

Whose policy is it anyway? International and national influences on health policy development in Uganda

SAM AGATRE OKUONZI¹ AND JOANNA MACRAE²

¹Ministry of Health, Uganda, and ²Health Policy Unit, London School of Hygiene and Tropical Medicine, UK

As national resources for health decline, so dependence on international resources to finance the capital and recurrent costs is increasing. This dependence, combined with an increasing emphasis on policy-based, as opposed to project-based, lending and grant-making has been accompanied by greater involvement of international actors in the formation of national health policy. This paper explores the process of health policy development in Uganda and examines how major donors are influencing and conflicting with national policy-making bodies. Focusing on two examples of user fees and drugs policies, it argues that while the content of international prescriptions to strengthen the health system may not be bad in itself, the process by which they are applied potentially threatens national sovereignty and weakens mechanisms for ensuring accountability. It concludes by proposing that in order to increase the sustainability of policy reforms, much greater emphasis should be placed on strengthening national capacity for policy analysis and research, building up policy networks and enhancing the quality of information available to the public concerning key policy changes.

Introduction

The capacity of multilateral and bilateral agencies to exert greater leverage over national policy-making processes has increased in proportion to the dependency of many governments on donor support of the recurrent financing of the health system. In many countries, 20% to 50% of recurrent health budgets is provided by international aid (World Bank 1993a).

As the health sector has been affected by the wider environment of national economic decline and international economic policy, so it has become included in the wider set of policy-based lending conditions, common to the more conventional elements of structural adjustment and stabilization policies (Foltz 1994). Donor involvement in health policy-making therefore derives both from the level of their financial commitment and from a broader ideological and political basis which seeks to gain control over policy environments through conditionalities.

Focusing on Uganda, this paper explores the implications of increasing international involve-

ment in health policy development in poor countries, and examines the processes through which donors seek influence on the health policy stage. Building on two examples, it analyzes the origins of national vulnerability to donor influence, and describes how international agencies articulate with national processes of policy-making and legislation. The first example is that of user-fee policy, initiated by a national health policy review committee and promoted by the International Monetary Fund (IMF) and the World Bank as part of the economic structural adjustment programme (SAP). The second is the national drug policy initiated and directed by the Danish International Development Agency (DANIDA).

The remainder of the paper comprises 4 substantive parts. Firstly, the political and economic context of policy-making in Uganda is described. This is followed by a brief historical review of health policy in the country. Thirdly, the two case studies are described and analyzed. Finally, the implications of donor influence on policy-making are discussed with reference to the sustainability and accountability of health policy.

Uganda in crisis: the economic and political context

Uganda attained political independence from Britain in 1962 and inherited a modest economy. During the 1960s, economic growth averaged 5.1% per annum, significantly higher than the population growth of 3%. In January 1971, the military, led by Idi Amin, overthrew the elected civilian government of President Milton Obote. The Amin years were characterized by widespread violence and repression. Between 1973 and 1980 incomes per capita declined by 6.2% annually, 10 times the average rate in sub-Saharan Africa as a whole (Lateef 1990). This dramatic economic decline was associated with a political regime which sought to maintain power by extending control over all aspects of production and distribution through a dramatic expansion of the state bureaucracy (Commonwealth Secretariat 1979; World Bank 1993b). Yet, the incapacity of the state to meet the basic needs of its population created a climate which promoted the informalization of the economy, reflected in a retreat to subsistence production and the development of a vibrant and sometimes violent parallel economy (Green 1981).

In 1979, the military government was overthrown by a coalition of several groups of freedom fighters backed by the neighbouring Republic of Tanzania. The internal divisions between these groups soon became apparent, however, paving the way for a succession of coup d'états. In 1980 a military government, strongly supporting the Uganda People's Congress (UPC), organized a multi-party election. The election, widely regarded as fraudulent, saw the return of Milton Obote as President. Disenfranchised, the other political parties separately waged war against Obote's government: at the forefront of the insurgency was the National Resistance Army (NRA), led by Yoweri Museveni.

The international community had resumed assistance to Uganda following Obote's accession to power. However, a substantial amount of resources were diverted to contain the growing insurgency, and by 1985 GDP had further declined.

The NRA reached Kampala in February 1986, overthrowing the Obote government. Its poli-

tical wing, the National Resistance Movement (NRM), established a government and has since embarked on trying to implement the ten-point programme it developed during its insurgency struggle. This programme set out to achieve democracy and security; eliminate all forms of sectarianism; defend national boundaries from external aggression; achieve an integrated and self-sustaining economy; rehabilitate war-ravaged areas; end corruption; improve the living conditions of those who had suffered disproportionately from previous government policies, especially those displaced by conflict and those from deprived areas such as Karamoja; improve living conditions of salaried workers; establish human rights; and promulgate relevant and acceptable national constitution (Hiscock et al. 1993).

Through the Resistance Committee (RC) system, popular democracy has been established up to the village level. The system allows citizens aged 18 years and above to participate in decision-making at 6 levels of representation. It enables individuals to achieve elected office, regardless of their political, religious and ethnic affiliations.

In its first years of power, the NRM was confronted by renewed insurgency in the north and east of the country. However, by 1992 peace and stability had been secured throughout most of the country, although some pockets of insecurity persist, and the country remains vulnerable to the effects of conflict in neighbouring countries, including Sudan and Rwanda. Freedoms of speech, expression and the press have become increasingly real in recent years, and elections to form a constituent assembly to discuss the new national constitution were held in March 1994.

In its 7 years in power, the NRM government has accomplished major rehabilitation of infrastructure and reversed economic decline. By June 1993, economic growth was at 7.5% per annum and inflation had fallen to an unprecedented negative 3% (Uganda 1993b). Despite this economic progress, Uganda remains a very poor country, UNICEF (1993) ranking it as the 19th least developed country in the world. The GDP is only US\$212 per capita, 90% of which is skewed to 10% of the population (UNICEF 1993; Uganda 1992). The debt burden is enormous, accounting

for 39% of the GDP; 77% of all export earnings are used to service debt and interest repayment (Uganda 1992). Thus the impressive economic growth has had only a minimal effect on the quality of life of the majority of the country's population.

Balance of payments and budget deficit problems have continued to force the government to rely heavily on external aid. In 1987, the government introduced a structural adjustment programme under the auspices of the IMF and World Bank. The economy has been slow to respond to the austerity measures imposed by the Bretton Woods institutions, particularly in the rural areas (Lateef 1990). Tax revenues remain substantially below the average for sub-Saharan

Africa: 8% of GDP compared with an average of 18% for the continent as a whole.

The weak capacity of the public sector to raise revenue has led to a high degree of dependence on international donors to support public expenditure, which accounts for 19% of GDP, nearly 60% of which is financed by donors (Uganda 1993b). In the health sector, aid dependence is also high, particularly for primary health care expenditures, 66% of which are supported by international donors (Hiscock et al. 1993).

Health policy in Uganda: a history of external influence

Table 1 summarises major events in Uganda's health policy history.

Table 1. Summary of main health policy events in Uganda

Period	Actors	Policy issues	Policy content
1887-1894 (Initiation)	IBEAC	Staff and workers health needs	Limited curative care
1895-1961 (Expansion)	Colonial office Colonial administration Missionaries	Tropical disease Evangelization Inequality of access Legitimacy	Expansion of health facilities Training institutions Free treatment Preventive care
1962-1970 (Expansion)	MoH Colonial office Missionaries	Equity of access Unequal health status Low health status	Expansion of health facilities Preventive care
1971-1979 (Status quo)	MoH Missionaries	Maintaining status quo Contracting finance Political instability Large infrastructure	Minimal charge policy
1980-1985 (Relief/Emergency)	MoH Donors NGOs Missionaries	Displaced people Hunger/malnutrition AIDS Destroyed infrastructure Weak health system Insecurity	Emergency/Relief PHC policy Vertical programmes Regional health services
1986-1993 (Reform directed by donors)	Donors NGOs/Missionaries MoH Uganda Pharmaceutical Society The press	(As above) Prioritization Inefficient resource use Political legitimacy Inappropriate health care organization Inequity Fragmenting health system Basic health care package	Selective PHC Basic care approach User-charges Reconstruction of physical structures (First Health Project) Community participation CHWs Decentralization No further expansion of health facilities Civil service retrenchment. Regionalization of health system Verticalization Community Health and AIDS Project

Colonialism and the immediate post-independence period

A Western model of health care was introduced in Uganda in 1878 when the Imperial British East Africa Company (IBEAC), a trading concern, first brought doctors to look after its staff, including its Indian workforce, constructing Ugandan Railways. The Colonial office took over administration of the company in 1894 and established a medical department in what was then the Uganda Protectorate (Uganda 1989).

Initially, the department was meant to meet the health care needs of the colonial staff. However, a succession of epidemics, including plague, sleeping sickness, small-pox, malaria and later, syphilis, forced the administration to extend medical care to native Africans (Uganda 1987). At the same time, missionaries started to provide medical care, as part of a wider process of evangelization. Thus, by independence in 1962, a considerable health care infrastructure had been established. This consisted of urban hospitals, a number of rural health centres, nursing schools and two schools to train medical assistants, plus a network of health inspectors for the promotion of home hygiene.

In recognition of its expanded function, the colonial Medical Department was upgraded to Ministry of Health in 1961. The period from 1961 to 1970 saw the rapid expansion of physical infrastructure, notably the construction of Mulago Teaching Hospital in Kampala and 22 rural hospitals. Thus, health policy in the decade following independence reinforced the curative and urban biases of the colonial health system, paying relatively little attention to preventive and promotive aspects of health care. Underlying this strategy was both the influence of Western-trained medical professionals, and a confidence that the economy would continue to grow and provide a sustainable source of revenue to maintain a free national health service.

The war years: 1970–1986

The political events of the 1970s constituted a major threat to the public health system. The effects of the expulsion of the Asian community in 1972, and the flight of others during this time, halved the number of doctors, and left a fraction of the number of pharmacists in the country. The government's attention was focused on its

own political survival, and thus social services were pushed to the margin. It was only possible for civil servants to make decisions about small changes in existing policies largely inherited from the colonial era. Moreover, the pursuit of more equitable access to health care by expanding the health infrastructure into rural and underserved areas, was rendered impossible in the face of rapidly contracting health finance. The country's international isolation also denied health professionals an opportunity to participate in wider debates concerning health and health policy. For example, Uganda sent a representative to the Alma Ata conference on Primary Health Care in 1979, but due to the deteriorating security and political situation, the ideas promoted by the meeting could not be diffused to a wide audience and translated into a clear PHC strategy (Macrae et al. 1993). Thus, the medical model continued to dominate, and those within the system sought to effect remedial actions to sustain it (Uganda 1989).

When Milton Obote returned to power, international aid began to flow to Uganda once again. The hopes of rehabilitating the country after the Amin years were quickly dashed, however, as conflict once again intensified, further weakening the health care system. At the same time, health needs dramatically increased: massive population displacements and the breakdown of the limited preventive services led to an increase in communicable and vector-borne diseases and malnutrition. War also played a large role in the rapid spread of the HIV/AIDS epidemic because of widespread rape, large-scale movements of military personnel and the breakdown in family structures and increasing levels of poverty (Smallman-Raynor and Cliff 1991; Bond and Vincent 1990).

This context of instability had important implications for the organization and delivery of international aid in Uganda. The need for humanitarian aid led to a proliferation of international relief agencies, particularly NGOs, developing programmes in the country. The effective breakdown of public health services placed these international agencies in the forefront of health provision. In the absence of government co-ordination of these efforts, the health system became further fragmented and increasingly dependent on international personnel and financing.

Thus, by 1986, many international agencies had gained a strong foothold in service provision, acting largely outside central and local government structures, while at the national level, capacity to coordinate and direct these activities had declined.

The early 1980s also saw the increasing dominance of selective, vertical programmes. The delivery of services such as immunization was relatively feasible in a context of camps for displaced populations, compared with developing comprehensive and integrated services nationally. When the NRM came to power in 1986, both national politicians and international agencies, such as UNICEF, sought to expand these vertical programmes rapidly throughout the country. Underlying this strategy was the assumption that they could provide the platform for more integrated primary health care services. Yet in a context of almost total breakdown of the national health care system, this early emphasis on vertical services meant that they became particularly dominant, overshadowing other aspects of provision (Macrae et al. 1993).

Aiding recovery? International aid and rehabilitation

In 1986, the process of recovery and rehabilitation began in large areas of the country, despite the on-going insurgency and violence in the northern regions. A Health Policy Review Commission was formed in 1987 to examine past policies and legislation and to identify policy gaps. The Commission's wide ranging report reaffirmed many elements of past policies and promoted a two-pronged strategy which sought to rehabilitate the existing health system *and* to develop further primary health care services (Uganda 1987). The report suffered from two major weaknesses however: firstly, it failed to acknowledge the depth of the health financing crisis in the country; secondly, it assumed that major changes in primary provision could be affected without major reform of the secondary and tertiary sectors (Macrae et al. 1993).

At a national level, development of strategic health policy was slowed by limited capacity within the Ministry of Health and by the limited political interest in the health sector. Thus, the recommendations of the Health Policy Review

Commission had still not been translated into legislation and policy before the development of the National Health Plan in 1991. The main features of this ten-year plan are presented in Box 1.

Box 1. Key points of the National Health Plan 1991-2000

- * Restatement of commitment to comprehensive PHC policy
- * Priority accorded to community participation through a network of health committees at different levels of the RC system and the promotion of Community Health Workers (CHWs)
- * Decentralization of the health care administration to districts and institutions
- * Promotion of intersectoral collaboration and coordination especially between ministries, NGOs and donors
- * Promotion of private practice and its regulation and control
- * Encouraging and partly integrating traditional medicine in the formal health system
- * Reorganization of health care into 4 levels; first referral level (health centre), secondary level (rural/district hospitals), tertiary level (regional and specialist hospitals) and apex or/quaternary level (national referral and teaching hospitals)
- * Promote alternative methods of health financing starting with user-fees and community financing. The feasibility for insurance and other forms of health financing is to be determined by research.

Source: Uganda (1989)

The publication of the ten-year plan prompted a major outcry from donors. The primary point of contention was that the budget for the plan exceeded available resources four-fold. Since inadequate resources were available from the public sector, it was argued, a much more minimal package of services should be made

available from the public health system (Macrae et al. 1993; Hiscock et al. 1993).

The concern of donors, particularly the World Bank, about the direction of health policy in Uganda prompted the increased involvement of international advisers in the process of health policy development, and increasing use of conditionalities on health assistance. In 1992, a three-year health plan, largely developed by expatriate advisers, was published (Uganda 1992; Uganda 1993b). This lays out 5 major policy recommendations:

- a) there should be no further expansion of health care infrastructure;
- b) priority should be given to restoring the functional capacity of existing facilities;
- c) the health system should be reoriented to PHC;
- d) a basic health care package approach should be used, determined by local needs and available resources;
- e) user-charge policy should be promoted as one way of financing health care.

In order to illustrate the role of international agencies in promoting this new agenda for health in Uganda, two elements of the national health plan are worth examining in some detail – the promotion of user-fees and the development of an essential drugs policy.

User-charge policy

Historically, publicly-provided health care has been free in Uganda. Over the years, however, official policy has been overtaken by events. The extremely low salaries of health workers has resulted in the widespread practice of informal charging. In 1987, the Health Policy Review Commission proposed the introduction of user-fees in order to boost income for the health sector. It argued that patients attending public health facilities were already paying, and that mission facilities were able to provide better quality of care because of their income from fees. The Ministry of Health therefore appointed a National Task Force for Health Financing (NTFHF) in 1989 to work out mechanisms to implement the policy.

The Task Force recommended fee structures and procedures of financial management. It also advised on the necessary prerequisites to implement

the new system: receipts, cash boxes, bank accounts, health facility management committees, training of the committees in simple accounts, making the public aware of the policy and legislation to allow collection and retainment of funds at the health facilities. The Task Force provided guidelines outlining for which services fees would be charged and which patients should be exempted.

A cabinet White Paper was prepared and a Bill on user-charge policy was completed in 1990.

Before the Bill was presented to the National Resistance Council, the legislative body, scepticism about user-charge policy was expressed in the media and by several politicians. Opponents of the policy argued that since people were already paying for government health services through general taxation, user fees constituted a double payment. Secondly, it was suggested that as the quality of care in public health facilities was so poor, people would not and should not pay for it. It was also argued that since the majority of people were poor or did not have ready access to cash, introduction of user fees would increase the barriers to access to health care, so worsening existing inequalities. The President himself was one of the opponents of user fees, remarking several times that charging patients was unacceptable. This seems to have finally sealed the fate of the Bill: at its first reading, it was thrown out of the NRC.

With hindsight a number of explanations have been offered as to why attempts to introduce user fees failed in Uganda in 1990. Some have argued that there was inadequate lobbying of politicians and they therefore remained uninformed about the potential gains to be made by introducing fees. Others maintain that the NRC's decision reflected the opinion of ordinary people who not only expected the government to improve health services but to eliminate illegal charging of patients and maintain free health care. Still others believed that it did not succeed because the Ministry of Health could not finance the measures necessary to ensure smooth implementation, such as improvements in quality, management and training for health facility committee members. Many attributed the rejection of the Bill by the NRC to bad timing: parliamentary elections were due shortly and people had become wary of the increasing taxation.

Despite the formal rejection of the user-fee policy by the national legislative body, there was a loophole which enabled the Ministry of Health to encourage the introduction of charges for health services. District authorities were empowered to raise revenue and set guidelines for doing so within their administrative boundaries. The local health committees, which effectively set policy for individual health facilities, were therefore able to introduce user fees if they chose to do so. Thus, there was a major dichotomy between national level 'policy' and local strategy for health financing.

The World Bank moved in to break this stalemate. The opportunity used was the negotiation of a new loan. In 1992 the five-year First Health Project (FHP) ended. The FHP had achieved physical rehabilitation of 10 hospitals and a number of satellite health centres, but was widely criticized for its limited success in restoring functional capacity to health facilities (World Bank/GoU 1992). The second health project, known as the Community Health and AIDS Project (CHAP) sought to correct these imbalances by focusing on a limited and selected set of primary health care interventions covering the whole country. This loan would only be granted, however, on condition that the government adopted a national policy promoting user fees.

Table 2 summarizes the main factors for and against user-charge policy.

Table 2. Summary of factors for and against user-charge policy

Factors for	Factors against
World Bank's paradigm of market efficiency	Presidential remarks
World Bank's conditions for Loan	NRC's rejection
Low health financial base	Increasing general taxation
Poorly paid health workers	Increasing school fees
HPRC recommendation	Economy now less speculative
NGOs support	Prerequisites not met
Extensive illegal charging	Introduced too fast initially
'Legalisation' by lower councils	Exemption methods unworkable
Improved quality care in facilities which charge	Pending parliamentary elections
Rehabilitation of health facilities	Ill-informed public
	Poor quality health services
	Weak national interest groups
	Opposed by the press

The drug policy

The Uganda Essential Drugs Management Programme (UEDMP) began in 1985 with the assistance of DANIDA and the Danish Red Cross to provide rural health facilities with essential drugs. Initially conceived as an emergency programme to provide stocks of basic pharmaceuticals to rural health facilities which had for years been without drugs, it soon became the main source of drugs and equipment for the whole country.

Until the introduction of the UEDMP, the government had only been able to provide a dozen or so of the 277 items on the national essential drugs list, and even then its supplies were erratic. The 1970 Drug and Poison Act did not provide an effective deterrent to the vibrant illegal trade in drugs. The concern about unregulated marketing of pharmaceutical products was heightened by the rampant sale of banned, trial and expired drugs to unsuspecting customers. In a bid to stop this practice, the Ministry of Health posted drug inspectors to all districts in 1991, and made licensing of private drugs shops and clinics more strict. Despite these measures, illegal trading of drugs continued largely unabated.

In 1990 the first phase of UEDMP ended, but DANIDA indicated its willingness to extend the programme into a second phase lasting 10 years, but only on certain conditions. Firstly, a new drug policy providing laws for the manufacture, procurement, distribution, marketing, storage and quality control of drugs had to be enacted. Secondly, only drugs approved by the government would be allowed into the country. Thirdly, a national drug authority should be set up to oversee drug importation, manufacture and distribution. Fourthly, the Central Medical Stores would have to become autonomous from the Ministry of Health and fall under DANIDA administration. It would be renamed National Medical Stores and would sell drugs to government, non-government and private facilities. The new stores would be the only agency responsible for procurement and importation of human drugs into the country.

These conditions created disquiet both within and outside the Ministry of Health. The Uganda Pharmaceutical Society and the media strongly

opposed the intended policy, arguing that DANIDA was trying to monopolize the drug industry in Uganda and to promote drug sales for Danish firms. Sensing mounting resistance, DANIDA gave the government an ultimatum: either the policy was enacted by December 1992 or support for the Essential Drugs Programme would cease. By March 1993, the Bill for the Drug Policy and Authority had been prepared, but not tabled, for consideration by the NRC. Consequently, DANIDA cut down the drug supply by two-thirds, causing a country-wide outcry.

Nevertheless, in May 1993 the Bill was rejected by NRC at its first reading. The Minister of Health pleaded with members of the NRC to consider the Bill seriously for the sake of restoring drug supply by DANIDA. An NRC Select Committee was accordingly appointed to ex-

amine the Bill. At its second reading, the Drug Policy and Authority Bill was passed with several amendments.

Table 3 summarizes the key features of the process, content and outcomes relating to drug and user fee policy in Uganda.

Discussion

Concepts of policy-making in weak states

Conventional concepts of 'policy-making' are based upon analyses of Western political systems where national politicians and governments, albeit influenced by other actors, are the primary policy-makers (Leichter 1979; Blondel 1990). Under these models national political systems are the means by which values, goods and services are allocated.

Table 3. Analysis of two health policy issues

Policy components	User-charge policy	Drugs policy
Process	Bank conditionality Closed door negotiation View gathering by HPRC Consensus building by NTFHF Unsuccessful legislation Devolution of decision making to lower levels Limited debate by the press	Donor conditionality Legislation Debate by the press Closed door negotiation
Content	Fund generation Efficiency of resource use Protection of the poor Improving quality of health care Compliance with World Bank's prescription	Improve management Enforce laws Update laws Protect donor interest Compliance with WHO/World Bank recommendations
Actors	World Bank MoH/HPC/NTFHF NRC UNICEF The press	DANIDA NRC MoH UPS The press
Main determinants of outcome	Donor conditionality Widespread practice	Donor conditionality Donor interest for drugs market Widespread illegal marketing of drugs
Outcome	Policy hanging in balance No central policy guidelines Variety of models for implementation	Laws enacted 'Authority' created New stores to be established UPS is disgruntled

The two case studies presented here illustrate a number of features, which question the appropriateness of conventional analyses of policy-making in countries which have limited national political and bureaucratic capacity and which are highly dependent on international aid.

Between 1986 and 1991 there was no clear health policy framework in Uganda: policy might be described as being in a state of free-fall. In the absence of an overarching strategy, the proliferation of different project-based interventions, funded by different agencies, effectively created a series of unintegrated 'micro-policy' environments (Macrae et al. 1993). These micro-policies were defined vertically in terms of the type of intervention, for example immunization, and geographically within the confines of small project areas. While there was little integration with any national policy, these micro-policies were linked to the internal policies of the international agencies involved. The interventions thus largely reflected the values, ideologies, objectives and priorities expressed by organizations in New York, Washington and London, not those of any national political system.

By 1991 the freedom granted to international agencies to operate their own micro-policy environments was potentially limited by the development of a strategic national plan. Until this time, relatively few donor resources had been committed to strengthening national policy-making and planning capacity. Unwilling and unable to finance the plan which implied a substantial and perhaps unsustainable level of donor inputs, getting 'policy' rather than 'project' right became an important concern for the key donors. The major instrument used to achieve this objective for both user-fee and drug policies has been strict conditionality, often promoting confrontation with national politicians, and increasing use of expatriate technicians to formulate national policy documents.

Donor influence in policy development raises a number of questions concerned less with the technical merit of alternative policy options for such issues as health financing strategies and the composition of essential drugs lists, than with issues of accountability, sovereignty, information, sustainability and appropriateness in the health policy domain.

Accountability and sovereignty

An important characteristic of recent policy developments in health financing and drugs policy in Uganda has been the attempt by international donors to influence the legislative process in favour of their policy prescriptions. Politicians are being placed in the unenviable position of balancing their own reservations about particular policies against the risks of withdrawal of major donor financing, as is shown clearly in the essential drugs example.

This pressure on national legislatures sits uncomfortably with other aspects of donors' policies which seek to promote democratic institutions and good governance. In Uganda genuine attempts, often encouraged by the international community, have been made to develop accountable and grassroots institutions through the Resistance Councils and popular democracy. There is concern that if donors hold these elected institutions to ransom over particular aspects of policy, the lines of accountability and sovereignty become blurred.

The risks associated with a shift in these lines of accountability become accentuated because it is unclear who takes responsibility for the failure of policies prescribed by international donors. The World Bank's own evaluation of the First Health Project, for example, cites many serious weaknesses in its design and implementation (World Bank/GoU 1992), yet the people of Uganda remain responsible for paying back the loan. As the donor community demands stronger mechanisms of accountability in public life in developing countries, it might be argued that similar systems are required to monitor the impact of international actions.

Information

As discussed above, politicians and the media raised a number of important and legitimate questions about the appropriateness of donor prescriptions for the health sector in Uganda.

In particular, there was concern that user fees were unaffordable for the majority of the country's population, and that the low levels of fees that would have to be charged in order to maintain coverage would not yield sufficient resources to resolve the country's grave financing crisis.

The lack of relevant information about the likely impact of user fees strengthened political resistance to their introduction. It is clearly important to ensure that major policy decisions are informed by high quality research in pilot areas to demonstrate the implications of a national policy.

In Uganda, such studies have only been conducted since the introduction of the Bill to the NRC (see Mwesigye 1994). Under these conditions there is the risk that attempts by donors to introduce policies untested in a particular economic and political context will be seen as driven primarily by ideology rather than by a concern to develop strategies appropriate to national and local conditions.

Sustainability

Foltz (1994) has argued that a crucial condition of maintaining the sustainability of policy-based approaches to international assistance will be ensuring that policy-makers and politicians feel that they own policies. In the case of Uganda, many national actors perceived the value of both the essential drugs and health financing policy positions favoured by the different donors. In the case of the introduction of user fees, national, district and international policy-makers and planners promoted the introduction of user fees in Uganda. Different actors saw user fees as a means of achieving different objectives. Some agencies (such as the Ministry of Health, the World Bank and certain bilateral donors) saw it primarily as a means of increasing revenue and releasing public sector resources for other activities, while others (such as the Health Policy Review Commission and UNICEF) were more sceptical about the potential yield of user fees, but emphasized their value in providing a focus for community involvement in management of health facilities. At the district level, user fees were perceived as a means of reducing dependence on income from the centre and effecting a more decentralized approach to health planning.

The process by which donors sought to influence the adoption of these policies was by imposing strict conditionalities, not to build coalitions and support national fora for debate and discussion. The weakness of national fora for discussion, reinforced by the lack of information available on the likely outcomes of different policy op-

tions, has brought into sharp contrast the power of international agencies to control the policy domain. This situation has heightened the need for policy partnerships between international and national actors, rather than the politics of domination which currently predominates. Once again, such a strategy will rely upon supporting the development of national institutions to enable effective research and debate on key policy issues.

Conclusions

Donors and their implementing partners are rightly concerned with the growing levels of dependence on international assistance to financially sustain the health system in the Third World. Urgent and radical measures are required to respond to these difficulties, and user-fees and essential drugs policies constitute one means of adjusting to a context of declining resources.

This paper has been concerned less with an exploration of the costs and benefits of the reform measures proposed by the international community than with a concern with the process by which these measures are implemented in poor countries such as Uganda. It has been suggested that neither national nor international actors have the monopoly of wisdom on how to respond to the crisis in health in Uganda; on both sides vested political and commercial interests and ideology serve to colour 'rational' debate. We have argued that developing appropriate and sustainable health reforms will rely not simply on identifying technical solutions, but on ensuring national ownership of policy changes. This does not imply that donors should simply hand over a blank cheque to recipient governments, nor does it suggest that the international community does not have a valuable contribution to make to national policy debates. Rather it suggests that partnerships need to be built with formal and informal policy actors to identify viable and appropriate strategies which can be implemented by institutions that are accountable to the users of health services.

References

- Blondel J. 1990. *Comparative Government*. New York: Phillip Allan.
- Bond G, Vincent J. 1991. Living on the edge: Changing social structures in the context of AIDS. In: Hansen HB,

- Twaddle M (eds). 1991. *Changing Uganda: the dilemmas of structural adjustment and revolutionary change*. London: J. Currey, pp 113-29.
- Commonwealth Secretariat. 1979. *The Rehabilitation of the Economy of Uganda*. Report by a Commonwealth Team of Experts, London. (2 volumes).
- Foltz AM. 1994. Assessing health sector reforms in Africa: the role of non-project assistance. *Health Policy and Planning* 9 (4): 371-84.
- Green RH. 1981. Magendo in the Political Economy of Uganda: Pathology, Parallel System or Dominant sub-model of Production. *IDS Discussion Paper* 164. University of Sussex, UK.
- Hiscock J, White J, LaFond A. 1993. *Sustainability in the Health Sector Part 1: Uganda Case Study*. London: Save the Children Fund (UK).
- Lateef KS. 1991. Structural Adjustment in Uganda: the initial experience. In: Hansen HB, Twaddle M (eds). 1991. *Changing Uganda: the dilemmas of structural adjustment and revolutionary change*. London: J Currey, pp 20-42.
- Leichter HM. 1979. *A Comparative Approach to Policy Analysis: health care policy in four nations*. Cambridge: Cambridge University Press.
- Macrae J, Zwi A, Birungi H. 1993. A Healthy Peace?: Rehabilitation and Development of the Health Sector in a "Post"-Conflict Situation — The Case of Uganda. Mimeo. London: Health Policy Unit, London School of Hygiene and Tropical Medicine.
- Mwesigye RF. 1994. Effects of user charges on quality of curative services in Uganda's rural health units. Mimeo. London and Entebbe: London School of Hygiene and Tropical Medicine/Ministry of Health, Uganda.
- Smallman et al. 1991. Civil war and the spread of AIDS in Central Africa. *Epidemiology of Infectious Diseases* 107(1): 69-80.
- Tomasevski K. 1990. Human Rights Violations and Development aid: From Politics towards Policy. Occasional paper. London: Commonwealth Secretariat, Human Rights Unit.
- Uganda Government. 1987. The Government White Paper on Recommendations contained in the report of Health Policy Review Commission. Entebbe: Ministry of Health.
- Uganda Government. 1989. *The Ten Year Health Plan*. Entebbe: Ministry of Health.
- Uganda Government. 1990. *National Task for Health Financing Issue Paper*. Kampala.
- Uganda Government. 1992. *Three Year Health Plan 1993-95*. Entebbe: Ministry of Health.
- Uganda Government. 1993a. *Ministry of Finance and Economic Planning, Uganda: Background to the Budget 1993/4*. Kampala.
- Uganda Government. 1993b. *White Paper on Health Policy Update and Review*. Entebbe: Ministry of Health.
- UNICEF. 1993. *The State of the World's Children 1993*. UNICEF, Oxford University Press.
- World Bank. 1993a. *World Development Report: Investing in Health*. Oxford: Oxford University Press.
- World Bank. 1993b. *Uganda: Growing out of poverty*. Washington DC: Africa Country Department II, Country Operations Division, IBRD.

Acknowledgements

The authors would like to thank Gill Walt and Lucy Gilson for their valuable comments on earlier drafts of this paper. Joanna Macrae's contributions to the paper are based on a study concerning post-conflict rehabilitation and development of the health sector in Uganda, co-funded by the Health Economics and Financing Programme in the London School of Hygiene and Tropical Medicine (funded by the ODA) and Health Net International.

Biographies

Sam Agatre Okuonzi is a Senior Medical Officer and Health Planner in the Planning Unit of the Ministry of Health, Uganda. Before his appointment to this post, he served as a District Medical Officer for 6 years. He was a member of the National Task Force for Health Financing from 1989 to 1992. He has recently completed a Masters Degree in Health Planning and Financing at the London School of Economics and the London School of Hygiene and Tropical Medicine.

Joanna Macrae is a Research Fellow in the Health Policy Unit at the London School of Hygiene and Tropical Medicine. Her current research focuses on policy-making and implementation in countries recovering from prolonged conflict, funded by the Overseas Development Administration (UK).

Correspondence: Joanna Macrae, Relief and Disasters Policy Programme, Overseas Development Institute, Regent's College, Inner Circle, Regent's Park, London, NW1 4NS, UK.