2011:4 Sida Review

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Final Report

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Sida Review 2011:4

Commissioned by Embassy of Sweden in Uganda

Date of final report: November 2011

Published by Citat

Art. no. Sida61456en

URN:NBN urn:nbn:se:sida-61456en

This publication can be downloaded from: http://www.sida.se/publications

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Evaluation of Swedish Health Sector Programme Support in Uganda 2000-2010

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Acronyms and Abbreviations

AHSPR	Annual Health Sector Performance Report
AMREF	African Medical and Research Foundation
BEmOC	Basic Emergency Obstetric Care
BTC	Belgian Technical Co-operation
CEmOC	Comprehensive Emergency Obstetric Care
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
CYP	Couple Years of Protection
DFID	Department for International Development (UK)
DHO	District Health Officer
DP	Development Partner/s
EmOC	Emergency Obstetric Care
GAPR	Government Annual Performance Report
GAVI	GAVI Alliance (formerly Global Alliance for Vaccines and Immunisation)
GBS	General Budget Support
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GoU	Government of Uganda
HDP	Health Development Partner/s
HPAC	Health Policy Advisory Committee
HPDG	Health Partners' Development Group
HRH	Human Resources for Health
HSS	Health Systems' Strengthening
HSSIP	Health Sector Strategic & Investment Plan (GoU) 2010/11-2014/15
HSSP	Health Sector Strategic Plan (GoU): HSSP I 2000/1-2004/5 & HSSP II 2005/6-2009/10
IMR	Infant Mortality Rate
JAF	Joint Assessment Framework
JBSF	Joint Budget Support Framework
JRM	Joint Review Mission
KII	Key Informant Interview
LSA	Local Service Agreement
LSTM	Liverpool School of Tropical Medicine (UK)
LTIA	Long-term Institutional Arrangement (GFATM)
MDG	Millennium Development Goal
MH	Maternal Health
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal and Neonatal Health
MoFPED	Ministry of Finance, Planning & Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Medium-term Expenditure Framework
MTR	Mid-term Review
NDP	(Uganda) National Development Plan 2010/11-2014/15 (the successor to PEAP)
NMR	Neonatal Mortality Rate
ODI	Overseas' Development Institute (UK)
OECD-DAC	Organization for Economic Co-operation and Development - Development Assistance Committee

PEAP	Poverty Eradication Action Plan (2004/5-2007/8; extended to end June 2010)
PEPFAR	President's Emergency Program for AIDS Relief
PER	Public Expenditure Review
PNFP	Private Not For Profit (health service providers, e.g. Catholic, Protestant & Muslim Medical Bureaux)
PPFP	Public-Private Partnership for Health
QA	Quality Assurance
SEK	Swedish Krona
SIDA	Swedish International Development Co-operation Agency
SPS	Sector Programme Support
SRH & R	Sexual & Reproductive Health & Rights
SWAp	Sector-wide Approach
TA	Technical Assistance
TASO	The AIDS Support Organization
TFR	Total Fertility Rate
TOC	Theory of Change
ToR	Terms of Reference
UGX	Uganda Shilling
UNFPA	United Nations Population Fund
UNHCO	Uganda National Health Consumers' Organization
UNMHCP	Uganda National Minimum Health Care Package
USAID	United States Agency for International Development
WHO	World Health Organization

Acknowledgements

The evaluation team would like to thank all those who gave their time to participate in interviews and to provide information and documentation in support of the assignment, in both Uganda and Sweden.

Members of the team met many representatives of the Ugandan Ministry of Health and would particularly like to thank the Permanent Secretary for facilitating those meetings and the visit to the health department in Iganga District. Individual members of staff were helpful and informative. The team also wishes to express its thanks to all those health workers and civil servants whom we met in Iganga.

The team had meetings at the Ministry of Finance, Economic Planning and Development, as well as with representatives from the UK Department for International Development (DFID), the US Agency for International Development (USAID), the Belgian Development Agency (BTC), Italian Co-operation, the European Union (EU), the World Bank, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Health Organization (WHO) and representatives of civil society organizations.

Staff members at the Swedish Embassy in Kampala, in particular the Sida Health Adviser, were welcoming, supportive and provided valuable insights. Members of the team also met Sida staff members in Sweden with previous experience of working in Uganda.

Jessica Rothman and Dr Ian Christoplos provided support and quality assurance throughout the entire evaluation process.

Draft report meetings were held in Stockholm on 26th October 2011 and in Kampala on the 31st; a presentation was also made at the Swedish Embassy in Kampala on 10th November. Comments and points raised, for which the evaluation team members are grateful, have been included in this final report. The draft report (submitted on 2nd November) was reviewed by Sida, with comments received on the 16th. This report represents the final document on the evaluation. A final presentation will be conducted at Sida in Stockholm on 8th December.

1. EXECUTIVE SUMMARY

1. BACKGROUND TO THE EVALUATION

The Terms of Reference (ToR) state that: 'The evaluation will review the health sector performance over the time period 2000-2010 and assess whether Sweden has added value to the overall pool of external resources going to the health sector. [The evaluation will seek] to determine if the sector programme support (SPS) modality, as used by Sweden, is relevant, effective, efficient and sustainable in reaching the health sector goals set out in the country cooperation strategy for Uganda 2009-2013 and beyond.'

The objectives of the evaluation have been threefold: to examine the historical perspective of Swedish support to the health sector between 2000 and 2010; to consider the current (2011) situation in terms of overall health indicators and sector performance and results; and to look forward, to provide rationale and recommendations as to future modalities, i.e. whether to continue with the current mix of sector budget support (SBS) and project support, or entirely or partially to apply other approaches. Furthermore, a total of twenty-one ToR questions and three additional issues have been addressed.

2. METHODOLOGY

The evaluation applies a results and performance evaluation approach. This approach allows attention to outputs, outcomes, results and (to a lesser extent) impacts. This report primarily considers descriptive and normative questions: what Swedish SBS to health has achieved, how it may be valued and whether expected and planned results were/are being achieved. The evaluation methodology focused on key informant interviews and review of relevant documents (both specific to Uganda and from an international perspective). Core questions were developed for both Kampala and Iganga District interviews; these provided the common basis for all meetings. Members of the evaluation team expanded on the core questions where appropriate.

This final report incorporates discussion points from the meetings held in Stockholm and Kampala on 27th and 31st October and 10th November, and addresses comments received from Sida on 16th November.

3. LIMITATIONS OF THE EVALUATION

One significant limitation of the evaluation is the fact that it covers a decade of Swedish SBS support to health, from 2000 to 2010. Therefore, the team has found inevitable gaps in individual and institutional memory and in documentation. Another limitation is the delay in publication of the 2010 Uganda Demographic and Health Survey (the UDHS), which will provide the most comprehensive data set for assessing performance in health indicators since 2006.

Because the ethos of the sector-wide approach (SWAp) - and latterly the Paris Declaration- focuses on joint support and an absence of national 'flag waving', tracking attribution specific to Swedish or other donors' inputs has been found to be difficult. The same is true with regard to a close evaluation of the degree to which Swedish inputs have promoted additionality. Aid architecture has changed considerably over the decade under evaluation, e.g. with the increasing focus on the Paris Declaration principles, the creation of global vertical programmes such as the Global Fund to fight AIDS, TB and Malaria (GFATM) and the President's Emergency Program for AIDS Relief (PEPFAR) and indeed the shifting focus of Swedish international development assistance priorities. Moreover, the national Ugandan health sector has seen alteration, e.g. decentralization and corruption and governance challenges. All such factors have provided challenges in terms of coherent narrative and longitudinal perspectives.

4. THE HISTORICAL PERSPECTIVE: SWEDISH HEALTH SBS

Key findings:

- Swedish financial support has been significant, with its SBS contributions representing an average of between 5 and 10 % of the entire Ugandan health budget between 2000 and 2010
- Sweden's commitment to the SBS modality through the SWAp mechanism is viewed with respect. Such commitment is viewed by government and development partner stakeholders as having allowed Sweden to participate in policy dialogue

- Sweden has twice been Chair and Co-Chair of the Health Development Partners' Group (the HDPG), a key forum for debate and sector oversight
- Sweden's support through SBS has been highly relevant in the context of OECD-DAC's definition of coherence with beneficiaries' requirements, country needs and partners' and donors' policies
- Sweden's proven commitment has allowed it to promote attention to even difficult issues such as sexual and reproductive health rights and overall health rights. Such activities represent measures of effectiveness and relevance
- Sweden's sustained support to issues of access to contraception and other sexual and reproductive health (SRH) services can be considered to represent potential for long-term benefit
- Swedish support to SBS has broadly scored well in terms of efficiency, effectiveness, relevance, sustainability and appropriateness specific to internal management and focus. External factors and influences have had impacts beyond Swedish control
- Swedish support to health SBS has additionally been found to have comparative advantage through its championing of its priority issues and has added value, e.g. through dedicated support to country ownership and the SWAp mechanism, including more recently when wider commitment has altered
- However, while both Sweden's support to SBS and the SWAp and its own administrative functions have been efficient and effective, impact has been challenged by health system and wider structural public administration
- Recent positive developments, e.g. new senior management at the Ministry of Health and the return of DFID to health SBS, represent opportunities for renewed attention to efficiency and effectiveness.

5. HEALTH SECTOR PERFORMANCE AND RESULTS

Consideration of overall health sector performance in this report includes attention to the development of health sector policy instruments, the (partial) decentralization of health service delivery and inefficiencies in the health sector, including budget allocations and Human Resources for Health (HRH) structures. The current development partner assessment of health sector performance as poor or modest is also addressed. Health sector funding is also reviewed.

Key findings:

- Uganda has made progress in the health sector, most significantly between 2000 and 2005/06. During this time, there was a focus on decentralization and on resources reaching the lower levels of the system:
    - The maternal mortality ratio reduced from 505 to 435 and the infant mortality rate from 88 to 76
    - New out-patient attendance improved from 0.60 visits per capita in Financial Year (FY) 2001/02 to 0.80 visits per capita in FY 2008/09
    - Deliveries in health facilities increased from 23% in FY 2001/02 to 40% in 2007/08
- Such advances have not always been maintained or moved forward at the same rate. One of the most compelling reasons is the 3.2% per annum population growth. The population has increased from 24.2 million in 2002 to an estimated 34.6 million in 2011; close to half of all Ugandans are aged 15 and under
- It can be argued that for core health indicators to remain static or to experience only very modest improvements, can be seen as a relative achievement
- Shortages of health workers, inadequate health infrastructure and equipment, inefficiency in the sector, and inadequate research have all affected service delivery at all levels
- The current core development partner indicators are those in the Joint Assessment Framework; there is an opinion (e.g. voiced by DFID) that these are valid but with unrealistic targets.

6. FINDINGS AND CHALLENGES (LINKED TO THE ToR QUESTIONS)

- See 4 and 5 above, sections 3 and 4 in the report for discussion and especially Annex 4 for detailed consideration of overall health outcomes and impacts 2000-2010
- Key points emerging from the two ToR questions specific to Swedish support to both SBS and more widely are that its contributions have had positive impacts on accountability, financial management and movement towards greater understanding of the importance of health rights

- Evaluation findings linked to the set of eleven questions that address SBS and aid modality indicate that application of the SBS modality through the SWAp mechanism has allowed development partners, including Sweden, to have genuine inputs to policy dialogue
- This was especially true in the years (ca. 2000-2004/5) when the SWAp was supported by many donors and represented a coherent and powerful joint voice
- The extent to which SBS has contributed to increased improvements in public health spending has changed over time: the early years of SBS are widely deemed to have been generally efficient, including in terms of resource allocation and disbursement arrangements
- The 2008 Health Sector Strategic Plan II Mid-term Review discusses the decline in the overall health sector performance and the reduced role of the SWAp in terms of overall efficiency and improvements and effective disbursement mechanisms
- Regarding whether the SBS modality *per se* (and within that the Swedish contribution) has had an impact on issues of transparency, accountability and wider corruption: findings suggest a degree of positive input, in an often challenging environment (e.g. the corruption linked to GFATM and GAVI - formerly the Global Alliance for Vaccines and Immunization; now the GAVI Alliance)

- A further set of questions addresses issues of multiple funding modalities, the advent of vertical global funding and the relative strength of Swedish leverage within this changing aid environment
- The challenges inherent in increased off-budget funding, as well as much expanded focus on specific diseases, and the distortions of these approaches, have all placed much strain on the health sector at central and district levels, and on managers and service providers
- SBS as a modality (i.e. distinct from its relative financial inputs, which are currently modest as part of the overall on and off-budget funding) is viewed extremely positively by the Ugandan Ministry of Health (MoH), as it allows a degree of oversight and control
- Adherence to Paris Declaration principles can best be described as patchy; while a number of partners describe positive recent trends, e.g. greater harmonization and alignment, others that mutual accountability is in fact limited and that a number of partners reduce such explicit commitment should clear results not be forthcoming
- Swedish leverage is considered to be significant, because of its consistent support to SBS, its principled support to often difficult issues (e.g. adolescent sexual and reproductive health) and its focus on accountability, e.g. through Technical Assistance to financial management

- A final question requests attention to how coherent the findings of this evaluation are with the phase I and II Paris Declaration Uganda reviews
    - In summary, it can be stated that there is coherence regarding the findings of the three studies. Thus, broadly, the Phase I review provides a generally positive assessment up to 2006, while the Phase II review paints a more sober and less results and outcome-oriented picture.

7. LOOKING FORWARD AND RECOMMENDATIONS

- An over-arching recommendation is that there should be genuine, careful transparent transition planning and application of change management processes should Sweden exit from SBS, or reduce such commitments
- A further general recommendation is to ensure that there be more frequent evaluations of Swedish support in the future; this assignment has inevitably found gaps in institutional memory and incomplete documentation, which may well mean that all lessons learned and best practices have not been recorded.

Potential modalities for Swedish support

1. Continuing with the SBS modality

- Sweden should continue to allocate a proportion of its health support to SBS
- Sweden has developed deep-rooted, much admired and respected support to SBS since 2000

- The general consensus of evaluation respondents from all categories (public sector, development partners and non-state actors) is that Sweden's departure from SBS would herald the general collapse of the modality
    - One, among many potential repercussions, would be the closing of a channel for direct, honest, open debate with government, including the discussion of difficult and otherwise minimally supported health issues, e.g. SRH & Rights (SRH&R)
- Sweden's commitment to the Paris Declaration principles and Accra Agenda objectives is well-known; SBS and the SWAp mechanism represent the clearest and most coherent link to these principles and objectives
- The recent major study of SBS led by the Overseas' Development Institute and Mokoro broadly recommends continued emphasis on and support to the SBS modality. This recommendation is balanced by another: that all such support needs to ensure greater attention to implementation and results, and a better balancing of action on outcomes vis-à-vis process.
- Many years, and much effort, have been invested in trying to get development partners to support and strengthen Ugandan government health systems through SBS. If these do not deliver, the options seem to be either to stay and try to improve the system while sending a political signal (possibly through reduced funding), or to find other existing mechanisms as vehicles for support already aligned in the sector programme
- In this context there may be an argument for reducing SBS support as a proportion of overall Swedish health funding to Uganda, i.e. transferring a proportion of those funds to other modalities.

2. A less aligned form of sector programme support, such as a World Bank trust fund or a donor pool

- This modality is considered by a minority of development partners to have the potential to offer opportunities for Sweden to target specific health inputs, e.g. support to alleviate the current challenging HRH situation
    - However, overall perceptions are lukewarm at best
- Thus if such an option were considered, it would be essential to develop resource management systems, performance-based contracting/management, Memorandum of Understanding (MoU) and other instruments in partnership with the GoU and the MoH
- It would also be imperative to ring fence activities in such a way that they not only complemented the current Health Sector Strategic & Investment Plan (HSSIP) and existing sector support, but are genuinely coherent with HSSIP Monitoring & Evaluation (M&E) systems, with robust mechanisms for lessons learned and best practices to inform the overall health sector
- An alternative version of this type of support could be earmarking support to certain activities within the HSSIP. This would guarantee implementation, or at least funds for implementation, for specific areas that reflect Swedish priorities. However, there is a clear risk that adopting specific sections of the reform strategy would crowd out Government of Uganda (GoU) funding, and thereby GoU long term commitment.

3. Project support to national government, more or less aligned

- This modality has some potential, but would require the tightest possible conditionality and monitoring and evaluation frameworks
- This modality is currently receiving considerable support from development partners in the challenging Ugandan health environment
- Any such support would have to be inextricably linked to the Joint Assessment Framework (JAF) and HSSIP indicators, with tight focus on performance-based process and outcome. It would also have to be genuinely harmonised and aligned with GoU approaches; otherwise the project modality cannot be claimed to be coherent with the ethos and core principles of the Paris Declaration and the Accra Agenda for Action
- Swedish transaction costs would be likely to be substantial.

4. Project support to a local or international NGO

- Project support to non-state actors (primarily civil society organizations/international and local non-governmental organizations (NGOs)) is the other major health development assistance modality currently applied by Sweden in Uganda, in addition to SBS

- This modality (long supported by Sida in Uganda) continues to have potential, but as is the case with project support to national government (see above), it would require continued attention to the tightest possible conditionality and monitoring and evaluation frameworks
- Care would have to be taken to continue to ensure that any such support would be able to provide strategic input to existing Swedish priority areas, e.g. health rights, rather than seeking to support more general service delivery
- As is the case with other types of project support, any new such interventions would also have to be genuinely harmonised and aligned with GoU approaches so far as is practicable and appropriate.

Modalities not recommended

The following modalities are listed in the ToR and have been addressed in the evaluation; they are not recommended for further consideration by Sweden in its support to the health sector in Uganda.

- General Budget Support
- Programme support to local government
- Project support to local government
- (Additional) support to a global vertical health fund active in Uganda

An additional potential modality: PNFP programme support

- This represents a potential modality not listed in the ToR. Discussion here as to its inclusion represents a contribution to the debate over future Swedish support
- An on-budget and more directly earmarked support to Private not for Profit (PNFP) providers may have the potential to accelerate positive progress and performance
    - PNFP health service providers represent major actors in the Ugandan context; they deliver health services in remote, challenging and under-resourced parts of Uganda, where health needs are great. PNFPs are adversely affected by current budget allocation processes. There is opportunity to co-ordinate health services provided by district and PNFP facilities. PNFP providers are able to avoid rigid public sector health systems regarding staffing and salary setting (and may experience overall less extreme HRH shortfalls)
- The potential gains from this type of support are that it could strengthen the longer term capacity of the system to make use of existing resources, and that it could relatively quickly (through using already existing PNFP health system structures) be able to increase direct service delivery in Swedish and other health priority areas
- This option has been positively viewed by Uganda-based development partners. One recommendation is that if Sweden were to consider this option it should build in sustainability and scaling-up from the outset, not least so as to avoid project approaches and a short-term focus.

A possible new approach: a 10-year Memorandum of Understanding

This is the vehicle for support applied by DFID in Rwanda (more widely than the health sector). Apparently, one of its objectives is that through dedicated, guaranteed support over a longer time span than is currently applied, a more results-based approach may be applied and stand a greater chance of being achieved. It may be that consideration of a longer funding period than is commonly the case for projects might also allow greater opportunity for a more focused, evidence and performance-based and value for money approach, with tighter linking into country systems and health systems strengthening (HSS) support.

Increased focus on multisectorality

The MoH has expressed its opinion that it is now timely to seek to address inter-related health issues in partnership with other sectors, e.g. education and transport/roads. Thus, for instance, it might be possible for development partners to consider expanded support to in-school health education and initiatives for out-of-school youth, addressing sexual and reproductive health and rights (as is already supported at Naguru by Sweden), or to address impacts of infrastructural developments on HIV infection (e.g. new roadside communities and linked sex work). Such expansion might require a widening of development partners' co-ordination mechanisms and engagement with line ministries.

2. THE SBS EVALUATION: BACKGROUND

2.1 RATIONALE FOR THE EVALUATION

The Terms of Reference (ToR) state that: 'The evaluation will review the health sector performance over the time period 2000-2010 and assess whether Sweden has added value to the overall pool of external resources going to the health sector. [The evaluation will seek] to determine if the sector programme support (SPS) modality, as used by Sweden, is relevant, effective, efficient and sustainable in reaching the health sector goals set out in the country cooperation strategy for Uganda 2009-2013 and beyond.' (Embassy of Sweden, Kampala 2011a – see also Annex 1.)

The evaluation remit is to review Sida Uganda health SPS support as delivered by the Sector Budget Support (SBS) modality through the sector-wide approach (SWAp) mechanism; however, there is consideration in this report of Swedish project support (the other modality applied by Sweden to the health sector during the decade), where such information provides additional insights.

The objectives of the evaluation have been threefold: to examine the historical perspective of Swedish support to the health sector between 2000 and 2010; to consider the current (2011) situation in terms of overall health indicators and sector performance and results; and to look forward, to provide rationale and recommendations as to future modalities, i.e. whether to continue with the current mix of SBS and project support, or entirely or partially to apply other approaches. A total of twenty-one ToR questions have also been addressed.

2.2 METHODOLOGY

The evaluation applies a results and performance evaluation approach (see 4.2 in the Inception Report for full definition and description). This approach allows attention to outputs, outcomes, results and (to a lesser extent where direct attribution is concerned) impacts**.** For a detailed discussion of the challenges inherent in tracking and measuring impact in the context of SBS and the SWAp mechanism, again see the Inception Report. It is relevant to note here that this is a performance evaluation; as such, findings and recommendations do not aim to address the complete longitudinal and higher-level *impacts* of Swedish support. This report primarily considers descriptive and normative questions: what Swedish SBS has achieved, how it may be valued and whether expected and planned results were/are being achieved.

The evaluation methodology focused on key informant interviews and review of relevant documents (see Annex 7 for a full bibliography). Existing national and other data sets and information were reviewed, including health sector Joint Review Mission (JRM) reports, annual reports, mid-term reviews, internal Sida documentation, and national MDG reports. Attention was given throughout fieldwork and draft report writing to the 2010 Sida *Evaluation Guidelines*, the 2010 OECD-DAC *Quality Standards for Development Evaluation* and the Indevelop quality assurance processes. Another core evaluation process approach has been to adhere to Paris Declaration principles and OECD-DAC Guidelines. See section 4 of the Inception Report for detailed discussion of methodology and approach.

Core questions were developed; these provided the common basis for all meetings. See Annex 3, which contains the two sets of core questions; the first set was used in interviews with Ministry of Health and other public sector employees and development partner representatives, while the second was used during the field visit to Iganga District and Key Informant Interviews (see Annex 6 for a schedule of people met). Members of the evaluation team expanded on the core questions where appropriate.

2.3 LIMITATIONS OF THE EVALUATION

A major limitation of the evaluation is the fact that it covers a decade of Swedish SBS support to health, from 2000 to 2010. Therefore, the team has found inevitable gaps in individual and institutional memory and in documentation. These are indicated in the body of the report. For example, a number of the ToR questions (discussed in section 5.1.3 and most fully in Annex 4) require attention to issues beyond the core remit of the evaluation, such as national socio-cultural factors and social determinants of health over time, on which it has only been possible to give brief and general comments.

In addition, the ToR require consideration of changes in the international development environment and Uganda-specific issues that have occurred since 2000. Thus the Paris Declaration, the advent of vertical global programmes such as GFATM and ever-increasing attention to the Millennium Development Goals (MDG) represent approaches, interventions and modalities that cannot solely be reviewed in the context of Sweden's position and support as from 2000; the same is true of the changes in development partners' engagement with SBS as supported through the health SWAp mechanism. The report addresses Sweden's changing responses to both the international environment and Uganda-specific factors.

Another limitation in terms of tracking performance of health indicators is the fact that the 2010 UDHS data has not yet been fully analysed and was not available at the time of the evaluation for public review. Therefore, the most reliable, up-to-date and comprehensive data set with regard to the maternal mortality ratio (MMR), the neonatal mortality rate (NMR), the infant mortality rate (IMR) and other core health indicators is unavailable.

The ToR and subsequent discussion with Sida representatives indicated that the evaluation was not to address Swedish support to HIV & AIDS interventions. This limitation has been observed.

3. THE HISTORICAL PERSPECTIVE

3.1 SWEDISH SUPPORT TO HEALTH SINCE 2000 THROUGH THE SECTOR BUDGET SUPPORT MODALITY

3.1.1 Definitions of Sida support

This report evaluates *sector budget support* to the Ugandan health sector between 2000 and 2010. SBS is defined by Sida as one approach within overall *sector programme support*. The following definitions were provided by the Swedish Embassy in Kampala (see Annex 2 for the full document):

'*Sector Programme Support*: A financial support to a sector programme/SWAp. The support may concern a whole sector/policy area or a part of a sector/policy area. A sector programme support involves a process where several donors make a coordinated financial support to a sector policy and sector plan under the leadership of the partner country. The sector programme support can take the form of

a. *a sector budget support* or
b. a sector programme support where the donor funds are channelled through a pool common for the participating donors.

Sector Budget Support (the example given by Sida is the SBS to the Ugandan health sector): A sector programme support financed by budget support. Sector budget support is a financial contribution to the partner country's budget in order to support the implementation of a country's policy and plan for a sector, part of sector or policy area. When applying sector budget support, the funds are part of the partner country's budget process and managed according to the country's systems and procedures for public financial management, as for general budget support. The difference is that with sector budget support, the conditions, dialogue and the follow-up of results focus mainly on sector-specific issues.' (Sida - not dated).

The evaluation ToR state: 'As the sector support is un-earmarked and part of the SWAp approach and the Paris agenda for aid effectiveness, the SPS funding is integrated with the domestic funding for the health sector. This means that national systems for budgeting, planning, monitoring, reporting and auditing are utilized.' (Embassy of Sweden, Kampala 2011a). In Uganda, SBS health funding is channelled through the Uganda Treasury. It should be noted that SPS is used in a number of the ToR questions (see section 5 and Annex 4); however, it is the SBS modality (as an element of SPS) that is under evaluation.

3.1.2 An overview of all Swedish support to health 2000-2010

Swedish support to the health sector in Uganda during the period 2000 – 2010 has throughout contained two major components: sector budget support and project support to areas identified as key for Swedish targeted efforts.

As can be seen from the table and chart below and from the discussion in 3.1.2, the sector budget support share of total health support increased over the evaluation period.

Project support, which does not form part of this evaluation, has focused on three main areas:

- Policy and Institutional Development: e.g. support to health economics activities, Mbarara-Lund institutional collaboration and policy development
- HIV & AIDS, SRH&R and young people: e.g. support to WHO, support to TASO, Straight Talk, Naguru Teenage Centre and later on in the evaluation period provision also for CSO support to health rights and support to a Civil Society Fund
- Technical Assistance (for further discussion of TA inputs please see below, section 3.1.4).

Sida does not formally monitor its SBS inputs (in line with the harmonization and alignment agenda of the Paris Declaration since 2005, but overall presenting challenges in terms of tracking results and impacts for this evaluation). The Health Sector Strategic Plan (HSSP) I and II indicators (see Annex 3 for full details) have been reported on annually since 2001, in the Annual Health Sector Performance reports. SBS partners have jointly measured and tracked inputs through these indicators. In 2008 the Joint Assistance Framework (the JAF: wider than the health sector) was introduced and agreed by 13 development partners. JAF reporting and tracking of performance against its Matrix are now the basis for Swedish disbursements (see also 4.2.2).

3.1.3 Sida financial inputs

Sweden has provided significant on-budget financial resources through SBS during the implementation of both the HSSP I (2000/1-2004/5) and II (2005/6-2009/10) and continues to do so during the implementation of the Health Sector Strategic and Investment Plan (HSSIP III) 2010/11-2014/15. The OECD reports that between 2006-2008 Sweden represented the 6th largest funding development partner overall to the health sector in Uganda (both on and off-budget).

Table 1: Overview of Swedish financial allocations to the Ugandan Health Sector 2000 – 2010, disbursements and budgeted allocations (planned and actual)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Health sector budget support disbursed	5 223	514	6 432	8 823	8 629	8 808	9 603	5 605	9 150	9 708
Health sector budget support planned	2 158 Average per year for 2000 to 2003			11 046 Average per year for 2004 to 2007				7 343 Average per year for 2008 to 2011		
Other health sector support disbursed	644	1 352	1 514	3 248	3 431	3 024	4 379	3 109	1 538	3 517
Other health support planned	1 838 Average per year for 2000 to 2003			3 452 Average per year for 2004 to 2007				2 797 Average per year for 2008 to 2011		
Health sector % total Swedish support	20%	8%	24%	29%	25%	19%	24%	13%	20%	31%

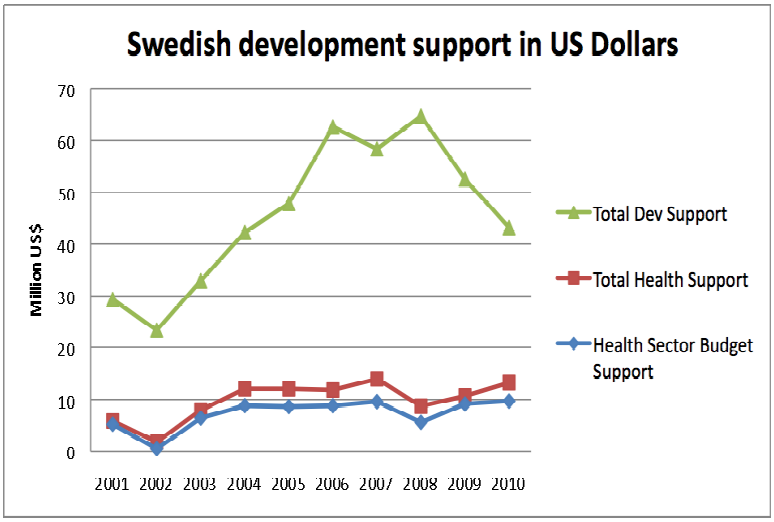
(All amounts shown in USD. USD and average exchange rates per year. Other health sector support includes all health support excluding SBS, e.g. project funding and technical assistance.)

Funding provided by Sweden to health SBS has varied considerably over the evaluation period, but has been approximately equivalent to between 5 and 10 % of the Uganda government health budget, except for the calendar year 2002 when it was considerably smaller. This share is approximate, due to average exchange rates calculations and the fact that the Uganda budget year is not the same as the Swedish. This information could be used - with caution - for an (again approximate) indication of how great a proportion of Ugandan publicly funded health system outcomes and results between 2000 and 2010 can be attributed to Swedish sector budget support, for instance the number of births attended by skilled health workers, reductions in maternal, infant and under-5 mortality and uptake of routine immunisation. This approach would be in line with that applied by a number of other development partners active in the Ugandan health sector.[1]

To provide another demonstration of amounts and trends in Swedish support to the Ugandan health sector between 2000 and 2010:

[1] The evaluation team was told by another major Ugandan health development partner that it has 'solved the attribution problem' by calculating the percentage of the total health budget that it contributes. It then takes 'credit' for an equal percentage of results and outcomes.

Chart 1: Swedish support to the Ugandan health sector (USD) as a proportion of its total development assistance



In addition to the funds described above, Sweden managed Norway's health support to Uganda from 2002 to 2006 (the agreement was signed in December 2001). The 2003 Sida/Swedish Embassy *Assessment Memo* indicates that Sweden would be the channel for 30 million Norwegian Kronor per year for four years, with Norway as a so-called 'silent partner'.

Issues of additionality/'fungibility' [2]

Because of the lack of coherence between schedules for the Uganda budget and Swedish disbursements (Uganda FY 1/7 -30/6 vs. the calendar year for Sweden), it is not possible to make a detailed judgement about additionality of Swedish SBS funding. However, given how the SBS modality works in Uganda, negotiated as it is between the Ministries of Health and Finance, Planning and Economic Development (MoFPED), the link is stated to be 'very weak' between how large the support is, and the amount of additional funds provided to the Uganda health sector. There is also a widespread opinion among key evaluation respondents that there is no expectation of such a link: partly because there is an obvious measurement problem and only proxies can be used, and partly because there is no such formal link, i.e. no requirement that the funds should be additional. This clearly has repercussions in terms of leverage.

These issues have been a topic for Swedish consideration and concern throughout the evaluation period. In the risk analysis that forms part of the 2000 Sida/Swedish Embassy *Assessment Memo*, the paragraph on fungibility states that one of the risks of pooled support is that increased donor funds to health might replace Government of Uganda funds to the sector. The Memo additionally notes that the Ugandan Ministry of Finance had provided a written statement to the Ministry of Health and development partners stating GoU contributions to health would increase over the next three years. At the time this statement was assessed to be sufficient for Sweden – if not as an assurance of additionality then at least as a GoU commitment to health sector funding.

The 2003 Memo again raised the issue of additionality. It was noted that the increased contribution from Sweden should ideally be reflected by an increase in the MTEF ceiling for the health budget. This was discussed by the Swedish Ambassador and the Minister of Finance in May 2003; the Minister expressed the GoU commitment to the sector, but also pointed out the need to look at the totality of resources to all sectors. No agreement was reached on additionality. The debate has since moved on and additionality no longer seems to be a health sector development partner requirement or condition. This is justified from a theoretical perspective, as the SBS ethos entails provision of funding and expectations of results, without prescribing how those results are to be achieved (in line with the Paris Declaration principle of country ownership). However, one major current challenge in the

[2] Additionality in this context is equivalent to fungibility, i.e. when donor funds replace government funds. We have preferred to use additionality, because it seems to be the currently most applied term in development dialogue. Additionality is sometimes also described as 'an absence of crowding out' of funds.

health sector is that targets may be set unrealistically high; they are seldom achieved. There is a risk of a vicious cycle as Ministries are encouraged to set high targets to justify a greater allocation from the MoFPED. Thus if the MoH sets what may be realistic targets that are perceived within wider GoU circles as (too) low, there is a risk of this approach being interpreted as the MoH having too modest ambitions; this could lead to funding cuts. There are additional challenges in terms of indicator levels: most health indicators are currently more outcome/impact than output oriented, which can result in short-term difficulties in terms of achieving targets. See also section 4.1.3 for discussion of the health sector M&E indicator package. The MoH is hampered in its efforts to address these high-level indicators, due to the ineffectiveness of the public finance system.

3.1.4 Policy dialogue/advocacy

The *Assessment Memoranda* from 2000, 2003 and 2008 form the basis for the allocation decisions of Swedish support to the Uganda health sector programme through sector budget support. They contain – or should contain – the policy and advocacy issues that Sweden was to pursue in the sector dialogue during the period under evaluation.

The *Assessment Memo* for 2000-2003 did not spell out any specific dialogue issues. Rather it highlighted areas of weaknesses in the overall health system and in the HSSP I and indicated where technical support would be used to strengthen the health system, for example in issues around gender and youth. This Memo also highlighted the limited Embassy capacity to participate in dialogue on the Poverty Action Fund (the modality for support), as well as within the health sector, as a potential risk/weakness. There was then only a part-time Health Adviser in the Embassy and no full-time Embassy economist. The need to strengthen Embassy capacity was identified and it was suggested that a National Programme Officer for health be recruited by the Embassy.

The *Assessment Memo* for the period 2003 – 2007 specifically mentions the need to raise issues of gender in health policy dialogue. Other Swedish priority areas in sector dialogue were fungibility of funds as well as resource allocation to different sub-sectors or levels within the health sector (the proportion of resources going to districts vs. higher levels, etc.).

The 2008 *Assessment Memo* [3] is the only one to contains a separate paragraph discussing explicit policy dialogue from a Swedish perspective. It spells out that Sweden would "… *focus its attention on promoting:*

- *Further harmonization and alignment of all development partners in the sector, i.e. promote the SWAp arrangement and increased aid effectiveness.*
- *Increased focus on service delivery results and improved management for results.*
- *Issues related to planning, budgeting and sector financing.*

Key dialogue issues, at all levels, would be:

- *Sexual and Reproductive Health and Rights and HIV & AIDS prevention, emphasizing the high population growth, gender equality, and the situation in conflict affected areas.*
- *Human Resources for Health, emphasizing capacity development to mitigate the strains on the health system due to the shortage of health workers.*
- *Improved financial management and control in the health sector, emphasizing overall planning and budgeting, transparency, accountability and effective allocation and use of resources."* [4]

Analysis of the three *Assessment Memoranda* indicates that Sweden/Sida has become more focused on how best to participate in sector dialogue over time. Dialogue issues are more clearly spelled out in the latter part of the period and thus easier to measure and evaluate in terms of outcome. It should be noted, however, that none of the *Assessment Memoranda* discusses the design of an evaluation or foresees the appropriateness of such a review in terms of tracking and assessing Sweden's participation in the SWAp and sector dialogue. Mechanisms

[3] Embassy of Sweden, Kampala 2008. *Support to the Health Sector Strategic Plan (HSSP II) in Uganda 2008 – 2011, Embassy of Sweden, Kampala, 6 June, 2008 (Assessment Memo)*.

[4] Embassy of Sweden, Kampala, 2008. Ibid (p34).

for assessing its support have been entirely reliant on the joint monitoring and evaluation systems in the wider health sector. While this is in line with sector principles and the Paris and Accra Agendas, greater understanding of attribution and impact would be reliant on more frequent, internal evaluations of the effectiveness of Swedish support to health dialogue and its inputs to other health issues. It has become apparent during this evaluation of a decade's Swedish SBS that institutional memory and documentation are incomplete, with the result that it has not been possible to achieve a full overview of process, performance and outcomes and indeed impact of such support.

3.1.5 Technical Assistance

Sweden provided support to Uganda through long-term technical advisers until 2007. There was also an element of institutional collaboration between Ugandan health institutions and Swedish counterparts. No formal evaluation has been undertaken of the relative efficacy of Technical Assistance (TA) in the Ugandan health sector; the decision to end such support appears to have been based on a global re-focusing of Sida to strive towards fewer yet larger contributions and more general attention to new forms of support.

Swedish-funded TA posts with a focus on district systems and financial management were already in place within the MoH at the beginning of the sector programme in 2000, as a continuation of the District Health Services Project, co-funded with the World Bank. In addition, a post was created for a "Young People and Gender Advisor" in 2000. This post was, however, never filled in the MoH but other technical support was subsequently provided through other modes of financing, e.g. through the Bilateral Expert Programme and the Junior Professional Officer programme through the UN system and assistance to relevant NGOs.

TA to the MoH had ongoing focus on strengthening district planning and financial management systems. One of the TA posts addressed an increased focus on health systems from a wider perspective, aiming to strengthen attention to human resources for health, gender and human rights in the Ugandan health sector. It was agreed in 2008 that the Partnership Fund (a fund created to support the sector programme and its structures) would replace TA and that the MoH would start being able to plan for and fund its TA from pooled funds, rather than having individual development partners placing technical support within the Ministry. At the same time, Sida had an ambition to move towards fewer but larger contributions. Hence, Swedish TA funds were transferred to the pooled funding mechanism. However, the specific TA pooled fund did not materialise. Instead Belgium and Sweden decided to support a project within the MoH to strengthen institutional development, leadership and governance structures, with specific reference to regional referral hospitals in two of the regions, so as to improve supervision of lower level health service delivery. This project began in 2011 and Sida is a silent partner with funding delegated to BTC.

3.1.6 Monitoring and Evaluation and Swedish conditions

The 2000 *Assessment Memo* states that Swedish support would be monitored through the jointly established mechanisms in the Sector Programme and through the indicators and targets agreed in the HSSP I. See Annex 3 for tables setting out all HSSP I and II and HSSIP indicators and health trends; these tables highlight changes over time.

The 2003 *Assessment Memo* notes that infant and maternal mortality indicators had not made sufficient progress (see Table 2 below for an overview of trends). Therefore, it suggests that the Swedish support should be monitored – within the framework of the HSSP - with a particular focus on changes in infant and maternal mortality. The Memo states that a realistic level of improvement should be made before mid-2005, and that if no such progress was made, Swedish support to the health sector programme would be reconsidered. A high, medium and low scenario of funding was developed and funds were to be released according to the results in the sector.

The 2008 *Assessment Memo* does not address this type of semi-conditionality on a bilateral basis. Instead, it spells out that Swedish support is governed by the achievements of targets in the Joint Assistance Framework and in the HSSP II, as assessed by the Joint Reviews on an annual basis. Four specific areas are highlighted for Sweden

to track:

- Percentage of Government of Uganda budget allocated to the health sector
- Percentage of deliveries taking place in a health facility
- Couple Year Protection
- Proportion of approved posts filled by health professionals

The discussion in the Memo concludes that Sida will follow these indicators and take action - if needed, jointly with other development partners.

Table 2: Swedish priority health indicators: trends since 2000

Indicator	**2000/1** (UDHS or other)	**2004/5 or 2005/6** (AHSPR/UDHS)	**2009/10** (SUP 2009/AHSPR 2009-10/HSSIP)	**2015 MDG target** (UMDG 2010)
The 4 indicators prioritised in the 2008 Swedish Assessment Memo				
1. % of GoU budget allocated to health sector	7.3%	9.7 (2004/5 AHSPR)	9.6% (HSSIP)	15% (Abuja Declaration)
2. % supervised delivery/ proportion of deliveries in GoU/PNFP HFs	39%	42%	42% (SUP) 33% (AHSPR)	100%
3. CPR	23% (all methods)	23.6% (all)	24% (SUP) (all)	No target
4. Proportion of approved posts filled by health professionals *	40%	75%	54% (HSSIP)	No target
Other key MNCH and SRH & R health indicators				
Total Fertility Rate	6.8	6.7	6.7	No target
Population (growth rate 3.2% pa)	24.2 million (2002)		34.6 million (2011-estimate)	No target
Unmet need for FP (NB: among married women only)	35%	41%	41% (SUP)	No target
Maternal Mortality Ratio (per 100,000 live births)	505	435	435 (SUP; projected)	131
Infant Mortality Rate (per 1,000 live births; deaths < 1 yr)	88	76	76 (SUP; projected)	31

*(Sources: Uganda Demographic & Health Surveys 2000/1 & 2006; Annual Health Sector Performance Reviews; State of Uganda Population report 2009; Health Sector Strategic & Investment Plan III 2010; Uganda Millennium Development Goal Report 2010; * the 2010 Uganda MDG Report states that there are fewer than 2,000 midwives currently in post in Uganda.)*

There has been no formal M&E of the SBS other than through the HSSP I and II and now the HSSIP indicators, which are reported on each year through the Annual Health Sector Performance Reviews (AHSPR). The Joint Budget Assistance Framework (wider than the health sector) was introduced in 2008; thirteen development partners participate in the process, reporting on which forms the basis for Swedish disbursements. Sweden has no independent process of M&E specific to SBS and the SWAp mechanism. A set of process indicators has recently been developed, to be used to monitor donor co-ordination and commitments; these may provide a useful addition to the health system performance indicators.

The current core development partner indicators are those in the Joint Assessment Framework; the DFID opinion is that these are valid but with unrealistic targets. There appears to be an increasing understanding of the need to include lower-level indicators (milestones and what are known in DFID parlance as output-level and/or nested logframe indicators). Attention to this by Sweden is recommended as part of its future modality dialogue.

3.2 EFFICIENCY, EFFECTIVENESS, RELEVANCE, SUSTAINABILITY AND APPROPRIATENESS IN THE CONTEXT OF SWEDISH SUPPORT TO THE HEALTH SECTOR 2000-2010

3.2.1 Efficiency

The OECD-DAC definition of efficiency is: '*A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results*.'

The evaluation shows that Swedish administrative efficiency specific to the SBS modality has been high and consistent. Human resources in health increased over the decade at the Swedish Embassy and were well justified. Based on discussion with evaluation respondents and the evaluation team's expert analysis, SBS appears to be one of the most administratively efficient modalities.

The efficiency of the SBS modality in delivering value for money in the context of service delivery is dependent on the Ugandan health system's capacity and efficiency. Basic health system efficiency indicators show slow progress, e.g. the percentage of births attended by skilled attendants and the relative funding for health centres levels III and IV. The most frequently used allocative efficiency indicator in health systems' assessments, how much is spent on PHC relative to higher level health services, shows slow progress in Uganda (see World Bank 2008). Budgeting and planning systems based on national norm setting appears to be inefficient and ineffective and hampers decentralized budget allocations to district level. The Ugandan health system has (and has had) ample opportunity to improve efficiency. The decentralisation process embarked upon in the early 2000s has not been fully implemented. In fact evaluation respondents (from both development partners and in the public sector) mentioned that at present there appears to be a 're-centralisation' trend in the health sector.

Many such structural inefficiencies and inequities are functions of the public administration system and cannot be changed solely by health sector action or by the conditions or inputs of any one development partner. This finding is in line with that described in the ODI & Mokoro SBS study, which concludes that service delivery efficiency is typically not sector specific, but dependent on how the general public administration system functions (see ODI & Mokoro 2010a and also 2010b-e). See more detailed discussion on the budgeting system and norm setting for HRH in 5.2.6. see also sections 4.1.2, 4.3.2 and 5.1.4 for consideration of other aspects of efficiency.

Despite such challenges, Sweden does appear to have opportunity to continue to work towards the refocusing of attention on efficiency through its support to SBS. This is because of its relatively high leverage in policy dialogue. This can perhaps be enhanced due to the return of DFID, with its UK government-led prioritisation of value for money and results-based support. The health sector M&E Framework and the structure of quarterly financial and performance reporting has only relatively recently been instituted; this provides an opportunity to work towards greater system efficiency, because such regular reporting will allow monitoring of what is functioning – and what is not.

3.2.2 Effectiveness

The OECD-DAC Glossary defines effectiveness as: *'The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance*.'

One conclusion of this evaluation is that Swedish support as provided through the SBS modality has been effective in terms of influencing policy dialogue and intervention priority setting for its core areas, most notably perhaps the rights-based approach to health (see e.g. 3.3.2 for further discussion). Despite its relatively modest financial contributions and compared to larger partners, Sweden has consistently had a high profile in the MoH. Moreover Sweden's voice has been heard with effect in the wider health development partner arena, in part because it has chaired and co-chaired the Health Development Partners' Group (HDPG) twice during the decade.

Swedish support has been successful in contributing to shaping an effective SWAp process and implementing reform in the health sector (Hutton 2004, Jeppson 2004, Örtendahl 2007 plus AHSPRs from 2001 onwards present different and evolving perspectives on the progress or otherwise of the health SWAp). The actual SWAp *process*

continues to function well as a principle, despite many development partners no longer supporting the mechanism and weak management in the MoH for a number of years. Judging from evaluation key informant interviews with other development partners, this environment appears currently to be changing for the better, e.g. with new high-level management at the MoH and the return of DFID to health SBS, to a degree because it deems pre-requisites for effective support have improved. However, the impacts of any such positive trends on the relative effectiveness of service delivery have yet to be seen.

Health sector reforms have slowed in recent years; this limits SBS effectiveness. It is clear that the Ugandan health system experiences serious and varying challenges in translating budget allocations into efficient health service delivery. One reason is apparent lack of prioritisation regarding effective allocation of resources according to local needs. The example of the Iganga District RESCUER project is one example of the lack of absorptive capacity within the GoU at central and lower levels to capitalize on best practices and noteworthy improvements in key health indicators. Thus, notable RESCUER achievements in reducing the MMR could not be sustained once funding ceased. See 6.2.5 below for discussion.

The Swedish experience of the SBS modality being effective in influencing sector policy and (to an extent) prioritisation, while having less consistent success in achieving service delivery results, is also noted as a common limitation of the SBS modality in the major, recent review conducted by ODI and Mokoro (see again ODI & Mokoro 2010a-e). Thus overall ODI and Mokoro SBS findings are that the picture on service delivery outcomes is mixed. The review studied several sectors, including health. While there has been a widespread and significant expansion in the ***quantity of services*** being delivered, there has been ***far more limited overall progress in improving the quality of those services and the equity with which they are delivered*** (including in the health sector). Thus demand-side issues such as quality of care, health rights and equality of access require further prioritisation, as do supply-side attitudes, behaviours and service delivery support mechanisms, e.g. appropriate curricula and supportive supervision structures.

3.2.3 Relevance

The DAC definition of relevance is: "*The extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies.*"

In this sense, Swedish support must be assessed as having been highly relevant. Sida has supported Ugandan national priorities through recommended mechanisms such as SBS and has striven to strengthen sector co-ordination mechanisms through direct interventions for policy development and later through support to the Partnership Fund. Sida's objectives for SBS have not been different from those of the MoH and the GoU and have focused on how Sida can support Uganda to achieve national priorities. Sida has also taken on donor co-ordination roles, which is important in a SWAp. Sida has had the beneficiaries' requirements, country needs and global priorities as well as partner and donor policies at the forefront in all its support phases between 2000 and 2010. Sida has admittedly highlighted for Sweden important dialogue issues - but these have always been consistent with the objectives of the GoU in the respective strategic plans for the health sector.
However, there is one exception to this general assessment of relevance in terms of coherence: drugs and medical supplies and supply chain management. Through the Joint Assistance Framework, it has become a well-established process that each development partner focuses on only a few (normally three) sectors of support in which it has comparative advantage and/or is seen by Uganda as a key partner. Sweden was identified as a key partner in the field of health. In 2010 it was agreed that Sweden would remain in the sector while another partner, Danida, would withdraw.

This process was described by evaluation respondents as transparent and thoroughly discussed, including with GoU representatives. Nonetheless, the view of the evaluation team is the process of disengagement was not sufficiently shared with the MoH; as a result it did not feel informed or consulted. There seems also to have been a misunderstanding of the role of Sida vs. that of Danida. Danida at a technical level and the MoH apparently had the impression that Sida would henceforth lead on priority areas of Danish health sector support in the area of drugs and the supply chain. However, this was never Sida's intention and was not agreed by Sida, as far as the evaluation team can ascertain. This misunderstanding, and (perhaps) insufficient consultations among the

stakeholders prior to the Danida withdrawal, resulted in disappointment on the side of the MoH regarding discontinued support in this important area. A gap persists in technical and financial support in this area; this needs to be jointly addressed by all health sector partners, so as to assess where the greatest comparative advantage lies for providing support in this technical area.

3.2.4 Sustainability

The OECD-DAC definition of sustainability is: '*The continuation of benefits from a development intervention after major development assistance has been completed. The probability of continued long-term benefits. The resilience to risk of the net benefit flows over time*.' See also the discussion in 3.3 and 3.4.

It must be noted that it is challenging to disentangle the sustainability of specific Swedish inputs in the context of SBS through the SWAp mechanism, given its core commitment to movement away from attribution and individual country tracking, emphasised in particular since 2005 and the adoption of the Paris Declaration (see e.g. Örtendahl 2007, the various ODI & Mokoro SBS reports (all 2010) and Pearson 2010). In addition, there are different types of sustainability to be considered, most pertinently that of health outcomes (e.g. improved MMR and IMR) and that of health systems strengthening. It is a simple fact that however effectively and appropriately any SBS partner might support health systems strengthening, its continued effectiveness is ultimately dependent on political will and emphasis: this applies as much in Uganda as elsewhere.

The issue of the counterfactual applies in this context as it does for tracking of impact: without appropriate control groups or structures, it is difficult to measure relative sustainability of interventions (e.g. had Sweden solely supported non-state actor projects between 2000 and 2010, might sustainability of its interventions have been more or less?).

Nonetheless, during the decade under evaluation Sweden has unquestionably sustained the clarity and focus of its support and its position as a core member of SBS and the SWAp. Thus there has been tangible, sustained engagement on policy development, with health partner structures (e.g. through HDPG and the Health Policy Advisory Committee (HPAC)); there has been a deepening prioritisation over time of health issues that might otherwise not have been addressed, or less so (such as SRH&R). A valid and credible point is that had Sweden not supported such health and related accountability issues, it is likely that there would have been less attention and action. For instance, overall health rights (and SRH & R within these) do now have a higher profile in the overall debate; several key informants suggested that it would now be impossible completely to disregard such factors, to return to ignoring people's rights to information and health services. These approaches are now incorporated in the HSSIP, both as expressed in the text describing country policy, and in the developed indicator package, which now much better reflects rights issues (e.g. access distributed across socio-economic groups). This does represent *de facto* sustainability of Swedish efforts, especially if these results from the SBS are seen in the light of the alternatives. Thus, successful health project activities (dependent on external funding) have proved to have post-project sustainability problems. The added value created by the Swedish SBS support can, therefore, be assumed to be relatively sustainable.

In addition, given the current situation with regard to core maternal and child health (MCH) and SRH indicators (see table 2, above and Annex 3), Sweden's sustained support to issues of access to contraception and other SRH services can be considered to represent potential for long-term benefit (however modest that might be, given other challenges beyond Swedish control, e.g. socio-cultural resistance, lack of access to contraception, sexual violence).

3.2.5 Appropriateness

This is defined by Sida as referring firstly to the overall health situation in Uganda, secondly in relation to achievement (or otherwise) of health results and thirdly the relative impact of Swedish support. It must be noted that here too it is challenging to track the appropriateness of Swedish inputs over such a long period of time and in a development environment where such major shifts have occurred as the Paris Declaration, the advent of the International Health Partnership and its Compact, global vertical health programmes and funds such as PEPFAR and GFATM and a gradual move away from the high point of the health SWAp (before 2004/5).

Within these constraints, analysis of Swedish comparative advantage and added value, as well as consideration of its actual inputs since 2000 to the health sector and the high regard in which such support is viewed by GoU, development partner and civil society respondents (including those whose own modalities of support or funding are different), indicate that Swedish support to health has been appropriate.

3.3 SWEDISH COMPARATIVE ADVANTAGE

3.3.1 Overview 2000-2010

This section of the report does not solely refer to Swedish support through the SBS, but to the entirety of its health inputs between 2000 and 2010.

A frequent comment made by evaluation key informants was that 'Sweden punches above its weight'. In other words, and in the view of MoH and development partner stakeholders, Sweden has been demonstrably coherent in its support and approaches over time. This is considered the case despite its relatively modest financial and TA inputs to the sector since 2000, when compared with e.g. USAID, the Global Fund and DFID. The fact that Sida Advisers have twice been Chair and Co-Chair of the HDPG between 2000 and 2010 represents a practical example of the high-level strategic and policy contributions made by Sweden.

From evaluation key informant interviews, it is clear that Sweden has managed to make itself associated with policy dialogue on many of the issues that were initially identified in the three *Assessment Memoranda* (2000, 2003 and 2008) as key from a Swedish perspective for the health sector and linked policy dialogue.

Interviewees from both the MoH and development partners mentioned that Sweden had played an important role as an advocate for:

- Sexual and Reproductive Health and Rights
- Human Rights and health
- Gender
- Accountability and transparency
- Harmonisation and alignment (the Paris and Accra Agendas).

Interviewees did not strongly associate Sweden with action on maternal health. This may be due to the fact that more partners are active in this field. In addition, Sweden was not directly linked to the equity and health dialogue, although this can be associated with the dialogue on human rights to a certain extent.

3.3.2 Sweden's championing of challenging issues

A number of respondents stated that Sweden has championed a number of health and related issues that might not otherwise have received the same degree of attention and eventual support within the health sector. This has continued to be the case despite often slow progress, e.g. on adolescent SRH & R and improvements in the Contraceptive Prevalence Rate (CPR). These issues, almost entirely coherent with those that have received advocacy from Sweden, include:

- Sexual and Reproductive Health and Rights (including the CPR)
- Adolescent SRH & R
- Overall Health Rights
- Public sector accountability, primarily but not exclusively within the MoH

It should be noted that several respondents, including a former Sida Health Adviser, pointed out that these issues evolved over the decade under evaluation. In other words, Sweden did not enter the third millennium with a clear agenda to address all the challenging issues it currently champions. As earlier mentioned, the same has been true of current priority areas (e.g. SRH & R and accountability): focus on these has become more explicit over time and some of the issues were raised as part of the overall dialogue concerning the Country Co-operation Strategy with Uganda, which guides Sweden's development co-operation.

Sexual and Reproductive Health and Rights
Sida is currently the only Development Partner (except UNFPA) said to be providing consistent inputs and support to SRH & R. It has increased focus over time through national instruments, e.g. support to inclusion of CPR as an HSSIP (and JAF) indicator. Through project inputs, Sida has also supported SRH initiatives in post-conflict – in the Internally Displaced Persons' camps and resettlement areas, components often otherwise neglected.

Adolescent SRH & R
A few development partners, CSO and public sector respondents mentioned that, in addition to Sweden supporting the often challenging overall area of SRH & R, it has also championed the highly political and sensitive issues of adolescent SRH & R, including the very contentious issue of abortion and post-abortion care. These are difficult issues to discuss in Uganda and many other development partners have restrictions on their ability to support work in these fields. It was felt that Sweden has raised the profile of these issues and has supported CSOs that can make a difference (a further comment was that much more remains to be achieved in these areas and that Sweden cannot work alone).

One such example of support was funding for the Guttmacher Institute study on unsafe abortion (ca. 2005). Unsafe abortion is all too often brought about by adolescents' (and adults') lack of knowledge of contraception and lack of access to appropriate services and as such clearly linked to Sweden's focus on health rights. The ongoing project support to the *Naguru Teenage Information and Health Centre* represents another important component of Swedish inputs.

Overall health rights
Sweden is currently providing support to the *Voices for Health Rights*' project (managed by the Uganda National Health Users' Consumers' Organization and eight further CSOs): this represents an opportunity for strengthening of the evidence base and attention to Quality Assurance from both the client/patient (demand) side and the health worker (supply) side. The comment was made by both MoH and development partner respondents that the VHR project demonstrates the consistency of Swedish support over time for an increasingly robust, informed and active platform for health rights, that includes civil society actors and voices and does not only work within MoH and other government structures.

Another indication of long-term Sida inputs to promotion and sustaining of health rights is that it supported the CSO Uganda National Health Consumers' Organization (UNHCO) to develop the *Patients' Charter*. Sweden has also funded a Junior Professional Officer position at WHO Uganda, explicitly to work on health and human rights, initially between 2005 and 2007 and again from 2010 onwards. Such activities, of course, also link into health sector accountability.

Public Sector accountability
Sweden has contributed to transparency and accountability in the health sector, e.g. by providing training in financial management, audit development services and advocacy for more robust M&E. Direct attribution is not possible, but the MoH acknowledges the strong Swedish support; Uganda today has the makings of a robust financial and service delivery quarterly reporting structure (despite reporting and disbursement delays and variable quality and completeness of reporting). The MoH releases funds quarterly against the approved budget and an audited expenditure report from the previous quarter. Technical performance reports are also provided quarterly from districts to the MoH. Swedish advocacy has led to specific focus in the HSSIP III on accountability. The inclusion of a Sida-promoted health impact indicator in the HSSIP: *% clients expressing satisfaction with health services (waiting time)* represents progress on addressing issues of health service providers' accountability to demand-side (patient/client) health users.[5]

[5] One comment made by several evaluation respondents was that despite the inclusion of the indicator, much more needs to be done to strengthen accountability mechanisms and to entrench demand-side perspectives in overall Quality of Care activities.

3.4 SWEDISH ADDED VALUE

This discussion as to whether and how Swedish support to health through SBS between 2000 and 2010 has added value to the sector is informed by the views of evaluation respondents working in the MoH, and those of development partners active in health and representatives of civil society organisations. A number of key points were discussed.

3.4.1 Support to GoU ownership

It is clear that Sweden has added value to the health sector in the Sector Programme context through its active participation in, and chairing of, HDPG and other health fora and through sector dialogue with the MoH and other health sector partners. Sida has added value to health sector dialogue through its focus on accountability and transparency; it has assisted both the MoH and development partners with capacity building efforts in this field.

One frequent comment in evaluation interviews with MoH and other GoU respondents was that Sweden has demonstrated its consistency and transparent adherence to principles of country ownership, both before and after the adoption of the Paris Declaration in 2005. This position continues to be appreciated. A number of development partners made similar points.

Thus, Sida has made itself known as a partner that stands by and promotes the 2005 Paris Declaration and the 2008 Accra Agenda actions on harmonisation and alignment. It has impressed on partners, donors as well as government, the importance of adhering to these principles, perhaps more than any other donor in the sector. Such emphasis has obviously grown over time as the international development environment has changed, with its increasing focus on country ownership, etc.

Although these are demonstrably issues close to other development partners' hearts, it can be concluded from evaluation interviews that Sweden has added value in the areas of accountability, transparency, harmonisation and alignment. This has particularly been the case during the latter half of the decade. Many other development partners do not seem to have had similar capacity, ability (and, indeed, perhaps also home country support) to provide such explicit support.

3.4.2 Support to the SWAp mechanism

To reiterate, sector programmes are built on a system where government and donors move from bilateral discussions to sector-wide negotiations with all relevant partners through structures established for that purpose, to solve the problems of the sector, to discuss sector priorities and utilisation of joint resources. It is key to the functionality of a SWAp that the development partners refrain as much as possible from continuing bilateral discussions and missions and use jointly established channels for dialogue.

With this context in mind, it is noteworthy that Sweden has supported the SWAp since its inception in 2000 and remains one of the very few development partners to have maintained such commitment over time. This support is attributable, at least in some part, to the SWAp, despite relatively slow progress after the first few years' noteworthy successes in terms of improvements in health service delivery and core health indicators. The advent of the SWAp coincided with the HSSP I, within the overall framework of the Poverty Eradication Action Plan.

4. HEALTH SECTOR PERFORMANCE AND RESULTS

4.1 OVERVIEW OF THE UGANDAN HEALTH SYSTEM: THE CURRENT SITUATION

As an introduction to this section 4, it must be emphasised that Uganda made noteworthy progress in the health sector, most significantly between 2000 and 2005/06. Thus, the MMR was reduced from 505 to 435 and the IMR from 88 to 76. During this time, there was a focus on decentralisation and on resources reaching the lower levels of the system. New out-patient attendance improved from 0.60 visits per capita in FY 2001/02 to 0.80 visits per capita in FY 2008/09. Similarly, deliveries in health facilities increased from 23% in FY 2001/02 to 40% in 2007/08. As will be seen below, such advances have not always been maintained or moved forward at the same rate for a variety of reasons. One of the most compelling reasons is the 3.2% per annum population growth which has inevitably placed major strains on the health system, not least in terms of access to maternal and child health services and the quality of their delivery.

The publication of the UDHS 2010 will provide the most comprehensive overview of the current state of Ugandans' health and of progress on key indicators.

4.1.1 National instruments and systems

The over-arching policy and strategic framework currently governing the Ugandan health sector is enshrined in the *National Health Policy II* (2010). Central to delivery of the HSSIP (also known as the HSSIP III) and attainment of the sector goal and objectives is the *Uganda National Minimum Health Care Package* (UNMHCP). The core strategies of the UNMHCP are aligned to the Millennium Development Goals; the 2010 National Development Plan (the NDP; a national instrument noted by several respondents as having insufficient social sector focus) includes attention to national programmes, e.g. SRH, child health, HIV, TB, malaria and nutrition.

Evaluation respondents stated that development of the HSSIP was informed by the priorities of the NDP. Lessons learned in HSSP I and II also shaped the HSSIP; while the NHP I and HSSP I and II are said to have aimed at improving health service delivery through health system reform, the HSSIP also has focus on increasing availability of, and access to, quality health services (i.e. potentially a more demand-side oriented approach).

The health system consists of the District Health System (Communities, Village Health Teams, Health Centres II, III and IV). It also includes general hospitals, Regional Referral Hospitals and National Referral Hospitals (levels V, VI and VII). The district health system is further divided into Health Sub-Districts with each supposed to have a referral facility, either an HC IV or general hospital.[6] Private-not-for profit (PNFP) health providers (which in total provide ca. 50% of all services, most notably facilities under the aegis of the Catholic, Protestant and Muslim Medical Bureaux) receive a subsidy from GoU consolidated funds; their relative share of PHC funding has decreased over time. The private wings of public hospitals, PNFP and Private Health Providers are financed through user fees, which were abolished in the public health sector as from 2000; user fees were abolished for first level services in the public sector in March 2001.

In Uganda almost all health services are delivered through primary health care levels I-IV. All four health facility levels play crucial roles in prevention activities, service delivery based on need and health data and actual antenatal, perinatal and postnatal care and neonatal, infant and child health services. The relative priority given to these aspects of SRH and child health in overall health service delivery is *de facto* the main quantitative approximate indicator of the impact Swedish support has had on the functionality of the health system.

4.1.2 Inefficiencies in the health sector

Central to the achievement of health sector objectives is adequacy of human resources for health (HRH). In November 2008, 51% of approved positions at national level were filled in the public health sector. However, there were variations among districts, with some districts in Northern Uganda having less than 40% of the public

[6] Annual Health Sector Performance Report 2007/08 and Health Sector Strategic Plan III 2010/11-2014/15.

health sector posts filled in 2007/8 (MoH 2009a). The prevailing shortage of trained health workers at all levels has gravely compromised delivery of quality health services (see also section 6.2.3 for discussion of the situation in Iganga District). Reasons for the many vacancies include insufficient training capacity, unattractive remuneration and retention of health workers with the right skills in both private and public health facilities; gender-linked issues include insufficient security at both health facilities and accommodation. There continue to be weaknesses in leadership and management of HRH at all levels of the health system, slow and inadequately transparent recruitment practices and inappropriate distribution of health workers.

Public sector HRH numbers at district level are set by national norms, as are wages for all health worker cadres. As a result, the number of available staff becomes a decisive factor in resource allocation and recruitment, and retention challenges adversely affect allocations to deprived/remote areas. Attempts are made from the central level to pay salary top-ups to staff in such areas, to mitigate HRH shortfalls. This has not yet been effective. The public budgeting system, of which health is part, allows little room for manoeuvre at the district level. District health authorities are assessed by their performance against national health indicators, but their autonomy to change service delivery, HRH allocations, etc. to meet local needs is very limited.

A number of other constraints were mentioned by evaluation respondents (and discussed in documentation) as having contributed to the stabilisation or poor performance of most health indicators. These include the stagnation of the non-wage recurrent budget for health service delivery, the increasing marginalisation of PNFP health services with regard to access to funds from the state budget, and mixed reports on access to basic medicines (in the context of the new SCM delivery system (characterised as push to district level and below by several evaluation respondents) centralised within the National Medical Stores since 2009). [7]

4.1.3 Development partner assessment of health sector performance

It is pertinent to quote at some length from the Joint Budget Support Framework (JBSF) development partners' December 2010 assessment of the Joint Budget Support Framework, as it represents the most recent overall appraisal of health sector performance.

'***Health**:* the health sector's performance was poor against headline sector results. In some cases, performance declined for the second year in a row. Most...indicators rely heavily on the procurement of key inputs (essential medicines, vaccines, contraceptives) and a functioning supply chain. Even in the face of insufficient budget allocation, [the MoFPED has] reported non-spending of funds released to the Ministry of Health for the procurement and distribution of key inputs such as vaccines (only 14.42Bn Uganda shillings (UGX) was spent by MoH of 33.6Bn UGX released)...JBSF development partners concur with the assessment in the GAPR that the following targets were not met: number and proportion of deliveries in health facilities; couple year protection; immunisation coverage of ... [DPT3]; and the proportion of health facilities without drug stock outs for 6 tracer drugs.' (Development Partners' Delegation 2010: iii & 36).

One relatively common theme throughout evaluation interviews was that while the Joint Assistance Framework has tightened focus on key indicators, there appears to be an inadequate system for genuine leverage. Therefore, the view was expressed that while many JAF health indicators are red flagged, there does not seem to be an effective mechanism for accountability from the side of the MoH. A related point made was that the MoH has not taken on ownership of the JAF process.
As previously mentioned, the DFID opinion is that JAF indicators are valid but with unrealistic targets. There appears to be an increasing understanding of the need to include lower-level (and realistic) indicators (milestones and what are known in DFID parlance as output-level and/or nested logframe indicators).

[7] See also Guzman & Taylor 2010.

4.2. HEALTH SECTOR DEVELOPMENTS 2000-2010

4.2.1 Movement towards achievement of core health indicators

Uganda has a fast growing population (3.2% per annum), expanding from 24.2 million in 2002 and estimated to reach 34.6 million in 2011.[8] Population size and its growth have a powerful impact on the health care delivery system in Uganda, given a GDP growth rate of 7.2 per annum and a nominal per capita income projected to increase from US$506 in 2008/09 to about US$850 by 2014/15.[9] The inevitable challenges imposed on the health sector in the light of Uganda's population growth (the 3rd highest in the world; close on 50% of the population is aged 15 and under) need to be considered in any discussion as to relative progress towards achievement of health indicators. One perspective might be that simply not to go backwards in terms of key indicators, but to remain static in the context of continuous population growth, represents an achievement.

The subject of population growth, demographic trends and the Total Fertility Rate (currently 6.7) and the implications for Uganda as a whole appear to require more prioritized attention and action from all partners engaged in the Ugandan health sector.[10] A 3.2% annual population growth rate has impacts on all components of health service delivery, has repercussions for all other HSS building blocks and will place considerable and long-term demands on the system. Such high population growth also has implications for all health sector development assistance, whichever modality is applied. This is just as true for SBS through the SWAp mechanism.

The health of Uganda's population has improved overall during the evaluation period (with gender-based, regional and other variations). Life expectancy has risen from 45 years in 2003 to 52 years in 2008. Trends in key indicators have been positive if moderate: the under-five mortality rate has reduced from 156 in 1995 to 137 deaths per 1,000 live births in 2006, while the NMR was 33 per 1,000 live births in 2000, and 29 in 2006, accounting for 40% of infant mortality. As earlier mentioned the maternal mortality ratio reduced from 527 to 435 per 100,000 live births between 1995 and 2006; however, MMR continues to be off-track in terms of achieving the MDG. The proportion of health centres without medicine stock-outs decreased from 33% to 26% over the period.

The above progress registered in the health sector was a result of improved availability of resources including finances, health infrastructure and equipment; increased accessibility to especially government services; improvements in management and strengthening of information, education and communication campaigns. Such scaling up of programmes and expansion of the number of health facilities has, however, meant that more staff, equipment and medicines are required to run health facilities and provide services (especially when population growth is taken into account). Thus a shortage of health workers, inadequate health infrastructure and equipment, inefficiency in the sector, and inadequate research have all affected service delivery at all levels. Therefore, while a degree of progress in health indicators has been achieved during the decade under review (but with wide regional variation, northern post-conflict challenges and with significant disparities in terms of access for vulnerable groups), the 2003 HSSP I and the 2008 HSSP II mid-term reviews indicate the scale of the ongoing challenges, not only specifically regarding the MDGs, but for the entire health sector. Key constraints militating against the achievement of MDGs 4 (*reduce child mortality*) and 5 (*improve maternal health*) are HRH shortages and funding shortfalls. Table 3 indicates issues to be addressed.

[8] Uganda Demographic Profile 2011.

[9] National Development Plan 2010.

[10] It is noteworthy that few recent reports, e.g. Pearson's 2010 review of the Malawi health SWAp and ODI & Mokoro 2010a-e, refer in any depth to the implications of population growth for the health sector. The Uganda evaluation suggests that closer attention would be relevant, and not only in that country, in terms both of health sector performance and action to address population growth (with due acknowledgement of the many deep-rooted sensitivities inherent in the subject).

Table 3: Progress on the four core health indicators in the JAF Matrix

Indicators	DP rating (as of end 2010)
Number and proportion of deliveries in health facilities (health centres and hospitals)	**NOT MET**
Contraceptive Prevalence Rate	**No data**
Couple Year Protection	**NOT MET**
Number and proportion of children immunised with DPT3	**NOT MET**

(Source: JAF2 Appraisal (December 2010))

See also the discussion above, in 3.1.6 and 4.1.3, regarding JAF targets and the need to incorporate lower-level and more realistic indicators and targets.

4.2.2 Movement towards achievement of MDG 4 and 5

Despite impressive gains in the early years of the decade, Uganda faces very considerable challenges if it is to achieve MDGs 4 and 5. Here too, population growth is a relevant factor. The 2010 Uganda MDG report states that progress is slow on all three relevant targets. To contextualise the MDGs: one woman dies every hour and a half in childbirth in Uganda, upwards of 6,000 every year (and this official figure is likely to be an under-estimate); under-five mortality is currently reported at 120 per 1,000. The GoU has in recent years again acknowledged the challenges, e.g. by introducing the 2007 *Roadmap to Accelerate Reduction of Maternal and Neonatal Mortality and Morbidity* and the *MDG Acceleration Framework*. The latter document prioritises four key maternal health interventions: emergency obstetric care, skilled attendance at birth, family planning and effective antenatal care. Considerable attention is also currently being given to increasing the number of midwives and seeking to ensure better national coverage of such key health workers; UNFPA is a major partner in this activity. The HSSP III states that priority will be given to child health interventions, in order to ensure that Uganda achieves MDG 4. A costed Child Survival Strategy has been developed; emphasis will be on implementation of interventions that it sets out.

The health sector continues to be faced with a lack of adequate financing, facilities, supplies, medicines and staff in terms of achievement of MDGs 4 and 5. While 95% of women nationally in 2005/6 made at least one antenatal clinic visit, only 47% made four or more visits, as recommended by WHO and UNFPA (UDHS 2006). Only 42% of births are assisted by skilled providers (it is relevant to note the absence of a coherent definition for SAAB) and 63% of women in rural areas give birth at home compared to 20 % of women in urban areas.

4.3 HEALTH SECTOR FUNDING [11]

4.3.1 Overall trends 2000-2010

The GoU is a signatory to the 2001 Abuja Declaration, which set a target of 15% of national budget being allocated to the health sector. Between 2000/01 and 2009/10, health expenditure as a proportion of GoU expenditure showed a moderately increasing trend towards levels just below 10%.[12] Hence, Uganda has in fact prioritised health vis-à-vis other public commitments in the budget throughout the decade, even though the country is still far below the Abuja Declaration target. The modest positive trend is an indicator of commitment, even though a shrinking public sector (lower public spending relative to GDP) has led to the GoU spending little relative to the size of the economy.

The absolute level of public funding (excluding off-budget) was USD10.4 per capita in 2008/09, far below estimated requirements (NDP 2010). This has affected all inputs in the sector. For example, current annual per capita expenditure on essential medicines is only USD0.87 against an estimated requirement of USD 2.4 per capita. During the period between 2001/02 to 2008/09, development partners' contributions fluctuated between 46 and 54% of the annual budget (as set out in the Medium-term Expenditure Framework).

[11] The evaluation was limited in its opportunity to address outcomes and trends in health indicators, because the 2010 UDHS data are not yet available. In addition, all indicators discussed in this section are subject to regional and other variation, e.g. with the northern (post-conflict) region generally exhibiting worse performance.

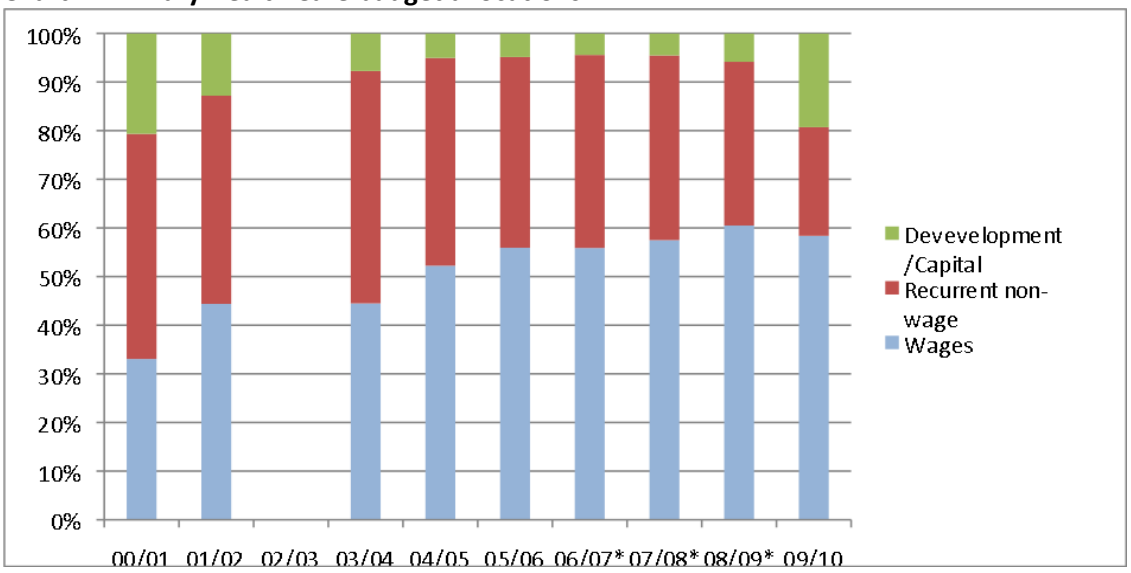
[12] Ministry of Health, 2010b. *Health Sector Strategic & Investment Plan: Promoting People's Health to Enhance Socio-economic Development 2010/11 – 2014/15. July 2010*. Kampala: MoH. Page 29.

Commonly associated with low levels of public funding for health, individual households' out of pocket spending on health has also increased over this 10 year period, an indication that public commitment to health has not increased sufficiently in line with the expanding economy and that those who can spend more on health themselves do so, resulting in inequity of access to services. Increasing out-of-pocket expenditures are also associated with financial risk protection problems, i.e. that households risk becoming poorer due to health needs and related expenditure. There has been no in-depth analysis since 2006 of catastrophic expenditures (this refers to a situation where the proportion of household money spent on health care has significant negative impact on other expenditure, e.g. on food or school fees) and impoverishment due to health needs in Uganda. Therefore, it is difficult to judge specific consequences of inadequate public funds for risk protection. However, the HSSIP includes a core indicator on this topic; its baseline states that 28% of Ugandan households have experienced catastrophic payments. This is a high percentage when compared with other similar countries.

4.3.2 Trends in health sector funding to district and sub-district services

Uganda increased its focus on Primary Health Care (PHC) services in the late 1990s and into the earlier years of the evaluation period.[13] It has not managed to sustain that development and increase its priority to PHC services; on the contrary slightly less was spent on PHC as a share of the total health budget during more recent years. There is no pre-defined share of GoU spending that is earmarked for PHC, but clearly the indicators in the JAF, HSSPs I and II and the HSSIP will not improve markedly without either stronger focus on PHC in resource prioritisation, or demonstrably increased efficiency in service delivery (preferably both). This is also shown by the limited success in performance shown by MCH indicators.

Chart 2: Primary Health Care budget allocations



(*Shares for 06/07, 07/08 and 08/09 are based on the first 6 months only)

The situation on the ground, the pre-requisites for actually delivering MCH services, is also hampered because the wage share of district allocations is increasing over time. This is probably partly due to the intrinsic demands of the public budgeting system. Regardless of the reason, ability to meet demand-side needs is limited. The relative decrease in funding for recurrent non-wage expenditures compromises the health system and makes it very inefficient.

The recurrent budget is also used for supporting PNFP health service delivery at district level (drug supply and recurrent utilities), while PNFPs typically cover wages and capital investments themselves (partly funded by user fees). When the recurrent budget shrinks, it becomes more difficult for districts to support and work with PNFP health facilities. This limits use of existing provider structures and hampers access to quality services.

[13] Okwero P, A Tandon, S Sparkes, J McLaughlin & J G Hoogeveen, 2010. *Fiscal space for health in Uganda*. World Bank Working Paper 186. Africa Human Development Series.

5. FINDINGS AND CHALLENGES (LINKED TO ToR QUESTIONS)

This section of the report addresses all twenty-one ToR questions. Please refer to Annex 4, where all ToR questions are fully considered; key points are given here. Seven of the ToR questions address outcomes and impacts (see section 1 in Annex 4), eleven focus on SBS and aid modality issues (see Annex 4, section 2) and the remaining three discuss more challenging questions (in the context of evaluation limitations), dealing as they do with wide-reaching socio-cultural issues (Annex 4, section 3). Three additional questions are included in the ToR to be addressed as a result of the evaluation process, two of which review the SPS modality, with the third focusing on the Paris Declaration; these are reviewed in 5.4, in section 4 of Annex 4 and also in section 6 below, in the body of the report. Section 5.4 considers gaps in the evaluation ToR.

5.1 HEALTH OUTCOMES AND IMPACT (DIFFERENT ASPECTS) OVER THE 10-YEAR PERIOD

The five ToR questions that address trends and priorities in the overall Ugandan health sector, government support to HSS and development of the overall health system over the evaluation decade have been considered in sections 3 and 4. Key points emerging from the two ToR questions specific to Swedish support are that its contributions have had positive impacts on accountability, financial management and movement towards greater understanding of the importance of health rights.

5.2 SBS AND AID MODALITY ISSUES

These issues are intrinsically dependent on a combination of effective long-term institutional memory and detailed documentation of processes and outcomes. This evaluation has sought to arrive at a comprehensive overview, although gaps have emerged. Findings indicate that application of the SBS modality through the SWAp mechanism has allowed development partners, including Sweden, to have genuine inputs to policy dialogue, especially in the years (ca. 2000-2004/5) when the SWAp was supported by many donors and represented a coherent and powerful joint voice. Swedish support to SBS has been addressed above. As noted elsewhere, Swedish financial contributions to the health sector have represented ca. 5% between 2000 and 2010; however, government of Uganda share of health financing has seen only modest growth. The extent to which SBS has contributed to increased improvements in public health spending has changed over time: the early years of SBS are widely deemed to have been generally efficient, including in terms of resource allocation and disbursement arrangements, while the 2008 Health Sector Strategic Plan II Mid-term Review discusses the decline in the overall health sector performance and the reduced role of the SWAp in terms of overall efficiency and improvements and effective disbursement mechanisms. The ToR question linked to whether the SBS modality *per se* (and within that Swedish contributions) has had an impact on issues of transparency, accountability and wider corruption suggests a degree of positive input, in an often challenging environment (e.g. the corruption linked to GFATM and GAVI).

Four questions address issues of multiple funding modalities, the advent of vertical global funding and the relative strength of Swedish leverage within this changing aid environment. The challenges inherent in increased off-budget funding, as well as much expanded focus on specific diseases, and the distortions of these approaches, have all placed much strain on the health sector at central and district levels, and on managers and service providers. SBS as a modality (i.e. distinct from its relative financial inputs, which are currently modest as part of the overall on and off-budget funding) is viewed extremely positively by the MoH, as it allows a degree of oversight and control. Adherence to Paris Declaration principles can best be described as patchy; while a number of partners describe positive recent trends, e.g. greater harmonisation and alignment, others that mutual accountability is in fact limited and that a number of partners reduce such explicit commitment should clear results not be forthcoming. Given that the Busan Paris Declaration High-level Forum 4 in November 2011 will prioritise attention to mutual accountability, there is scope for renewed and invigorated consideration in the Uganda environment.

Swedish leverage is considered to be significant, because of its consistent support to SBS, its principled support to often difficult issues (e.g. adolescent sexual and reproductive health) and its focus on accountability, for instance through Technical Assistance to financial management.

5.3 MORE CHALLENGING ToR QUESTIONS

The three questions below are more challenging to answer, being less amenable to review in the time available. Other limiting factors are that attention to issues mentioned in the questions has been patchy in the Ugandan context over the decade under evaluation and that effective attention to gender and social determinants of health would require gender and social analyses beyond the scope of this assignment. The three questions are included in part I of the ToR: *health outcomes and impact over a 10-year period*.

The evaluation team has considered these questions through review of existing studies and summary of secondary data, as well as drawing on findings from a visit to Iganga district visit. This triangulation has allowed what can only be a partial overview of complex issues.

1. *What have been the major health results for poor people at local level, taking gender and regional differences into consideration*
2. *Have the regional differences in health outcomes persisted or deepened during the period?*
3. *Health outcomes and impact should be analysed both in relation to health systems' development and increased access to health services for poor people, as well as to factors outside the health sector such as social determinants of health*

An indication of a less than optimal balance between central and local autonomy and power relations, and their implications for health service delivery, can be seen in the findings from the evaluation team's visit to Iganga District. Public sector respondents in the District stated that districts have no opportunity to discuss budget allocations with central government and that it is not possible at the district level to track and monitor the majority of off-budget funding. This lack of information and overview is considered to result in inefficiencies, duplication and lack of harmonisation and alignment, all of which contribute to ineffective health service delivery and less than optimal health outcomes.

5.4 ToR QUESTIONS RELATED TO RECOMMENDATIONS AND LESSONS

Two of the three ToR questions in the final set address whether Swedish support to the SBS modality should continue and which other modality or modalities might be relevant and appropriate. These are addressed elsewhere in this report. The third question requests attention to how coherent the findings of this evaluation are with the phase I and II Paris declaration Uganda reviews. In summary, it can be stated that there is coherence regarding the findings of the three studies. Broadly the Phase I review provides a generally positive assessment up to 2006, while the Phase II review paints a more sober and less results and outcome-oriented picture.

The relevant text in the ToR states: *3. How do the lessons learnt from this evaluation compare with the findings of the phase one and two evaluations of the Paris Declaration, and what are the implications of the Ugandan experience in light of prevailing trends and lessons learnt in aid harmonization and alignment?*

Question 3a: evaluation lessons learned vis-à-vis Paris Declaration Phase I and II findings

There is coherence regarding the findings of this Swedish SBS support to health evaluation and those of the Phase I and II Uganda Paris declaration reviews. As discussed at several points in this report, the early years of the decade (until around 2004/5) coincided with what can be seen with hindsight as the high point of the SPS/SBS modality and the SWAp mechanism. While the Paris Declaration on Aid Effectiveness was agreed and signed only in 2005, the SWAp mechanism can be viewed as at least in part a precursor of the Declaration principles. This is evidenced in the SWAp principle of expanding and deepening country ownership, often in connection with health system decentralization (a feature of the period in Uganda), and in the core focus on seeking genuinely increased harmonization and alignment, in itself a response to concerns over what was at the time felt to be an over-proliferation of vertical, unsustainable projects. Accountability and a robust attitude to risk (fiduciary and otherwise) represent further SWAp principles that were applied in the Ugandan context in those early years.

The core Paris Declaration principles ('dimensions') were viewed in the Phase I review to have been effectively introduced and progress made (despite the short period of time that had elapsed since Declaration signing). The findings of this evaluation indicate that such progress can, at least in part, be attributed to the health SWAp. At

that time it enjoyed the support of many development partners, whose co-operation with the MoH was described both at the time and subsequently, as close and focused.

As noted in the Uganda Phase II review, the changing aid architecture has had considerable impact overall on the aid environment in country, with repercussions also for Paris Declaration principles. Thus the emergence of non-traditional sources of development assistance and finance (e.g. China and India) and the proliferation in the last decade of vertical funds for global and regional health initiatives, led by multilateral donors and large private foundations (e.g. PEPFAR, GFATM, GAVI and the Bill & Melinda Gates' Foundation), have offered new funding opportunities in Uganda. These vertical programmes have become increasingly important in delivery of assistance in the health sector; it is fair to state that none has throughout been a wholehearted, explicit supporter of all the Paris Declaration principles.

External factors include political changes in development partner countries. These have inevitably shaped the extent of development assistance provided by any one development partner, that country's priorities and its partnership arrangements and disbursement modalities.

Question 3b: implications of the Ugandan experience in light of prevailing trends and lessons learned in aid harmonization and alignment

The Phase II report discusses the changes in the Uganda health sector between 2006 and 2010/11 and the relative relevance of the Declaration principles (GoU (OPM) 2011; see also Wood *et al* 2011 and SADEV 2011). While *country ownership*, *harmonization* and (to a lesser extent) *alignment* have seen some degree of forward movement in Uganda, *mutual accountability* and perhaps especially *managing for results* remain at best work in progress, with much still to do to achieve common ground and coherence between all relevant parties.

The Paris Declaration and its principles cannot be considered solely responsible for both positive or negative development assistance and overall health trends and that disentangling relative impact is somewhat futile. Nevertheless, one key lesson learned is that embedding principles that require genuine transparency and greater partnership and mutual respect is a long-term project, which is still very much work in progress in Uganda. As can be seen from the varied success of the SWAp as a harmonisation and alignment mechanism, and the enduring presence of projects, it cannot be assumed that a once successful approach will remain so strong. The role of Sweden has been pivotal in ensuring that Paris Declaration principles have at least remained active items on the overall health development partners' agenda.

5.5 GAPS IN THE EVALUATION ToR

The Inception Report notes (in 3.1.4) that there are no demand-side/health service user/community specific questions in the ToR, despite the frequent mention of (aggregate) poor people. In addition, there is no reference to the gender aspects of access, health-seeking behaviour and social determinants of health. Issues of quality assurance (from both the supply and the demand-sides) are similarly not addressed.

The evaluation team sought, within the limited time it had available, to review gender and other issues relevant to access to health services and health-seeking behaviours. An overall, and admittedly broad-brush, finding is that the SWAp approach in Uganda did not adequately address gender aspects of health-seeking behaviour and overall access; the same is true for national and development partner instruments, most notably the HSSP I and II, the HSSIP and the JAF. This is regrettable, given the detailed attention to such matters, e.g. the Uganda work undertaken in 'gender mainstreaming in sector-wide approaches' by the UK Liverpool School of Tropical Medicine.[14] While that study is now somewhat outdated, its findings and recommendations (unfortunately) continue to hold true, e.g. the need for genuine and long-term attention to both internal (institutional) and external (service provider) gender mainstreaming in the health sector.

[14]See e.g. the 2002 collection edited by Theobald *et al*, entitled *Papers presented at sector-wide approaches: opportunities and challenges for gender equity in health* and the 2003 LSTM *Policy Briefing: gender mainstreaming in sector-wide approaches*, to which the evaluation team leader contributed.

A general comment in the context of review of Ugandan health sector indicators (HSSP I and II) is that they have been inadequately disaggregated and demonstrate insufficient attention to gender and other socio-cultural barriers to health care, to social determinants of health and to regional and other variation. Just one example among many: '% of households with at least 1 ITN' fails to consider the often reported possibility/likelihood that the insecticide-treated net may not be used by those in most need, i.e. (pregnant) women and under-fives.

It may be that the enhanced focus on social and cultural aspects of health-seeking behaviour seen in the HSSIP and in other key documents such as the 2010 Uganda MDG Report, will herald increased, longitudinal attention to such matters. Thus the HSSIP has a strong focus on rights aspects of health. Evaluation respondents from the MoH and development partners referred to this as a result of Swedish participation in the process and its championing of rights-based approaches. There is an HSSIP section on guiding principles, which provides a set of rights-based principles for health. The M&E framework includes performance indicators disaggregated by gender, literacy level and socio-economic quintile. Of course, it remains to be seen what the practical implications of such attention may be and to what extent this will translate into service delivery inputs and health outcomes. Nonetheless, the level of ambition has certainly been raised and a system for performance management is emerging.

6. LOOKING FORWARD

This section of the evaluation report considers the information gathered during the assignment with regard to development assistance modalities. Attention is given to the optimal future approach to be adopted by Sweden in its support to the Ugandan health sector.

The ToR require that the evaluation: '*consider each option in the Ugandan context [and] weigh the advantages and disadvantages of these options in terms of achieving results, achieving these results sustainably, and living up to Sweden's commitments in the Paris Declaration 2005 and Accra Agenda for Action 2008 (ownership, alignment, harmonization, results and mutual accountability).'*

As is always the case in an evaluation of a (health) sector where development partners support a range of modalities, different opinions were expressed and a variety of recommendations made by respondents as to the best way forward for Swedish support to the Ugandan health sector. What follows is both a synopsis of the most common and coherent themes (as well as acknowledgement of sometimes quite sharply divergent positions) and also analysis of current practice as a springboard for future activities.

Modality recommendation: transition planning
The evaluation team makes one over-arching recommendation, to be considered whichever modality or modalities come to be applied for Swedish support to the Ugandan health sector: *that there be genuine, careful transparent transition planning and application of change management processes should Sweden exit from SBS, or reduce such commitments*.[15]

This recommendation is informed by the experience of Danida's exit from the Ugandan health sector, described (often vividly and with regret) by a range of evaluation respondents. See 3.2.3 above for details. One key lesson learned from Danida's exit is that communication at the earliest possible stage is imperative; another is that joint transition planning and attention to the best managed exit strategy are equally essential. Failure to communicate and plan may well have negative impacts on the overall functionality and credibility of HPAC and HDPG – and indeed SBS more widely.

Given the widespread respect with which Swedish support to health is viewed, any failure to engage with transition planning, should this be necessary, would be contrary to its long-established and hard-won position of trust.

More frequent evaluations of Swedish support
While the rationale for not commissioning a separate evaluation of Swedish health SBS between 2000 and 2010 is understood and acknowledged, this evaluation recommends that more frequent evaluations be undertaken in the future, e.g. every three of five years. This shorter time span would enable more effective analysis of lessons learned, best practices and overall performance, and would facilitate more detailed overview of institutional memory and documentation.

6.1 CONTINUING WITH THE CURRENT MODALITY (SBS)

Please see section 3.1.1 and Annex 2 with regard to Sida definitions.

6.1.1 provides the recommendation relevant to SBS, while the remainder of section 6.1 discusses definitions, current international development assistance views on SBS and the Ugandan SBS situation as of 2011. The rationale for such detail is to contextualise the recommendation.

[15] It is in this potential environment of transition that attention to the *Theory of Change* might be applied (see section 4.3 in the evaluation Inception Report).

6.1.1 Recommendation

Sweden should continue to allocate a proportion of its health support to SBS. There may be an argument for reducing SBS support as a proportion of overall Swedish health funding to Uganda, i.e. transferring a proportion of those funds to other modalities. However, as is discussed immediately below, to remove Sweden entirely from SBS would be likely to have negative consequences in terms of its position in the Ugandan health sector and its opportunities to voice and support specific priorities and sometimes difficult issues. In addition, Sweden's commitment to the Paris Declaration principles and Accra Agenda objectives is well-known; SBS and the SWAp mechanism represent the clearest and most coherent link to these principles and objectives.

6.1.2 Discussion and rationale

Sweden has developed deep-rooted and much admired and respected support to SBS since 2000. The general consensus of evaluation respondents from all categories (public sector, development partners and non-state actors) is that its departure from SBS would herald the general collapse of the modality; one among many potential repercussions would be the closing of a channel for direct, honest, open debate with government, including the discussion of difficult and otherwise minimally supported health issues, e.g. SRH&R.

Many years and much effort have been invested in trying to get development partners to support and strengthen Ugandan government health systems through SBS. If these do not deliver, the options seem to be either to stay and try to improve the system while sending a political signal (possibly through reduced funding), or to find other existing mechanisms as vehicles for support already aligned in the sector programme.

The recent major and extremely informative study of SBS led by the Overseas' Development Institute (ODI) and Mokoro broadly supports continued emphasis on and support to the SBS modality. This recommendation is balanced by another: that all such support needs to ensure greater attention to implementation and results, and a better balancing of action on outcomes vis-à-vis (possible over-prioritization of) process.[16] The ODI and Mokoro reports (2010a-e) also discuss the difficult issue in the context of SBS of balancing support to governance, harmonization and alignment (all of which Sweden has actively promoted over the years and on which some definite progress has been seen, both within and outside the SWAp, e.g. through HPAC, HDPG and non-SWAp partners aligning with the JAF) and seeking evidence of results and value for money. Direct attribution and allocation of impact are not feasible in a SWAp, whose partners relinquish a degree of direct autonomy and linkage between inputs and outputs, performance and outcomes.

'Overall, the study confirmed that SBS is a potentially important and effective modality for supporting improved service delivery in developing countries. However, its record has been mixed in implementation. SBS has supported greater efficiency in the use of public resources, by facilitating improvements in planning, budgeting, and financial management and accountability. But progress has been uneven and would have been greater in the absence of certain correctable weaknesses in the design and delivery of programmes. SBS has also helped to support the expansion of service delivery, and thus the possibility of widened access to basic services, by financing a major share of service delivery inputs. *However, it has not effectively addressed the quality and equity of service delivery*.' (ODI & Mokoro 2010b; p1. Emphasis added.)

The IHP *Compact* (to which Uganda and Sweden are signatories) indicates that a preferred modality for development assistance to health is SBS. This is because the Compact is viewed as a key step in putting the Paris Declaration into practice in the health sector – so doing *inter alia* by seeking to harmonize and align otherwise parallel interventions (IHP 2007).

SBS in Uganda: the current situation

The current situation in Uganda is somewhat volatile with regard to development partners' preferred health support modality; influences include national governments' positions, varying perceptions of GoU commitment to the social sectors, persistent concerns over corruption, accountability and related matters and, as ever,

[16] This concern over best balance between process and structures vis-à-vis implementation and attention to outcomes is one that can legitimately be expressed with regard to the Paris Declaration and the Accra Agenda.

awareness of the continuing poorly performing core health indicators and the ongoing need for external assistance so that Ugandans' health needs can be addressed.

Therefore, it can probably justifiably be claimed that the health sector is experiencing a somewhat fragmented support base; this is certainly the case when compared with the early years of the SWAp, ca. 2000-2004/5. The question is: to stay and work from within SBS or to move to other, less closely harmonized and aligned modalities.

One significant development in terms of health SBS is that DFID has recently decided to return to this modality, focusing on accountability and leverage opportunities and on health outputs as linked into the Joint Assistance Framework and its six health indicators. This is despite what was termed by a respondent from another major development partner as a recent 'informal stock take' of current modalities, apparently leading to an overall shift back towards more focus on project support and away from budget support. According to the same respondent, the current attitude towards either GBS or SBS in Uganda is 'fairly negative' among the majority of development partners.

The DFID rationale for returning to budget support is the extreme under-funding of the health sector (currently estimated at perhaps 35% of the funding required) and the lack of progress towards achieving the health MDGs. DFID will provide £27.5 million between FY 2011/12 and FY 2014/15 through a Health Service Delivery Grant. DFID on-budget support will be balanced by off-budget grant allocations and all support will be anchored by the Joint Assistance Framework.[17]

6.2 OTHER APPROACHES

The ToR state that the evaluation should provide information relevant to 'the consideration and preparation of a new phase for continued health sector support; provide input to the design of a new programme of long-term support to the health sector, including conclusions, recommendations and lessons based on results (outcome and impact), remaining critical issues and expected challenges.'[18]

Issues to be addressed are: what are the advantages and disadvantages of different aid modalities and channels for possible Swedish support to the health sector during the coming period?

The ToR list the following possible options for supporting the health sector in Uganda:

1. *General budget support*
2. *Sector budget support or a highly aligned sector programme support [such as] Sida has been providing so far* – see 6.1 for discussion of this modality
3. *A less aligned form of sector programme support, such as a World Bank trust fund or a donor pool*
4. *Project support to national government, more or less aligned*
5. *Programme support to local government*
6. *Project support to local government*
7. *Project support to a local or international NGO*
8. *Support to a global vertical health fund active in Uganda*

6.2.1 General budget support

Recommendation

The finding of this evaluation is that it is not advisable for Sweden to fold the entirety of its support to health into specified General Budget Support (GBS).

[17] 'The health sector remains hugely under-funded in Uganda, with expected levels of funding likely to be around a third of the minimum required to mount an effective nationwide response to tackle slow progress towards the relevant MDGs. To meet the MDG target for maternal mortality, Uganda's maternal mortality ratio needs to decline by 65% in the next five years - a rate nearly five times faster than what has been achieved in the past. There is a huge unmet need for family planning in Uganda - six out ten women want to use family planning methods whereas only two are using services now. Less than half of all women are attended by skilled health personnel at the time of delivery.' (DFID Uganda n/d – 2010/11. *SBS Rationale*).

[18] Please refer to the discussion on limitations regarding measurement of impact in the Inception Report.

Discussion and rationale
The overall rationale for this finding is that GBS is unlikely to allow Sweden the same opportunity and flexibility to continue to champion optimal outcomes and performance in the health sector and to maintain its comparative advantage and added value in the sector. As background to the current situation, and as described in the development partners' Appraisal (Development Partners' Delegation 2010) eleven partners, including Sweden, have an agreement with the GoU to provide budget support under a Joint Budget Support Framework (JBSF). A Joint Assessment Framework (JAF) was developed, and was endorsed by the GoU and development partners in October 2009.

It is clear that adoption of the GBS modality is a (home country) political decision and that its relative appropriateness for the Ugandan situation has not been established by each development partner according to technical criteria. GBS development partners met by the evaluation team indicate that mechanisms are being developed. There is also said to be (currently) strong leadership from the MoFPED as well as a strong and involved group of development partners. All such partners have signed up to the Joint Assistance Framework in accordance with Paris Declaration principles of harmonisation, alignment and division of labour. However, problems with corruption and transparency persist and the issue of genuine leverage from development partners when health results are not delivered remains to be addressed. Development partners continue to respond and act differently when results are presented and there is as yet no concerted effort to take joint action when results are not forthcoming.

It is also relevant to note here that several evaluation respondents stated that GBS and SBS are interchangeable in the Ugandan context and that to differentiate between the two modalities has limited practical value. Thus the view of a major development partner is that if any development partner provides financial inputs to the MoFPED consolidated fund, then it is giving GBS. At best there is a 'virtual pool' for health funding from development partners; there has been and is no earmarking to a sector. This is claimed to be the current situation, despite development partners such as Sida and BTC agreeing with the MoFPED that their funds will go to the MoH through the SWAp mechanism. A related comment made by several respondents is that this structure (*de facto* GBS) means that it is extremely challenging to address issues of additionality, let alone fungibility, in the health sector. (In addition, see the Inception Report for a discussion on the difficulties of tracking impact for any one development partner contributing to any type of budget support with sector links.)

The general consensus appears to be the following. If Sweden continues to define its development assistance to health as SBS (or decides on another modality or a combination of SBS and other approaches) rather than labelling it as part of GBS, its opportunities for leverage (however limited those might be), focus on and tracking of accountability and continued prioritisation of e.g. health rights, will be greater. However 'virtual' the difference between GBS and SBS may be in terms of financial allocation mechanisms, moving into GBS is seen potentially to dilute explicit nation-to-nation support to the public health sector. Such a shift might well also be viewed as a retrograde step in the Swedish context, with its high profile and long-lasting direct, visible engagement with the Ugandan health sector. As a relatively small financial player in the Ugandan health context, Sweden would risk losing its high profile and acknowledged partnership credentials were the decision taken to move into GBS.

6.2.2 A less aligned form of sector programme support, such as a World Bank trust fund or a donor pool
Recommendation
This modality has a degree of potential to offer opportunities to target specific health inputs, e.g. support to alleviate the current challenging HRH situation (this is also a view put forward by several key development partners). Please note that such support would be Uganda-specific, i.e. it would be entirely separate from the contributions Sweden gives to GFATM and GAVI at a global level. See also 6.2.7.

Discussion and rationale
If such an option were considered, it would be essential to develop resource management systems, performance-based contracting/management, MoU and other instruments in partnership with the GoU and the MoH. It would also be imperative to ring fence activities in such a way that they not only complemented the HSSIP and existing sector support, but were genuinely coherent with HSSIP M&E systems, with robust mechanisms for lessons

learned and best practices to inform the overall health sector. Otherwise there are undoubted risks of parallel systems and an old-fashioned project approach, where outcomes and impacts may be short-lived and not amenable to scaling up.

An alternative version of this type of support could be earmarking support to certain activities within the HSSIP. This would guarantee implementation, or at least funds for implementation, for specific areas that Swedish priorities. However, there is a clear risk that adopting specific sections of the reform strategy would crowd out GoU funding, and thereby GoU long term commitment. In other words, Swedish support would risk not being in addition to existing funding for that specific purpose. It is also difficult for the GoU, with a constrained health budget, to move back into something which has been externally funded. Hence sustainability would be difficult.

Development partner respondents stated that Sweden previously provided funding to the (SWAp) Partnership Fund, jointly with Italian Co-operation and the BTC (and perhaps other partners). This Fund ceased operation in 2010, due at least in part to issues over disbursements and financial and other management. There appear also to have been differences of opinion regarding the extent to which the Partnership Fund represented increased ownership of the SWAp by the MoH. Another example of Swedish support through a Fund is the HIV/AIDS Civil Society Fund, a multi-donor initiative that provides grants to non-state actors wishing to implement projects.

There are currently pooled funding mechanisms for bursaries (to improve the HRH situation), co-funded by USAID, Danida and Italian Co-operation (and apparently achieving results). The mechanism applies where districts request health workers (in districts where health facilities are below the 60% of standard establishment level). Development partners support nurses and other staff. These staff members are required to serve for two years in those specific posts. Many health facilities benefiting from the pooled fund support are PNFPs.

Danida previously led on the development of a similar pooled fund modality for drug and medical supplies' procurement and management. While processes leading to decisions are not entirely clear to the evaluation team, Danida no longer supports such approaches (while it does continue its support to e.g. Supply Chain Management). No other development partner appears to have taken over the lead role for such support.

6.2.3 Project support to national government, more or less aligned [19]

Recommendation

This modality has some potential, but would require the tightest possible conditionality and monitoring and evaluation frameworks. Any such support would have to be inextricably linked to the JAF and HSSIP indicators, with tight focus on performance-based process and outcome. It would also have to be genuinely harmonised and aligned with GoU approaches; otherwise the project modality cannot be claimed to be coherent with the ethos and core principles of the Paris Declaration and the Accra Agenda for Action. There would also be challenges of transaction costs, e.g. Swedish Embassy/Sida inputs over time.

This modality is currently receiving considerable support from development partners in the challenging Ugandan health environment.

Discussion and rationale

One consistent and strongly voiced opinion, stated by both MoH staff and development partner representatives, was that Sida should absolutely not return to the old-fashioned, vertical, parallel type of project support. This would not be welcome and would be viewed as a definitely retrograde step. Many years, and much effort, have been invested in trying to get development partners to support and strengthen GoU systems, with Sweden often taking a major and visible role in such processes. If these do not deliver, the options seem either to remain within SBS and try to improve the system, while sending a political signal (possibly through reduced funding), or to find already existing and aligned mechanisms as vehicles for support.

[19] Evaluation of project support was explicitly not a feature of the assignment. Therefore, evaluation project modality findings and recommendations are a combination of relatively few meetings with organizations managing and implementing projects and team members' knowledge and experience of health projects in Uganda. The same proviso applies to discussion in 6.2.5 and 6.2.6 below.

The project support that Sida/Sweden has been undertaking in conjunction with SBS is seen as beneficial by development partners, *if it is combined with a thorough knowledge of the sector at large, an engagement in the joint fora established in the sector, and it addresses key issues relevant to the overall health sector priorities*. This combination of support was mentioned by several partners as useful, even by development partners that have not been able to have this combination themselves. It was noted that smaller projects or technical assistance in key areas enable partners to gain insights into the system, which is valuable in policy dialogue. Several development partners put forward the rationale for increased support to projects. USAID is the major player in this regard in Uganda. The most frequent rationale is that SBS has in the past few years been fraught with challenges and the SWAp mechanism has significantly slipped from its position of early achievement between 2000-2004/5.[20]

There appears to be increasing impetus among health development partners for what might best be termed 'joint project support'. This is where two or more development partners combine funding and seek more streamlined management (and reduced transaction costs) and presumably a degree of closer co-ordination with government structures than is usually the case with projects. For example, DFID will transfer funds to USAID for joint support to Family Planning through partnership with PFNPs and other CSOs. Sweden already transfers funds to BTC for project support.

It has of course to be borne in mind that project support can be contentious due to perceived and/or actual lack of control over resources by the public sector, as well as creation and/or entrenchment of parallel systems. While there may well be powerful arguments in favour of project support from the development partner side (e.g. tighter controls over financial resources), insistent questions persist regarding the balance between project modalities and genuine country ownership, mutual accountability, sustainability and harmonisation and alignment. Such arguments are well-rehearsed and positions often entrenched from both perspectives. This is true in Uganda as in many other environments.
By marked contrast, the evaluation found a strong consensus in the MoH against any expansion of off-budget project support. A major area of disquiet is the lack of sustainability of project interventions – there do not appear to be robust mechanisms for capturing lessons learned and best practices. This point should be viewed in the light of widespread concerns over the weakness of health system M&E. Another area of concern mentioned by MoH respondents was that TA provided under project support can be (too) short term to enable institutional capacity development and attention to sustainability.

6.2.4 Programme support to local government

Recommendation
This modality is not recommended.

Discussion and rationale
UNICEF represents a major supporter of this modality. It is directly supporting the 54 districts with the highest morbidity and mortality in actual numbers (not as a percentage of the population) with cash transfers. This support provides some of the financial inputs in a flexible manner to be used in accordance with overall sector objectives as spelled out in the HSSIP III.

There are a number of reasons why it would not be appropriate for Sweden to support this modality. It was underlined by UNICEF that this type of support requires very considerable investments in terms of district-level management and monitoring and on the ground. UNICEF has had to make significant investments to place staff in the field, to cover several districts so as to ensure the smooth operation of the support, due to often extremely weak public sector absorptive and human resources for health capacity. This has resulted in additional and significant transaction costs. In addition to the administrative requirements, this modality has the disadvantage of potentially/actually 'Balkanizing' Uganda, as not all districts are covered by this support. Another negative

[20] The USAID respondent was extremely positive about the SBS role of Sweden and work undertaken in the past few years by Sida, e.g. Advisers being Chairs and Co-Chairs of the HDPG and its consistent emphasis on specific issues, such as health rights (the latter primarily through project support).

outcome is the well-nigh inevitable creation of parallel administrative procedures, however closely aligned such support might seek to be with district plans. Earmarked funding is unlikely to be effectively managed or applied. Establishing such systems would also directly go against basic Paris and Accra principles of alignment, hitherto strongly supported by Sweden.

6.2.5 Project support to local government

Recommendation

This modality is not recommended.

Discussion and rationale

A number of issues emerged during the evaluation fieldwork to indicate that project support to local government is not the best use of Swedish development assistance to health in Uganda. Harmonisation and co-ordination place a huge burden on local government structures when donors provide direct support to projects at the local level. Districts with many donors have problems in co-ordinating inputs, even where the best of intentions exist. Because the evaluation team had opportunity to visit Iganga District, issues are addressed in some depth here.

District-level constraints

Harmonisation and coordination pose a huge burden on local government structures when development partners provide direct support to projects at the local level. It is further a risk that the districts or local areas selected are not the ones in most need, as some of the really needy areas are less accessible due to security and logistical constraints.

Sustainability of projects at District level is likely to remain severely constrained for the foreseeable future, in the context of what a Ugandan health stakeholder termed 'virtual decentralisation'. This refers e.g. to political considerations and to the limited funding available to Districts from the central government. For instance, Iganga District receives 100 million UGX per annum for recurrent non-wage capital costs (e.g. maintenance and infrastructure); recurrent wage allocations are UGX 2.4 billion per annum. The actual allocations to provision of health services are UGX 150 million per annum, with disbursements in quarterly tranches.
This situation appears to have been exacerbated in light of the ongoing proliferation of Districts: while there were 80 Districts at the time of the publication of the UDHS in August 2007, up from 56 in 2006 when the survey was undertaken, there are currently 112.

As an example of District-level challenges, Iganga does not receive sufficient allocation to fill 100% of health posts; as of September 2011 ca. 70% are filled, with serious shortages of doctors, nurses and midwives as well as specialist staff such as a radiographer for the Level 5 Hospital. In addition, the 100% definition was apparently set quite some time ago when the Ugandan population was smaller, with the consequence that even a 100% HRH provision might not necessarily be adequate to provide health services geared to current population needs. Evaluation respondents stated that District HRH criteria are governed by financial considerations, more or less in a 'one-size-fits-all' approach, without due attention to individual Districts' needs. Absorptive capacity remains a major challenge in terms of any District managing project support.

The examples of the UNFPA RESCUER project in Iganga and LUMUST in South West Uganda

UNFPA supported the *Rural Extended Services and Care for Ultimate Emergency Relief* project in Iganga and other Districts between 1996/1997 and 2000. The focus was on reproductive health services, particularly emergency obstetric care (EmOC), with hiring of midwives, training of Traditional Birth Attendants, provision of radios, provision of *Mama Kits* and other interventions to address the *Three Delays* that hamper timely and life-saving access to EmOC. The national MMR was at the time ca. 800; by the end of the RESCUER project it had apparently reduced to between 354 (UNFPA calculation) and 200 (data provided by the Iganga District Health Officer). UNFPA respondents also stated there had been no maternal deaths in Iganga during the lifetime of RESCUER. Whatever the true MMR figure may be, it is apparent that RESCUER had a definite impact; unfortunately it was short-lived and unsustainable.

There was no exit strategy; neither the MoH nor Iganga District took over RESCUER approaches and activities. The MMR has returned to national levels.[21]

Another relevant example may be the LUMUST 2004-2009 project, one of whose core objectives has been to improve access to and quality of health care in South West Uganda. Lund University represents the Swedish partner and the project is funded by Sida until end-2011; it is now in its exit phase. While this project appears to have had considerable success in strengthening research and teaching capacity at the Department of Community Medicine at the Mbarara Institute of Science and Technology, the final evaluation report describes relatively modest success with demand-side and health rights aspects of implementation and little focus on such sustainability issues.

Lack of coherence with Paris Declaration objectives and the Accra Agenda for Action
In addition, project support to local government structures runs counter to the principles of the Paris Declaration and the AAA, both of which discuss country ownership and country-led health systems strengthening as key components of development assistance.

6.2.6 Project support to a local or international NGO [22]

Project support to non-state actors (primarily civil society organizations/NGOs) is the other major health development assistance modality currently applied by Sweden in Uganda, in addition to SBS.

Recommendation
This modality (long supported by Sida in Uganda) continues to have potential, but as is the case with project support to national government (see 6.2.3 above), it would require continued attention to the tightest possible conditionality and monitoring and evaluation frameworks. Care would have to be taken to continue to ensure that any such support would be able to provide strategic input to existing Swedish priority areas, e.g. health rights, rather than seeking to support more general service delivery.
As is the case with other types of project support, any new such interventions would also have to be genuinely harmonised and aligned with GoU approaches so far as is practicable and appropriate.

Such tightness of fit and purpose can be more challenging in the context of support to NGOs (often for entirely appropriate reasons of independence and support to strengthening civil society voice and inputs). In this context, it is relevant to note the lively debate about the actual role of civil society in the entire Paris Declaration and Accra Agenda process vis-à-vis desired and/or claimed engagement.[23]

Discussion and rationale
Please note the proviso that this report defines 'local or international NGO' as expanded to include UN agencies and also PFNPs (as previously mentioned, the largest PNFP bodies are the Catholic, Protestant and Muslim Medical Bureaux), which provide a major percentage of all primary health care in Uganda (thus faith-based health facilities provide more than 50% of all maternal and child health care in Uganda). UN agencies include UNFPA, with which Sweden is stated to have had a long-lasting and much appreciated relationship in Uganda.[24]

The 2011 Sweden Development Co-operation document describes Swedish support to non-state actors as follows:

[21] A more positive legacy of RESCUER is that the current northern Uganda RH UNFPA-managed project supported by Sida is described as a 'mini-RESCUER'. There happens to be sufficient institutional memory in UNFPA for positive lessons learned to have been updated, transferred and effectively applied.
[22] Please also see 6.3, which discusses an additional modality not specified in the evaluation ToR: PNFP programme support.
[23] E.g. see the paper written by the evaluation team leader (Gruber 2011).
[24] There was opportunity during the evaluation to meet UNHCO and also UNFPA, UNICEF and WHO. There was insufficient time to schedule meetings with PNFP organizations.

'Sida is mainly supporting the health sector in Uganda by providing budget support to the public health system, but is also supporting non-state actors who complement government efforts in improving access to quality health services, and who act as watchdogs on the GoU and advocate for health rights. On-going and planned projects focus primarily on sexual and reproductive health, maternal health, advocacy for health rights and institutional improvements in the field of planning, leadership and management of the health sector.' (Embassy of Sweden, Kampala 2011: p9).

6.2.7 Support to a global vertical health fund active in Uganda

Recommendation

This modality is not recommended. Sweden already provides funding at global level to GFATM and GAVI; any more country-specific support to the overall funding does not appear to be consistent with Swedish approaches. See also 6.2.2.

Discussion and rationale

A quite broadly held view among both MoH and development partner representatives is that the advent of vertical health funds such as the Global Fund, GAVI, the Bill and Melinda Gates' Foundation (and of course also PEPFAR) has been a major reason for the decline of support to the SWAp and its subsequent reduced vigour. All such vertical funds are outside SBS and the SWAp mechanism; their financial weight and influence have undoubtedly led to diversification of approaches and fragmentation of effort within the overall health sector. This continues to be the case, regardless of recent increased focus by e.g. the Global Fund on health systems strengthening. Parallel systems have been created and transaction costs have increased.

There have been major problems with the transparency and accountability of these funding streams. Relevant in this discussion is acknowledgement of the corruption issues experienced by the Global Fund and to GAVI, which had many and varied repercussions. The MoH has a somewhat jaundiced perception of the reality of commitment by global health funds: while these sign up to Paris and Accra principles and action points on harmonisation and alignment, there remains the insistence on tracking individual funding streams and having parallel (additional) M&E structures (e.g. GFATM). This inevitably places considerable strain on already weak systems and does not noticeably contribute to the Three Ones' approach, including its commitment to a single, national M&E system.

6.3 AN ADDITIONAL POTENTIAL MODALITY AND A POSSIBLE NEW APPROACH

6.3.1 PNFP programme support

As already mentioned, this represents a possible modality not listed in the ToR. Discussion here represents a contribution to the debate over future Swedish support. [25]

Recommendation

This modality has potential; previous experience indicates small-scale support to targeted PNFP providers can deliver significant results. It is important that any such support plan from the outset for evidence-based interventions and scale-up.

Discussion and rationale

An on-budget and more directly earmarked support may have the potential to accelerate positive progress and performance. Private Not For Profit (PNFP) health service providers represent major actors in the Ugandan context. PNFPs already deliver health services in remote, challenging and under-resourced parts of Uganda, where health needs are great. At present PNFP providers are supported with public funds from the recurrent PHC budget. This is probably an effective way of making use of PNFP service delivery structures, but such providers are adversely affected by the current budget allocation process, which has resulted in reduced recurrent funds.

[25] DFID is currently supporting a PFNP project in one Ugandan region; it has volunteered to share its draft concept document with the Kampala Swedish Embassy. One DFID comment is that even small funding sums can make a big impact with PNFP providers; a recommendation is to plan from the outset for scale-up and not to be too small scale.

There is opportunity to co-ordinate health services provided by district and PNFP facilities. PNFP providers are able to avoid rigid public sector health systems regarding staffing and salary setting (and may experience overall less extreme HRH shortfalls).

Because PNFP providers are not fully part of national health planning processes, there is an additional potential benefit from more direct PNFP engagement with national and district authorities. PNFP providers are increasingly relying on user fees for revenue and recurrent costs.[26] GoU funds subsidise PNFP providers; therefore, the benefit of those funds is provided to those who can afford user fees. This could be mitigated by programme focus on equity in access, building on the rights-based approach.

In designing a programme that would support another health service delivery system, there are a number of important issues to be addressed, so as to avoid the development of parallel structures. These would be inefficient and unsustainable. Ideally, a programme in support of PNFP providers would strengthen capacity in the ministry to purchase health services from the PNFP sector. A long term outcome of such support could conceivably be enhanced GoU ability to use public funding by strategic purchase of services from the PNFP sector. Therefore, any such Swedish support should be on-budget, the interventions planned by the MoH, and M&E be part of routine district data management. In order to avoid adverse HRH allocation and rather to contribute to strengthening of HRH in currently under-served areas, any such PNFP programme should focus on such areas. The programme should support more effective and equitable allocation and geographical distribution of health workers.

The potential gains from this type of support are that it could strengthen the longer term capacity of the system to make use of existing resources, and that it could relatively quickly (through using already existing PNFP health system structures) be able to increase direct service delivery in Swedish and other health priority areas. The GoU is responsible for the entire health system, including services delivered by PFNP and other private providers. Purchasing health from existing PNFPs strengthens such providers' control over what is provided, and for whom, i.e. increased potential to manage the health system, so that those most in need will receive services.

6.3.2 10-year Memorandum of Understanding

This is the vehicle for support applied by DFID in Rwanda (more widely than the health sector). Apparently one of its objectives is that through dedicated, guaranteed support over a longer time span than is currently applied, a more results-based approach may be applied and stand a greater chance of being achieved. It may be that consideration of a longer funding period than is commonly the case for projects might also allow greater opportunity for a more focused, evidence and performance-based and value for money approach, with tighter linking into country systems and HSS support.

[26] Tribal Health, 2010. *Health Sector Fiduciary Risk Assessment* (section 3.7).

ANNEX 1. TERMS OF REFERENCE

Evaluation Purpose

The evaluation will review the health sector performance over the time period 2000-2010 and assess whether Sweden has added value to the overall pool of external resources going to the health sector and seeking to determine if the sector program support (SPS) modality, as it is used by Sweden, is relevant, effective, efficient and sustainable in reaching the health sector goals set out in the country cooperation strategy for Uganda 2009-2013 and beyond. The objectives of the evaluation are threefold:

1. Looking back. To review the effectiveness, impact and appropriateness of the SPS aid modality to the implementation of Uganda's health sector objectives and plans, based on the 10-year Swedish experience. The evaluation should pay specific attention to determining the Swedish added value to policy development and health sector performance and possible tangible results of Swedish financing and strategic dialogue. What have been the results and added value of the Swedish support to this program during this period? These results include:

- The marginal benefit to the program and the sector of Sida's financing for the program
- The benefits to the program and the sector of Sida's giving a relatively flexible support
- The benefit to the program and the sector of Sida's giving a very aligned support as opposed to a less aligned support in terms of using country systems
- Sweden's effect on donor coordination on the program and the sector
- The effect of Sida's dialogue on the program and the sector

2. Overall sector performance and results. To review overall health sector performance and make results visible and usable, given the available financing for the health sector over time. This includes analyzing health improvements in Uganda; trends in epidemiology, health financing and policy development and reforms from a 10-year perspective and challenges that have persisted or emerged over the 10-year period. What has been accomplished in the health program and generally in the health sector during 2000-2010? This part of the evaluation must build almost exclusively on the work of earlier evaluations and studies. In addition:

- How important is the program for the development of the health sector, i.e., what portion of the progress and setbacks in the health sector can reasonably be attributed to the sector program?
- What role has Sweden played in the sector program and in the sector?

3. Looking forward. To use the evaluation in the consideration and preparation of a new phase for continued health sector support; to provide input to the design of a new program of long-term support to the health sector, including conclusions, recommendations and lessons based on results (outcome and impact), remaining critical issues and expected challenges. What are the advantages and disadvantages of different aid modalities and channels for possible Swedish support to the health sector during the coming period? The alternative ways of supporting the health sector in Uganda are:

1. General budget support
2. Sector budget support or a highly aligned sector program support like what Sida has been providing so far
3. A less aligned form of sector program support, such as a World Bank trust fund or a donor pool
4. Project support to national government, more or less aligned
5. Program support to local government
6. Project support to local government
7. Project support to a local or international NGO
8. Support to a global vertical health fund active in Uganda

Consider each option in the Ugandan context. Weigh the advantages and disadvantages of these options in terms of achieving results, achieving these results sustainably, and living up to Sweden's commitments in the Paris Declaration 2005 and Accra Agenda for Action 2008 (ownership, alignment, harmonization, results and mutual accountability).

Intervention Background

Sweden has a long experience of development cooperation in the health sector in Uganda. The Swedish support should be seen within the context of all the donors active in the health sector and in the progress of harmonization and alignment over the years. Impact and improvements in health are therefore not always easy to identify as specific related to the Swedish support.

After 10 years of cooperation in health within SPS modalities there is a need to evaluate and review the specific Swedish added value and comparative advantage in this context, both when it comes to modalities, harmonization and alignment and specific health indicators, outcomes and impact, including sensitive issues like Sexual and Reproductive Health and Rights (SRHR).

Over the time period spanning ten years 2000 to 2010, an approximate of 550 Million SEK has been disbursed through the SPS modality to the Ministry of Finance, Planning and Economic Development, and Health to implement the Government of Uganda's health sector's strategic priorities in line with the two consecutive five-year health sector strategic plans, HSSP I 2000/01-2004/05 and HSSP II 2005/06-2009/10. Development partners', including Sweden's, support to the health sector is guided by a sector-wide approach, Swap, which was put into place already with the first HSSP in 2000.
Over the ten years of SPS bilateral agreements, Sida and the Embassy have not conducted its own full evaluation into the performance, trends and results of the health sector, but have consistently relied on available reporting and documentation available from the Government of Uganda, other development partner agencies, civil society and independent consultancy reports. A number of stand-alone evaluations have been carried out by Sida/the Embassy regarding various projects only. As the sector support is un-earmarked and part of the Swap approach and the Paris agenda for aid effectiveness, the SPS funding is integrated with the domestic funding for the health sector. This means that national systems for budgeting, planning, monitoring, reporting and auditing are utilized.

There is a wealth of reports and reviews that have carefully monitored the health sector and its performance over the past ten years. However, none of these have specifically evaluated the Swedish added value to the sector through the un-earmarked SPS.

Stakeholder Involvement in the Evaluation

- Stakeholder involvement during the preparation phase as well as the entire evaluation process is essential for quality and ownership. There should be stakeholder involvement also in discussion on findings, lessons learned, conclusions and recommendations to both Sweden and Uganda.
- The intended users of the evaluation are first of all those involved in the daily work and cooperation between Sweden and Uganda in the health sector, first of all Embassy staff and its health specialists and technical staff at the MoH in Uganda.
- Other donors should be invited, consulted and coordinated with.
- Civil society organizations, other social networks and groups as well as academia's participation and perspectives in Uganda should be part of the process.

Evaluation Questions

Health outcomes and impact (different aspects) over a 10-year period

- Based on the key national health indicators in the National Health Policy and Health Sector Strategic Plan, HSSP I, 2000-2005 and HSSP II, 2005-2010, what are the major trends seen over both time periods in terms of both epidemiology and sector priorities for the GoU?
- What have been the major health results for poor people at local level taking gender and regional disparities into consideration?
- Have the regional differences in health outcomes persisted or deepened during the period?
- How have the MDGs faired (Maternal and Child mortality rates, HIV and AIDS prevalence as well as other communicable diseases) over the period?
- What have been the Government's main priorities for the health sector and have those changed over time? Have the priorities resulted in improved health outcomes in the priority areas?

- Health outcomes and impact should be analyzed both in relation to health systems development and increased access to health services for poor people, as well as to factors outside the health sector such as social determinants of health.
- What have been the major systemic achievements and setbacks regarding the health system's development, based on the six WHO building blocks (service delivery, health workers, information, medicines, financing, governance), over the period?
- Based on the National Health Policy and Health Sector Strategic Plan, HSSP I, 2000-2005 and HSSP II, 2005-2010 how has the national health system developed?
- What specific support has Sweden given to health system development, within the SPS, complementary support and/or in active dialogue and advocacy?
- What is the view of Ugandan health sector stakeholders on Sweden's impact and contribution to the health sector over the time period? What is the perceived comparative advantage and added value of Sweden?

- *SPS and Aid modality issues*
  - To what extent has the SPS modality contributed to the establishment of relevant policy development and dialogue, focused on key government strategies and priorities for the health sector?
  - How has the health financing of the health sector changed in the 10 years, including the GoU share of health financing versus external funding, both on and off-budget?
  - How has the emergence of the health Swap in 2000 contributed to reinforce Sweden's impact and to the sector's performance?
  - What has been the scope for dialogue and impact regarding Swedish efforts to promote SRHR and other sensitive issues, within the realm of the SPS aid modality? What factors have influenced this scope?
  - How has the Swedish support been harmonized and adjusted to ensure complementarity with other donor support?
  - To what extent has SPS to health contributed to improvements (including efficiency) in public health spending?
  - Has SPS contributed to transparency, accountability and efforts to fight corruption?
  - What are the perceived gains and constraints for the GoU with multiple financing modalities?
  - In what way has the arrival of the global health programmes, with substantial funding (Global Fund, GAVI, PEPFAR, PMI etc.) affected to Sweden's impact and to the sector's performance, in particular to areas of Swedish concern such as SRHR, health systems development and prevention of HIV and AIDS?
  - Are appropriate harmonization and alignment procedures and mechanisms in place to facilitate a large influx of funding from the global health programmes and others?
  - Has Sweden's leverage diminished as huge volumes of external funding from global disease-specific programmes have increased?

Recommendations and Lessons

Based on conclusions and findings, results analysis and challenges, the evaluation should respond to the following questions:

- Should the SPS aid modality be recommended to continue in its current form in the forthcoming health sector support programme with Uganda in order to best achieve objectives and maximum impact? Elaborate on risks, pros and cons based on different political and economic scenarios.
- What are other feasible alternative options to SPS and how can such programmes be designed to secure poor people's access to health services in a long term, sustainable perspective? Elaborate on partnership with local government partners as well as non-state actors including the private sector and civil society.
- How do the lessons learnt from this evaluation compare with the findings of the phase one and two evaluations of the Paris Declaration, and what are the implications of the Ugandan experience in light of prevailing trends and lessons learnt in aid harmonization and alignment?

Methodology

- Must adhere to OECD/DAC Evaluation Standards (OECD/DAC Guidelines and Reference Series; "Quality Standards for Development Evaluation"). Both the review process and review report may be assessed against the standards prior to approval.
- Use existing knowledge on methodology when evaluating SPS, country systems and budget support.
- Participatory with stakeholder involvement: key stakeholder interviews, focus group discussions, multi-stakeholder workshops to validate findings.
- Review and use of available health systems research on Uganda.
- It is important that the consultants have read the available material and are well oriented in the Ugandan health sector before they approach stakeholders in Uganda.
- Mixed Evaluation Team

Work Plan and Schedule

- An implementation plan, including consultants and competencies to be used, methodology to carry out the evaluation, budget and time plan should be presented to Sida at latest June 15.
- A short inception report outlining in some detail how the consultants intends to conduct the assignment, including methodology when evaluating SPS, budget support, country systems and health systems should be presented to Sida at latest August 31.
- The evaluation should be carried out during September-October 2011, including preparations and workshops to discuss findings, lessons learned, conclusions and recommendations.
- Maximum a total of 16 consultancy weeks distributed between 2-4 consultants with relevant complementary competencies.

Reporting

- Draft report to discuss in workshop in Uganda in October 2011.
- Draft report to discuss in workshop in Stockholm in October-November 2011.
- Final report in presentation in Stockholm in November 2011, at latest November 30.
- The report should be in English and concise, between 30-50 pages, excluding annexes.

Evaluation Team

- 2-4 consultants with complementary competencies. One should be Team Leader and one should be national or from the region.
- Needed competences are: Health and development cooperation in Health, including Health systems and SRHR.
- Aid modalities, including sector program and budget support.
- PFM
- Evaluation experience, including experience of participatory evaluation methodologies.
- Experience of the Uganda context and/or the region.
- Experience from health sector and/or public service.
- Knowledge and understanding of Sida and the Swedish development cooperation and relevant Swedish policies.

ANNEX 2: SIDA DEFINITIONS OF FORMS OF CO-OPERATION

This document was provided by the Swedish Embassy in Kampala.

The concept of form of cooperation describes the focus and the design of the cooperation between Sida and its cooperation partner. The form of co-operation includes the degree of steering of resources as well as the extent of use of the cooperation partner's systems and structures.

The forms of cooperation are divided in three main groups, as follows:

Programmes

General budget support for poverty reduction
Core support to an organisation
Sector budget support
Sector programme support with pooled funding
Support to specific programmes and funds managed by an organisation

Project support
Project support

Experts
Experts
Training/Scholarship in Sweden
Training/Scholarship in partner country
Resource-based development

When deciding which form of cooperation a contribution/component shall have, remember that it is the form of cooperation with the agreement partner that counts, not the purpose.

Form of co-operation	Definition	Example	Programme- Based Approach	Investment related project	Trade development	Technical cooperation
PROGRAMME						
General budget support for poverty reduction	A non-earmarked financial contribution to the partner country's budget, in order to support the implementation of a national development programme in the form of a strategy for development and poverty reduction (PRS or equivalent). The funds are transferred to the recipient government's national treasury, are brought together with all other budget revenues and are managed according to the recipient's budgetary procedures and the systems for public financial management. The disbursements of general budget support are dependent on the cooperation country having fulfilled the agreed conditions for disbursement. The form of cooperation is regulated by specific guidelines for general budget support for poverty reduction (Government decision 2008-04-10). A specific form of general budget support is the so-called temporary budget support. This form is regulated by the same guidelines and is classified as general budget support**.**	General budget support to Tanzania	Yes	-	-	-
Core support to an organisation	Core support to an organisation. Core support concerns funds which are not earmarked for specific programmes or projects, but are funds that contribute to the organisation's total budget and activity. The funds are brought together with the organisation's other revenues and are managed according to the organisation's own budgetary procedures, as well as procedures and systems for implementation and follow up.	Core support to institutions in the cooperation countries, international or non governmental organisations, foundations, public-private partnerships or research institutes. Core support to Transparency International	Yes	-	2, 1 or 0	2,1 or 0
Sector programme support	A financial support to a sector programme/sector-wide approach (SWAp). The support may concern a whole sector/policy area or a part of a sector/policy area. A sector programme support involves a process where several donors make a coordinated financial support to a sector policy and sector plan under the leadership of the partner country. The sector programme support can take the form of					

	a. a sector budget support or b. a sector programme support where the donor funds are channelled through a pool common for the participating donors .					
a. Sector budget support	**A sector programme support financed by budget support. Sector budget support is a financial contribution to the partner country's budget in order to support the implementation of a country's policy and plan for a sector, part of sector or policy area. When applying sector budget support, the funds are part of the partner country's budget process and managed according to the country's systems and procedures for public financial management, as for general budget support. The difference is that with sector budget support, the conditions, dialogue and the follow-up of results focus mainly on sector-specific issues.**	**Sector budget support to the health sector in Uganda** Health sector support to Zambia	Yes	-	2, 1 or 0	2, 1 or 0
b. Sector programme support with pooled funding.	A sector programme support financed by a coordinated financial support from several donors to a separate bank account, so-called "pool" that is managed jointly by the donors and/or the recipient part. The account/pool is regulated by specific conditions and procedures regarding for instance disbursement, follow-up, reporting and audit. The procedures are common to all donors of the pool. Pooled funding is characterized by common programme documents and by a joint agreement between the cooperation partner and the donors regarding the form of financing. **The difference between sector budget support and sector programme support with pooled funding, is that when choosing sector budget support, the partner country's systems and procedures for public financial management are used, whereas with pooled funding, specific arrangements are used, agreed upon between the partner country and the donor countries (to a varying degree).**	Sector programme support to education in Honduras	Yes/ No	-	2, 1 or 0	2, 1 or 0

Support to specific programmes and funds managed by an organisation	Support to an organisation in order to support a specific sector, policy area/thematic area or a geographical area. This type of aid may concern either a contribution where an organisation (often an international organisation) is used as an implementation channel (e.g. support to a Multi Donor Trust Fund, administrated by the World Bank) or a contribution to a part of an organisation's own work area (e.g. support to a research institute for research within a thematic area.) The difference between core support and support to a specific programme managed by an organisation is that in the latter case the support is earmarked for a programme or a work area. When it comes to core support, the contribution is not earmarked for specific programmes and activity areas, but constitutes a core support to the total activity of the organisation.	Contribution to Fast Track Initiative (Education for All) by the World Bank Afghanistan Reconstruction Fund Support to research programme (which is not reported as organizational support or project support).	Yes/ No	-	2, 1 or 0	2, 1 or 0
PROJECT SUPPORT						
Project support	A project is a set of "inputs", activities and outputs, agreed with the partner country or another part to reach specific objectives/outcomes within a defined time frame, with a defined budget and a defined geographical area. The characteristics of a project, in contrast to a programme, is that a project has a well defined purpose in relation to the recipient partner's work area and has well defined and limited resources and activities. The donors' resources are to a great extent earmarked and the contribution follows to a great extent specific procedures and reporting requirements. A large project with a number of different components is sometimes referred to as a programme, but should nevertheless be recorded as a project in the statistical reporting system. When it comes to the difference between "Project" and "Support to specific-purpose programmes and funds managed by an organisation, an important aspect is to what extent the donors' resources are earmarked. With projects, there is a higher degree of steering of resources regarding resources and activities. When it comes to specific programmes, the use of the donor's funds is not steered	Zambezi ferry crossing, Moçambique The co-operation between RFSU and MAMTA, India	Yes/ No	Yes/ No	2, 1 or 0	2, 1 or 0

	towards certain activities. Instead, the contribution constitutes a broad support from several donors to one or several programmes.					
EXPERTS						
Experts	Swedish experts on the field and international organizations (seconded personnel), consultants, teachers, university graduates, researchers, trainees, etc which are financed directly by Sida or indirectly by other Swedish authorities, institutions or organizations.	Seconded personnel National experts	Yes/ No	-	2, 1 or 0	2
Training/Scholarship in Sweden	Courses/study programmes in Sweden, aiming at capacity building of the participants from partner countries.	Part of ITP's operations carried out in Sweden, Palme section (Linneus-Palme)	Yes/ No	-	2, 1 or 0	2
Training/Scholarship in partner country	Study programmes and research in the recipient country aiming at capacity building of the participants from the partner countries. Developing orientated social and cultural programmes perfomed in the recipient country. Conferences, seminars, work shops, exchange visits performed in the partner country.	South-South-operation, Part of ITP's operations carried out in the partner country, e.g. the Swedish Research Links-programme	Yes/ No	-	2, 1 or 0	2
Resource-based development	Competence development and educational services to Swedish citizens, in order to enlarge, instruct and increase the use of the Swedish resource base in the bilateral and multilateral development cooperation and to increase the share of qualified Swedish personnel within preferential international organizations.	JPO, BBE, JED, SARC, MFS, Internships, courses at Sida Civil Society, Athena (SMUL), Linneus section of Linneus-Palme	No	-	2, 1 or 0	0

Definition of Programme based approach

A programme based approach is a way of engaging in development cooperation based on the principle of coordinated support to a locally owned development programme, like a national strategy for poverty reduction, a sector programme, a thematic programme or an *organizational programme.*

Donor countries may work according to a programme based approach in different ways and by using a series of different types of aid. For contribution to be classified as a programme based approach the following criteria have to be fulfilled:

i) The recipient country or the organization exercises its leadership on the programme/project

ii) one single all covering programme and one budgetary framework is used.
iii) there is a formalized process for donor coordination and harmonization of donor procedures to at least two of the following systems: i) reporting, ii) budgeting, iii) financial controlling and iv) procurement and that
iv) the support uses at least two of the following systems: i) local systems/processes for the formulation of programmes, ii) systems/processes for the realization of programmes, iii) systems for the financial controlling and local systems for the follow up and evaluation/assessment.

Definition of technical cooperation

Technical cooperation means financing of activities whose main purpose is to increase the level of knowledge and skill among personnel in institutions/organizations in the developing countries, i.e., to increase these countries' human capital or their capacity to make use of their resources such as labour force, capital, natural resources and enterprise more efficiently. This includes labour costs, training and research as well as necessary equipment and other administrative costs with reference to this.

ANNEX 3. HSSP I AND II AND HSSIP III INDICATORS AND TRENDS IN HEALTH SECTOR PERFORMANCE

This Annex provides background information on health sector indicators during the evaluation period (2000-2010). It contains tables setting out health sector performance during HSSPI and II (taken from AHSPRs). These tables are considered vis-à-vis PEAP indicators and PEAP health outcomes (PEAP was the Poverty Eradication Action Plan 2004/5-2007/8; extended to end June 2010). The PEAP has now been superseded by the National Development Plan. This Annex also includes current (HSSIP III) indicators and targets.

Indicators common to HSSP I (2000/1 – 2004/5) and HSSP II (2005/6 – 2009/10)						
Category	**Indicator**	**Baseline**		**Target**		**Comments**
		HSSP I	**HSSP II**	**End HSSP I**	**HSSP II**	
		Various dates	FY 2004/5	2004/5	FY 2009/10	
1. Input	% GoU budget allocated to health	7.3	11.2 (allocation) 9.7 (expenditure)	10.0	13.2	**HSSP II**: stagnation over medium-term; may not achieve HSSP II target
2. Input	% PHC Conditional Grant released on time (non-salary recurrent & capital)	__	100	100	100	**HSSP II**: need to have comparable year on year data for meaningful trend analysis. Target achievable over HSSP II period
3. Input	Total public [GoU & DP] p.c. allocation to health	$4.80	$7.80	$10	$$18.00	**HSSP I**: Indicator not good measure of equity; more levels of funding for HSSP **HSSP II**: exceeded target when off-MTEF DP funds included; need to agree numerator & denominator
4. Process	% disbursed PHC Conditional Grants that are expended	50.0	99	95	100	**HSSP I**: Improved financial flows & management procedures have produced 'spectacular' [by whose measure?] incr. in absorptive capacity at D level **HSSP II**: downward trend over medium term; need comparable year on year data for meaningful trend analysis
5. Process	Proportion of districts submitting complete & timely HMIS monthly to MoH	15.6	85	80	100	**HSSP II**: downward trend over medium term. Unlikely to achieve HSSP II target unless major remedial action taken
6. Process	% HFs without stockout of	29.1	35	65	80	Well off target for **HSSP II**; unlikely to achieve target unless major

	Chloroquine, measles vaccine, ORS & Cotrim					remedial action taken to mainstream into HMIS. Maintain as PEAP/NDP indicator
7. Process	% population residing < 5km from HF [public or PNFP] providing minimum health package	57.0	72		85	**HSSP II**: Up-to-date status unknown; lack regular source of comprehensive data
8. Output	% < 1 year receiving DTP3 on schedule	41.4	89	80	90	**HSSP II** target is achievable. Maintain as PEAP/NDP indicator?
9. Output	Proportion health posts filled by trained HWs	33	68	48	90	**HSSP II**: lack regular source of comprehensive data; need to agree data source & responsible entity. Maintain as PEAP/NDP indicator
10. Output	Contraceptive Prevalence Rate (HSSP I)/Couple Year Protection (HSSP II)	15	223,686	30	494,908	**HSSP II**: substantial progress over medium term; HSSP II target achievable. Maintain as PEAP indicator
11. Output	Prop surveyed pop expressing satisfaction with health services	_____	_____	_____	____	Survey to be conducted at end **HSSP I**
12. Output	Urban/rural HIV prevalence rates	10.9 urban 4.3 rural 6.8 national average	6.4	5.0	4.4	**HSSP II**: lack regular data for trends; ANC surveillance site reports not available. Maintain as PEAP indicator?
13. Output	% deliveries in HF [GoU/NGO], with supervising HW	25.2 HMIS & 38.0 UDHS 1995	25 (utilisation) 38 (supervised by HW)	35 HMIS & 45.0 UDHS	50 & 60	**HSSP II**: improvement over the medium term; possible to achieve HSSP II target if health system challenges addressed. Maintain as PEAP indicator
14. Output	Total GoU/NGO OPD utilisation Per Patient Per Year	0.40	0.90	0.7	_____	**HSSP II**: stagnation over the medium term; HSSP II target achievable. Maintain as PEAP/NDP indicator
15. Output	**HSSP I**: HF-specific sections per 1,000 deliveries within HF catchment area/**HSSP II**: Caesarean sections per expected pregnancies (Hospital)	14.0 per 1,000 LB	4%	25-30	10%	**HSSP II**: no regular source of comprehensive data; challenges with numerator & denominator. Review indicator in preparation for HSSP III
16. Output	Prop TB cases notified vs. expected	50	52	80	70	**HSSP II**: stagnated over medium term; may not achieve HSSP II target
17.	**HSSP I**: Malaria CFR <5	_____	55%	_____	70%	

	years/**HSSP II**: proportion of <5 w. fever who receive malaria treatment within 24 hrs of a CDD					
18.	% fever/uncomplicated malaria (all ages) correctly managed at HFs		65		100	**HSSP II**: lack regular source of comprehensive data; to review indicator in prep for HSSP III

New indicators in HSSP II				
		Baseline HSSP II FY 2004/5	**Target FY 2009/10**	**Comments**
Process	Proportion of districts submitting quarterly assessment reports	20%	90%	Unlikely to achieve target for HSSP II; information not readily available in current HMIS – to [address in] HSSP III
Process	% of health units by level providing all components of the UNMHCP	_____	_____	Lack regular source of comprehensive data; to revisit in preparation for HSSP III
Process	% of health units providing EmOC	20%	60%	Lack regular source of comprehensive data; to revisit in preparation for HSSP III. Agree on numerator and denominator and differentiate between BEmOC and CEmOC
Output	Caesarean sections per expected pregnancy (hospital)	4%	10%	No regular source of comprehensive data; challenges with numerator and denominator. To review indicator in preparation for HSSP III
Output	Proportion of TB cases that are cured	65%	85%	Modest improvements over medium term; it is possible to achieve target
Output	Proportion of pregnant women receiving a complete does of IPT2	30%	75%	To agree regular data source – HMIS? Others sources for comparison and validation
Output	% of households with at least one ITN	_____	70%	Good progress over medium term; expected to achieve HSSP II target. Data [are] often inconsistent; need to agree on comprehensive and regular data source
Output	% of households with pit latrine	57%	72%	Stagnated over the medium term; unlikely to achieve HSSP II target unless special effort is made. Maintain as PEAP indicator

Trends of performance against 8 core PEAP indicators during HSSP I and II

Indicator	Achieved FY 2000/01	Achieved FY 2001/02	Ach'd FY 2002/03	Achieved FY 2003/04	Achieved FY 2004/05	Achieved FY 2005/06	Achieved FY 2006/07	Achieved FY 2007/08	Ach'd FY 2008/09	Ach'd FY 2009/10	Target HSSP II (09/10)
Proportion of approved Posts filled by Trained Health workers	40%	42%	66%	68%	68%	75%	38.4%	38.4%	56%	56%	65%
Proportion of Health facilities without stock –out of 5 tracer medicines & supplies	54.9%	55%	N/A	N/A	35%	26%	35%	28%	26%	41%	70%
OPD Utilization in Govt & PNFP Units	0.43%	0.6%	0.72%	0.7%	0.9%	0.8%	0.9%	0.8%	0.8%	0.9%	1%
Couple Years of protection (CYP)			228,675	223,686	234,259	309,757	357,021	361,080	549,594	460,825	494,908
DPT 3 /Pentavalent vaccine coverage	48%	63%	84%	83%	89%	89%	90%	82%	85%	76%	95%
Household latrine coverage	82%	62.4%	87%	43%	57%	58%	58.5%	62.4%	67.5%	69.7%	70%
National Average HIV Sero- Prevalence at ANC Surveillance sites	6.1%	6.5%	6.2%	NA	6.2%	6.2%	9.7%	7.0%	5-10%	6.5%	4.4%

PEAP related outcomes

Indicators (Achieved)	FY 2000/01	FY 2001/02	FY 2002/03	FY 2003/04	FY 2004/05	FY 2005/06	FY 2006/07	FY 2007/08	FY 2008/09	FY 2009/10
IMR (deaths /1,000 live births)	91	89	88	88	76	76	76	76	79	74
Under 5 MR (deaths /1,000 live births)	157	156	147	138	138	137	137	137	138	137
MMR (deaths /100,000 live births)	505	505	505	505	505	435	435	430	440	435

HSSIP III Core Performance Indicators

The indicators highlighted in grey are those that correspond wholly or in terms of overall purpose to HSSP I and/or II indicators

Indicator domain	Indicator	Baseline (& year)	Target (2014/15)
Health impact	Maternal Mortality Ratio	435 (2006; UDHS)	131
	Neonatal Mortality Rate	70 (2006; UDHS)	23
	Infant Mortality Rate	76 (2006; UDHS)	41
	Under 5 Mortality Rate	137 (2006; UDHS)	56
	% of households experiencing catastrophic payments	28 (2009; Household Survey)	13
	% clients expressing satisfaction with health services (waiting time)	46 (2008; MOH Survey)	70
Coverage for health services	% pregnant women attending 4 ANC sessions	47 (HMIS; 2009/10)	60
	% deliveries in health facilities (public and PNFP)	33 (HMIS; 2009/10)	90
	% children < 1 yr immunised with 3rd dose Penta	76 (HMIS; 2009/10)	85
	% children 1 yr immunised against measles	72 (HMIS; 2009/10)	95
	% pregnant women who have completed IPT2	47 (HMIS; 2009/10)	70
	% under 5s with fever receiving malaria treatment within 24 hours	13.7 (HMIS; 2009/10)	85
	% eligible persons receiving ART	53 (HMIS; 2009)	75
	% of new smear + cases notified, compared to expected (case detection rate)	56 (HMIS 2009/10 & NTLP)	70
Coverage for health determinants	% of households with a pit latrine	69.7 (HMIS 2009/10 & UDHS)	72
	% U5 children with height/age below lower line (PR)	38 (UDHS; 2006)	28
	% U5 children with weight/age below lower line (PR)	16 (HMIS; UDHS 2006)	10
Coverage for risk factors	Contraceptive Prevalence Rate	24 (UDHS 2006)	35
Health System outputs (availability, access, quality, safety)	Per capita OPD utilisation rate (m/f)	0.9 (HMIS 2009/10)	1.0
	% of villages with trained VHTs, by district	31 (HMIS 2009/10)	100
	% of health facilities without stockouts of any of the 6 tracer medicines in previous 3 months (1st line antimalarials, Depo, Suphadoxine/ pyrimethamine, measles vaccine, ORS, Cotrim	41 (Annual MoH Drug Survey 2009/10)	80
	% of functional Health Centre IVs providing EmOC	23 (HMIS 2009/10)	50
	Annual reduction in absenteeism rate (M/F)	------- (Panel Survey)	20
Health investments	% of approved posts filled by trained health workers	56 (HMIS 2009/10)	75
	General Government allocation for health as % of total govt. budget	9.6 (MoFPED 2009/10)	10.0

ANNEX 4. FINDINGS AND CHALLENGES (LINKED TO THE ToR QUESTIONS)

This annex contains the full text pertaining to the discussion of the twenty-one ToR questions; these are briefly covered in section 5 of the report. Gaps in the ToR are considered in the final section of this Annex.

1. HEALTH OUTCOMES AND IMPACT (DIFFERENT ASPECTS) OVER THE 10-YEAR PERIOD

The five health sector and Uganda-specific questions related to outcomes and impact, all of which are wide-ranging, would require more detailed examination than the evaluation schedule allowed in order to be fully answered. The questions go beyond the specifics of Swedish support into a general health sector overview, which it has not been possible to achieve in more than the broadest terms in the time available for the evaluation. Furthermore, it must be borne in mind that it has not always been possible to discover all detail and processes relating to *health outcomes and impact* questions that seek to address the entire period since 2000. On occasion there has been insufficient documentation and/or institutional memory to arrive at comprehensive discussion of e.g. all aspects of the overall development of the health system. In addition, a number of approaches and priorities have evolved over time, e.g. the Paris Declaration, The Accra Agenda, enhanced focus on the MDGs, the IHP+ and attention to major systemic developments based on the six WHO HSS building blocks.

1.1 Based on the key national health indicators in the National Health Policy and Health Sector Strategic Plan, HSSP I, 2000-2005 and HSSP II, 2005-2010, what are the major trends seen over both time periods in terms of both epidemiology and sector priorities for the GoU? [27]

Please see Annex 3 for a full overview of HSSP I and II indicator trends and also for consideration of performance pertaining to core health indicators in the PEAP. There were 18 indicators in HSSP I; a further 8 were added to HSSP II. As noted above in the introduction to section 4, there were initial and considerable improvements in key maternal and child indicators and advances in other indicators, with slower movement over the past 5 or so years. In addition, please see section 4.2.

Table 1: Positive trends in common HSSP I and II indicators (2000-2010) and in new HSSP II indicators (2004/5-2009/10)

Common HSSP I & II Indicators	**Comment (in AHSPR)**
% disbursed PHC Conditional Grants that are expended	**HSSP I**: 'spectacular' improvements [By comparison: '**HSSP II**: downward trend over medium term; need comparable year on year data for meaningful trend analysis']
% < 1 year receiving DTP3 on schedule	**HSSP II** target [of 90%] is achievable
Contraceptive Prevalence Rate (HSSP I)/ Couple Year Protection (HSSP II)	**HSSP II**: substantial progress over medium term; HSSP II target achievable [NB: see e.g. 5.1.2 below for an alternate perspective]
% deliveries in HF [GoU/NGO], with supervising HW	**HSSP II**: improvement over the medium term; possible to achieve HSSP II target if health system challenges addressed
New HSSP II Indicators	**Comment**
Proportion of TB cases that are cured	Modest improvements over medium term; it is possible to achieve target [85%]
% of households with at least one ITN	Good progress over medium term; expected to achieve HSSP II target [70%].

[Comments in square brackets made by the evaluation team]

Year on year performance on the majority of indicators common to HSSP I and II are reported in the AHSPRs and the two Mid-term Reviews as modest, as having experienced downward trends or having stagnated.

[27] Please note that the evaluation team was advised not to review Swedish development assistance to HIV & AIDS interventions; this is relevant for a number of ToR questions.

A general point in the context of review of Ugandan health sector indicators: they are inadequately disaggregated and demonstrate insufficient attention to gender and other socio-cultural barriers to health care, to social determinants of health and to regional and other variation. Just one example among many: '% of households with at least 1 ITN' fails to consider the often reported possibility that the mosquito net may not be used by those in most need, i.e. (pregnant) women and under-fives.

A relatively contemporary overview of performance and trends comes from the December 2010 JAF report: 'The health sector's performance was poor against headline sector results. In some cases, performance declined for the second year in a row. Most...indicators rely heavily on the procurement of key inputs (essential medicines, vaccines, contraceptives) and a functioning supply chain. Even in the face of insufficient budget allocation, [the MoFPED has] reported non-spending of funds released to the Ministry of Health for the procurement and distribution of key inputs such as vaccines (only 14.42Bn UGX was spent by MoH of 33.6Bn UGX released).

Further, the MoU between MoH and the National Medical Store has not been signed...Broadly speaking these oversights are symptomatic of characteristic deficiencies in the management of the health sector as reflected by the MoH's weak leadership.'

The health sector continues to be plagued with a lack of adequate facilities, supplies, medicines and staff. While 95% of women nationally made at least one antenatal clinic visit, only 47% made four or more visits, as recommended by WHO and UNFPA, etc. (UDHS 2006). Only 42% of births are assisted by skilled providers (it is relevant to note the absence of a coherent definition for SAAB) and 63% of women in rural areas give birth at home compared to 20 % of women in urban areas.

1.2 How have the MDGs fared (Maternal and Child mortality rates, HIV and AIDS prevalence as well as other communicable diseases) over the period?

Despite its noteworthy achievements in the past ten years in terms of reducing the MMR, the IMR and the U5MR, Uganda continues to face considerable challenges if it is to achieve health MDGs 4 (*reduce child mortality*) and 5 (*improve maternal health*), the MDGs to receive attention in this evaluation report. The 2010 Uganda MDG report states that progress is slow on all three relevant targets. To contextualise the MDGs: one woman dies every hour and a half in childbirth in Uganda, upwards of 6,000 every year (and this official figure is likely to be an under-estimate); under-five mortality is currently reported at 120 per 1,000. The GoU has in recent years acknowledged challenges, e.g. by instituting the *Roadmap to Accelerate Reduction of Maternal and Neonatal Mortality and Morbidity* and the *MDG Acceleration Framework*. The latter prioritises four key maternal health interventions: emergency obstetric care, skilled attendance at birth, family planning and effective antenatal care. Considerable attention is also currently being given to increasing the number of midwives and seeking to ensure better national coverage of such key health workers; UNFPA is a major partner in this activity.

Another factor militating against effective work towards MDG 4 and 5 targets is the continuing and seemingly almost intractable unmet need for contraception. Thus the 2006 UDHS indicates unmet need among married women of 41%; the actual contraceptive prevalence rate was then 24% for all methods, an increase of 1% since the 2000/1 UDHS. The total fertility rate is currently 6.7.

1.3 What have been the Government's main priorities for the health sector and have those changed over time? Have the priorities resulted in improved health outcomes in the priority areas?

Much of the discussion here is informed by 1.1 and 1.2 (see immediately above), as well as by sections 3 and 4.

The over-arching policy and strategic framework governing the Ugandan health sector in 2011 is enshrined in the National Health Policy II (2010). Central to delivery of the Health Sector Strategic and Investment Plan (HSSIP III) and attainment of the sector goal and objectives is the Uganda National Minimum Health Care Package (UNMHCP). The core strategies of the UNMHCP are aligned to the Millennium Development Goals. The UNMHCP has formed the basis of GoU health sector priorities throughout the decade.

Please again see Annex 3 for HSSP I and II indicators, as these give an overview of priorities as supported by the SWAp modality. The HSSP II states that 'The overall development goal of the HSSP II is *the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life*. The programme goal, retained from HSSP I, is *reduced morbidity and mortality from the major causes of ill-health and premature death and reduced disparities therein*.'

SRH & R was a 'priority programme for HSSP II'. The overall goal of the programme was to accelerate the reduction of maternal and neonatal morbidity and mortality and to help achieve MDGs 4,5 and 6. A number of key initiatives were developed and launched during HSSP II in support of related issues, such as the *Roadmap for accelerating the reduction of maternal and neonatal mortality and morbidity in Uganda 2007-2015*, with its attention to improving access to emergency obstetric care.

Child survival increasingly became a priority during HSSP II, with re-focusing on e.g. routine immunization, integrated management of childhood illnesses. This attention was occasioned by slow progress towards achievement of MDG 4 (this remains the case; see the 2010 Uganda MDG Report). Other key objectives included communicable diseases (obviously much addressed off-budget by PEPFAR, GFATM, the President's Malaria Initiative and Roll Back Malaria and latterly (to a rather modest extent) neglected tropical diseases. Non-communicable diseases are discussed in the AHSPR for 2009/10, primarily as a future consideration. Further developing priorities over the decade included overall Health Sector Strengthening, addressing the challenges of decentralized health structures, increased participation of communities (e.g. through Village Health Teams). HRH has become an increasing focus over time, as training, employment and retention challenges have become ever more apparent.

1.4 What have been the major systemic achievements and setbacks regarding the health system's development, based on the six WHO building blocks (service delivery, health workers, information, medicines, financing, governance), over the period?

WHO published its Framework for Action in 2007 (the midpoint of the timeframe for achieving the 2015 MDGs). This articulated the 6 health system strengthening building blocks and the rationale for prioritisation of these. There has subsequently been rapid and widespread adoption of the framework and increased attention to HSS, in Uganda as elsewhere.[28] Unsurprisingly there are few explicit discussions of HSS as a coherent strategy in health sector documentation earlier than 2007, whether Swedish or GoU.

Most current development partner assistance to HSS is through the project modality. Thus BTC and Sida are co-funding a project entitled *Institutional capacity building in planning, leadership and management in the Ugandan health sector* and the World Bank is supporting wider public sector leadership and governance interventions (Sida has a delegated partnership contract with BTC). In this context it needs to be mentioned that the proliferation of projects and vertical programmes have all had their impacts, adverse and otherwise, on health systems strengthening and pertinently on the sustainability of such inputs.

Overall, HSS interventions have not achieved desired outcomes in terms of indicators. As noted in the development partners' assessment of the 2010 GAPR 'Most...indicators rely heavily on the procurement of key

[28] It is relevant briefly to point out that there have been many critical voices raised internationally about what has been perceived to be the biomedical and supply-side bias of the WHO HSS building blocks; civil society has been especially vocal. Issues that have occasioned much debate include the absence of client/patient (demand-side) inputs. These would ideally include health service user definitions of accountability of health workers and public health sector systems and client participation in monitoring and evaluation of progress towards acceptable quality of care standards, more explicit attention to health rights and a stronger and more mainstreamed focus on gender and other socio-cultural aspects of relative access to health services, etc. Such critical perspectives are pertinent in the context of Sweden's championing of accountability, SRH&R and gender in Uganda. GFATM has recently developed its CSS: community systems' strengthening, to be planned and implemented in tangent with HSS and incorporating a client/community-based perspective and viewing health service users as partners (and ideally also as critical voices and monitors of quality assurance).

inputs (essential medicines, vaccines, contraceptives) and a functioning supply chain': these are deemed to be inadequate or poorly performing.
A few points are made below with regard to individual HSS building blocks. See also e.g. 5.3 for consideration of the realities of inadequate HSS at district level.

Service delivery
The per capita cost of providing the UNMHCP was estimated at USD 41.2 in 2008/09. However, the actual level of public funding (excluding off-budget) was USD 10.4 per capita in 2008/09, far below estimated requirements (NDP 2010). This has affected all inputs in the sector and had a detrimental impact on HSS, especially capacity to deliver appropriate and quality services. The 2008 *Uganda Service Provision Assessment Survey* sets out in exhaustive detail the level to which health services function and the challenges in delivering quality services in the context of inadequate capacity. That survey indicates the shortfalls in all six HSS building blocks. One stark finding is that a full package of basic services is available in only five out of every ten health facilities (across all levels).

The inclusion of a demand-side focused indicator in HSSIP III (*% clients expressing satisfaction with health services (waiting time))* does indicate increased attention to quality of service delivery. Swedish support to health rights (including SRH&R) represents another contribution to development of space for voices to be heard in terms of demanding improved service delivery.

HRH/health workers
See also section 4 for detailed discussion. Only 56% of all positions in the staff establishment are currently filled by qualified staff. There are fewer than 2,000 midwives active in Uganda. Issues of recruitment, retention and professional development appear to have received inadequate, sustained attention; the same appears to be true with regard to supportive supervision, provision of adequate standards of accommodation and transport, etc. The very few health workers met during the evaluation were impressive in their wish to provide quality services; currently the system does not effectively and sufficiently support such ambitions.

Information/M&E
This is acknowledged in a wide range of reports (e.g. many of the AHSPRs, the 2003 and 2008 Mid-term reviews of HSSP I and II) as a relatively weak link in the HSS chain. Iganga respondents spoke of seldom if ever receiving feedback on HMIS and other reports, resulting in a lack of enthusiasm to collect data. The development of an evidence based approach to service delivery that takes account of any locally specific health needs requires considerable attention. Here too mention must be made of the proliferation of M&E systems occasioned by vertical programmes and projects, and the impacts the collection and reporting of such amounts of data have on under-functioning health systems. The overview of the HSSP I and II indicators in Annex 2 demonstrates the limited data available over time to track their progress.

Drugs, medical supplies and commodities
Current annual per capita expenditure on essential medicines is only USD 0.87 against an estimated requirement of USD 2.4 per capita. This serious shortfall has direct implications for the medicines' HSS building block.

Finance/financial management
Evaluation information indicates a wide variety of financial allocation and management issues, linked not only to financing *per se* but very much also to issues of governance.

Thus the health capital investment budget should in principle be able to allocate to new builds (facilities) and renovation and upgrading of existing facilities. However, there appears to be (over) emphasis and promotion of new builds rather than refurbishment. This situation is likely to have been exacerbated due to the proliferation of new districts and related political imperatives. While more health facilities are unquestionably needed, there is no point in buildings that cannot deliver appropriate and effective care.

More generally, managerial decision-making powers with regard to priorities within the health sector budget line do not seem to be in the district, but at budget-setting level. Once again, this has adverse implications for governance as well as financing.

Governance
See also 2.7 below. Reference has already been made at several points in this report to corruption and financial probity issues. Several development partner respondents mentioned the definite shift in recent times towards greater accountability within the GoU, pointing to the increased oversight view of the Office of the Prime Minister (apparently such shifts in themselves have occasioned quite some debate in the line ministries, including the MoH). Such actions indubitably address a number of governance issues; less attention continues in the general Ugandan context to be given to civil society voice and people's engagement with health and other rights as equal partners rather than as primarily passive recipients.

1.5 Based on the National Health Policy and Health Sector Strategic Plan HSSP I (2000-2005) and HSSP II (2005-2010) how has the national health system developed?

The HSSP states: 'Given lessons learnt during the implementation of HSSP I, the HSSP II programme overview was amended to illustrate more clearly that implementing the UNMHCP is the main approach for achieving the sector programme goal. The HSSP II re-prioritised the UNMHCP, and the interventions within each component of the package, in favour of the proven strategies and interventions that were expected to produce the best possible impact on morbidity and mortality in Uganda. This prioritisation was also intended to guide resource allocation within the...MTEF and the annual sector budget.' (xi)

'The HSSIP states: 'During the implementation of the HSSP I and II, the overall development agenda for Uganda was guided by the Poverty Eradication Action Plan, revised every three years, the Millennium Development Goals and other international and regional health commitments. Over this period, the health sector investments in both the public and private sectors yielded modest successes, including a reduction in the MMR from 505 in 2001 to 435 in 2006, a decline in the IMR from 89 in 2001 to 75 in 2006 and an increase in life expectancy at birth from 46.9 years in 2001 to 51 years in 2006. Despite these successes, health systems and other challenges prevented attainment of key national and international targets.' (MoH 2010b; iii)

1.6 ToR questions on outcome and performance directly linked to Swedish support

1. ***What specific support has Sweden given to health system development within the SBS, complementary support and/or in active dialogue and advocacy?***

See also discussion at several points in section 3, e.g. 3.4 and 3.5. The Swedish contribution to increased accountability and transparency in the health system, specifically as a result of Swedish support over time, was highlighted by respondents from both the government and the donor side. Although this study is focusing on Swedish sector budget support, it was noted by several partners that Sweden has also contributed to strengthening systems at district level, through technical support to district management and financial management systems.

Sweden has made itself known in the Ugandan context for supporting accountability and vocalising transparency issues in the sector dialogue both with the GoU and also with other development partners. Swedish efforts over time to increase *accountability* in the overall health system have had tangible outcomes and potential results. Thus Swedish advocacy has led to specific focus in the HSSIP III on accountability, with the inclusion of a Sida-promoted health impact indicator: *% clients expressing satisfaction with health services (waiting time)*. This represents progress on addressing issues of health service providers' accountability to demand-side (patient/ client) health users. This indicator is seen as an important contribution to an improved system, made possible by the Swedish policy dialogue in combination with training and project support to relevant non-state actors that are advocating for health and rights.

2. *What is the view of Ugandan health sector stakeholders on Sweden's impact and contribution to the health sector over the time period? What is the perceived comparative advantage and added value of Sweden?*
For discussion of comparative advantage and added value, please see 3.4 and 3.5. That text is not repeated here. Sweden has been, and continues to be seen, as a valuable partner in the health sector in Uganda. Swedish engagement in sector dialogue and its willingness twice to take on the demanding task as Chair of HDPG has been much appreciated and is viewed by Ugandan and international partners alike as a tangible demonstration of commitment to the sector.

The fact that Sida Health Advisers have had longer term postings in Uganda (based in the Embassy, i.e. not as TA) during the period under evaluation was also highlighted as an advantage. MoH staff noted in particular the need for partners in the dialogue who know the sector and its challenges. The comment was made several times that relevant policy dialogue questions can only be asked once a thorough understanding of the situation has been acquired, another reason why Sweden's contributions are viewed with respect.

Other development partners, not part of the sector budget support group, highlighted the unique position of SBS partners (at present only Sweden and Belgium). The point was made that the MoH gives more weight in policy dialogue to SBS partners. Therefore, despite relatively small amounts of support (e.g. compared to the US) more doors are open for sector budget support partners. They have opportunity to ask sensitive and pertinent questions about accountability and transparency in the Ugandan government system, to an extent untenable for project support partners.

The Belgian Embassy also confirmed that SBS is seen as a political tool as well as a technical sector support tool, in the sense that when Belgium decided to withhold funds, the MoH was immediately engaged at the highest level. In relation to withholding even larger funds in projects, the sector budget support funds are seen more as a validation of the sector and its efforts. Therefore, any withdrawal of funds is taken "personally" in a stronger way than if a project is closed or such disbursements are stalled.

2 SBS AND AID MODALITY ISSUES

The majority of questions here are intrinsically dependent on a combination of effective long-term institutional memory and detailed documentation of processes and outcomes. The evaluation has sought to examine all questions in detail, through KII with a range of stakeholders, document review and triangulation of findings, so as to arrive at a comprehensive overview. Most of the questions are predominantly qualitative, the main exceptions being 2.2 and 2.6.

2.1 To what extent has the SPS modality contributed to the establishment of relevant policy development and dialogue, focused on key government strategies and priorities for the health sector?

The SPS modality has given the partners supporting the sector a voice in policy dialogue; under the framework of the SWAp, dialogue structures have been created where development partners and the GoU discuss priorities and develop strategies jointly. It is not possible for the purposes of this evaluation to separate the SWAp from the SPS but it is clear, as has been highlighted above, that the sector budget support/earmarking gives such partners a stronger voice in policy dialogue and opportunities to raise key issues, including those that are politically and socially sensitive. This is true despite the description of 'virtual funding' to SPS.

To provide some historical context: the early years of SPS (through SBS and the SWAp mechanism) were undoubtedly successful in terms of contributions to policy development and to improved health outcomes. As Örtendahl (2007) states: 'The Memorandum of Understanding guiding the SWAp process included two particularly important features: 1) an obligation from the government to steadily increase the budget for health; and, 2) a commitment from development partners to increasingly use general or sector budget support as the principal aid modality. Both government and development partners strove to implement and deliver upon their commitments. The resource flow to the health sector improved considerably; more staff was hired and new infrastructure (predominantly in the primary health care domain) was developed.' (p1). See also Hutton (2004).

Unfortunately this high point for the SWAp mechanism did not last. The following reasons are often given: reduction over time in GoU health funding; movement away from SBS into other modalities; weak health systems; and weak governance coupled with corruption. The current situation in October 2011 is that Sweden is *not* making its disbursement of SBS financial allocations. The final Swedish disbursement for the Sweden-Uganda health sector agreement for FY 2010/11 was cut from SEK 35 million to SEK 20 million, due to the JAF review finding of overall poor performance. Those SEK 15 million were re-allocated to UNFPA. Moreover, Sweden had planned to extend the current bilateral agreement until FY 2011/12, with an additional SEK 70 million. This extension has not been forthcoming and Sweden does not presently disburse any SBS to health.

Disbursements from Belgium (the other 'full' SWAp partner) are also currently partially on hold.

The evidence of this evaluation indicates that those development partners (perhaps particularly Sweden) that have kept the faith with SBS have continued to have genuine inputs to policy dialogue; the long-term commitment to SBS and the greater alignment of funding with GoU structures have been viewed by the MoH and other public sector bodies as enabling such debate and contributions.

There is a valid debate, albeit outwith the remit of this evaluation, to be conducted regarding the relative balance between GoU health priorities and development partner imperatives. In other words, what might the extent of GoU focus on e.g. SRH & R have been without the impetus (and global policy and implementation dialogue, e.g. as expressed through the MDGs and the IHP) of international concerns? This counterfactual represents an important aspect of Sweden's long-term commitment to such difficult issues; even if only modest progress has been seen, this might have been absent were it not for Sweden's support.

2.2 How has the health financing of the health sector changed in the 10 years, including the GoU share of health financing versus external funding, both on and off-budget?

See also 4.2.1 and 4.2.3 for detailed discussion of external and off-budget funding trends. As can be seen from Table 2, the GoU share of health financing has seen only modest growth over time; if the very significant population increase is factored in, it is apparent that funding shortfalls are considerable. It is obvious that strengthening health systems and delivering appropriate and high quality services becomes ever more challenging in the face of a rapidly growing population when such numbers are not matched by sufficient increases in real term financing. For instance, there are direct and negative implications for maternal, neonatal, infant and child health services, as can be seen when trends in performance and outcomes of health indicators are reviewed.

Table 2: Expenditures on health

	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Population of Uganda (million)	24	25	26	27	28	29	30	31	32	33
Share of Government expenditure to health	7,3%	9,7%	9,7%	10,0%	9,4%	10,4%	9,7%	9,8%	10,5%	11,6%
Government health expenditures % GDP	1,8%	2,0%	2,2%	2,2%	1,9%	1,9%	1,8%	1,6%	1,5%	1,6%
Government per capita spending on health in US $	4,2	4,6	5,2	5,2	5,9	6,7	6,6	7,3	7,6	8,1
Out-of-pocket % of total health spending	41%	38%	37%	37%	43%	47%	52%	52%	54%	53%
Budget Year	**00/01**	**01/02**	**02/03**	**03/04**	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**
Share of PHC in health budget	44%	51%	n/a	50%	54%	54%	39%*	60%*	50%*	47%

(Sources: WHO National Health Accounts data & PHC data Uganda Budget Performance reports
***Only first half of budget year)**

As of 2011, there is a widespread view that a disproportionate share of donor off-budget funding in Uganda is allocated to two communicable diseases (HIV & AIDS and Malaria), with an emphasis on treatment rather than prevention, whereas other health areas such as child health, family planning and sexual and reproductive health rights (SRHR) are neglected.

Other relevant factors include the proliferation of Districts over the decade and the question of how great a proportion of government health funding at this level has been allocated over time to administrative structures and how much to health facility levels I-IV and service delivery. Such issues may represent just a couple more influences connected to the overall decline or stagnation of service delivery and health outcome indicators experienced in Uganda between 2000 and 2010.

2.3 How has the emergence of the health SWAp in 2000 contributed to reinforce Sweden's impact and to the sector's performance?

Sweden has been throughout one of the most consistent supporters of the health SWAp, continuing as a core partner and funder from the early successful years to the present day. The consensus is that the Uganda health SWAp was a high performer and flag bearer for the sector-wide approach between its inception in 2000 and 2004/5. The Uganda health SWAp had to that date received international acclaim for its design and implementation. Hutton's view is that the following factors influenced positive outcomes: 'The SWAp marked the start of a major change in the way many donors provided their support to the health sector – now often using an un-earmarked allocation via the budget of the Ministry of Financing, Planning and Economic Development (MoFPED).

In the same year, the Health Sector Strategic Plan (HSSP) was implemented [the HSSP I], which was prepared within the framework of the Poverty Eradication Action Plan. In 2003 a mid-term review of the HSSP was completed, reporting good progress.' (Hutton 2004; 4)

Thus in effect the early years of the health SWAp applied a number of the principles that were adopted in the 2005 Paris Declaration, e.g. harmonised joint planning, development partner alignment and country ownership. See also Jeppson (2004) for discussion of positive early processes.

Thereafter the SWAp as a modality began to experience difficulties, such as reduced development partner support (in part due to the advent of global programmes and serious issues of corruption and mismanagement). As Örtendahl (2007) describes: 'The early years of the Uganda health SWAp are generally considered a success story, but its performance has declined in recent years. A number of factors, including decreased government health spending, changes in aid modalities used by development partners, weakening government leadership, and poor governance in the health sector can help to explain this decline in performance.'

During the successful SWAp years, an economy of scale appears to have emerged among SBS partners. This meant that the relatively limited Swedish resources could yield a bigger result than would otherwise have been possible, e.g. if Sweden had managed a project with all the administration and management costs that are involved in such development assistance.

It should be noted that the leverage opportunities of SBS development partners up to 2004/5 have been assessed as larger in relation to their financial contribution, when compared with those partners supporting the project modality. Despite such early influence, it is notable that during the latter part of the decade leverage has not been utilized to its full extent and/or not co-ordinated with GBS and GBS partners. Many evaluation respondents pointed to the weak results of the health sector as from ca. 2005, with the health sector showing red flags on the majority of indicators. Remarkably, this lack of progress does not seem to have led to any concerted action from development partners. One of the presumed advantages of pooled funding is that supporting partners will jointly be able to exert an influence bigger than that of the individual donor. Such concerted action does not seem to have been utilized at all and in fact, several respondents pointed to the lack of joint action/statements on the

health sector during the period. This was mentioned as a problem that is not unique to the health sector but is also apparent in the GBS group, where each development partner appears to make individual decisions as to whether to disburse the next tranche of funds.

Therefore, while Sweden may have been able to achieve greater early SBS results through economies of scale, it does not appear to have exhausted the possibilities of exerting pressure and seeking to create change in the context of weak leadership of the sector.

Despite the reduction in numbers of development partners supporting the SWAp, as a mechanism and process it continues to be effective in terms e.g. of promoting Paris Declaration principles and supporting health policy dialogue. Its continued validity can be seen in the recent decision by DFID to re-enter SBS to health; another recent action has been the appointment of new staff members at the MoH, some of whom were interviewed for the evaluation. All spoke warmly of the appropriateness of the SWAp mechanism. Therefore, opportunities for greater SWAp effectiveness may be returning.

2.4 What has been the scope for dialogue and impact regarding Swedish efforts to promote SRHR and other sensitive issues, within the realm of the SPS aid modality? What factors have influenced this scope?

Sweden has consistently been able to raise and gain ground in areas of Swedish concern such as SRHR, accountability and transparency, health rights and in the development of the SBS process itself, through its overall high profile, its consistency of support to the ethos of SBS and through its support to increased harmonization and co-ordination. Important factors have been knowledge of the sector and a Swedish long-term commitment to the SWAp. Several respondents, particularly those from the MoH, underlined the fact that the Swedish Embassy health advisers have stayed for several years and have shown a willingness to work with the sector, address problems head-on and to take on tasks on behalf of the sector. These are all contributions that have given Sweden high credibility in the sector as a trustworthy partner – and have facilitated the possibility of raising issues of concern and being heard by other SWAp partners (and indeed the wider group of health development partners, e.g. USAID).

Please also see 3.3 and 3.4.

2.5 How has the Swedish support been harmonized and adjusted to ensure complementarity with other donor support?

This has been done throughout the decade through the SWAp itself and through Swedish sector budget support being utilized in accordance with the jointly agreed priorities in the sector, in HSSP I and II and now in the implementation and M&E of the HSSIP. The development of the JAF has provided a tightening of focus and development partner attention to health sector issues of accountability, performance and results; these have informed the development of the HSSIP III and its M&E Framework.

The three Swedish *Assessment Memoranda* and the assessment of Swedish support between 2001 and 2007 discuss changes over time, occasioned by e.g. other development partners moving out of the SWAp, the advent of new international instruments such as the Paris Declaration and vertical global programmes (Embassy of Sweden 2000, 2003, 2007 and 2008). Focus on SBS through the SWAp modality remained a constant and coherent Swedish priority.

Thus the assessment of support between 2001 and 2007 states: 'There is a need to concentrate the future Swedish development cooperation, although the programme portfolio during the last couple of years has been streamlined and the number of contributions has decreased. The concentration should primarily be accomplished by moving away even further from stand-alone projects to SWAp and programme based approaches, seeking arrangements of division of labour and delegated cooperation. The concentration should be guided by the results on sector level achieved so far, as well as the Swedish comparative advantages at sector level.'

2.6 To what extent has SPS to health contributed to improvements (including efficiency) in public health spending?

As is discussed elsewhere in this report, the early years of SBS are widely deemed to have been generally efficient, including in terms of resource allocation and disbursement arrangements. Thus the HSSP I Mid-term Review (MTR 2003) notes the following: [The SWAp partnership is] 'healthy, with most of its co-ordination structures working well. Compliance with the common working arrangements is high but not universal. Many more partners have adopted budget support as the modality of funding and resource allocation is shifting progressively towards supporting the [Uganda National Minimum Health Care Package] and district health services [unspecified as to exactly how]. Significant progress has been made towards achieving a number of key HSSP output targets.' (iii)

Jeppson (2004) states: 'The justification for SWAp is to simplify the implementation of financial support to the health sector and ensure government ownership. To a large extent, this is what has taken place. But the districts, the true implementers, have been assigned a very limited role under SWAp.'

The 2008 HSSP II MTR indicates the decline in the overall health sector performance and the reduced role of the SWAp in terms of overall efficiency and improvements and effective disbursement mechanisms: '[The sector] stagnation/slowing down [has been] analysed as due *to inter alia*: lack of significant growth in GoU financial allocations to the health budget; stagnant/declining levels of funding to service delivery levels, including district health services and PFNP, inadequate and/or irregular availability of drugs and supplies; challenges in management. All have had impact on quantity and quality of health service delivery.'

By this time fewer development partners were as committed to the SWAp as had been the case in its early and (relatively) effective and efficient years.

2.7 Has SPS contributed to transparency, accountability and efforts to fight corruption?

This has been a challenging question to answer, chiefly because the majority of documents do not disaggregate development assistance modalities such as SPS/SBS specific to transparency, accountability and corruption. However, and broadly, the answer is yes. There has undoubtedly been better oversight of SBS funds than is the case for some of the larger project-type inflows in the sector.

Ongoing overall challenges are demonstrated by the December 2010 JAF2 Appraisal, which states (with reference not only to the health sector): 'GoU could have had more success in tackling corruption and bringing to account senior level individuals responsible for the misuse of public funds. The JBSF DPs need to demonstrate value for money for their aid programs and to show that funding directed to GoU is used effectively, transparently and with full accountability.'

The GFATM and GAVI issues regarding corruption are well known. A widespread view is that part of the problem was that e.g. GFATM support was not included in sector mechanisms for accountability and control. As a result, fewer eyes were scrutinizing the use of those funds. The Global Fund has since integrated its support into the sector mechanisms; the hopes are that this will enhance accountability and transparency.

Neither HSSP I (2000/1-2004/5) nor HSSP II (2005/6-2009/10) contains an indicator that explicitly addresses such issues from the supply-side (health service provision). Because development partners providing SBS and (previously or currently) supportive of the SWAp have made coherence with these national plans (and the PEAP, now replaced by the NDP) a cornerstone of such support, the absence of explicit monitoring and evaluation (and indeed discussion of leverage options should such issues not be adequately addressed) means that close tracking over time may well have been difficult. Moreover, documentation of any such processes is relatively limited.

In addition, there is the vexed question of decentralisation and actual vs. what has been termed 'virtual' devolution of autonomy, power and management of health budgets and performance at District level. Issues of

transparency, accountability and action against corruption must be viewed in the light of such complexities. Nonetheless, it is appropriate to mention that a frequent and positive comment from development partners was that the MoH has recently taken serious steps to address corruption, with new senior management and clear direction to ensure the ministry becomes more transparent and accountable. This was also discussed frankly within the MoH. It may be that this new broom approach was one of the reasons why DFID has decided to return to health SBS and to appoint a Health Adviser for the first time in three years (although home government positions have played their part too). The links between the HSSIP and the JAF and the increased oversight role of the Office of the Prime Minister were also described several times as other positive trends.

However, in this context the issue of genuine leverage has to be considered: one comment about the JAF, made by bilateral on and off-budget development partners and UN agencies, is that there appears to be no ultimate sanction or leverage, other than withdrawal from on-budget support to the health sector. There are opportunities for red flags galore, as evidenced in the December 2010 JAF appraisal and the JAF sets conditions for crosscutting issues of governance, but there are no apparent mechanisms for effective, incremental attention.

Specific to Swedish inputs: Sweden has contributed to financial transparency and accountability in the health sector, by providing training in financial management, audit development services and advocating consistently for a more effective and accountable reporting system. It is not possible to say how strong direct attribution is in this respect, but the MoH acknowledges Sweden's strong support and Uganda today has a *relatively* robust structure for quarterly reporting of both finances and service delivery. The MoFPED releases funds quarterly against approved budgets and audited expenditure reports from the previous quarter, while technical performance reports are now sent to the MoH. However, problems with late reporting and varying quality continue.

2.8 What are the perceived gains and constraints for the GoU with multiple financing modalities?

The MoH clearly favours the SBS modality in terms of ownership and transparency from the development partners. It was described as a genuine partnership, where opportunities for frank debate exists. It should be noted that focused discussion was not held with the MoH or the MoFPED regarding off-budget funding, whether to global health programmes or to projects. Thus for example neither the potential positives of global health programmes (e.g. infusion of very significant amounts of funding and support to HSS initiatives) nor negatives (e.g. distortions of the health sector through focus on specific diseases such as HIV, TB and malaria and what might best be termed internal parallel structures where central MoH staff are dedicated to e.g. GFATM and GAVI) were addressed. Such comments did emerge from meetings with development partners. Multiple financing modalities in a context of limited absorptive capacity (and not only at central, but crucially also at District level) result in severe human resource, co-ordination and management pressures. This is true irrespective of how positively or otherwise any one such financing modality might be viewed.

2.9 In what way has the arrival of the global health programmes, with substantial funding (Global Fund, GAVI, PEPFAR, PMI etc.) affected Sweden's impact and the sector's performance, in particular areas of Swedish concern such as SRHR, health systems' development and prevention of HIV and AIDS?

This decade has seen more than a doubling of global development assistance in health. Much of the increase has been for specific global programmes such as GFATM and PEPFAR and much has been accomplished. However, there is concern that the improvements in health outcomes have not been proportionate to the increase in funds and that they have contributed to fragmentation of the sector. A recent study commissioned by GFATM noted "little conclusive evidence either way" on the influence of disease-specific global health initiatives on health systems strengthening.

An important point in the context of overall health sector performance is that weak health systems (which is the situation in the Ugandan public health system) are frequently unable to make best use of additional funds (often extremely significant). This can and does lead to a proliferation of vertical, off-budget programmes and projects, as has happened in Uganda.

These funding flows are often parallel and do not always support health system structures; in fact they sometimes undermine them in challenging situations/settings, e.g. where there are HRH constraints. The implications of the

parallel structures have been seen at all levels of the system; they have frequently been highlighted by Sweden as a major problem, in particular during the latter part of the decade. Much sector attention has been diverted to these parallel funding mechanisms, often at the cost of the development of the regular health administrative, management and financing systems (and others of the six HSS building blocks). The issues surrounding these funding flows have occupied much ministerial and development partner time and effort. Of particular concern has been the lack of balance in funding for treatment vis-à-vis prevention in HIV & AIDS. Another major systemic concern has been the creation of parallel systems that undermine the longer term development of the health sector.

One comment made in the context of the challenges faced by the Ugandan health system after the advent of global health programmes is that due to the difficulties in effective harmonization and alignment of new funds with existing systems and activities, there has been increased duplication, patchy distribution of support and services at district and sub-district levels. Such factors have serious implications in terms of human resources for health (with many health workers preferring to work for global programmes) and overall lack of attention to transparency and other core Paris Declaration principles.

2.10 Are appropriate harmonization and alignment procedures and mechanisms in place to facilitate a large influx of funding from the global health programmes and others?

Action appears to be going in the right direction, in the sense that major funders such as the Global Fund have increasingly harmonized and aligned with the existing health system. Yet much work still needs to be done in this respect. The sector also has the added challenge of emergency funding for post-conflict health inputs in northern parts of Uganda. These need to be transformed into support for longer term development.

2.11 Has Sweden's leverage diminished as huge volumes of external funding from global disease-specific programmes have increased?

Yes and no. It is of course true that larger donors with more significant funding flows have a special influence that is correlated with the size of their funding. However, several of these big donors noted that Sweden has had a larger influence than Sweden's funding size merits, due to its long-established championing of the Sector Budget Support modality and thanks to being an active member of sector programme structures. Several partners pointed out that donors earmarking support to the health sector, such as Sweden (despite it being virtual earmarking), have privileged access to MoH staff and political leadership. As a result, such partners are able to play a bigger role than their funding would have allowed had they been "only" project donors.

3. MORE CHALLENGING ToR QUESTIONS

Section 3.1.2 of the Inception Report notes that the three questions below are more challenging to answer, being less amenable to review in the time available. Other limiting factors are that attention to issues mentioned in the questions has been patchy in the Ugandan context over the decade under evaluation and that effective attention to gender and social determinants of health would require gender and social analyses beyond the scope of this assignment. The 2010 UDHS will doubtless address such matters in detail. The three questions are included in part I of the ToR: *health outcomes and impact over a 10-year period*.

The evaluation team has considered these questions through review of existing studies and summary of secondary data, as well as drawing on findings from a visit to Iganga district visit. This triangulation has allowed what can only be a partial overview of complex issues.

Detailed attention to the three questions set out below has not been possible.

What have been the major health results for poor people at local level, taking gender and regional differences into consideration. Have the regional differences in health outcomes persisted or deepened during the period? Health outcomes and impact should be analysed both in relation to health systems' development and increased access to health services for poor people, as well as to factors outside the health sector such as social determinants of health

The following quote continues to be relevant to all three questions: 'The SWAP process has changed the relationship between the various actors in the health sector. The working relationship between donors and the MOH has been facilitated and interaction strengthened. Health policy has thus become a more central instrument for the management of health services, while steering has become more indirect. However, top-down communication between the MOH and the districts still predominates, and significant elements of direct steering remain. As a consequence, the rationality for health planning and prioritization tends to develop in different directions. The centre tends to adopt the same rationalities as the international health agencies and the donor community, while the periphery tends to be governed more by perceived local needs and power relations.' (Jeppson 2004)

The overview of Swedish support to Uganda 2001-7 states: 'Several key health indicators have improved significantly since 2001...The availability of health services has increased (out-patient attendance per capita rose from 43% in 2000/01 to 90% in 2005)...Although child mortality and maternal mortality [have reduced], progress has been less than expected due to weak population policies and poor outcomes in the sexual and reproductive health and rights area. Northern Uganda and the Karamoja sub-region stick out as having worse, sometimes much worse, health status and indicators than other parts of the country. This is especially so for HIV & AIDS prevalence, child mortality and maternal mortality in the IDP camps in the north... The situation in Northern Uganda has improved but remains serious. It is characterised by human suffering, violence and human rights abuses. The poverty levels are exceptionally high. However increased security and prospects for peace, will provide a window of opportunity to combat poverty more effectively. (Embassy of Sweden, Kampala 2007).

A contemporary indication of a less than optimal balance between central and local autonomy and power relations, and their implications for health service delivery, can be seen in the findings from the evaluation team's visit to Iganga District. Findings from that visit can be used as a partial proxy for discussion of the three questions – with due acknowledgement of the limited extrapolation value of what was a brief visit to district health workers and facilities.

Public sector respondents in the District stated that districts have no opportunity to discuss budget allocations with central government and that it is not possible at the district level to track and monitor the majority of off-budget funding. This lack of information and overview is considered to result in inefficiencies, duplication and lack of harmonization and alignment, all of which contribute to ineffective health service delivery and less than optimal health outcomes.

A Health Centre level III was visited in Iganga. It became apparent that at this facility, despite dedicated and well-trained health and auxiliary workers, the lack of adequate resources precludes effective health service delivery. Thus the health centre has no electricity, no overnight accommodation for a nurse and/or midwife, the nearest source of water is 1.5 km distant, and drugs and other commodities are now again managed through a push system that allows no flexibility to reflect any local circumstances. One adverse health outcome is that women continue to deliver with the support of Traditional Birth Attendants – this was said to have become more marked since *Mama Kits* ceased to be provided to women making their 4th antenatal visit (apparently as a result of the return to the push system).

4. ToR QUESTIONS RELATED TO RECOMMENDATIONS AND LESSONS

The relevant text in the ToR states:

Based on conclusions and findings, results analysis and challenges, the evaluation should respond to the following questions:
1. Should the SPS aid modality be recommended to continue in its current form in the forthcoming health sector support programme with Uganda in order to best achieve objectives and maximum impact? Elaborate on risks, pros and cons based on different political and economic scenarios.
2. What are other feasible alternative options to SPS and how can such programmes be designed to secure poor

people's access to health services in a long term, sustainable perspective? Elaborate on partnership with local government partners as well as non-state actors including the private sector and civil society.
3. How do the lessons learnt from this evaluation compare with the findings of the phase one and two evaluations of the Paris Declaration, and what are the implications of the Ugandan experience in light of prevailing trends and lessons learnt in aid harmonization and alignment?

Please refer to section 6 in the body of the report for close and detailed discussion of questions 1 and 2. For consideration of question 3, see below.

Question 3a: evaluation lessons learned vis-à-vis Paris Declaration Phase I and II findings
There is coherence regarding the findings of this Swedish SBS support to health evaluation and those of the Phase I and II Uganda Paris declaration reviews. Thus broadly the Phase I review provides a generally positive assessment up to 2006, while the Phase II review paints a more sober and less results and outcome oriented picture.

As discussed at several points in this report, the early years of the decade (until around 2004/5) coincided with what can be seen with hindsight as the high point of the SPS/SBS modality and the SWAp mechanism.
While the Paris Declaration on Aid Effectiveness was agreed and signed only in 2005, the SWAp mechanism can be viewed as at least in part a precursor of the Declaration principles. For instance, this is evidenced in the SWAp principle of expanding and deepening country ownership, often in connection with health system decentralization (a feature of the period in Uganda), and in the core focus on seeking genuinely increased harmonization and alignment, in itself a response to concerns over what was at the time felt to be an over-proliferation of vertical, unsustainable projects. Accountability and a robust attitude to risk (fiduciary and otherwise) represent further SWAp principles that were applied in the Ugandan context in those early years.

As can be seen in Table 3, the core Paris Declaration principles ('dimensions') were viewed in the Phase I review to have been effectively introduced and progress made (despite the short period of time that had elapsed since Declaration signing). The findings of this evaluation indicate that such progress can at least in part be attributed to the health SWAp. At that time it enjoyed the support of many development partners, whose co-operation with the MoH was described both at the time and subsequently, as close and focused.

Table 3: Progress on implementation of the Paris Declaration principles in Uganda by 2006

Dimensions	Baseline	Challenges	Priority Actions
Ownership	High	The need to strengthen – perhaps through output-based budgeting – the links between plans, expenditure frameworks and budgets	To implement the first Annual Poverty Eradication Action Plan Implementation Review recommendations
Alignment	High	Implementation still relies on parallel project implementation units	Continue to strengthen country systems for public financial management and procurement
Harmonization	Moderate	Co-ordination of donor missions and country analytical work needs to be strengthened	Build on successful Country Integrated Fiduciary Assessment experience with co-ordinating country analysis
Managing for Results	High	Some (relatively limited) fragmentation of government information systems	Establish National Integrated Monitoring and Evaluation Strategy
Mutual Accountability	Moderate	No mutual assessment has taken place	Conduct mutual assessment, perhaps as part of Uganda Joint Assistance Strategy review

(**Source: OECD-DAC 2006)**

As noted in the Uganda Phase II review, the changing aid architecture has had considerable impact overall on the aid environment in country, with repercussions also for Paris Declaration principles. Thus the emergence of non-traditional sources of development assistance and finance (e.g. China and India) and the proliferation in the last decade of vertical funds for global and regional health initiatives, led by multilateral donors and large private foundations (e.g. PEPFAR, GFATM, GAVI and the Bill & Melinda Gates' Foundation, have offered new funding opportunities in Uganda. These vertical programmes have become increasingly important in delivery of assistance in the health sector; it is fair to state that none has throughout been a wholehearted, explicit supporter of all the Paris Declaration principles.

In fact it has 'increasingly become apparent that vertical funds for global and regional health initiatives such as GAVI, PEPFAR and GFATM risk undermining core Paris Declaration (and SWAp) principles such as harmonization, co-ordination, mutual accountability and an integrated sector policy framework. In addition the large number of development partner funded projects operating in Uganda that are outside the health SWAp modality, often with little engagement with the MoH and other GoU institutions, have further exacerbated lack of cohesion and co-ordinated planning. Another challenge identified in the 2011 phase II evaluation of Paris Declaration implementation in Uganda is 'difficulties in coordination with the UN agencies' (GoU (OPM) 2011; xi).

External factors include political changes in development partner countries. These have inevitably shaped the extent of development assistance provided by any one development partner, that country's priorities and its partnership arrangements and disbursement modalities. The phase II evaluation notes that 'changes in government in Sweden and the United Kingdom have resulted in more conservative signals that cut back on aid flows overall and call for more stringent measures around aid to counter corruption and financial leakages... Fatigue over slow or non-realisation of tangible development results from SWAps appears to have started creeping in and holding back development partner support towards certain critical sectors.' (ibid; xi).

Question 3b: implications of the Ugandan experience in light of prevailing trends and lessons learned in aid harmonization and alignment

The Phase II report discusses the changes in the Uganda health sector between 2006 and 2010/11 and the relative relevance of the Declaration principles (GoU (OPM) 2011; see also Wood *et al* 2011 and SADEV 2011). While *country ownership*, *harmonization* and (to a lesser extent) *alignment* have seen some degree of forward movement in Uganda, *mutual accountability* and perhaps especially *managing for results* remain at best work in progress, with much still to do to achieve common ground and coherence between all relevant parties.

It must be reiterated that the Paris Declaration and its principles cannot be considered solely responsible for either positive or negative development assistance and overall health trends and that disentangling relative impact is somewhat futile. Nevertheless, one key lesson learned is that embedding principles that require genuine transparency and greater partnership and mutual respect is a long-term project, which is still very much work in progress in Uganda. As can be seen from the varied success of the SWAp as a harmonization and alignment mechanism, and the enduring presence of projects, it cannot be assumed that a once successful approach will remain so strong. The role of Sweden has been pivotal in ensuring that Paris Declaration principles have at least remained active items on the overall health development partners' agenda.

Another point of relevance, briefly mentioned elsewhere in this report, is that there are concerns that the Paris Declaration and the Accra Agenda for Action have focused perhaps too much on process, rather than actual end points, i.e. results and performance and means of achieving these (e.g. through performance-based contracting and management and/or strengthened supply and demand-side accountability and QA indicators). Increased attention to the implications of this imbalance can be seen in the Uganda health sector, e.g. in the DFID Uganda *SBS Rationale* document (DFID Uganda n/d – 2010/11). Furthermore, another lesson is that once civil society and non-state actors generally have a greater say in development assistance (something that has slowly come to have

a higher profile in the Paris Declaration and Accra Agenda contexts, however imperfectly and inadequately), expectations and demands for greater genuine influence and partnership cannot be reduced or withdrawn. This issue appears to remain slightly contentious in the Ugandan context; here too the role of Sweden in supporting and promoting SRH & R and overall health rights must be noted.

5. GAPS IN THE EVALUATION ToR

The Inception Report notes (in 3.1.4) that there are no demand-side/health service user/community specific questions in the ToR, despite the frequent mention of (aggregate) poor people. In addition, there is no reference to the gender aspects of access, health-seeking behaviour and social determinants of health. Issues of quality assurance (from both the supply and the demand-sides) are similarly not addressed.

As can be seen from discussion in sections 3 and 4 in the body of the report and sections 1-3 in this annex, the evaluation team has sought, within the limited time it had available, to review gender and other issues relevant to access to health services and health-seeking behaviours. An overall, and admittedly broad-brush, finding is that the SWAp approach in Uganda did not adequately address gender aspects of health-seeking behaviour and overall access; the same is true for national and development partner instruments, most notably the HSSP I and II, the HSSIP and the JAF. This is regrettable, given the detailed attention to such matters, e.g. the Uganda work undertaken in 'gender mainstreaming in sector-wide approaches' by the UK Liverpool School of Tropical Medicine. While that study is now somewhat outdated, its findings and recommendations (unfortunately) continue to hold true, e.g. the need for genuine and long-term attention to both internal (institutional) and external (service provider) gender mainstreaming in the health sector.

A general comment in the context of review of Ugandan health sector indicators (HSSP I and II) is that they have been inadequately disaggregated and demonstrate insufficient attention to gender and other socio-cultural barriers to health care, to social determinants of health and to regional and other variation. Just one example among many: '% of households with at least 1 ITN' fails to consider the often reported possibility/likelihood that the mosquito net may not be used by those in most need, i.e. (pregnant) women and under-fives.

It may be that the enhanced focus on social and cultural aspects of health-seeking behaviour seen in the HSSIP and in other key documents such as the 2010 Uganda MDG Report, will herald increased, longitudinal attention to such matters. Thus the HSSIP has a strong focus on rights aspects of health. Evaluation respondents from the MoH and development partners referred to this as a result of Swedish participation in the process and its championing of rights-based approaches. There is an HSSIP section on guiding principles, which provides a set of rights-based principles for health. The M&E framework includes performance indicators disaggregated by gender, literacy level and socio-economic quintile. Of course it remains to be seen what the practical implications of such attention may be, and to what extent this will translate into service delivery inputs and health outcomes. Nonetheless, the level of ambition has certainly been raised and a system for performance management is emerging.

ANNEX 5: EVALUATION METHODOLOGY AND TOOLS

The entirety of the evaluation has applied Sida and Indevelop evaluation criteria. *Sida's Evaluation Guidelines 2010* have been followed, as have internal Indevelop procedures. All such work has been based on OECD-DAC guidelines and Paris Declaration and Accra Agenda principles.

Methodology
The evaluation has applied a combination of thorough document review, both in advance of fieldwork and after, with Key Informant Interviews (KII) that allowed detailed discussion and opportunity for crosschecking points with a wide range of respondents.

The process of pre-fieldwork evaluation work focused on creation of an Inception Report, whose development was informed by OECD-DAC, Sida and Indevelop approaches and principles. The Inception Report was approved by Sida on 15th September 2011 and the evaluation moved forward into fieldwork as from 19th September.

Draft report workshops were conducted at Sida in Stockholm on 27th October and in Kampala on 31st October. The draft report was submitted to Sida on 2nd November, for review by Sida. Comments were received on 16th November and the final report submitted on the 30th. A final presentation was given at Sida in Stockholm on 8th December 2011.

Tools
KII represented the tool used during the evaluation. KII were conducted with a wide range of respondents from the public sector (the MoH, the MoFPED and medical, financial and planning officers in Iganga District, development partners (Swedish Embassy, Sida (in Kampala and Stockholm), USAID, DFID, the EU, the World Bank, BTC, Italian Co-operation, UNFPA, UNICEF and WHO) and civil society organizations (UNHCO).

The two sets of questions that follow were used during the Uganda fieldwork phase of the evaluation. Neither represents a complete set of questions; they served as guides to the individual evaluators. Questions were also developed to reflect individual respondents' particular focus, expertise and/or long-term perspectives.

1. Evaluation of the Swedish Sector Programme Support to the Health Sector in Uganda 2000-2010: core questions

1. Brief overview of the health sector in Uganda: government priorities over the time under evaluation, development of the national health system as expressed in the HSSP I, II and III, actual implementation. Strengths, barriers, achievements, lessons learned.
2. Financing of the health sector during the past 10 years: developments, changes.
3. M&E of health sector and evidence-based planning: how strong, effective, applied?
4. Overview of the mechanisms of Sida financial inputs to health through the GoU [not off budget, not project support] – share of Ugandan health financing, coherence with national plans and government health priorities.
5. How does the respondent define the health SWAp? What are its key benefits to the health sector if any? [How] does Sida financial support to health fit into this modality? Is it the most appropriate and effective? Probe if appropriate.
6. What added value has Sida brought and currently brings to the health sector? [consider here funding streams, etc]?
7. Were/are there any areas (e.g. gender, health rights?) that might not otherwise have been addressed by the health sector between 2000 and 2010 had it not been for Sida support?
8. Has Sida had any comparative advantage in its support 2000-2010 to the health sector?
9. Swedish support to health TA: [define TA from the Swedish perspective]. Any key areas (maternal health; policy development; programmatic/ implementation, e.g. district financial management) where this was

provided by Sida, its added value in the overall context of the health sector?

10. Tracking impact through MMR, SRHR and accountability/attention to corruption [Swedish priority areas]: has this been feasible? How has this been done? How focused on Sida inputs has any such measurement been?

Additional question areas:

The role of civil society in the Uganda health SWAp
Implementation of health services supported through the SWAp: how gender focused?
Human Resources for Health constraints: how significant, the impacts, the implications over time?
Links between the health SWAP and HIV programming
Decentralised delivery of health services: the impacts of the health SWAp

Development Partner questions

Why are you as a donor supporting or not supporting the SPS modality? What are the viable options for health SPS?

Key questions Iganga District visit (26/9 2011)

1. Iganga health profile: any particular priorities, social determinants of health, etc.
2. How many health facilities are there in Iganga (levels I-V/VI)? Capacity to deliver services?
3. HRH – are there sufficient health workers or all cadres in all health facilities? What effects have trends of health funding had on recruitment and retention? Has Iganga experienced any support from DPs that has had an impact on HRH?
4. Has decentralisation resulted in genuinely greater autonomy for Iganga in determining its own health priorities (HRH, infrastructure, service delivery, etc)? Has decentralisation also resulted in more engagement from potential/actual health service clients, e.g. in QA, the Village Health Teams?
5. Iganga District/Development Plan: overall process of its development, health components and how negotiated?
6. Iganga health budget from central level: explain the process and changes over time (as far back as possible, since the decentralisation process began/HSSP I). Allocations vis-à-vis disbursements, recurrent expenditure (salaries and also other).
7. What proportion of the district budget is funded by central govt/DPs/local revenue? Are there any budget lines that Iganga can normally not exhaust and for what reason. Has there been earmarking of health funding? If so, what effects has it had on service delivery at the district level?
8. [We want to understand the bureaucracy, level of District autonomy, level of MoH/MoF control and overall red tape in the system].
9. Iganga experience of working with DPs – e.g. which modality, degree of district ownership of entire process, planning & implementation process, how monies disbursed, M&E and reporting, outputs and outcomes. How sustainable?
10. Is there any project support to Iganga (and from which DP)? If yes, has this had an impact on health indicators, and why?
11. Iganga experience of working with Sida (if it applies): same questions as for all DPs, plus follow up on any particular positives or negatives.
12. What is the relative focus in Iganga on MH, SRH (and rights), gender aspects of health (supply and demand sides) and accountability mechanisms (again, both supply and demand side perspectives)? What have been the practical, service delivery realities (if any) of the implementation of the MNM Roadmap? Any health-specific (or other sector) action on gender issues?

ANNEX 6: INTERVIEW SCHEDULE AND PEOPLE MET

Monday 19 September	Activity	People Met & Position	Organisation/ Location
10.30 – 13.30	Team meeting		Kabira Club, Naguru
14.00 – 15.00	Malin Krook Christine Johansson	First Secretary/Senior Programme Manager, Health Sector Counsellor/Head of Development Co-operation	Swedish Embassy, Nakasero
15.30-17.00	Team planning meeting		Kabira Club, Naguru
Tuesday 20 September			
08.30-13.30	Team preparation		Kabira Club, Naguru
14.30 – 16.00	Dr Mohammed K. Mohamed	Permanent Secretary	Ministry of Health
16.00-16.30	Planning meeting with Rogers Enyaku & Tom Aliti	Ag. Asst Commissioner, Health Services Budget & Finance & Principal Finance Officer	Ministry of Health
Wednesday 21 September			
08.30–10.00	Dr Nelson Musoba	Partnership Arrangements with Development Partners	Ministry of Health
10.30-11.30	Peter Okwero	Senior Health Specialist	World Bank
14.30-15.30	George Bagambisa Dr Robert Basala Aliyu Walimbwa James Mugisha Didacus B Namanya	Asst Commissioner, Planning Principal Health Planner Senior Health Planner Senior Health Planner Geographer	Ministry of Health
15.00-16.00	Robina Kaitiritimba		Uganda National Health Consumers' Organisation
Thursday 22 September			
11.00–12.30	Megan Rhodes, former Chair of IDPs on HPAC	Health Team Leader	USAID
11.00-12.30	Peter Ongwaro Ogwal		Danida
13.00-13.30	Dr Amandua Jancito	Clinical & Infrastructure	Ministry of Health
15.00-16.00	Juliet Nabyonga	National Professional Officer	WHO
16.30-18.30	Team work		
Friday 23 September			
09.00 – 10.30	Dr Claudia Hudspeth	Chief, Health and Nutrition. Also Chair of DPs on HPAC	UNICEF
11.00-12.00	Martin Ejerfelt	Controller	Swedish Embassy, Nakasero
13.00-18.00	Team work		
Saturday 24 September			
09.00-17.00	Team work: document review, draft report structure, etc.		
Monday 26 September	**FIELD VISIT IGANGA** A-C KM, JW & JG, accompanied by Malin Krook		

09.00-10.15	Dr David Muwanguzi	District Health Officer	Iganga District Administration
10.30-10.45	Daniel Adorer Andrew Babigaisa	IT Officer	DSS Project, Iganga office
11.00-11.20	Milton Mukluma Shaban Nkutu	MP South Iganga District Chairperson	 Iganga District Administration
11.45-12.15	Tantalu Muzamiru	Senior Finance Officer	Iganga District Administration
14.00-14.45	Rebecca Kafugo Loy Namutamba Colline Nkwanga	Comprehensive Nurse Nursing Assistant Lab Assistant	Busowobi Health Centre III, Nakigo sub-county, Iganga District (visit facilitated by Patrick Byekwaso)
15.00-15.20	Issah Magoola	Population Officer	Iganga District Administration
Tuesday 27 September			
10.00-11.00	Wilfred Fieremans	First Secretary, Development Co-operation	Belgian Embassy
12.00-14.30	Team work		
15.00-16.30	Rogers Enyaku Tom Aliti	Ag. Asst Commissioner, Health Services Budget & Finance Principal Finance Officer	Ministry of Health
Wednesday 28 September			
08.00-09.00	Dr Jennifer Wanyana		Ministry of Health
08.30-09.30	Fredrick Matyama	Assistant Commissioner, Infrastructure and Social Service Department	MoFPED
10.00-12.30	Team work		
13.00-14.15	Maria-Jose Pallares Paredes Sybille Schmidt	Head of Social Sectors Economist	EU Delegation Uganda
15.00-18.00	Team work		
Thursday 29 September			
08.30-10.00	Dr Wilfred Ochan Dr Ishmael Mdifuna Dr Primo Madra Immaculate Nalikka	Asst. Representative Senior Programme Officer (RH) National Programme Officer Programme Assistant	UNFPA
09.00-10.30	Anne A. Labeja	National Programme Manager/Economist	Swedish Embassy
11.30-13.30	Team preparation for 30/9 debrief		
14.00-15.00	Simon Kenny Joti Tewari	Results Advisor Health Advisor	DFID
15.30-17.30	Team preparation for 30/9 debrief		
Friday 30 September			
08.30-11.00	Team preparation for debrief		
11.30-13.00	De-briefing to Solome Nampewo	National Programme Manager, HIV/AIDS, Health Sector	Swedish Embassy
Friday 14 October			
	Dr Paolo Giambelli	Health Project Co-ordinator	Italian Co-operation

In addition, two draft report meetings were held at Sida in Stockholm and in Kampala.

Sida Stockholm meeting 27/10 2011

Those present:
Moa Bergman
Sven Olander
Ulrika Hertel
Göran Paulson
Anne Lindeberg (all Sida)

and Jens Wilkens and Janet Gruber

Kampala meeting 31/10 2011

Those present:
Simon Kenny (Results Adviser, DFID)
Joti Tewari (Health Adviser, DFID)
Dr Nelson Musoba (Senior Health Planner, Health Planning Dept, Ministry of Health)
Silveria Alwoch (UNCHO)

and Anna-Carin Kandimaa Matterson and Dr Hizaamu Ramadhan

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EVALUATION OF SWEDISH HEALTH SECTOR PROGRAMME SUPPORT IN UGANDA 2000-2010

The evaluation examined Swedish support to the health sector between 2000 and 2010 and considered the 2011 situation in terms of overall health indicators and sector performance and results. It looked forward, to provide recommendations for future modalities: whether to continue with the current mix of sector budget support (SBS) and project support, or to apply other approaches. Swedish SBS contributions have been significant, representing between 5 and 10 % of the entire Ugandan health budget 2000-2010. Sweden's commitment to SBS is respected by government and development partners and is in line with the Paris Declaration. Sweden's position has supported attention to challenging issues, e.g. public sector accountability and adolescent sexual health. One key finding is that Sweden should continue to allocate a proportion of its health funding to SBS.

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