

Economic Success or Human Development Failure? Development Partners or Development Parasites? The truth behind the truth: Evidence from Uganda

By

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During the 1990s, and especially over the second half of the decade, Uganda experienced high economic growth, falling income poverty, and relative political stability. In addition, while it's still too early to assess properly the medium term impact of direct budget support (DBS) on the lives of poor people, Uganda features among the few countries where real gains have been made in terms of scaling up the delivery of basic health and education services, increasing the focus of the budget, and giving people confidence to claim their rights (DFID, 2004).

There is evidence to support the claim that the period between 1992 and 2000 may mark the transition of Uganda from recovery to fresh growth. Recovery has necessitated the rehabilitation of traditional export crops, the restoration of the public sector and a reversal of the retreat to subsistence. In this economic environment, the percentage of Ugandans who were poor decreased sharply from 56% in 1992 to 34% in 2000.

Over the five year period 1998/99-2002/03, however, real annual growth slowed down from 6.7% per annum, registered in the previous five year period, to 6.0% per annum. In addition, between 2000 and 2003, inequality (measured by the Gini coefficient) rose from 0.395 to 0.428, and the percentage of Ugandans living in poverty increased from 34% to 38%. Herein, greater insight into these figures is elucidated.

The poverty reduction of the 1990s was achieved through a very high rate of consumption growth, and high rates of GDP growth. Between 1992 and 1997, a critical factor in consumption growth was the increased prices that producers received for their crops. Because agricultural marketing was liberalised, farmers were able to benefit from the increase in the world price of coffee. The unit export price for Ugandan coffee tripled from 0.82 US\$/kg in 1992/93 to a peak of 2.55 US\$/kg in 1994/95. Hence, the most dramatic poverty reductions were experienced by cash crop farmers.

By implication, it should not come as a surprise that the increase in poverty since 2000 is partly attributed to a decline in agricultural growth and a decline in farmers' prices, reflecting world market conditions (MoFPED, 2004).

The concerns that have been raised about the growth slow-down in Uganda are not to be exaggerated. Research carried out by the Ministry of Finance shows that it is easier to start an episode of rapid growth than it is to maintain one in the longer run.

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Looking at twenty episodes of sustained strong growth in Africa during the period 1960 – 1996, the research shows that fifteen episodes had terminated before the end of the period. Of the remaining five, which included Uganda, only Botswana and Mauritius had sustained strong growth for more than fifteen years. As of 2002/03, Uganda has equalled the achievement of both Botswana and Mauritius, by sustaining strong growth for more than fifteen years in spite of the slight relative slowdown seen over the past five years.

Of greater concern are the findings of the increase in the percentage of Ugandans living in poverty, and the widening inequality gap between the poor and their wealthier counterparts. This is especially so, on the basis that the Poverty Eradication Action Plan (PEAP) commits the Ugandan government to the overriding priority of tackling poverty, and of Uganda's remarkable (and unprecedented) achievements in its quest to eradicate poverty.

In light of these facts, the following questions become inevitable, and shall be addressed, in turn, in the following sections of this paper: (i) What on earth could have gone so wrong between 2000 and 2003 to generate the reversal in the trend of Uganda's record of both poverty and inequality reduction. Are Ugandans "dying for economic growth, as a result of a flawed economic policy" (Okuonzi, 2004)? (ii) What is hampering the country's development and the effective implementation of the PEAP, encouraged and supported by the development partners?

(i) ECONOMIC SUCCESS OR HUMAN DEVELOPMENT FAILURE?

The Poverty Eradication Action Plan (PEAP) is Uganda's national development framework and medium term planning tool. It also guides the formulation of policy and implementation of programmes through the sector-wide approach and decentralization. The ultimate objective of the PEAP remains the improvement of the quality of life of the poor, and the population as a whole. By its very nature, the PEAP is a highly dynamic plan of action, with the aim to respond as promptly and effectively as possible to the needs of the nation.

In the context of the PEAP, a number of sectors have successfully contributed, both directly and indirectly, to poverty reduction. Even in the context of the Millennium Development Goals (MDGs), government has made substantial progress particularly in terms poverty eradication, educational achievements, gender equality in primary education, and HIV/AIDS. Performance has been less impressive in terms of reducing infant and maternal mortality. Further, improving the access to safe water and sanitation presents an interesting anecdote, due to a relatively strong record on water, but remarkably slow progress on sanitation.

Government's commitment to poverty reduction focuses on private sector development and export-led growth. Notably, private investment and export growth require a number of supportive measures such as low and stable inflation and interest rates, a competitive exchange rate, and growth in domestic savings. These targets can only be achieved by a gradual reduction in the fiscal deficit and donor aid dependency.

Contrary to the perception that government's economic strategy is based solely on reducing its fiscal deficit (at the expense of depleting public spending and worsening social welfare), however, evidence from the Ministry of Finance, Planning and Economic Development clearly shows that over the past decade, government has given higher priority to increasing public expenditure than reducing the fiscal deficit. Over the past fifteen years, government expenditure on the health and education sectors alone as a percentage of the budget more than doubled (from less than 15% to 35%). Today, government spending on both health and education amounts to over 800Bn Shillings, with education having the largest share of any sector in the budget. Further, the Long-Term Expenditure Framework (LTEF) projects that public expenditure will increase by an average of 8.7% per annum, with health and education continuing to be strategic expenditure priorities.

According to Honourable Ssendaula, Minister of Finance, Planning and Economic Development, "Uganda has been extremely fortunate to receive consistent financial support from a number of development partners over the past decade. Without their support, we would have been unable to finance half of our planned expenditure, as our domestic revenues have been, and remain, insufficient to cover our expenditure needs. Indeed, without this support, we probably would not have achieved the significant reduction in poverty witnessed by all since the early 1990s.

Notably, however, this support has come at a cost. Our deficit has almost doubled, and our debt burden is once again threatening to become unsustainable, in spite of the

generous debt relief we received under the Highly Indebted Poor Countries (HIPC) initiative.

Recent experience suggests that a high fiscal deficit, funded by donor aid, is not compatible with the government's objective of poverty reduction. Aid flows into the Ugandan economy in 2003/04 amounted to over US\$1bn, and exceeded the value of Uganda's export earnings by more than US\$100m. Such large aid flows placed appreciation pressures on the exchange rate, diminishing the price incentive for export production, and reducing the international competitiveness of Ugandan products. Moreover, the current level of the exchange rate is on the verge of rendering the maize, tea and tobacco sectors unprofitable, and squeezing profits in other export sectors such as coffee and cotton by lowering the farm gate prices being paid in Shillings to farmers.

These sectors are the income backbone of the rural economy. Due to the structure of our economy, affected farmers cannot switch easily to a more profitable export sector such as flowers, which would require a large initial investment, or diversify into fish when they do not live by a lake shore. Further, the farmers do not have the capital or the technology to add value instantly to their output. A fall in the profitability of their products on account of exchange rate appreciation has a direct knock-on effect on their income levels, which in turn lowers demand for locally produced goods and services, thus slowing economic growth in all sectors of the economy, not just agriculture".

Policy Focus: The Health Sector

Since 2000, there have been significant improvements in health sector outputs, reflecting improved access to and utilisation of the Minimum Health Care Package by the Ugandan population. A number of PEAP indicators, which were selected to assess performance of the health sector, have shown marked improvement (see **Table 1**).

Table 1: PEAP indicators

No.	PEAP Performance Indicator	Baseline value (99/00)	2000/01	2001/02	2002/03
1.	OPD utilisation (Government of Uganda and PNFP)	0.40	0.43	0.60	0.72
2.	DPT 3 coverage (< 1 year)	41%	48%	63%	84%
3.	Proportion of approved posts filled with trained health staff	33%	40%	42%	53%
4.	Deliveries in health units	25.2%	22.6%	20.9%	20%
5.	Urban/rural specific HIV sero-prevalence (national average)	6.8%	6.1%	6.2%	6.2%

Source: Ministry of Health

Out Patient Department (OPD) attendance has increased dramatically in most health facilities across the country. Total OPD new attendance increased from 9.3 million in FY 1999/00 to 17.7 million in FY 2002/03. The OPD utilisation rate has therefore improved from a baseline rate of 0.40 visits per person per year in FY 1999/2000 to 0.72 visits per person per year in FY 2002/03.

The increase in OPD utilisation is attributable to a number of government interventions aimed at increasing access of health services by the poor. These include: the abolition of user fees, expansion of rural lower health facilities, provision of subsidies to the Private Not For Profit (PNFP) sub-sector, the introduction of Health Sub-Districts structure, recruitment of qualified health workers and increases in the volume of essential drugs purchased for the health centres.

Immunisation services also improved significantly over the last three years. DPT 3 coverage, another important HSSP and PEAP indicator showed significant improvement over the last three years, increasing from 41% in 1999 to 84% in 2002/3.

Reproductive health services, however, have not improved despite substantial improvements in other PEAP indicators. Whereas the rates of antenatal clinic attendances have continued to improve (92% attended at least once), the proportion of deliveries conducted in health facilities has declined from 25.2% in 1999 to 20% in 2002/3. Contraceptive Prevalence Rate (CPR) has also stagnated at 23% for the last three years. This has resulted in high fertility rates and high population growth rate.

Government has continued to implement active HIV prevention strategies that have effectively sustained the declining trend of HIV sero-prevalence. This has now stabilised at around 6.2% at the Antenatal Clinic surveillance sites. It is hoped that the increasing trend in condom use and the rise in age at first intercourse will sustain this positive trend. New and effective components of HIV control have been introduced in the campaign against HIV/AIDS, these include: extension of voluntary counselling and testing (VCT) services, increasing the number of centres offering services for prevention of mother to child transmission of HIV (PMTCT) and improving the capacity to provide and deliver antiretroviral (ARV) treatment.

Malaria has continued to be the major cause of morbidity and mortality in the country. Government has strengthened the prevention, control and treatment strategies for malaria. The strategy of Home Based Management of Fevers was successfully launched and implemented in 10 districts with remarkable success. Information obtained from community distributors' registers shows 74% of under-five children receiving appropriate treatment within 24 hours of onset of symptoms and has markedly reduced morbidity and mortality due to malaria in those communities. In addition, the use of insecticide treated materials (ITMs) has been strengthened. Use of bed nets is still low, estimated at only 15% of which 22% were of children under-five.

The example from the health sector does not stand alone. Even outside the boundaries of individual sectors, government has been able to identify critical areas of multi-sectoral intervention to improve the quality of life of the poor, and the population as a whole.

For instance, between 1995 and 2000, infant mortality increased from 81 to 88 deaths per 1,000 births. During the same period, under-five mortality increased from 147 to 152 deaths per 1,000 births, while maternal mortality fell only marginally from 527 to 505 per 100,000 live births. In addition to their negative impact on the quality of life, high mortality contributes to perpetuation of poverty, and hinders economic development.

In response to these findings, the government set up a Task Force on Infant and Maternal Mortality to propose a strategic programme for rapid reduction of mortality in Uganda. According to the work carried out by the Task Force, (i) although high mortality is a health outcome, it is not solely the responsibility of the health sector, and activities geared towards reduced mortality are multi-sectoral; (ii) mortality reduction does not feature as an immediate, or as the central focus of current national development policies. Mortality is generally taken as a peripheral problem, loosely appended to key policies.

It was also recognised that the problems facing mothers in achieving a healthy status can be divided into 3 dimensions: (i) problems within the household (and community), (ii) problems with access and (iii) problems at health facilities (private and public). For example, the decision to seek ante-natal care and deliver at a health facility can be subject to 3 sources of delay – delay at home in the decision to seek health care; even if the decision is taken, the female may face delay in reaching the health facility due to poor accessibility; once at a health unit, there may not be the facilities to care for her adequately.

The recommendations directed at the household (and community) level focus on areas that seek to improve the conditions for women within the home and thereby improve their health status and their ability to receive appropriate health care. A woman might be unwilling to leave the household for an uncertain period of time because of childcare, or household workload. Poor status within the household might also restrict the woman's decision. Childbirth is not generally regarded as an illness and thus a husband may forbid a woman from seeking medical attention unless there is a serious emergency, in which case a decision is frequently taken too late for help to be possible. Clearly, even if conditions within the household are conducive to females seeking health care, this is undermined if there is no way of reaching a health unit. Thus, at the access stage, the most obvious hindrances to women receiving health care include lack of transport, roads, communication and money for fares. At the dimension of service delivery, in this case health, it is obvious that if there are no qualified staff, equipment, drugs and supplies in place, then effective health care cannot be delivered, and pregnant women will be reluctant to travel in order to receive poor quality service. Other reasons that women have given for this low demand include the cost of additional requirements (e.g. gloves, a mackintosh), rudeness of staff, lack of privacy and inflexibility with regard to cultural differences (e.g. method of disposal of placenta).

These three dimensions of policy intervention bring together supply- and demand-side factors of service delivery. As a result, it is imperative to sequence policy actions in order to guarantee functional, reliable, and accessible health facilities, before mobilizing communities to ensure high demand for health services.

This work by the Task Force on Infant and Maternal Mortality was accurately reflected in the Poverty Eradication Action Plan, which (under the Task Force's recommendations) highlights infant and maternal mortality among the priority policy issues to be addressed in the short- and medium-term, through a number of interventions including malaria control, family planning, improved sanitation and health care, and revitalization of community development workers.

(ii) DEVELOPMENT PARTNERS OR DEVELOPMENT PARASITES?

According to the Ministry of Finance, Planning and Economic Development, domestic revenue is projected to finance 57% of total expenditure in 2005/06, as compared to 55% this financial year. This figure is expected to rise to 64% by 2007/08, reflecting government's gradual efforts to improve fiscal sustainability without causing undue disruptions to public expenditures programmes.

The remaining 43% of government expenditure in 2005/06 is projected to be fully funded by donor resources. On the bases of donor projections, however, the government of Uganda is not in a position to secure the required financial resources for the financial years 2006/07 and 2007/08. In spite of government's efforts to avail timely and reliable expenditure projection for the medium term, many donors are unable to provide robust projections for their project funding as far ahead as 2006/07 and 2007/08. This clear deficiency of the donor community presents no easy challenge for the government of Uganda, which is forced to gradually run down its (already depleted) reserves to make up for the potential shortfall.

Additional data from the Ministry of Finance, Planning and Economic Development suggest that project funding is expected to account for 56% of donor funding in 2005/06, as compared to 54% in 2004/05 and 48% in 2003/04. This increase in project support as a proportion of total donor support is contrary to government's stated preference for direct budget support (DBS), which provides a way to enhance budget discipline by promoting optimal resource allocation.

According to the Ministry of Finance, Planning and Economic Development, the lack of incentive to limit donor project expenditures at a sectoral level has placed upward pressure on the aggregate fiscal deficit, which in turn has complicated monetary policy, and especially exchange rate, management. In more general terms, project aid often also has political strings attached and it may promote local business interests of the donor, fuel corruption, and distort public funds from social services to project management, in place of the real development needs of the recipient. Evidence from the health sector in Uganda² provides a rich source of data to evaluate project support vis-à-vis DBS, and assess the true motives behind the operations of certain donor agencies in Uganda.

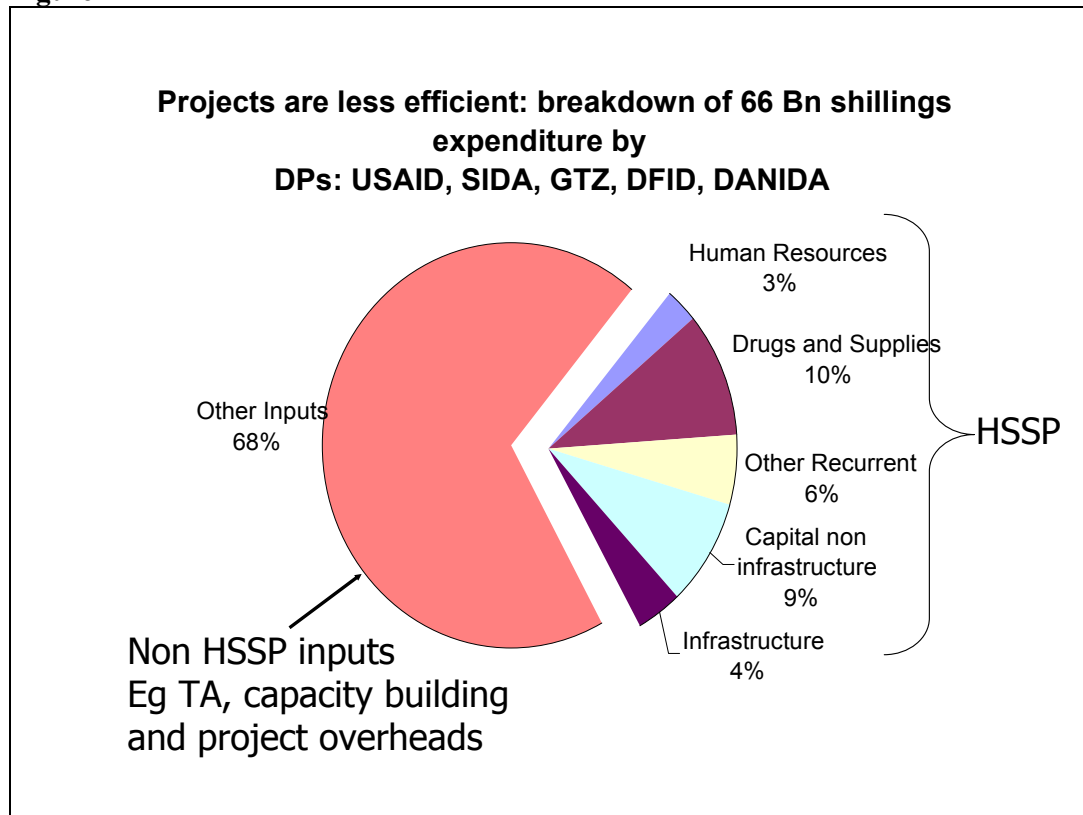
For a country at the forefront of development reforms, the 2001 Uganda Demographic Health Survey figures (based on 2000 data) on infant and maternal mortality were extremely disappointing. A wide range of factors contributed to this poor performance but financing and management problems were particularly implicated. A breakdown of the estimated \$6 per capita spent on public and NGO health services in 1999/2000 showed that: (i) The majority of the government budget (66%) was allocated to large hospitals and the central Ministry of Health, which tended to benefit the urban (and therefore better off) population; (ii) Donor projects tried to stimulate the development of primary health care services but proved relatively ineffective and inefficient; (iii) Patient fees throughout the system raised little revenue, exemption schemes did not work and as a result, utilisation of services by poor people was very low.

² Yates R., 2004

Due to these financing conditions, very little (at most \$2 per capita) was being spent on basic health care inputs (drugs, health workers salaries, health centre maintenance etc.) in rural areas. As a result, the coverage and quality of services was inadequate.

On the ineffectiveness and inefficiency of project aid, a recent analysis from the Ministry of Health has shown that for five large donors (i.e. USAID, SIDA, GTZ, DFID, DANIDA) providing project support only 32% of funds are spent on basic health care inputs, while 68% goes towards technical assistance, project management costs and high cost investment goods and services (see **Fig. 1**). By implication, increasing project spending is less likely to result in more basic inputs and is therefore less likely to generate increases in outputs.

Figure 1



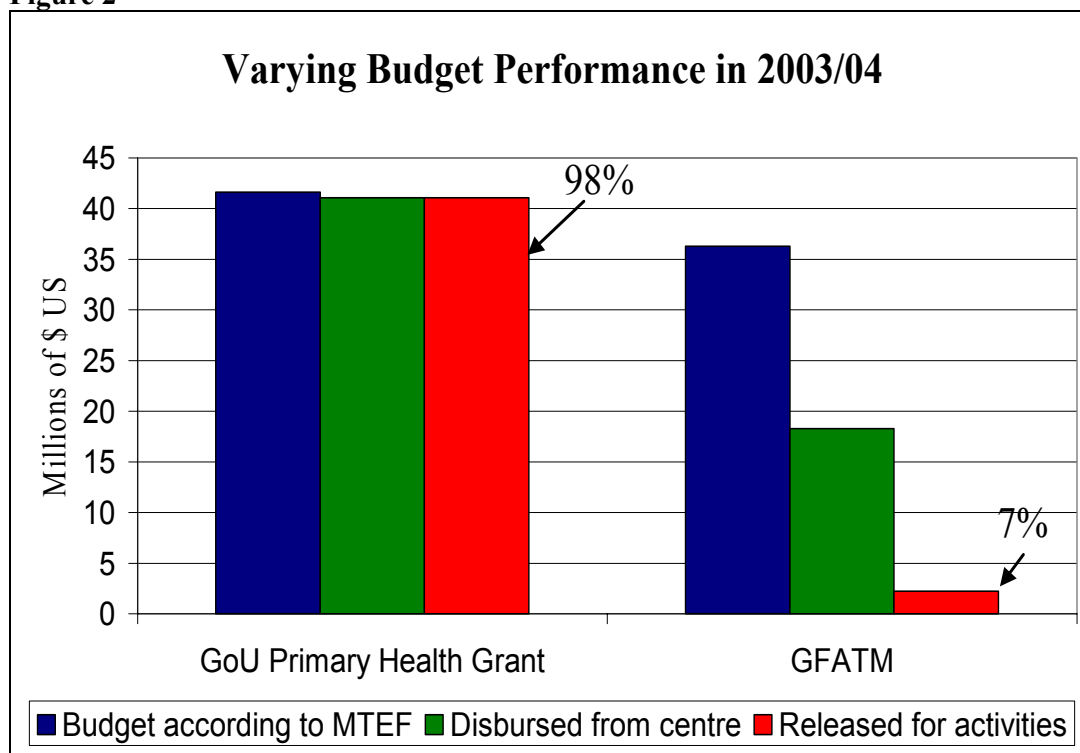
Source: Ministry of Health

On a similar note, **Fig. 2** highlights the poor budget performance of a highly politicised, yet much applauded, donor driven basket of funds: the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM). Clearly, both disbursements from the centre and releases for planned activities under the Global Fund are highly ineffective and inefficient vis-à-vis disbursements and releases from the budget of the government of Uganda. Thus, the government budget remains a much more effective and efficient financing mechanism than project funding.

These and other findings make it clear that efforts to serve disadvantaged population groups are not reaching their intended beneficiaries nearly so well as their sponsors often believe (Gwatkin, 2003). Without more serious efforts to improve social services in order to reach the poorest segments of the population, sovereign

governments together with their alleged development partners might never succeed in their quest to alleviate the burden of poverty and improve the quality of life for the population as a whole.

Figure 2



Source: Ministry of Health

Note: The MTEF is Uganda's Medium Term Expenditure Framework

The Ugandan government is gradually taking important measures to increase the quantity, and enhance the quality of service delivery. Since 2000, there has been a small revolution within the Ugandan health sector. Through implementing a Sector Wide Approach (SWAP), the government of Uganda has managed to improve the supply of basic health care services to its population.

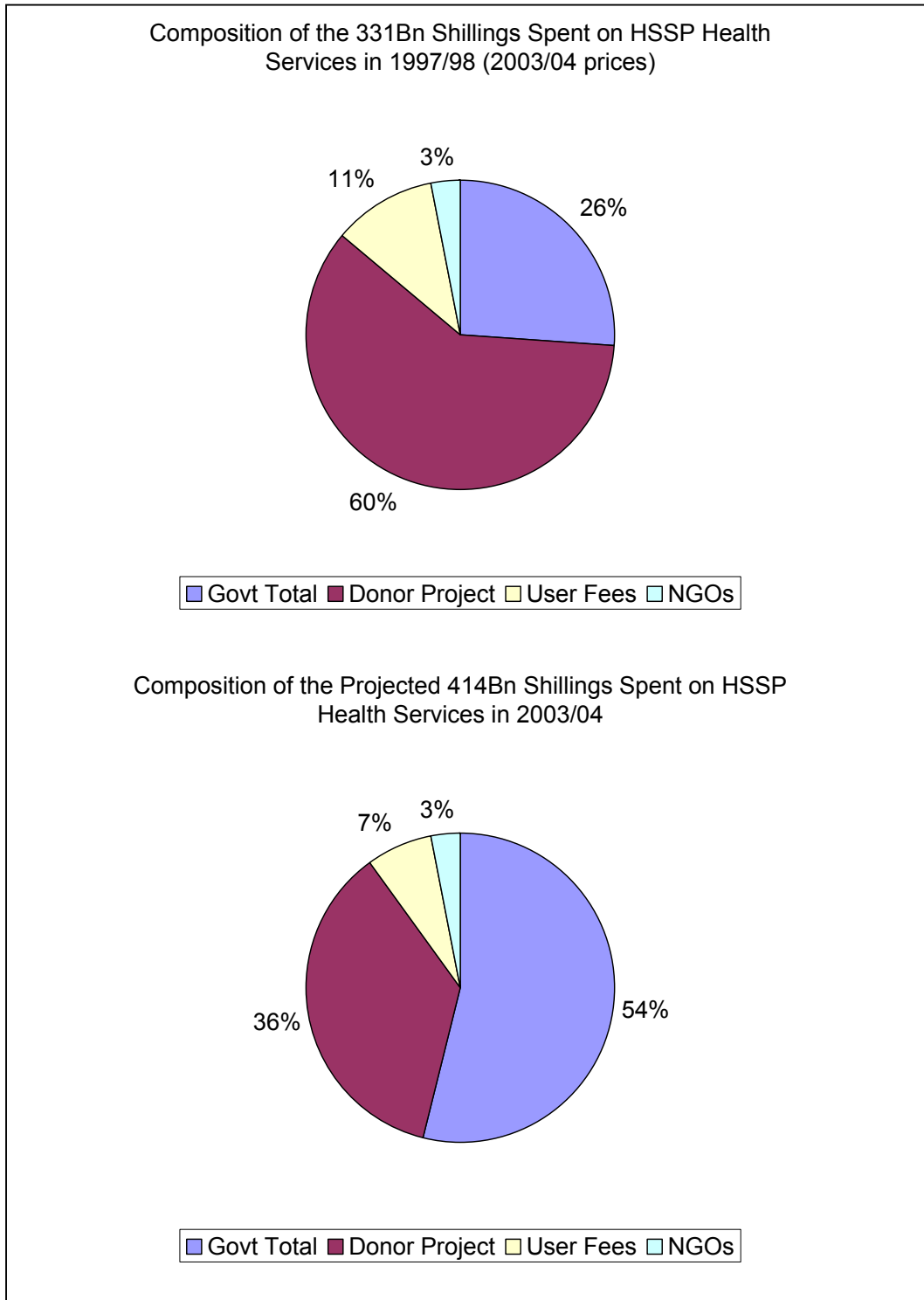
The defining characteristics of a SWAP are that all significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector and progressing towards relying on government procedures to disburse and account for all funds.³ This definition, in emphasising a shift towards reliance on government financing mechanisms to fund a coordinated policy and expenditure programme, sums up the essence of the Ugandan Health SWAP.

Right from the outset of the SWAP, the government of Uganda stated that general budget support was its preferred donor financing mechanism. The UK Department for International Development (DFID) concurred with this approach and with other partners, began switching resources from projects to government budget systems. As a result, since 1999/2000 the government's budget has doubled in real terms, and

³ Brown et al., 2001

since 2000/01 it has become the primary financing mechanism for the sector (see **Fig. 3**).

Figure 3



Source: Ministry of Health

Now that the government of Uganda controls more of the finances flowing into the sector, it has been able to allocate these resources more efficiently.⁴ In particular, there has been a dramatic increase in funding for primary health care services with district budgets increasing seven times.

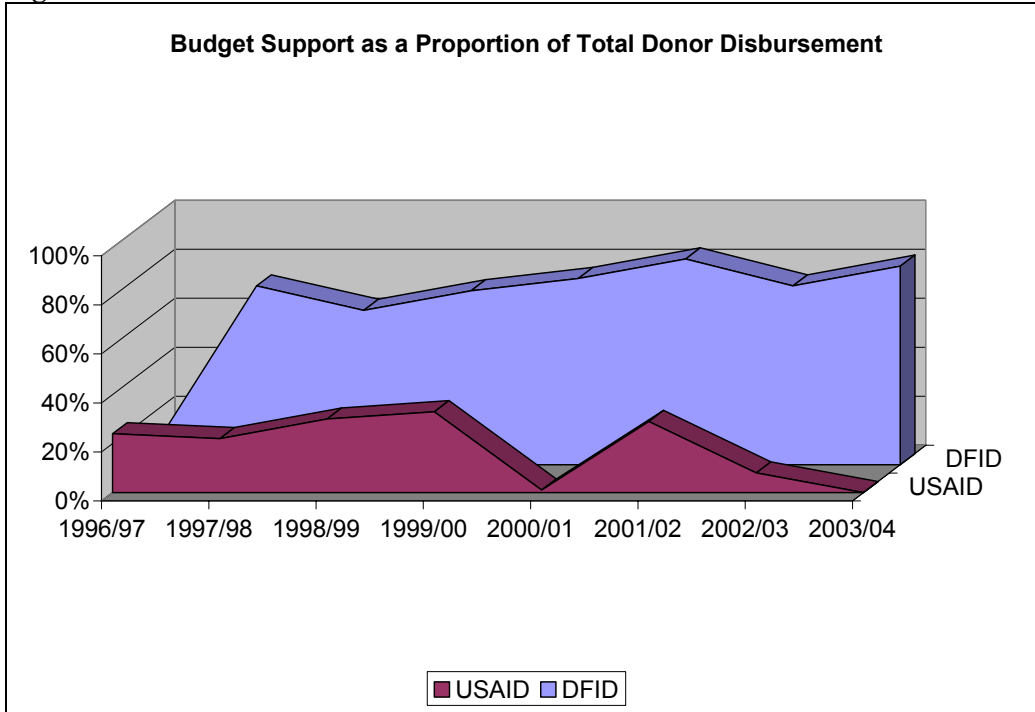
For developing country social sectors, the key message appears to be that government led SWAPs can deliver significant returns relatively quickly. In particular, tackling a broad range of supply side and demand side constraints simultaneously appears to be beneficial. Furthermore, the government budget appears to be a much more effective and efficient financing mechanism than project funding.

DFID's mission "to eliminate world poverty and support the achievement of the Millennium Development Goals (MDGs)", and its efforts to integrate operations in the context of the PEAP have not been reinforced by a number of donors, who have earned themselves the title of development parasites. With the US Agency for International Development (USAID), spearheading the list of development parasites, these organizations remain aliens to Uganda's dynamic development plan. Moreover, their resilience to embrace and support the government's development agenda results in a number of parallel programmes yielding a large degree of duplication and financial wastage.

The provision of budget support vis-à-vis project aid in Uganda provides a suited example to clarify the distinction between development partners (i.e. DFID-like) and development parasites (i.e. USAID-like). **Fig. 4** shows budget support as a proportion of total donor disbursement. In light of Uganda's effective and efficient management of DSB, while DFID switched up to 80% of its resource contribution to Uganda from projects to government budget systems, USAID did not show any sign of compliance with the government's bequests.

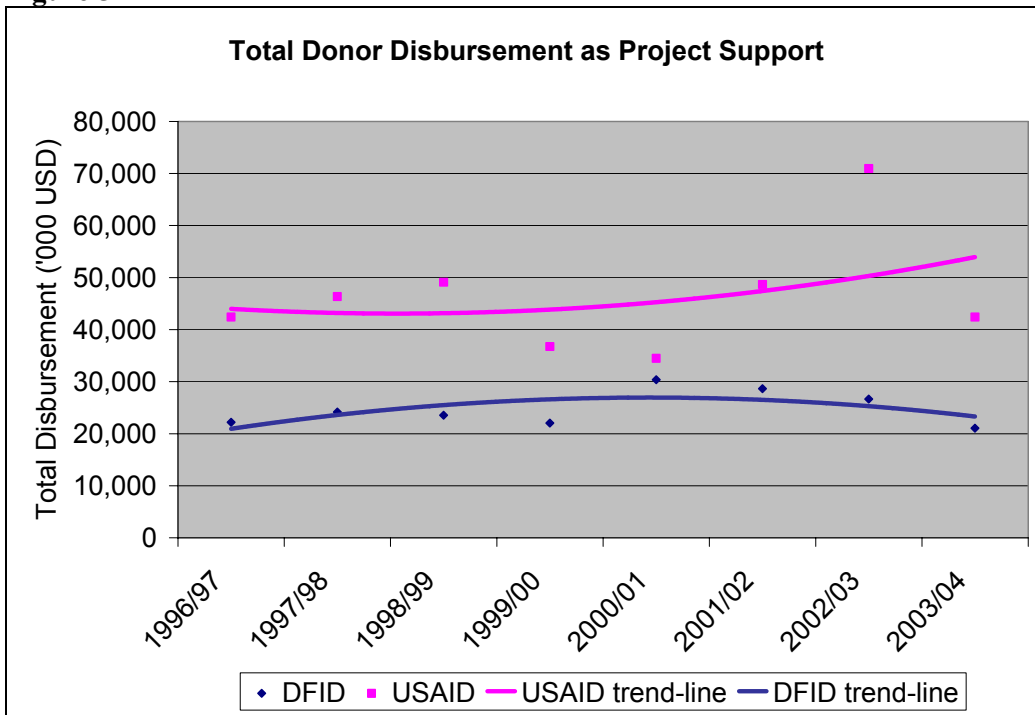
⁴ The Ministry of Health's presentation to the annual Public Expenditure Review in 2003 (available from DFID Uganda) highlights areas where the sector has improved allocative and technical efficiency.

Figure 4



Source: Ministry of Finance, Planning and Economic Development

Figure 5



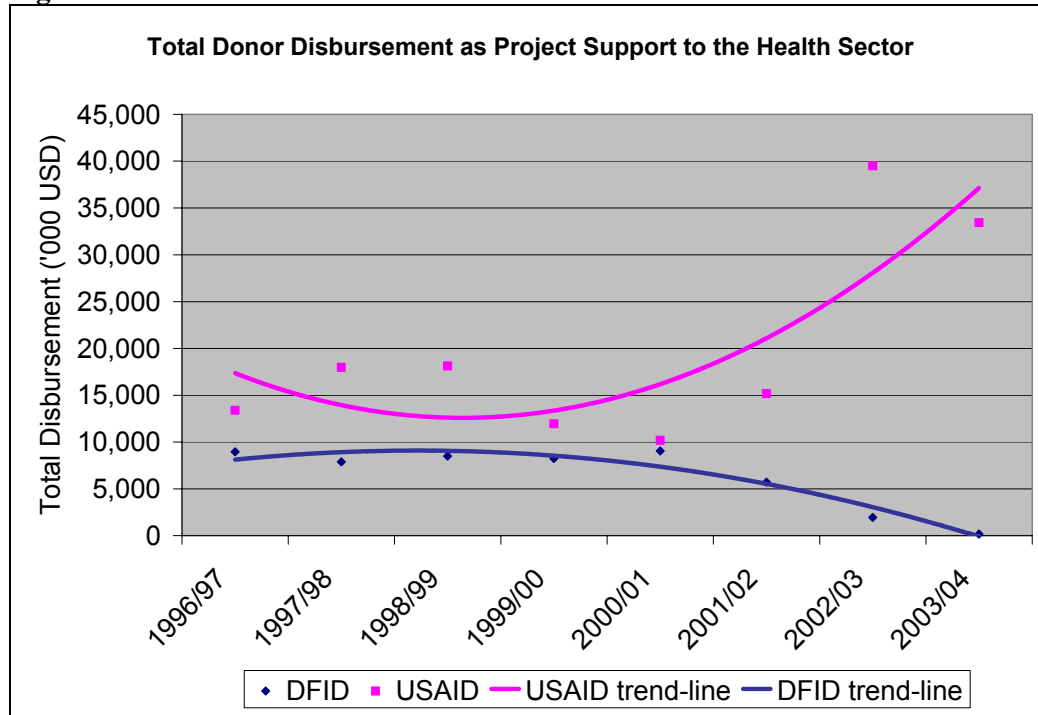
Source: Ministry of Finance, Planning and Economic Development

Fig. 5 shows that in terms of total donor disbursement as project support, while since 2000 DFID embarked on a policy of gradually reducing its total disbursement as project support, USAID jumped on the opportunity to fill the project-support-gap left

open by the development partners moving towards DBS, and consistently increased disbursement as project aid.

The manifestation of USAID’s distorted motives becomes clearer from **Fig. 6**, which shows total donor disbursement as project support to the health sector alone. In spite of high ineffectiveness and inefficiencies associated with project aid, it seems paradoxical that, while DFID’s total disbursement as project aid to the health sector gradually declined, USAID’s project aid grew exponentially without showing any sign of trend reversal.

Figure 6



Source: Ministry of Finance, Planning and Economic Development

According to Jeffrey Sachs, “the risks of currency overvaluation from donor-financed health spending are overstated and there are no justifiable reasons to prevent donors from providing ... the necessary inputs for provision of health care in a poor country”. Notably, however, the financing of health cannot be determined in isolation from the rest of the government budget. Optimal public expenditure planning must consider the relative benefits of spending in each of the different sectors of the budget. Government should attempt to utilise all of its available budgetary resources in a manner, which maximises returns across all sectors of the budget and best meets the country’s strategic priorities, as identified in the PEAP. Moreover, only if aid were more predictable, channelled through the budget, and attempts were made to spend a greater proportion on essential imports (e.g. drugs, textbooks, etc.), it would not matter so much if additional aid increased the apparent deficit.

It follows that development parasites, like USAID, have overturned international development into a profitable enterprise, benefiting US based professionals, firms, industries, and ultimately the US economy. In this process, developing countries like Uganda have been subjected to unprecedented levels of political manipulation and

economic exploitation. President Bush's Emergency Plan For AIDS Relief is no exception to the rule. As a result, US pharmaceutical companies, lobbying parties and a strategically selected club of stakeholders are guaranteed a large share of the Emergency Plan funds, arguably as a token of appreciation for their continued and most recent electoral support to the current US administration.

CONCLUSION

The government of Uganda has developed a rather effective strategy to address economic growth hand in hand with improved social welfare. The ability to absorb temporary and permanent shocks to the system, and the integrity of the officials responsible for the implementation of the Poverty Eradication Action Plan (PEAP) – at all levels – are the most important determinants of the plan's success. There is evidence to support the claim that the following factors have been the main architects for the reversal in the trend of Uganda's record of poverty reduction.

Uganda's high rate of population growth at 3.4% makes it the third fastest growing country in the world. Preliminary analysis suggests that such a high rate of population growth is due to persistent high fertility levels (approximately 7 deliveries per woman). Notably, if Uganda maintains the current population growth rate, the population will increase to 54 million in the year 2025, effectively doubling in less than 25 years. This will make it near prohibitive to provide adequate social services for the population as a whole.

According to the Ministry of Finance, Planning and Economic Development (2004), both theory and evidence clearly show that there are significant payoffs to Uganda if its fertility rate is reduced and population growth consequently slowed from its current rate of 3.4% per annum. As a result, through the Reproductive Health Division of the Ministry of Health, government is advocating and supports a decline from 6.9 to 5.4 children per woman in the reproductive age bracket.

On a different note, Uganda is a large recipient of project aid from development parasites like the American government. As it was shown at the outset, not only is project aid grossly ineffective, but it also provides a breeding ground for corruption benefiting a small local elite, and primarily the development parasites, at the expense of the majority of the population in the recipient country. Unsurprisingly, therefore, Uganda continues to feature among the top 10 most corrupt countries in the world on Transparency International's corruption rating index. Further, between 2000 and 2003, the national inequality index, measured by the Gini coefficient, rose from 0.395 to 0.428.

All of the above, together with 17 years of insurgency in the northern part of the country have severely depleted the nation's resources, eroded the gains from improved social spending (as reflected in stagnating infant and maternal mortality rates), and slowed down the pace of Uganda's progress towards poverty eradication.

To conclude, this paper argues that government's effective implementation of the PEAP and its credibility have been compromised by the proliferation of development parasites. To this effect, in the words of Honourable Ssendaula, Minister of Finance, Planning and Economic Development, government needs to continue to implement its policy of gradual deficit reduction and reduced aid dependency, by mobilising more local resources to finance government's expenditures. Alternatively, Uganda could follow India's example to prune its dependence on foreign money, by radically restricting its list of donors, and only accepting aid from a strategically selected club of development partners.

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