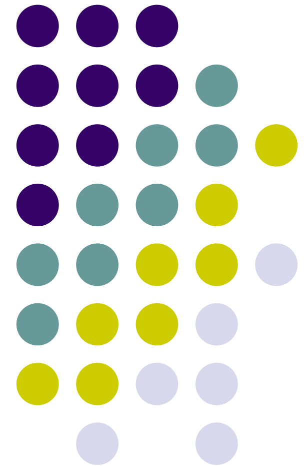
RENEWING THE CASE FOR SWAPS IN HEALTH



PRESENTED TO

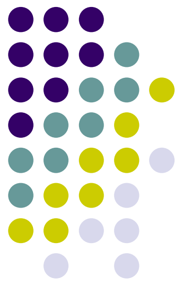
HLSP PANEL ON SWAPS

UNITED KINGDOM

27th September 2006

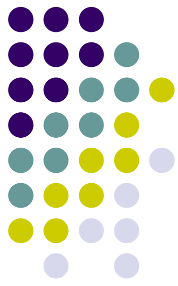
By Robinah Kaitiritimba

BACKGROUND



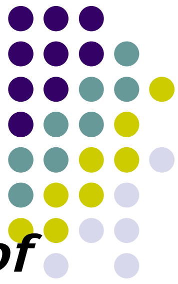
Since SWAps in 2000, there has been remarkable improvement in Health Sector funding, partnership –PPPH, planning and mg't and capacity. However, challenges remain, (e.g. focus on malaria, curative vs prevention, HIV at the expense of culture, gender), community mobilization and poor coordination.

SOME CURRENT INDICATORS



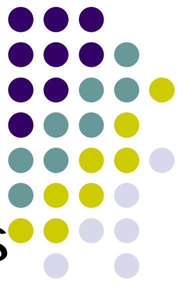
- Donor support to budget - 50%
- 35% of people live below poverty line
- Infant mortality (2000) - 88.4 per 1,000
- Maternal mortality - 505 per 100,000
- 85% of population depend on agriculture
- 45% illiteracy rate.
- *"Ill health is the most frequent cause and consequence of poverty"*

CONSUMER/PROVIDER VOICES

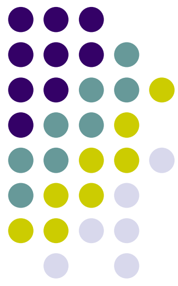


- Poor people define poverty beyond income to include, ***"sense of powerlessness, inability to influence what is happening around them"*** MoFPED, UPPAP (2003).
- Governance – inadequate community empowerment for participation in gov't programs, prioritisation, implementation and accountability, lack of supportive legal framework and mechanisms, timely redress and justice.
- ***"a poor man has no voice in the community...... government programme are imposed on us when we do not know their origins and at times when they are not our priority. Upgrading of our Health Units was a total miscalculation in Wakiso. We preferred just a maternity centre".***
- ***"Limited progress has been made in empowering communities to take responsibility for their own health"*** MoH (2004).

SOME OF THE BENEFITS



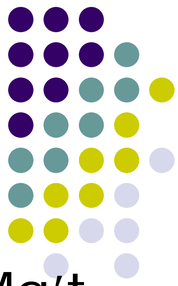
- Choice and commitment to national targets as in (PEAP and HSSP) by both government and donors which has increased funding for health with related sectors (education, water and sanitation, etc). ***"Wet vs dry sector syndrome".***
- Choice of budget vs project support.
- Division and focus on specific roles by the MoH in planning, restructuring, M&E and supervision.
- Shared responsibility for accountability - MoH, MoFPED and Civil society.
- Abolition of user fees.
- Opening up of planning budget and performance review processes – stakeholder participation. (PPPH)



ADVANTAGES CONT'D

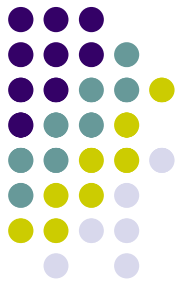
- Decentralization – autonomy of districts to prioritise – planning, decision making, implementation and monitoring.
- National framework, National prioritisation - basket funding – HSSP, PEAP
- Gender/HIV/AIDS mainstreaming.
- Public Private Partnership for Health - PPPH

CHALLENGES



- Inadequate capacity at the district level for planning, Mg't, budgeting, M&E
- Misuse of resources. Lack of commitment and M&E capacity at MoH.
- Rigidity of MTEF- ceilings and lack of innovation for alternatives.
- Understanding of issues, SWAps, Gender,
- focus on curative and clinical aspects – other than prevention, professional physicians
- Partnership with non clinical partners, CSOs, advocacy and public health, referral systems, resource sharing.
- multiple structures – (HUMCs, Malaria distributors, Parish development committees – PDCs, Village Health Team-VHT, AIV/AIDS initiatives.
- Underlying power centres and relationships

DO WE STILL NEED SWAps



- ***"we reach home when lunch is not ready, because parents dig till lunch time. we go back hungry feeling as if our intestines are coming out of our stomachs. Many of our friends do not come back but instead roam for jack fruits in the villages".*** PEAP (2003).

- ***"malaria has always attacked me now I am much weaker than before, I no longer dig for hours. When my husband or children are sick, this also affects my schedule, my daughter has to leave school and at the end of it all we have less food and less produce to sell"***

Woman, Kawiti, Masindi