

Are reproductive health NGOs in Uganda able to engage in the health SWAp?

Frank Mugisha¹, Harriet Birungi^{2*} and Ian Askew²

¹*Regional Centre for Quality of Health Care, Makerere University, Kampala, Uganda*

²*FRONTIERS in Reproductive Health Program, Population Council, Nairobi*

SUMMARY

This paper explores the ability for reproductive health (RH) non-governmental organizations (NGO) in Uganda to survive in the context of SWAp and decentralization. The authors argue that, contrary to the perceptions that this context may increase NGO's financial vulnerability, a SWAp and a decentralized system may provide an opportunity that should be embraced by NGOs to enhance their sustainability and effectiveness by reducing their current dependency on donor funding. The paper discusses the systemic weaknesses of many NGOs that currently make them vulnerable, and observes that unless these weaknesses are addressed, such NGOs will lose their space in the SWAp and decentralization arena. The authors suggest that NGOs need to recognize the opportunities that participating in public-private partnerships through a SWAp can offer them for long-term and significant funding. They need also to develop their capacity to pro-actively participate in a SWAp and decentralized context by becoming more entrepreneurial in nature, through re-orienting their organizational philosophies and strategic planning and budgeting so as to be able to partner effectively with the public sector in accessing funds made available through health sector reform. Copyright © 2005 John Wiley & Sons, Ltd.

KEY WORDS: SWAp; decentralization; NGO; reproductive health; Uganda

INTRODUCTION

Sub-Saharan African countries have increasingly adopted Sector Wide Approaches (SWAp) to address health care system problems. Planning for initiating a SWAp in Uganda began in 1998, and was led by the Ministry of Health (MOH) and some major donors in the health sector; implementation started in July 2001. A SWAp in Uganda was conceived along the international framework (see Cassels, 1997;

* Correspondence to: Dr H. Birungi, c/o Population Council, General Accident Insurance House, Ralph Bunche Road, P.O. Box 17643, Nairobi, Kenya. E-mail: hbirungi@pcnairobi.org

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Peters and Chao, 1998) as a sustainable partnership for different health care actors, based on agreed policy and strategy, involving central and district governments, donors, the private sector, non-governmental organizations (NGO) and communities. The assumption underlying these partnerships is that all actors desire to have shared objectives in the development of the government's long-term strategic vision for the sector, with the consequence that the government evolves an enabling environment that would allow for effective coordination of efforts among all partners.

In particular, strengthening the collaboration and partnership between the public and private sectors of health care is an important guiding principle of the Uganda National Health Policy (MOH, 1998) and the Health Sector Strategic Plan (HSSP), 2000/01–2004/05 as well as the decentralization policy. Under the decentralized system considerable financial powers, functions and responsibilities have been transferred from the centre to elected local governments. The districts develop annual work plans for the health sector, that are linked in parallel to national level HSSP through a 5-year strategic district health sector plan. Districts are also mandated to approve budgets and are the statutory implementers of the national sector programs. Collaboration between districts and other civil society institutions (NGO, community based organizations (CBO) and communities) in service delivery is encouraged (Local Government Act, 1997).

A 'public private partnership in health' (PPPH) policy that includes a spectrum of possible relationships between public and private¹ actors has evolved. The PPPH policy encourages some degree of private sector participation in the delivery of a traditionally public domain service as well as a broad range of health financing options; promotes competition between different service providers; recognizes the role and contribution of the private sector in health development; and defines the institutional framework within which to coordinate, implement, monitor, evaluate and enrich a partnership (MOH, 2003). Thus it is within these policy frameworks that reproductive health (RH) NGOs are expected to participate if they are to access funding for health care services.

Prior to introduction of the SWAp, donors interacted directly with the various technical programmes within the MOH and with the NGOs, offering both technical and financial support on a project-by-project basis and usually at the central level. This situation resulted in serious coordination problems within the Ministry, and led to confused relations among donors, the MOH and NGOs. Under the SWAp the vast

¹The private sector includes the following sub-sectors:

Private Not for Profit Providers (PNFP): this category of providers is motivated by concern for the welfare of the population and includes agencies providing health services from an established static health facility to the population and those that work with communities to provide non-facility based health services.

Non-facility based Private PNFP: includes most of the local and international organizations working in the health sector commonly referred to as NGOs.

Facility based PNFP: these are mainly religious-based health care providers, notably three umbrella organizations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB).

Private Health Practitioners: this encompasses all cadres of health professionals in the clinical, dental, diagnostics, medical midwifery, nursing, pharmacy and public health categories who provide private health services outside the PNFP.

majority of funds are now channelled directly to one 'basket' at the Ministry of Finance (MOF), which directly remits delegated (conditional) and unconditional (block grants) funds to the MOH and the districts for implementation of their plans. Negotiations between the MOH and donors are now largely focused on sector-wide budgetary support, rather than individual programmes or projects (Jeppsson, 2002). Direct and project-specific funding to MOH programmes and to NGOs is to be gradually phased out so that all health sector funding is channelled and coordinated through the central ministry. The management of health services and district funds is a decentralized function. Here, NGOs operating at the district level are expected to prepare work plans that they submit to the district for approval and funding (Jeppsson, 2002).

As a consequence, the historical role of NGOs as implementers of donor-funded projects is expected to become redundant over time. Indeed, because of this transitory phase between relying on directly funded discrete projects or core support, to participation in a coordinated sector-wide funding mechanism, NGOs are already noticing less and insecure funding (NORAD, 2002), and concerns are being raised that as project funding continues to decrease NGOs will end up losing much of their funding base (MOH, 2003). Whether it can be replaced through participation in the SWAp is the challenge currently facing reproductive health NGOs in Uganda.

METHODS

This paper is based on an assessment carried out during March–April 2002 of 16 NGOs identified by the Reproductive Health Department (RHD) of the MOH as being among the largest NGOs in the country engaged in reproductive health. These NGOs and their key distinguishing features are listed in Tables 1 and 2 identify criteria of affiliation, location and type of services offered. The assessment sought to identify the actions that the NGOs are, or would be, undertaking to prepare themselves for greater sustainability in the near future. Here, sustainability is defined as a measure of an organization's ability to serve its stakeholders over time and broaden sources of funding and subsequently increase its ability to deliver vital services to the target population (Abt Associates Inc, undated). A major limitation of the assessment is that it is confined only to the internal situation of NGOs (see Table 3); perhaps a broader picture encompassing the external situations would have proved otherwise.

Data were gathered through semi-structured individual interviews with one or two key managers (Chief Executive Officers and accountants/human resource managers) in each NGO. In addition, unstructured interviews were held with staff from six organizations providing funding to the NGOs (DfID, European Union, UNFPA, Pathfinder International, Commercial Market Strategies project, and the African Youth Alliance), and with two representatives from the Uganda MOH. Data were collected through asking each individual a series of open-ended questions about specific issues concerning the ways in which NGOs plan, finance and manage their activities. The responses were tape-recorded and transcribed, and the transcriptions were then analysed manually for content.

Table 1. Key distinguishing features of NGOs

Key features	NGOs
Faith-based umbrella organizations	Uganda Catholic Medical Bureau (UCMB) Uganda Muslim Medical Bureau (UMMB) Uganda Protestant Medical Bureau (UPMB)
Facility-based and largely rural	All the above three bureaus Family Planning Association of Uganda (FPAU) Marie Stopes Uganda (MSU)
Non-facility based and Advocacy NGOs	Safe Motherhood Initiative (SMI) Women and Children's Crisis Centre (WCCC) Straight Talk Foundation (STF) African Medical Research Foundation
Professional Associations	Association of Uganda Women Doctors (AUWD) Uganda Private Midwives Association
HIV/AIDS/STD focus	The AIDS Support Organization (TASO) AIDS Information Centre (AIC) Naguru Teenage Centre
Internationally affiliated entities	World Vision (Uganda) Care (Uganda)

NGO representatives were asked whether they had a strategic plan and to avail a copy for review. Each plan was reviewed to assess inclusion of the organization's vision, strategic objectives, marketing strategy, exit strategy, core functions and financial and non-financial resources. Other aspects included whether the plan identified the NGO's competitors, analysed the implications of health sector reforms and/or SWAp, and whether a critical analysis of the socio-economic environment had been undertaken.

The analysis was structured according to six issues that have been identified as the 'key systems' of sustainability for NGOs (Abt Associates, undated, CMS, undated), presented in Table 2. However, since these systems and/or issues do overlap in some instances, in the presentation of results that follows the six issues have been organized into four categories: strategic planning; financial resources, accounting and planning; institutional governance, human resource management and transparency; and marketing planning.

RESULTS

Strategic planning

In this assessment, strategic planning was concerned with whether the NGO had gone through a process for charting its future direction; defining strategies to use to reach defined goals; whether it had examined its current situation and vision for the future; and whether the NGO had prepared a strategic plan.

Virtually all of the NGOs have a vision and/or mission statement. Despite strategic planning being recognized as a crucial organizational and management function for successful organizations (Abt Associates, undated, CMS, undated), nearly half

Table 2. Reproductive health and other services delivered by NGOs

NGO	Reproductive health and other services delivered
Family Planning Association of Uganda	Safe motherhood, family planning (FP) and counselling; STI diagnosis and management; immunization and child care; postnatal care; post abortion care; treatment of minor ailments; training; advocacy and community-based services; ANC; malaria treatment in pregnancy; laboratory services; voluntary counselling and test (VCT); addressing harmful cultural practices, e.g. female genital cutting, gender-based violence, adolescent health services, etc
Uganda Catholic Medical Bureau	Provision of a range of RH services except modern contraceptive. These include ANC and postnatal care; sexually transmitted diseases (STD) diagnosis and management; and deliveries. Providing information and technical advice to affiliated units
Uganda Private Midwives Association	Antenatal and post natal care; deliveries; FP; immunizations and well baby care; syndromic management of STD, HIV counselling; health education; minor curative services; training in infection control, post abortion care, life saving skills and business skills and income generating activities etc
Association of Ugandan Women Medical Doctors	Adolescent health: health education for youth; STD treatment and management; VCT; contraceptives distribution to adolescents; general gynaecological examination; post abortion care; cancer examinations etc
Straight Talk Foundation	HIV/AIDS counselling; adolescent sexual and reproductive health (SRH); adolescent-driven newspapers; service through straight and young talk newspaper insertions accessible to literate youths in 15 000 schools; radio shows in the countries main languages; etc
The AIDS Support Organization	Family planning with emphasis on dual protection; HIV/AIDS Counselling, testing, care and support; STD screening and management; stress management; community-based management of TB; laboratory services, training of counsellor etc
Safe Motherhood Initiative	Pregnancy monitoring; post abortion care; counselling victims of domestic violence; STD/HIV/AIDS counselling, family planning, ANC etc
Marie Stopes Uganda	RH & FP; counselling in FP, management of STD and other conditions; antenatal care, postnatal care, post abortion care, curative care; vaccination; STD diagnosis and treatment; VCT, Diagnosis and treatment of other medical conditions etc
Uganda Muslim Medical Bureau	Affiliated clinics provide FP; ANC, and post natal care; deliveries; immunizations, STI/HIV/AIDS management and counselling; health education; minor curative services etc
Uganda Protestant Medical Bureau	Affiliated clinics provide FP services, ANC and post natal care; post abortion care; STD diagnosis and management; perform deliveries; coordinates capacity building projects in RH etc

of the NGOs have no strategic plan; moreover, two officials did not believe strategic planning to be an important function for their organization. Even those NGOs with strategic plans seem to feel that plans are difficult to translate into concrete ways of improving their financial sustainability. Only one NGO has made a critical analysis of their operational environment; in its 2001–2005 Strategic Plan, a clear

Table 3. Key issues and questions

Key issue	Key questions
Background information	Length of time the NGO has been in operation. Whether NGO has a strategic plan and if the plan is followed in the implementation of organizational goals
Service delivery	Whether NGO has a mission statement and vision Reproductive health services the NGO provides Planned activities in the year before the assessment and whether all planned activities were implemented
Institutional governance	The strong and weak points of programs for the NGOs Governance systems Whether NGO has a Board of Directors, how they function and how they contribute to the organization
Financial management and planning	Current sources of funds of the NGOs Whether the sources of funds are stable What the NGO has done to become financially sustainable Whether NGO has a performance reporting system Whether the NGO gets audited and what happens to the audit report.
Human resource planning	Whether NGOs has an organizational chart delineating all staff positions Whether NGO plans for human resource and how Staff turnover rate of the NGO
Marketing planning	Whether NGO has a marketing strategy How NGO attracts funding How NGO lets its clients know about its RH services How NGO sets fees for its services Perceived environmental factors (financial, social, geographical, cultural factors) working for or against the NGO

consideration is made of the SWAp and the strategic implications for the organization's future are explicitly considered (Uganda Catholic Medical Bureau, 2000). Its plan also highlights organizational strategies for repositioning itself in light of a restructured national health care system and the SWAp. All other NGOs' strategic plans fell short of addressing critical issues such as identifying their clients and their competitors. None of the plans indicates how the organizations intend to compete with other key players in the RH field in Uganda, and none of them has an 'exit strategy' for how to function when their current sources of support end.

Virtually all the strategic plans that have been developed appeared overly ambitious, as reflected in a clear mismatch between the strategic objectives, proposed activities and the resources available to implement the activities. The number and scope of activities planned for the year are simply too many and complex given the limited human and financial resources available. The tendency is for many of the NGOs to over-emphasize the importance of diversifying their activities to meet a wider range of needs and often more audiences, but do not look critically at their comparative advantage and identifying their niche for undertaking these activities

and reaching new audiences. Ten of the NGOs claimed to offer 10–30 RH services. These would seem particularly susceptible to over-diversification.

Financial resources, accounting and planning

This component assessed NGO's financial availability, mobilization and management. Chief Executive Officers and Accountants were asked about how they manage the organization's finances, the range of financial resources available to them including donor support and income from other sources, be they fees for service, grants, or contracts from MOH and local governments. They were also asked whether they cost their services and whether they have undertaken any 'ability and willingness to pay' studies.

Fourteen of the NGOs had up-to-date audited accounts and produce regular financial statements. However, most lack viable planning mechanisms to generate financial resources on a sustained basis. Many aspects of financial planning are done haphazardly. For example, when asked how they set fees for their services, only three NGO representatives could tell how much income these fees generate. The rest of the NGOs had no basis for estimating an acceptable level of fees, or even how much income these fees would generate. Some of these NGOs had created a price list for their services but these are usually not followed, or adapted by each clinic or affiliate.

All NGOs have limited funding options. Some 80%–100% of the total budget for the 16 NGOs comes from donor sourcing. Four of the faith based NGOs also receive government subsidies in the form of 'delegated funds', contributing 30% of their funding. These NGOs continue to lobby the government to maintain this funding. Two of the NGOs reported receiving less than 1% of their annual budget from government in the form of tax exemption on capital goods. Also, two HIV/AIDS NGOs had been contacted by the MOH to submit proposals for funding to implementing specific activities. There is little evidence, however, of successful and resourceful NGO—local government funding partnerships; partnerships at this level are far less advanced than at the central level. None of the NGOs mentioned mechanisms to seriously pursue such a partnership as part of a funding alternative. Indeed, NGO managers lamented having very little or no influence at district level, as well as their lack of skills necessary to lobby local governments for funding.

Most NGOs have not prepared a transition strategy to move from donor funding to alternative sources of income. Significant effort is devoted to sustaining this funding mechanism through writing proposals for donor funded projects, complying with the donors' reporting requirements, and cultivating strong relations with the donors. Conversely, very little staff time is devoted to reviewing and strengthening income generation opportunities or relations with district funding sources.

The funding organizations themselves appear to maintain this 'donor dependency' by continuing project-specific and core support to the NGOs, without also assisting or encouraging them to develop the technical and management capacity, and entrepreneurial philosophy, to raise income from other sources. The view expressed by some of the informants from funding organizations is that the existing level of donor support to NGOs should end, but as none of the NGOs have an exit strategy there is an expectation for them to continue with project support. In

addition, there are still some donors that prefer to continue with project support, as they feel more comfortable with the higher level of control and accountability that they can exert through this mechanism.

Only one NGO reported having carried out a 'willingness to pay' study; instead some simply increase service prices when they are felt to be too low without knowing what effect this may have on the services attractiveness, and whether it will improve or decrease efficiency and equity. As one NGO official put it: 'what we discovered 6 years ago is that we down loaded rising costs of delivering services on to the people, with the resultant effect of shrinking the service. The user fees were raised, which led to a remarkable decline in service utilization—especially outpatient services, which affected mainly women and children.'

Institutional governance and human resource management

The institutional governance component assessed the existence of a functioning Board of Directors, how the Board functioned and contributed to the organization, while human resource management assessed whether NGOs had an organizational chart and a human resource plan.

About half of the NGOs have relatively strong governance structures. They have functional boards that meet regularly to make decisions based on audited reports. One of the NGOs, for instance, has a Board of Directors, which, according to our informants from funding organizations, has proven itself credible in providing strong leadership in management and programmatic direction, which has enabled the NGO to lobby successfully for funding, rent-free premises, drugs and tax exemptions.

Managing human resources, however, is weak in all the NGOs. All 16 NGOs lacked a human resource development policy, one third did not have an organizational chart and job descriptions for their employees, and virtually all could not provide data on staff turnover. Two of the NGOs had recognized these weaknesses and at the time of the assessment were in the process of reviewing their structures to harmonize the way in which their human resources were organized and managed.

With the exception of faith-based NGO's, all other NGOs employ staff on short-term contracts because of their dependency on time-limited projects, which means that maintaining staff continuity depends on continually searching for funding from donors for more projects. Staff movement from NGOs to the government and private sector because of this insecurity is a serious problem. Moreover, the HIV/AIDS NGOs reported losing several staff due to a growing international demand for skilled staff in providing AIDS-related services.

Market planning

Marketing in this context is conceived to mean the NGOs' ability to adapt the techniques of business marketing to create a demand for the services they provide, and this ability was analysed in our study. NGO representatives were asked whether they had a marketing strategy for attracting clientele, informing clients about services, making services accessible and available as well as attractive. Eighty percent of

the NGOs made little effort at marketing themselves or their services and none have a strategy or plan to do so. The faith-based NGOs argued that their beliefs limit them in doing so because they are not allowed to advertise. However, all NGOs use a variety of communication channels to inform potential users about their services, including newsletters, brochures, media programmes, displaying information on notice boards, publication and distribution of catalogues of services and IEC materials.

Three quarters of the NGOs have a limited perspective of the potential range of clients they could serve. For instance they did not consider the government as a potential 'client', in the sense that it could be a purchaser of their services. To attract the government as a consumer, however, NGOs would need to align their vision to that of the overall health sector strategic plan, dialogue with government, offer services in a way that is attractive to the government, and would also have to be able to meet the government's accounting requirements—clear outputs for public funds justified by clear returns and submission of realistic work plans, quarterly reports and physical reports. Only three NGOs seemed able to fulfil these accounting requirements. One of these NGOs has started systematically documenting and disseminating information on service delivery impact on health care outcomes to the Government and others. Two of the faith-based NGOs have a proven capacity to dialogue with the government; these capacities have earned them membership on the Health Policy Implementation Committee (HPIC), which was initiated by the MOH to develop the National Health Sector Strategic Plan. Their involvement in this committee is important for credibility and image and enhances their opportunities to propagate better access to care and equity for the less privileged.

Are NGOs sufficiently prepared to participate in the SWAp and decentralized system?

Overall, our findings show that NGOs are not fully prepared for active engagement in the health sector SWAp and decentralization in Uganda—most still have weaknesses in terms of key systems such as strategic planning, marketing, managing human resources, governance and have limited funding options. Drawing from our analysis, we have classified these NGOs into four categories along a continuum of 'preparedness'—limping, surviving, transitory and thriving. For an NGO to be judged as thriving and well placed in the SWAp context it should have in place a:

- Strategic plan and is capable of implementing that plan;
- Manageable human resource development plan and management information systems plus other institutional management systems;
- Marketing strategy based on an analysis of its potential to offer or sell its services to specific clientele, both individual and organizational;
- Philosophy of being customer oriented and participatory;
- Goal of serving the poor but also able to serve the richer for cross-subsidization;
- Strategy to enable it to exit from existing donor relationships and replace these with other means of generating income; and
- Capacity to generate its own funds from a variety of sources.

Clearly none of the NGOs sampled could be categorized as thriving, but this category is included here as illustrative of an operational definition of how to become a sustainable NGO within the Uganda SWAp and decentralized system.

Transitory category. Only three of the NGOs assessed fall in this category because they are less project oriented, have a well-articulated vision and/or mission statement that is aligned to the Government's long-term strategic vision, as well as sound institutional management and functioning financial systems. A major limitation, however, is that two of them are still largely donor dependent and lack an exit strategy and evidence-based costing of services. The transitory NGOs are beginning to re-position in the changing context and have the basic systems in place to be engaged actively as a partner with the government. They have proven that they can market themselves and have created a credible image for themselves to the government by documenting and disseminating information on how their service delivery contributes to the overall health sector outcomes. These NGOs are also key actors in the new public-private partnership that is evolving in Uganda (Birungi *et al.*, 2001; MOH, 2003). The MOH and local governments are now sub-contracting with them to render certain RH services. The possibility for these NGOs to deliver equitable health for the less privileged is also being enhanced through government delegated funds.

Surviving category. Six of the NGOs can be classified as 'surviving' because they have some of the critical sustainability systems in place and acceptable governance structures. All except one has a strategic plan, while most have either a weak MIS or none at all. All lack marketing strategies and have weak financial systems. They are surviving in the reproductive health arena because, despite these weaknesses, they have been able to continue to attract donor project funding, but it is questionable whether they can continue to survive when such funding stops under the SWAp.

Limping category. The remainder of the NGOs lack virtually all of the key systems for sustainability. None of the organizations in this category had a strategic plan, a functional board of trustees or governing council, or a human resource development policy. In addition, interviews with respondents from the MOH and funding organizations indicated some concerns about financial accountability with some of the NGOs.

The limping NGOs, and some of those in the surviving category, are highly disadvantaged in the context of the SWAp. They have not taken the SWAp and/or the decentralized context into account when preparing their strategic plans, perhaps deliberately, as some of them would prefer to stay well separated from the Government for ideological reasons. By disregarding the SWAp and decentralization, however, they are making themselves vulnerable to losing support from donors too. As long as both the government and NGOs depend on donor support, and as most of this is to be channelled through the SWAp, even if they do not want to work with the government there is little choice for these NGOs but to play the SWAp game if they are to access this type of funding (Jeppsson, 2002). The new context also demands that NGO must know that accountability whether by donor or district partners is a

basic requirement, which any corporate entity should be able to satisfy. This type of accountability entails clear outputs for public funds justified by clear returns, submission of realistic work plans and quarterly reports and responding to highly conditional central government and district development programmes that target poverty reduction in the health sector.

The alternative is for NGOs to raise income through selling their services, but as most of these NGOs seek to serve the poorest of the poor this is not a viable option, leaving them in a difficult situation. But the fact that some NGOs are prepared to take this stance without actively seeking alternative ways of addressing their desire to see an equitable distribution of health care, confirms that they still do not fully comprehend the SWAp process and what they need to do to participate and even thrive within it (Lule, 2002).

CONCLUSION

The intention of the SWAp and the decentralized system in the health sector in Uganda is to increase the 'intimacy' of the relationship between central government, local government, NGOs, private sector, communities and donors for improving effectiveness in achieving commonly agreed goals (Hay, 1998). This new way of working together requires that managers of RH NGOs see themselves as entrepreneurs pro-actively seeking opportunities to provide their services, as well as meeting the needs of their service consumers. Consequently they need to market their vision of how they can participate in the SWAp to the government, donors, local government, others in the private sector and, importantly, the consumers of their services. NGOs are also expected to participate actively in the development of the long-term strategic vision for the health sector as well as to collaborate with local government in service delivery. Thus, both SWAp and decentralization can offer opportunities for RH NGOs to become financially sustainable in the long-term if they can dialogue with government and build their capacity to participate actively in the SWAp. However, NGO-government and district level partnerships are far less advanced. The ability for NGOs to adapt to this new situation requires that they become more entrepreneurial, by developing an organizational philosophy and strategies to mobilize resources through combining their institutional capability to plan, manage and evaluate their activities effectively with the capacity to understand and use the new policy environment in their own favour (Mills, 1998). Dialogue and collaboration between RH NGOs and the central government under the SWAp, and local governments under the decentralization policy, can only be enhanced, however, if all parties share common objectives. The NGOs must recognize and strive to adapt to the new situation immediately, so as to exploit it and enhance their financial and programmatic sustainability. However, they cannot do this on their own. An equal responsibility rests with the government and its development partners to ensure that the NGOs can build their capacity to participate effectively in the SWAp and under the decentralized framework. If not, Uganda risks losing the unique services these NGOs are currently contributing, not least of which is their ability to reach the poorest of the poor.

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REFERENCES

- Abt Associates Inc. (undated). *Fundamentals of NGOs Financial Sustainability*. Pathfinder International: Watertown, MA.
- Birungi H, Mugisha F, Nsabagasani X, Okuonzi S, Jeppsson A. 2001. The Policy on Public-Private Mix in the Ugandan Health Sector: Catching up with reality. *Health Policy Plan* **16**(Suppl. 2): 80–87.
- Cassels A. 1997. *A Guide to Sector-wide-approach for Development: Concepts, Issues and Working Arrangements*. WHO: Geneva.
- Hay R. 1998. *Health Services in Uganda*. A Consultancy Report submitted to the World Bank. World Bank: Kampala.
- Initiatives Inc. 1999. *Reproductive Health Integration Issues*, Volume 2 Number 1 January.
- Jeppsson A. 2001. Financial priorities under decentralisation in Uganda. *Health Policy Plan* **16**(2): 187–192.
- Jeppsson A. 2002. SWAp dynamics in a decentralized context: experiences from Uganda. *Soc Sci Med* **55**: 2053–2060.
- Kruse SE. 2002. *SWAp and Civil Society: The Roles of Civil Society Organizations in Sector Programs*. NORAD Report 2/2004.
- Local Government Act. 1997. Uganda Printing and Publishing Corporation, 1997.
- Lule E. 2002. *Why Should African NGOs be Concerned about Generating Local Financial Resources?* Report of the Conference on Financial Sustainability for African RH NGOs. Population Council: Nairobi.
- Mills A. 1998. To Contract or not to Contract? Issues for low and middle-income countries. *Health Policy Plan* **13**(1): 32–40.
- Ministry of Health. 2003. *National Policy on Public Private Partnership in Health* (Editorial Draft). Uganda Ministry of Health: Kampala.
- Ministry of Health. 1998. *National Health Policy (1997/98–2006/7)*. Health Policy and Planning Unit, Uganda Ministry of Health: Kampala.
- Peters D, Chao S. 1998. The sector-wide approach in health: what is it? Where is it leading? *Int J Health Plan Mgmt* **13**: 177–190.
- Uganda Catholic Medical Bureau. 2000. *Strategic Plan, 2001–2005*. Uganda Catholic Medical Bureau: Kampala.