general NGO networks: DENIVA and the NGO Forum.

4.2. Legal Framework

The Constitution supports the existence and free operation of civil society organisations. Besides the Constitution, the NGO Registration Statute governs NGOs 1989. The Statute provides for the registration and regulation of NGOs. It defines an NGO as *"a Non Governmental Organisation established to provide voluntary services including religious, educational, literary, scientific, social or charitable services to the community"*. The Statute further provides that no organisation should operate in Uganda unless it has been duly registered with the Board and a certificate issues.

The NGO Bill

The new NGO Registration (Amendment Bill 2000) is perceived to restrict space for NGOs and increase control by the State. Key issues are a new requirement for a permit on top of registration, new provision on non registration of NGOs whose objectives are *"in contravention of any Government plan, policy or public interest"*, new penalties and fines for individuals in NGOs, new NGO registration Board composed of State officials and security organs, appeals for non registration or cancellation of certificates lies with the Minister of Internal Affairs and the proposed Bill contradicts the constitution to the extent that it threatens the autonomy of civil society organisations in pursuit of their objectives.

The NGO Bill is, however, still at committee level in the Parliament providing the NGOs an opportunity to have an input into the Bill. NGO networks like NGO Forum and DENIVA have been part of the process. The Government states that the intention with the bill is not to create rigidity and control, but to improve the process of registration and define the difference between NGOs and CBOs.

4.3. Confrontation or Collaboration

In particular the NGOs have come to play a crucial role in providing basic services to vulnerable groups and marginal areas in Uganda. The suggested public private partnership in health is aimed at CSOs complementing the Government in provision of services mostly to rural and poor communities. The Government of Uganda is increasingly recruiting CSOs as its partners. This shift represents a dilemma for CSOs in the need for CSOs to create partnership with the Government on the one hand and access funds from public sector and at the same time remain independent from the State – in order to hold the Government accountable.

Influential literature on NGOs in Uganda argues that NGOs engaged in service provision do not confront and enter into conflicts with the Government. The development support and service delivery NGOs are said to be top-down, rather narrowly focussed and heavily reliant on foreign funding, all features that limit their potential for grassroots empowerment and locally rooted advocacy. Susan Dicklitch in "The Elusive Promise of NGOs in Africa 1998" concludes that NGOs in Uganda

"...remain a fragmented, uncoordinated and unorganised sector in Uganda, the movement is not monolithic, nor does it have strong leadership. Even when organisations do engage the regime directly or indirectly, there tends not to be a

coordinated effort, limiting the amount of influence that the organisation has vis-à-vis the state. Given the lack of coordination, competition, dependence on foreign funding for survival, the relative youth and political focus of most NGOs in Uganda, the NGO sector does not presently represent a strong vehicle for the development of a democratic civil society capably of pressurising the state and keeping it accountable and responsive to democratic initiatives…".

The same arguments are supported by the recent NORAD study (Thue 2000). Susan Dicklitch is building her arguments on case studies and evidence from 1992-93 – and even if some of the features of civil society have remained the same, we believe that significant changes have occurred during the last ten years – leading to a stronger and more vibrant civil society – but also to a more complex civil society. What are some of the developments?

Donor Dependence
Civil society remains almost entirely dependent on external donors. Donor assistance to civil society has increased considerably in the last few years and has bolstered its growth. The support has often been targeted at those issues that the donors consider important. Effective service delivery NGOs used to be favoured by donors. Much of the financial support has now been shifted towards building CSO capacity in advocacy, but also in addressing issues of democratization and the protection of human rights.

There are several new programmes and initiatives (UPHOLD funded by USAID, EU in NGO capacity building, Global Health Fund, etc.) which will depend on strong involvement of CSOs and provide massive funding to the sector. It is highly uncertain to what extent there are sufficient CSOs at national and in particular at district level to absorb and effectively utilize such funds. There seems also to be marginal communication and coordination between donors on assistance to civil society. The Government and donors should consider "A civil society SWAp".

Fragmentation
Civil society remains fragmented, but the emerging networks and alliances between like-minded CSOs should not be ignored on issues like international debt, disability, women, human rights, anti-corruption, etc. The medical bureaux of the faith-based organizations are also examples of effective networking – and with documented results. The NGO Sector study found that "Ugandan NGOs are heavily networked into each other. Some 72% of surveyed NGOs belong to a local NGO network or umbrella organisation. The most commonly cited are the NGO Forum (67%), DENIVA (30%) and UNASO (20%)

A silent watchdog?
Serious humanitarian and human rights issues are said to be absent from the CSO agendas which could reflect a confined political space, but also demonstrate political servility among the CSOs. We believe that the current state of affairs in Uganda's civil society is quite complex.

The political environment has been and still is conducive for the growth and work of those CSOs doing service delivery. On the other hand – and as we will argue for in Chapter 4: there is no automatic conflict between service delivery and advocacy –

meaning that CSOs assisting people in need for water, health, education, etc. – almost by definition are not involved in or will advocate for social and political change. Grounding in practical work can also provide the motivation, arguments and legitimacy for speaking up for the poor when rights are violated.

It is also interesting that the new NGO sector study (Barr 2003) states that raising awareness and advocacy are the two main NGO activities. Nearly all Ugandan NGOs are involved in raising awareness in one way or another – HIV/AIDS, nutrition, gender issues – and often human rights and protection of the environment. The study presents as a striking feature from the survey the importance given by NGOs to "talking" as opposed to physical delivery of goods and services.

Most large NGOs are increasingly and explicitly combining service delivery and advocacy – even if the level of advocacy is cautious as judged by the advocacy organisations. As compared to the situation in 1992/93, there is an increasing number of human rights organisations – speaking up against the Government and which continue to exist. We will show later (Chapter 4) that the Government do not favour and support their own critics. There are examples of manipulation, cooptation, registration, control and suppression of CSOs by the Government, but there are also examples of a more vibrant civil society speaking up against the Government or those following more collaborative change strategies.

It can also be argued that within the context of a "no-party" system in Uganda, CSOs have supplemented the role of political parties in stimulating openings for political participation. In a political system in which the parties cannot challenge the authority or the accountability of the Government, other actors such as civil society have to some extent played this "watchdog" role. Women's and youth organisations and other CSOs representing special interest groups have created channels other than political parties for the articulation and representation of interests of their members. This function has been particularly important for providing traditionally excluded groups, such as women, person with disabilities and youth access to power that had been denied them in formal politics.

4.4. Civil Society Participation in the PRSP Process

CSOs in Uganda under the leadership of Uganda Debt Network were involved in the formulation of the Poverty Reduction Strategy Paper (PRSP) from December 1999 to May 2001 (AFRODAD 2002). In Uganda, the formulation of the PRSP coincided with the desire by the Government to revise the Poverty Eradication Action Plan (PEAP) that was first developed in 1997 after two years of extensive consultations with CSOs. It was therefore decided by the Government and agreed with donors that the Uganda PEAP would also be the Uganda PRSP.

The decision to involve CSOs in the formulation of the PRSP came about as a result of continuous pressure and demands by CSOs to participate in policy design, planning and formulation. Although, this was not the first time they were included in influencing policies, it was the first time that they were deliberately included in policy design, planning and formulation. CSOs had largely been involved in policy implementation and service delivery.

However, the decision to include CSOs also came as a result of increased pressure from donors and international aid agencies. For instance, the demand for a tripartite participation between donors, government and civil society in the Structural Adjustment Participatory Review Initiative (SAPRI) from 1996 to 1999 in which Uganda was involved was a critical factor in influencing the policy processes in Uganda.

NGOs and grassroots organisations also became involved in the first participatory Country Assistance Strategy (CAS) of The World Bank in 1997. The experience from the CAS consultations became the basis for the establishment of the Uganda Participatory Poverty Assessment Project (UPPAP).

CSOs are also involved in sector working Groups. The Uganda Debt Network for instance participates in the Macro Working Group discussions on macroeconomic issues and the budget framework. It is also a member of the Poverty Eradication Working Group (PEWG) that seeks to mainstream poverty eradication in the plans for all working groups.

The report from AFRODAD (2002) adds *"In recognition of their role as serious development partners and actors in the policy arena, CSOs have since 1999 earned themselves another open space to participate in the Consultative meetings that are held annually".*

Their conclusions are: *"The Uganda experience of CSO participation in the preparation of a PRSP shows that Government commitment to these consultations is essential. ... Most Governments in Africa are not yet ready to accept CSOs as serious stakeholders in policy planning, but the Government of Uganda ensured that CSOs were given enough space in the PEAP/PRSP process by organising independent consultations and incorporating as much of their inputs into the documents as possible. ... Moreover, the Government did not dictate the agenda of the CSOs in the consultations and the Planning Ministry ensured that CSOs were regularly represented in the PEAP/PRSP process".*

But it is admitted that CSOs were left out in the later stages of the process and also that most NGOs did not have staff capacity and skills to engage in meaningful dialogue with Government and donors on macro-economic policy issues. Deliberate efforts are needed to build the capacity of CSOs to have a greater impact on policy planning, implementation, monitoring and evaluation. And some government officials still regard CSO participation merely as an exercise to legitimise the Government agenda and view criticism from CSOs with suspicion.

There is limited political space in Uganda – also for civil society which means that their activities are restricted to matters outside the explicit political arena of formal democracy. The suppression of voices of the opposition – particularly of advocates of political pluralism – explains the fact that many NGOs and other CSOs are afraid to step beyond a certain point in their advocacy work. It also explains why the Government has been more receptive to CSOs within the domain of service delivery and not advocacy.

5. ASSESSMENT OF CSO ROLES

This chapter seeks to answer more directly and in summary form the questions posed by the study through a discussion of the hypotheses from the Inception Report. The chapter does not stand-alone and builds on the presentation and analysis in the previous chapters about the country context, health sector and civil society.

5.1. Level of Involvement

- *There has been an increasing involvement of CSOs in SWAps, but originally the involvement was marginal and CSOs contributions were not recognised as important.*

This is partly confirmed for the health sector. The facility based private not-for-profit providers (FB-PNFP) were involved from the initial stage of policy formulation in working groups and committees. Non-facility based NGOs, on the other hand, were not involved and are not yet systematically part of the SWAp - process.

The FB-PNFPs are members of and take active part in the Health Policy Advisory Committee (HPAC) and Joint Review Missions, the Advisory Board on Health and the National Health Assembly and the Working Group on the Public Private Partnership in Health (PPPH 2002).

As such, they have access to the most important meetings for policy discussion. There is also an increased collaboration and participation of PNFPs in the sector and their concerns receive Government attention (Joint Review Mission 2001), but it is a heterogeneous group with different interests and various levels of involvement.

The process of formulating the SWAp was participatory, but not representative. Some stakeholders were either left out or were brought on board at a late stage in the process. The facility based NGOs were for instance much better organised than the other NGOs and the Government could relate to them more easily. Public sector was heavily represented from central level (MOH), but district officials were marginally involved. The private sector was largely represented by executive secretaries of medical bureaux and to a limited extent by medical superintendents and administrators of health facilities.

Further, traditional healers, informal providers and consumers were not consulted. The involvement of private for profit and non-facility based NGOs are under way. In that sense, they were not deliberately excluded, but had first to organise themselves.

In recent years, the Government of Uganda has also been involved in other national efforts to engage civil society, namely, the Vision 2025 exercise, the Uganda Participatory Review Initiative (SAPRI), the Poverty Eradication Action Plan (PEAP) and the Plan for Modernisation of Agriculture (PMA) – so the experience from the health sector is not unique.

DFID carried out a study (Lister&Nyamugasira 2001) to identify CSOs in Uganda that were active in policy dialogue and advocacy, and to assess the level of civil society involvement in policy formulation, implementation and monitoring in all

sectors. Overall, the study found that *"CSO engagement with Government in policy processes has been increasing, and there is widely perceived to have been an opening space for this to occur, especially at the national level. Nonetheless, although engagement is often through structured and defined processes, the basis on which engagement takes place is often unclear and contradictory. There is little discussion or analysis of which groups constitute legitimate participants in the processes and why. Inclusion in policy processes is unpredictable and civil society often relates with the state on the basis of clientilism or patronage".*

The most marked increase in recent years has been CSOs as contributors invited to participate in policy formulation processes – even if the health sector showed the opposite – NGOs inviting themselves. Representatives of civil society have had seats at the negotiation tables in broad cross-sectoral processes, such as the PEAP and PMA and in sectoral planning. As shown earlier, it is widely considered that the PEAP process constituted a breakthrough in relationships between CSOs and some parts of Government.

More critical voices state that the Government only invites CSOs to participate in policy formulation, when the policies have already been drafted. CSOs are given a day before the consultative meetings to review the policies. They are simply called to rubber stamp decisions already taken. The environment is also more enabling for CSOs that are providing services and disabling for CSOs that are in advocacy and lobbying.

Such rubberstamping is happening and the participation of CSOs in policy processes still suffer some several limitations, but the involvement of CSOs in the discussion of the health sector programme is an example of a more genuine involvement. There is little doubt that Uganda is a strong and impressive case of CSO involvement in a regional perspective.

- *The new generation SWAps have moved towards a redefinition of the state – providing a framework for enabling interventions by a variety of actors.*

This is confirmed for Uganda. The objectives of the new policy for public private partnerships are to promote the recognition and value of the role and contribution of the private sector in health development and to define an institutional framework within which to coordinate, implement, monitor, evaluate and enrich the partnership.

This document and other national policy documents are positively endorsing the need for a strong private health sector in Uganda and laying out principles for partnership instead of talking of regulation and control.

- *Interactions between Government and CSOs is still limited and strained by mutual scepticism and reluctance.*

The answer is mixed. The question of semantics, fears, obstacles and who controls whom often assumed a central place in the policy negotiation process between Government and NGOs, but the final outcome was positive – at least for the facility based NGOs.

The current interaction between facility based NGOs and MOH is perceived to be good at both sides. There are frequent consultations and the organisations are formally represented in Government committees. Other NGOs have been much less involved and are also more sceptical to the Government and its bureaucracy. The new policy is perceived as positive, but concerns have been raised by the private stakeholders, especially about the use of the word "integration" in the policy document, which carries signals about being swallowed up by government. It was also argued that the issue of what is public and what is private must be clearly defined – making a distinction between private for profit and not for profit initiatives.

On the Government side, there seems to be more scepticism about NGOs at district than at national level and more among politicians than bureaucrats in MOH and MFPED. Some politician's questions the Government's increased direct funding of NGOs since public hospitals and health centres are in desperate need of more public support. The same sentiments are also expressed at district level: *"Why give away money to NGOs already well resourced by international NGOs and donors?"*

The differences were partly explained by lack of information and knowledge among district officials and politicians about the role of private health providers. A seminar was organised in 2002 ("Mapping the Way Forward in Strengthening the Government of Uganda and NGO sector partnership"). The objectives were to improve the understanding of the Government programme on public private partnership and *"limit the scepticism between Government and NGOs, and develop strategies that can enhance meaningful partnership"*.

A review (Birungi et.al. 2001) found that Uganda tried to evolve a policy based on consensus, but that a framework for integration was missing. The policy process was found to be tortuous and the mix was interpreted differently. The review concluded that despite the significant role played by the private sector, it remained isolated from the national planning process until recently. This could be true for the private sector, but the non-for-profit providers have progressed much further in particular in the last two years (after the Birungi review was completed).

- *Policies of stronger public/private partnerships are still more aspirational than providing clear and realistic guidelines.*

This is not confirmed. The working group of public private partnership was established already in 1997. A desk office was funded in MOH to coordinate activities of the private sector. The working group also developed a policy for "Partnership with Facility-Based Private Not-For Profit Health Providers"[9].

The policy document might not be clear on all issues, but it is much more than aspirational. Two pending are user fees in private hospitals and the need for more effective procedures for transparency and accountability – or in other words a demand from Government of open information about all sources and level of income, total expenditures and performance data. None of the facility based NGOs were against providing such information. MOH stated that some organisations try to keep sources

[9] The introduction covers all CSOs and the private sector, while the specific guidelines apply only to the facility based NGOs.

and data on level of income for themselves in order to avoid cuts in Government subsidies in years when private donations increase.

5.2. What CSOs were Involved?

What CSOs were asked to take part in the design process and why?

- *Participation is first and foremost based on invitation from Government.*

This is not confirmed for the health sector. The facility based NGOs initiated the dialogue with the MOH – mostly because of their difficult financial situation. They were listened to and the outcomes of the negotiations were for them positive. They became part of the formulation of the new health sector plan and in 1999 they received a Government subsidy totalling 1 billion Uganda shilling -mostly to NGO hospitals. Currently, they are receiving about 18 billion Uganda shilling covering about 30% of the expenditure of their health facilities (hospitals and health centres).

The Government's reasons for providing such subsidies are many: The facility based health NGOs have been and are still key providers and in some places the only providers of health services in Uganda – in particular in remote and rural areas. They also provide services and use procedures in delivery similar to the public – except in a few cases. Their services are of national importance and cannot be ignored. From the Government's perspective, the subsidy is also a small and "lucrative" investment from a financial point of view – by providing 30% of the expenses - 40% of all hospitals in the country get funded 100% through private donations (20%) and user fees (50%).

Lister&Nyamugasira (2001) comes to a different conclusion from studying a broader sample of policy processes: *"Data from this study showed that participation in these processes is by invitation and not all are invited."*

- *Controversial advocacy organisations tend not to be invited by the Government to discuss SWAps.*

This is confirmed. Controversial NGOs have not been part of the discussion of the health SWAp – so in that sense they were not invited. On the other hand, there are few controversial health NGOs to invite. Such NGOs operate mostly in other areas. The four facility based NGOs are primarily providing health services and have no reputation and intention of becoming overtly controversial. They have adopted a collaborative strategy with the Government, which does not imply that that they are completely silent.

They prefer to make their voices heard from within the system and are of the opinion that a non-confrontational approach with the Government and working from within give them more power and opportunities to voice their concerns. As such, those organisations have imposed on themselves a level of self-control or "discipline" as a price for collaboration, which in practice means to avoid certain sensitive political issues. There are, however, examples where they have collected information and background material on sensitive issues and made that information available to other NGOs better equipped for political advocacy.

Lister&Nyamugasira (2001) found that CSOs which disagreed fundamentally or would be disadvantaged by the policies proposed are not invited to policy processes. For example, labour unions are not invited. It seems true that inclusion is more based on the organisations perceived added value from the Government's perspective, rather than on any conception of a democratic right to contribute.

- *The basis on which involvement from CSOs take place is unclear.*

The reasons for involving facility based NGOs were obvious. They were key health service providers of national importance and they were well organised in four medical bureaux. For the other NGOs - providing non-facility based health services, it was much less clear. They were not well organised as the faith based organisations. There is no network of health NGOs and it is apparently a problem for any Government to select and involve a few organisations, when there are a large number of organisations to select from. The same is true with traditional healers and the broad range of private for profit health providers.

- *Mostly national CSOs are involved in SWAps.*

This is confirmed. The strongest NGOs in Uganda are urban based with national coverage. The broad range of NGOs and CBOs at district level are much weaker and less equipped for discussing health policy – and also with weaker links to central government.

It was anticipated that under the policy of decentralisation, policy formulation would increasingly be occurring at district level. Findings suggest that policy formulation is extremely centralised (Lister&Nyamugasira 2001). The translation of national policy happens through District Development Plans and a few CSOs with sufficient capacity take part in the formulation of these plans, but not as much and systematic as at national level.

5.3. Roles CSOs Played

What roles have CSOs played and how have they played those roles?

(a) As contributors to policy discussion and formulation:

- *The involvement of CSOs as contributors to policy discussion is on the increase, especially at national level.*

On the whole, there is a widespread perception that the space for CSOs to influence policies has been expanding, but the space is to a large extent politically determined. In some areas, such as political participation of women or people with disabilities, space for participation is guaranteed by the Constitution, but not in other more controversial areas. On the other hand, CSOs are not excluded from discussions of macro economic issues, governance, democracy and human rights, but CSO involvement is much more common in the social sector.

- *Sectoral policy documents make limited reference to the involvement of civil society.*

This is not confirmed. The Health Policy and Strategic Plan for Uganda is recognising the private sector as a major partner in health care and service delivery.

The autonomy of NGOs is also enshrined in the new constitution: *"Civic organizations shall retain their autonomy in pursuit of their declared objectives"* (The Uganda Constitution 1995, Section ii). Both documents provide the background for the new policy of public private partnership in the health sector.

- *Consultations have tended to be strongest at the development stage of a SWAp and fade away once the programme gets underway.*

This is not confirmed for Uganda. Consultations were from the beginning more than ad hoc. Several collaborative and consultative mechanisms were institutionalised. A public private partnership programme is in place and NGO representatives are permanent members of committees and working groups and take part in joint reviews every year.

- *CSOs lack the capacity and skill to take part in policy discussions.*

This is mostly confirmed. The level of skills and capacity is scarce and unevenly distributed among the organisations. The facility based NGOs have qualified leaders to represent and talk on behalf of their members and capacity to organise, lobby and advance interests, but this happened more recently and the Moslems for instance admitted openly their long-time struggle for putting a national structure in place.

The medical bureaux do not channel funds to their members and cannot charge any overhead for covering operating expenses. They have received some funding from the Government, but these important mediating mechanisms are understaffed and experience problems to meet the demands from MOH.

In general, CSOs have not always a technical grasp of the issues, a proper understanding of government procedures and ability to interact and contribute in environments, which often are found intimidating. It is a problem that most of them do not have the time and capacity to use the space opened for them for consultations and meetings. There are still only pockets of capacity within civil society – which means that donors and Government overuse some strong organisations.

- *There is limited capacity in Governments to interface with CSOs and the private sector.*

This is not confirmed for the health sector. There is an NGO desk and a public private partnership programme at national level. In some districts, there are also a District Desk Officer for the PNFP sub-sector and a PNFP coordination committee (a requirement in the new public private policy). In other words, there are Government officers with responsibility for liasing with NGOs and private sector.

(b) As advocates and lobbyists:

- *Governments are uncomfortable with CSOs in their roles as advocates and watchdogs and reluctant to accept the legitimacy of an oppositional "voice".*

The answer is many-sided. Existing literature and "common wisdom" about NGO – Government relationships in Uganda state that the Government is not only uncomfortable with critical NGO voices, but is actively controlling, monitoring, co-opting and suppressing "difficult" and critical NGOs (Dicklitch 1998 and Thue 2002).

The legal environment for CSOs is still restrictive and the discussions about the new NGO Bill are still not resolved. There is an obvious tendency for some parts of the Government to take a controlling perspective towards civil society. This is particularly true on sensitive political issues. CSOs challenging the Government can be labelled "political opposition" and their activities defined as illegitimate.

Most Governments in Africa are also uncomfortable with outside criticism. There is no tradition or understanding of the need to support its own democratic opposition – which is true also in Uganda. But this is not the same as to say that any opposition or criticism is not accepted, or that there has been a progressive development over time. Dicklitch's book was written in 1998 and based on material collected in 1992-93. Some of her statements need to be revised and updated and not only reproduced. There are evidence of a more open and relaxed relationship between the Government and CSOs:

- There have been several initiatives by the Government to consult with NGOs (a national workshop in 2002, a programme to improve Government – NGO partnership, a new NGO study, regular meetings between NGOs and the Prime Minister's Office).
- Several policy documents and statement from leading politicians provide support for the need and legitimacy of a strong civil society.
- Civil society in Uganda is more vibrant in 2003 than ten years ago – referring to active and leading national CSOs (not all the 3500 registered as NGOs).
- There is a large group of active and vocal human rights advocacy organisations, which are operating (mostly with support from international donors though).
- It has become more common for NGOs to combine service delivery and advocacy. The major development oriented NGOs have advocacy programmes. TASO as an HIV/AIDS organisation for instance defines advocacy for PLWHA's and protection of their human rights as part of their mandate.
- NUPIDU as the umbrella organisation for the disabled has successfully lobbied the interests and rights of disabled people at the highest level.

Donors used to be less interested in funding advocacy and "watchdog" organisations than effective service providers. However, as part of the new policy agenda for civil society, donors are increasingly interested in funding activities promoting human rights, advocacy, good governance, etc.

Many CSOs wrestle with the tensions between increased participation in policy processes and issues of independence and autonomy from the state. This tension is exacerbated by the dependence of CSOs on external sources of funding. Those most

able to maintain their independence are those with independent sources of funding, mostly international NGOs and those with links to external donors.

- *Civil society is fragmented with competing networks and umbrella organisations.*

This is mostly confirmed except for the faith based organisations which have successfully organised themselves through medical bureaux. Other CSOs have so far been weakly organised. This is now changing as reflected in the new NGO Sector study describing Ugandan NGOs as "heavily networked". There has been some competition between the NGO Forum (a network for mostly advocacy organisations) and DENIVA (a network for mostly development NGOs). The NGO Forum was initiated and funded by external donors and some NGOs are of the opinion that it is not well anchored among Ugandan NGOs. DENIVA is said to be more owned by local organisations. There are several networks and umbrella organisations based on a thematic focus and target groups as explained in chapter 3.

Some of the networks have been successful, but the proliferation of networks has also led to confusion and duplication with competition within and between networks for recognition and credit.

(c) As service deliverers (operators):

- *CSOs are mainly being invited and involved in SWAps as service providers – sub contracted by national or district authorities.*

This is mostly confirmed. The Government was obviously most interested in the facility based NGOs, but this group of NGOs were not sub contracted. They were given a Government subsidy – a grant.

NGO facilities are increasingly integrated within the public health system. An NGO facility is delegated funds from GOU for their general operations and in addition, some NGO facilities have been designated as the lead facility within their sub district and will receive the PHC conditional grant -through the local authorities who administer the funds.

Donors on the other hand is moving in a different direction expressed most clearly by DFID in Uganda*:"DFID is moving away from traditional service delivery projects and is channelling assistance directly through the budgets of governments demonstrably committed to pro-poor policies… representation of the voices of the poor, building strategic partnerships between Government and civil society and in between donors in support of civil society, and the role of civil society in holding Government to account for its pro-poor commitments".*

Sub-contracting of NGOs in the area of service delivery is not common in sector programmes – in the sense that district NGOs implement government programmes as a result of a tendering process. Donors on the other hand have sub-contracted international NGOs and management firms to implement projects. But changes are underway. Lister&Nyamugasira (2001) found that *"significant changes are occurring to the context and structure of service provision with the shift towards sector-wide approaches and budget support. CSOs will increasingly be sub-contracted by district*

authorities. Many sources confirmed that certain district authorities require "commissions to be paid for the rewarding of contracts, and that the districts tend to contract those organisations which do not challenge them".

There is so far little analysis of the issue of sub-contracting, its implications and how to cope with them. A shift to SWAps seems to lead to stronger CSO involvement in policy processes, but the same shift might lead to less independence and autonomy for CSOs during implementation.

- *Service delivery and rights based CSOs are perceived as antipodes while the relationships between service delivery and rights based programming remain unclear and under defined.*

Rights-based advocacy forms the centre stage of the strategy for Uganda Debt Network (UDN). UDN has embarked on a campaign for rights-based approaches to development, which looks at development not simply in terms of human needs or developmental requirements, but in terms of the society's obligations to respond to the rights of individuals. It aims at empowering people to demand justice as a right, not as charity and gives communities a moral basis for which to claim international assistance when needed.

It is our impression that UDN is an exception. A rights-based approach is not common and well-known among most CSOs in Uganda.

- *CSOs are seen to have comparative advantages in providing services to marginalised and hard to reach groups in ways Government cannot.*

This is confirmed. CSOs have traditionally been providing more services to remote and marginal area where there have been no or few Government services – and where public servants have been unwilling to live. Several of the new donor funded programmes for NGOs are focussing on Northern and Eastern parts of Uganda.

- *CSOs involved in service delivery have often higher legitimacy as lobbyists and impact on policy processes than CSOs only doing advocacy.*

This is mostly confirmed. The facility based NGOs were offered seats at the negotiation table. A track record of effective service delivery was their entrance ticket and they have been listened to – partly due to their practical experience and commitment.

In some policy processes, involvement in service delivery seems as a pre-requisite for participation in policy formulation, as Government tends to engage with CSOs when it can see a clear advantage in doing so, as is illustrated by the involvement of the facility based NGOs.

The trend towards a separation between service delivery and advocacy by some donors might therefore decrease the impact of CSO advocacy. A move away from service delivery reduces CSOs knowledge of actual conditions at the grassroots and their legitimacy with policy-makers. It removes also a point of entry for NGOs at local level for education, mobilisation and capacity-building on rights-based issues

(Lister&Nyamugasira 2001). Although some service delivery CSOs is passive "gap-fillers", this need not be the case. Service-delivery can be a springboard for influence in policy formulation and a key component in assisting people in need.

(d) As monitors (watchdog) of rights and for particular interests:

- *The Government is not willing to open up for systematic review and impact analysis of SWAps from field based CSOs.*

Lister&Nyamugasira (2001) found that monitoring of Government activities by civil society is weak at all stages of the policy process. The monitoring and evaluation of the health sector programme by CSOs is also not yet developed and no mechanisms for systematic review have been established.

With CSOs increasingly dependent on Government funding and contracts with district authorities, their ability and position to monitor the same authorities might also be weakened.

Examples of CSO monitoring are found in for instance the "Poverty Assessment Monitoring Exercise". The Uganda Debt Network has designed and is piloting a Community Based Monitoring and Evaluation System (CBMES) with a potential for replication. UDN started monitoring the utilisation of the Poverty Action Fund in 17 districts to ensure that services reach the intended beneficiaries in particular the poor. In May 2000, UDN established Poverty Action Fund Monitoring Committees in 17 districts to empower grassroots to participate in monitoring and check occasions of corruption. The new initiative moves the monitoring from district level down to community level and the idea is to empower communities to articulate their development needs and priorities, as well as mobilise communities to take part in planning, management and evaluation of service delivery.

CSO review is one of the key roles supported by new donor policies for CSOs – clearly expressed by DFID:

"Clear roles are emerging in the following areas:
- *Promoting, monitoring and strengthening pro-poor policies.*
- *A stronger role in demanding accountability from Government in delivering on its commitments to pro-poor change.*
- *Stronger partnerships between Government and civil society in delivery of services."*

(e) As innovators introducing new concepts and initiatives:

- *There is little evidence that CSOs contribute to SWAps as innovators – introducing innovative concepts and initiatives.*

We were not able to collect sufficient information on this issue. The facility based NGOs are involved in traditional health services, but in for instance HIV/AIDS several NGOs have played important innovative roles.

(f) As financiers:

- *CSOs play a marginal role as financiers of SWAps.*

This is confirmed in the sense that CSOs are not providing funds to the health basket. On the other hand, the health CSOs are providing significant support to the implementation of the national health sector plan – even if the funding does not go through the Government systems. The facility based NGOs and most of the others share and support the aims and objectives of the strategic plan and their efforts make a significant contribution to the realization of the strategic objectives of the SWAp.

- *CSOs are part of national sector policy, but funds do not flow through the Government budget.*

This is not confirmed. Funds are not channeled from NGOs to Government, but money flows from the Government budget directly to NGOs in the form of subsidies and through sub-contracting.

- *CSOs are increasingly funded directly by the government through contractual arrangements.*

This is partly confirmed even if we do not know the level of sub-contracting.
The arrangement at district level – as part of decentralisation – is that NGOs have to tender for Government health projects in competition with the private sector. The new NGO Sector study found that a under one quarter of the surveyed NGOs have been paid to provide a service for another organisation – which is 40% of the time another NGO and 25% of the time the Government.

A new NGO programmes (UPHOLD funded by USAID) aims to establish trust funds for NGO projects at district level where NGOs and CBOs can apply for financial support. An international private firm will manage the national project and national and international NGOs might be sub-contracted to implement components of the programme. Such projects may run the risk of weakening government control and coordination and build parallel structures.

5.4. What are the Effects of SWAps

(a) To what extent and how are CSOs funded as part of the SWAp?

- *The funding of CSOs through SWAps is limited.*

The funding of CSOs is limited compared to the total health budget, but in Uganda there is at least a considerable amount of money which is channeled to the facility based NGOs and others.

- *International CSOs and bilateral donors remain the donors of national CSOs.*

Systematic data is not available, but the hypothesis can most likely be confirmed. The facility based NGOs are not so interesting since few international CSOs and bi-

/multilateral donors are funding them. Most of their external support comes from private donations and churches in Europe. The NGO Sector Study concluded that the NGOs as a whole received most grants from international NGOs – accounting for nearly half of total funding in 2001. Grants from bilateral donors are the next largest category with grants from local government the third largest source of grant funding. The sector as a whole derives very little revenue from local fundraising from members and non-members.

The picture of NGO funding that emerge from these figures is one in which most funding comes from outside sources – international NGOs and bilateral donors and is allocated to a small number of Ugandan NGOs.

As a general rule, both national and local CSOs have very few independent sources of income and depend almost entirely on external donors. Government funding of CSOs is marginal.

TASO is an interesting example. Only 5% of their total budget for last year (approx. 7 Mill. US$) is covered by MOH and the remaining 95% from donors like USAID, DFID, DANIDA, EU, etc.)

The TASO example helps to clarify an important policy issue: One would assume that donors providing financial support to the health basket, over time would reduce their direct support to NGOs in the area of health with the argument that NGOs should be able to access funds from MOH and the health sector budget. There is also evidence that several major donors are moving in this direction, but not all. EU has expressed that funding of TASO will be withdrawn with reference to the funding of the health sector programme. SIDA considers it as a long-term aim to shift direct NGO support to sector programmes, but will continue funding NGOs directly. NORAD has not reduced its support through Norwegian NGOs in favor of the health basket – both channels of support are still used.

DFID is also supporting TASO and several other NGO initiatives, but have expressed in its strategic framework for working with civil society that *"DFID is moving away from traditional service delivery projects and is channeling assistance directly through the budgets of governments demonstrably committed to pro-poor policies….. The majority of DFID funds in Uganda are now channeled towards supporting the Uganda Government's own budget within the framework of the Poverty Eradication Action Plan and sector wide approaches. We will encourage, where appropriate for these resources to be used by Government to promote partnerships between Government and civil society, and in particular to procure services from civil society.*

To complement our support to Government's implementation of the PEAP, and in line with this strategic framework, DFID will support a limited number of civil society organisations in the areas of:

- *Democratization and civic education*
- *peace building*
- *advocacy, lobbying and monitoring of pro-poor economic and social policy*

In order to optimise our support to civil society organisations we will be engaged in fewer separate initiatives than previously".

Reactions from national CSOs to the new trends are mixed. NGOs receiving direct support appreciate and prefer such arrangement and fear Government bureaucracy and procedures. It could also be argued that national CSOs should not be funded exclusively by the Government. It protects their independence if some of their income derives directly from international NGOs, which also see it as their role to strengthen their partners. If funding of national CSOs is going to be mainly through sub-contracting, this may affect their identity and autonomy as NGOs.

It is positive for national NGOs to deal with their own Government in terms of funding and mechanisms for funding of NGOs should be part of health sector programmes. On the other hand, a level of direct support from external partners could and probably should be maintained.

There are inherent dilemmas in the current funding of CSOs in Uganda. On the one hand, there has been a strong effort to establish a sector wide approach in health – to reduce the fragmentation followed by projects and harmonise donor interests and work towards more efficient and rational utilisation of scarce resources – not only for the public sector, but also civil society. The health programme is Uganda has not yet achieved those objectives, but there are positive signs that the sector is moving in the right direction.

On the other hand – donors follow conflicting policies on SWAps. There are currently a number of donor-funded programmes directly targeting CSOs at district level. Some are designed outside the coordinating mechanisms for the national health sector programme and funds will not be channeled through Government systems. There are short-term benefits in such an approach, but it will increase fragmentation through new parallel structures and as such undermine the SWAp intentions. The massive support for CSOs and CBOs at district level is also built on the premise that there are a lot of organisations "out there" – ready and capable of absorbing funds and implementing cost-effective projects for the poor showing good results.

Civil society at district level is much weaker than at national level. There are few organisations ready to absorb large amounts of funds and with the ability to perform effectively – in the short run. A strong and vibrant civil society will only emerge as a result of a long-term capacity building process – as is also true for the development of Government structures at district level.

(b) Have SWAps supported or delayed ongoing decentralisation efforts in the country?

- *SWAps and decentralisation are strategies pulling in opposite directions.*

The Poverty Eradication Plan (PEAP) paved the way for Uganda to access debt-relief under the HIPC-initiative and provided also the content of the country's Poverty Reduction Strategy Paper.[10]. The Poverty Action Fund (PAF) channels resources from HIPC, donor budget support and the Government's own resources to the PEAPs five priority sectors: primary education, primary health care, water and environmental

[10] See Kasumba and Land (2003) for the full argument.

sanitation, agricultural and rural development and rural roads. Almost 90% of the PAF is for support to social sector. The PAF has been a key instrument in encouraging the move to sector and budget support, because it ensures that funds are channeled to the highest priority programmes under strict conditions.

But the Local Government Act states that two-thirds of the funds must be transferred to local authorities. The PAF has therefore become the most important transfer system of resources from central to local government and is the main instrument for distributing sector funds as conditional grants into the local government system.

The Government is thus faced with an inherent tension – between fulfilling its commitment to driving the fight against poverty and its obligations to funding partners, while at the same time respecting the principle of local government autonomy prescribed by the Local Government Act. Tensions have emerged between policies of decentralization and poverty eradication.

Advocates of decentralisation argue that PAF conditional grants undermine the process of developing autonomous local governments and contradict the principle of devolution in the Local Government Act. Local councilors rather than being encouraged to take ownership of the local development process and held accountable to their constituents, remain spectators to a centralised planning and budget allocation process. Three quarters of transfers for local government recurrent expenditure are in the form of conditional grants, mainly financed from PAF. Central government transfers account for about 90% of all local government income and the responsible line ministry has designed the conditions for each grant, as part of their sector plans. Local councils have more or less ended up as implementers of central government plans.

On the other hand, conditional grants are justified by districts lack of capacity for effective management of resources and delivery of services. Local authorities are criticized for poor planning, poor financial management and weak technical supervision – and for not necessarily adhering to the PEAP priorities. In other words, it is still necessary for central government to retain decision-making powers and impose conditions on the utilization of resources – as for instance illustrated in the central decision to allocate resources to NGO health facilities.

Some argue that conditionalities are needed to ensure that a proportion of the resources channeled to the local level must target non-state actors. The feeling is that without such earmarking, it is likely that councils would keep all the resources for themselves. Decentralisation may cut off civil society from funding. On the other hand, the strict conditionalities may ensure funding of some NGOs, but reduce local council's flexibility to fund more and other NGOs.

Looking to the future, SWAps do not need to be in tension with decentralization. The Fiscal Decentralisation Strategy provides a basis on which SWAps can facilitate both the implementation of PEAP while reinforcing the process of decentralization, but steps need to be taken in order to ensure that local governments have the capacity to meet its obligations.

- *Decentralisation have challenged the monopoly of a top-down Ministry approach and opened up for stronger CSO involvement.*

Uganda has introduced principles for decentralisation providing the districts with a high level of autonomy in terms of decision making when it comes to setting of priorities, allocation of resources, funding, etc. The country is moving in such a direction and in the process of change a number of anomalies and constraints has emerged. As already mentioned, the level of unconditional grants from central Government is low. In the health sector, hospitals are still owned by the Government, doctors are employed and paid by MOH while the districts employ nurses, etc.

Funds from Ministry of Finance for all health facilities owned by the faith-based organisations are still earmarked (there are specified budget lines for each facility even announced in newspapers). The districts are not allowed to change such allocations. The ceilings come as directives from MOF and the total allocation to NGO facilities result from negotiations between the FB-PNFP (medical bureaux) and MOF at national level. In other words, the decentralised system has strong centralised elements. The current arrangement has obvious positive benefits for the facility based NGOs. It is sufficient for them to argue and justify their position at central level and the funding of their services is predictable and secure.

Ministry of Finance informed, however, that the system will be changed. Districts will in the future be given minimum fixed ceilings for each sector and districts will have the authority to move funds between sectors as long as they are above the minimum ceilings. Funds from private hospitals and health centers will most likely not be earmarked by central level in such a system which means that the facility based NGOs will have to negotiate with each district where they have facilities. As such, funding will be much more dependent on district priorities.

In a study of decentralisation and civil society in Uganda (Nsibambi 1998), it is stated that decentralisation and civil society was perceived as two pillars of democracy and good governance. By bringing decision-making closer to the people, dentralisation should promote popular participation, transparency and accountability. A vibrant civil society should not only inform the making of public policy, but also articulate popular needs and demands, and above all, act as a watchdog against authoritarian tendencies. Findings did not confirm this assumption. The effect of over centralisation was a weak civil society that could not check the excess powers of the state, nor enforce accountability of public officials. The state and its institutions continued to dominate and infiltrate civil society. And decentralisation has not yet been able to reverse such trends.

The study also found that decentralisation has not really enhanced citizen participation in decision making at the lowest level (LC I and LC II levels). A number of small organisations were found, but none that attempted to influence government policy. *"On the ground, particularly in rural areas where the majority of the population lives, civil society hardly exists. A few local organisations that have emerged spontaneously are driven by survival strategies rather than the desire to influence public policy".*

This is said to be true also at the national level: *"The majority of NGOs are developed in relief and development programmes to enable the country to recover from decades of anarchy and decay. The main concern for the population is to survive and ensure that basic services are accessible. Since NGOs mainly address demand driven needs, empowering beneficiaries politically to confront the central political arena is not directly addressed".*

(c) Have Norwegian/international organisations been involved and how are they affected?

- *Few Norwegian CSOs are involved in SWAps.*

There are no Norwegian NGOs directly involved in the health SWAp. All the Norwegian organisations are supported directly from NORAD in Oslo (with approx. 50 mill. NOK each year). All the Norwegian organisations are working with and through local partners – also with health projects. A review will soon be carried out by NORAD of all the Norwegian NGOs and their partners

- *International NGOs are still the dominant technical and financial supporters of national CSOs.*

Partly confirmed. We do not have figures to make a comparison, but assume that the direct support from bi- and multilateral organisations to Ugandan NGOs is higher than their support from international NGOs. With the increased funding from Government and even use of international consulting firms, there needs to be a new discussion of the potential added value of international NGOs as funders of local NGOs. What counterparts or funders are best equipped to build civil society in Uganda: international NGOs or bi-/multilateral donors in collaboration with private sector firms? Or the Government?

- *There is no forum and few mechanism through which Norwegian CSOs can take part in SWAps*

This is confirmed. Norwegian NGOs have not been involved in a discussion of Norwegian health sector support to Uganda, but there are mechanisms to use for such discussions.

- *There has been a tendency in NORAD to view Norwegian NGOs mainly as service providers in relation to SWAps.*

Not possible to confirm.

5.5. Potential for Stronger CSO Involvement in SWAp

The study was also asked to assess the "potential, promising and realistic approaches for the strengthening of participation of civil society at local and national levels in sector programmes".

The following are observations and recommendations which have emerged through the study process:

- The CSO involvement in the health sector programme in Uganda – in both the formulation and implementation has been extensive and commendable. Some CSOs invited themselves to negotiations and have as a result increased their influence and resources.

- But the participation is skewed and to a large extent limited to the large and well-organised medical bureaux of the faith-based organisations and also to their representatives at national level.

- The partnership between Government and civil society is in the process of being formalised at policy level and MOH remains a supporter of increased public-private collaboration. Government funding of CSOs is more often questioned at district level and among some politicians than by central ministries.

- There is a need to:
  (a) Speed up the involvement of the non-facility based NGOs and finalise the policy document also with this group of organisations.
  (b) Initiate a process where also district level NGOs and community based organisations can be brought into the partnership with Government. The same is true for stakeholders in traditional medicine.
  (c) The medical bureaux must be provided sufficient resources to play a role as mediators between their members and the Government.
  (d) The roles of CSOs in health care needs to be discussed more at district and political level. Government funding of CSOs is currently negotiated centrally and forwarded to districts as conditional grants. It is most likely that CSOs in the near future will have to negotiate with district councils for funding of primary health care and health facilities.

- CSOs have played roles in the health SWAp, but relatively few roles. The major roles have been as contributors to policy discussions and formulation of the health programme. Their participation in implementing the programme has been more limited – and concentrated to a few NGOs – in particular faith based organisations. The funding has increased significantly over the last two to three years, but the amounts are still proportionally small.

- CSOs are mainly invited and involved in the health sector programme as service providers – partly through subsidies to health facilities run by NGOs and partly through sub-contracting. The latter still happens at a limited scale. CSOs have not played major roles as advocates or watchdogs or in monitoring and evaluation of the implementation and performance of the health programme. Neither have CSOs played any significant role as innovators – introducing new concepts and promising new initiatives. NGO health care fills important gaps in Government capacity to deliver services, but provide few alternative and innovative approaches.

- There is a need to address the issue of stronger CSO involvement in monitoring and evaluation of sector performance. The typical service providers may not be well equipped to perform such functions and could also experience conflicts of interests – in districts where they are implementing programmes. More specialised NGOs should be encouraged and supported to perform M&E functions. The systems and tools developed by the Uganda Debt Network for poverty monitoring seem to have potential for wider application.

- There is considerable donor interest for civil society and funding of civil society organisations – increasingly at district level and in Northern and Western parts of

the country. Major donors like USAID and EU are working on new programmes which will provide NGOs with new opportunities for substantial funding. There is also a current trend among donors of the health sector programme to decrease direct funding of international and national NGOs – with the argument that NGOs should in the future be funded by the Government through the sector programme. Donors have also introduced a distinction between service delivery and advocacy – and are increasingly supporting and funding CSOs mainly in their advocacy roles – and in particular those CSOs working on human rights, democracy and governance issues.

- Civil society in Uganda is much stronger and more vibrant than in most other countries in the region, but its capacity is still limited. Of the 3500 registered NGOs it is said that only a few (3 to 500) are able to receive donor funds and implement programmes – and the few strong and successful NGOs tend to be over-funded. We did not observe any formal coordination and communication mechanisms among donors for support to civil society. Maybe time has come to discuss and establish a "civil society SWAp" to prepare for a more strategic and systematic support.

- It is a positive development that national CSOs are able to access funds directly from their own Government and get used to Government rules and procedures. We are, however, of the opinion that direct support from donors and international NGOs should be maintained as a matter of principle – but possibly at reduced levels. In a situation with extreme constraints and demands on public resources, Government funding of CSO will most likely be limited. CSO capacity for sub-contracting is also inadequate and too much public funding may easily jeopardise CSO's independence and autonomy – and their ability to represent a critical voice. Most African Governments tend still to be sceptical towards their own critics.

  As such, donors should maintain a parallel system of funding CSOs – through sector programmes and directly. We also believe that international NGOs are important partners for Ugandan CSOs – not only as financiers, but also technically and morally. International networks provide a certain level of security and a channel of communication for national NGOs. The added value of international partnership is not a given, however – and there is a lot of rhetoric from international NGOs and the organisations they are supporting. On the other hand, donors should not rule out such added value as a matter of principle (as seems to be the case for donors like Dfid and USAID).

- The distinction introduced by donors between service delivery and advocacy is too rigid. Most large NGOs combine service delivery and advocacy and it is not necessarily so that service delivery rule out or reduce advocacy. It is true that direct Government funding to service delivery leads to a collaborative – and not a confrontational strategy towards. But grounding in practical experience and exposure to injustice and violation of rights at community level provide NGOs also with evidence and motivation for speaking up – or encouragement to let others speak up on their behalf. Evidence based advocacy tend to have higher credibility and potential impact in Government circles. In brief, donors should rethink their policies on the service delivery – advocacy dichotomy.

Annex 1: Mandate

Purpose
The purpose of the country studies is:

(a) To review the roles of civil society organisations in selected sector programmes – in particular in relation to roles played by CSO, analysis of opportunities and constraints, and results achieved.
(b) Provide advise and recommendations to NORAD, Embassies and Norwegian NGO on how to improve the interaction between social sector SWAps and civil society.

The country studies will be used to discuss the relevance and validity of the issues and questions developed in Chapter 4 in this report. The entry point is the interface between national CSOs and sector programmes. Within this context we will also review the roles played and contributions made by Norwegian NGOs.

In countries where NORAD has undertaken a study on Norwegian support to Civil Society, the insights from these studies should be linked to the studies proposed here.

Questions for the Case Studies
1. What are the characteristics of CSOs in the social sector in the respective countries and who are the key players?
2. Who are funding CSOs and what is the role of Norwegian organisations?
3. What are Government policies and practices vis-à-vis civil society?
4. What is the background for and scope of SWAps in the country?

Assessment of CSO Roles
1. What is the level of involvement of CSOs in the formulation and implementation of SWAps in the country?
    - There has been an increasing involvement of CSOs in SWAps, but originally the involvement was marginal and CSOs contributions were not recognised as important.
    - The new generation SWAps have moved towards a redefinition of the state – providing a framework for enabling interventions by a variety of actors.
    - Interactions between Government and CSOs is still limited and strained by mutual scepticism and reluctance.
    - Policies of stronger public/private partnerships are still more aspirational than providing clear and realistic guidelines.

2. What CSOs were asked to take part and why?
    - Participation is first and foremost based on invitation from Government.
    - Controversial advocacy organisations tend not to be invited by the Government to discuss SWAps.
    - The basis on which involvement from CSOs take place is unclear.

3. What roles have CSOs played and how have they played those roles?

(c) As contributors to policy discussion and formulation:
- The involvement of CSOs as contributors to policy discussion is on the increase, especially at national level.
- Sectoral policy documents make limited reference to the involvement of civil society.
- Policy formulation is still extremely centralised.
- Consultations have tended to be strongest at the development stage of a SWAp and fade away once the programme gets underway.
- CSOs lack the capacity and skill to take part in policy discussions.
- There is limited capacity in Governments to interface with the private sector.

(d) As advocates and lobbyists:
- Governments are uncomfortable with CSOs in their roles as advocates and watchdogs and reluctant to accept the legitimacy of an oppositional "voice".
- Civil society is fragmented with competing networks and umbrella organisations.
- There is no common CSO voice and national networks are weak or absent.

(e) As service deliverers (operators):
- CSOs are mainly being invited and involved in SWAps as service providers – sub contracted by national or district authorities.
- Service delivery and rights based CSOs are perceived as antipodes while the relationships between service delivery and rights based programming remain unclear and underdefined.
- CSOs are seen to have comparative advantages in providing services to marginalised and hard to reach groups in ways Government cannot.
- CSOs involved in service delivery have often higher legitimacy as lobbyists and impact on policy processes than CSOs only doing advocacy.

(f) As monitors (watchdog) of rights and for particular interests:
- The Government is not willing to open up for systematic review and impact analysis of SWAps from field based CSOs.
- The Government is not willing to invite to discussions or fund their own critics.

(g) As innovators introducing new concepts and initiatives:
- There is little evidence that CSOs contribute to SWAps as innovators – introducing innovative concepts and initiatives.

(h) As financiers:
- CSOs play a marginal role as financiers of SWAps.
- CSOs are part of national sector policy, but funds do not flow through the Government budget.

- CSOs are increasingly funded directly by the government through contractual arrangements.

Effects of the SWAps

1. To what extent and how are CSOs funded as part of the SWAp?

   - The funding of CSOs through SWAps is limited.
   - International CSOs and bilateral donors remain the donors of national CSOs.
   - Local CSOs meet several barriers in accessing funds from the Government.
   - The Government wants to maintain control and dominate CSOs.
   - Cash strapped districts are reluctant to release funds for CSO activities.

2. Have SWAps supported or delayed ongoing decentralisation efforts in the country?

   - Decentralisation have challenged the monopoly of a top-down Ministry approach and opened up for stronger CSO involvement.
   - CSO involvement has provided support for a multi-sectoral response.
   - Mostly national CSOs are involved in SWAps.
   - If district- and community based CSOs are involved in SWAps, it is the role as service providers.

3. Have Norwegian/international organisations been involved and how are they affected?

- Few Norwegian CSOs are involved in SWAps.
- International NGOs are still the dominant technical and financial supporters of national CSOs.
- There is no forum and few mechanism through which Norwegian CSOs can take part in SWAps.
- There has been a tendency in NORAD to view Norwegian NGOs mainly as service providers in relation to SWAps.

4. What are potential, promising and realistic approaches to strengthening the participation of civil society at local and national level in sector programmes?

- What are the potential roles of formal and informal groups?
- Which groups/organisations have capacity and skills to a more active involvement?
- What are the most relevant area of involvement?

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Annex 3: People Met

Aina Bergstrøm, Resident Coordinator, Save the Children, Norway
Augustine M. Muserero, Programme Officer, Uganda Debt Network
Christoffer Ssëngedo, Uganda Community Based Health Coordinating Association
Daniel Giusti, Executive Secretary, Uganda Catholic Medical Bureau
Dr. Alex G. Coutinho, Chief Executive Officer, TASO
Dr. Islam Ndifuna, Executive Secretary, Moslem Medical Bureau
Dr. Juliet E. Bataringaya-Wavamunno, Technical Assistant, Health Planning Department, Ministry of Health
Dr. Kirunga, Ministry of Health
Filippo Curtale, Technical Adviser, PPPHR.
George Bagambisa, Assistant Commissioner Planning
Kato Ahmed, Accountant, Uganda Private Midwife's Association
Olive Bwanika, Norwegian Embassy
Randi Lotsberg, Second Secretary Development, Norwegian Embassy
Robert Cunnane, Chief, Health, HIV/AIDS and Education Office, USAID
Ros-Mari Båløw, Senior Adviser social affairs, Swedish Embassy
Sabati, Head of Administration, Uganda Protestant Medical Bureau
Sandra Erickson, Independent Consultant
Tom Kityo, Resource Mobilisation Officer, TASO
Tore Gjøs, Ambassador, Norwegian Embassy

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04	5	SWAps and Civil Society – The roles of Civil Society Organisastions in Uganda's Health Sector Programme	Discussion
04	6	SWAps and Civil Society – The roles of Civil Society Organisastions in the Health Sector in Mozambique	Discussion

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NORAD's Information Centre
P.B. 8034 Dep.
N-0030 Oslo
Norway

Tel: +47 22 24 20 60
Fax: +47 22 24 20 66
informasjonssenteret@norad.no

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