

# UGANDA: WINNING HUMAN RESOURCES FOR HEALTH

Case study (Full) | Jillian Larsen | December 2015

## INTRODUCTION

A developing nation faces choices about where to direct its limited resources. Civil Society Organizations (CSOs) have an important role to play in identifying and advocating budget priorities. While economic development must always have a prominent place in a nation's planning and investment, CSOs can ensure that social goals and the development of human resources are not pushed aside. In this case study, we see that cooperation among experienced CSOs, evidence-based advocacy, collaborative engagement with new partners, and a willingness to confront opponents directly and publicly have brought significant achievements to the Human Resources for Health (HRH) Campaign in Uganda.

Uganda has experienced remarkable economic growth and improved stability since President Museveni came to power in 1986. Between 1992 and 2012 Uganda more than halved its poverty rate from 56 percent to 22 percent, and despite the global economic slowdown in recent years, the country maintains a projected economic output of 6.2 percent GDP growth in 2014/15.<sup>1</sup> Despite the enormous achievements in poverty reduction and expanded access to social services, in particular access to universal primary education, improvements in the delivery of health services and in basic health outcomes have been much slower.

Over the period 2011-2012 CSOs planned and implemented the HRH Campaign in response to budget shortfalls, severe staffing shortages for human resources, and the continuing poor health outcome indicators. With the goal of stopping preventable maternal deaths, the primary objective of the campaign was to win an additional budget allocation of UGX 260 billion (approximately US\$100 million) to fund the recruitment and increased remuneration of health workers. The campaign brought together patients, health workers, professional organizations, and a wide cross-section of CSOs that conduct advocacy work on human rights issues and health priorities, including HIV/AIDS, sickle cell disease, and maternal health. For the HRH Campaign, the groups that came together in this coalition agreed to work together because basic staffing at health centers in Uganda was a priority concern for all of them.

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<sup>1</sup> "Uganda Overview," World Bank, 2014, available at: <http://www.worldbank.org/en/country/uganda/overview>; and Uganda Economic Update 4, World Bank, 2014, available at <http://documents.worldbank.org/curated/en/2014/06/19804777/reducing-old-age-economic-vulnerabilities-uganda-improve-pension-system>

In their advocacy work for the HRH Campaign the national and international organizations engaged with other stakeholders, including the Ministry of Health, the Ministry of Finance, and members of parliament, sometimes as allies and sometimes as adversaries. They embarked on an aggressive national strategic communications campaign.

Despite a challenging political environment in which health and human resources for health were not prioritized, the campaign managed to secure an allocation of UGX 49.5 billion (approximately US\$20 million) to the health budget, which made possible the recruitment of an additional 6,889 professional health workers. While this figure fell short of the target of 10,000 more health workers, it increased the number of health workers significantly. The campaign also resulted in a doubling of the salaries of doctors at the Health Center (HC) IV level.<sup>2</sup> Campaign successes were the result of ambitious targets, bold tactics, and a wise use of political power. For example, those involved in the campaign rejected the entire draft national budget for 2012 until the Ugandan president committed the government to an increased allocation for expenditure on health.

## THE PROBLEM OF INADEQUATE FINANCIAL AND HUMAN RESOURCES FOR HEALTH CARE IN UGANDA

### INADEQUATE FUNDING FOR HEALTH CARE IN UGANDA

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The area of basic maternal health is one indicator that reflects the inadequacy of the health budget in Uganda. Improvements in this area have been slow and halting. In 1990, Uganda's maternal mortality ratio (MMR) was 527 deaths per 100,000 live births. Ten years later it stood at 505 deaths per 100,000 live births, and in 2006, at 435. However, in 2011 the improvement in MMR stalled at 438 deaths per 100,000 live births.<sup>3</sup> This figure is 330 percent higher than the Millennium Development Goal set in 2000, when Uganda committed itself to achieve an MMR of 131 deaths per 100,000 live births by 2015.<sup>4</sup>

The unacceptably high rate of maternal deaths is the result of a number of factors. Only 48 percent of women receive prenatal care throughout their pregnancy, and skilled birth attendants are present at only 58 percent of all births.<sup>5</sup> The most common contributors to maternal deaths in Uganda are hemorrhage (26 percent), complications from indirect conditions such as malaria or HIV (25 percent), sepsis (22 percent), and obstructed labor (13 percent).<sup>6</sup> While exact figures are not readily available, multiple studies have shown that unsafe abortion (which remains illegal in Uganda) is also a high

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<sup>2</sup> International NGO, November 14, 2014.

<sup>3</sup> *Uganda Demographic and Health Survey*, (Kampala: Uganda Bureau of Statistics, 2011), available at: <http://www.ubos.org/onlinefiles/uploads/ubos/UDHS/UDHS2011.pdf>

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> "Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda," Republic of Uganda, Ministry of Health, 2010, available at: [http://www.nationalplanningcycles.org/sites/default/files/country\\_docs/Uganda/uganda\\_mnh\\_roadmap\\_2007-2015.pdf](http://www.nationalplanningcycles.org/sites/default/files/country_docs/Uganda/uganda_mnh_roadmap_2007-2015.pdf)

contributor of maternal mortality.<sup>7</sup> Most of these deaths could be avoided by ensuring access to basic emergency obstetric and newborn care, but providing such services would require sufficient numbers of skilled health staff, basic equipment, and medical commodities.

Uganda's public health sector is guided by such documents as the National Development Plan 2010/11-2014/15, National Health Policy II 2010-2020, and a Health Sector Strategic and Investment Plan (HSSIP) 2010/11-2014/15. Overall, the strategies provide good frameworks and outline a Ugandan National Minimum Health Care Package. If implemented, this would improve health outcomes in the country. However, there remains a serious mismatch between the plans and the funds that are allocated, as well as serious challenges in implementation, management, oversight, and accountability.<sup>8, 9</sup>

The National Development Plan sets a target of allocating 11.6 percent of overall budget expenditure on health, and the HSSIP target is to devote a minimum of 9 percent of the budget in order to deliver the National Minimum Health Care Package.<sup>10</sup> Both of these targets are well below the 15 percent target that the government of Uganda committed itself to under the 2001 Abuja Declaration.<sup>11</sup> Indeed, as a percentage of overall expenditure, funding for the health sector has actual been declining in recent years. (See Figure 1).

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<sup>7</sup> Stephen Malinga and Anthony Mbonye, "Maternal Morbidity and Mortality in Uganda," Submission to All-Party Parliamentary Group on Population, Development & Reproductive Health), December 8, 2008, UK; and Freddie Ssengooba et al., "Unintended Pregnancy and Abortion in Uganda," *Maternal Health Review Uganda*, Makerere University Institute of Public Health, n.d.

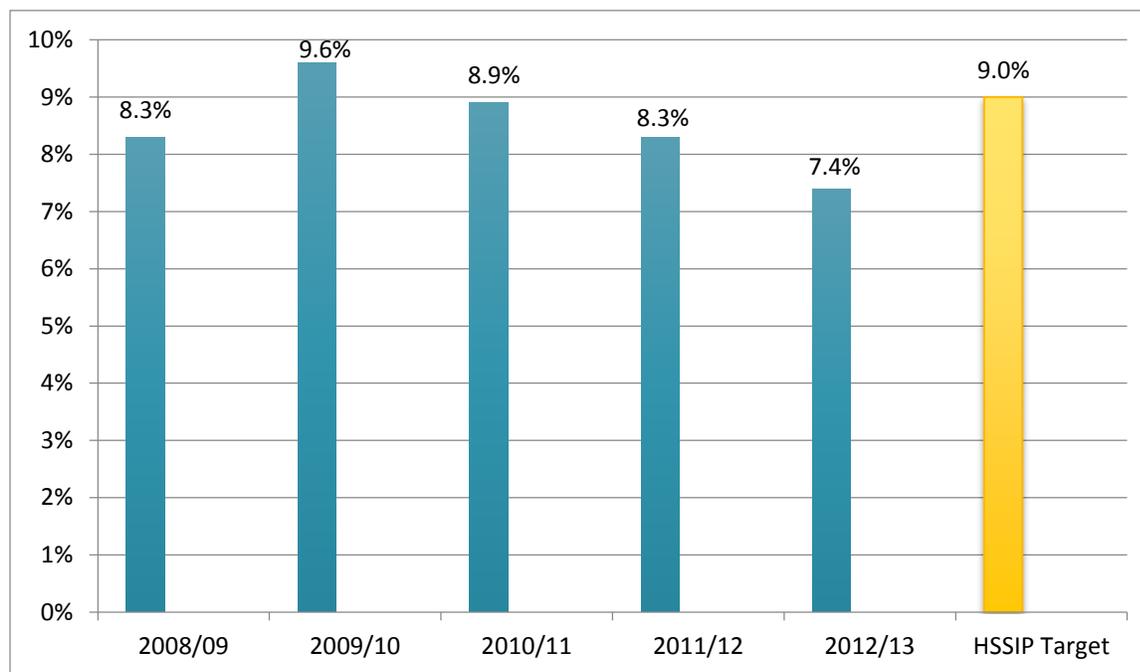
<sup>8</sup> Focus Group Discussion, Action Group for Health, Human Rights and HIV/Aids, November 4, 2014.

<sup>9</sup> International NGO, November 14, 2014; comments by an official, Ministry of Finance, November 2014. [[Q: THIS MUST HAVE BEEN SPOKEN BY THE OFFICIAL?]]

<sup>10</sup> "Annual Health Sector Performance Report 2012/13," Republic of Uganda, Ministry of Health, 2013, available at: [http://health.go.ug/docs/AHSPR\\_2013.pdf](http://health.go.ug/docs/AHSPR_2013.pdf)

<sup>11</sup> The Abuja Declaration: Ten Years On," World Health Organization, 2011, available at: <http://www.who.int/healthsystems/publications/Abuja10.pdf>

FIGURE 1. HEALTH ALLOCATIONS AS PERCENTAGE OF TOTAL GOVERNMENT BUDGET



Many stakeholders in Uganda, and indeed the Ministry of Finance itself, argue that the current priority in the country is to “create an environment for doing business in Uganda.” Investment priorities are in what the government refers to as the “productive” sectors, including infrastructure, roads, and energy.<sup>12</sup> Health, despite its potential impact on human capital in the country, is viewed as a “nonproductive” or “consumptive” sector and is not seen as adding value to the economy.<sup>13</sup> One official at the Ministry of Finance said, “We may not be able to meet all the needs because of the limited budget envelope on which so many priorities rely. We need a road. We need electricity. We need to make the economy move much faster. Not that we are neglecting the lives of our people, but we have to make a choice. How do we sustain the facility if the economy is not growing? We need to sustain services through increased taxation.”<sup>14</sup>

This view of the health sector as “nonproductive” has contributed to recurrent underinvestment in the sector and has resulted in major gaps in the delivery of health services, which are hampered by shortages in human resources, planning, and management skills, especially at the district level.<sup>15</sup> Although 72 percent of households in Uganda live within five kilometers of a health facility (public,

<sup>12</sup> Official. Ministry of Finance.

<sup>13</sup> Comments by an official, Ministry of Health, November 2014.

<sup>14</sup> Comments by an official, Ministry of Finance, November 2014.

<sup>15</sup> “Uganda Country Operation Strategy,” World Health Organization, 2014, available at: [http://www.who.int/countryfocus/cooperation\\_strategy/ccsbrief\\_uga\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_uga_en.pdf)

private, or nonprofit), access to health services is limited due to poor infrastructure, inadequate medicines and other health supplies, too few staff, and absenteeism by health staff members.<sup>16</sup>

A recent survey of service delivery by the World Bank found that only 35 percent of health providers could diagnose such common conditions as diarrhea with dehydration, and malaria with anemia. In addition, only 20 percent of the time did public providers follow the correct actions to manage maternal and neonatal complications. The same report established a 52 percent rate of absenteeism, and indicated that only 44 percent of the public health facilities had all six of Uganda's essential drugs.<sup>17</sup> Access to life-saving services such as HIV treatment improves economic productivity. Research in Uganda has linked HIV treatment with greater earning power and a greater likelihood that children of HIV positive parents will stay in school.<sup>18</sup> It is important to challenge the misperception among Ugandan politicians and technocrats that health is merely a consumptive area of the economy. Apart from the fact that health is a human right, a lack of robust investment in a health sector that delivers health services equitably dramatically undermines economic development.

## THE CRISIS IN HEALTH CARE STAFFING IN UGANDA

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This chronic underfunding of the health sector has been particularly evident in the area of human resources for health. Public health staffing is marked by insufficient recruitment, inequitable deployment, and inadequate remuneration of health workers at all levels of the health system, in particular at the level of the district and below. In 2008 just 56 percent of health worker posts were filled, and in 2011 that figure had only increased to 58 percent. (See Figure 2.) Moreover, these figures only take the actual number of listed positions into account, which to date remains static because government has not increased its recruitment of health workers to keep up with population growth and increased demand.<sup>19</sup> According to one CSO member, current health worker-to-patient ratios established by the Ministry of Health have not been adjusted for population growth for decades.<sup>20</sup>

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<sup>16</sup> "The Second National Health Policy," Republic of Uganda, Ministry of Health, 2010, available at: [http://www.usaid.gov/sites/default/files/documents/1860/National\\_Health\\_Policy\\_July\\_2010.pdf](http://www.usaid.gov/sites/default/files/documents/1860/National_Health_Policy_July_2010.pdf)

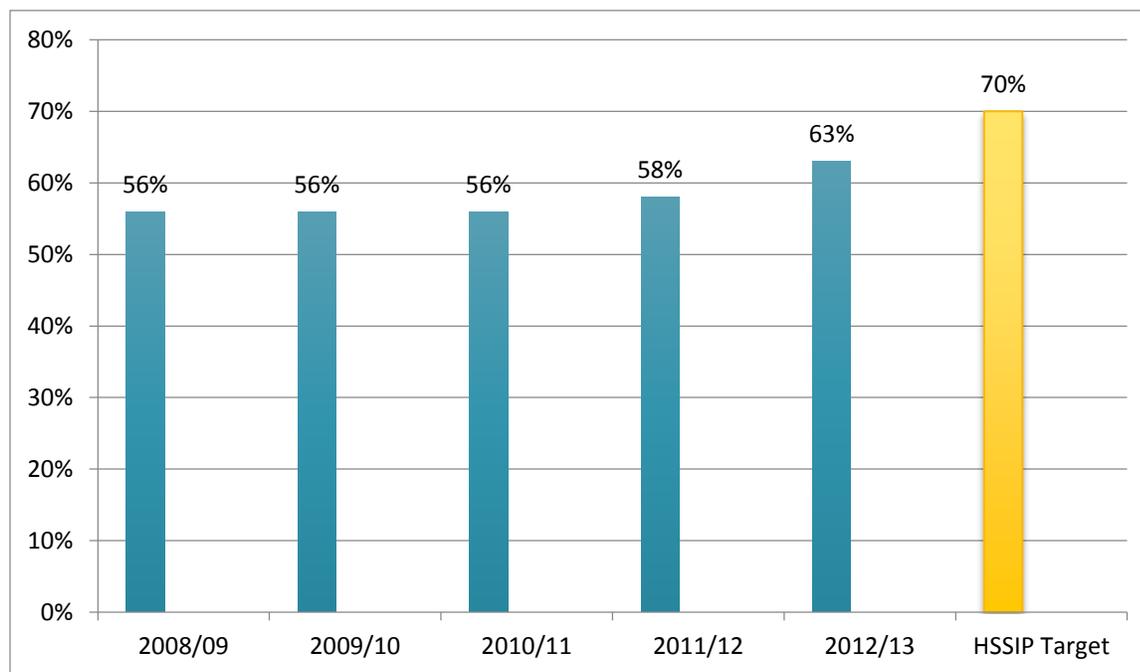
<sup>17</sup> "Education and Health Services in Uganda: Data for Results and Accountability," World Bank, 2013, available at: [http://www.wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/11/18/000456286\\_20131118105216/Rendered/PDF/826660ESW0Ugan090Box379862B000UO090.pdf](http://www.wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/11/18/000456286_20131118105216/Rendered/PDF/826660ESW0Ugan090Box379862B000UO090.pdf)

<sup>18</sup> H. Thirumurthy H. et al., "Improved Employment and Children's Education Outcomes in Households of HIV-Positive Adults with High CD4 Counts: Evidence from a Community-wide Health Campaign in Uganda," 19th International AIDS Conference, Washington, D.C., abstract THAE0102, July 2012.

<sup>19</sup> Comments by an official, Ministry of Health, November 2014.

<sup>20</sup> CSO, email communication, 12/20/2014.

FIGURE 2. PERCENTAGE OF APPROVED POSTS FILLED BY HEALTH WORKERS



There is also considerable disparity between districts in the levels of staffing. According to the Uganda Human Resources for Health Report (2011), over one-third of the districts in Uganda had significantly less than 50 percent staffing levels. Indeed, a handful of districts, including Buhweju, Namayingo, Amudat, Kabale, Moroto, Namutumba, and Ibanda had less than 35 percent of the necessary staff, whereas other districts, such as Kampala, had over 75 percent of its posts occupied.<sup>21</sup> Underlying socioeconomic, gender, and geographical disparities, combined with variable shortages in key staff and infrastructure, contribute to the wide differences in health status across the country.<sup>22</sup> For many years disparities in health sector staffing were not addressed. As one health official said, remote regions “were just left to languish.”<sup>23</sup> As a result of a recruitment ban, newly graduated health workers were not absorbed into the public sector.

The importance of human resources within health systems cannot be underestimated. Staff shortages, limited funding for recruitment, gaps in skills and competencies, low retention, and poor motivation negatively affect health outcomes. Since the spotlight was put on the global health workforce crisis a decade ago, efforts to strengthen national human resources for health strategies have intensified.<sup>24</sup> In

<sup>21</sup> *Human Resources for Health Bi-Annual Report* (Kampala: Ministry of Health, 2011).

<sup>22</sup> “Uganda Country Operation Strategy,” World Health Organization, 2014, available at: [http://www.who.int/countryfocus/cooperation\\_strategy/ccsbrief\\_uga\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_uga_en.pdf).

<sup>23</sup> Comments by an official, Ministry of Health, November 2014.

<sup>24</sup> Rachel Deussen and Wanda Jaskiewicz, “Using Evidence for Human Resources for Health Decision-Making: An Example from Uganda on Health Workforce Recruitment and Retention,” Capacity Plus Project, 2014, available at: <http://www.capacityplus.org/files/resources/using-evidence-human-resources-health-decision-making.pdf>

2008 Uganda's midterm review of its Health Sector Strategic Plan II (2005/06-2009/10) highlighted high staff turnover, absenteeism, and low productivity as key determinants of poor performance by the health work force. Such factors undermined the goals of improving fertility; reducing maternal and child mortality; reducing malnutrition; lightening the burden of HIV/AIDS, tuberculosis, and malaria; and reducing disparities in health outcomes.<sup>25</sup> A 2008 study by the Ministry of Health that measured health worker satisfaction, motivation, and intent to stay in the health field, revealed that health workers considered both financial and nonfinancial incentives important. In line with these findings, the Ministry of Health developed a motivation and retention strategy to "strengthen the capacity of the health system to improve the attraction, retention, equitable distribution, and performance of the health workers." To address high vacancy rates and low motivation, the ministry placed recruitment and retention of health workers at the center of the Health Sector Strategic Plan III (2010/11–2014/15).<sup>26</sup>

## THE OBJECTIVES AND METHODOLOGY OF THE CASE STUDY

### OBJECTIVES

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This case study is part of a series of case studies undertaken by the International Budget Partnership (IBP) Initiatives Learning Program which aims to build evidence of civil society's efforts to bring about budget changes in a range of countries. This study focuses specifically on the HRH Campaign that took place between 2011 and 2012 in Uganda. The case study aims to:

- 1) describe the planning and execution of the Human HRH Campaign;
- 2) identify changes in government behavior and policies that the campaign contributed to; and
- 3) explain the relationship between the campaign activities and government actions and consider factors on both sides that contributed to the outcome of the campaign.

The report begins with an overview of the methodology and some background on the campaign's key stakeholders. It then examines the specifics of the 2012 HRH Campaign in some depth, documenting the planning, objectives, stakeholders, timeline, campaign tactics, and government response. It concludes with a discussion of the campaign's impact, its lasting outcomes, and the lessons to be learned.

### METHODOLOGY

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This case study used qualitative research methods and drew on multiple sources of information, including a review of relevant literature, interviews with key informants, and focus group discussions. Firstly, a systematic literature review was undertaken of project documentation and campaign documents (conceptual documents, meeting reports, activity narratives, etc.), media and newspaper reports, documents from the government of Uganda, and of literature relating to human resources for

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<sup>25</sup> Ibid.

<sup>26</sup> Ibid.

health and the budget process in Uganda. Secondly, a series of interviews were carried out with the relevant stakeholders.

Based on findings from the literature review and initial interviews, the research methodology was refined to prepare for in-country data collection, and field work was carried out in the period 2-26 November 2014. Preliminary meetings took place with the Action Group for Health, Human Rights and HIV/AIDS (AGHA) country staff to review and refine the proposed methodology, generate a preliminary list of key informants, and conduct an initial focus group discussion of the case study. Thirty-seven informant interviews were conducted at the national level, including 17 with CSOs, international NGOs, and professional bodies; six with the current or former members of the Parliament of Uganda; three with the media; three with multilateral or bilateral development organizations; and eight with government of Uganda officials at the Ministries of Finance, Planning and Economic Development, and Health.

In some cases, interviewees were contacted or interviewed on more than one occasion. In order to identify key informants, a preliminary list was drawn up by AGHA, and it included members of parliament, officials in the relevant government ministries and agencies, CSOs, development partners, and relevant professional organizations. Additional key informants were identified using a “snowball technique,” that is, getting contact information for additional key stakeholders through the initial interviews.

After the data were analyzed, key issues identified, and emerging trends identified, a wrap-up meeting was held in Uganda on 26 November 2014 with members of the Coalition for Maternal, Child and Newborn Health Steering Committee, who were given summary findings and had an opportunity to comment. Their comments, as well written comments provided by the IBP, AGHA, and HealthGAP, were also incorporated into this study.

## BACKGROUND TO THE HUMAN RESOURCES FOR HEALTH CAMPAIGN

### BUILDING COLLABORATION AMONG STAKEHOLDERS

A strong feature of the HRH Campaign was the extent to which it brought together a range of national and international CSOs in a collective pursuit of a shared goal. It was a unique collaborative effort involving a broad cross-section of stakeholders to engage the Ugandan government on its health budget. The campaign partners pooled their resources, undertook collaborative planning, developed a shared analysis of their political environment, and communicated a shared campaign message. The participation of groups that had considerable experience in health advocacy campaigns contributed to the ability of the HRH Campaign to develop grassroots support and power.

This broad collaboration was the result of a particular set of events that developed in 2011. Between 2008 and 2011 CSOs in Uganda pursued their own agendas and ran independent campaigns, often on related issues. While collaboration was built between some CSOs on specific health issues in Uganda, such as access to medicine, organizations did not collectively challenge government on health sector spending. The events that brought CSOs together in 2011 were largely the result of strategic litigation

and advocacy efforts at the national level under the banner of “Petition 16,” an initiative challenging the government of Uganda for violating the constitution by not providing essential maternal health care services. Added to this, two major international events brought CSOs together around a common cause. The first was the Inter-Parliamentary Union, hosted in Uganda in March 2012, and the preparatory work undertaken for that event. The second was CSO advocacy around the UN General Assembly meeting in 2011. The CSOs wanted the government to make a renewed commitment to meeting the UN’s Millennium Development Goal (MDG) targets on maternal health and to accelerate their progress in that area. Key organizations were able to connect these campaigns and events and join forces around a common campaign for human resources for health.

At the same time, relationships were growing between the Ministry of Health and Intrahealth/The Capacity Project (an international NGO implementing a USAID-funded “Uganda Capacity Plus” program, described below), between CSOs and the Ministry of Health, and between CSOs and key parliamentary committees. All of these stakeholders, working together on a common agenda in 2011 and 2012, were able to collectively pressurize the government into making the additional budgetary commitments for increased recruitment and remuneration for health workers in 2012.

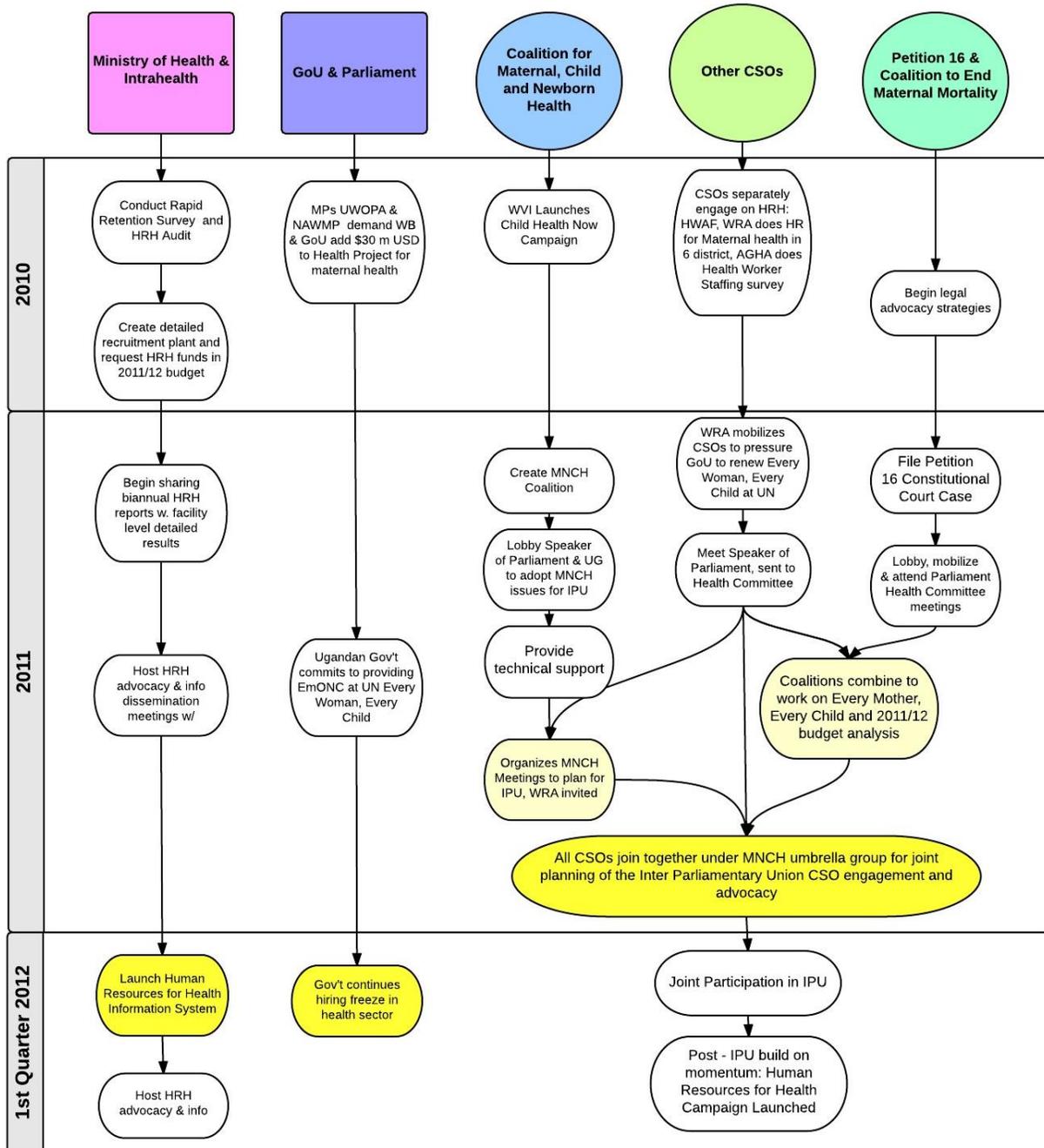
The 2012 HRH Campaign cannot be understood without understanding this context, so this section will examine the background on each of the core groups of stakeholders.<sup>27</sup> A summary of this section is graphically depicted in Figure 3. The critical moments that brought CSOs together are highlighted in yellow.

- a) Work being coordinated by the White Ribbon Alliance, Save the Children and a number of other CSOs to encourage the Government of Uganda to renew its commitments on maternal health under the “Every Mother, Every Child” campaign at the UN.
- b) World Vision International’s leadership to bring to coordinate CSO engagement on the 126<sup>th</sup> Inter-Parliamentary Union which was to be hosted by Uganda in early 2012 and which ultimately led to the formation of the Coalition on Maternal, Child and Newborn Health.

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<sup>27</sup> It should be noted that there were many other organizations and coalitions working on similar or related issues during this period, for example the Voices for Health Rights Coalition and the Health Workforce Advocacy Forum. These other stakeholders were ultimately brought into these events and participated under the auspices of Petition 16 or the Coalition for MNCH. There is an extremely high degree of overlap between coalitions in Uganda, which are frequently formed on the basis of a particular campaign and/or as the result of funding for particular campaign issues.

FIGURE 3. KEY MILESTONES THAT LED TO 2012 HUMAN RESOURCE FOR HEALTH CAMPAIGN



A number of organizations and agencies worked together to make the HRH Campaign a success. Several of the more central ones are detailed below.

#### THE MINISTRY OF HEALTH, INTRAHEALTH, AND THE DEVELOPMENT OF THE HUMAN RESOURCES FOR HEALTH INFORMATION SYSTEM (2007-2012)

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Since 2007 the Ugandan Ministry of Health has worked with the Uganda Capacity Program and the Uganda Capacity Plus Program to strengthen the information systems related to human resources in the health sector. These programs were financed by USAID and implemented by Intrahealth, an international NGO.<sup>28</sup> Through this partnership, the Ministry of Health began collecting detailed information on health worker staffing across the country. As capacity was built and the information system developed, the ministry began to produce bi-annual reports on HRH in Uganda. In 2010 and 2011 information on staffing in the health sector became more widely available and the ministry started to engage with CSOs and MPs.<sup>29</sup> Data produced by this initiative at district and national level has made possible evidence-based advocacy and highlighted the crisis in health sector staffing.

During this same period the Ministry of Health made a number of attempts to secure additional resources in the annual budget development process in order to recruit more staff in the health sector. These efforts did not meet with success. In 2009 when the ministry made the request, it was told that the funds had not been approved because no recruitment plan was attached to the ministry's budget. One ministry official called this a "cover up" rationale, since the resources would not have been granted in any case. In 2010 and 2011 the Ministry of Health created comprehensive recruitment plans, but again didn't receive any additional resources to fill the identified human resource gaps.<sup>30</sup> Each year the ministry would go through a national planning process, identify vacancies, undertake recruitment planning, and advocate for the budget, only to be told that "roads and electricity" are the priorities.<sup>31</sup> In 2012, 42 percent of health worker positions were still vacant yet the Ministry of Public Service confirmed an ongoing freeze on staff recruitment in all public services due to insufficient funds.<sup>32</sup>

In February 2012 the Ministry of Health and USAID/Uganda jointly launched the country's Human Resources for Health Information System (HRHIS). The ministry made a commitment to increase transparency and accountability in the health system.<sup>33</sup> The new information system is an electronic system that captures detailed information on health workers, location, staffing, vacancies, and annual human resources.<sup>34</sup> Information that can be used by the ministry for projections for budget purposes can easily be extracted and analyzed. HRHIS can be accessed from the Ministry of Health headquarters;

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<sup>28</sup> International NGO, November 14, 2014.

<sup>29</sup> Ibid.

<sup>30</sup> Ibid.

<sup>31</sup> Ibid.

<sup>32</sup> "Using Data to Successfully Advocate for Health Workforce Funding," CapacityPlus, November 2014, available at: <http://www.capacityplus.org/using-data-to-successfully-advocate-for-health-workforce-funding>.

<sup>33</sup> "Uganda Launches National Human Resources for Health Information System," *Intra Health International*, n.d., available at: <http://www.intrahealth.org/page/uganda-launches-national-human-resources-for-health-information-system>

<sup>34</sup> "Using Data to Successfully Advocate for Health Workforce Funding," CapacityPlus.

all four health professional councils (the Uganda Medical and Dental Practitioners Council, Uganda Nurses and Midwives Council, the Pharmacy Council, and the Allied Health Professionals' Council); Mulago and Butabika national referral hospitals; the 13 regional referral hospitals; and 69 local government districts.<sup>35</sup>

This HRHIS data would later prove critical to the ministry and civil society in their advocacy efforts. CSOs had previously done piecemeal research on health worker staffing but lacked the capacity to gather detailed information at the national level.<sup>36</sup> In 2011 when the more detailed data became available with analysis down to the district level, CSOs and the Ministry of Health were able to use this information to advocate for additional budget allocations to address the HRH staffing gaps. MPs looking at reports could see obvious health workforce disparities within and between districts. According to one official at the ministry, the vacancies were “so glaring” that you couldn’t expect health centers to even be functional.<sup>37</sup> According to Intrahealth, “As evidence became more and more available over the years and the human resource information system was maturing, we had more data, we informed policy makers, and that motivated action.”<sup>38</sup>

#### PETITION 16 AND THE COALITION TO STOP MATERNAL MORTALITY

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The Center for Health, Human Rights, and Development (CEHURD) was founded in 2007 as a research and advocacy organization focused on the enforcement of human rights and the justiciability of the right to health in Eastern Africa.<sup>39</sup> Much of CEHURD’s expertise and area of focus is on legal advocacy in Uganda. One of their more prominent initiatives was the filing of Constitutional Petition No. 16 of 2011, colloquially referred to as “Petition 16.” This petition argues that, by not providing pregnant women with adequate health care, the government of Uganda has violated the constitutional rights of women.

Through this petition, CEHURD urged the court to declare that government failure to provide essential maternal health commodities to health facilities, and the unethical behavior of medical personnel that led to the death of expectant mothers, infringed on women’s rights to life and health. The petition charged that “The omission by government and commission by government’s agents are to blame for the rampant avoidable high maternal and infant mortality.”<sup>40</sup> Areas of government neglect raised in this petition included the non-provision of the basic health package, inadequate human resources for maternal health, stockouts of essential medicines, and inadequate financial resources and capital

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<sup>35</sup> “Bringing Health Workforce Information to the Public in Uganda,” Vital Blog - IntraHealth International, November 25, 2014, available at: <http://www.intrahealth.org/blog/bringing-health-workforce-information-public-uganda>

<sup>36</sup> Focus Group Discussion, Action Group for Health, Human Rights and HIV/Aids, November 5, 2014; and Civil Society Organization, November 6, 2014.

<sup>37</sup> Comments by an official, Ministry of Health, November 2014.

<sup>38</sup> International NGO, November 14, 2014.

<sup>39</sup> “Objectives,” CEHURD, December 6, 2014, available at: <http://www.cehurd.org/about/objectives/>

<sup>40</sup> Centre for Health, Human Rights and Development (CEHURD), “The Import of Constitutional Petition No.16 of 2011,” October 2011.

investment. These omissions have resulted in the public sector being unable to meet the requirements of universal health care access.<sup>41</sup>

Although the campaign in support of Petition 16 was focused on legal advocacy, the organizers realized that they also needed to mobilize the public to support the case and to pursue other channels for advocating maternal health. In partnership and collaboration with Health GAP, an AIDS and human rights activist organization with staff based in the Uganda, Kenya, and the US, CEHURD formed an alliance called the “Coalition to Stop Maternal Mortality.”<sup>42</sup> This coalition brought together 29 CSOs, many of which participated in one or more of the other coalitions working on similar issues.<sup>43</sup> One way that they began organizing the coalition was through the creation of a Google Group to coordinate planning and share updates and key messages. For example, a small working group might meet to decide on an action to be taken, such as a demonstration at the court, and would then communicate the details through the Google Group on what should be worn, who should be mobilized, and what the talking points should be.<sup>44</sup>

Some of the key messages used for advocacy by this group included a focus on “16 deaths daily,” based on UN statistics for maternal mortality in Uganda that show that on average 16 women die every day during childbirth.<sup>45</sup> As Petition 16 was gaining momentum, the Ugandan government purchased fighter jets for \$760 million U.S. dollars, a figure that was double the entire health budget for the year.<sup>46</sup> This issue was picked up by the coalition and communicated widely through the press.<sup>47</sup>

In March 2012 five months after it was filed, Petition 16 had still not been heard in court.<sup>48</sup> At



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<sup>41</sup> Ibid.

<sup>42</sup> Civil Society Organization, November 10, 2014.

<sup>43</sup> Coalition membership includes the Coalition for Maternal, Child, and Newborn Health; Voices for Health Rights; the Coalition to Stop Maternal Mortality; and the Uganda Coalition for Access to Essential Medicines. Many CSOs also participate in other coalitions, such as the White Ribbon Alliance, Health Workforce Advocacy Forum, etc.

<sup>44</sup> Civil Society Organization, November 13, 2014.

<sup>45</sup> Parliament of the Republic of Uganda, “Motion for a Resolution of Parliament Urging Government to Institute Measures to Address Maternal Mortality and Other Matters Incidental Thereto,” December 15, 2011; and “Activists Take Maternal Deaths Fight to Court,” available at: <http://www.monitor.co.ug/SpecialReports/-/688342/1178228/-/view/printVersion/-/k3ghxf/-/index.html>

<sup>46</sup> “allAfrica.com: Uganda: Health Budget Increased, But..”

<sup>47</sup> Civil Society Organization, November 11, 2014; and “UGANDA: Maternal Deaths Against Constitutional Rights,” Inter Press Service, December 6, 2014, available at: <http://www.ipsnews.net/2011/07/uganda-maternal-deaths-against-constitutional-rights/>

<sup>48</sup> “Uganda’s Maternal Petition Case Still Not Heard Five Months on; Key Correspondents, December 6, 2014, available at: <http://www.keycorrespondents.org/2012/03/15/ugandas-maternal-petition-case-still-not-heard-five-months-on/>

times the coalition encouraged the public to come to the court, on one occasion mobilizing close to one thousand three hundred people.<sup>49</sup>

This strategic litigation provided an opportunity for civil society to challenge the low priority accorded by government to the health rights of pregnant women. The court case provided an important mobilizing focus for NGO leaders and grassroots organizers, who saw to it that the courtroom was packed for every hearing, provided briefings for the media, and lobbied key members of parliament. The coalition put pressure on lawmakers and the administration to demonstrate their support for improving maternal mortality through increased allocations to the health sector budget. Coalition members considered the Petition 16 litigation action to be a means to an end, an important component of a multilayered campaign directed at parliament, the judiciary, and the executive.<sup>50</sup>

#### WHITE RIBBON ALLIANCE

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In 2011 the White Ribbon Alliance (WRA) Uganda recognized an opportunity to put pressure on the government to renew its commitments to maternal and child health. The Ugandan government was to attend the 66th session of the UN General Assembly, where additional commitments were being sought for governments and the private sector to join the UN's "Every Woman, Every Child" global campaign. The WRA wanted the Ugandan government to renew its dedication to the UN MDGs 4 and 5 on maternal and child health and to accelerate progress toward achieving those goals.<sup>51</sup> WRA and the CSO Save the Children convened a meeting of a wide range of stakeholders to strategize on how to lobby the Ugandan government on this issue in preparation for the UN General Assembly session. Some current and past MPs were keen to get involved as they were personally committed to the issue of maternal health and were already members of the White Ribbon Alliance. Many women MPs were already active on the issue of maternal health, particularly through the Uganda Women's Parliamentary Association and the Network of African Women Parliamentarians Uganda branch.<sup>52,53</sup>

One initiative taken by an MP proved to be very important for the WRA. The Honorable Sarah Nyombi requested a meeting with the speaker of parliament. At the meeting, the speaker suggested that they also meet with the Parliamentary Social Services Committee (later to become the Committee on Health)

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<sup>49</sup> Civil Society Organization, November 14, 2014; and "Health Workers on Silent Strike," *The Observer*, December 21, 2014, available at: [http://www.observer.ug/index.php?option=com\\_content&view=article&id=20820:-health-workers-on-silent-strike](http://www.observer.ug/index.php?option=com_content&view=article&id=20820:-health-workers-on-silent-strike)

<sup>50</sup> Civil Society Organization, November 11, 2014.

<sup>51</sup> Under MDGs 4 and 5, between 1990 and 2015, Uganda committed to reduce by two-thirds the mortality rate of children under 5; to reduce by three-fourths the maternal mortality rate; and to achieve universal access to reproductive health care. According to a 2013 report by UNDP, *Millennium Development Goals Report for Uganda*, the nation is on track to meet goal 4, but has not been making progress toward reducing maternal mortality and expanding access to reproductive health care.

<sup>52</sup> Member of Parliament, November 20, 2014.

<sup>53</sup> For example, in 2009 the World Bank and the Government of Uganda were preparing the Uganda Health System Strengthening project, a \$100 million USD project that was intended to be purely an infrastructure project for health as requested by the government. After the pre-appraisal was complete and the project preparation was nearly done, women MPs told the Ministry of Finance that, unless there were funds for maternal health in the project, they would not approve it in parliament. Thus, in early 2010, the World Bank committed an additional \$30 million U.S. dollars to the project to be used for family planning and basic equipment for emergency obstetric care for 230 health care facilities.

which was in the midst of the budget process.<sup>54</sup> This was the first time that WRA had attended the committee meetings, and it served as the basis for their engagement with key members of parliament, such as the Honorable Samuel Lyomoki (head of the Committee on Health). It was also at this meeting that Samuel Senfuka of WRA met Asia Russell of Health GAP which was actively working with CEHURD, Petition 16, and the Coalition to End Maternal Mortality.<sup>55</sup>

This chance encounter was the first meeting between the Coalition to Stop Maternal Mortality and WRA and proved critical to forging an alliance between these two movements. Together they convened a meeting to bring together stakeholders from the coalition for Petition 16, WRA, and other organizations that had been engaging the Ugandan government delegation to the UN General Assembly.<sup>56</sup> The work of this now larger collaborative effort among CSOs was successful in getting the Ugandan government to renew its commit to the UN's "Every Woman, Every Child" campaign. It pledged to ensure that Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services in hospitals would be increased from 70 percent to 100 percent, and from 17 percent to 50 percent in health centers III and IV, and that basic EmONC services would be available at all health centers. Additional commitments were made to ensure that skilled providers are available in hard-to-reach areas, and to improving family planning and the prevention of the transmission of AIDS to newborns.<sup>57</sup>

#### COLLABORATION BETWEEN PARLIAMENT'S SOCIAL SERVICES COMMITTEE AND CSOS

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Another important precursor to the HRH Campaign in 2012 emerged when the Social Services Committee suggested to CSOs that they not simply request more resources, but should also help to monitor and scrutinize budgets by analyzing the Ministerial Policy Statement.<sup>58</sup> After reviewing the Ministerial Policy Statement, the CSOs identified a number of key issues that should be prioritized in the health sector, in particular the areas of maternal health and human resources for health, and requested that the parliament allocate UGX 75 billion to "health worker recruitment and retention." On 31 August 2011 the CSOs shared talking points with the Social Services Committee,

##### **Key Talking Points from CSOs to Social Services Committee – Aug. 31, 2011**

- Uganda is facing a preventable tragedy of maternal deaths. Sixteen women die every day and 6,000 each year.
- Indicators of access to maternal health services have become worse. For example, attended deliveries declined from 40 percent in 2008 to 33 percent in 2010.
- Rural health centers are grossly understaffed.
- Reallocation of UGX 75 billion. "Specifically, this allocation would fund: a) an increase in allowances for skilled health workers including nurses, midwives, and clinical officers, and b) an increase in staffing norms to 65% of posts filled-through recruiting an additional 5,000 health workers to be posted in rural areas. "

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<sup>54</sup> Civil Society Organization, November 24, 2014.

<sup>55</sup> Ibid.

<sup>56</sup> Ibid.

<sup>57</sup> "Uganda Commitments," Every Woman, Every Child, October 27, 2014, available at: <http://www.everywomaneverychild.org/commitments/countries/uganda>

<sup>58</sup> Civil Society Organization, November 14, 2014.

identifying key issues of concern in the 2012/13 Policy Statement.<sup>59</sup>

According to one member of the CSO team, they did an extremely detailed analysis, reviewing line-by-line the Ministerial Policy Statement for Health. The team also made use of information gathered from their work with various technical working groups and policy committees at the Ministry of Health. CSOs that were linked to global bodies that provided funding to the Ministry of Health were also to provide information on the purpose of certain funds provided to the Ugandan government.<sup>60</sup> They examined various budget lines to see if they could find funds that could be reallocated to fill critical HRH shortages. The team was able to identify about UGX 5 billion that they argued highlighted inconsistencies in the budget and was not being used well. They proposed that these funds be reallocated to HRH.<sup>61</sup>

When the CSOs presented their findings to the Social Services Committee in parliament, the committee summoned the Permanent Secretary from the Ministry of Health to testify before parliament, and accused his agency of “eating money.”<sup>62</sup> These efforts resulted in UGX 5.57 billion being reallocated to “facilitate the recruitment and payment of critical staff in HCIVs.” This intervention is described as an “internal reallocation of funding” to support “about 400 graduate health workers and interns [who] have been directly posted to regional referral hospitals and other government health units. Discussions are under way to have the service absorb them under local governments’ payroll.”<sup>63</sup>

This funding reallocation was granted reluctantly by the Ministry of Health, which felt that it was under attack by CSOs. The ministry felt that CSOs were trying to “sabotage” the agency and that they had used their positions in working groups and committees to steal insider information which was then brought before parliament.<sup>64</sup> Although the reallocation of the UGX 5 billion was a small victory, the relationship with the Ministry of Health had been damaged. According to some CSOs, the ministry made an attempt to remove the CSO on the Health Policy Advisory Committee, and intervention was required from an international organization to prevent this.<sup>65</sup> CSOs also reported that individual members faced a backlash at a personal level and felt threatened.<sup>66</sup>

On the other hand, MPs, and particularly those on the Social Services Committee, appreciated the budget analysis work done by the CSOs. One member of the committee said that the CSOs had helped them to identify funds that were going to be eaten, therefore parliament viewed them positively.<sup>67</sup> The

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<sup>59</sup> “Talking Points to MPs During the Session,” August 31, 2011.

<sup>60</sup> Civil Society Organization, November 14, 2014.

<sup>61</sup> Civil Society Organization, November 11, 2014.

<sup>62</sup> Civil Society Organization, November 11, 2014.

<sup>63</sup> “Key Questions from Civil Society on the National Budget Framework Paper for the Health Sector FY 2012/2013.” To find the document, Google the title.

<sup>64</sup> Civil Society Organization, November 14, 2014.

<sup>65</sup> Ibid.; and Civil Society Organization, November 11, 2014.

<sup>66</sup> Civil Society Organization, November 14, 2014.

<sup>67</sup> Member of Parliament, November 17, 2014.

technical support given by international and national CSOs to MPs strengthened their partnership which proved to be important in the HRH Campaign in 2011.

Having received a reallocation of only 5 billion UGX in the budget preparation cycle, the CSO alliance continued to lobby MPs to pass a resolution in parliament on the issue of maternal health. CSOs held meetings with a selection of MPs and the Committee on Health to draft a motion on maternal mortality.<sup>68</sup> The Honorable Bakireke Namboze presented this motion to parliament on 29 November 2011. The Social Services Committee investigated the matter by consulting with CSOs and technical experts at the Makerere University School of Public Health and prepared a report presenting the findings. CEHURD, White Ribbon Alliance, Health GAP, and other CSOs drafted the resolution and worked extensively on getting support for it from political parties and from the media. The committee presented the report to parliament in December 2011, documenting key challenges in the health sector and recommending a number of resolutions be passed to address these issues. In the same month parliament passed the resolution, which requested the government to enforce maternal death audits, take action on established causes of maternal deaths, develop a compensation plan for families of women who die of maternity-related causes at government facilities, allocate 15 percent of the budget to health as per the Abuja Declaration, and address the critical shortage of medical professionals, in particular by expanding recruitment of midwives by 5,000 by the year 2015.<sup>69</sup>

#### WORLD VISION AND THE IPU

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Alongside the work of Petition 16 and other coalitions of CSOs, World Vision, a Christian organization devoted to improving the health of the poor (and particularly children) was also hard at work.

In 2011 the Inter-Parliamentary Union (IPU) decided that Uganda should host its 2012 meeting. The IPU was established in 1889 and is the international organization of parliaments. Every year, one or two IPU assemblies or conferences are held, bringing together parliamentarians from member states to study international problems and make recommendations for action.<sup>70</sup> The IPU Uganda meeting brought together over 1,500 members and their staffs from all over the world. World Vision encouraged Ugandan CSOs to establish a national coalition to engage with the IPU and advocate that reproductive and maternal health issues be taken up at the 2012 IPU meeting.<sup>71</sup>

World Vision invited the national coordinator of White Ribbon Alliance to attend planning meetings. Samuel Senfuka from WRA attended one of the meetings. Mr. Senfuka was a leading figure in the coalition that put pressure on the Ugandan government to renew its commitments to the UN MDGs. He had also begun collaborating with the Coalition to Stop Maternal Mortality on budget analysis with the Parliamentary Committee on Social Services. This was the critical juncture in building a national alliance around the issue of maternal health, bringing together the Coalition on Maternal, Newborn, and Child

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<sup>68</sup> Civil Society Organization, November 11, 2014.

<sup>69</sup> Parliament of the Republic of Uganda, "Motion for a Resolution of Parliament Urging Government to Institute Measures to Address Maternal Mortality and Other Matters Incidental Thereto," December 15, 2011.

<sup>70</sup> "What Is the IPU?" December 6, 2014, available at: <http://www.ipu.org/english/whatipu.htm>

<sup>71</sup> Civil Society Organization, November 24, 2014.

Health, WRA, and the Coalition to End Maternal Mortality. Towards the end of 2011, all the CSOs came together for the common purpose of lobbying at the IPU Uganda meeting in March 2012.

In preparation for the meeting the CSOs developed a common platform. The coalition benefited from the now close working relationships that were held with the speaker of parliament who helped to ensure that maternal health was high on the agenda at IPU.<sup>72</sup> The event itself was well attended by members of the Ugandan Parliament, and it served as an important opportunity for the CSOs to engage with MPs and to raise their concerns relating to maternal, newborn, and child health, and begin to ask for more resources for the health sector.<sup>73</sup> The CSOs were included on the program, presented petitions, participated in panel discussions, and were given slots at the conference as delegates. They organized breakfast meetings and press conferences to communicate their message.<sup>74</sup> One CSO member said that before IPU, “MPs did not see the power of investing resources in maternal, child, and newborn health. They thought that the government was investing enough. CSOs showed them that the budget process was not need-based, not participatory, not inclusive, and that what we were seeing was insufficient investment.”<sup>75</sup>

The 2012 IPU meeting was the first time that CSOs had pooled their resources, both monetary and non-monetary, in support of a collective agenda. They printed advocacy materials, posters and t-shirts.<sup>76</sup> The IPU meeting also attracted significant media attention on issues

#### Excerpts from IPU Resolution

##### **“Access to Health as a Basic Right: The Role of Parliamentarians in Addressing Key Challenges to Securing the Health of Women and Children”**

1. *Calls upon* all parliamentarians, both men and women, and the IPU, to take all possible measures to generate and sustain the political will as well as the appropriate resources needed to achieve the MDGs by 2015, and to put in place the policies and commitments needed for the post-2015 period;
2. *Encourages* parliamentarians to collaborate and build partnerships with relevant stakeholders to achieve the health-related MDGs, working closely with governments, civil society, local communities, health care professionals, academics and research institutions, multilateral organizations, global funds and foundations, the media and the private sector;
12. *Calls upon* parliaments to use the oversight and accountability tools at their disposal throughout the budgetary process, as well as innovative financing approaches, to ensure that adequate domestic financial resources are allocated for sexual, reproductive, maternal, newborn and child health, and for achieving MDGs 4, 5 and 6 at the national level;
13. *Requests* parliaments to ensure that the domestic funds and aid allocated to women’s and children’s health are released and used for the relevant programs;
19. *Further encourages* parliamentarians to advocate for increasing the number of midwives, assistance with the recruitment, training and support of professional midwives, and the provision of accommodation for mothers, near or in the hospital if necessary, before their delivery, in order to gain access to professional and monitored delivery;

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<sup>72</sup> Ibid.

<sup>73</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 4, 2014.

<sup>74</sup> Ibid.

<sup>75</sup> Ibid.

<sup>76</sup> Ibid.

related to maternal mortality, which made these an increasingly prominent item on the Ugandan political agenda.

Due to their close work with the rapporteur appointed to report on the proceedings of the IPU meeting, a member of the Ugandan parliament with whom they had worked before, the CSOs were actively involved in writing the IPU Resolution. “Access to Health as a Basic Right: The Role of Parliamentarians in Addressing Key Challenges to Securing the Health of Women and Children,” was passed in April 2012. The final resolution incorporated most of the Ugandan CSOs’ suggestions.<sup>77</sup>

The IPU meeting was a critical juncture in 2012. It served as an opportunity for parliamentarians to find their voice on the issue of maternal mortality. Through the final resolution, they made additional policy commitments on this issue. The IPU also brought CSOs together, enabling them to build on their previous work on issues such as Petition 16, and giving them “a united voice and helping to galvanize and strengthen efforts.”<sup>78</sup> They were able to publicize the issues of maternal health and increase their profile in the public arena, heightening its political importance.<sup>79</sup>

Furthermore, the IPU meeting strengthened the relationship of the CSOs with parliament. The Hon. Sylvia Namabidde suggested that CSOs could support MPs by providing research and analytical support, needs assessments, and solid evidence; and by engaging the media and supporting information exchange among MPs.<sup>80</sup> The Hon. Lulume Bayiga specifically said that CSOs need to raise attention on the need for additional health budget resources in Uganda, since the government isn’t following through with financial commitments, and the president doesn’t understand the importance of issues of maternal, newborn and child health.<sup>81</sup>

## PLANNING FOR THE HRH CAMPAIGN

### KEY CAMPAIGN STRATEGIES

In the years leading up to the HRH Campaign in 2012, CSOs’ involved in individual and cooperative advocacy work related to government funding for maternal health in Uganda had a wide range of valuable campaign experience. Alongside the range of tactics they employed, their experience of collaboration, and their strategic partnerships with MPs and government authorities provided a solid foundation from which to challenge the Ugandan government on budget choices. CSOs’ were able to make use of this rich experience and apply lessons learned in their 2012 HRH budget campaign. It is useful to outline some elements of experience that the HRH Campaign could draw on.

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<sup>77</sup> Civil Society Organization, November 24, 2014.

<sup>78</sup> *Report on CSOs-IPU Side Events and Maternal Health Panel Discussion Held on 3rd April 2012 at Parliament of Uganda Conference Hall.*

<sup>79</sup> Uganda National Health Consumers’ Organization (UNHCO), “Advocacy Achievements.”

<sup>80</sup> White Ribbon Alliance, “Report on CSOs-IPU Side Events and Maternal Health Panel Discussion Held on 3rd April 2012 at Parliament of Uganda Conference Hall,” Kampala, Uganda, April 2012.

<sup>81</sup> Ibid.

## COLLECTIVE ACTION

The CSOs found that working together on a common platform for the IPU meetings, budget advocacy work, and Petition 16 enabled them to be much more effective. In practice this meant allowing individual CSOs to take the lead in areas where they had specific technical expertise, for example, CEHURD in their legal advocacy work; AGHA and Health GAP in their budget analysis, technical analysis of the HRH crisis, media outreach, grassroots mobilization, and policy advocacy; and WRA Uganda on issues of maternal health. At the same time, the campaigns were coordinated to share specific goals and demands of government that related to all the CSOs. Working as a coalition also mitigated the risks for individuals and individual CSOs, particularly with regard to any backlash, political pressure, or targeting of individual staff members. This was a strategic decision in response to personal attacks by ministry officials on members of CSOs in 2011 after they successfully challenged government on wasting funds that could be allocated to human resources for health services. Working as a coalition allowed CSOs to “protect the frontline” from retaliation.<sup>82</sup>

## DIVERSIFYING TACTICS

Bringing all the CSOs together resulted in a shared objective carrying a joint message. But the campaign work was pursued through a range of tactics, including budget analysis, legal action, text messaging, media engagement, lobbying, petitions, and other means of advocacy.

## POOLED RESOURCES

In taking collective action, the CSOs were able to access additional resources for their coalition work. For example, resources in the hands of the Coalition for Maternal, Child, and Newborn Health became available to the wider alliance, and CSOs were able to pool their individual resources to magnify the impact of individual CSO budgets.

## WIN-WIN COLLABORATION WITH THE MINISTRY OF HEALTH

Given the challenges the CSOs experienced when directly facing off against the Ministry of Health, CSOs specifically sought to engage the Ministry of Health in a win-win collaboration in 2012. This was viewed as an inside-outside strategy and was critical to the success of their 2012 work.<sup>83</sup> The CSOs also engaged the ministry through the Technical Working Groups (TWGs), including the Human Resources TWG, Budget TWG, and Maternal Health TWG.

## CLOSER RELATIONSHIPS WITH PARLIAMENT

The advocacy work of the CSOs benefited considerably when they were able to work with parliament through the Committee on Social Services (later the Committee on Health) and by developing collaborative relationships with allies in parliament. They contributed to the work of MPs by providing valuable technical and analytical support to the Committee on Health. In particular they provided

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<sup>82</sup> Civil Society Organization, November 11, 2014.

<sup>83</sup> Ibid.

supporting analysis of the budget and the Ministerial Policy Statement and gave key inputs to MPs who lack time and resources to carry out this work.

#### “BITING APPROACH”

The CSOs also changed their advocacy efforts from what they referred to as a “gentleman’s approach” to a “biting approach.” They become more direct and forceful in their campaign tactics in their 2012 campaign work. This also helped to improve the clarity of their campaign messages in ways that resonated with the public, and made it nearly impossible for the public, the media, and MPs to ignore the campaign.

#### CAMPAIGN PLANNING

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Following the successes and challenges in parliament, in the judiciary, and at the IPU in 2011 and early 2012, CSOs came together in early 2012 to strategize on the way forward. A meeting was convened by the Coalition for Maternal, Child, and Newborn Health and attended by other CSO stakeholders such as the White Ribbon Alliance and the Coalition to Stop Maternal Mortality.

At the initial planning meeting, CSOs discussed whether they should join forces as one coalition or remain separate. They decided that they would remain independent but signed a memorandum of understanding and created a joint steering committee in May 2012.<sup>84</sup> One of the reasons that the coalitions stayed separate was that they held different opinions on some reproductive health issues, particularly the issue of abortion. Some CSOs advocated providing access to abortion in Uganda, but others, particularly religious organizations, were not interested in supporting this cause.<sup>85</sup>

The memorandum of understanding specified that the coalition work should draw on the comparative strengths and advantages of its members, and that the loose coalition that had been formed for the IPU meeting would have a “good opportunity to follow-up on the resolutions from the meeting.”<sup>86</sup> The CSOs, now working officially as a collective, were awarded a \$20,000 grant through the MNCH, which they planned to use to gather evidence for budget advocacy, strengthen the coalition and build the capacity of its member CSOs, and engage in policy advocacy. Small working groups were created to focus on each of these areas, with the WRA taking the lead on evidence for budget advocacy, AGHA and HealthGAP on policy engagement, and CEHURD on strengthening the coalition. In addition to grant funds received by the coalitions, the CSOs agreed that they would pool their own resources in order to improve their chances of achieving their joint goals.<sup>87</sup>

Building on lessons from their engagement with the IPU meeting, the CSOs agreed that they would work as a collective, but that if one organization had a particular expertise or comparative advantage that

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<sup>84</sup> Civil Society Organization, November 24, 2014.

<sup>85</sup> Civil Society Organization, November 10, 2014.

<sup>86</sup> “Memorandum of Understanding. Civil Society Coalition on Maternal, Newborn and Child Health.”

<sup>87</sup> Civil Society Organization, November 24, 2014.

organization would be the spokesperson for that specific issue and would take the lead with the support of the other partners.<sup>88, 89</sup>

### CAMPAIGN OBJECTIVES

The CSOs agreed that the core focus of the campaign work for the 2012-2013 budget should be on the recruitment, motivation, and retention of health workers. Specifically, the CSOs were requesting UGX 260 billion for the recruitment and skills development of health care workers.<sup>90</sup> That figure was supposed to cover increases in salaries for critical groups of workers, and for the recruitment of health workers so as to increase staffing from 58 to 70 percent.<sup>91</sup>

### ACCESS TO DATA

One condition that was required to get this campaign off the ground was publicizing detailed staffing data. To make an impact the information had to be analyzed and interpreted, and it had to be politicized in such a way that it would get the attention of the general public and of politicians.

As was described above, the Ministry of Health, with support from Intrahealth and the Uganda Capacity Program, had developed a new health information system that provided access to detailed health staffing data. The ministry had tried to get additional resources for health staffing for a few years but had failed. In 2012, the ministry decided to use data to sensitize stakeholders about the problems. The extent of understaffing was “so glaring” that the health centers could not be expected to be operational. CSOs picked up this information and used it. “We owe them [the CSOs] a lot of credit. As a civil servant you can’t be so aggressive. The government may not understand,” said one Ministry of Health official. CSOs can challenge the government about why there is money for defense but not for health care. The data gathered were very detailed, all the way down to the district and facility level, and allowed the ministry and the CSOs to do costing of their staffing and remuneration proposals.<sup>92</sup> This detail information was important for the success of the campaign.

### STAKEHOLDERS

The stakeholders in this campaign included a broad cross-section of Ugandan society. On one side, advocating for additional HRH resources were the CSOs which were engaged in advocacy, lobbying, budget analysis, and grassroots engagement; citizens who participated in the campaign by contacting their MPs, attending events, and protesting; Intrahealth, the Uganda Capacity Program, and the Ministry of Health that generated detailed data on the human resources for health crisis, prioritized this issue in their Ministerial Policy Statement, and worked with CSOs as allies in 2012; and allied members of parliament. In the middle stood the media, providing detailed coverage of HRH budget debates, CSO activities, and the maternal health situation in Uganda, thus pressuring the government. On the other

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<sup>88</sup> International NGO, November 10, 2014.

<sup>89</sup> Civil Society Organization, November 24, 2014.

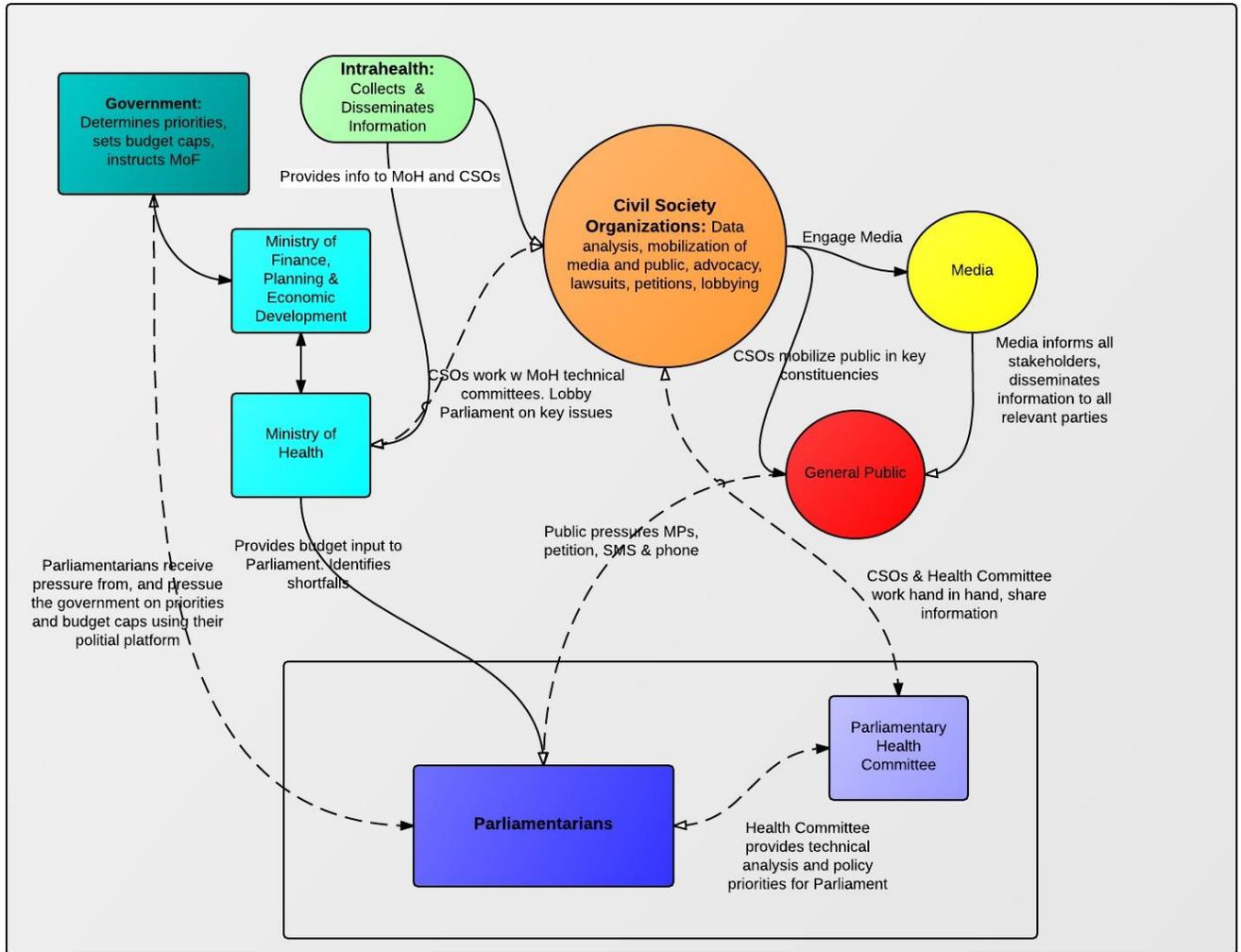
<sup>90</sup> *Parliament of Uganda, eNewsletter*, available at: <http://www.parliament.go.ug/enewsletter/index.php/home>.

<sup>91</sup> Civil Society Organization, November 14, 2014.

<sup>92</sup> Civil Society Organization, November 24, 2014.

side were the Ugandan government, in particular the cabinet, the president and his National Resistance Movement (NRM) political party, and the Ministry of Finance, Planning, and Economic Development; members of parliament who followed the party line; and most members of the Budget Committee. Figure 4 below outlines the relationships between these stakeholders and their roles in the HRH Campaign.

FIGURE 4. CAMPAIGN STAKEHOLDERS



## IMPLEMENTING THE HRH CAMPAIGN

### A CHRONOLOGY OF THE MAJOR EVENTS IN THE CAMPAIGN

#### MAY 2012

In May 2012 AGHA released a statement on the budget framework for the fiscal year (FY) 2012/2013. The press statement recognized that there had been some positive developments in Uganda's health

sector, such as the recruitment of 1,000 health workers and a reduction from 20 to 12 days per month in stockout of essential medicines, but it also noted that there had been an overall reduction in the national health budget from 8 percent to 5 percent, which was far from the Abuja declaration target of 15 percent which government had committed itself to fulfill.<sup>93</sup>

On 22 May CEHURD and the Coalition to Stop Maternal Mortality organized a press conference and held a peaceful march to the constitutional court to protest the delayed actions on Petition 16, and the draft 2012/2013 health budget, which, they argued, is a “reduction compared to last year... and does not prioritize the urgent need to end preventable maternal deaths.”<sup>94</sup>

#### JUNE 2012

In June 2012 the court ruled on Petition 16. The court ruled the petition should be dismissed because the constitutional court has no competence to address the crisis of preventable maternal mortality. CEHURD filed an appeal on 11 June in the Uganda Supreme Court.<sup>95</sup>

The Minister of Finance, Planning, and Economic Development presented a budget speech to parliament on 15 June each year. Parliament’s Committee on Social Services asked CSOs to analyze the health sector budget. The CSOs reviewed the budget framework papers and budget documents and looked for wasted allocations so that they could propose the redirection of funds to increase the resources for health financing.<sup>96</sup>

#### JULY 2012

In early July AGHA issued a statement calling on the national government to account for stolen funds from Global Fund allocations for FYs 2009/2010 and 2010/2011. This followed a report in *The Daily Monitor* newspaper of 2 July 2012 that the auditor general had unearthed inaccurate accounts and exaggerated expenditures by staff members in the Ministry of Health worth UGX 78 billion.<sup>97</sup>

In the same month the Committee on Social Services was separated into specialized committees to focus on key issues. It was at this time that the Committee on Health was officially created under the

#### **CSO Talking Points from Coalition to Stop Maternal Mortality for the May 22<sup>nd</sup> Protest**

But where will the money come from? We know Uganda can find these resources—for example, already UGX 377 billion has been spent on VIP health care abroad for government officials, while poor people are suffering. If UGX 377 billion were invested in the people, it would be enough to hire the thousands of additional health workers and to increase the pay of all health workers, with enough left double the national budget for essential medicines.

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<sup>93</sup> Action Group for Health Human Rights and HIV/AIDS, “Report for Health Policy Action Fund and Oxfam,” October 2010.

<sup>94</sup> CEHURD, “Talking Points: Peaceful March to Constitutional Court on May 22,” May 2012.

<sup>95</sup> Uganda National Health Consumers’ Organization (UNHCO), “Advocacy Achievements,” n.d.

<sup>96</sup> Civil Society Organization, November 14, 2014.

<sup>97</sup> Action Group for Health Human Rights and HIV/AIDS, “Report for Health Policy Action Fund and Oxfam,” October 2010.

leadership of the Honorable Dr. Samuel Lyomoki. This committee was able to focus exclusively on health issues and make strategic recommendations.

CSOs presented their analysis of the national budget framework paper for the health sector for FY 2012/2013 to the new Committee on Health, identifying key issues and questions that they thought the committee should raise with the Ministry of Health.<sup>98</sup> The issues included the critical shortage of health workers, on which the proposed budget took no new action, and the shortfall in budget for motivation and retention of health workers. AGHA prepared a budget analysis and CSO position paper for the committee. This paper outlined the resources required for the recruitment and remuneration of health workers.<sup>99</sup>

#### AUGUST 2012

In August 2012 the Committee on Health submitted a report on the Ministerial Policy Statement for the Health Sector to the Ugandan parliament. This report brought up many of the issues that had been raised by the CSOs. The report argued clearly that the dearth of human resources for health constituted a crisis, and that the government had ignored repeated recommendations. It urged parliament to take block the entire budget for FY 2012/2013 until additional resources were allocated to fill the HRH gap.<sup>100</sup>

#### Excerpt from Committee on Health Report

“the Committee has come to the conclusion that there is a crisis in the area of human resource for health. The Committee is convinced that the major challenges within the health sector revolve around poor remuneration and inadequate motivation of the health workers....Parliament has for now a longtime consistently recommended for strategies to address this most important binding constraint to the achievement of health goals. However, these recommendations seem to have largely been consistently ignored...Specifically in response to the escalating human resources for health crisis, the Committee (previously the Social Services Committee) has previously and consistently recommended that a motivation package be availed to the health workers. For example, in May 2012, after examining the preliminary budget estimates for the Health Sector, the Committee recommended that UGX 260 Billion be availed this FY to enhance the consolidated allowances of the health workers. However, this recommendation was not adopted by the Government, as the recurrent budget for the health sector was not increased in line with the said recommendation. ***The Committee strongly urges Parliament to address the human resource for health crisis by appropriating extra UGX 260 Billion to enhance the consolidated allowances for the health workers. To enforce the implementation of this recommendation the Committee proposes that passing of the sector budget and indeed the entire budget be deferred [SIC] until this matter is addressed.***”

On 29 August the parliament adopted the report of the Committee on Health and directed the government to provide an additional UGX 260 billion to recruit people for the health sector and to

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<sup>98</sup> “Key Questions from Civil Society on the National Budget Framework Paper for the Health Sector, FY 2012/2013,” n.d.

<sup>99</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 4, 2014.

<sup>100</sup> *Report of the Parliamentary Committee on Health on the Ministerial Policy Statement for the Health Sector for the Financial Year 2012/2013*, Social Service Committee, December 2011.

enhance their salaries. The proposal was supported in parliament despite protests by Prime Minister Amama Mbabazi.<sup>101</sup> This report tied the hands of parliament, since once the report and the recommendations on human resources for health were adopted, it became the official position of parliament and could not be superseded until a subsequent year.

## SEPTEMBER 2012

In early September health workers went on a “go slow” strike, demanding that government improve their pay and working conditions. The Uganda National Health Consumers’ Organization (UNHCO) organized a press conference and the Hon. Dr. Lyomoki, chair of the Committee on Health, spoke of the dangers of uncommitted health workers and the need for additional government funds for the health budget.<sup>102</sup>

On 10 September UNHCO addressed a letter to parliament expressing support for the committees and members who were pushing for budgetary allocations for human resources for health. This letter also invited members of parliament to join a CSO breakfast meeting on 13 September. Later that day, the health care debate dominated parliamentary proceedings. The prime minister rejected a proposal to cut funds from other ministries, departments, and agencies, including the Defence Ministry, the Bureau of Statistics, and the Electoral Commission, for the sake of the health budget.<sup>103</sup>

On the following day CSOs presented a petition to parliament to address the health worker crisis. This petition supported the MPs who were demanding UGX 260 billion for human resources for health. It specifically requested the speaker not to limit discussions to the committee but to involve the floor, and it asked her to clearly state the need for a minimum UGX 260 billion.<sup>104</sup>

On 17 September, in the midst of the budget controversy, the president held an NRM caucus called “budgeting for self-sustaining economic growth, social transformation, and services delivery” at the state house. This was one of a number of executive caucuses and actions aimed at influencing MPs and swaying their votes. In that meeting the president protested the method of trying to block the budget and said that “last minute approaches” were wrong and would cause more problems for the country. The MPs agreed not to push ahead with cutting funds and reallocating them to the Ministry of Health.<sup>105</sup>

The president requested that the Ministry of Finance review the proposal put together for UGX 260 billion. The Ministry of Finance did so and came back to parliament with the offer of UGX 39 billion, but this was rejected by MPs and CSOs as insufficient.

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<sup>101</sup> “Parliament Directs Govt. to Provide UGX 260bn In Health Budget,” Uganda Radio Network, available at: <http://ugandaradionetwork.com/a/story.php?s=45051>

<sup>102</sup> “Health Workers on Silent Strike,” *The Observer*, September 6, 2012.

<sup>103</sup> “Find Shs260b for Health or We Block Budget, Say MPs,” November 20, 2014, available at: <http://www.monitor.co.ug/News/National/Find-Shs260b-for-health-or-we-block-budget--say-MPs/-/688334/1506636/-/cajrd/-/index.html>

<sup>104</sup> CSOs, “Civil Society Petition, Speaker of Parliament: Urgent Attention to Address the Health Worker Crisis in Uganda,” September 14, 2012.

<sup>105</sup> “Health Budget: Museveni Blasts NRM MPs at State House,” November 20, 2014, available at: <http://chimpreports.com/5981-health-budget-museveni-blasts-nrm-mps-at-state-house/>

On 18 September the media reported that the CSOs planned to “storm” parliament to exert pressure on MPs to block the budget until they had managed to secure the requested UGX 260 billion for health sector staffing.<sup>106</sup> The CSOs simultaneously hosted breakfast and press meetings before parliament sessions. They received information from MPs that the government was “trying hard to counter our actions by pushing for the budget to be passed, and even scrapping of the proposed 39 billion.” However, MPs indicated that they would continue to support the CSO campaign.<sup>107</sup>

On the following day the CSOs met with MPs where they agreed on strategies to continue to block the budget.<sup>108</sup> The Honorable Dr. Twa Twa presented a petition on the budget allocation for the Ministry of Health on behalf of CSOs. The petition reiterated the need to allocate UGX 260 billion to human resources for health, and argued for the prioritization of the recruitment of midwives. The petition requested that the Committee on the Budget and the Committee on Health collaborate to achieve this goal.

The president called a meeting with the vice president, speaker of parliament, the minister of health, and the chair of the Budget Committee, to try to resolve the budget crisis. He reportedly endorsed “building the production line” before “spending on consumables.” He and the chair of the Budget Committee agreed on this point, and the others were left in disagreement on budget priorities. The Ministry of Health was directed to work with the Budget Committee and the Ministry of Finance, Policy, and Economic Development to reach accord on the budget for 2012/2013.

In the days that followed, the NRM held caucus meetings in an attempt to bring party members together on the budget issues. The prime minister advocated that MPs not try to block the budget and the president and encouraged them to focus spending on the “productive” sectors and argued that “social services consume, but do not generate.” According to a newspaper report, the MPs at the caucus agreed in principle that more funds needed to be allocated to the health sector, but could not agree where this money could come from within the budget.<sup>109</sup>

The president urged MPs from his party not to stick to the budget request of UGX 260 billion.<sup>110</sup> Prime Minister Mbabazi addressed parliament on 25 September, stating that the executive and the Budget Committee had met and proposed an additional UGX 49.5 billion be allocated to the health budget. “We all agreed on the urgent need to improve the health care in the country,” he said, “therefore, we shall now address the human resource challenges so as to have a properly functioning system.”<sup>111</sup> The additional allocation to health required cuts to many ministries and government bodies. The money

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<sup>106</sup> Yasim Mugerwa, “CSOs to Storm Parliament Today Over Health Budget,” November 20, 2014, available at: <http://mobile.monitor.co.ug/News/CSOs+to+storm+Parliament+today/-/691252/1510114/-/format/xhtml/-/jicycr/-/index.html>

<sup>107</sup> *Report on Budget Advocacy and Petition for UGX 260 Billion*, September 18, 2014.

<sup>108</sup> “I Can’t Be Intimidated Says Kadaga,” December 21, 2014, available at: <http://www.newvision.co.ug/news/635445-i-can-t-be-intimidated-says-kadaga.html>

<sup>109</sup> “Gov’t Agrees to Allocate Additional sh39b to Health,” December 21, 2014, available at: <http://www.newvision.co.ug/news/635471-gov-t-agrees-to-allocate-additional-sh39b-to-health.html>

<sup>110</sup> “How Government Broke MPs’ Backs in Budget Deadlock.”

<sup>111</sup> “Govt to Recruit 6,172 Health Workers - Mbabazi,” *New Vision*, September 6, 2012

would be used to recruit 6,172 health workers as well as to increase the salaries paid to doctors at HC IVs.<sup>112</sup>

The motion was passed, as NRM MPs had collectively decided to support the offer and not pursue the UGX 260 billion previously advocated.<sup>113</sup> This reduced budget focused on filling the gaps in HC IIIs and IVs rather than across the entire health system and recruitment of staff to critical groups, and only provided a salary increase for doctors at HC IVs. On 26 September the Ministry of Health issued a press statement announcing that an additional UGX 1.3 million would go towards increasing doctors' salaries at HC IVs.<sup>114</sup> The budget finally passed as the prime minister made UGX 6.5 billion available immediately and the additional UGX 43 billion was to be made available through a supplementary budget.

## OCTOBER 2012

AGHA and VHR members held a press conference on the health budget for FY 2012/2013 for health workers and demanded a greater commitment by the government towards financing the health sector to improve health outcomes, specifically among women.<sup>115</sup> While they indicated their disappointment at only getting UGX 49.5 billion instead of the UGX 260 million for which they had campaigned, the CSOs were happy that they had made significant progress and had been able to secure resources to recruit more health workers.

### **CSO Press Release: "More False Promises or Genuine Policy Commitment?"**

The CSO press release stated, "Ugandan Civil Society wishes to publicly express our disappointment with the GoU Executive's decision to ignore the report of the Parliamentary Budget Committee, which identified resources through reallocations to recruit and increase remuneration for professional health workers in HC IIIs and IVs" and they were unhappy it was through a supplementary budget.<sup>1</sup>

## CAMPAIGN RELATIONSHIPS, STRATEGIES AND TACTICS

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The CSOs used many tactics in the HRH Campaign, tapping into their expertise and experience and using grassroots mobilization and advocacy, as well as high-level lobbying in policy-making circles. The CSOs agreed that in 2012 they had adopted a "biting approach." Their efforts were high profile, widely covered in the media, and directly challenged the ruling party's position.<sup>116</sup> They sought to get a specific increase to the health budget allocation, and they pressurized MPs to block the entire budget if this was rejected. One CSO member described this as "trying to herd 400 cats," since MPs normally just have the power to say yes or no on the budget, and not to propose a reallocation of resources.<sup>117</sup> However, MPs

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<sup>112</sup> Ibid.

<sup>113</sup> "How Government Broke MPs' Backs in Budget Deadlock."

<sup>114</sup> Ministry of Health, "Government Increases Doctors' Salaries by USH. 1.3 Million."

<sup>115</sup> Action Group for Health Human Rights and HIV/AIDS, "Report for Health Policy Action Fund and Oxfam."

<sup>116</sup> Focus Group Discussion. Action Group for Health, Human Rights and HIV/Aids, November 5, 2014.

<sup>117</sup> Civil Society Organization, November 11, 2014.

found that they did have the power to influence the budget approval process. In addition, while in the past CSOs had been seen as opponents of the Ministry of Health, this time they positioned themselves as allies. Details on these tactics are spelled out below.

#### COLLABORATION WITH MPS AND ENGAGEMENT WITH THE MINISTRY OF HEALTH

MPs played an important role in this campaign by leading the battle within parliament. The CSOs supported the MPs throughout this process by providing technical inputs and analyses and encouraging MPs to decide collectively on policy positions and to organize themselves before key parliamentary debates. CSOs supported the work of the MPs by mobilizing the media and their constituencies to put pressure on the government. The CSOs stayed in close communication with the MPs throughout the campaign, phoning them, texting them, and setting up meetings. One former MP said that with all this engagement and lobbying, the “noise behind it [the campaign] became so great that people really had to listen.”<sup>118</sup>

The CSOs relied on existing relationships with key MPs that they had built over the course of past campaigns. WRA had past and present MPs in their membership that they could rely on, and they worked closely with a number of MPs, including the speaker herself. The CSOs strengthened a number of relationships with key allies in parliament, both “champions” supporting their cause and “advisers” who would counsel them on strategies and tactics.<sup>119</sup> Some of these relationships had been built over the course of the previous campaigns and budget analysis work. For example, the close working relationship with the committees meant that the CSOs were privy to insider information on who should be targeted on the campaign, which MPs they could work with, and where they needed to mobilize constituencies.<sup>120</sup>

They also had key allies who were passionate about health issues or who could provide leadership. For example, the chair of the Health Committee, Sam Lyomoki, was known for his dedication, honesty, and strong leadership. He was a medical professional himself, well respected by other MPs, and had built strong relationships with the CSOs. When he spoke on issues relating to human resources for health, he used biblical references that “touched the hearts of so many members. His strategy was to show that the issues were not political, you don’t have to be selfish, and you have to serve humanity.”<sup>121</sup>

At the time of the campaign, many MPs were relatively new to parliament. Some junior MPs were more outspoken, having been elected on platforms that promised change. The Honorable Minister Cerinah Nebanda, who was elected in 2011, was the youngest MP and also known for being extremely outspoken. Despite the fact that she was a member of the ruling party, she took them to task on issues that she cared about. She was a key ally in the HRH Campaign. When security agents tried to chase away CSO supporters who were distributing flyers and stickers as MPs entered parliament, she said, “They are

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<sup>118</sup> Interview with Member of Parliament. November 12, 2014.

<sup>119</sup> Civil Society Organization, November 14, 2014.

<sup>120</sup> Ibid.

<sup>121</sup> Clerk, Parliament of Uganda, November 11, 2014.

not going anywhere, they have not done anything.” She took some stickers and started pinning them to her colleagues.<sup>122</sup> She stood up for the CSOs and their right to participate in the legislative process.

The CSOs used these relationships to target MPs for strategic engagement. For example, they worked with three NRM MPs that they had identified as individuals who would stand up to pressure from within their party. They explained to them that even though the NRM leadership was against the health budget increase, this proposal was actually aligned with the NRM Party Manifesto. They helped these MPs to frame their arguments about how increasing human resources for health was a means to defend the NRM Party and fulfill its platform.

One tactic that was used frequently throughout this campaign was to organize MP breakfast meetings before key debates. The CSOs invited a wide range of MPs for these meetings, including NRM and opposition party members, people from different committees within parliament, as well as from the relevant associations that could be allies. The meetings were used to present evidence of problems, market the campaign and advocacy issues, gain allies, and allow MPs a chance to prepare their arguments and organize themselves before the debates.

The CSOs convened about 10 breakfast meetings in 2012. Media representatives were always present at these meetings and were invited to interview MPs. The MPs were further enticed to attend the meetings with payments of approximately UGX 100 thousand which helped to ensure high turnout.<sup>123</sup> According to one MP, these breakfast meetings allowed MPs to sit side by side and agree on common positions before going to parliamentary debates.<sup>124</sup> Another MP said the CSO information and analysis shared at breakfast meetings allowed them to take evidence-based positions and stick together on issues of health, despite pressure from the party and the executive.<sup>125</sup>

As had been requested after the IPU meeting in March 2012, the CSOs had continued to provide technical support and advice to MPs through their budget analysis work. The CSOs gathered and analyzed information, and disseminating it to MPs.<sup>126</sup> One MP said they engaged CSOs because they “had better data ... and were in touch with the grassroots.”<sup>127</sup> A former member of the Committee on Health said that the CSOs provided information which “helped us take government to task to increase funding and open the ceiling on recruitment of health workers ... it wouldn’t have been possible for us MPs to generate those statistics.”<sup>128</sup>

The CSOs regularly presented their questions and analyses to the parliamentary committees and to MPs. The MPs returned the favor by offering advice of their own. For example, when the CSOs first reviewed

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<sup>122</sup> Civil Society Organization, November 18, 2014.

<sup>123</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 5, 2014.

<sup>124</sup> Member of Parliament, November 20, 2014.

<sup>125</sup> Ibid.

<sup>126</sup> Ibid.

<sup>127</sup> Clerk. Parliament of Uganda.

<sup>128</sup> Minister of Parliament.

the budget policy statement, they began to look for resources within the Ministry of Health that could be reallocated to human resources, but the funds were not sufficient. The Health Committee advised them to review the entire budget to identify resources.<sup>129</sup> Also, the Health Committee advised the CSOs that they should not look at salary increases for health workers because that would trigger a raise in all public sector salaries. The committee suggested instead that they review the option of increasing allowances.<sup>130</sup>

According to one Ministry of Health official, CSOs used to see themselves as “watchdogs” or “pressure groups” trying to point out the mistakes of the ministry rather than as its partners. This relationship changed in 2012.<sup>131</sup> The CSOs explain that in 2012 they sought to be much more conciliatory in advocating a win-win position with many of the technical staff members at the Ministry of Health, who themselves had been requesting for additional resources for staffing for a number of years. Because of this new approach and their ongoing engagement in the technical working groups, the CSOs engaged in the HRH Campaign were seen as helpful partners of the ministry, and were invited to make a presentation on key issues and concerns to the Budget Commissioner.<sup>132</sup>

This approach to government helped the CSO’s to gain access to insider information. Some individuals within the Ministry of Health were also members of CSOs as part of their volunteer work. While they did not want to be seen as being opposed to the government, they could provide “real information” about budgets and policies to help the CSOs in their advocacy work.<sup>133</sup>

#### GRASSROOTS MOBILIZATION

The CSOs strategically mobilized people in the constituencies of policymakers who were opposed to increasing the budget for human resources for health. For example, the CSOs mobilized communities in the prime minister’s home district, as well as constituents from the district of the Hon. Minister Ranga, head of the Budget Committee. These members were selected at CSO planning meetings, and while there was no budget for grassroots mobilization, the information was communicated through a Google group, and organizations in those areas were asked to collect signatures, mobilize people, and get people to send text messages and make phone calls.<sup>134</sup> One member of a professional association said that this was very powerful because “politicians fear the voters. If the voters are well informed they can realize a very big change.”<sup>135</sup>

The CSOs also deployed a messaging strategy that combined grassroots mobilization with short text messages through a bulk text messaging service in Kampala. In the former, short messages were sent to local constituencies together with the phone number of their MP. The recipients were then asked to

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<sup>129</sup> Civil Society Organization, November 14, 2014.

<sup>130</sup> Ibid.

<sup>131</sup> Official, Ministry of Health, November 2014.

<sup>132</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 4, 2014.

<sup>133</sup> Professional Association, November 17, 2014.

<sup>134</sup> Civil Society Organization, November 13, 2014.

<sup>135</sup> Professional Association, November 2014.

send the message to their MPs. The CSOs would go to communities and explain the key issues, and they would then integrate the message campaign into their other work. Some MPs were not happy with this tactic and felt that the CSOs were mobilizing people against them. However, the CSOs judged the overall impact to be positive for the campaign.

In addition to the grassroots mobilization, bulk text messages were sent by the CSOs themselves directly to MPs to remind them about key issues and to exhort them not to pass the budget without the health-related additions. For example, a message might say “16 mothers die every day. Don’t pass the budget without 260 billion for health workers.”<sup>136</sup> These text messages were sent twice a day during the final weeks of the budget standoff to remind MPs just as they were going into a parliamentary session.<sup>137</sup> Bulk text messages to MPs were mainly employed toward the end of the campaign, particularly during the period that the MPs were under significant pressure to approve the budget.<sup>138</sup>

### DEMONSTRATIONS AND PETITIONS

On a number of occasions the CSOs mobilized health workers, CSOs, and the general public to demonstrate at parliament. Many demonstrations took place as part of the “Petition 16” movement, and the CSOs also presented petitions to parliament. In 2012 they presented a “call for action” petition to parliament with 600 signatures. While this may seem like a modest number, not many petitions in Uganda are able to gather this many signatures as it is not as a widely used technique. Thus petitions have a big impact. To get a petition heard, the CSOs worked with the clerk of parliament who would schedule the petition’s presentation to the speaker. This delay provided a few additional weeks to mobilize and prepare a demonstration to coincide with the presentation of the petition. The CSOs would include a cross-section of stakeholders in the public demonstration, including health workers who could share their stories.<sup>139</sup> The CSOs also mobilized members of the public to sit in the gallery of parliament to listen to the discussions on health workers and budget.<sup>140</sup>

### MEDIA AND PUBLICITY

Throughout the campaign, members of the media were key allies. The media was targeted by the CSOs throughout the campaign. Uganda has a group of journalists assigned to cover the parliament and political affairs. When the campaign culminated in a budget standoff this was regarded as the most important political issue of the time. This resulted in daily stories covering the debates in parliament.

At the same time that the CSOs targeted the media, journalists in Uganda were increasingly covering health issues. A number of journalists have specialized in this area and have dedicated their careers to covering health issues. For example, one reporter said that she has been covering health issues for four years and that health journalists in Uganda have begun to organize themselves, for example through a

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<sup>136</sup> Minister of Parliament.

<sup>137</sup> Civil Society Organization, November 24, 2014.

<sup>138</sup> Focus Group Discussion. Action Group for Health, Human Rights and HIV/Aids, November 5, 2014.

<sup>139</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 5, 2014.

<sup>140</sup> Civil Society Organization, November 24, 2014.

Facebook “health journalist page.”<sup>141</sup> Some reporters have joined the Health Journalist Network in Uganda, an organization started in 2011 which convenes annual conferences and meets periodically to discuss health issues and to produce a “Health Digest.”<sup>142</sup>

During the HRH Campaign, the CSOs reported that they decided to engage media in order to ensure that they were well informed and understood the core issues at stake and take them seriously. The CSOs organized a breakfast meeting with editors to link the issues around health budgets and human resources to health outcomes and preventable deaths.<sup>143</sup> They also held carefully timed press conferences, for example immediately after the president threatened to discipline MPs who were not supporting the party position. After that press conference, multiple stories appeared about how the CSOs planned to “storm” parliament.<sup>144</sup>

The CSOs succeeded in developing a few key campaign messages that resonated well. Before scheduled events, the CSOs would share talking points and key messages through their listserv, so that all the participating CSOs would have a unified message. For example, one message that got significant coverage concerned health spending abroad.<sup>145</sup> The CSOs had identified that the government of Uganda was spending nearly US\$154 million every year on VIP health treatment abroad, yet what the campaign was demanding was only two-thirds of that figure in order to vastly improve medical services for large numbers of citizens within the country. They argued that the government was compromising the lives of the majority of the people to serve the privileged few, and that, if medical services improved domestically, VIPs could stay home for medical treatment.

Another key campaign message was the continuous focus on “16 women dying every day” or “a whole taxi” of women.<sup>146</sup> This was based on UN statistics that showed that on average 16 women die every day in child birth, which happens to be the same number of people that can fit in a typical public taxi (or *matatu* as it is called locally), the most common form of transportation in Uganda. This provided a specific image of how many women in Uganda were dying of preventable, maternal health related issues each day.

**Example of CSO Messaging on Government Health Spending Abroad**

I could not believe that my government can spend 377 billion shillings (US \$154 million) annually on medical expenses of its senior officials abroad! This huge sum of money could save many women from dying in hospitals because of no medicine, no midwives,” said Dorcas Amoding of CHAIN Uganda.<sup>1</sup>

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<sup>141</sup> Journalist, November 6, 2014.

<sup>142</sup> See <http://www.hejnu.ug>

<sup>143</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 5, 2014.

<sup>144</sup> Civil Society Organization, November 24, 2014.

<sup>145</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 4, 2014.

<sup>146</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 5, 2014.

## THE IMPACT OF THE HRH CAMPAIGN

### GOVERNMENT RESPONSE TO THE CAMPAIGN

The government responded to the Human Resources for Health Campaign by allocating an additional UGX 49.5 billion specifically to fill the critical gaps in the budget for human health resources. When announcing this funding the prime minister said, “I am happy to inform you and this august house that we have managed to struggle and get sufficient funds to embark on the recruitment of a total 6,172 health personnel at HC IIIs and IVs.” He added: “Accordingly, we have managed to identify additional UGX 6.5 billion as seed money to enable the Ministry of Health to start on this endeavor. This will enable the ministry to embark on recruitment of categories of health workers ... medical officers working at a HC III will earn UGX 2.5 million per month, including consolidated allowance.”<sup>147</sup>

These additional funds not only provided monies to recruit over 6,000 new health workers in HC IIIs and IVs, but also provided medical doctors in HC IVs with a salary increase which actually doubled their salaries from UGX 1.2 million per month to UGX 2.5 million per month, effective beginning October 2012.<sup>148</sup> As a result, by the end of 2013, health worker staffing levels at HC IIIs and IVs jumped from 58 percent in 2011/12 to 63 percent in 2012/13.<sup>149</sup> This was a big boost to the sector.<sup>150</sup> Despite this growth, only one-third of the districts met the target of 70 percent staffing for 2012/13, which speaks to the magnitude of the problem of health staffing in Uganda. While doctors at HC IVs received salary increases, raises were not given to other critical front-line health workers, such as midwives and nurses. Nor did the funding allow for more recruitment at HC IIs and regional referral hospitals.<sup>151</sup> After the budget was passed, the government created a task force to help coordinate and facilitate the massive recruitment exercise. This task force brought together stakeholders from the relevant ministries, as well as development partners and CSOs, and helped to ensure that the various stakeholders could hold one another accountable, address challenges as they arose, and ensure that the recruitment was completed as per the agreed upon budget.<sup>152</sup> Intrahealth provided coordination and secretarial support for the task force.<sup>153</sup>

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<sup>147</sup> “How Government Broke MPs’ Backs in Budget Deadlock,” November 18, 2014, available at: <http://www.monitor.co.ug/News/National/How-government-broke-MPs-backs-in-budget-deadlock/-/688334/1518512/-/s90vp1z/-/index.html>

<sup>148</sup> “Press Statement from the Ministry of Health: Government Increases Doctors Salaries by USHS 1.3 Million,” Ministry of Health, September 26, 2012.

<sup>149</sup> “Annual Health Sector Performance Report 2012/13,” Republic of Uganda, Ministry of Health, 2013, available at: [http://health.go.ug/docs/AHSPR\\_2013.pdf](http://health.go.ug/docs/AHSPR_2013.pdf)

<sup>150</sup> International NGO, November 14, 2014.

<sup>151</sup> “Civil Society Reaction to Parliament’s Passage of the 2012/13 Budget,” press release, CSOs, 2012.

<sup>152</sup> International NGO, November 14, 2014.

<sup>153</sup> Official, Ministry of Health, November 2014.

## FOLLOW-UP CAMPAIGN ACTIONS

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Following this preliminary victory, the CSOs realized that they needed to continue the HRH Campaign work to ensure that the commitments made by government were fulfilled. This has involved monitoring government implementation of the recruitment of health workers to ensure that the budget resources allocated are actually having an impact and that health workers are recruited and still in their posts.<sup>154</sup> When the CSOs were invited for an update by the Ministry of Health on the status of the recruitment, they decided to undertake their own data collection so they would be able to report back as well. The CSOs sampled some districts and brought back a report to the ministry on some of the challenges, such as the delay in the release of funds. The CSOs have gathered information independently and have continued to work with the Committee on Health and the Ministry of Health to ensure that there is ongoing pressure on government to fulfill its commitments.<sup>155</sup>

The CSOs also continued to collaborate through their coalitions in order to maintain a uniform and collective set of demands in each budget cycle. For example, in the 2013/2014 budget, the CSOs focused their efforts on retention and remuneration of the recruited health force, and on getting wage increments for those who were left out in 2012/2013. This effort succeeded, and many health workers have already received a raise as a result. In 2014/2015 the CSOs have begun focusing their attention on non-wage primary health care spending, which constitutes the operational funding for health centers.<sup>156</sup>

## BLOCKING THE BUDGET

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Perhaps the biggest question arising from this campaign is why MPs from both the ruling party and the opposition joined forces and succeeded in blocking the budget until additional resources were allocated for human resources for health, despite being under great political pressure to capitulate to the executive branch and the ruling party. This is particularly unusual in Uganda where it is rare for opposing political parties to work together and where the dominant political party has been in power since 1986 and holds a tight grip on political space in the country.

This question was asked of almost all respondents, and it is clear that no single explanation is sufficient. There were many reasons that brought MPs together on this issue:

- *It was a highly visible political issue that constituents cared about and couldn't be ignored.* Human resources for health and maternal health issues had become a highly visible political issue. The CSOs and the media had succeeded in raising the profile of this issue to a point where MPs had to take it seriously. A CSO member said that MPs “were between a rock and a hard place... it was popular, we had blown it in the news, radio talk shows, and people were supportive of the health committee.”<sup>157</sup> The CSOs combined legal advocacy, public demonstrations, budget analysis, lobbying, and high levels of media engagement to make the issue the most prominent on the

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<sup>154</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 5, 2014.

<sup>155</sup> Civil Society Organization, November 24, 2014.

<sup>156</sup> Civil Society Organization, November 24, 2014.

<sup>157</sup> Member of parliament, November 17, 2014..

national agenda during the budget discussions, and virtually impossible for MPs to ignore. Ultimately, the MPs all had to take a position, and taking a position against human resources for health could prove politically disastrous for them in their districts, despite the fact that doing so risked negative impacts for them on the national stage.

- *MP leadership and dedication.* A number of individual MPs provided great leadership on this issue and were personally committed to this campaign. They were willing to incur political risk. The most prominent of these was the Hon. Dr. Samuel Lyomoki, chair of the Committee on Health, who worked with fierce dedication and passion. His leadership was critical, as was that of others, such as the Hon. Cerinah Nebanda (RIP) and some of the other Parliamentary associations, such as UWOPA and NAWMP. The speaker, the Hon. Rebecca Kadaga, also proved herself to be an impassioned leader who is unwilling to capitulate to pressure and is dedicated to the issues of maternal health.
- *Critical moral and political support for MPs.* The CSOs kept close tabs on the government tactics, and their own campaign tactics evolved throughout the process to ensure that MPs were always supported. For example, toward the end of the budget standoff, when the ruling party was holding caucuses to pressure MPs, the CSOs immediately followed those events with their own meeting with MPs to “keep them focused.”<sup>158</sup> The CSOs armed MPs with the information they required to make evidence-based arguments in parliament and also provided them with camaraderie and helped to mobilize the public to support these positions.
- *Evidence-based campaign.* The MPs reported that the research given to them made them aware of “the gravity and magnitude of the situation. We were really informed.”<sup>159</sup> They also reported that, even though they had received political threats they had to stand firm because of the information they had received. The availability of information disaggregated down to the district level was extremely important. The MPs from districts with the lowest health worker staffing levels were not previously aware of this problem, and they couldn’t look away, given the stark disparity between districts. MPs reported that they found it hard to ignore the evidence once the issues were on the table. The information clearly depicted a health worker crisis across the country.

## POSITIVE AND NEGATIVE OUTCOMES

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The 2012 HRH Campaign had many lasting outcomes, both positive and negative. The positive outcomes included:

- *Increase in health workers and in doctors’ salaries.* Between October 2012 and April 2013, Uganda added 6,889 new workers to its national health work force, thanks to a provision approved by the Ugandan parliament.<sup>160</sup> Doctors working at HC IVs more than doubled their salaries.

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<sup>158</sup> Civil Society Organization, November 18, 2014.

<sup>159</sup> Former Member of Parliament, November 12, 2014.

<sup>160</sup> IntraHealth International, “A Surge of New Recruits for Uganda’s Health Workforce,” May 15, 2013, available at: <http://www.intrahealth.org/page/a-surge-of-new-recruits-for-ugandas-health-workforce>.

- *Relationship between parliament, CSOs, and the Ministry of Health.* The CSOs reported that perhaps the “biggest achievement” of the campaign was the improved relationship between the parliament and the CSOs. There is now an understanding, spelled out in a memorandum, between the NGO forum and parliament. Parliament now calls on CSOs every year to explain their priorities and key issues in the health sector. For example, in 2013 the CSOs focused on the issue of non-wage primary health care funding.<sup>161</sup> The CSOs also reported that the HRH Campaign had led to increased access to the Ministry of Health and an improved working relationship. For example, one CSO was invited to take part in the Ministry of Health Budget TWG.<sup>162</sup>
- *Increased attention to health finance and maternal health issues.* The CSOs reported that newspapers now understand the importance of health issues and report on them daily.<sup>163</sup> According to one CSO, the media engagement during the HRH Campaign helped to create a cadre of journalists which began to report on health issues regularly.<sup>164</sup>

However, there were also negative impacts of the campaign that had a lasting impact:

- *Threats and reshuffling of cabinet members and committees.* After the campaign was over, CSOs reported that MPs who had been allies in the campaign were threatened. The cabinet was later reshuffled, and those MPs who had been on the side of civil society supporting the HRH Campaign lost key positions.<sup>165</sup> For example, when the chair of the Committee on Health’s term expired, he was not reappointed to the committee and was instead appointed to another committee where his skills were not as relevant. One MP said they replaced him because he “caused trouble to government.”<sup>166</sup> Another staff member at parliament suggested that this was because he had “lost the favor of the political parties.”<sup>167</sup>
- *Changes in budget process.* Some CSOs suggested that this was a pyrrhic victory because their role, and the role of MPs in terms of budget oversight and advocacy, had declined as a result of changes carried out by the executive immediately following the campaign’s budget victory.<sup>168</sup> One CSO indicated that the budget process had changed from being “parliament business” to being “cabinet business.”<sup>169</sup> Indeed, it appears that both the cabinet and the Ministry of Finance were upset that the budget had been blocked in parliament and that their hand was forced. They viewed it as arm-twisting and political blackmail.

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<sup>161</sup> Civil Society Organization, November 14, 2014.

<sup>162</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 5, 2014.

<sup>163</sup> Civil Society Organization, November 14, 2014.

<sup>164</sup> Focus Group Discussion, Action Group for Health, Human Rights, and HIV/Aids, November 5, 2014.

<sup>165</sup> Ibid.

<sup>166</sup> Minister of Parliament, November 17, 2014.

<sup>167</sup> Clerk, Parliament of Uganda, November 11, 2014.

<sup>168</sup> Civil Society Organization, November 14, 2014.

<sup>169</sup> Ibid.

Therefore, government took steps to avoid this risk in the future. In January 2013 the government proposed a resolution that would have the ruling party spearhead the budget-writing process: “It was resolved that the NRM leadership and other individuals form a committee to lead the national budget preparation process in order to give the country an NRM budget as promised in the NRM manifesto.”<sup>170</sup> This committee is chaired by the president and includes the vice president and the prime minister, as well as other line ministers and NRM members.<sup>171</sup> According to an international development organization, this newly formulated committee is a “Presidential Advisory Committee,” which includes 20 members of the NRM and is chaired by the president himself. While it does not replace any step in the existing budget process, it has added a new layer to the process, such that at every step the budget and all revisions made to it are closely scrutinized and under the oversight of this committee.<sup>172</sup>

An official at the Ministry of Finance said that this committee has no impact on the budget process, but other organizations seem to disagree on the impact of the new oversight committee. An MP from the ruling party said that there had been changes to the budget process. In particular, the Advisory Committee tries to involve MPs and in particular the chairs of key committees in pre-budget activities. This is intended to coopt them into the process so that they cannot later shoot down the budget on the floor of parliament. The MP said that this “somehow undermines the powers of campaigns” and the “political advocacy of the chair people of those committees”<sup>173</sup>

## LESSONS LEARNED FROM THE HRH CAMPAIGN

Many lessons can be drawn from the work of civil society on the health budget in Uganda, and these lessons are applicable to other civil society budget campaigns.

1. *The importance of collaboration.* This campaign was effective because many stakeholders joined forces around a common platform, using their collective and individual technical expertise, power, and influence to create a campaign strong enough to get the attention of the media, parliament, and the executive. Key to the success of the campaign was the extent and consistency of grassroots mobilization. The campaign achievement was not the result of one event, but of multiple complementary efforts by the CSOs to collaborate and to get smarter, stronger, bolder, and more strategic in their actions. The success of the HRH Campaign speaks to the power of building broad coalitions, an effort that can be anticipated and planned as a specific strategy. What made it successful in this case was that the coalitions were built to include not only a broad cross-section of citizens and civil society organizations, but also key government officials, members of parliament, and the media.

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<sup>170</sup> “NRM Now to Spearhead Budget-Writing Process, November 18, 2014, available at: <http://www.monitor.co.ug/News/National/NRM-now-to-spearhead-Budget-writing-process/-/688334/1674552/-/qdnsyu/-/index.html>

<sup>171</sup> Ibid.

<sup>172</sup> International Development Agency, December 5, 2014.

<sup>173</sup> Member of Parliament, November 20, 2014.

2. *The importance of organizing and communicating.* The success of the coalitions involved in the HRH Campaign depended on organization and keeping all members up to date, well-informed, and engaged on the campaigns. They did this through the use of a Google group – a very simple and free online tool that enables communication to a broad audience of subscribers, as well as through the formation of working groups focused on particular areas of expertise. These working groups were dedicated and effective in their particular areas. For example, CEHURD and HealthGAP led the charge on legal advocacy, but they stayed in close contact with the rest of the members to communicate event information, mass mobilization, and key messages before public events and press conferences. These simple organizing tools, as well as regular meetings of the working groups and the larger forum, kept all members on board with a common agenda and ensured that the coalition spoke with a unified voice to the media and other stakeholders.
3. *Win-win campaigns with key ministries and officials.* Building on the lessons of 2011, the CSOs explicitly sought to pursue a strategy that would create a win-win outcome for the Ministry of Health and for civil society. The primary aim was to increase the health budget so as to reduce maternal mortality. By doing so, the CSOs made strong allies within the ministry and within government who provided them with high-level access and insider information. At the same time, key campaign messages were adopted officially by the ministry and other stakeholders in their reports, and this gave additional leverage to the CSOs lobbying and advocating on these issues. The CSOs were seen by ministry officials as providing fuel to the fire. The issue of human resources for health had been identified as a priority area by the ministry, and with support of Intrahealth the requisite data identifying this problem were available. But it was the CSOs that had the machinery in place for advocacy and could push hard on these issues, politicize them, and so influence policy.
4. *Direct confrontation when required.* In 2012 the CSOs decided to adopt a more “biting” approach to their advocacy, which meant that they pursued a confrontational campaign aimed at blocking the entire budget if the government of Uganda did not provide the additional resources being requested for the health sector. Ultimately, this strategy was successful. This approach meant that the CSOs no longer presented maternal health and health budget issues as “charity” or “awareness-raising” issues. Instead, they framed the issue as one of basic human rights, and the violation of those rights as a political issue.
5. *Wide range of tactics.* In the HRH Campaign, the CSOs used multiple tactics, including media engagement, grassroots mobilization, protests, petitions, civil litigation, MP events and meetings, budget analysis, lobbying, and text messaging. The use of multiple tactics and framing the issue as a political one drew significant attention to the HRH Campaign and meant that the media reported on them regularly. The campaign could not be ignored by politicians.
6. *Evidence-based advocacy.* The HRH Campaign was successful because it built on a strong evidence base, which the CSOs were able to politicize. The human resources for health crisis was clearly documented, and detailed data and data analysis on the issue were available due to the

work of the Ministry of Health in collaboration with the Uganda Capacity Project. The CSOs took up was able to use this evidence effectively for campaign purposes.

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