MAPPING HEALTH RESOURCE PARTNER INSTITUTIONS (HRPI):

Modeling a sustained approach for strengthening health governance and stewardship in low-income countries

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Foreword

The global study on supporting the leadership of Ministers and Ministries of Health and its report "Strong Ministries for Strong Health Systems", undertaken by ACHEST and the NYAM recommended that countries develop effective governmental and non-governmental Health Resource Partner Institutions(HRPIs) to support health system stewardship and governance functions of the ministries of health. The study pointed out the importance of organizations both in and outside of government that can provide needed expertise and resources to ministries of health. The study noted that every country needs to cultivate and grow a critical mass of individuals, and institutions that interact regularly among themselves and with their governments, parliaments, and civil society as agents of change, holding each other and their governments to account, as well as providing support. These include professional associations, national academies of medicine and science, universities, free standing think tanks, research and development organizations, business, private sector, NGOs and the media.

As a first step towards marshaling the HRPIs in the countries, a protocol and framework for mapping HRPIs, other governmental agencies and non-governmental organizations was developed and implemented in five countries namely Kenya, Malawi, Mali, Tanzania and Uganda. The purpose of these mapping studies was to identify and characterize HRPIs active in countries as a prelude to understanding how best they can work better with their respective governments especially the Ministries of Health to advance health system governance in sub-Saharan Africa in particular. As can be seen in the detailed country reports, it was found that while many such institutions were found in all the countries studied, they were strong in some countries and are used effectively by MOHs. In other countries, they were weak and rarely worked with the governments. In all countries these institutions need to be strengthened to provide the level of intellectual and human resources necessary to support effective health systems performance and governance. Ministries of health on the other hand were in some cases seen as insular and reluctant to collaborate with HRPIs.

During the 2nd Congress on Health Systems governance in March 2012, all the five countries presented and discussed their respective mapping study reports. It was unanimously agreed and recommended that all the five countries and ACHEST: 1) Develop mechanisms to link the work of HRPIs to Ministries of Health in order to utilize their expertise. 2) Make arrangements to develop the capacity of HRPIs so that they can play support roles to their governments more effectively. 3) Develop a new tool to be used for modeling a stronger working relationship between HRPIs and MoH as the next steps in implementing these recommendations. 4) The reports of the five countries to be widely disseminated. 5) Modify and adapt the mapping tool for use by other countries in mapping and collaborating with HRPIs.

We would like to recommend these reports to all who those who grapple with strengthening health systems in LMICs and welcome comments on the reports and are available to engage in further dialogue on how this stream of work can contribute to the achievement of better health outcomes.

In conclusion we wholeheartedly thank the Rockefeller Foundation, the government and people of Norway through NORAD for the financial grants that made it possible for this work to be undertaken.

We also thank the governments of Kenya, Malawi, Mali, Tanzania and Uganda for their willing participation in the study and commitment to strengthen their respective health systems.

Prof. Francis Omaswa

Executive Director

African Center for Global Health and Social Transformation (ACHEST)

Acknowledgement

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Dr. Peter Eriki

Director of Health Systems

African Center for Global Health and Social Transformation.

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Acronyms and Abbreviations

ACHEST	African Centre for Global Health and Social Transformation
AFLI	African Leaders Institute
AGHA	Action Group for Health Human Rights and HIV/AIDS
AGM	Annual General Meeting
AMREF	African Medical Research and Education Foundation
CSO	Civil Society Organization
DANIDA	Danish International Development Agency
DFID	Department for International Development
EPRC	Economic Policy Research Center
EU	European Union
FBO	Faith Based Organization
HAP	Health Action Plan (Ministry of Health)
HEPnet	Health Economic Policy network
HPA	Health Professional Association
HPAC	Health Policy Action
HRPI	Health Resource Partner Institution
HSSP	Health Sector Strategic Plan
JCRC	Joint Clinical and Research Center
MoDe	Ministry of Defense
MoF	Ministry of Finance
MoH	Ministry of Health
MoLG	Ministry of Local Government
MUBS	Makerere University Business School
MUCHS-SPH	Makerere University College of Health Sciences - School of Public Health
NGO	Non-Governmental Organization

PSFU	Public Sector Foundation of Uganda
PSU	Pharmaceutical Society of Uganda
SIDA	Swedish International Development Agency
UAHPA	Uganda Allied Health Professional Association
UMA	Uganda Medical Association
UMMB	Uganda Muslim Medical Bureau
UNAS	Uganda National Academy of Science
UNMU	Uganda Nurses and Midwives Union
UNRHO	Uganda National Health Research Organization
UPMPA	Uganda Private Medical Practioners Association
URCS	Uganda Red Cross Society
USAID	United States Aid Agency
WHO	World Health Organization

Executive Summary

This mapping study is a follow-up from a previous scoping study on how to strengthen ministries of health. The scoping study identified institutions that could be used to strengthen the governance and leadership of the health sector. These were collectively called Health Resource Partner Institutions (HRPIs) and the purpose of the study was to identify and characterize HRPIs in order to provide the necessary knowledge and understanding to involve them with the Ministry of Health (MoH) in order to advance health system governance.

Twenty-nine HRPIs were studied in detail via questionnaires and interviews when possible. Selected institutions were targeted for study in detail, most based in Kampala, Uganda's capital, and focused on issues of health policy, human resources for health, and advocacy. Twenty percent of the HRPIs in the study received funding from the national government (via the MoH or other government institutions) and additional funding from consultancies and fees for services rendered. All of the HRPIs in this study received a large part of their funding from external sources, however, most still lacked adequate funding for their activities.

A majority (86%) of the HRPIs collaborated with national universities, the most common being Makerere University College of Health Sciences - School of Public Health (MUCHS-SPH). Thirty-eight percent of the HRPIs in the study had links with foreign governments and 52% with bilateral and multilateral organizations. Eighty-five percent of institutions reported engaging in health policy development, mainly through participation in policy forums on research, analysis and policy development.

HRPIs expressed frustration with the lack of direction and support when working with the MoH. Specific issues cited by HRPIs were weak leadership, poor coordination and management, lack of accountability, negative staff attitudes, and inadequate resources. Several HRPIs did, however, acknowledge their own lack of capacity and resources and the need for better management skills within their own institutions.

Key recommendations:

- Foster stronger formal partnership between HRPIs and MoH.
- Create greater understanding and recognition of the role HRPIs can, and do, play in the work of the MoH.
- Create a culture of locally driven research and evidence that is shared and used to inform policy.
- Improve management and leadership skills and build the capacity the MoH and HRPIs.
- Significantly increase funding and resource mobilization.
- Establish or identify an MoH department that is devoted to defining the involvement of HRPIs in implementing health plans, namely the Health Sector Strategic Plan (HSSP). Develop clear input and output indicators and plans to strengthen identified areas of weakness among HRPIs and within MoH.

I. Background

The study on supporting Ministries of Health Leadership and its report "Strong Ministries for Strong Health Systems" strongly pointed out the importance of organisations both in and outside of government that can provide needed expertise and resources to ministries of health. It noted that every country needs to cultivate and grow a critical mass of individuals, groups and institutions that interact regularly among themselves and with government, parliament, and civil society as agents of change, providing support and holding each other accountable. Government agencies and regional and international organisations play supportive roles to the MoH. A similar relationship between in-country players is essential to promote cross-learning and build support systems. These in-country players can be defined as Health Resource Partner Institutions (HRPIs) and include professional associations, national academies of medicine and science, universities, free standing think tanks, research and development organisations, businesses, NGOs and the media.

The "Strong Ministries for Strong Health Systems" study therefore recommended that countries develop effective governmental and non-governmental HRPIs to support the health system stewardship and governance functions of the ministries of health. HRPIs are well positioned to support government in enhancing people's health through policy formulation and implementation, health service provision, and enhancing governance and stewardship. Governments and ministries of health are therefore encouraged to marshal and collaborate with HRPIs as health resources to the MoH and to examine ways to enlist the support of HRPIs to work more closely with them in developing and implementing health policy.

While many HRPIs may be strong in certain countries and used effectively by the MoH, they may not exist, hardly be used, or weak in the areas of health governance and stewardship in other countries. In many countries these institutions need to be strengthened to provide the level of intellectual and human resources necessary for effective health systems performance and governance. Ministries of health on the other hand have sometimes been seen as insular and reluctant to collaborate with HRPIs. As a way forward, stakeholders recommended that HRPIs be identified and characterised to provide the necessary knowledge and understanding in order to design a mechanism for involving them more effectively with the MoH to advance and enhance health and health systems governance.

Towards this goal, this study of mapping HRPIs in Uganda was commissioned. The study was conducted between July and October 2010. The purpose of this mapping study is to identify and characterize HRPIs in Uganda in order to provide the necessary knowledge and understanding to help design a mechanism for involving them more effectively with the MoH to advance health and health system governance. Specific objectives of the study are to:

1. Identify and characterize the HRPIs;
2. Gain better knowledge and understanding of HRPIs, their activities, strengths and weaknesses, needs, and their impact on health stewardship and governance;
3. Identify different methods by which HRPIs can strengthen health governance and stewardship; and,
4. Recommend a model by which HRPIs could be facilitated to strengthen health governance and stewardship in Uganda.

II. Summary of the Terms of Reference

The survey was coordinator by ACHEST who commissioned and guided the consultant's work conducting of the survey. The survey was undertaken in two phases: phase one was from April to May 2010 and involved pre-testing the survey instrument and phase two, the main part of the study, was from July to September 2010. The consultant's Terms of Reference (ToR) included the following (Annex 1: complete ToR):

5. Participate in the modification or country adaptation of the study tool by carrying out a pre-test of the tool and revision of the tool in consultation with the ACHEST Study Coordinator.

6. Identify, locate and administer questionnaire to selected local HRPIs that are involved or have the potential to participate in national health stewardship and governance

7. Draw a table listing all possible HRPIs in the country including information on their location, their key areas of work, how they have worked in health stewardship and governance, and how they can be supported to strengthen national health stewardship and governance.

8. Carry-out detailed study and follow-up of 10 – 15 HRPIs by administering the tool, collecting and recording data using the questionnaire

9. Compile data from the core 10 - 15 HRPIs and from other HRPIs which manage to submit reasonably well completed questionnaires, analyze and present the data for easy interpretation

10. Write a clear and concise report.

11. To present the report at a joint workshop.

III. Data Collection and Analysis Methods

A questionnaire was developed in line with the earlier study on ministerial leadership for health to gather data relating to the set objectives. Questions were both structured and semi-structured, with a few open ended questions intended to capture insights from the institutions' point of view, and to identify challenges and good lessons for addressing specific issues. The questionnaire was systematically pre-tested and modified before its dissemination. (Annex 2: Study Questionnaire).

Institutions were identified by ACHEST as, or with potential to be, HRPIs. Physical addresses and telephone contacts were searched for and obtained from websites or by word of mouth. Institutions from the different categories were invited to participate in the study through hand delivery of the questionnaire invitation package, targeting heads of institutions as the respondents.

The study consultant conducted follow-up by phone and where possible by e-mail. In most cases, respondents requested for an electronic copy when contacted but most responses were through hard copies. In several cases, interviews were arranged and questionnaires completed during in-depth discussions at visits to the HRPI. In one instance the interview was conducted by telephone. Clarifications were sought through e-mailing.

Completed questionnaires were compiled as they were received and data were separated into quantitative and qualitative data then entered into MS Excel. Data analysis was undertaken with support of a statistician. Data was coded and entered in work sheets and analyzed using Stata or QSR Nudist. Semi-quantitative data was analyzed in Stata 10 (Stata Corp, 2007) using counts and frequencies, for simple comparisons without other statistical inferences. Qualitative data was first broadly synthesized, categorized, and summarized manually alongside the questionnaire themes. Data was additionally indexed using short thematic descriptions and assigned numerical codes using QSR NUDIST software (1994) for ease of identification. Most inferences were made by extracting data manually from the summary sheets, and conclusions and recommendations drawn.

Certain assumptions and limitations must be taken into consideration. It must be assumed that all institutions identified are, or have the potential to be, HPRIs. Lack of defined criteria of HRPIs, and absence of a register/source of HRPIs meant the number identified may not have been exhaustive; it is assumed these represent close to 80% of HRPIs existing in the country. The hand-delivery of the questionnaire to the targeted top executives in the institutions was not successful and its completion by the intended recipient was only possible in half the cases. The broad nature of information requested involved several players in different areas in large institutions resulting in repeated loss of questionnaires and considerable delays. The designated respondents may not have been the best source of information as a number of respondents failed to provide the required information. Additionally, only institutions based within Kampala participated in the study, even then the location and contacts of some institutions could not be traced due to lack of current directory and absence of institutional websites which served as the main source of addresses and contact information of the institutions. Finally, the study time coincided with several key meetings in the country, which made accessing the respondents difficult and delayed.

Survey Outcome

General outcomes

Forty-five institutions were identified for the study (Annex 3: HRPI Information). Questionnaires were hand-delivered to 34 selected institutions. Subsequent electronic delivery of the questionnaire when possible proved more effective in successful delivery and subsequent completion of the questionnaire.

Twenty-nine (85%) of the questionnaires were completed; 20 of these (69%) were face-to-face, in-depth interviews and 9 (31%) were self-administered. Follow up requests for clarification went unanswered, which negatively affected the quality of information, especially in cases where the questionnaire was self-administered.

Information gathered from websites proved essential and invaluable to the process. Of the completed questionnaires, 19 (66%) were completed by the intended respondents, the rest were designated to some other person by the intended respondent in the institution.

IV. Findings

a. Location

Most of the HRPIs are stationed in Kampala and surrounding suburbs, with only some Universities based relatively far outside of the city. While most institutions have fixed offices and addresses with direct communication details (telephone/email, website), others lacked physical addresses and communication ability which made contact difficult. (See Table 1 for complete details).

b. History

Table 1 shows the HRPIs in this study have been in existence for varied periods; some were established in 1923 and others as recently as 2007. The ten long-standing institutions included the Christian Medical Bureaus, the Health Professional Associations (HPAs), most NGOs and Makerere University institutions comprising 34%. Thirteen HRPIs (44%) had been in existence for 10 – 30 years, including research institutions, the media, and private sector institutions. Six (20%) NGOs, Think Tanks and the health development group were established during the last 10 years.

c. Geographic scope

Twenty five of the HRPIs studied were local Ugandan institutions based and operating in

Uganda with head offices in Kampala. Two were branches of Kenyan-based NGOs; one was part of a network with head quarters in South Africa, and the other, a local media publication, was affiliated with a Kenyan-based media house. Twelve (41%) of the HRPIs had branches. Of these 12, 7 were Ugandan based with anywhere from 1 – 5 up-country branches, 2 had international branches - ACHEST in the USA and UMU in Sierra Leone – and 3 were externally based institutions with branches in several countries in the region. Some institutions had presence in countries where they had no branches through partners and coalitions. This was the case for AMREF, which has a presence in 30 African countries; JCRC in 15 African countries; MUBS has a presence in the Great Lakes Region; and, EPRC in the East African countries. Several HRPIs without branches operated country wide through out-reach and partners' programs. (See Table 1)

d. Legal status

All 45 institutions are categorized in line with the categories of HRPIs described earlier. Table 3 shows that 66% of the HRPIs identified were non-governmental and 34% were government/public institutions. Included were 6 universities and 3 academies, 6 professional organizations, 8 health research bodies, 3 think tank organizations, 1 management and 2 business/private sector institutions, 9 service delivery NGOs, 6 media institutions and 1 development partners group. Half the universities and two thirds of academies were public institutions within Makerere University. Five of the 6 professional bodies were health professional associations/societies, and 6 of the 8 health research institutes were national institutions. All 3 Think Tank bodies were independent organizations, the management institute was a public training institute for mainly public servants and the 2 business organizations were from the private sector but government initiated.

The 9 NGOs included 3 faith based medical services bureaus, 2 regional health care implementing NGOs, 1 international services and advocacy NGO, and 2 health and human rights advocacy CSOs. The media bodies included a private FM radio station and one national television channel active in broadcasting health issues, 4 daily and one weekly newspapers, and a journalists alliance organization that trains local journalists and provides a web based training and information source for better dissemination of health information. The health development partner group is an informal organization comprising all Ugandan-based bilateral and multilateral institutions through which joint discussions with the MoH and other government institutions are directed.

Table 1: HISTORY AND GEOGRAPHIC SCOPE OF HRPIs STUDIED (* HRPI STUDIED IN DETAIL)

No.	Health Resource Partner Institute (HRPI)	Year established	Founders	Headquarters Location	Branch Location(s)	Countries of operation
UNIVERSITIES						
1*	Makerere University College of Health Sciences (MUCHS)	1923 (revised 2007)	Government; University Council	Uganda	None	Uganda
2*	Makerere University School of Business Studies (MUBS)	1998	Government; University Council	Uganda	Arua; Jinja; Mbarara	Uganda
3	Uganda Martyrs University Department of Health Sciences (UMU)	1993	Private Institution; Catholic Diocese	Uganda	Uganda; Sierra Leone	Uganda, Sierra Leone
ACADEMIES						
4	Economic Policy Research Centre (EPRC)	1994	Government (MUK council); Cambridge-Oxford Society	Uganda	None	Partners in East African country institutions
5	Makerere Institute for Social Research (MISR)	1948	Government; Makerere University of EA	Uganda	None	Uganda
6*	Uganda National Academy of Sciences (UNAS)	2000	National Academy of Science &Technology; Individuals (group of local scientists)	Uganda	None	Uganda
HEALTH PROFESSIONAL BODIES						
7*	Uganda Medical Association (UMA)	1964	British Med Association	Uganda	Regionally	Uganda
8*	Uganda Nurses and Midwives Union (UNMU)	1964	Individual Professionals	Uganda	Districts	Uganda
9*	Uganda Allied Health Profess Association (UAHPA)	1966	Individual-local professionals	Uganda	Regional Hospitals	Uganda
10*	Pharmaceutical Society of Uganda (PSU)	1970	Government; Ministry of Health	Uganda	None	Uganda

11*	Uganda Private Medical Practitioners Association (UPMPA)	1980	Local professionale	Uganda	None	Uganda
HEALTH RESEARCH INSTITUTES						
12*	Uganda National Health Research Organization (UNRHO)	1997	Government; Ministry of Health; Health Research Institutions	Uganda	Five Member Institutions (no official branches)	Uganda
13	Joint Clinical Research Centre (JCRC)	1991	Government; Ministry of Health; Ministry of Defense	Uganda	Seven Regions	Uganda; Partners in 15 African Countries
THINK TANKS						
14*	African Centre for Global Health and Social Transformation (ACHEST)	2005	Local Individuals; Foundations	Uganda	United States of America	Uganda; United States of America
15*	African Leadership Institute (AFLI)	2004	Local individuale	Uganda	Moroto	Uganda
16*	Health Economics and Policy Network (HEPNet). Uganda Chapter	1999	Individuals Health Policy Specialists in 5 regional universities	South Africa	Uganda, Tanzania, Zimbabwe, Nigeria, Kenya, Zambia, and Ghana	Uganda, Tanzania, Zimbabwe, Nigeria, Kenya, and Zambia
MANAGEMENT INSTITUTIONS						
17*	Uganda Management Institute (UMI)	1968 (revised in 1999)	Governments of East Africa; Makerere University	Uganda	Out-reach centers in Mbarara & Gulu	Uganda
BUSINESSES/ PRIVATE SECTOR						
18	Private sector Foundation of Uganda (PCFU)	1995	Government	Uganda	None	Uganda
NON-GOVERNMENTAL ORGANIZATIONS						
19*	Uganda Catholic Medical Bureau (UCMB)	1955	Catholic Diocese	Uganda	None	Uganda
20	Uganda Protestant Medical Bureau (UPMB)	1957	Church of Uganda	Uganda	None	Uganda
21	Uganda Muslim Medical Bureau (UMMB)	1998	Uganda Muslim Council	Uganda	None	Uganda

22*	AMREF	1957	Individual professionals Kenya	Kenya	Uganda, Tanzania, South Africa, Ethiopia, South Sudan, Kenya	All named countries –big programs. Programs in 30 other African countries
23	Uganda Red Cross	1964	Government; International Federation of Red Cross Societies	Uganda, Geneva	Local in regions	Network of other RCS world-wide
24*	Action Africa for Health (AAH)	1997	Individuals - Kenya & Original AAH in German	Kenya	Kenya, Uganda, Zambia, Somalia	Kenya, Uganda, Zambia, Somalia
25*	Uganda National Health Consumers Association (UNHCO)	1999	Individual Health Professionals	Uganda	Partners and coalitions in all districts	Uganda
26*	African Human Health Rights and HIV/AIDS (AGHA)	2003	Local professionals	Uganda	None	Uganda
MEDIA						
27	Monitor Publications Ltd. (MPL)	1992	Local professional; Nation Media Group	Uganda; Kenya	None	Nation media house
28*	Uganda Health Communications Alliance (UHCA)	2007	Local Individual Journalists	Uganda	None	Uganda
HEALTH DEVELOPMENT PARTNERS GROUP						
29*	Health Development Partners Group (Multilaterals, Bilaterals)	2000	Ministry of Health; Bilateral and Multilateral Institutions	Uganda	None	Uniquely for Uganda-country wide

e. Governance of the institution

Table 2 shows various governance bodies of the HRPIs. In several cases the governing structure is unclear as a result of inadequate information from respondents. In general, government and public autonomous institutions have Governing Councils/Boards while most of the other HRPIs have either a Board of Trustees (8) or Board of Directors (5). Four institutions have both a board of trustees and a governing council. Thirteen HRPIs had a general assembly/AGM and 6 stated they had directors as well. One NGO had an Advisory Board and Directors while another had Steering Committees assembly as governing body.

Table 2: GOVERNING BODIES OF HRPIs

Organs that apply to the governance of the institution	Number (%)	HRPI
Governing Council/ Committee	15 (52%)	AFLI, AGHA, AMREF, MUCHS, MUBS, PSU, URCS, UCMB, UHCA, UMA, UMI, UMU, UNHRO, UNAS, UNMC,
Directors	13 (44%)	UAHPA, PSFU, UNHCO, UPMB, AAH, ACHEST, AMREF, JCRC, UNHRO, UNMC, EPRC, MISR, The Monitor
General Assembly/ AGM	11 (38%)	HEPNet, JCRC, PSU, UAHPA, UHCA, UMMB, UPMB, UPMPA, UNAS, UNHCO, UNMC
Board of Trustees/ Directors	7 (24%)	AAH, AMREF, JRC, PSU, UCMB, UNHRO, UNMC
Other	4 (14%)	**Advisory board** (ACHEST); **Secretariat** (UHDPG); **Steering Committee** (HEPNet); **Executive Committee** (AGHA)

f. Founders (institutions/individuals)

The HRPIs studied were established or founded by Government by groups of individual professionals (11), through government institutions (10), by private institutions (6), or by institutions together with individuals (2). Public university institutions, research and academic bodies, and one professional organization were founded by Government; faith-based health bureaus were founded by institutions, and most health professional associations, NGOs, Think Tanks, and Media Outlets were founded by individuals. The Uganda National Academy of Sciences (UNAS) was founded by Ugandan academics in conjunction with the Uganda National Council for Science and Technology, and The Monitor was established by local journalists and the Nation Media Group of Kenya. The Uganda Red Cross was founded by Government as part of the International Federation of the Red Cross/Crescent Network.

The legal statutes and governance of the 29 HRPIs studied are quite varied. As shown earlier in Table 3, institutions were established by government, private institutions, groups of individual professionals, or by both institutions and individuals. Table 3 shows 9 institutions established by law, 19 registered, one special charter and one memorandum of understanding. Government-instituted HRPIs (7) were established either by Act of Parliament (4) or established by Law (4), but 2 government initiated institutions were registered as autonomous not for profit limited liability/ limited by guarantee companies. Most non-government HRPIs were not for profit organizations; founded by individuals were registered under the NGO act, as non-profit limited by guarantee or for profit limited companies, or as associations; and those founded by private institutions or by together with individuals, were under special charters. The development partners group functions under a memorandum of understanding between the group and Government/MOH. Of note, statues among the HPAs differed; PSU was established by act of parliament, UMA was registered as a company limited by guarantee, UNMU registered under labor laws in MOL, UAHPA as an association under the ministry of education and UPMPA as an NGO. The Uganda Red Cross, an international NGO was established by law and registered as a civil society/NGO.

Table 3: THE VARIOUS LEGAL STATUTES OF THE HRPIs

Types of institutions	Number (%)	Name of HRPI
Non-government	13(45%)	UCMB, UMMB, UNHCO, AGHA, AAH, UNMC, UAHPA, UPMPA, AAH, AFLI, AMREF, HEPnet,
Government	5 (17%)	MUCHS, MUBS, UNHRO, UMI, PSFU
Government - autonomous registered	2	EPRC, JCRC
Not for profit company-limited by guarantee	4(14%)	UMA, UHCA, ACHEST, JCRC, EPRC,
Academia	3(10%)	EPRC, MISR, UNAS
Media	3(10%)	The Monitor Humanitarian Intern.CSO (URCS); Private university (UMU)
Bilateral/multilateral	1(3%)	UHDPG
The legal status under which the HRPI was established:		
Established by law	9(32%)	MUCHS, MUBS, UNHRO, UMI, PSU, UHCA, UNAS, UCMB, URCS
Registered	19 (66%)	AAH, ACHEST, AFLI, AGHA, AMREF, EPRC, HEPnet, JCRC, MISR, Monitor, UAHPA, UMA, UMMB, UPMB, UMU, UNHCO, UPMPA, UNMC, UNAS
Other – MoU with MoH	1 (3%)	UHDPG
Other - special autonomous charter	1(3%)	UNAS

Funding for the HRPIs

Sources and level of funding for the institutions are summarized in Table 4. The government provided some funding to 20%, or 9 of the 29, HRPIs in the study, mostly government-initiated institutions including universities, national research institutes and some other select institutions (UMA, EPRC, UMMB). Institutions that have been promised funding by MoH but not been implemented are not included. The government funding was made through MoH (4) and other government agencies (5) and ranged from 3% to 48% of the institutions' budgets, not big enough to fully support any institution. Although PSU and URCS were established by act of Parliament, they receive no funding from government. All HRPI including those receiving funds from government received most funding from various other sources; regional funding agencies (2), bilateral agencies (9), multilateral institutions (10), International Research funders (3), own income generation (10), membership fees (7) and others (7). The funds from the various agencies and organizations came in the form of grants (start-up and on-going) but mostly project/program specific and accounted for 65% to 90% of all the funding for HRPIs. Membership fees were raised by all health professional associations and PSFU, but contributed 10-30% of revenue except for PSU and UAHPA where it was the sole source of revenue. Targeted income generation activities which included tuition fees of learning

institutions, consultancies or technical support contributed (20-100%) to revenue of the 20 HRPIs studied in detail. Other note worthy sources included Corporates and special foreign national fund-raising offices (AMREF), property rental (UNMU) and pharmaceutical companies (UPMPA, AMREF, UMA, JCRC). There was no funding from national public and private sector agencies. In general most institutions' funding base was insecure and inadequate; this was most notable in the HPAs whose main source of income came from limited membership fees.

Table 4: MAIN SOURCES OF FUNDING FOR HRPIs

Main Source of Funding	**HRPIs receiving funding *number*** *(name)*	**Level and type of funding** ***Name*** *(% of funding)*
Ministry of Health	4 (JCRC, UMA, UMMB, UNHRO)	**JCRC** (3%); **UMA** (5%); **UMMB** (40%) [Includes funds from government agencies]; **UNHRO** (>80% no details);
Other ministries or government agents	**5** (EPRC, MUBS, MUCHS, UMI, MISR)	**EPRC** (48%); **MUBS** (25%); **MUCHS** (40%); **UMI** (10%); **MISR** (10%)-through Makerere Univ.
African regional agencies	**2** (EPRC, HEPNet)	**EPRC** (25% from African Capacity Building Foundation); **HEPNet** (from South Africa government)
Bilateral organizations	**9**(AAH, ACHEST, AFLI, HEPNet, UHCA, UNAS, UNHCO, UNHRO, JCRC)	**AAH** (ICCO [Dutch] – 29%; EDD [Germany] – 24%); **ACHEST** (Rockefeler-50%, NORAD/ ASPEN-10%, and SIDA-40%); **AFLI** (Netherlands Emb – 30%, Deepening Democracy progr-40%); **HEPNet** (DANIDA– 10%); **UHCA** (US Emb. – 40%); **UNAS** (US Academy of Sciences – 70%; IAP – 5%); **UNHCO** (DFID – 50%, CODAID[Dutch] - (30%)); **UNHRO** (no details); **JCRC**-grants, Ds programs support)
Multilateral organizations	**10** (AAH, AFLI, AGHA, UMMB, AMREF, UMA, PSFU, UNHCO)	**AAH** (UNHCR – 30%, USAID – 7%, Others – 10%); **AFLI** (UNICEF – 30%); **AGHA** (National Endowment for democracy – 40%); **UMMB** (UNFPA – 30%); **AMREF** (35%; no further details given); **UMA** (contribute 85% through projects); **PSFU** (WB/EU – no details given); **UNHCO** (WB/ EU – 10% to produce citizen report), **UPMPA** (WHO- HINI program support -); **UNMU**- (60% WHO etc–Projects)
International Research funders	**3**(EPRC, JCRC, UMU)	**EPRC** (International development Research Centre – 22%)); **JCRC** (Research grants & HIV Care programs – 80%); **UMU** (Research grants – 85%)
Membership fees	**7** (PSU, UAHPA, UMA, UMMB, UCMB, UPMPA, PSFU)	**PSU** (100%); **UAHPA** (100%); **UMA** (10%); **UMMB** (30%); **UNMU** (20%); **UPMPA** (10%); **PSFU**-unspecified
Own income generation	**10** (JCRC, MUBS, PSFU, Monitor, UCMB, UHCA, UMI, UNMC, UPMB)	**JCRC** (17%); **MUBS** (75%); **PSFU** (no details); **Monitor** (100%; **UCMB** (22%); **UHCA** (10%); **UMI** (90%); **UNMU** (20%) **UPMB** (20%)

Other sources	**9 (**AGHA, AMREF, MISR, MUCHS, UCMB, UPMPA, URCS)	**URCS** (Red Cross contributions from different countries accounts for 85%; local contributions – 5%); **AMREF** (Unique national offices in extern countries-45%. Corporates like Barclays Ltd, Pharmaceuticals Corps, etc account for 20%); **AGHA** (Oxfam, OSIEA contributes 40%); **MUCHS** (external donors contribute 50%– no further details given); **MISR** (external donors contribute 90%– no further details); **UCMB** (external donors contribute 72%– no further details given); **UPMPA** (Pharmaceuticals 70%– towards CMEs); **UNMU**-property rental

g. Partner institutions, institutional links and networks

All institutions stated they had links with other institutions and/or belonged to networks. Table 5 shows a general distribution of institutions and the linkages. Twenty five (86%) were had working partnership or collaboration with universities; 19 (65%) were collaborating with some other academic institution; 24 (83%) were working with the national government, mostly the MoH; 17 (59%) were collaborating with research institutions; 11 (38%) had links with some foreign government or institution; and 15 (52%) with bilateral/multilateral institutions.

The 20 in-depth study HRPIs provided details on the nature of their links to institutions. The institutions linked with universities cited mostly Makerere University College of Health Sciences - School of Public Health (MUCHS-SPH); a few cited Mbarara and Gulu University, and several external universities from the USA were listed. Areas of collaboration or partnership included research, joint training and contribution to development of curriculum, and education exchange programs with external universities. The academia and research institutions collaborate with several counterpart institutions in the region and globally, partnering in shared research and implementation of initiatives and programs, and in dissemination of information and research findings.

Links with national government were mostly through the MoH, involvement on various boards (HPAC and NGO council), and participation in various forums. Two institutions had links with the national parliament - AFLI with parliamentary select committees to assess MPs performance and UNAS on convening a platform for MPs to discuss and deliberate on role of science in policy. Development partners worked with all government sections and academic institutions. All HRPIs had links with foreign governments, mostly through bilateral organization technical assistance and funding of programs, similar to the links with multilateral organizations. Some HRPIs (52%) were affiliated to various formal networks within Uganda (NGOs /CSO networks, FBO health network, media network); regional professional, academic and research networks (AGHA, UNAS, UNRHO, HPAs, MUCHS, HEPnet), and international networks (UNMU, UMA, PSU were affiliated to related commonwealth and global health professions federations, UNAS to international academies). Most of the networks offered opportunity to share information and research, and/or offered support (e.g. training) for each other.

Table 5: INSTITUTIONAL LINKS

Linked Institution	HRPIs with links *number (%)*	Nature of link
University	**25 (86%)**	**Training-related** (UHCA, UPMPA, UNMC, PSFU, PSU, UNHCO, UNHRO, UCMB, UMA); **Joint research** (UNMC, AMREF, MUCHS, UMA, ACHEST, UNAS, UNHRO); (e.g. level of research tools- score card collaboration between AFLI & Univ of Columbia and UCLA)
Other academic institutions (specify)	**19 (65%)**	**Training-related** (e.g. PSU, UNMC, UMI, UAHPA, AMREF); **Networking** (UMI, all universities)
Research institution	**17 (59%)**	**Technical advice** (e.g. MUCHS, JCRC, AMREF, PSU); **Research grants, information sharing** (AMREF);
National government	**24 (83%)**	**Program implementation** (UCMB, AFLI, PSFU); **Regulation** (UMA, PSU); Technical advice (PSU, UNAS, UNHRO, UHDPG); **Funding** some MOH activities (UNAS, UNHCO)
Foreign government	**11 (38%)**	**Seeding financial support** (UHCA, AAH)
Multilateral organization	**15 (52%)**	**Funding joint programs** (ACHEST, UNMC); (ACHEST, UHDPG, UNHCO, AFLI)-e.g. WHO guidelines on human rights, other specific implementing guidelines, UNICEF- **Advocacy** (tracking funds)project
Other (specify)		**Networking with NGOs** (UPMPA, UMMB, UPMB) **Advocacy** networks
Comments/ conclusions on links: Only in-depth study HRPIs elaborated on specifics of their linkages with other institutions.		

h. Technical details, and areas and types of work

Several areas of work were presented for institutions to indicate their work focus. This question was analyzed in the 20 in-depth study HRPIs which substantiated aspects of involvement outlined in Table 6. Institutions had several varied areas of work focus; with most HRPIs involved in health policy (85%), advocacy (80%), technical assistance (80%), and human resources (70%). The specific work on policy was varied but included engaging in policy dialogue, policy analysis, policy development, implementation, research and capacity building. Advocacy work focused on the right to health, quality of services delivery, and resources investment; a special transparency focus involved developing score card used for assessing performance (MPs scored), while technical assistance involved all areas including support of good governance. Eleven (55%) had main focus on healthcare programs as implementers at district and community levels through conducting research, building capacity and monitoring of services. Fewer HRPIs (35-45%) worked in other areas including health systems (35%) with focus on research and capacity building; health financing (45%) focusing on resource mobilization and program management, community participation (45%) on community mobilization on accountability issues; and disease specific programs implementation. Only 3(15%) institutions were engaged in work related to economic policy, trade and health (research and capacity building). Other areas of focus by some institutions included monitoring and evaluation of performance of specific programs and services at district and health unit levels, development of various technical tools and information sharing and dissemination through the media, workshops and other avenues. Research was included in most of the focused areas of work.

Table 6: HRPIs AREAS OF WORK

Area of Focus	n (%)	HRPIs	Specifics
Health policy	17(85%)	AAH, ACHEST, AGHA, AMREF, HEPNet, MUBS, MUCHS, PSU, UAHPA, UCMB, UHDPG, UMA, UNAS, UNHCO, UNMU, UNHRO, UPMPA	[Only UHCA, UMI, MUBS, Monitor, and AFLI were not directly involved]. **Policy dialogue and analysis** (e.g. AMREF, UCMB, UMA); **Policy implementation** (e.g. MUBS, UCMB); **Research and capacity building** (e.g. MUCHS, AMREF**); Participation in the national health policy development** (e.g. UMA, UNMC, PSU, UNHCO, etc)
Health systems	7(35%)	HEPNet, MUCHS, UAHPA, UMA, UNAS, UNMU, UNHRO	**Research and capacity building** (e.g. MUCHS, UNMU, UMA); Facilitate networking (e.g. UNAS)
Health care programmes	11(55%)	AAH, AMREF, MUCHS, PSU, UAHPA, UCMB, UHDPG, UNAS, UNHCO, UNMC, UNHRO	Research and capacity building (e.g. MUCHS, AMREF); Monitoring and evaluation (e.g. PSU, UCMB, UPMPA, AAH, AFLI); Implementation of health care programs (AMREF, HEPNet, UCMB)

Disease specific programmes	9(45%)	AMREF, MUBS, MUCHS, UAHPA, UCMB, UHDPG, UNHCO, UNMC, UNHRO	Implement and coordinate programs (e.g. AMREF, UCMB); Research (e.g. MUCHS); Technical advice (UHDPG, UNMU)
Human resources	14(70%)	AAH, ACHEST, AGHA, AMREF, MUCHS, MUBS, PSU, UAHPA, UCMB, UHDPG, UNAS, UNHCO, UNMU, UNHRO	Research and capacity building
Health financing	9(45%)	ACHEST, AGHA, AMREF, HEPNet, MUBS, UCMB, UNHCO, UNMU, UNHRO	Resource mobilization and management (e.g. through advocacy; networking etc)
Community participation 9(45%) ACHEST, AGHA, AMREF, MUCHS, UAHPA, UCMB, UNHCO, UNMU, UNHRO			Community mobilization or public health education (UAHPA, UNHCO, UCMB); Accountability on service delivery (UNHCO, UCMB)
Economic policy, trade and health	3(15%)	AAH, MUBS, UHDPG	Research and capacity building (MUBS); Advice (AAH)
Technical assistance/ advice	16 (80%)	AAH, ACHEST, AGHA, AMREF, HEPNet, MUBS, MUCHS, PSU, UAHPA, UCMB, UHDPG, UMA, UNAS, UNHCO, UNMU, UNHRO	Advice on policy (e.g. HEPNet, UHDPG, UNAS, MUCHS, UNMC, PSU), health systems (e.g. HEPNet), good governance (e.g. ACHEST, HEPNet, UHDPG, UNMC); drug guidelines (e.g. PSU), HRH issues (UNMU, UAHPA)
Advocacy	16 (80%)	AAH, ACHEST, AFLI, AGHA, AMREF, HEPNet, MUBS, MUCHS, PSU, UAHPA, UCMB, UMA, UNAS, UNHCO, UNMU, UNHRO	Advocacy on quality services, resource investment through the media, public education, etc

Other specify	4(20%)	AAH, UNHCO, ACHEST, UMI	Monitoring and evaluation of some projects (AAH); development of technical tools/ documents e.g. patients charter by UNHCO, HP and strategy for UPDF by ACHEST, Health management curricula by UMI, etc; Fund some programs or workshops (*n = 4* [UNAS,])

i. Participation in health stewardship and governance

Table 7 gives a summary of ways the study institutions have engaged in specific areas dealing with health governance and stewardship. Most institutions stated "yes" to several areas of involvement in national and regional governance and stewardship. It was however noted that details provided on the specific aspects of involvement by several institutions did not concern health governance or stewardship, but rather the institutions' own programs.

Among the different areas specified, HRPIs were most involved in the areas of health policy development, partnership with other stakeholders including SWAp and networks, and monitoring and/or evaluation. Seventeen (85%) institutions (all categories) reported engaging in health policy development, mainly by participation in the different forums on policy discussions and formulation, policy research and analysis, sitting on various policy task forces and working groups, joint review teams, and participation and contribution to the HAP, HSSPs 1/2/3, in MOH. Several institutions engaged in research, most notable academia, think tanks and advocacy civil society institutions.

Institutions active in partnerships and networks (75%) were varied; training and health delivery institutions, advocacy CSO and health professional groups were involved in networks and forums for collaborations within Uganda but little regional involvement was cited. HPAs were members of the commonwealth and international federations (UNMU, UMA, PSU) but failure to pay the membership fees barred them from participation. Only 3 (15%) specifically mentioned SWAp (FBOs). Research institutions, academies and universities belonged to many global networks but little was given on local partnerships. A number of HRPIs (70%) responded to involvement in monitoring and evaluation of performance of programs in MOH but some did not specify exact aspects of involvement. Responses on aspects of involvement included researching on budgetary allocations to health sector, workers staffing levels, performance of national medical stores and access to essential medicines in health sector. Involvement in accountability by HRPIs (45%) included tracking of donor funds (PEPFAR, GAVI, Global Fund for AIDS, TB and Malaria), and on grass-root evidence of performance of funded programs as the major activities. Organizational reforms actions by 45% of HRPIs included the Ministerial Leadership Initiative, the reviews on decentralization and access to health services by 9 institutions. Implementing NGOs and others (35%) were involved in coordination, mainly by coordinating members of their networks in following the national guidelines, and the researchers coordinating institutional research agendas.

Table 7: HRPIs INVOLVEMENT IN HEALTH GOVERNMENT AND STEWARDSHIP

HRPI participation in national or regional health governance	HRPIs *n (%)*	HRPIs involved in (Areas):	Comments on how/ways HRPIs involved
Policy: Health policy development	17(85%)	AAH, ACHEST, AGHA, AMREF, HEPNet, MUBS, MUCHS, PSU, UAHPA, UCMB, UHCA, UHDPG, UMA, UNAS, UNHCO, UNMU, UNHRO	[UMI, AFLI, UPMPA were not directly involved in policy]. Research: MUCHS, AMREF, HEPNet, UNAS; Advice: all the 17 HRPIs; Member of HP development committees or strategic plans AGHA, AMREF, UNMU, UAHPA, UDHPG, UCMB, UMA, UNHCO, UNHRO; Stimulates debate & disseminate info: UHCA; Participate and contribute to formulation in HAP, HSSP1: AMREF, HPAs, CSOs
Oversight: legislation process and development	6(28%)	AFLI, AMREF, PSU, UNHCO, UNHRO, AGHA	Oversight on service delivery outlets: PSU; Developed a patient charter: UNHCO; Advocacy: AGHA, UNHCO
Research: Health policy and systems development	10(50%)	ACHEST, AMREF, HEPNet, MUBS, MUCHS, PSU, UHDPG, UMI, UNHCO, UNHRO	Bottom-up policy analysis: AMREF; National Health Policy research: HEPNet, UNAS; Convene and facilitate forums for policy translation (Mal control & Nutrition policies)
Regulation: Rules and procedures of management	9(45%)	AMREF, PSU, UAHPA, UCMB, UHDPG, UMA, UNAS, UNMU, UNHRO	Drug guidelines and pharmacy outlets: PSU; Surveys on standards and pharmacy services-pharmaco-vigilance: PSU; adherence to international guidelines: UHDPG
Incentives development and application: Staff payment, and retention strategies	6(30%)	ACHEST, AMREF, MUBS, UHDPG, UMA, UNMU	Support incentives through budget push: UHDPG; Innovative HR management & implementation of incentives: UPMB, UCMB, AMREF; Suggestions towards effective HR retention: UNMU, UMA, AMREF
Partnership with other stakeholders: SWAP and networks	15(75%)	AAH, AGHA, AMREF, HEPNet, MUBS, MUCHS, PSU, UMA, UHDPG, UAHPA, UCMB, UNAS, UNHCO, UNHRO, UNMU	Networking and collaborations: MUBS, MUCHS, UNHRO; AGHA; developed forum for HPAs, CSO: UMA, AGHA, AMREF, UNHCO; Created forums for health and nutrition, & disease specific policies, workshop, etc: UNAS

Organization: Organizational reforms, including restructuring and decentralization	9(45%)	ACHEST, HEPNet, MUCHS, PSU, UHDPG, UCMB, UNHCO, UNHRO, UNMU	Reviews organizational reforms: UNHCO; Monitoring of impact and advocacy at district level: ACHEST, UNHCO, AAH, FBOs
Accountability: Consultancy or research to track funds with outputs or amount of work done	9(45%)	AGHA, AFLI, AMREF, HEPNet, MUBS, UHDPG, UNHCO, UNAS, UNHRO	Tracking PEPFAR, GAVI, UNICEF funds (HEPNet, AFLI, UNHCO); Grass-root evidence (AMREF, UNHCO); Work with HDP indicators to monitor accountability (UHDPG)
Monitoring and evaluation: Assessing the level of performance against programme objectives and planned targets	14(70%)	AAH, ACHEST, AMREF, ALI, AGHA, MUBS, MUCHS, PSU, UCMB, UHDPG, UMA, UPMPA, UNHCO, UNMU	Monitors budgetary allocation to health sector, staffing levels, access to EMHS (AGHA) Implementing NGOs (UCMB, UPMB, AMREF URCS, AAH)
Coordination: alignment of individuals and institutions to nationally agreed goals and processes	7(35%)	ACHEST, AGHA, AMREF, UHDPG, UCMB, UNAS, UNHRO	Coordinates several networks (AMREF); guides its members to follow national guidelines (UCMB); Convenes and offers opinion on typical issues e.g. malaria, mental disorders (UNAS); Coordinates several institutions and research (UNHRO)

j. Support to the Ministry of Health

Problems and challenges of working with MOH on governance and stewardship

Responses to this open question were extensive and wide-ranging. Key challenges the HRPIs reportedly faced working with the MoH is detailed below. Common challenges presented related to the strength of individual HRPI, the focus of work of the institution, and nature of relationship with the MOH. For example, health professional associations focused more on issues dealing with corresponding health professionals and health services delivery than on governance. Training and research institutions focused on relevant research and evidence-based implementation. Advocacy CSOs centered on civil society involvement in health strategic planning and accountability, while implementing NGOs and FBOs addressed management issues from headquarters, to district and community level.

The major problems and challenged cited by the HRPIs were as follows;

1. **Considerable bureaucracy** in the MOH led to delays in all processes. HRPIs reported that, *"things don't move"* and the "MoH does not want to hear what we can do with what we have."

2. **Lack of accessibility, coordination and cooperation** within the MOH was considered a major hindrance to getting things done. This challenge was expressed in terms of difficulty in accessing key persons or relevant authority, difficulty accessing information, particularly when multiple departments of people are required, poor communication channels and a lack of knowledge of who is responsible for what. As one HRPI stated, **"**coordination is poor within the MoH**"** and occasionally, the presence of parallel, competing structures creates confusion

resulting in significant issues with accessibility and cooperation with of the MoH with the HRPIs.

Additionally, the attitude among the MoH staff was described as generally lacking in openness and willingness to cooperate. One HRPI reported that "officers do not often attend our meetings when invited, missing opportunities to jointly address issues and find solutions." Similarly, an HRPI commented that, "Aattendance at some strategic meetings was based on allowances/ salary top ups rather than on importance." Low morale was also reported as contributing to the negative attitudes of MoH staff.

3. **HRPIs strongly felt a lack of leadership, drive and consistency** at the central and district levels. HRPI's described the a "shunning of public responsibility" within the MoH, further reporting delayed or lack of decision-making on agreed issues, especially in recent times with many "acting" positions in place at the top level. Failure of appropriate delegation, for example for travel and attendance at meetings by staff who lack the appropriate technical competency for the meeting limits the richness of discussion and the potential of the meeting to produce valuable outputs. One HRPI reported: "There is dichotomy of oversight between MOH and Ministry of Local Government (MoLG) with in-fighting at district level which is hindering decisions and progress in implementing activities especially jointly with private sector implementers."

4. **Poor planning, lack of focus and priority setting** is of major concern for HRPIs, especially the use of indigenous national priorities based on research findings. Failure of the MoH to articulate and set strong policy priorities and mandates is a major challenge to implementing sustainable programs. As a result, donor initiated priorities are often brought in to fill the gaps.

5. **Lack of accountability** throughout the MoH was cited as a major challenge, with one HRPI saying, "Government and does not want to be held accountable," also that, "there is so much interference from politics and in-fighting." Poor accountability means the MoH is unable to measure and account for donor funds. "There is waste of resources and donor funds through over-spending on too many meetings/workshops that don't bear any results."

6. **Appropriate capacity** was emphasized as critical in the ministry but interviewees reported it difficult to identify and measure in-house capacity in different areas. It was reported that "good staff are overworked and competent technical staff were overlooked, with no incentive, while those seen as lazy/incompetent were not disciplined/removed, killing morale and bringing down the system". Management skills in MOH managers were considered low overall, with ministry's failure to take up opportunities for training from many management and training HRPIs. "MOH is unable to set strong policies and priorities, and has failed to move research to policy and to implementation; lack of competence for assigned roles/tasks is contributing to this weakness". Inability to set priorities for research and national research priorities was seen as major pitfall.

   More critical was failure to utilize available local researchers and research findings, translating research into quality programs, and inability to adopt evidence-based interventions and programs. Shortage of or lack of capacity in MOH to undertake important technical work, and which could be done and easier by various HRPIs (research, developing tools, manuals and guidelines) was repeatedly pointed out. It was also perceived that MOH prefers to work with donors and their consultants than with local experts. "There is lack of awareness and recognition of beneficial value for training of MoH staff, which is readily available".

7. **Recognition of and working with HRPIs** proved to be a serious issue and vehemently expressed. Complete lack of understanding and appreciation of the importance of the various complementary roles HRPIs play and their potential to contribute more was echoed by all HRPIs. "There is failure and unwillingness on the part of MoH to recognise and appreciate

the complementary role HRPIs can play, or this is considered unimportant." Universities, academia, researchers (private and public), and professional bodies saw the MoH fail to identify and utilize available local capacity and expertise to set the research agenda and carry out the needed research. HPAs pointed to health professionals' role in policy formulation and their capacity to do technical consultancies, and skills for services delivery envisaged in the stalled PPP initiative if subcontracted. The ministry did not recognise and reach out to HRPIs that could help MoH staff training such as on-the-job training in management skills. Civil society advocacy groups' failure to get invitations to participate in strategic meetings was considered "subordination" and due to lack of understanding of their role as watchdog.

It was stated that in general, the MoH did not take HPAs seriously and failed to take on advice from professionals. HPAs felt the MoH did not support or advocate for strengthening of the institutions through stronger legislature that would improve membership and funding. Financial support was either minimal or none at all although most of the associations activities were primarily work of MOH. Poor representation on key committees left some HPAs out of key discussions on policies and regulations that concern or affects their members (e.g. nurses & midwives training, professional development, working/employment policies and terms).

8. **Inadequate Resources.** MOH is under-funded and has very limited resources to carry out its mandate adequately.

Challenges related to HRPIs

In response to the question of what the weaknesses of HRPI in enhancing health governance, respondents made these comments:

1. **Inability for some HRPI to engage effectively with the MoH** in areas such as policy development, monitoring, and research. HRPIs cited inadequate capacity in to manage the organisations, especially NGOs, and to implement planned programs and projects.
2. **Failed management, accountability, and stewardship** in some of the HRPIs compromised their effectiveness in holding others accountable.
3. Many of the HRPIs, particularly technical and research focused institutions **lacked full understanding of what stewardship and governance issues were.**
4. **Lack of adequate funding and/or resources** to carry out required programs and activities. Insufficient funding made HRPI projects dependent donors. Some institutions, such as HPAs, have weak legislation and legal status resulting in poor membership, weak drive and minimal action.
5. Failure of the various institutions to appreciate the benefit of collective advocacy and action as well as networking, especially among smaller, local and regional institutions.

V. Suggestions on how HRPIs could enhance Governance and Stewardship

This summarizes responses to the question on how HRPIs could better support and enhanced health governance and stewardship. Suggestions mirrored the key issues raised in the challenges previously discussed and were as follows:

Strengthen the relationships between HRPIs and the MoH HRPIs called for recognition and appreciation of the different roles they play when working with the MoH. HRPIs also called for their increased participation in research and health policy planning.

Increase the involvement of research-oriented HRPIs in MoH priority setting. It is also recommended that HRPIs be involved in translating research into policy and ensuring its implementation.

Enhance the management and leadership in both the MoH and HRPIs through training. Capacity building could be undertaken by competent HRPIs.

Share and disseminate information in a timely manner from MoH and among the HRPIs, creating more opportunities for collaboration and employing different mechanisms for information-sharing.

Support HRPIs capacity building and better resources; training in institutional management, governance and accountability (especially of smaller NGOs); MoH should provide funds to some 'needy' institutions, support opportunities for HRPIs funds mobilization; contract local technical experts from HRPIs where appropriate

Individual Health Resource Partners

Many names were given by institutions responding to this question but few gave their contacts as shown in Table 8. In response to what area of health governance and stewardship, some did not elaborate, and few provided responses in line with the subject. Some names appeared more than once named by different responders/institutions as advocates, drivers for development, or facilitating supporters in various areas (specific policy development or implementation, programs, and engagement with MOH. Most are however mentioned as part of collective effort in initiating a program or institutions rather than as individuals actions.

Table 8: INDIVIDUAL HEALTH RESOURCE PARTNERS

Names / Institution	Area of contribution	Affiliation	Nominating HRPI
Prof. Omaswa	As DG/ MOH: (a)support for health system; (b) HRH Mnx policy push, enabling envir for NGOs at MOH; (c) Advocacy for strengthening of health systems	ACHEST	MUCHS, UNHCO, UNHRO, UNMU, UMA
Dr. Kamya	HIV Policy develop & program planning - MOH		UNHCO, UMU
Prof. Sewakambo	Spear heading linkage of health research to policy, HS res	MUCHS	UMU
Prof. Mayanja	Unspecified		UMI
Diane Mutayre	Health policy specialist, funders of HEPnet and drivers of research on HP		HEPnet
Dr. Kadama	-do-		-do-
Dr. Muhebwa	-do-		-do-
Dr. Azizah	-do-		-do-
Dr. Peter Mugyenyi	HIV/AIDS treatment research, leader on ART policy	JCRC	UNRHO, UNAS, JCRC
Dr. Elly Kabarira	AIDS care treatment driver	MUK	UNHRO
Dr. Mbidde	UVRI/ AIDS research	UVRI	UNHRO
Dr. Alex Opio	Surveys on behaviour and HIV/AIDS	MOH	UNHRO
Ndongo Ben	Push for legislation for professional practice		UAHPA
Kiyonga Chrispus	Stewardship, & use of evidence at MOH	Formerly MoH	UAHPA
Dr. Runumi	Health/ social insurance push	MOH	UAHPA
Hassan Mashinda	Leadership for resource mobilisation towards H/research	NMRI-Tanzania	UAHPA
Benjamin Sesasi	Inspirational, facilitated WHO support for cause		UHCA
Paul Kagwa	Source of information from MOH		UHCA
Dr. Sekimpi	Active participation		UHCA
Dr. Freddie Ssengooba	Source of information		
Dr. Robert Mwadime	Beneficial partnership		UHCA
Chris Conte	Volunteered time and resources setting up NGO		UHCA
Deborah Mesie	Beneficial partnership		UHCA
Irene Kulabako	Beneficial partnership		UHCA
Janet D Oburi	Advocacy		UNMU

H.E. Pres. Museveni	Advocacy- (spear-headed)		UNMU, AMREF
Dr. Lary Adupa	Advocacy		AMREF
Dr. L Kagwa	Resource person on govt policy – MOH		
Dr. Katumba Ssentongo	Governance. promoting public participation in decision making at district level	DHO Lyantonde	AMREF, UMU AGHA
Dr. Swahibu Mukiibi	Push & advocacy for Pharmaceutics regulation in region	PSU	PSU
Wilson Kutegeka	Develop.The clinic master software-to disseminate health inform	Monitor	MPL
Dr. Sam Okuonzi	Health policy and planning drive	ACHEST	MISR
Rev. Gideon B Byamugisha	HIV/AIDS prevention programmes and policy formulation		UMMB
Prof. George B Kirya	a) professionalism; b)Advocacy for quality of care (Est.APOQUA)	APOQUA	UMU UMA, AGHA
Dr. Sam Orach	Spear-heading activities of UCMB. Lead on working groups, driver for PPP	UCMB	UMU
Prof. P D'arbela	Drive to establish private post graduate training program		UMU
Dr. Alex Corthino	In charge Infectious Disease Institute -Uganda	IDI	UMU
Dr. James Tiberaderana	MOH malaria research (Academy expert Comm.on DDT	MOH	UNAS
Dr. Max otim	Expert Comm on biosafety and insecurity advocacy		UNAS
Prof. J T Kakitahi	Chair Expert committee on social sciences, Founders UNAS		UNAS
Prof. F.I.B Kayanja	Drive in Academy of science		UNAS
Sandra Kiapi	Advocacy (AGHA)		UMA, ACHEST, HDPG
Prof. E K Kirumira	Academy of science & Technology		UNAS
UHMG	Health marketing and awareness		MUBs
Uganda Religious council	Health governance		MUBS
JCRC	Stewardship		MUBS

VI. Discussion: Anaylsis and Interpretation

Characteristics of the HRPIs

Almost all the institutions were local institutions established by government, individual professionals or by private institutions and included all categories of HRPIs that can work with MOH in various ways to build health governance and stewardship.

Most institutions were long established, allowing time to build their respective field of work. Most institutions had functional offices, communication ability, and up-to-date websites, with country wide operations. Some large institutions had weak legislation, poor membership, lacked proper addresses and set ups with non-functional or inactive branches, an indication of inadequate resources, poor communication, and weak management structures. Institutions have been able to establish various links and networks; strong links were mostly collaborations in research and training with large local and external institutions. Few local and regional networks were in place and most collaboration between HRPIs were not strong or not as well focused as the international links, and these were mostly the research and academic institutions. In part this resulted from limited resources; strong linkages were associated with financial gains and other support to HRPIs.

All HRPIs were legally established; by acts of parliament; registered as not for profit special private institutions, under the NGO act, or as companies with limited guarantee, and all had in place Boards, Governing councils, and/or Directors as governing bodies. There was no clear pattern or association between type of legislation and governance, or with nature of institution; similar institutions like HPAs were established under different statutes which might be of significance in how well institutions function.

Funding

In general all institutions including MoH were under funded for their mandated activities. Funding for the institutions came from multiple sources; from national government, membership or student fees, professional services and other income-generating activities, and largely from the donor community. Government funding was almost limited to government initiated institutions and comprised only 10-30% of revenue. There was no financial support from business or cooperates within Uganda, except some very limited funding from the pharmaceutical companies mostly to support specific activities of HPAs, the reasons for this lack of support were not clear. The legislation under which some HPAs were established hindered their growth and limited their financial base. Weak organisational management and accountability, lack of capacity to develop and implement programs and to carry out research, and lack of revenue generating activities among several HRPIs contributed to the low state of finances and to weakness of the institutions.

Focus of work and involvement in health governance and stewardship

The information only relates to the specific information requested and may not be indicative of the main occupation of the institutions. Most institutions were engaged in health policy, advocacy, technical assistance to other institutions, and human resource issues as focus of their work and less on health systems, healthcare programs, health financing, and community participation as areas of work. Institutions engaged in health governance and stewardship were mostly involved in health policy development, partnerships and networks and in monitoring and evaluation activities. Few institutions were active in accountability, policy research, organisational reforms and regulations or other important areas of health governance and stewardship. While some institutions were strongly involved in health policy (research, formulation, implementation, monitoring), others were evidently limited in their participation and meaningful contribution. HRPIs were involved in various ways; universities and academic and research institutions focused on research and high level policy discussions

to govern health policies, and on training; services oriented NGOs were involved in services delivery policy and program implementation, management, performance evaluation, training and various research at grass root level; CSOs rights advocacy groups were focused on community participation, research and monitoring of different services delivery performance and resources allocation monitoring and accountability.

It was also evident from the responses that several respondents (especially from specific technical research institutions) were not clear about what involvement in governance and stewardship entailed and in this respect were unable to articulate their institutions' specific involvement in these areas.

Challenges/difficulties working with MOH on health governance and stewardship HRPIs were challenged by the lack of direction, progress, and support working with the MoH. Reasons for these challenges included bureaucracy, negative staff attitudes, weak leadership, lack of accountability, poor coordination and management, and inadequate resources. Additionally, all HRPIs strongly felt that their roles were not recognized and appreciated; and ministry did not engage HRPIs fruitfully in key areas of policy development, in priority setting, research and implementation, and did not make use of training institutions for training and enhancing capacity of MOH (especially in management). "*MOH does not take advice from us even on matters that directly concern us."* was echoed by especially HPAs. Some HRPIs were active and made important contributions to decisions made but these were not implemented which was frustrating. Any progress needs to start with addressing the relationship between MOH and HRPIs.

On the other hand, a number of HRPIs were limited by lack of adequate capacity and resources to undertake their activities and lacked the needed competence to engage effectively with MOH. Indeed weak institutional management skills and lack of accountability left some HRPIs unable to take MOH to account. Lack of adequate funding was across board and hindered implementation of actions (e.g. research on specific issues) and limited performance by institutions.

It was difficult to draw HRPIs away from expressing the general problems working with MOH rather than focusing on governance and stewardship issues; indeed many challenges were centered on individual HRPI issues and needs, but these were very similar for all institutions.

Suggestions on how HRPIs could enhance health governance and stewardship Suggestions were made on what was needed most in order to change the impasse. Full recognition and acceptance of the HRPIs as serious partners; with greater role and participation of HRPIs in shared research and priority setting to support policy, with better use of local expertise was considered of paramount importance. Enhancing leadership, management and other needed skills in MoH and HRPIs with support from competent HRPIs; use of HRPIs in monitoring and evaluation of performance and accountability, and better sharing and dissemination of information by MoH and among the HRPIs were equally important. Some HRPIs expressed the need for improvement in governance, management and accountability within their institutions by enhancing capacity and increasing funds mobilization. Emphasis was again geared more on specific needs of HRPIs from MoH and not focusing on what was needed to enhance health governance and/or stewardship. From the responses it was evident that participation of HRPIs in various areas in MoH was far from desired or effective level.

VII. Recommendations

1. **Build strong partnerships with HRPIs as stakeholders.** The need to build strong and better partnership between MoH and HRPIs in order to address national priority health issues was echoed by all HRPIs. Better understanding of the role the institutions play and their potential in bettering health and services in the country, and defining and formalising the partnership is critical. HRPIs are diverse and would support MoH in different ways and this calls for clear understanding and strategy on how best to utilise this resource. There is strong advocacy to move forward on the PPP initiative; this can be pursued and concluded. A well planned forum with the aim to "air" the problems and build consensus on how best to establish beneficial partnerships and collaboration between MOH and HRPIs as a first step would be useful. From this central understanding, mechanisms can be developed for addressing the various key areas that have been identified as follows:

2. **Better understanding, recognition and embracing the role of HRPIs in the work of MoH.** This is key to establishing positive working partnerships between the MOH and the very diverse HRPIs community. HRPIs need to be taken seriously as essential partners and enrolled in greater roles in all policy processes and take on greater tasks in implementation and monitoring. More effort should be made by MoH to engage and participate more in relevant initiatives by HRPIs in order to better understand the work and aspirations of the HRPIs. In addition MoH should actively seek and facilitate the work of HRPIs and help resolve issues affecting HRPIs that are dependent on the ministry (e.g. training, statues and legislation of HPAs). Creation of a HRPI desk at the MOH, for directed dialogue and effective communication between HRPIs and MoH, and to manage action on the various roles of different HRPIs would be important.

3. **Building a culture of locally driven research and evidence to drive policy**. Research undertaken with set priorities is considered more relevant and stronger evidence for policy and program implementation, and in this case available local expertise is underutilised in research to generate more evidence. Some of the institutions are interesting in engaging in health research process; this should be strengthened and expanded to all research and researchers, with focus on research priority setting, health policy and operational research. on contractual basis. Creating a data base of local expertise would facilitate this

4. **Build /enhance management skills and leadership of MOH**. Opportunities exist to build various capacities at MoH by competent HRPIs and this can be tapped into. The proposed training program on health management is a start that should extend to other institutions with capacity to build other needed skills (e.g. academies, knowledgeable NGOs, FBOs). The capacity building should have a focus on district level professionals and health team management in the health system.

5. **Share and disseminate information widely and strengthen networking.** Sharing information among HRPIs and between MoH and HRPIs was considered missing where information existed. Creating opportunities to share information and in a timely manner on research findings, new or changed policies, decisions on pending matters, and its wide dissemination is considered important for the MoH to undertake. Given the importance of networking in building capacity, networks especially at regional and local level, there is need to be support, strengthen and widen networks through improved communication, more commitment on the part of participants, and greater sharing of research. It is recommended to harness more use of the media, and creation of special health media, building on the health communication alliance initiative should be explored.

6. **Implementing agreed decisions** has been identified as a key failure in the ministry, which frustrates stakeholders' participation, disrupts planning, and halts programs. The PPP initiative is yet to be finalized and implemented; private sector perfected good practices could

be adapted and absorbed in public sector at district and peripheral health unit levels but the collaboration has remained informal and patched. MoH could work with and be informed by HRPIs, with implementing and monitoring experiences at grass-root levels. Enrolling such health partners into implementing processes (service delivers, program monitoring/ evaluation, operational research etc) should be explored and formalized.

7. **In- built monitoring mechanisms to assess performance.** Monitoring and evaluation should be at two levels; the achievement of the MoH in implementation of against set goals and the performance of the various HRPIs specific roles and contracted activities, with defined indicators.

8. **Support the HRPIs to be more effective.** While some institutions were solid and actively involved in health policy, research, formulation, and implementation, others were evidently weak and would greatly benefit from specific interventions to strengthen the institutions;

a. Improved technical and organizational management skills,

b. Support from MoH - facilitate changes in legislations governing HPAs; improve financial support for some basic operations and capacity building of NGOs (which has not grown for years or had ceased);

c. Contracting for technical and service delivery undertakings

d. Improved funds mobilization strategies

e. Improved networking with more competent institutions

9. Capacity building of the national health system should include and involve HRPIs in their appropriate areas under such a framework as shown:

VIII. Conclusions

- 45 HRPIs were identified and 29 studied in this study
- HRPIs belong to many categories, are mostly indigenous, legally established, funded from multiple sources which included government, own internal revenue generation and largely by donors as programmes support, had wide links with other institutions mostly focus on policy and advocacy, and are involved in governance and stewardship mostly through policy development and advocacy
- Several HRPIs are strong and others have interest in policy, advocacy and networking, but are weak in capacity to influence the MoH/ Government
- Key challenges for HRPIs in working with MOH included undefined relationship between MOH and HRPIs, inherent weaknesses within the ministry and weaknesses within the HRPIs themselves.
- Key recommendations for HRPIs to influence governance and stewardship include: a) establishing partnership with MoH/Government; b) formal recognition of HRPIs as equal partners in national health system; c) creating a culture of research for policy led by local expertise; d) capacity building in management and leadership in MoH and HRPIs; e) Sharing of information between and with MoH and HRPIs; implementing decisions; monitoring and evaluations of performance with possible development and use of score card to assess performance

A possible model that could be used to mainstream HRPIs in national governance and

stewardship plan would preferably have the following features:

- Creation of MoH/Government department be devoted to dealing with HRPIs and other non govt partners
- Health Strategic Plan to allocate roles to HRPIS according to capacity and comparative advantage
- Specific assignments in governance and stewardship to be allocated to HRPIs on contract
- Contracts should be based on clear M&E indicators that are linked to or drawn from national health system indicators
- Capacity building of the national health system should involve HRPIs where they are appropriate under the following framework:

Capacity Building elements	Provision	Management	M&E
Skills	Universities, academies, Research Inst. Competent NGOs	MOH,NGOs, Business and management training Institutions	MOH, University institutions, Grass root implementing NGOs
Human Resources	All training HRPIs, other, researchers private/public providers,	MOH, private/ public management institutions, competent NGOs	Researchers, academies, Universities, NGOs, Advocacy CSOs
Infrastructure	MOH, HRPIs	MOH	Researchers, providers organizations, CSOs
Organization	MOH, Competent NGOs,	Management institutions, Competent NGOs,	MOH, Researchers, Implementers, Advocacy groups
Systems	MOH, Implementers/ providers		MOH, HRPIs

IX. Publications

Fourteen of the 29 HRPIs in the study responded to the request to "list publications, if any that depict your involvement in health policy, stewardship or governance." (Question 33 - Annex 2). The information provided included either a list of publications or hard copies at the time of the interview, if conducted in person. ; too many to be enumerated. The publications included journal published review papers and research publications, quarterly or other regular institutional publications, newspaper pull-out magazines and large book forms (e.g. Assessment of MPs performance in parliamentary committees by AFLI; Strong Ministries for Strong Health Systems by ACHEST).

Annex 1. Terms of Reference

ACHEST STUDY TERMS OF REFERENCE FOR THE COUNTRY CONSULTANT

Mapping Health Resource Partner Institutions (HRPIs) in selected African countries to Model a Sustained Approach for Strengthening Health Governance and Stewardship in Low income Countries

Introduction

As part of a three year program to strengthen health stewardship and governance in low income countries, African Centre for Global Health and Social Transformation (ACHEST) is conducting a study to map out Health Resource Partner Institutions (HRPIs) to understand them better so that a strategy can be made to empower and give them appropriate capacity to support health system stewardship and governance. The goal of the study is to identify, locate and characterize HRPIs in **five** countries of **Kenya, Malawi, Mali, Uganda and Tanzania**. Each country study will be done by a Country Consultant. Information gathered on HRPIs will include name, location, area of work, history, geographical scope of operation, networks and linkages, resources, funding, achievements and impact. Ultimately, the study is expected to recommend models for strengthening the national health stewardship and governance using HRPIs.

Study Objectives

The study has the following objectives:

1) To gain better knowledge and understanding of HRPIs, their activities, strengths and weaknesses, needs, and impact on health stewardship and governance

2) To identify, locate and characterize HRPIs

3) To identify different ways and methods by which HRPIs can strengthen health governance and stewardship

4) To recommend models by which HRPIs can be facilitated to strengthen health governance and stewardship

Tasks for the Country Consultant

1. To participate in the development, modification or country adaptation of the study tool in consultation with the ACHEST Project Coordinator of the study

2. To identify, locate and administer questionnaire to all indigenous HRPIs that are involved or have the potential to participate in national health stewardship and governance

3. To draw a table listing all possible HRPIs in the country including information on their location, their key areas of work, how they have worked in health stewardship and governance, and how they can be supported to strengthen national health stewardship and governance.

4. To carry out a pre-test of the tool and revise the tool in consultation with the Project Coordinator

5. To carry out detailed study and follow-up of 10 – 15 HRPIs by administering the tool, collecting and recording data using the questionnaire

6. To compile data from the core 10- 15 HRPIs and from other HRPIs which manage to submit reasonably well completed questionnaires, analyze and present the data for easy

interpretation

7. To write a clear and concise report
8. To present the report at a joint workshop.

Report Format

The report will cover the following key elements:

- Executive summary including clear actionable recommendations
- Background of the study
- A summary of the ToRs in the consultants understanding
- The methods of data collection and analysis
- Findings; to be arranged under the following sub-headings:

1. Location
2. History
3. Geographical scope
4. Legal status
5. Governance of the institution
6. Founding institutions/ individuals
7. Partner institutions, institutional links and networks
8. Technical and areas and types of work
9. Involvement in health stewardship and governance
10. Support to Ministry of Health (MoH)
11. Publications: number, types, content, stewardship and governance issues etc.
12. Suggestions from HRPIs on how to strengthen stewardship and governance issues

- Discussion: analysis and interpretation
- Recommendations
- Conclusions
- Annexes to include ToRs, the study tool, detailed tables etc.

Deliverables

The expected deliverables are:

1. A table with a comprehensive list and key information on all HRPIs in the country
2. A list of 10 -15 HRPIs selected for a close follow-up and detailed study
3. A report on pre-test of the tool, with recommendations for revising or improving the study tool
4. A report with detailed recommendations

Country consultant

The consultant should have at least a master's degree in medical / health or social sciences, with a minimum of 5 years of research experience. Familiarity with and a special training in qualitative methods and health leadership and governance or health system development will be useful. Knowledge and familiarity with the country will be essential.

Timing

The consultancy covering the entire study will take 60 calendar days or two calendar months from the day of signing the contract. In any case, it should start not later than the June 30 and end not later August 31, 2010.

Coordination of study

The country studies will be coordinated at ACHEST by the Study Project Coordinator, located in Kampala, Uganda.

Annex 2. Questionnaire

ACHEST STUDY INSTRUMENT

Mapping Health Resource Partner Institutions (HRPIs) in selected African countries to Model a Sustained Approach for Strengthening Health Governance and Stewardship in Low income Countries

Background

This study is part of a bigger project on strengthening health stewardship and governance in Africa and other low income countries as a strategy to strengthen health systems. It is a follow-up to implement the findings and recommendations of a study report: "Strong Ministries for Strong Health Systems". One of the seven recommendations of the study is that "countries should develop effective governmental and non-governmental Health Resource Partner Institutions (HRPIs) to support the health system stewardship and governance functions of the ministries of health". As a way forward, it was recommended by stakeholders that HRPIs be identified and characterized to provide the necessary knowledge and understanding to design a mechanism for involving them to advance health and health system governance. The purpose of this study is to determine which institutions and individuals are active or have the potential to be effective HRPIs in 5 African countries. The HRPIs may be academic institutions, NGOs, think tanks, public and private sector institutions, development partner institutions or individuals.

The five countries selected for this study are **Kenya, Malawi, Mali, Tanzania and Uganda**. Information gathered is expected to include name, location, area of work, date of commencement of work, membership, resources available, funding sources, achievements and impact in the countries, region and world-wide.

The objectives of this study are to:

1) Gain better knowledge and understanding of African health policy and strategy organizations, their activities, impact, strengths, and needs;

2) Identify and characterize the HRPIs;

3) Identify different ways and methods by which HRPIs can strengthen health governance and stewardship; and

4) Recommend models by which HRPIs could be facilitated to strengthen health governance and stewardship in Africa.

Key definitions

Health system: personal health care services, public health services, health research systems and health in all other policies.

Stewardship: governments are stewards or protectors of public interest and have the ultimate responsibility to assuring conditions that allow people to be as healthy as possible.

Governance: is the alignment of multiple actors and interests to promote collective action towards an agreed goal.

Leadership: The ability to and the process of scanning of the environment, creating attractive vision and strategies, and inspiring and aligning actors and interests for action to achieve an agreed goal

Management: Involves planning, including scheduling activities, mobilizing and using resources, implementation, monitoring and evaluation, and feedback.

CONTACT INFORMATION

1	Name of respondent	
2	Title of respondent	
3	Contacts of respondent: Telephone Email Postal address	
4	Name of the institution in full	
5	ACRONYM	
6	Street address	
7	Province and / or district	
11	City or Town	
12	Country	
13	Telephone	
14	Email	
15	Website	

INSTITUTIONAL HISTORY AND GEOGRAPHICAL SCOPE

16	In which year was the institution established?	
17	In which country is the institution's headquarters located?	
18	Are there any branches??	
19	If so, where (which countries)?	
20	In what countries does the institution operate?	

LEGAL STATUS

21	What type of institution is it? Government NGO Bilateral organization Multilateral Other (specify)	
22	What is the legal status of the institution? Established by law Registered Other (specify)	

GOVERNANCE OF THE INSTITUTION

23	Which of the following organs apply to the governance of the institution? Tick as applicable.	
	Board of Trustees	
	Governing Council/Committee	
	General Assembly/ Annual General Meeting	
	Directors	
	Others (specify)	

FOUNDERS

24	Who or what organizations were the founders of the institution and which are their countries of origin or of current location	
	Name of founding institutions or individuals	Countries where these institutions are located. Also indicate the nationalities of the individual founders
	1.	
	2.	
	3.	
	4.	
	5.	

FUNDING SOURCES

25	What are three main sources of funding?	Approximately what percentage of funding of funding is from each source?

LINKS WITH OTHER INSTITUTIONSAREAS OF FOCUS / NATURE OF WORK

28	Which of the following are the principal areas of the focus of work? Tick as applicable	In what specific aspects?
	Health policy	
	Health systems	
	Health care programs	
	Disease specific programs	
	Human resources	
	Health financing	
	Community participation	
	Economic policy, trade and health	
	Technical assistance/advice	
	Advocacy	
	Other specify	

INVOLVEMENT IN HEALTH GOVERNANCE

29	In what ways has your institution participated in national or regional health governance?	Explain and give some examples
	Policy: Health policy development	
	Oversight: legislation process and development	
	Research: Health policy and systems development	
	Regulation: Development of rules and procedures of management	
	Incentives development and application: Staff payment, attraction and retention strategies	
	Partnership with other stakeholders: SWAP and networks	
	Organization: Organizational reforms, including restructuring and decentralization	
	Accountability: Consultancy or research to track funds with outputs or amount of work done	
	Monitoring and evaluation: Assessing the level of performance against program objectives and planned targets	
	Coordination: alignment of individuals and institutions to nationally agreed goals and processes	
	Others (specify)	

INDIVIDUAL HEALTH RESOURCE PARTNERS

30	List names of outstanding individuals who have made significant contribution to health governance and stewardship in the country or region		
	Names	Area of contribution	Email and telephone contact

PROBLEMS AND CHALLENGES OF WORKING WITH MOH IN GOVERNANCE AND STEWARDSHIP

31	List down the challenges your organization has faced in working with the Ministry of Health in health stewardship and governance. (What are the challenges you have faced in efforts to enhance health stewardship and Governance?

WAYS BY WHICH HRPIs CAN ENHANCE HEALTH GOVERNANCE

32	Suggest ways by which your organization could better facilitate health sector stewardship and governance.

PUBLICATIONS

33	Please list publications, if any, which depict your involvement in health policy, stewardship or governance.

Annex 3. Powerpoint Presentation of Report

1

Mapping of Health Resource

Partner Institutions (HRPIs):

Modeling a sustained approach for strengthening health governance and stewardship in low-income countries

Uganda

2

The purpose

To identify and characterize HRPIs in Uganda

3

Objectives

- Identify characterize all possible HRPIs in Uganda
- Gain better knowledge and understanding of HRPIs (activities, strength/weaknesses, needs, impact)
- Identify how HRPIs can strengthen health governance and stewardship
- Recommend a model by which HRPIs could be facilitated to strengthen health governance and stewardship

4

Data Collection and Analysis Methods

- A questionnaire was used to gather data
- Questions were both structured and semi-structured, with a few open ended questions
- Questionnaire was pre-tested and modified
- Study conducted by phone, e-mail, and in-depth interviews
- Quantitative and qualitative data was collected
- Data was coded, entered into work sheets and analyzed.
- Data analysis -QSR NUDIST software (1994)

5

Findings

Objective 1:Identify and characterize the HRPIs

- 45 HRPIs were identified, 29 studied in full

Characterized as

- Most established over 10 years ago
- Most(86%) were local HRPIs-functioning within the country boundaries
- 66% registered NGO, 34% Govt/public and 1% by special autonomous charter/laws
- Local HRPIs interphase mainly with other local institutions; while internationals interphase with international institutions

6

Objective 1: Identify and characterize the HRPIs- cont'd

Governance: 52% are managed by a governing councils and 44% by directors, others

- Common sources of funding are own income(10), Govt (9), and all greatly by multilateral organizations (10), bilateral at (9), others (12)
- All institutions had linkages/ networks with counterparts.
- Most linkages 86% are with universities, 83% with national government (MOH), academies/research institutions(88%), multilaterals and bilaterals (87%)

7

Objective 2: Gain better knowledge and understanding of HRPIs (activities, strengths, weaknesses, needs, and impact on health stewardship and governance)

Activities (wide range)

-85% of HRPIs were involved in health policy

-80% involved in advocacy and technical assistances -70% involved in HRH, Health Financing

- 70% in Health care and Disease specific programs

- 65% Others (Community participation, research, M&E)

Only 35% were involved in health policy and 3% in economic policy

8

Objective 2: Gain better knowledge and understanding of HRPIs- cont'd

HRPIs & MOH in health governance & stewardship

- 85% involved in health policy development
- 89% Organisational and regulations issues
- 68% Oversight & accountability
- 50% Health policy research
- 75% Parnerships with other stakeholders(SWAP)
- 70% M&E
- 45% Coordination
- 35% Others

9

Objective 2: Gain better knowledge and understanding of HRPIs- cont'd

MoH weaknesses *(cited)*

- HRPIs expressed frustration with the lack of direction and support when working with the MoH.
- weak leadership,
- poor coordination and management,
- lack of accountability,
- negative staff attitudes, and
- inadequate resources.

10

Objective 2:Gain better knowledge and understanding of HRPIs- cont'd

HRPI weaknesses

- Lack of capacity and resources
- The need for better management skills within their own institutions.

HRPI needs

- Recognition and appreciation of HRPI roles by MoH
- Direction, progress and support working with MoH
- Adequate capacity and competence to fruitfully engage with ministry of health

11

Objective 3: Identify different methods by which HRPIs can strengthen health governance and stewardship

- Strengthen relationship between HRPIs and MoH.
- MoH to include research oriented HRPIs in their activities.
- Enhance management and leadership in MoH and HRPIs

12

Objective 3: Identify different methods by which HRPIs can strengthen health governance and stewardship- Cont'd

- Timely sharing and dissemination of information from MoH and among HRPIs
- Support HRPIs capacity building and resource mobilization (MoH provide funds to institutions and seek their technical expertise.)
- It's important to build a database of clear individual health resource partners

13

Objective 4: Recommend a model by which HRPIs could be facilitated to strengthen health governance and stewardship in the 5 countries.

- Creation of effective department in ministry of health for HRPIs
- Roles of HRPIs to be allocated in the health strategic plan
- Specific assignments in governance and stewardship be allocated to HRPIs
- Capacity building of the national health system should involve HRPI under an identified framework

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Conclusion

- HRPI have potentially a big role to play in health stewardship and governance
- MoH needs to harness the roles of HRPIs in health stewardship and governance through instituting clear working procedures

ACHEST

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