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UGANDA: ALIGNING LOCAL AND NATIONAL CONCERN FOR MATERNAL HEALTH

CASE STUDY (FULL) | JILLIAN LARSEN | DECEMBER 2014

INTRODUCTION

Pregnancy should be a time of great joy. But for women in Uganda, who face a high risk of death or serious disability due to low-quality health services, it can also be a time of great peril. Using the maternal mortality ratio (MMR) as a means of measurement,[1] 438 Ugandan women will die for every 100,000 live births in the country.[2] When compared to Norway, a country with only four deaths per 100,000 births,[3] Ugandan women are 110 times more likely to die during pregnancy than their Norwegian counterparts.

Civil society organizations (CSOs) in Uganda have been working to address these challenges, by engaging in health sector budget advocacy and campaigns. In recent years, CSOs have experienced some notable achievements. One of the CSOs at the forefront of advocacy in relation to maternal and newborn health, is the White Ribbon Alliance for Safe Motherhood. The White Ribbon Alliance (WRA) is a membership organization that brings together a network of maternal and newborn health advocates at both international and national levels. It advocates the allocation of more resources, and the development of policies to prevent the deaths of women in pregnancy and childbirth, and challenges governments and politicians to fulfill their commitments in this regard.[4]

The WRA has a Global Secretariat that supports 13 autonomous national alliances around the world that have taken interest in the work of the WRA and become affiliates of the network.[5] This case study summarizes the history of efforts of WRA Uganda to improve maternal health in Uganda, sketches the

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[1] The maternal mortality ratio (MMR) is an internationally recognized indicator that measures the number of women who die for any reason related to their pregnancy or its management per 100,000 people, available at: http://www.who.int/healthinfo/statistics/indmaternalmortality/en/

[2] Uganda Demographic Health Survey, Uganda Bureau of Statistics, Kampala, 2011, available at: http://www.ubos.org/onlinefiles/uploads/ubos/UDHS/UDHS2011.pdf

[3] "WHO | Maternal Mortality Country Profiles," 22 December 2014, available at: http://www.who.int/gho/maternal_health/countries/en

[4] See http://whiteribbonalliance.org/

[5] *Ibid*.

alliance's early activities in this area, and reports on its recent campaign initiative, "Act Now to Save Mothers."

BACKGROUND TO THE PROBLEM AND THE WRA UGANDA CAMPAIGN

THE PROBLEM OF UGANDA'S HIGH MATERNAL MORTALITY RATIO

In 2000 the Ugandan government made a commitment to improve maternal health as part of the United Nations sponsored Millennium Development Goals (MDGs). At the time, the MMR in the country was 505 deaths per 100,000 live births, and government committed to reducing this by three quarters, to 131 deaths, by 2015. However, progress has been slow, and it is clear that Uganda will not meet this target.[6] As of 2011, Uganda's MMR remained 330 percent higher than what was proposed by MDG 5 which established targets relating to maternal health.

This high rate of maternal deaths is due to a number of factors. The most recent Uganda Demographic and Health Survey found that only 48 percent of women receive prenatal care throughout their pregnancies, and skilled birth attendants are present at only 58 percent of all births.[7] 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).[8] While exact figures are not readily available, many studies have documented that unsafe abortion (which remains illegal in Uganda) is also a significant contributor to maternal mortality.[9] Most of these deaths could be avoided by access to basic emergency obstetric and newborn care, but providing such services would require, at a minimum, sufficient numbers of skilled health staff, basic equipment, and medical commodities.

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[6] Under MDG 5, Uganda committed to reduce maternal mortality by 75 percent and achieve universal access to reproductive health care, but according to a 2013 report, Uganda has not been making much progress, Millennium Development Goals Report for Uganda 2013, available at: http://www.undp.org/content/dam/uganda/docs/UNDPUg-2013MDGProgress%20Report-Oct%202013.pdf

[7] Uganda Demographic Health Survey, Uganda Bureau of Statistics, Kampala, 2011, available at: http://www.ubos.org/onlinefiles/uploads/ubos/UDHS/UDHS2011.pdf

[8] "Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda." 2007-2015. The Republic of Uganda. http://www.who.int/pmnch/media/events/2013/uganda_mnh_roadmap.pdf

[9] Mallinga and Mbonye, "Maternal Morbidity and Mortality in Uganda"; Ssengooba et al., "Maternal Health Review Uganda"; "Unintended Pregnancy and Abortion in Uganda."

TABLE 1. KEY STATISTICS ON MATERNAL HEALTH SERVICES IN UGANDA

Table 1: Key Maternal Health Indicators for Uganda	
Indicator	**Uganda**
Maternal mortality ratio (per 100,000 live births)	438
Prenatal care coverage (%) at least one visit	94.9
Prenatal care coverage (%) at least four visits	47.6
Births delivered at a health facility (%)	57
Births attended by skilled health personnel (%)	58
Births by Caesarian section (%)	5.3
Post-natal care visit within two days of childbirth (%)	33
Total fertility rate (number of children per woman)	6.2
Pregnant women receiving intermittent preventative treatment for malaria (%)	62.2
Pregnant women with HIV receiving antiretroviral medicines to prevent transmission to newborn (%)	86.2
Unmet need for family planning (%)	34
Contraceptive prevalence (%)	30

Source: Family Care International, 2014 (using UBOS, 2011).

The failure to meet maternal health targets is largely the result of insufficient budget allocations to deliver the National Minimum Health Care Package. As a proportion of national expenditure, the total expenditure on health represented only 7.4 percent in the fiscal year 2013/14, a decrease from the 9.6 percent allocated in 2009/10.[10] This is well below targets that have been set for national health spending, including the 9 percent target indicated in the 2012/13 health sector annual report, 11.6

[10] "Annual Health Sector Performance Report 2012/13," Republic of Uganda, Ministry of Health, 2013.

percent proposed in the National Development plan, and less than half of what Uganda committed to as part of the Abuja declaration. [11, 12, 13]

The heath sector remains underfunded partly because of the limited resources that Ugandan government has at its disposal and because health is not high on the national list of priorities. The government's priority is the development of infrastructure, roads, and energy, with the hope this will create a more competitive business environment.[14] The prioritization of "productive" over "consumptive" sectors in the economy has led to a significant underinvestment in health, and more broadly in the country's human capital. However, in a country that is still largely dependent on subsistence agriculture and other labor intensive industries, the development of human capital is essential for economic growth.

The lack of political will to invest in Uganda's human capital has undermined the health sector and led to insufficient recruitment, remuneration, and retention of health workers; shortages of equipment, supplies, and medical commodities; and insufficient spending to cover basic operating costs of primary health care facilities. In 2011 only 58 percent of posts for health workers were filled.[15] Due to the inequitable distribution of health workers, seven districts were staffed at less than 35 percent, and over one-third of Uganda's districts had less than 50 percent staffing levels.[16] These shortages have created a serious health crisis as not even the most basic services can be performed if health workers are not present.

In addition to funding challenges, the health sector in Uganda also faces problems of mismanagement, corruption, inefficiency, and high levels of absenteeism. A recent survey by the World Bank established an absenteeism rate of 52 percent. Furthermore, only 44 percent of public health facilities had all six of the identified essential medicines available, and only 20 percent of the public health providers followed the correct actions to manage maternal and neonatal complications.[17] Health workers receive inadequate training and are not able to update their skills. Those familiar with the sector reported that health workers do not receive training on basic new technologies, such as vacuum aspirators, and that this is combined with poor management skills at the district level.

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[11] *Ibid*.

[12] "Joint Assessment Framework for FY 2012/13," Joint Budget Support Framework Uganda, 2014.

[13] "The Abuja Declaration: Ten Years On," World Health Organization, 2011, available at: http://www.who.int/healthsystems/publications/Abuja10.pdf

[14] Official. Ministry of Finance, 11 November 2014.

[15] "Using Data to Successfully Advocate for Health Workforce Funding | CapacityPlus," available at: http://www.capacityplus.org/using-data-to-successfully-advocate-for-health-workforce-funding

[16] Uganda, Ministry of Health, Kampala, 2011.

[17] "Education and Health Services in Uganda: Data for Results and Accountability." The World Bank, 2013. http://wwwwds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/11/18/000456286_20131118105216/Rendered/PDF/826660ESW0Ugan090Box379862B00OUO090.pdf

BOX 1. HEALTH WORKER EXPERIENCES

When discussing the challenges of being a health worker, one respondent said, "Being a midwife was my passion but the experience I have gone through here is making me think of going back to school to do something else. But when I look at the mothers, I just can't help but help them."

Another told us the story of a midwife who was trying to deliver a baby at night, unassisted, using a mobile phone as a flashlight. When the phone fell, blood spilled all over the midwife. The mother who was delivering was tested after the fact and was found to be HIV positive. The midwife took leave. The same maternity ward has no lights to-date and therefore now refers all mothers to the Lira referral hospital, and patients are obligated to pay the ambulance transportation costs, something which is a main deterrent factor for poor women getting care.

Visits to health centers confirmed these challenges in service delivery, and health workers themselves speak of being inadequately supported. For example, one health worker reported that while there should be six health workers at a facility, only two were currently present as the others were on leave or the positions were unfilled. This creates delays for mothers seeking care. The health worker indicated that mothers may come and wait, and not be attended to on multiple visits, which discourages them from seeking prenatal care or delivering their babies at the facility.[18] All of these challenges contribute to high rates of maternal mortality.

WRA UGANDA'S EARLY RESPONSES TO INADEQUATE FUNDING FOR MATERNAL HEALTH CARE

WRA Uganda has been very active on issues of maternal health and health budgets. The national alliance boasts a membership of 131 organizations (CSOs, professional associations, etc.) and close to four thousand individuals, including health workers, politicians, health advocates, mothers, and the general public.[19] The Hon. Janet Museveni, Uganda's First Lady, is herself an official patron of WRA Uganda and has supported its work since 2005. The alliance includes 15 current and former members of parliament (MPs), and, at the district level, is present in 13 of Uganda's 111 districts. A committee of seven people, including women, men, health workers, youth, and members of the media, provides leadership in each province. Committee members are volunteers and not employed staff, although they are given monetary and in-kind support (such as allowances, airtime, and meals) in order to coordinate and implement activities in their respective districts.[20]

WRA Uganda also participates in a number of other alliances dedicated to improving health for mothers in Uganda. Since 2011 WRA Uganda has been working closely with the Coalition to Stop Maternal Mortality, which was created as part of an advocacy group in response to the filing of constitutional

[18] Midwife, HC IV, n.d.

[19] WRA Uganda membership database, August 2013.

[20] Focus Group Discussion 1. White Ribbon Alliance Uganda, 4 November 2014.

court petition relating to maternal mortality and health as a human right. In addition, the alliance is a partner and active member of the Uganda Civil Society Coalition for Reproductive, Maternal, Newborn, and Child Health. These three coalitions bring together more than 100 CSOs in Uganda. WRA Uganda has also been collaborating with parliament and the Ministry of Health.[21] As a result, the alliance has a strong reputation and a positive working relationship with CSOs as well as with members of parliament, ministries, departments, and agencies.[22] These organizations and coalitions have had some notable successes in their advocacy work around maternal health.

For example, in 2011, in anticipation of the 66th session of the United Nations General Assembly, WRA Uganda wanted the government of Uganda to make additional commitments on maternal and child health as part of the Every Woman, Every Child global campaign in order to meet the 5th Millennium Development Goal on maternal and child health. The coalition worked together with Save the Children, HealthGAP, and the members of the Coalition to Stop Maternal Mortality to lobby MPs and the government of Uganda on these issues.

The coalition succeeded in pressuring the government of Uganda to make new commitments to the General Assembly. This included increasing comprehensive Emergency Obstetric and Newborn Care (EmONC) services in hospitals from 70 to 100 percent coverage, and in health center IIIs and IVs from 17 to 50 percent, and ensuring that basic EmONC services are available at all health centers. The government committed itself to ensuring that skilled health care providers are available in hard-to-reach areas, and made additional commitments regarding family planning and prevention of mother to child transmission (PMTCT) of HIV.[23]

Also in 2011, WRA Uganda and Health GAP began to work with the Social Services Committee in parliament (which became the Health Committee in 2012). At the committee's request, the two CSOs helped to analyze the 2011/12 Ministerial Policy Statement and budget. The CSOs identified over 5.5 billion Ugandan shillings (UGX)[24] within the health budget that they believed had been poorly allocated and should be reallocated to increase human resources for health care. Based on the CSO analysis, the Social Services Committee questioned the Ministry of Health and agreed to reallocate UGX 5.57 billion to "facilitate the recruitment and payment of critical staff in health center IVs."[25]

CSOs also collaborated with MPs for the Inter-Parliamentary Union meeting held in 2012, at which they raised issues related to maternal mortality and encouraged the passage of a resolution.[26] Following this,

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[21] International NGO, 10 November 2014.

[22] Professional Association, 15 November 2014.

[23] "Uganda Commitments."

[24] As of 12 November 2015, UGX 1 million is equivalent to US$284, available at: https://www.google.com/search?q=currency+converter&ie=utf-8&oe=utf-8#q=1%20USD%20to%20UGX

[25] "Key Questions from Civil Society on the National Budget Framework Paper for the Health Sector FY 2012/2013."

[26] (Forthcoming.) Larsen, J. *Case Study: Human Resources for Health Campaign*, International Budget Partnership, December 2014.

they persuaded parliament itself to pass its own resolution.[27] Building on this success, a broad cross section of CSOs, together with the Committee on Health in parliament and with the tacit support of the Ministry of Health, lobbied the government to commit an additional UGX 260 billion to health in the 2012/13 budget in order to resolve the human resources crisis within the health sector. Members of parliament united and blocked the passage of the entire budget until additional resources were allocated for health. In the end a compromise was reached, and the Ministry of Health was allocated an additional UGX 49.5 billion to recruit an additional 6,172 health personnel for health center IIIs and IVs, as well as to double the salary of doctors in health center IVs.[28]

With these achievements, and in response to the ongoing challenges on maternal health, persistent underinvestment in the sector, and failure of the government of Uganda to make progress towards MDG 5, WRA Uganda prepared the Act Now to Save Mothers campaign to target these specific issues. The campaign sought to hold the government of Uganda accountable for the commitments it had made in 2011 at the UN General Assembly, which included ensuring that half of health centers IV provide comprehensive emergency obstetric and newborn care (CEmONC), and that basic emergency obstetric and newborn care (BEmONC) services would be available in all health centers by 2015.[29] The focus on these issues was in many ways a natural extension of the earlier work, as it was WRA Uganda that coordinated the 2011 campaign to get the government to make those commitments.

Act Now to Save Mothers is a coalition campaign involving national and subnational media groups, local governments, members of parliament, human rights groups, health workers, and national and subnational nongovernmental organizations (NGOs).[30] The campaign has been supported by the WRA Global Secretariat, which raised funds for the campaign and provides ongoing technical support.

THE OBJECTIVES AND METHODOLOGY OF THE ACT NOW TO SAVE MOTHERS CASE STUDY

THE OBJECTIVES OF THE CASE STUDY

Documenting the WRA Uganda's Act Now to Save Mothers campaign was undertaken by the International Budget Partnership's Learning Program and aims to generate evidence on civil society's efforts to bring about budget changes in different countries. This case study seeks to do the following:

1) Explain the planning and execution of the Act Now to Save Mothers campaign between the last quarter of 2012 and December 2014, focusing not only on what they did and how they did it, but also considering why they made the choices they did.

[27] "Resolution Urging Government to Institute Measures to Address Maternal Mortality and Other Matters Incidental Thereto," Parliament of Uganda, 15 December 2011.

[28] Forthcoming. Larsen, "Case Study: Human Resources for Health Campaign."

[29] White Ribbon Alliance Uganda, "Policy Brief," available at http://whiteribbonalliance.org

[30] *Ibid*.

2) Document and explain changes in government behavior or rules that the campaign helped to bring about.

3) Explain the relationship between the campaign activities and government responses, both positive and negative.

This report describes the context of the WRA Uganda initiative, the campaign planning and strategy development process, the evidence-gathering phase of the campaign, the dissemination of these findings and advocacy and lobbying activity, and government's response up to December 2014. It concludes with a discussion and lessons learned from this campaign experience.

THE METHODOLOGY USED TO PRODUCE THE CASE STUDY

This case study used qualitative methods and drew on multiple sources of information, including a review of relevant literature, key informant interviews, and focus group discussions. Firstly, a systematic literature review was undertaken that included campaign documents (conceptual documents, meeting reports, quarterly reports, activity narratives, etc.), media and newspaper reports, documents from the government of Uganda (such as parliamentary reports and documents from the Ministry of Health), and literature on health financing and the budget process in Uganda. Secondly, interviews with key informant were carried out via Skype with staff at the WRA Global Secretariat in the United States of America and the United Kingdom.

Based on findings from the literature review and interviews, the research methodology was refined to prepare for data collection in Uganda where field work was carried out in November 2014. Inception meetings were held with the WRA Uganda country staff to review and refine the methodology, identify the locations for district level visits, and generate a preliminary list of key informants at the national and subnational levels. Three focus group discussions were carried out with the staff to gather their views on the campaign. In addition, interviews with key informants were undertaken at the national level. In order to identify key informants, a preliminary list was drawn up and from these initial interviews, the researcher identified additional key informants. The 39 interviewees included CSOs and professional bodies, current or former MPs, media representatives, officials of the Uganda Ministry of Finance and Ministry of Health, as well as international development organizations, international NGOs, and other stakeholders. A full list is available in Appendix 1.

At the subnational level, Act Now to Save Mothers focuses on three districts: Mityana, Kabale, and Lira. Due to time and cost constraints, only Lira and Mityana were selected for research visits because of their proximity to Kampala. Site visits were carried out to elicit the views and experiences of WRA Uganda district members, district and sub county officials, district health leaders, health staff, and community members. In particular, the researchers sought views on the campaign tactics, health facility assessment, and facility-level impacts of the campaign. Individual health facilities were also chosen to participate in the research. These facilities were selected by the WRA Uganda team based on their active participation in the campaign. In total, the researchers spoke with 29 people at the district and sub district level.

After completion of the field work, a wrap-up meeting was held with the WRA Uganda staff to share preliminary findings and clarify outstanding issues. The information that was collected through the research was verified across the various interviews and data sources and analyzed in order to identify key issues and trends. Finally, the research results were written up in this case study report.

CAMPAIGN PLANNING

WRA STRATEGIC PLANNING: AN OUTCOMES-BASED APPROACH FOR NATIONAL CAMPAIGNS

As a membership organization, WRA takes a broad-based approach meant to foster ownership of its campaigns by all alliance members, and to include the widest possible cross section of stakeholders from national to local level.[31]

WRA has a five-year strategic plan that guides the direction of the alliance. In the 2013-2018 Strategic Plan, WRA made "a strategic move away from initiatives designed to secure new commitments in the international arena, and instead place emphasis on supporting campaigning for national delivery of commitments."[32] One of the core values underlying WRA's strategy is the idea that citizens are central to holding governments accountable for their commitment. They should demand particular actions of government rather than merely being beneficiaries of government-determined transparency and answerability. Because citizens hold a special social contract with their leaders, WRA determined that they were better placed than external agents to hold national governments to account.[33] In practice, this meant that the WRA Global Secretariat and national alliances increased their efforts to pressurize governments to uphold existing commitments, rather than develop new commitments. It also meant that grassroots engagement in campaigns was the increasing focus of WRA's work.[34]

BOX 2. BRINGING ABOUT LASTING CHANGE (WRA STRATEGIC PLAN 2013-2018)

- The first step in bringing about change is to locate power at the community level and recognize citizens as the most effective agents of change.
- Lasting change in society comes about when enough people join forces to demand that their government adopts and implements the right national policies, and devotes sufficient resources to deliver those policies.
- Social accountability is essential to see progress. WRA has documented drivers of success, including generating demand for rights and better services, leveraging intermediaries to legitimize the demand of poor and marginalized women, and sensitizing leaders and health providers to respond to women's needs.

This focus guided the Act Now to Save Mothers campaign from the earliest stages of the planning process. The planning process began with the Global Secretariat, which prepared a grant request in

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[31] Focus Group Discussion 4, White Ribbon Alliance Uganda, 26 November 2014.

[32] WRA Strategic Plan, 2013-2018, available at http://whiteribbonalliance.org

[33] White Ribbon Alliance for Safe Motherhood Secretariat, October 2014.

[34] White Ribbon Alliance Secretariat, 27 October 2014.

consultation with the national alliance teams. According to WRA documents, this grant request included support for campaigns in three countries aimed at improving the delivery and expanding the use of maternal health services "by advocating new or improved policies, sufficient resource allocation, proper implementation of policies and expenditures of resources; and addressing other barriers to accessing life-saving care for mothers."[35] Three countries were selected for participation in the national advocacy and accountability campaigns, including Nigeria, Tanzania, and Uganda.[36]

While it was the Global Secretariat that prepared the broad funding application, it did so in consultation with the country offices. The application outlined that the first activity under the grant would be to support the development of a specific campaign and articulate a campaign strategy in each country, and that this planning process would "review commitments made, analyze gaps, and document successes to establish an evidence base for advocacy and communications campaign strategy development." [37]

Once the Global Secretariat had secured campaign funding, a project orientation and kickoff meeting was held in Washington, D.C. with the participating national alliances. At this meeting, the country teams agreed to focus the campaigns on accountability for existing commitments.[38] This consultation process represented a shift, as national alliance members reported that in previous campaigns they had felt like implementers for campaigns that were planned and controlled at the international level. With this campaign they felt as though they had full ownership of the process at the national level from the beginning.[39]

Simultaneously, key changes in staffing were also being made at the global level that influenced the shape, design, and outcomes of this campaign. In particular, Ray Mitchell joined the WRA Global Secretariat in January 2013 as the new director of Advocacy and Campaigns. He brought with him a wealth of experience, including two decades of grassroots advocacy work. He provided technical support and worked closely with the country teams to help them develop their campaigns and campaign strategies. In early 2013 Ray facilitated an empowering process that sought to define campaign activities according to what needed to be achieved.[40]

WRA staff in Uganda said that Ray Mitchell kept asking important questions like, "Why are you doing this? What do you want to get? Is it the right way to achieve your intended objective?" This changed the way that they worked.[41] They also said that previous campaigns were not focused on specific interventions and outcomes, and they were now doing more to mobilize and build awareness at the community level. The Ugandan WRA team chose specific pilot districts for their campaign where they

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[35] White Ribbon Alliance Grant Proposal, 2014.

[36] White Ribbon Alliance for Safe Motherhood Secretariat, October 2014.

[37] "Grant Proposal Application."

[38] Focus Group Discussion 1. White Ribbon Alliance Uganda, 4 November 2014.

[39] *Ibid*.

[40] White Ribbon Alliance for Safe Motherhood Secretariat, October 2014.

[41] Focus Group Discussion 1. White Ribbon Alliance Uganda, 4 November 2014.

were confident of bringing about change, and they were able to be more specific and focused, making it easier to track results.

The new hands-on approach of the WRA global team required much more in-depth technical support for the country alliances. WRA staff in London and Washington, D.C. provide continuous support to the national alliances through ongoing technical support and assistance at different phases of campaign development and implementation. Their role has been particularly important during the campaign planning and strategy development phases. Regular phone calls with country teams allowed them to reflect on their activities and share experiences. These included discussion of thematic issues, such as how to have meaningful engagement with citizens, what was working and not working in campaign activities, and what challenges the different teams experienced.[42] The global level team maintained a "bird's eye perspective" and could see where the country teams might learn from each other.

WRA UGANDA: BUILDING CAMPAIGN CAPACITY ON THE GROUND

The WRA has a small but highly capable and effective staff in Kampala. WRA Uganda provides leadership, coordinates and manages the alliance, implements campaign activities, and sees to day-to-day administration. In the course of research for the campaign, many respondents highlighted the key role of these staff members, who are well respected and known to be very committed,[43] have "a vigor and love for what they do,"[44] are a "small, but very passionate and dedicated team,"[45] and who themselves admit to being highly organized.[46]

With a focus on outcomes, and because planning was more systematic, strategy and tactics could evolve in relation to opportunities and challenges, even though the goals and objectives of the campaigns remained constant. The campaigns emphasized outcomes and influencing key decision makers. For example, an intended outcome might be to get the parliamentary Health Committee to push for additional resources for the health budget. The plan might envision 10 steps to achieve this outcome, but in the event only one step might be needed.

The WRA Uganda campaign built on previous work and relationships that had been developed over the years. The alliance has been very active with other members of civil society on the issue of maternal health and health budget advocacy, and is a highly credible organization with strong relationships with policymakers and technical ministerial staff. Furthermore, WRA Uganda has developed a positive working relationship with the Ministry of Health, and with many MPs and parliamentary committees. This is largely a result of the collaborative WRA approach of promoting mutually beneficial outcomes.

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[42] White Ribbon Alliance for Safe Motherhood Secretariat, October 2014.

[43] Focus Group Discussion. District Leadership, n.d.

[44] International NGO, 17 November 2014.

[45] *Ibid*.

[46] Focus Group Discussion 4. White Ribbon Alliance Uganda, 26 November 2014.

One founding member of WRA Uganda reported that they see their role as being to "supplement, not to counter" the Ministry of Health.[47]

This relationship has been tested and improved over the past few years, during which WRA Uganda has worked together with the Ministry of Health to expand financing under a Human Resources for Health campaign.[48] Under this campaign, the ministry, MPs, and CSOs successfully advocated for an additional UGX 49.5 billion for human resources for health, and a strong relationship between the partners developed.

WRA Uganda is respected for technical expertise and has members on a number of Ministry of Health committees, including technical working groups for Maternal, Child, and Newborn Health and Human Resources for Health. They also work closely with the budget committee. CSOs are represented on the highest level Health Policy Advisory Committee that advises the Ministry of Health.[49] The Ministry of Health Budget Division reported having a positive working relationship with CSOs and helps to build their capacity.

Since 2011, WRA Uganda has been working hand in hand with MPs (15 of whom are members of the alliance), as well as with various parliamentary committees on budget and health. MPs report that the alliance and other CSOs help to link them with their constituencies, and that CSOs provide them with significant technical assistance in analyzing budgets, conducting research, and gathering data for policy making and advocacy.[50]

MPs in Uganda have been proactive in the area of maternal health. For example, in 2009, the World Bank and the government of Uganda prepared the Uganda Health System Strengthening Project, a US$100 million project that was intended to be an infrastructure project for health as requested by the government. According to stakeholders knowledgeable about the process, 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 US$30 million to the project to be used for family planning and basic equipment for emergency obstetric care for 230 health care facilities.

The relationship between WRA Uganda and other CSOs is also strong. Through their joint advocacy and collective efforts in 2011 and 2012, CSOs were able to get additional budget allocations for health, and additional commitments on maternal and child health.[51]

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[47] Professional Association, 15 November 2014.

[48](Forthcoming.) Larsen, J. *Case Study: Human Resources for Health Campaign*, International Budget Partnership, December 2014.

[49] Official, Ministry of Health, November 2014.

[50] Former Member of Parliament, 12 November 2014.

[51] (Forthcoming.) Larsen, J. *Case Study: Human Resources for Health Campaign*, International Budget Partnership.

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The Act Now to Save Mothers campaign was able to build on previous experiences of WRA Uganda:

- **Collaboration with the Ministry of Health.** In 2011 CSOs scrutinized the Ministry of Health budget, and this put them in direct conflict with the ministry, which viewed them as a watchdog. In 2012 CSOs succeeded in working collaboratively with the Ministry of Health and WRA Uganda and built on this experience in the Act Now to Save Mothers campaign, engaging the ministry at every stage of the process at both district and national levels.

- **Collaboration with CSOs and other stakeholders.** Engaging other stakeholders in a common campaign platform enhances the power, influence, and expertise on the campaign. WRA Uganda developed close relationships with other stakeholders through work in preceding years, and they leveraged this by engaging potential partners in a participatory planning process at the beginning of the campaign. They linked this to the work of other CSOs, for example evidence gathered through this campaign is also being used by the Coalition for Maternal, Child, and Newborn Health Advocacy.

- **Evidence-based campaign.** The 2012 Human Resources for Health campaign, in which the alliance collaborated with the Ministry of Health to successfully increase the budget allocation for human resources for health, demonstrated to CSOs the importance and power of evidence-based advocacy.

- **Multiplicity of tactics.** In previous campaigns, CSOs had found success in pursuing multiple tactics simultaneously, including lobbying and advocacy at the national level, as well as grassroots mobilization, using the media, and taking advantage of a variety of means to raise the profile of the campaign issues. The Act Now to Save Mothers campaign engaged in bottom-up and top-down strategies and used various tactics to achieve its goals.

- **Linking the campaign to the national budget cycle.** In the previous two fiscal years, WRA Uganda had participated in budget analysis and advocacy efforts at the national level. In the design of the new campaign, the timeline was developed to align with the national budget cycle in Uganda. The team gathered and analyzed evidence at the earliest stage of the national budget process. The information and analysis could then be used for advocacy efforts that coincided with budget discussions at the district level and national level. The national level campaign launch event was to coincide with the budget process in the Ugandan parliament.

IDENTIFYING THE CAMPAIGN GOAL AND OBJECTIVES

At the initial campaign strategy workshop in February 2013 Ray Mitchell and Katy Woods from the WRA Global Secretariat facilitated a participatory process of defining the goals and objectives of the Ugandan campaign, and a theory of change that would inform the initiative. A wide range of stakeholders, including health workers, UN agencies, NGOs and CSOs, and current and former MPs were involved in

the process.[52] It also included "very helpful" input from the Ministry of Health.[53] The workshop took place about four months after the CSO coalitions had succeeded through their 2012 budget advocacy campaign to secure an additional UGX 49.5 billion for human resources for health. Therefore the working relationships were strong, and people were optimistic about the prospects for the new campaign.[54]

By focusing on the question, "Why are women dying?" participants in the workshop were able to explore problems relevant to their own experiences. Health workers were able to link the problems they face in their district facilities with discussions about campaign goals and objectives related to EmONC.[55, 56] Participants formulated campaign goals and objectives, and developed a theory of change and general strategy for the campaign.[57] On the final day of the workshop, external participants were invited to attend, including former MPs, donors, and other key stakeholders. The workshop participants outlined the campaign to them and solicited their feedback.[58]

CAMPAIGN GOAL

Ensure that "The government of Uganda upholds its commitment to ensure that comprehensive emergency obstetric and newborn care increases in health center IVs from 17 percent to 50 percent and that basic emergency obstetric care services are available at all health centers."

Basic emergency obstetric and newborn care (BEmONC) includes:

1. Treatment of infections (sepsis).
2. Treatment of high blood pressure (pre-eclampsia and eclampsia).
3. Treatment of severe bleeding (hemorrhage).
4. Manual removal of the placenta.
5. Removal of retained uterine products following miscarriage or abortion.
6. Assisted vaginal delivery using vacuum extractor or forceps.
7. Resuscitation of newborns.

Comprehensive emergency obstetric and newborn care (CEmONC) includes all the services offered by BEmONC, as well as the provision of obstetric surgery (caesarean section and blood transfusion).[1]

CAMPAIGN OBJECTIVES

In order to achieve this goal, the campaign planning identified three objectives:

1. In three pilot districts, district officials will request and allocate sufficient funds from the Ministry of Health for EmONC services by 2015.

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[52] White Ribbon Alliance for Safe Motherhood, Secretariat, October 2014.

[53] Focus Group Discussion 1. White Ribbon Alliance Uganda, 4 November 2014.

[54] Civil Society Organization, November 10-13, 2014.

[55] Focus Group Discussion 1. White Ribbon Alliance Uganda.

[56] International NGO, November 10, 2014.

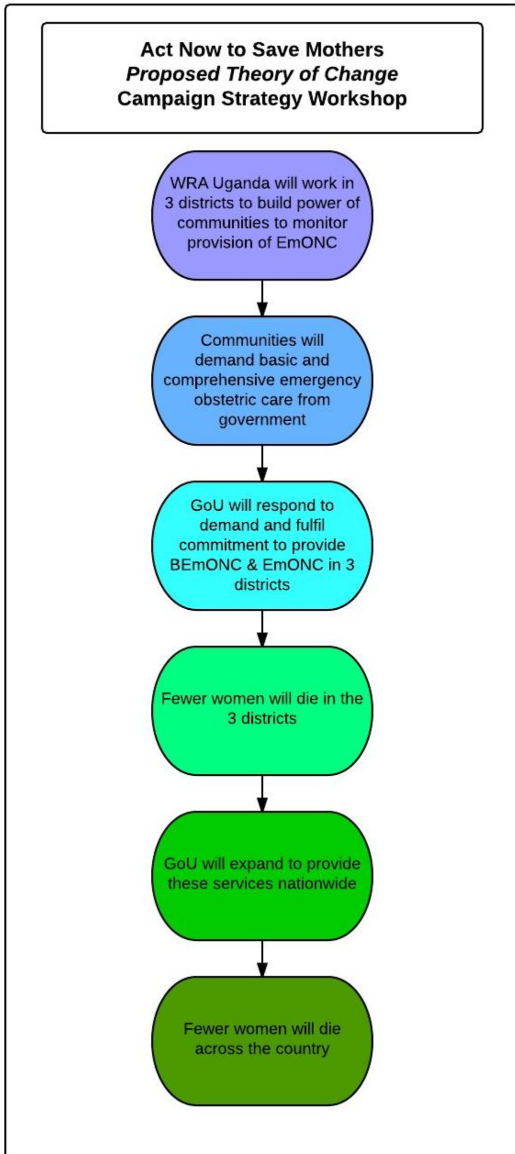
[57] Kristin Savard, "Follow Up -- Documents," 27 October 2014.

[58] White Ribbon Alliance for Safe Motherhood, Secretariat, October 2014.

2. The Minister of Health will allocate sufficient funds to fulfill government's commitment to improve recruitment, deployment, and motivation of health workers at health center IIIs and IVs by 2015.1

3. The Minister of Health and the Head of National Medical Stores will allocate sufficient funds for the procurement and delivery of EmONC equipment and supplies by 2015.

A month later, in March 2013, a working group of nine people convened to refine the ideas that had come out of the workshop,[59] and to draw up strategy documents. This team undertook a detailed national power mapping exercise and a SWOT (strengths, weaknesses, opportunities, and threats) analysis in order to identify the key stakeholders, risks, and opportunities.



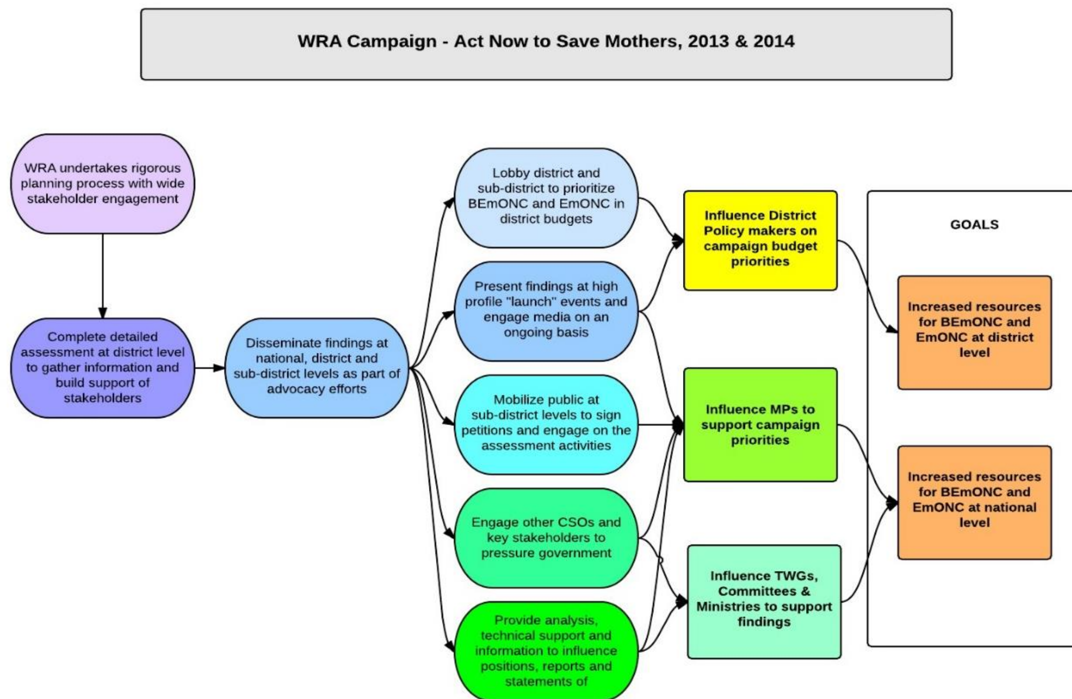
Based on the campaign goal and objectives, the early strategy workshop developed a theory of change that would underpin the planning and implementation of the campaign. The theory of change begins with grassroots engagement, education, and mobilization of communities around the campaign demands for EmONC and BEmONC services from the government of Uganda. This theory of change assumes that the government will respond to that increased demand, and that this will result in improved service delivery and ultimately reduced maternal mortality in the three selected districts. According to the theory articulated in the campaign strategy document, the reduction of maternal deaths in the three districts would then inspire the government to expand these services nationwide, which would reduce maternal mortality across the country.[60]

The campaign strategy explicitly laid out a two-pronged approach that aimed to get government officials at both the district and the national levels to prioritize funding for EmONC by working from a top-down and bottom-up approach simultaneously. From the bottom, communities and health facilities would be mobilized so as to apply pressure on district officials to prioritize funds for maternal health in their budgets. These same people, as well as district health officials, would apply pressure on MPs, Ministry of Health officials, and other government agencies. From the top, the alliance worked with

[59] "Stakeholders Power Mapping Meeting," White Ribbon Alliance, Uganda, 28 March 2013.

[60] "WRA Uganda Campaign Strategy: Act Now to Save Mothers," White Ribbon Alliance, n.d.

the Ministry of Health, MPs, and the relevant committees in parliament, with the aim of influencing key decision makers to apply downward pressure on the districts to prioritize funds for maternity-related services, as well as to persuade the ruling party and the Ministry of Finance to expand financing in this area at the national level. The aim was to have mutually reinforcing top-down and bottom-up efforts working simultaneously.[61] This theory of change was developed at the beginning of the campaign process. While the campaign plans have subsequently evolved with regard to the activities necessary to achieve the objectives, the theory of change has remained constant. Below is a chart outlining the key activities and goals for the campaign.



[61] White Ribbon Alliance for Safe Motherhood, Secretariat, October 2014.

OPERATIONAL PLANNING

WRA Uganda selected three districts in which to pilot the campaign. While the campaign sought impact on the national level, it wanted to have a measurable impact in a few places from which lessons could be learned and then scaled up.[62] The districts selected were Lira, Mityana, and Kabale. These three districts were selected for regional political balance, as maternal mortality “hotspots”, and because of the active presence of a district alliance.[63] The campaign also focused on health centers IIIs and IVs, because these are the facilities where most people receive health services, and because the government had made a commitment at the UN to focus on expanding services in these centers specifically. [64]

After the preliminary campaign design was complete, a second planning stage took place to help operationalize the campaign. The task now was to develop the campaign work plan, budget, timeline, mile stones, and a monitoring and evaluation plan.

Ray Mitchell travelled to Uganda to facilitate a week-long campaign planning workshop. This workshop focused participants on thinking concretely about key milestones and outcomes, and how to achieve these. The objective of the workshop was to complete a campaign planning grid for the first year of the campaign. Participants had to consider: What do we want to achieve, and what achievements do we consider to be milestones? Participants identified activities they could undertake themselves (such as direct lobbying), what persuaders would do (open up channels of communication and influence decision makers), and what community-based activities and media activities would be required?[65] Global Secretariat members reported that they had never seen this level of detailed planning from any other organization and that it’s been “exciting to work this way.”[66] Another said that it made an “immense difference” in the campaign implementation.[67]

Ray emphasized the importance of community engagement and grassroots participation. These activities could not just be token gestures, but needed to add power and pressure to the campaign.[68] Participants reported that this planning process was tedious and extremely time consuming, but that it assisted them to think through exactly who the campaign would target, and why.[69] This helped participants to see how to influence the important decision makers.[70]

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[62] Focus Group Discussion 1. White Ribbon Alliance Uganda.

[63] Civil Society Organization, November 10, 2014.

[64] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[65] White Ribbon Alliance for Safe Motherhood, Secretariat, October 2014.

[66] White Ribbon Alliance for Safe Motherhood, Secretariat, October 2014.

[67] White Ribbon Alliance, Secretariat, October 2014.

[68] White Ribbon Alliance for Safe Motherhood, Secretariat, October 2014.

[69] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[70] White Ribbon Alliance, Secretariat, October 2014.

IMPLEMENTING THE CAMPAIGN

A PARTICIPATORY ASSESSMENT OF EMONC SERVICES

As an aspect of the campaign, WRA Uganda required information regarding the provision of and access to EmONC and BEmONC. In August 2013, the alliance held a meeting at the Ministry of Health with the Commissioner of Reproductive Health to establish the availability of current information on the status of the provision of emergency obstetric and newborn care. The commissioner indicated that the available information was old, dating back to 2004. Because the services were inadequate, EmONC equipment had been procured in the 2012/2013 fiscal year and dispatched to various districts."[71]

WRA Uganda then held meetings with the District Health Officer (DHO) in each of the three selected districts to determine the availability of information at the district level. The meetings were also used to introduce the campaign to the DHOs. District committee members also attended the meetings. At the district level, it was clear that the DHOs lacked current information on EmONC service provision in their districts.[72] The WRA team discussed the possibility of conducting an assessment and made it clear to the DHOs that the purpose was not "investigating performance," but to collect information that would be needed to put forward demands to the Ministry of Health in order to improve the services offered by health centers.

WRA Uganda decided they needed to carry out their own assessment and received authorization from the Ministry of Health to do so in the three districts.[73] They wanted to go to all health center IIIs and IVs in the three districts. This meant visiting 43 health centers, 31 health center IIIs and 12 health center IVs. They considered a number of different tactics for carrying out the assessment.

WRA in Tanzania undertook a similar assessment, using just the National Coordinator and a WRA Tanzania Regional Representative, and did not include a broader technical team or participatory approach. However, the Ugandan national alliance insisted that they needed to use a broad-based participatory approach. Allowing people to go to the health facilities and participate in the assessment would result in a high level of buy-in, and everyone would understand the results. They also saw this as a means by which they could inspire "district-driven action" following the assessment. WRA Uganda wanted to simplify the process so that community members could participate and understand the campaign from the beginning.[74] The national secretariat also saw this as an opportunity to engage with and build the capacity of the district alliances, which would work on the assessment together with the district leadership and other local leaders and would ultimately help build consensus and lasting relationship with communities.[75]

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[71] Quarterly grant report. White Ribbon Alliance. September 2013.

[72] The White Ribbon Alliance, "Quarterly Progress Report," September 2013.

[73] White Ribbon Alliance Uganda, "Policy Brief," 2014.

[74] Focus Group Discussion 4. White Ribbon Alliance Uganda, November 26, 2014.

[75] *Ibid*.

WRA Uganda adapted and made use of an assessment tool developed by the World Health Organization (WHO). Their adapted version of the tool was reviewed by the Ministry of Health, WRA, and WHO. A one-day planning workshop was convened in each district. Aimed at fostering bottom-up demand for improved service delivery at the district level, the WRA included many stakeholders in this planning process and in the subsequent assessment. This included representatives from each of the health center IIIs and IVs in the district, the DHO, the district health team, the village health teams, political leadership, councilors, media, and opinion leaders. In each district, there were over 50 people at the planning workshop. Two assessment teams were establish in each district, with representatives from WRA Uganda (national and district), a representative of the DHO, and a senior midwife to provide technical input in each time. The district health centers were divided between the two teams.[76]

At each facility, in addition to the assessment team, health workers, local leaders, and community members were invited to participate in the assessment process. More than 20 people participated at each facility. Care was taken to ensure that health workers did not feel that they were being audited, and that they could see that the intention was to promote openness, discussion, and an exchange of views among all participants with the aim of providing assistance.[77]

Amongst other things, the review included the functionality of theaters, levels of staffing, and the availability of medical commodities and equipment, as well as an assessment of basic infrastructure and water and electricity supplies.[78] Checklists were easy to understand, and verification was carried out during a walk-through inspection. Once all the facilities had been assessed, the teams debriefed and shared their preliminary observations, and agreed on next steps.[79]

Participants gave positive feedback about their experiences in this participatory assessment process. One CSO participant remarked of the campaign, “What made the campaign beautiful was the fact-finding mission and presentation of findings at the district level. You have a problem, you know specifically what it is, and all the stakeholders in the district can understand it.”[80] Because of the broad cross-section of stakeholders involved, and understanding that the assessment was not an audit, the process encouraged local ownership of the assessment findings.[81] The DHOs endorsed the assessment report because they had been involved in the process.[82] This joint ownership also made it easy to market the report.[83]

The assessment process helped to open new lines of communication between stakeholders who had typically had very little interaction. For example, one person said that “one of the biggest successes has

[76] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[77] *Ibid*.

[78] Focus Group Discussion. White Ribbon Alliance, Lira, n.d.

[79] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[80] Civil Society Organization, November 10, 2014.

[81] White Ribbon Alliance. Secretariat, October 2014.

[82] Member of Parliament, November 11, 2014.

[83] Focus Group Discussion. White Ribbon Alliance, Lira.

been the breakdown of communication barriers between health workers and district officials" who got to know each other and stopped "pointing fingers" during this process. This provided a "huge morale boost" to health workers who previously felt underappreciated.[84] According to WRA Uganda, this experience promoted "shared responsibility."[85]

The information gathered through the assessment increased the awareness of many stakeholders. Health workers who thought they knew everything ended up learning more about referral processes.[86] One Ministry of Health official said that while some issues were expected, such as the lack of medical officers at health center IVs, other issues surprised them, such as shortages of equipment.[87] Leaders at the district level often did not know the problems facing health centers, or why mothers in their areas were being referred to distant facilities.[88]

The assessment identified significant challenges in the provision of the most basic EmONC services in the three districts. (See Table 2.) According to the findings, none of the health center IVs in any of the three districts could provide caesarean sections or blood transfusions. In Lira, none of the health center IIIs or IVs had running water. In addition, none of the three districts met the full staffing norms as per the Ministry of Health's minimum requirements for health center III or IV.[89]

TABLE 2: SHORTFALLS AND GAPS IN EMONC SERVICES

Leading Causes of Maternal Death	Related EmONC Service Essentials Assessment Findings
Hemorrhage (Severe bleeding)	• Severe bleeding accounts for 26% of all maternal deaths in Uganda. • None of the 12 health center IVs provides blood transfusions across the three districts. This is mainly due to unreliable facilities, such as electrical power to enable proper blood storage, and lack of laboratory staff, reagents, and other supplies. • Stockouts of crucial drugs to prevent postpartum hemorrhage were reported at five out of 43 health centers.
Sepsis (Infection)	• Infection accounts for 22% of maternal deaths in Uganda. • Stockouts of life-saving antibiotics were reported at two out of 43 health centers. • Sanitation facilities were inadequate to serve large numbers of clients, increasing the risk of infection. In Lira, none of the nine health centers had piped water, and only one out of 12 and seven out of 22 in Mityana and Kabale had piper water, respectively. • Health workers frequently used their money to buy charcoal or paraffin in order to properly sterilize instruments and often requested pregnant

[84] White Ribbon Alliance for Safe Motherhood, Secretariat, October 2014.

[85] *Ibid*. and ; Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[86] Focus Group Discussion. White Ribbon Alliance, Lira.

[87] Official, Ministry of Health.

[88] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[89] "White Ribbon Alliance Uganda, "Policy Brief," 2014.

	women to buy gloves for their delivery because health centers did not have adequate supplies.
Pre-eclampsia and Eclmapsia (High blood pressure)	• Eclampsia accounts for 6% of maternal deaths in Uganda. • Stockouts of the inexpensive life-saving drug, magnesium sulfate, which treats eclampsia, were reported in 10 out of 43 health centers. • Even where magnesium sulfate was available, some midwives reported inadequate skills to administer the drug and manage eclampsia. In addition, health workers needed further training to recognize symptoms of eclampsia. • Five out of nine health centers in Lira, seven out of 12 in Mityana, and 11 out of 22 health centers in Kabale lacked basic equipment to measure women's blood pressure in maternity units.
Obstructed Labor	• Delivery instruments are needed to safely deliver a baby when there is an obstructed labor. However, in Lira, only four out of 9 health centers had a complete set of delivery instruments, while in Kabale, only 15 out of 22, and in Mityana, only six out of 12 had complete delivery sets. In Kabale, all manual vacuum aspiration (MVA) equipment/kits had expired without being replaced. Only three out of 9 health centers in Lira had oxygen regulators. • Only one health center IV out of 12 across all three districts provided caesarean sections. Other health center IVs do not have working operating theaters or lack qualified health workers to provide surgery and blood transfusion services. Kabale had none of the 14 required medical officers, seven anesthetic officers, seven anesthetic assistants, and seven theater assistants for its seven health center IVs.

Following completion of the assessment, WRA Uganda moved into the next stage of the campaign to disseminate the findings of the assessment and to advocate and lobby for increased budget resources for BEmONC and CEmONC at the district and national levels. The alliance explicitly set out to have a two-pronged strategy that involved engaging national government to prioritize its funding of emergency care, while the districts themselves made similar demands from the bottom up. This created upward pressure from health facilities to the districts and from the districts to the national politicians, as well as downward pressure from national politicians to the districts. The strategy was to have mutually reinforcing mechanisms working simultaneously.[90]

At this stage the campaign activities included: 1) disseminating results at the national and subnational levels to increase awareness, engage the media, and influence opinions of the public and policymakers; 2) mobilizing citizens to demand change through the use of petitions and other tactics; and 3) providing technical input, reports, and analyses to the relevant ministries, technical working groups, and committees to try and influence their positions on the budget.

[90] White Ribbon Alliance for Safe Motherhood, Secretariat, October 2014.

EVIDENCE-BASED ADVOCACY THROUGH PUBLIC PETITIONS

The campaign sought to engage citizens at the grassroots level. In the first phase of the campaign, WRA Uganda did this through the participatory assessment. In the second phase of the campaign, the alliance engaged the public through a series of subnational events in the participating districts, and through petitions which were presented by citizens to their respective members of parliament.

In Uganda the use of petitions is relatively new and therefore generated interest.[91] In order to get petition signatories, WRA Uganda summarized the key issues from the assessment into a one-page document with very clear requests for each particular district. The district alliances organized community meetings to discuss the issues presented in the petitions, and collected signatures. Each district collected between 700 and 1,000 signatures.[92] In Kabale district, the petition included signatories not only from that district, but from across the entire Kigezi region.[93]

BOX 3. PRIORITY RECOMMENDATIONS AND ACTIONS

The health facility assessment findings were summarized at the launch events and encouraged stakeholders to request sufficient funds to address key identified gaps and contribute to upholding the government's commitment of providing life-saving obstetric emergency care services at health center IIIs and IVs. Recommendations included:

- Fill the existing human resource for health gaps at health center IIIs and IVs as a follow up of 2012/2013 national recruitment drive.
- Provide a comprehensive motivation package for health workers in order to avoid financial waste of prior investments in human resource recruitments.
- Functionalize operating theaters by allocating sufficient funds to renovate and equip the theaters.
- Double primary health care funds non-wage and capital development to support and boost recurrent costs, staff housing, running water installations, and electricity provisions.
- Prioritize procurement of adequate essential medicines, health supplies and equipment for EmON.
- Provide running water and light in labor and antenatal wards.

District teams and communities organized meetings to present the petitions to the District Speaker in their district. The petition specifically advocated the district council prioritize EmONC funding in the district budget framework.[94]

After sharing the petitions, WRA Uganda convened a number of meetings and initiatives at the district and subcounty levels to try to ensure that the findings of the assessment were addressed in the 2014/15 budget, which was then under preparation. The timing of these activities was aligned with the budget timeline so that the information could be used to prioritize women's health.[95]

[91] *Ibid*.

[92] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[93] Member of Parliament, November 13, 2014.

[94] White Ribbon Alliance, "Quarterly Progress Report" December 2013.

[95] *Ibid.*

In December 2013 WRA Uganda, together with the DHOs, convened more detailed dissemination meetings at district level in order to coordinate with the district budget preparation processes. The dissemination meetings mobilized a wide cross-section of district stakeholders. Participants with influence over the budget process were targeted for these meetings, including national, district and subcounty political leadership, chiefs, key maternal health NGOs, alliance members, and media representatives.[96]

For example, in Lira district, after presenting the petition, WRA Uganda organized subcounty meetings in areas that had been identified as having acute service delivery problems, so that they too could demand additional budget resources. After presenting the petition to the District Speaker in Lira, the national team also organized meetings in Amach and Ogur subcounty headquarters to meet with local leaders and share the assessment findings. They emphasized the need to prioritize the renovation of operating theaters in those subcounties, so that local leaders would include those requests in their budget submission to the district for the 2014/15 fiscal year.

In Mityana District, WRA Uganda met with three subcounties identified as having the poorest basic emergency and newborn care services to encourage them to prioritize these issues in the budget. For example, in Kalangaalo subcounty, national leaders met with local leaders to try to encourage them to demand that their health centers be made functional by allocating sufficient funds to meet their needs.[97]

In Lira and Kabale districts, WRA Uganda organized meetings with the Health Standing Committees before the district budget conferences. These meetings brought in external district councilors and a representative of the DHO to meet with the committee and encourage them to prioritize EmONC when they scrutinize the budget submissions from the budget conference.[98]

In Kabale specifically, meetings were convened on short notice in response to a revised budget call circular from the Ministry of Finance. That circular required local governments to submit their budget framework papers sooner than anticipated. WRA Uganda organized within days to share assessment findings with the subcounty officials and to request that they help fill the identified gaps.[99]

WRA Uganda also sought to bring the petitions and key findings from the district-level assessments to attention at the national level, so as to mobilize support and action among stakeholders and target communities for collective budget advocacy. They wanted to garner media attention by planning launch events at the district and national levels in April 2014.[100] For each event an organizing committee was formed, and WRA Uganda developed advocacy and promotional materials, mobilized communities to

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[96] *Ibid*.

[97] *Ibid.*

[98] *Ibid*.

[99] *Ibid.*

[100] "Concept Note: Health Facility Assessment for Emergency Obstetric and Newborn Care Provision in Kabale, Lira, and Mityana Districts," White Ribbon Alliance, n.d.

participate in the launch event, and set up media activities and speeches.[101] The launch event, "Emergency Obstetric and Newborn Care: A Priority Intervention to Reduce Maternal and Newborn Deaths in Uganda, Act Now to Save Mothers," was held in each district for one day in April, culminating in a national-level launch event on the April 25.[102]

BOX 4. TESTIMONY BY A SURVIVOR OF OBSTETRIC COMPLICATIONS AT THE "ACT NOW TO SAVE MOTHERS" NATIONAL LAUNCH EVENT

Ms Evelyn Ajok, a twenty-year-old woman from Lira district, shared her experience of an obstetric complication where she nearly lost her life but survived with a disability. Ajok was 18 when she got pregnant. She experienced obstructed labor at her nearby health center III but there were delays to get an emergency operation because the facility had no ambulance and Ajok did not readily have money for private transport. By the time she reached Lira Regional Referral Hospital it was too late to save her baby. While Ajok is lucky not to be one of the maternal death statistics, she got a vesicovaginal fisitula (VVF). "I do not think I would like to be pregnant again. The experience was so traumatizing," Ajok emotionally disclosed. Her urine and stool now uses the same passage.

In each district, WRA Uganda invited key stakeholders to the launch events, including CSOs, district and subcounty officials, health workers, and other stakeholders. They also made sure that in each district a member of parliament from the area was present to officially receive the petition from the community. These elected leaders were asked to present the petition to the Ugandan Parliament.[103]

At the national level, the alliance targeted key individuals to participate in the event, including the Minister of Health, who came to the event and publicly committed support for the issues raised in the petitions.[104] WRA Uganda also sought representation from the Ministry of Finance, Ministry of Health, Ugandan Parliament, the Network of African Women Ministers and Parliamentarians (NAWMP) Uganda Chapter, Uganda Parliamentary Forum for Children (UPFC), Uganda Women Parliamentary Association (UWOPA), maternal and newborn health professional associations, health development partners, WRA Uganda members, and the DHOs from the three targeted districts.[105]

The launch event featured the presentation of key findings from the district assessments as a basis to guide government resource allocation. The alliance invited a survivor of obstetric complications to come and speak at the event. Many respondents commented on how powerfully she spoke and what an impact it made on them to hear the pain of her experiences.[106]

WRA Uganda has worked over many years to identify allies and gain the support of key parliamentarians, as part of its overall strategy to identify "champions who have influence on others"

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[101] White Ribbon Alliance, "Report of Act Now to Save Mothers Campaign Launch," April 2014. [[Q: ADDED MONTH TO MAKE IT LOOK MORE "OFFICIAL."]]

[102] "Concept Note: Health Facility Assessment for Emergency Obstetric and Newborn Care Provision in Kabale, Lira, and Mityana Districts," White River Alliance, n.d.

[103] Focus Group Discussion 2. White Ribbon Alliance Uganda.

[104] International NGO, November 7, 2014.

[105] "Concept Note: Health Facility Assessment for Emergency Obstetric and Newborn Care Provision in Kabale, Lira, and Mityana Districts," White River Alliance, n.d.

[106] International NGO, November 7, 2014.

and to engage "with the right spokesperson."[107] As part of the alliance model, some MPs are members of the alliance and serve as key allies on issues of maternal health.[108] Due to many years of advocacy on these issues by CSOs and MPs, the issue is now one of political importance in Uganda.[109] One member of a professional association commented that, not only do politicians in Uganda care about maternal health, but they also work on this issue as a "good strategy for garnering voters" for it "gives them leverage."[110]

Therefore, at the national level, WRA Uganda worked to target key stakeholders, raise awareness based on their findings, and influence the national budget process. The coalition did these things through a series of planned events, as well as by taking advantage of new opportunities to lobby critical players.

For example, on 17 October 2013, WRA Uganda identified an opportunity to share preliminary results with the Minister of Health and present a small petition to commemorate National Safe Motherhood Day by joining an official function in Apac District. There, they were able to present a petition to Hon. Minister of Health Ruhukana Rugunda (who was appointed the Prime Minister in 2014), calling on the government of Uganda to uphold its commitment to resource the provision of EmONC. The petition gathered more than 800 signatures from health CSOs, citizens from eight districts, and media representatives. WRA planned to gather more signatures over the course of the campaign to demonstrate the demand from citizens for the government to uphold its commitment.[111] While this petition was not intended in the original campaign plan, such key events present opportunities that the alliance does not want to overlook.[112]

WRA Uganda and the MPs who participated in the district launch events presented the campaign petitions to the Ugandan Parliament. It was only in July 2014 parliament gave it consideration.[113] When it was presented to parliament, the Speaker of Parliament, who was known to WRA Uganda and had supported the Human Resources for Health campaign in 2012, assigned the petitions to the Parliamentary Committee on Health and directed the committee to investigate the matter and report back to the full body.[114, 115]

One MP explained that the petition was successful at getting the attention of the Speaker and other members because it was based on research and facts. She said that the campaign had presented something that was "not half-baked."[116] Moreover, this was an issue that resonated in parliament,

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[107] Focus Group Discussion 4. White Ribbon Alliance Uganda, November 26, 2014.

[108] *Ibid.*

[109] (Forthcoming.) Larsen, J. *Case Study: Human Resources for Health Campaign*, International Budget Partnership, December 2014.

[110] Professional Association, November 8, 2014.

[111] The White Ribbon Alliance, "Quarterly Progress Report," December 2013.

[112] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[113] Member of Parliament, November 13, 2014.

[114] (Forthcoming.) Larsen, J. *Case Study: Human Resources for Health Campaign*, International Budget Partnership, December 2014.

[115] Member of Parliament, November 11 and 20, 2014.

[116] Former Member of Parliament.

because even though the research was only carried out in three districts, the problem is widely known and affects all of the members' districts. Another MP emphasized that the petition is from "the people who go to get services" and represents "their cry, their plea." However, he said that parliament can be slow, and even while "people are still dying, we don't see any response from the government."[117] While it was clear that petitions "don't give an immediate result," they can "be the future basis for a budget increase."[118]

The main outcome of this petition was the instruction to the Committee on Health to investigate the issues and report back to Parliament. Based on this assignment, the committee sent representatives to visit Kabale district in September 2014 on a fact-finding mission. MPs said that they were shocked at what they discovered and that many health centers failed to meet the minimum standards. They further plan to visit Lira district. However, at the time of writing, this trip had been postponed and was scheduled to be carried out in the last quarter of 2014, or the first quarter of 2015. Throughout this process WRA Uganda has continued to follow up with the relevant MPs and with the Committee on Health to keep them engaged on these issues and ensure that the district visits are completed.[119] The final report of the committee should be in time to influence the 2015/16 budget preparations.

LOBBYING PARLIAMENT FOR BUDGET IMPROVEMENTS

Since 2011, WRA Uganda has been actively collaborating with the Ministry of Health, the Technical Working Groups at the Ministry of Health, and various other committees of parliament, including the Committee on Health and the Budget Committee. In 2012, CSOs specifically pursued this relationship building as a strategy, and built positive relationships with the Ministry of Health and technical stakeholders.[120]

WRA Uganda continued this engagement and reaffirmed its technical expertise through the Act Now to Save Mothers campaign. Because of their engagement on the 2012/13 budget issues, the Ministry of Health was receptive to the alliance and viewed them as key allies on budget issues.[121] WRA Uganda is considered credible and is trusted by parliamentarians and technical people within the ministries. One former MP said that they have worked seriously with CSOs, "They would assist us critically in looking at issues. Politicians are good at talking, but on the critical issues, we need technical input." WRA Uganda helps to give "research and well-informed, statistical analysis for presentation."[122]

In January 2014, after completion of the district assessments, WRA Uganda requested the opportunity to present the findings to the Ministry of Health Technical Working Group (TWG) on Maternal, Child, and Newborn Health. This is a working group of which WRA Uganda is a member by virtue of being a

[117] Member of Parliament, November 11, 2014.

[118] Member of Parliament, November 13, 2014.

[119] *Ibid*.

[120] Larsen, J. *Case Study: Human Resources for Health Campaign*, International Budget Partnership, December 2014.

[121] Focus Group Discussion 2. White Ribbon Alliance Uganda, November 5, 2014.

[122] Former Member of Parliament.

stakeholder in maternal and newborn health. The purpose of the meeting was to report on the assessment findings, get the endorsement of the TWG for the campaign, and urge the Ministry of Health to support making EmONC a priority.[123] This meeting was timed to demonstrate the key gaps identified early in the budgeting process and was also aimed at urging the Ministry of Health to allocate sufficient funds for the Kabale, Lira, and Mityana districts. In order to draw additional attention to these issues, the alliance participated in a national radio program before the event to share their findings publicly.[124] Following the TWG meeting, WRA Uganda was asked to present its findings to the Minister of Health, who subsequently promised to take action on them by expanding budgetary resources.[125]

WRA Uganda also met with the budget division to discuss key issues, including the enhancement of salaries for health workers and Primary Health Care Non-wage payments for operational costs. At that time, in 2013, they were working on a second draft of the budget for 2014/15, and the Ministry of Health agreed to include the issues highlighted by WRA Uganda among the non-funded priorities. A specific request was made for additional money to recruit staff, motivate midwives, increase salaries, as well as to double the Primary Health Care Non-wage allocation. These requests were captured in the "Health Sector Ministerial Policy Statement" for the 2014/15 fiscal year."[126]

In May 2014, when Minister Rugunda presented the proposed budget for the health sector for 2014/15 to the Parliamentary Committees on Health and Budget, both proposals included the unfunded priorities requested by CSOs, which included a request for UGX 129 billion for wage enhancement of midwives at health center IIIs, UGX 2.5 billion for the recruitment of an additional 3,000 health workers, and a request for additional funding for Primary Health Care Non-wage payments and equipment.[127] On the specific request of the Non-wage contribution, the Ministerial Policy Statement identified a gap of UGX 39.5 billion to make the current facilities (without the proposed staff recruitment) operate at a reasonable level.[128]

When the budget was read publicly in July 2014, the Minister of Finance, Planning, and Economic Development (MoFPED) said that UGX 450 billion had been allocated to enhance salaries of public servants. She specifically mentioned that teachers (who were very active through a teachers' union) would receive funds but made no mention of how much would be allocated to health workers.[129] WRA Uganda, together with CSO budget advocacy partners, responded to the budget by demanding to know how much of the increment would go to health workers.[130] After one week, the Ministry of Public

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[123] The White Ribbon Alliance, "Quarterly Progress Grant Report," December 2013.

[124] *Ibid*.

[125] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[126] Focus Group Discussion 2. White Ribbon Alliance Uganda, November 5, 2014.

[127] Hon. Dr. Rugunda, Minister of Health, "Highlights of the Health Sector Budget Framework Paper for FY 2014/15," May 3, 2014.

[128] *Ministerial Policy Statement FY 2014/15: Health*, Ministry of Health, Kampala, Uganda, n.d..

[129] Focus Group Discussion 2. White Ribbon Alliance Uganda.

[130] *Ibid*.

Service provided a detailed proposal that provided a salary increment of 18 percent for midwives and some other types of health workers, and 13 percent for other groups.[131]

While this achievement was not solely the result of the WRA campaign, but also the result of larger CSO and parliamentary advocacy efforts, WRA Uganda felt as though the information provided from the three district assessments contributed to strong evidence-based arguments.[132]

After the budget speech, the Parliamentary Committee on Health invited CSOs to present their views on the budget statement. CSOs reviewed the policy statement, and in July 2014, WRA Uganda, together with its CSO budget advocacy partners, appeared before the Committee on Health. In the previous year, they had succeeded in requesting more funds for the recruitment of health workers; therefore, all the CSOs agreed that they would focus on the issue additional funds for recruitment, remuneration for health workers to improve their motivation, and the operational costs that had been highlighted during the assessment.[133]

In September 2014, the Parliament of Uganda approved a new budget which did provide the requested salary increment for health workers. These salary increases were confirmed by DHOs and health workers during the campaign review meetings held in August 2014 in Kabale, Lira, and Mityana districts.[134] While parliament did not provide additional resources for Primary Health Care Non-wage payments in this year, the fact that it was included as a non-funded priority may help for them to secure the increase in the 2015/16 budget.

PROCUREMENT OF MEDICAL SUPPLIES

WRA Uganda's Act Now to Save Mothers campaign succeeded in taking the challenges experienced at the level of health facilities up to both district and national levels. An example of this relates to the procurement challenges identified through the health facility assessment.

One of the key assessment findings was the existence of shortages of equipment and key health commodities in the health centers. During the dissemination meetings, it emerged that part of the problem was in the procurement planning process, and linkages between facilities, the district level, and the national level in carrying out this planning. It was not even clear to the authorities which steps came first in the process, or which equipment might be provided by the National Medical Stores (NMS). WRA Uganda set out to understand the procurement issues and processes, share that with the district team, and help to bring people together to find a way of improving the provision of medical equipment and supplies.[135]

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[131] *Ibid*.

[132] Professional Association, November 12, 2014.

[133] White Ribbon Alliance, "Quarterly Progress Grants Report," October 2014.

[134] *Ibid*.

[135] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

WRA Uganda worked with the DHOs, who compiled a list of the missing equipment. They requested support from the NMS, which indicated that it is not their mandate to procure equipment. WRA Uganda was directed to the Commissioner of Clinical Services at the Ministry of Health, who acknowledged that budgetary constraints largely prevented them from providing equipment. They then engaged with PATH, an international nonprofit health organization that is working on a UN lifesaving commodities initiative, and are now working together on a request to ensure that newborn resuscitation devices are categorized as vital equipment. They also want to see these devices included on the NMS procurement form and in the basic kit for health center IIIs.[136]

In January 2014 WRA Uganda held a meeting with NMS to discuss how to procure sufficient drugs, equipment, and supplies to provide EmONC in the three districts that had been visited during the assessment. After getting feedback from the national level, the WRA Uganda team held follow-up meetings at the district level to encourage teams to develop procurement plans that reflected the needs identified in the health facility assessments. The districts shared some of the challenges they faced, including inadequate budgets, lack of clarity on the procurement process, and a paucity of information on new medicines and supplies.[137] The district medicines management teams worked on their procurement plans and made presentations to everyone on how they could avoid shortages on key commodities.[138]

WRA Uganda held a second meeting with the NMS to give feedback from the district meetings and the NMS general manager committed to work with the alliance and the three districts to get access to lifesaving medicines and supplies.[139] As a result of this WRA Uganda initiative around procurement, CSOs now think that the information system has been improved enough that there will be fewer stockouts and better overall planning at the district level.[140]

THE MEDIA AND ADVOCACY

No campaign that is aimed at drawing public and government attention to a problem is complete without an active recruitment of the media. Throughout the campaign, WRA Uganda engaged with the media in order to “amplify voices” from the districts so that they could be heard at a national level.[141] It has been a key part of campaign strategy to engage the media at every step of the process, from campaign planning to the assessment, and throughout all of the budget advocacy and lobbying. WRA Uganda invited media outlets to join the alliance.

[136] *Ibid.*

[137] White Ribbon Alliance, “Quarterly Progress Grant Report," December 2013."

[138] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[139] The White Ribbon Alliance, “Quarterly Progress Grant Report,” December 2013.

[140] Civil Society Organization, November 10, 2014.

[141] Civil Society Organization, November 13, 2014.

A district alliance member said that they include media representatives in all their activities to raise the profile of the campaign and that such engagement has "opened our eyes to health reporting."[142] This district representative reported that the local media scheduled a time on the radio where the DHO and other health stakeholders could speak on priority issues. At a district level, WRA Uganda saw that the "media gives voice to the voiceless," and they used the media to empower communities and put pressure on the government. They agreed, "We want politicians to be ashamed and think that they are not doing enough."[143]

WRA Uganda invited the media to participate in the district health facility assessment. They wanted the media to understand the core issues and have substantive information.[144] This led to reports in the media about some of the things that the teams observed. For example, in one health facility, there was a large generator that had been purchased, but because it had never been connected, it had been abandoned and a giant ant hill had been built into it. The media report drew attention to the issue, and the next day local leaders went to see if it was true. This resulted in the generator being cleaned, a new shelter built to house the machine, and the facility getting connected to a power supply.[145] In another example, during the assessment in Lira district, a leading FM radio station broadcast nine news items on the preliminary findings.[146]

At the national level, WRA Uganda has built a relationship with the media over a number of years. In the current campaign they focused their efforts on the Parliamentary Press Association journalists, because of their knowledge of health budget issues.[147] After the launch events, breakfast meetings were held with the editors of key media outlets and with Parliamentary Press Association members. These meetings helped journalists understand the key issues of the campaign as budget discussions were getting underway.[148]

Increasing media coverage has been given to maternal and women's health in Uganda, as it has become an important political issue. A cadre of journalists passionate about health and with experience on the subject has emerged, gaining specialized skills on health reporting and devoting time and energy to these issues. Overall, the media engagement by WRA Uganda has been described as "impressive," since they are good at documenting and communicating on the campaign activities.[149]

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[142] Focus Group Discussion. White Ribbon Alliance, Mityana, n.d..

[143] Focus Group Discussion. White Ribbon Alliance, Lira.

[144] Focus Group Discussion 2. White Ribbon Alliance Uganda, November 5, 2014.

[145] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[146] White Ribbon Alliance, "Quarterly Progress Report," December 2013.

[147] Focus Group Discussion 1. White Ribbon Alliance Uganda, November 4, 2014.

[148] Focus Group Discussion 2. White Ribbon Alliance Uganda, November 5, 2014.

[149] International NGO, November 10, 2014.

Throughout this campaign, WRA Uganda has been active on social media, including a campaign blog, Facebook, and Twitter. They use photographs and quotes from politicians to help document and share their work and community engagement.[150] The WRA Uganda Facebook page has over 1,600 “likes.”[151]

GOVERNMENT RESPONSE TO THE CAMPAIGN

As of December 2014, the time of writing, the Act Now to Save Mothers campaign is at its midpoint. The first year of the campaign was mainly devoted to identifying, defining, and planning the campaign; generating stakeholder buy-in; and carrying out the district assessments. In the second year, the campaign focused on budget advocacy, and lobbying at the subcounty, district, and national levels. With one year remaining, much more advocacy, awareness building, and lobbying are planned. Up to this point government responses have been largely positive.

DISTRICT LEVEL GOVERNMENT RESPONSES

At the district level, the campaign has changed the availability of information. Districts now have a very detailed understanding of service delivery challenges, and how important resolving these is to saving the lives of mothers and children.[152] The campaign has already altered the way budget resources have been allocated in the 2014/15 budget process. DHOs have in some cases changed their strategies, and this may have improved service delivery in certain districts and health centers. In most cases these changes do not reflect an increased allocation of resources, but rather the higher priority given to the use of existing resources to address issues of maternal and child health. Some examples of these changes in the districts that were assessed are given below.

KABALE DISTRICT

In Kabale, the assessment identified that the seven health center IVs in the district lacked a medical doctor. The district faces challenges in recruiting doctors, partly because it is a hard-to-reach and hard-to-serve district.[153] As a result of the assessment, the DHO prioritized the recruitment of a doctor and worked with the council members and WRA Uganda to identify new recruitment strategies. The DHO went to medical schools to seek new graduates. For those interested graduates, the district organized a study tour of the district and encouraged them to work in the district. As a result, in September 2014, Kabale recruited six medical doctors and deployed one at each of six health center IVs.[154]

In the same fiscal year, according to the 2014/15 Health Sector Budget, Kabale District prioritized spending on areas that would improve maternal health services in health center IIIs and health center IVs. This includes budget provisions as follows:

- UGX 26,2 million to complete the renovation of the maternity ward at Kyogo health center III;

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[150] White Ribbon Alliance for Safe Motherhood, Secretariat, October 2014.

[151] https://www.facebook.com/wrauganda.

[152] Professional Association, November 12, 2014.

[153] Member of Parliament, November 13, 2014.

[154] Focus Group Discussion 2. White Ribbon Alliance Uganda, November 5, 2014.

- UGX 10 million to install and connect Kamwezi Health Center IV to the national power grid; and
- UGX 16,2 million to construct a stance ventilated improved pit latrine at Muko Health Center IV. [155]

Finally, a partnership project of the African Medical and Research Foundation (AMREF), Health Africa in Uganda, WRA Uganda, and We Care Solar has donated solar suitcases to maternity wards in health center IIIs and IVs in Kabale District under a program called "Saving Lives at Birth (SLAB)". The solar kit includes solar lighting, a laptop, a charging device, and head lamps. These kits allow clinics which normally lack power or back-up power supplies to continue to provide services at night. This collaboration means that many of the health facilities identified by WRA Uganda have also received this support from the SLAB project.[156]

LIRA DISTRICT

In Lira District, officials said that they have specifically allocated funds based on the outcomes of the campaign. For example, they said that UGX 50 million had been allocated to renovate the surgical theaters at two health centers as a direct result of the campaign. The campaign had helped them realize the "lifesaving nature" of these facilities. The renovations are now a district priority. It is not new funds that are being used, but funds that had been allocated in other ways. In one case funds had been allocated to improve the doctor's house. The campaign showed them that there was no use in having a doctor if he couldn't perform his duties by having a surgical theater. They are also hoping that the newly functional theaters will help reduce referrals to the regional hospital.[157]

The district also indicated that UGX 30 million was allocated in the 2014/15 budget specifically to prioritize EmONC medicines.[158] They said that they provided additional budgetary funding for maintenance at Barr health center, and have allocated funds to complete construction at a health center where a contractor had run off with the remaining money before completion of the work.[159] Other budget areas mentioned during meetings were funds for solar power in one facility, a maternity ward that needed to be completed, and a birthing room.

According to the Health Sector Budget for 2014/15, the Lira District Local Government made the following additional budget allocations:[160]

- UGX 10 million allocated for installation of solar power at Ongica Health Center III;
- UGX 4 million allocated for construction of a placenta pit for Barr Health Center III maternity ward;
- UGX 16 million allocated to construct two stance drainable toilets and bathrooms at Barr Health Center III;

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[155] Kristin Savard, "Outcomes," October 20, 2014.

[156] International NGO, November 17, 2014.

[157] Focus Group Discussion 2. White Ribbon Alliance Uganda, November 5, 2014.

[158] Focus Group Discussion. White Ribbon Alliance, Lira, n.d.

[159] *Ibid.*

[160] Savard, "Outcomes."

- UGX 29,6 million allocated for completion of a maternity ward at Barr Health Center III;
- UGX 16 million allocated for construction of two stance drainable toilets and bathrooms at Barapwo Health Center IV; and
- UGX 16 million allocated for construction of two stance drainable toilets and bathrooms at Ogur Health Center IV.

Aside from funding issues, some district and subcounty officials reported behavior changes. In particular, the chair of a local council said the campaign's engagement with the community during the assessment process has resulted in more mothers now reporting for prenatal care, as well as couples attending HIV counseling.[161]

The Lira District Health Management Team said that the assessment helped them to identify gaps and improve their planning processes. For example, much more work had gone into the annual procurement plan, with more focus on medicines for maternal health. They expected fewer stock problems as a result.[162]

MITYANA DISTRICT

In Mityana, some health facilities reported that the assessment had helped them to get more staff, improve community engagement, and procure new equipment. They said that while people in the community used to fear health workers, they now approach them with their problems. With regard to the equipment, they indicated that they had received ultrasound equipment and training as a result of the Strides for Family Health Program funded by USAID.[163]

According to WRA Uganda, Mityana District achieved a number of other outcomes:[164]

- The completion of construction of Ssekanyonyi Health Center IV operating theater. At the time of the assessment, the construction works were found to be substandard, and the district leadership committed to redo the works and complete the project during 2014/15.
- The completion of construction of two staff houses at Kikandwa Health Center III and Kitongo Health Center III, and staff houses at Ssekanyonyi Health Center IV.
- The construction of four-in-one staff houses at Bulera health center III and Kabule health center III.
- The construction of staff quarters at Magala health center III and Naama health center III.
- The Ministry of Health recommitted and scheduled to rehabilitate a number of health centers IV, including Mwera and Kyantungo health centers IV in Mityana District, using an expected World Bank loan. These two health centers IV were assessed by WRA Uganda and found to be dilapidated.

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[161] J. P. Atine, Local Council Chairman III, Barr Subcounty, Lira District.

[162] Focus Group Discussion. Health Leadership, n.d.

[163] Focus Group Discussion. White Ribbon Alliance, Mityana, n.d..

[164] Savard, "Outcomes."

NATIONAL LEVEL GOVERNMENT RESPONSE

Many of the national level impacts that the campaign hopes to achieve were planned for the final year of the campaign in 2015. However, as has been described in this study, there were already some notable achievements at the time of data collection and writing. In particular these included:

- The inclusion of the Primary Health Care Non-Wage priorities as "unfunded," with a request for UGX 39.5 billion in the Ministry of Health Ministerial Policy Statement on the budget for the fiscal year 2015/16, and the inclusion of this issue in the Health Committee report. While the budget was not allocated in the current fiscal year, this provides a very good platform from which WRA Uganda can continue their advocacy and lobbying for the 2015/16 budget, as the position has already been adopted by the Ministry of Health and the Ugandan Parliament.[165] Getting included as an "unfunded priority" means prioritization in future years, and sometimes it is used by donors to identify priorities and funding gaps that they can contribute to.[166]

- The Parliament of Uganda responded to the citizen petition by instructing the Committee on Health to investigate the issues presented in the petition. The committee has already sent a team to Kabale District to probe the concerns raised, and as of December 2014 also planned to visit Lira District. Committee members confirmed that they can verify many of the problems related to medical commodities, equipment, staffing, and other matters raised by the report. Based on their findings, the team will write a report and generate recommendations. This will be discussed by parliament, and the recommendations considered. Such recommendations will constitute a directive to the Ministry of Health, which then has the responsibility to take action towards the next budget cycle.[167] While the latter part of this process had not yet taken place at the time of writing, it is likely that the recommendations of the committee will echo what was proposed in the citizen petition, which included the key demands from the WRA Uganda health facility assessment.

- The government of Uganda increased the salary of public service workers, including health workers, in the 2014/15 budget. The demand for higher pay for health workers was a key issue of the WRA Uganda campaign, and had also been advocated in the work of other CSOs. This salary increment will help in the recruitment and motivation of health workers.[168]

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[165] International NGO, November 10, 2014.

[166] Official, Ministry of Health, November 2014.

[167] Minister of Parliament, November 17, 2014.

[168] White Ribbon Alliance, "Quarterly Progress Grant Report," October 2014.

CAMPAIGN ACHIEVEMENTS AND LESSONS LEARNED

CAMPAIGN ACHIEVEMENTS AS OF DECEMBER 2014

The WRA Uganda Campaign Act Now to Save Mothers had demonstrated early successes, despite still being a work in progress.

At the district level, no government responses would have taken place without the WRA Uganda intervention. The participatory data-gathering phase of the campaign engaged a wide number of stakeholders, health facilities, subcounties, and districts. Field visits demonstrated high levels of stakeholder buy-in, ownership of the assessment results by district health and political leadership, and a keen understanding of the problems the districts face in delivering basic and comprehensive emergency obstetric and newborn care. The strategy was not without cost, in both time and resources. However, it has begun to bear fruit, and this grassroots-level investigative work is important for any CSO campaign that seeks to bring the public and various levels of government together to make common cause.

At the national level, the campaign is pushing the health agenda closer to giving priority to funding the operational expenses of health facilities, and identifying critical gaps and shortages in the provision of maternal health services. The fact that the Committee on Health responded to the petition by undertaking an investigation at district level, suggests that these issues will be adopted by parliament in the next budget cycle and that additional resources may be allocated.

These changes would most certainly not have happened without the WRA Uganda campaign. The assessment process gathered data which gave critical evidence to government officials and encouraged CSOs to continue their lobbying. The fact that WRA Uganda is a member of other CSO coalitions, in particular the Coalition for Maternal, Child and Newborn Health and the Coalition to Stop Maternal Mortality, and that WRA Uganda is itself a membership alliance, means that CSOs are working jointly at the national level to lobby and campaign on these issues. They are able to garner a high level of attention with their research findings and advocacy campaigns.

There have simultaneously been other joint efforts by CSOs (including WRA Uganda), international partners, and the government of Uganda to prioritize the issue of maternal health. The most important of these has been the development of the Reproductive, Maternal, Newborn, and Child Health Sharpened Plan for Uganda, which was launched in November 2013. The “Sharpened Plan” examines why Uganda has been making such slow progress on MDGs 4 and 5 and proposes strategies for accelerating progress in this area. The plan calls for increased investment in reproductive, maternal, newborn, and child health, and calls for five strategic shifts in the government services:

- a focus on the districts where there is a high mortality rate of children under five years of age;
- a scaling up of services for underserved populations;
- delivery targeted through high-impact interventions;
- education and empowerment for girls and women; and

- mutual accountability for results at all levels of the health system.

Because this plan is aligned with the Act Now to Save Mothers campaign it will not be easy in the future to ascertain exactly which national-level outcomes might be attributed to the WRA Uganda campaign, and which to the overall push to prioritize maternal and newborn health in the country. WRA Uganda has certainly played an important strategic role in these efforts, in particular through data collection and analysis, and by disseminating information. These activities have changed the priorities of government at all levels to reflect those of WRA Uganda's campaign.

Whether the results at the district level can be broadened to the national level remains to be seen. Movement has begun in national budgetary areas, and that's a hopeful sign. The pilot campaigns in three districts have required significant time and resources in order to mobilize at a grassroots level and engage all stakeholders. While this has contributed to the success of the campaign, it also means that replicating these achievements across more than 100 districts in Uganda will be challenging.

LESSONS LEARNED

Many lessons can be drawn from the achievements to date of the Act Now to Save Mothers campaign, and this is especially true of the strategies employed to involve a broad range of stakeholders.

WRA UGANDA'S INSIDER-OUTSIDER STRATEGY

WRA Uganda combined a bottom-up grassroots approach and a top-down approach. In addition, they used both an insider and outsider strategy, fostering relationships within key ministries and with policy makers, while simultaneously undertaking an aggressive lobbying and advocacy campaign to pressure the government to provide more resources. Taking both of these approaches simultaneously carried risks. For example, the outsider lobbying and grassroots mobilization might have damaged their relationships with government insiders.

What was unique about this approach and why it was successful, is that WRA Uganda strategically aligned themselves as insiders in support of the Ministry of Health agenda. For example, while they identified serious shortcomings in service delivery, they approached this as a problem of budget shortfall and did not blame the Ministry of Health. Thus the campaign could assist the Ministry of Health in requesting additional budgetary resources from the government of Uganda. Where WRA Uganda works to support budget formulation, it does so with the aim of securing more health funding for priority areas and not detracting from other Ministry of Health plans. Thus they are allies, and their inside access has not been compromised.

At every level of the campaign, WRA Uganda's wide stakeholder engagement fostered buy-in. Where they identified problems, they encouraged stakeholders to work collaboratively to develop solutions. At least one of the major problems in the delivery of health services in Uganda stems from underfinancing in the sector. By focusing on this known shortcoming, instead of on accountability or absenteeism, WRA Uganda members could become partners with the relevant district leaders, health care workers, Ministry of Health officials, and key parliamentarians. Lobbying and pressure tactics targeted a different

set of actors, in particular MPs who follow the party line of the National Resistance Movement, the Executive, and the Ministry of Finance.

INCLUSIVITY AND SHARED OWNERSHIP OF THE CAMPAIGN

The Act Now to Save Mothers campaign demonstrates the effectiveness of engaging a wide range of stakeholders from the time of the campaign's inception and planning, and all the way through the process of implementation. The WRA Uganda's wide stakeholder engagement means that other CSOs and coalitions, as well as the Ministry of Health and district and local leaders, all have a high degree of knowledge about the campaign and a sense of ownership. This has multiplied the campaign's effectiveness. During district consultations, district and subcounty leaders proved to be knowledgeable about EmONC and CEmONC, which was most certainly not the case before the campaign started.

The participatory assessment, which engaged parties from the level of the WHO, to the national Ministry of Health, to the districts, and all the way down to the health workers themselves, made it possible for a wide range of stakeholders to endorse the findings. While this campaign strategy was time-consuming and costly (since consultations have to take place at every phase), it proved to be highly effective, and is one of the key reasons why the campaign had a significant impact in its early phases.

This inclusive and participatory approach has also allowed WRA Uganda to connect grassroots voices to the district level, the district level to the national level, and the national level to international WRA activities. Connecting stakeholders at difference levels is a challenge for many campaigns.

The WRA teams at both the global and national levels, comprise highly committed professionals, with the right combination of skills and experience in advocacy and campaign work. The Ugandan team was commended time and again by external stakeholders for its hard work and commitment on issues of health and maternal mortality. The team members bring together experience on high-level policy advocacy, grassroots engagement, media and communications, as well as actual expertise in the health sector. The same can be said of the Global Secretariat team, which has provided ongoing technical support, particularly in the areas of results-oriented planning and campaign implementation, and has helped to facilitate exchanges and learning between alliance partners in different countries.

ACKNOWLEDGMENTS

The researcher would like to thank all members of civil society, the government of Uganda, professional associations, politicians, and international development partners for their participation in and support for this case study. A special thanks to the White Ribbon Alliance Global Secretariat and, in particular, Kristin Savard, Katy Woods, and Ray Mitchell for providing time, information, and comments on the draft of this report. This case study could not have been completed without the time, expertise, and support given by the White Ribbon Alliance Uganda National Secretariat, including Robina Biteyi, Faridah Luyiga Mwanje, and Ssebugwawo David. A special thanks to Samuel Senfuka who supported the completion of this research and was always available to provide clarification and input on issues related to this campaign. The researcher would also like to thank Albert van Zyl and Jessica Taylor of the International Budget Partnership for helping to guide the work and for providing detailed feedback, as well as consultant Filder Aryemo, who supported the field research.

APPENDIX 1

National Respondents			
	Name	**Title**	**Organization**
1	Agatha Ayebazibwe	Journalist (former)	Daily Monitor
2	Agnes Namiyingo	Every One Campaign	Save the Children
3	Agnes Tumwebaze	Communications & Advocacy Department	AMREF
4	Asia Russell	Executive Director	HealthGAP
5	Dennis Odwe	Executive Director	Action Group for Health, Human Rights & HIV/AIDs
6	Dr. Byamugisah Josephat	Chair - Department of Obstetrics and Gynecology	Makerere University College of Health Sciences
7	Dr. Colins Tusingwire	Assistant Commissioner, Reproductive Health	Ministry of Health
8	Dr. Ezaati Isaac	Director in Charge of Planning	Ministry of Health
9	Dr. Frank Kaharuza	Executive Director	Association of Obstetricians and Gynecologists of Uganda
10	Dr. Guubala Katumba	Registrar	Uganda Medical, Dental and Practitioners Council
11	Dr. Ntalazi Francis	Assistant Commissioner, Human Resources	Ministry of Health
12	Dr. Robert Tumukwasibwe	Clerk	Parliament of Uganda
13	Dr. Vincent Oketcho	Chief of Party	Intrahealth
14	Enid Mwebaza	Program Advisor	JHPIEGO
15	Gerald Twijukye	Budget Strengthening Initiative	Overseas Development Institute
16	Hon. Joy Ongom Atim	Member of Parliament	Parliament of Uganda
17	Hon. Lulume Bayiga	Member of Parliament	Parliament of Uganda
18	Hon. Matia Kasaija	Minister of State (Planning)	Ministry of Finance, Planning and Economic Development
19	Hon. Ninsiima Rita Ronah	Member of Parliament	Parliament of Uganda
20	Hon. Ssinabulya Sylvia	Member of Parliament	Parliament of Uganda
21	Honorable Sarah Nyombi	Former Member of Parliament	Parliament of Uganda
22	James Kintu	Director - Advocacy	World Vision
23	Joshua Wambogo	Executive Director	Uganda Alliance of Patient's Organization
24	Kakande Margaret	Head of the Budget Monitoring and Advocacy Unit	Ministry of Finance, Planning and Economic Development

25	Katy Woods	Global Campaigns Manager	White Ribbon Alliance for Safe Motherhood
26	Keith Muhakanizi	Permanent Secretary / Secretary to the Treasury	Ministry of Finance, Planning and Economic Development
27	Kenneth Mwehonge	Program Officer - Advocacy and Networking	Coalition for Health Promotion and Social Development Uganda
28	Kibuuka Andrew Miti	Coordinator - Programmes	Uganda Private Midwives Association
29	Kristin Savard	Advocacy and Campaigns Manager	White Ribbon Alliance for Safe Motherhood
30	Mable Kukunda	Advocacy and Networking Officer	Uganda National Health Consumers' Organization
31	Modibo Kassogue	Chieft, Keeping Children and Mothers Alive Section	UNICEF
32	Mugambe Kenneth	Director / Budget	Ministry of Finance, Planning and Economic Development
33	Noor Nakibuuka	Program Officer	Centre for Health, Human Rights and Development
34	Patrick Mwesigye	Team Leader	Uganda Youth and Adolescents Forum
35	Peter Okwero	Health Specialist	World Bank
36	Ray Mitchell	Director of Advocacy	White Ribbon Alliance for Safe Motherhood
37	Ruth Mukibi	Executive Director	Sickle Cell Association Uganda
38	Samuel Ibanda & Hassan Wasswa	Journalists	NBS Television
39	Tom Chandia Aliti	Principal Finance Officer, Budget and Finance Division - Planning Department	Ministry of Health

District & Sub-District Respondents			
	Name	Title	Institution
1	Anthony Ojuka	District Rep / Secretary Production	Lira District
2	Bill Okech	Journalist	Editor Arab Kop print media
3	Denis Okwir	District Coordinator	WRA
4	Denis Omara	Journalist	Radio Unity
5	Doreen Ebong	Nursing Officer	Lira Regional Referral Hospital
6	Dr Peter Kusolo	DHO	Lira District
7	Edimond Aceka	Assistant DHO in charge of Maternal health	Lira District

8	Florence Apio	Tutor	Nightingale Midwifery School
9	Fred Lwasa Mbijja	DHO	Mityana District
10	Hon Ogwang Oyang	Vice Chairman	Lira District Local Government
11	JP Atine	Chairperson LC3 / Secretary Health and Education	Barr Sub county
12	Lilly Okwir	Area Councilor	Amac Sub county
13	Martin Ocen Odyek	District Speaker	Lira District
14	Nelson Oyitakol	Chairperson Finance	Lira District Local Government
15	Nora Nabakunja	VHT	Bulera HC3
16	Patrick Ogwal	Media Coordinator / Journalist	Voice of Lango Radio
17	Ruth Nanjabe	Nurse	Bulera HC3
18	Sr Philomena Okello	Women Representative / Midwife	WRA / Lira Regional Referral Hospital
19	Sr Sarah Katumwa	Midwife	Mityana Hospital / WRA
20	Sr Barabra Zalwongo	Midwife	Bulera Health Center III
21	Tommy Egit Ojan	Men rep / board member	WRA
22	Tonny Bua	District Store officer	Lira District
23	Tony Todo	Area Councilor Aromo / Sectorial committee Health	Aromo Sub county
24	William Kadu	Journalist	Prime Radio / WRA
25	--	Midwife	Barr HCIII
26	--	Midwife	Bar HCIII
27	--	Midwife	Ogur HCIV
28	--	Mother / Family Planning client	Ogur HCIV