

UGANDA: WINNING HUMAN RESOURCES FOR HEALTH

Case study (Summary) | Jillian Larsen | December 2015

INTRODUCTION

While economic development will always have a prominent place in a nation's planning, civil society organizations (CSOs) can help to ensure its pursuit does not push aside other social goals. Uganda's Human Resources for Health (HRH) campaign, which won millions of dollars of new funding for health, provides a useful case study for how this can be done.

Between 1992 and 2012, Uganda experienced a period of sustained economic growth and halved its poverty rate. However, progress in the health sector, which is still seen by some political elites as a matter of secondary importance, has been less impressive. This led to substantial under investment in healthcare in Uganda. Birthing mothers have been amongst the worst victims of the budgetary neglect: each day 16 women die in childbirth in the country. Modest investments in the staff needed to provide prenatal and obstetric care could prevent this tragedy.

The HRH campaign was the result of many different actors coalescing around the single goal of securing the resources needed to bolster staff at health clinics. This case study brings to light many important lessons about successful coordination and communication, especially within civil society, as well as between CSOs and government actors, such as the legislature and line ministries. It also highlights the strength of a budget-focused strategy for directing the efforts of a broad coalition.

THE ISSUES: HEALTH AS AN UNDERFUNDED NATIONAL PRIORITY IN UGANDA

Since President Museveni came to power in 1986, Uganda has experienced remarkable economic growth and improved stability. According to World Bank data, between 1992 and 2012 the percentage of people living in absolute poverty in the country more than halved, falling from 56 percent to 22 percent. Despite these enormous achievements, improvements to the delivery of health services and health outcomes have remained elusive.

The state of basic maternal health reflects this lack of progress. In 1990, 527 women died per 100,000 live births. By 2011, Uganda's maternal mortality ratio was 438 deaths per 100,000 live births – three times the 131 deaths per 100,000 live births committed to as a part of the Millennium Development Goals (MDGs).

While there are many contributing factors to Uganda's high maternal mortality rate, a lack of access to basic emergency obstetric and newborn care is an important one. As of 2011, only 48 percent of women received prenatal care throughout their pregnancy and skilled birth attendants were present at only 58 percent of births. While a health facility can be found within five kilometers for a majority of Ugandan households, the facilities – particularly public ones – are often understaffed and hampered by absenteeism due to low pay and poor morale. According to a 2011 study by the Uganda's health ministry, less than two-thirds of the country's districts have even half of the healthcare staff required to deliver basic maternal healthcare.

On paper, health is a priority in Uganda. The right to health is enshrined in the constitution and the government has passed a series of policies and strategies to deliver a Ugandan National Minimum Health Package that would indubitably improve health outcomes in the country. However, the difference between the vision outlined in health policies and the resources allocated to fund them is stark. About 9 percent of the 2013/14 national budget was allocated to health, a decline from four years earlier and well below the 15 percent target that the government committed as a signatory of the 2001 Abuja Declaration.

The mismatch between action and rhetoric owes much to the perception among some policymakers that the health sector is nonproductive or consumptive. Indeed, as the President was fighting the efforts of the HRH campaign to boost health spending, his argument to members of parliament (MPs) was that "building the production line" – government investments in infrastructure like roads and energy – should be prioritized over "spending on consumables," such as health. To their credit, however, many MPs have championed the health sector and repeatedly made demands for higher spending.

While CSOs working on health in Uganda had differing strategies and aims, the staffing shortages caused by inadequate health spending was of common concern. It was against this backdrop that a network of civil society organizations gradually developed into a formidable force for influencing Uganda's budgetary priorities.

THE CAMPAIGN: HUMAN RESOURCES FOR HEALTH (HRH)

The HRH campaign was unique in that many national and international civil society actors came together to pursue one shared goal. In doing so they devised a unified message and mobilized both grassroots and high-level political support.

The network emerged less from a deliberate strategy than from a serendipitous series of events that began to coalesce in 2011. Indeed, preceding efforts to improve maternal health in Uganda created the conditions and built the resources needed for the success of the HRH campaign, illustrating how momentum for change can accrue over time as civil society networks grow and learn. Three previous campaigns, which achieved several gains in their own right, set the stage for the HRH campaign's success.

The first catalyst was the decision by the Center for Health, Human Rights and Development, a Kampala-based research and advocacy group, to launch Petition 16, a campaign which drew its name from the number of daily deaths resulting from complications in child birth. They argued that, by failing to provide pregnant woman health care, the government was violating the constitutionally guaranteed right to health, right to life, and the rights of women. While initially focused on legal advocacy, the group realized that it also needed to rally public support. To do so they enlisted a number of grassroots groups, including Health Gap, an HIV-AIDS and human rights activist organization. The resulting network, called the Coalition to Stop Maternal Mortality, was a precursor to the HRH campaign. One of the resources it created for the later campaign was a simple Google

Group – an online platform for sharing information that eventually helped the coordination of advocacy efforts and messaging.

The network expanded further as the White Ribbon Alliance pushed the Ugandan government to renew its commitment to MDG 4 (maternal health) and MDG 5 (child health) ahead of the UN's 66th General Assembly. This effort drew support from other CSOs, midwives, and – critically – a group of MPs that had already been pushing for more resources to be invested in health. As the White Ribbon Alliance and its network began to collaborate with the Coalition to Stop Maternal Mortality, MPs from the parliamentary committee responsible for health issues called on them to help monitor and scrutinize the proposed budget so that they could make more evidence-based demands. This cooperation became a vital part of the HRH campaign.

The third and final precursor to the HRH was World Vision's efforts to form a national coalition of CSOs advocating for reproductive, newborn, and child health in the run up to the 2011 Inter-Parliamentary Union meeting. This was the critical juncture at which all the CSOs were finally brought together, sharpening their sense of common purpose and the actions needed to cooperate towards their goals.

All three of these movements had significant and active constituencies at the grass roots level. These constituents could be called upon to provide popular support and mobilized for the campaign. For example, World Vision had been working on social accountability in a number of districts and the White Ribbon Alliance had been coordinating highly participatory assessments of the health sector in three counties. Meanwhile, the Coalition to Stop Maternal Mortality had been actively engaging community-based organizations, women, and allies in their legal activism.

After winning the influence they were seeking over the declaration that emanated from the IPU preparatory meeting, and solidifying the cooperation of MPs in the process, the network decided to set its sights on a more ambitious target. In early 2012 they resolved to push the government for an additional 260 billion UGX (approximately USD80 million) allocation for the 2012/13 budget to be spent on salary increases and recruiting and training new health workers. The Ministry of Health, with the support of Intrahealth, a CSO, had been gathering data on the inadequacy of staffing and its effects. Along with the accumulated experience of members within the network at doing budgetary analysis, this helped the network to build a strong evidence base for its demands.

The HRH campaign took its singular demand directly to the press, cultivating relationships with a growing group of journalists covering health issues. They also began to work with the newly created Parliamentary Committee on Health, which adopted the campaign's demand, along with much of its evidence and arguments, in their first report to the Parliament. Indeed, the Committee on Health set the stage for dramatic stand-off within the government, calling for the Parliament to reject the 2012/13 budget unless increased spending in health.

Meanwhile, the HRH campaign, drawing on its abilities to mobilize organizations and individuals from the grassroots to the national level, helped to coordinate a go slow strike among health workers. They began a petition and persuaded the Uganda National Health Consumers' Organization to express its support in a letter to Parliament.

The HRH campaign also maintained direct pressure on MPs, holding a breakfast meeting in September 2012 that led to a parliamentary debate on health spending later that day. They later presented the petition calling on the speaker to ensure that the discussion remained on the floor.

At this time the executive began its counter-campaign. The President and Prime Minister organized several executive caucuses and actions aimed at swaying MPs from supporting the HRH campaign. However, even MPs aligned with the ruling party joined those voicing demands and the debate over health resources became an exceptional expression of parliamentary independence in a country where the executive has not often had to contend with a balance of power. The Ministry of Finance eventually came back to parliament with a counter offer of 39 billion UGX, but this was rejected by MPs as insufficient. The media provided a blow by blow account of the stand-off.

The HRH campaign continued to feed information to the media and rally popular support through its partners, while supplying talking points, evidence, and encouragement to MPs in their confrontation with the executive. The stand-off ended when Prime Minister Amama Mbabazi addressed Parliament, stating that the executive and the Budget Committee had agreed to an additional 49.5 billion UGX. The funds, which would require cuts to many ministries and government bodies, would be used to recruit 6,172 health workers and increase the salaries of doctors at local health clinics.

The motion passed and the Prime Minister made 6.5 billion UGX available immediately and the additional 43 billion UGX through a supplementary budget.

TACTICS USED BY CAMPAIGN

1. Mobilizing active grass roots constituencies to provide popular support for the campaign.
2. Focusing the efforts of a broad network on a single budgetary demand.
3. Cultivating relationships with journalists covering health issues and conducting broader media advocacy through press conferences and briefings.
4. Using budget analysis and data on staffing to provide evidence-based arguments for the campaign and its allies, such as MPs.
5. Engaging in petition drives and demonstrations to show popular support.
6. Hosting regular breakfast meetings with MPs to provide talking points, information, and encouragement.
7. Facilitating effective communication within the network to ensure that all coalition partners stay on message and can coordinate the timing of their efforts.
8. Launching innovative public communications campaigns, including an SMS campaign targeting MPs, as well as effective public messaging and outreach.

CHANGES DUE TO THE CAMPAIGN

The efforts that preceded the HRH campaign, which achieved a number of symbolic and material victories in their own right, helped to establish the conditions and assemble the resources needed to secure a significant win by the HRH campaign. It should also be noted that the HRH campaign counted on strong allies at the Ministry of Health and within the Parliament.

Its success lay in its ability to bring all of these actors together in a concerted effort that was at once political, grassroots, technically sophisticated, and populist. By all accounts, the campaign played a crucial role in orchestrating efforts on multiple fronts and it is unlikely that such a significant increase in the budget for health

personnel would have been achieved without it. Indeed, many previous efforts that lacked such broad-based cooperation had failed.

The HRH campaign remains active. Following this preliminary victory, the coalition has continued to coordinate efforts to monitor the government's implementation of the recruitment of health workers. This has helped to ensure that the budget resources allocated are actually having an impact and that health workers have been recruited and remain in their posts.

The coalition continues to maintain a uniform and collective set of demands to the government in each budget cycle. For example, for the 2013/2014 budget, the group focused their efforts on retention and remuneration of the recruited health force and on getting wage increments for those who were left out the previous year. This effort succeeded, and many health workers have already received a raise as a result. In the 2014/2015 budget, CSOs began to focus their attention on non-wage primary health care spending, which constitutes the operational funding for health centers.

It is worth noting that, while the HRH campaign secured an important victory, it also sparked a backlash. The cabinet was reshuffled after the standoff and MPs allied to the campaign lost key positions. According to CSOs, the chair of the Committee on Health, for example, was appointed to another committee where his skills were not as relevant. In January 2013, the government proposed a resolution that would have the ruling party spearhead the budget process through a Presidential Advisory Committee. While the actual impact of this committee is debated, it undoubtedly represents an effort to preempt the kind of clash between the Parliament and the executive that won the health sector new resources. Such developments are a reminder that civil society campaigns are rarely linear – setbacks and reversals often create cause for new advocacy efforts.

OUTCOMES RELATED TO THE CAMPAIGN

- 1) The campaign attracted champions in the Parliament and the Ministry of Health.
- 2) It strongly influenced the agenda of the newly formed Parliamentary Committee on Health.
- 3) The campaign secured a reallocation of 49.5 billion UGX (approximately US\$ 15 million) to the health sector, paying for the recruitment of an additional 6,172 health workers and a wage increase for some doctors.
- 4) Further wage increases for those left out of the initial reallocation of resources to the health budget were later won.
- 5) The coalition continues to provide a mechanism for coordinating efforts to monitor the recruitment of health workers to ensure that the budget resources allocated are actually having an impact.

CONCLUSION

Above all, the HRH campaign illustrates how civil society networks develop over time, gaining new allies and new strengths. Many lessons from this case are applicable to other civil society budget campaigns.

The HRH campaign's success should not be considered an inevitable result of Uganda's recent legacy of health activism. But it was ultimately effective because it provided a common platform for many stakeholders to join forces. Together they were able to use their technical expertise, power, and influence to create a campaign capable of deploying resources at many different levels and pressure points. What made this campaign so successful in particular was that the coalition included not only a cross-section of citizens and CSOs, but also key

government officials, MPs, and the media. Simple but effective mechanisms for organizing and communicating kept this network together: the Google Groups platform, the media work, SMS messaging, and regular breakfast meeting with MPs, to name a few.

The case also highlights the importance of finding win-win budgetary goals to attract the cooperation of key ministries and officials. The campaign provided knowledge, coordination, and popular support to the MPs and health officials who had already been seeking to bolster health spending.

That said, the campaign did not confine itself to polite politics. It mobilized protests and encouraged the MPs to take a confrontational stance against the executive. It deployed a wide range of tactics at a number of levels that contributed to its success.

A strong evidence base was also central to the campaign. Its ability to demonstrate the importance and impact of underspending in health, and the relevance of this underspend to all partners, was instrumental in it being able to bring together such a broad coalition. Evidence was also crucial to the MPs who entered the parliamentary debate, and for making the campaign's case to the media and the public that healthcare can no longer be neglected.