Civil society advocacy for Sexual and Reproductive Health, Uganda

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Contents

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1. Background

Between 2009 and 2011, World Health Organisation (WHO) supported the Advancing Healthy Advocacy for Reproductive Health (AHEAD) project implemented through the German Foundation for World Population (DSW),. The project provided financial and technical support to civil society organisations (CSO) to develop and implement advocacy action plans to raise levels of government funding for Sexual and Reproductive Health (SRH) in Bangladesh, the Philippines and Uganda. An evaluation is being implemented to assess the contribution of this civil society advocacy to achieve a raised level of government funding along four dimensions: improved *participation*, greater *country ownership,* improved *transparency,* and better *accountability.*

This evaluation was implemented in Uganda, a low income landlocked country in East Africa, with a population of 33.5 million of whom 85% live in rural areas and 49% of whom were below 15 years (UBOS, 2008; UBOS and Macro Int, 2010). Uganda has one of the highest population growth rates (3.5%), a life expectancy that fell to 42 years in 2000 and rose to 52 years in 2007, mainly following trends in HIV and AIDS (UBOS 2009). Uganda's Human Development Index (HDI), a composite of life expectancy, education and per capita national income, rose from 0.312 in 1995 to 0.422 in 2010 (UNDP, 2010), mainly due to sustained GDP growth since the mid 1990s and improvements in education (UBOS and Macro Int, 2010). The recent financial crisis has not had significant negative effects, with foreign direct investment showing minimal decline (5.3% of GDP in 2007/08 to 4.6% in 2008/09), and development partners continuing to meet their obligations (GoUganda MOPFED, 2010b).

Figure 1: Map of Uganda

Source: Uganda Bureau of Statistics and Macro International Inc. (2007).

The government of Uganda has identified ill-health as a leading cause and consequence of poverty. While maternal mortality fell from 527 in 1995 to 430 in 2008, it remains high and only 42% of deliveries occured under the supervision of a skilled health worker in 2006 (UBOS and Macro Int 2007; UBOSand Maro Int 2010; UNDP 2010). Uganda has the highest total fertility rate in eastern and southern Africa (6.7%). In 2006 two thirds of Ugandan women had had a child by the age of 20 years, the contraceptive prevalence rate for all women was 52% and there was a high unmet need for family planning. With a highly unequal distribution of wealth - households in the lowest wealth quintile shared only 2% of total wealth, and hugh levels of poverty, communities are relatively reliant on public policies and spending to improve access to SRH and maternal health services (UBOS and Macro Int 2010). However, by 2009/10 only 2.5% of GDP and 9.6% of the government budget was allocated to the health sector and per capita health expenditure in the public sector was $11.40, below the level needed for basic health services (GoUganda MoH 2010). Out of pocket spending was at 51% of private spending in 2008 (WHO NHA database 2011). Underfunding of the health sector and cost barriers can undermine the ability of the health system to address SRH issues and availability of and access to SRH services, especially for those with high need. The focus in the AHEAD programme on improving awareness and engagement on improving public sector budgets for SRH thus addresses an important factor in improved SRH outcomes.

2. Country context

2.1 Social, political and cultural context

After decades of instability and dictatorship, the National Resistance Movement (NRM) in 1986 brought peace to large parts of the country (GoU MoFEPD 2008). Party political activity was prohibited until multiparty democracy was re-introduced in 2005. Uganda has a decentralised system of government with the 1995 Constitution and the 1997 Local Government Act mandating District Local Governments to plan, budget and implement health policies and health sector plans. Local Governments are responsible for delivery of health services, recruitment, deployment, development and management of health workers, passing of health related by-laws and monitoring of health sector performance, within within the framework of national priorities (GoU MoFEPD 2008). The political context in Uganda is thus one of strong centralised political power and decentralised local government authority (Ssewanyana, 2010). Parliament has been a forum for debate of national policies and budgets. The Network of African Women Ministers and Parliamentarians (NAWMP) Uganda chapter have, for example, been a consistent voice on issues affecting gender equity since their formation in July 2006. The February 2011 national Presidential and parliamentary elections brought in a vibrant younger generation of parliamentarians, including from NRM, who had by October 2011 raised a number of issues of accountability of the executive.

Uganda has had a relatively positive profile internationally, having negotiated debt relief under the Highly Indebted Poverty Initiative, reported on its Millennium Development Goals commitments, being signatory to the 2005 Paris Declaration on Aid Effectiveness and being judged in the 2008 OECD Survey as a 'front-runner in aid effectiveness (WHO DSW 2011). It has made commitments to numerous international treaties, including (with the date of ratification/accession) the African Charter on the Rightsand Welfare of the Child (1990); the African Charter on the Rights of Women in Africa (2003); the International Covenant on Economic, Social and Cultural Rights (in 1976); the International Covenant on Civil and Political Rights (in 1976), the Convention on the Elimination of all forms of Discrimination against women (in 1981). The 1995 Constitution of Uganda Objective XIV(b) obliges the state to ensure that all Ugandans access health services and Article 33 obliges the State to protect women taking their unique status and maternal functions into account (GoUganda 1995).

However, traditional and cultural practices and customs regarding polygamy, property ownership, widow inheritance, child marriages, female genital mutilation and bride price and gender division of labour and ownership of property also have a strong influence on society, including on reproductive choices. Many traditional and cultural practices discourage contraceptive use, and create conditions for early and frequent childbearing and large family sizes, conflicting with new aspirations to space childbearing and for women's autonomy in sexual and reproductive health (SRH) (John Hopkins 2010). While state policies have promoted gender equity, the 2008 Population Policy observed that gender values, attitudes and laws had not significantly changed to promote positive aspects of culture and discourage negative aspects for women's economic or social welfare (GoU MoFEPD 2008; 2010b). Since the late 2000's there has been increased policy engagement on family planning and SRH, with the involvement of high level actors such as Dr Musinguzi of Partners in Population and Development (PPD) and NAWMP. The October 2009 International Conference on Family Planning hosted in Uganda was an opportunity to raise political, policy and media attention to SRH, consolidated by a high level meeting between Ministry of Health and Ministry of Finance on the issue. Several trends have reinforced the efforts of key national actors on SRH, including the change in US government and thus policy and funding streams for SRH, including from USAID, UNFPA, DfID (up to 2009); World Bank (after 2010); the increased policy profile given to SRH and maternal health by members of parliament (MPs) and by the first lady, Janet Museveni, and the increased media coverage of SRH issues. These have converged to create a more conducive policy environment for SRH. MPs pointed out during the interviews that greater attention is being paid to gender sensitive budgeting, to maternal health and there is increased male involvement in SRH advocacy, although they also noted that this has been more strongly articulated at national than at district level (John Hopkins 2010).

2.2 Sexual and reproductive health in Uganda

There is some evidence that **maternal health and SRH status has improved** in the past decade. After a sustained focus on HIV prevention and treatment, HIV prevalence has fallen to 6.4% of the adult population. Access to ante-retroviral therapy has improved markedly, although there are still shortfalls in access to condoms, low levels of condom use in long standing relationships, and limited rural distribution and uptake of female condoms (GoU 2010). Adolescent fertility and maternal mortality has fallen, but remains high and unmet need for family planning has not fallen, with Uganda having the third-highest rate of unmet need for contraception in the world, relating in part to a growth in demand. (See Table 1). Uganda is not on track to meet its targets for MDG5, with physical, financial and social barriers to accessing reproductive health services, particularly for low income, less educated, rural women (UBOS, Macro Int 2007; MOH 2008b).

Table 1: SRH data in Uganda 1995-2010

Indicator	1995	2000/1	2005/6	2010
Contraceptive prevalence rate (%)	15	23	24	25
Adolescent birth rate -by women 15-19 years / 1000	198	190	159	na
Antenatal care coverage in women 15-49 yrs with a live birth in past 5 years: %>one visit	91	92	94	
%>four visits	47	42	47	50
Unmet need for family planning (%)	29	35	41	na
Maternal mortality rate /100 000	506	505	435	na
births attended by a skilled health worker (%)		39	42	na

Source UBOS and Macro Int 1996; 2003, 2006, 2010 GoU MoH 2010c

In contrast to sluggish performance, there has been growing attention to **policies aimed at improving SRH**, (see Box 1), suggesting a supportive policy environment for SRH (DSW RHU 2010).

Policies and strategies specifically for SRH in Uganda

The National Population Policy (2008) and The National AIDS Control policy (2007/8)
Laws against harmful traditional practices e.g. early marriage, Female Genital Mutilation (2009)
Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (2007-2015)
National HIV/AIDs policy (2007/8) including policy for PMTCT
Policy for HCT (2005) - provides for access to HIV testing & services
Ministry of Education and Sports policy for HIV (2006)
National Drug Policy (2001) and Reproductive Health Commodities Security Strategic Plan 2009 – 2014
Guidelines for Traditional Birth Attendants and Village Health Teams
The National Policy Guidelines and Service Standards for reproductive health services, May 2001
The Policy for the reduction of the mother-to-child HIV transmission in Uganda, (July 2001)
National Adolescent Health Policy 2004
Minimum age of sexual consent policy (Defilement Act) - in the penal code

DSW RHU 2010

These policies generally include commitments to improved budget allocations to widen availability and accessibility of quality services and community awareness (GoU MoFEPD 2008). A Reproductive Health Commodities Security Strategic Plan 2009 – 2014 supported financially by UNFPA outlines eight strategic objectives related to policies, coordination, political and financial commitment, financing, commodity security, demand and utilization of services, logistics, and monitoring and evaluation. A costed Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda, 2007 – 2015 mobilises resources for antenatal and obstetric services, promoting health-seeking behavior, and availability of family planning information (John Hopkins 2010), with complementary inputs from education, water and sanitation, food security, transport, communication, culture and community development (GoUganda MoFEPD 2010e; Bakeera et al 2009).

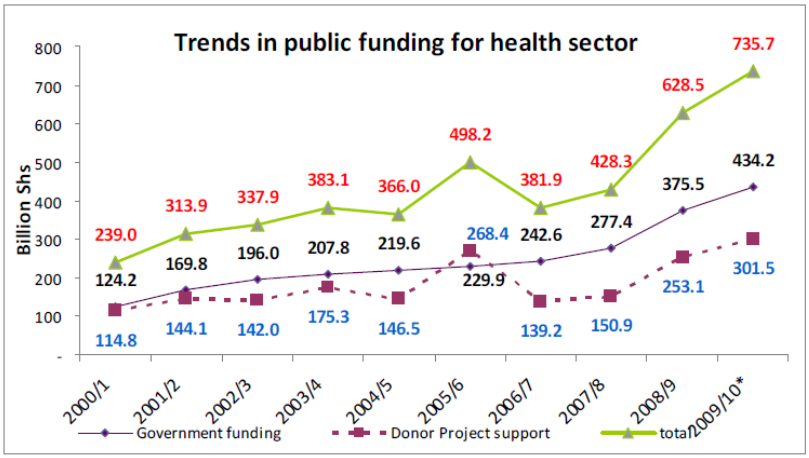
Despite this supportive policy environment, **policy implementation has been constrained by resource and systems challenges** including limited human resources, equipment and supplies; delays in release of funds from MoH to National Medical Stores (NMS) affecting the delivery of supplies; limited funding and capacity at district level which affects distribution of commodities to the district and lower levels and inadequacies in transport, communication and logistical support for

ambulances (GoU MoH 2008; 2010c). A 2009 assessment noted also that SRH was not a prioritised at local government level (John Hopkins 2010), an issue noted in the inception of the AHEAD project, and one that would affect policy implementation.

2.3 Financing for Sexual and Reproductive Health

The constraints noted above in availability and accessibility of SRH services and the funding for SRH needs to be understood in the context of the **overall underfunding of the health sector** (GoU MoH 2010b). Government share of financing to health has remained at around 9% in the period to 2010, below the 15% committed in Abuja in 2001 or the HSSP II target of 13.2% government spending (MOH 2005). Total per capita health expenditure in 2008 at US$33 was below the 2008/9 costing for the Uganda Minimum Health Care Package of $41.2 per capita or the 2011 /12 estimate of US$47.9 (World Bank, 2010; MOH 2008c). There appears to have been a vicious cycle of MoH arguing that improved performance depends on higher budget allocations and Ministry of Finance (MoF) arguing that allocations to health are reduced due to low sectoral performance (WHO DSW 2010).

Figure 1



MoH 2010c

Low levels of public financing have also led to a **high share of external funding**, with 40% of the total national health budget between 2008 and 2010 externally funded, although only 25% at district level (DSW RHU 2010). (See Figure 1). The larger share of this is off budget funding, posing an issue for both civil society and national and district leadership in budget accountability. Only 5% of contraceptive need in Uganda was funded by government in 2008, with external funding for RH of US$235.58 million in 2008 dominated by USAID (85% external funding) through project support and to CSOs (DSW RHU 2010; John Hopkins 2010). Hard budget ceilings imposed by the MoF also undermine motivation for budget support and leading to parallel funding arrangements for commodity procurement (Chattoe Brown, Bitunda 2006). Table 2 shows major funders for SRH including HIV. Of the on budget funding, ADB funded infrastructure, UNFPA reproductive health commodities, technical assistance, convening of the family planning working group and RH strategy; and World Bank supported RH as part of a loan for infrastructure and health workers.

Table 2: Health sector Development partner expenditure for 2008/09-2009/10

	Project support to health sector for in Million USD			
	FY 2008/09		FY 2009/10	
Name of Partner	**On Budget**	**Off Budget**	**On Budget**	**Off Budget**
African Development Bank (ADB)	20.16	-	15.75	-
UNFPA	1.10		0.88	-
World Bank (IDA)	-		4.80	-
DFID	0.45	5.05	0.36	6.03
USAID	-	152.9	-	147.99
PEPFAR		255.0		285
GFATM	89.98		71.99	
TOTAL all partners	**176.12**	**440.25**	**136.30**	**463.55**

Source ; MOFPED Budget speeches financial years 2008/9-2010/11 in GoU MoH 2010c

There is an expressed desire for strengthened mutual accountability. District leaders in Mityana district raised their difficulty with CSOs that come “with pre planned roles” that are “not flexible to district needs”. However they also note that non state actors can be engaged to improve co-ordination. GoU has negotiated specific compacts with international agencies and included them in national policy forums to manage their co-ordination and alignment to national policies (GoUganda,

MOH 2010d). MoH officials and district leaders interviewed sought for CSOs and non state actors involved in health to submit audited annual accounts and for international agencies to report off-budget health financing to the MoH (GoUganda MoH 2010b).

SRH reflects these patterns: The Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015) for 2009-2014 only was estimated to cost about US$80.8 million or US$16.6 million per year, excluding costs for RH medicines, equipment and supplies. An additional US$31 million per year was estimated to be needed to meet RH supplies and equipment, or 10% of the total health budget (DSW RHU 2010). UNFPA estimated in interviews that $22million was needed annually for reproductive health commodity (RHC) security (ie medicines and supplies only). **The shortfall in RH funding has led to shortfalls in commodity supplies**, with 18% of respondents in districts reporting in 2009 that their health units had "mama kits" and professional mid-wives and only 29% reporting that materials needed in labour units were present (Manyire 2010). Inadequacies in the wider health budget have also impacted on SRH services. In Mityana district, the Chief Administrative Officer observed that not having funds to build staff housing affected retention of health workers, and lack of ambulances affected uptake of referral services. Difficult and slow procurement procedures were also a block, leading to low shares of funds allocated being spent.

Figure 2: RH and Health budget 2005/6-2009/10

Tracking allocations and expenditures specifically for RH at national and district level is a challenge. It is not systematically documented and RH is merged within other budget lines. In 2011/12 we ascertained that RH resources are found in

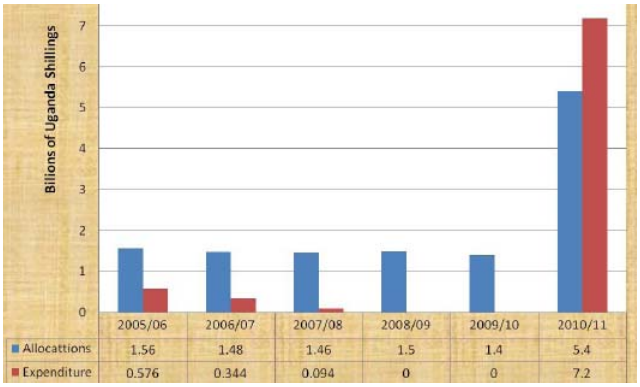
- the allocation from UNFPA through the budget (about US$1.5mn total)
- the allocation from USAID of approx $8mn on RHC paid to NMS to procure commodities for non state services
- the allocation of approximately US$10m in the World Bank loan for RHC, supplies, ambulances, clinical supervision.
- Direct budget allocations of US$8mn made to NMS for RHC (unclear whether this includes or excludes the UNFPA funds). These are estimates or allocations and do not represent expenditures, as presented in Table 2.

One outcome target for the AHEAD project was a 5% increase in RH budgets. With lack of clear information across 2010/11 and 2011/12 lines for these different funding flows (except for the World Bank loan which was provided itemised), and unclear information from the CSOs on what baseline they were using for the target of 5% increase, it was not possible to quantitatively test this change.

Nevertheless there was evidence that **RH funding has improved since 2010**. As Figure 2 shows, up to 2009/2010 the allocation to RH was well below estimated needs, with only 0.4% of national treasury funds for health allocated to RH/FP between 2005 and 2010, compared to the projected 8-10% needed. **Indicators of improvement in budget resources for SRH** included.

- An increase between FY 2009/10 and FY 2010/2011 in GOU contribution to contraceptives from less than 5% to 36% (Muwonge 2011), with expenditure rising above allocation in 2010/11 (See Figure 3).
- Combined USAID, UNFPA and GoU funds invested in procurement of contraceptives rose to US$7.6 Million for the financial year 2010/11

Figure 3: Allocations and expenditures for RH commodities



Source: Muwonge 2011

(36% from GoU, 46% USAID and 18% UNFPA) and UNFPA and USAID support for contraceptives rising from US$5mn in 2009/10 to US$9mn in 2011/12 (UNFPA; Muwonge 2011).

- Parliament refusal to endorse the World Bank health budget support (a loan) unless it included an allocation for SRH, increasing budget support by approximately $10 million in 2011/2012.

> *"This major shift in paradigm on GOU policy has been significantly influenced by PPD and civil society organizations advocating at high levels in Government and providing technical assistance to track the funding and ensure allocations are spent as planned".*
> Muwonge 2011

The contribution of advocacy to this change is explored in Section 4. However, **problems with the procurement procedures also had to be dealt with** as previous allocations were underspent. In 2010, PPD ARO (with funding from Advance Family Planning (AFP) Project, Gates Foundation and Packard Foundation) contracted a consultant to work with the MoF, MoH and NMS to reach an understanding to increase Government contribution towards procurement of RH supplies from 1.4 Billion to 7.5 Billion Uganda Shillings in the 2010/11 budget and for government to put a mechanism in place to allow CSO service providers to access contraceptives from NMS. Supply to CSOs had been interrupted due to private sales of commodities by some CSOs. The consultant actively tracked the allocations and provided support where necessary to ensure that allocations translated into actual expenditures, following up with MoH and NMS to ensure that NGO's access contraceptives from NMS. This work also had an effect in strengthening expenditures against allocations and improving commodity distribution, encouraging budget increases. GoU directed NMS to resume contraceptive supply to six national NGO's including RHU, MSU, Uganda Private Midwives Association, Mildmay Centre , TASO and PACE (formally PSI), more than tripled its funding for contraceptives and released 100% of allocated funds to NMS (Muwonge 2011). From key informant interviews, this prepayment allowed for embossment of supplies with 'GoU' reducing leakage. NMS took over direct distribution to facilities to facilitate distribution, and a push rather than pull system was implemented so that facilities were supplied with estimated needs. As this may be associated with its own problems of over-supply, PPD is currently implementing pilot work in two districts (Mayuge and Mukono) to assess capacities to absorb and use budgets for RH. With improved RH commodity supply, other constraints in the health system are now more evident, including shortages of health workers, particularly midwives, and the lack of accommodation, adequate pay and incentives to retain them in districts.

2.4 Budget process in Uganda

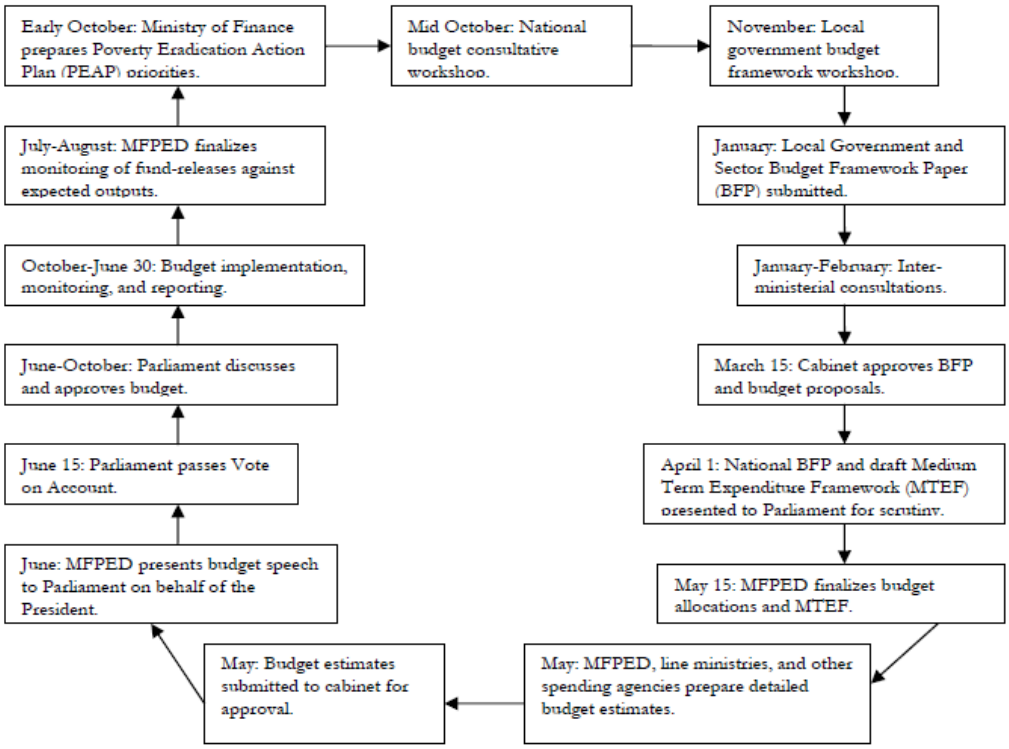
Uganda's budget system is well-defined in law (Budget Act 2001; Public Finance and Accountability Act 2003) and is outlined in Figure 4 overleaf. **The budget process provides a number of opportunities for information to the public and for public input** (de Renzio et al 2006), ie:

i. in October, when the budget consultative conference is held for members of Parliament, ministries, local government officials, private sector, civil society, funders, media;
ii. at the public expenditure meeting in May, to discuss the budget proposals;
iii. when the budget is presented to Parliament and released to the public by June 15 in advance of the start of new fiscal year on July 1, and
iv. Through audit reports made publicly available.

Notably the AHEAD project straddled two budget periods rather than a single cycle, commencing ahead of the tabling of the 2010/11 budget, but too late in its process to influence this, and ending before the 2011/12 budget process concluded.

A Parliamentary Budget Office provides technical support to MPs on the budget. The SWAp, MTEF, Poverty Action Fund (PAF), fiscal decentralization and Budget Framework Papers have also contributed to increased transparency and social dialogue on the budgets, and have raised demand for performance-based budgeting to demonstrate what outputs have been achieved with funds allocated (WHO DSW 2011). Since 2004, CSOs have also become increasingly involved in budget tracking and advocacy, such as through the Uganda Debt Network (UDN), Uganda National NGO Forum, Oxfam, DENIVA and the Forum for Women in Democracy (FOWODE). For example, UDN has built capacity in about 40 CSOs in a Community-Based Monitoring and Evaluation System and local-level monitoring committees in eight districts to review budget evidence and solve problems locally and to input to district budget dialogues (de Renzio 2006).

Figure 4: Uganda's budget process



(Source: A Citizen's Guide to the Uganda Budget Process, December 2004)

2.5 Civil society in Uganda and its relationship with the state

> "*Civic organizations shall retain their autonomy in pursuit of their declared objectives*" (The Uganda Constitution 1995, Section ii).

In Uganda the autonomy of CSOs is enshrined in the 1995 constitution. The **number of CSOs operating in Uganda has increased since the late 1980s, and CSOs have become more involved in advocacy, policy dialogue and social accountability in the 2000's.** Many CSOs are faith based CSOs and service non government organisations (NGOs), encouraged by a relatively stable political environment, supported by international funders and complementing the state in service provision. Indigenous NGOs are largely characterised by local membership – predominantly urban and localised – a high level of financial dependence on external sources, limited capacities and skills, poor sustainability and a preoccupation with service delivery roles as opposed to advocacy work (AGHA 2011; Kruse 2003). Several international NGOs operate in Uganda, most in service delivery and policy processes, with more secure funding and capacities.

Development support and service delivery CSOs are argued to have limited potential for grassroots empowerment and locally rooted advocacy (Kruse 2003), and government has reacted negatively to CSO involvement in processes perceived to be political or oppositional (de Renzio 2006). However since 2003, CSOs have been more involved in research, raising awareness, advocacy and engaging government on policy issues, including HIV/AIDS, nutrition, gender, human rights and protection of the environment (Kruse 2003). The most prominent CSO networks regularly participating in national processes in health were identified to be the Development Network of Indigenous Voluntary Associations (DENIVA with 700 organisations), the Ugandan National NGO Forum (with 1,000 members), the Uganda Network of AIDS Service Organisations (UNASO with 1,600 organisations with 44 district networks), MARCIS (Malaria), the Public Health Alliance (PHA), and the Coalition for Health Promotion and Social Development in Uganda (HEPS Uganda) (WHO DSW 2010). Beyond two general networks: DENIVA and the NGO Forum, CSO networks have also been established to strengthen collective advocacy on poverty, water and environment, disability, food security, anti-corruption and human rights (Kruse 2003). Various processes provide space for CSO participation, including those motivated through international processes, such as the Poverty Reduction Strategy

Paper and Poverty Eradication Action Plan and to facilitate eligibility for debt cancellation under the HIPC initiative (de Renzio 2006), and through national processes, such as the annual health sector reviews and National Development Plan (NDP). While early CSO engagement on SRH centred on policy recognition for SRH and resources for RH commodities, CSOs have also engaged more on SRH rights and access issues in recent years. For example, the Centre for Health, Human Rights and Development (CEHURD), a local CSO, petitioned the constitutional court in 2011, seeking declaration(s) that the non-provision of healthcare in government facilities leading to the death of mothers is an infringement on rights to life and health. This case, potentially highly oppositional, had attracted media attention to maternal health and a wide coalition of CSO support.

Parliament provides an important space for such civil society engagement on health, such as through the sessional committee on social services which has examined delivery on commitments on health financing and maternal and child health. AGHA noted, for example, that interaction with legislators has helped to raise issues on the AIDS budget, and facilitated budget information reaching CSOs. CSOs have also participated in district budget conferences and in various district committees (District HIV&AIDS Committee (DHAC), District Health Management Team, District OVC Committee, Health Unit Management Committee and District HIV&AIDS Advocacy Team). Participation in budget processes is reported to be constrained, however, by weaknesses in CSO technical and advocacy capacities, and by the fact that participation is mostly by invitation, with many CSOs not invited (de Renzio 2006). CSO participation in the Health Policy Advisory Committee (HPAC) advising the top management of the MoH, or the Uganda AIDS Commission Partnership Committee and its Technical Working Groups is thus noted to be limited to more established CSOs. Few CSOs, including those involved in this assessment, were found to be aware of the International Health Partnership (IHP+) or their role (DSW 2011).

Civil Society Advocacy Group invited over 100 CSO representatives to dialogue with the MoFPED on the 2011-2012 budget.

Ephariam Kamuntu, State Minister of Finance addressing the participants, said *"government can no longer afford to ignore the role of CSOs, because their input into the budget is of great value".*

Despite the opportunities for civil society- state engagement, **challenges have been noted in the interaction between civil- society and state**. On the one hand the legal environment is reported to place strict conditions on registration and functioning. For example the board regulating NGO activities has powers to terminate registration if it concludes that an NGO is violating a government policy or acting against the public interest, even if the activities are technically legal. In such a context, advocacy calls for strategic management of relations with government and strong communication capacities. CSOs that have a membership, that produce quality and valid evidence, or that have a strong credible role in service delivery are noted to be more favourably viewed by government (de Renzio 2006). Central and district government officials express concern over the unwillingness of CSOs to reveal information on their funding; and over the weak involvement of beneficiary communities in the planning of CSO activities (AGHA 2011).

The relationship between the government and civil society is currently a suspicious one as government thinks CSO are criticizing too much and CSOs think the government want to muzzle them" CSO respondent

These features are also reflected in CSO work on SRH. RHU reported, for example, that it has engaged parliament for about seven years on SRH and maternal health issues relevant to policy recognition and service delivery. The CSOs involved in such advocacy have included service delivery roles and technical capacities that give them leverage. However, as indicated above, **the range of advocacy issues and actors has widened in SRH,** including social mobilisation, budget advocacy and legal challenge around maternal health services, government accountability and transparency on GFATM (by the Action Group for Health, Human Rights and HIV&AIDS (AGHA), HIV and SRH rights and financing (such as by UNHCO and HEPS Uganda). This represented a relatively rich, if also fragmented, context of CSO activity and relationships for the work in AHEAD.

3. Methods

Within this context, between April 2010 and March 2011, the German Foundation for World Population (DSW) and WHO supported a consortium of Ugandan CSOs to implement the AHEAD project *'Action for Increased Government Funding for RH Uganda'* to mobilise parliamentarians to commit themselves to lobby and vote for increased government funding for SRH by 5% in 2011 and beyond. The project plan is shown in Annex 6.2.

The evaluation sought to understand what the experiences from AHEAD tell us about civil society's ability to influence national policy, planning and budgetary processes for SRH, and the pathways for such CSO influence. It sought to understand how the work in AHEAD affected the internal capabilities of CSOs and their relationship with external target groups. At a step removed, we use the learning from this as input for reflection on the role of civil society in implementing principles of aid effectiveness.

The Results Framework shown in Annex 6.1 guided the approach to the evaluation, exploring

1. **Context**: or what aspects external environment affected the processes and outcomes in AHEAD, particularly in relation to the political, policy, health and institutional environment; and CSO capacities and relations with the state;
2. **Inputs:** or the technical, financial, capacity building, materials, tools and knowledge development used in AHEAD;
3. **Mechanisms**: or the interactions, processes or strategies used to generate change; and
4. **Outcomes**: or the differences that the project has made or contributed to, particularly in relation to participation in and influence on and budgets for SRH.

The evaluation drew evidence from review of national documents (See Annex 6.3), including plans, and reports of the project; published and grey literature on SRH; official documents and policies, strategies, reviews and budget analyses; MoF Expenditure estimates and reports; and materials from partner organisations. Key informant interviews were carried out with 26 key informants from 14 organisations, including the lead CSO, CDFU, other CSOs; parliamentarians, district leaders from Mityana district; Uganda Health Communications Alliance, representing media; Ministry of health officials; technical and international agencies. The list of key informants is shown in Annex 6.4.

Some limitations were noted in the exercise: While the period for review was 2010-2011, not all official documents cover up to that recent date. It was difficult to obtain information on the exact amounts in all the different funding pools for SRH, both to ascertain the baseline levels in 2009/2010 and to identify the change to 2010/2011 as these are not all clearly earmarked in the budget estimates (discussed in further detail later). We were reliant on recall in individual interviews but there was some turnover of personnel, in particular the original lead person in CDFU Emebet Wuhib-Mutungi, and new personnel were found in some of the wider CSOs involved. We were not able to interview local WHO or University personnel due to time constraints. While the lack of clear earmarking of SRH budget information makes it difficult to assess the specific level of change, we were able to assess the trend, and the loss to the key informant interviews did not substantially affect the information obtained due to wider institutional memory, team work and documented reports.

Given that the Uganda AHEAD project started in March 2010 and ended in March 2011, with a budget of $25000, the limited resources and time for project implementation mean that activities, outputs and short term outcomes were more likely to be obtained than longer term outcomes or impacts. In fact the 2011/2012 budget was only debated after the project ended. The interviews made clear that the AHEAD project built on prior engagement on SRH policies, budgets and interactions between civil society, technical agencies, government and parliament on SRH that dated back to 2009. It was not possible to directly attribute outcomes in the national SRH budget to the AHEAD project per se, but rather to examine the contribution of AHEAD to the ongoing civil society interaction and engagement on SRH. While engagement with parliamentarians had been ongoing since 2008, the AHEAD work in Uganda did, however, include specific activities to strengthen the CSO coalition, deepen the advocacy with parliament and media and it added district level engagement as an important new aspect of the advocacy work.

4. AHEAD project: Findings

4.1 The AHEAD project

In April 2010 the German Foundation for World Population (DSW) with funding ($25 000) from WHO, contracted Communications for Development Foundation Uganda (CDFU) to implement the AHEAD project with DSW Uganda, Marie Stopes Uganda (MSU) and Reproductive Health Uganda (RHU). The project aimed to contribute to CSO efforts to ensure a sustained increase in SRH funding by Government, and specifically to mobilise MPs to commit themselves to lobby and vote for increased government funding for SRH by 5% in 2011 and beyond. It was scheduled to run from April 2010 to March 2011, with the planned and actual timings shown below:

Milestone	Planned timing	Actual timing
Existing advocacy materials identified and utilised	April to August 2010	April to August 2010
RH advocacy coalition strengthened by bringing other key CSOs and development partners on board	May to June 2010	May to June 2010
Media partnerships built for advocacy	May to June 2010	Sep – Dec 2010
Support for the pledge solicited and secured	July to August 2010	January 2011
Dissemination forums held	August 2010	January 2011
High profile pledge signing ceremony with media coverage	September 2010	Jan-Mar 2011
List of signatories to the pledge publicised	September 2010	March 2011
Activities of the signatories supported	Sep to Dec 2010	These activities are being implemented by NAWMP
Activities of the Signatories monitored	Sep 2010- Feb 2011	
Progress reviewed and shared with partners	March 2011	

Based on background evidence of the high fertility rate, including of adolescent pregnancy, unmet need for family planning, low level of deliveries assisted by skilled personnel described earlier, the project aimed to foster through advocacy understanding on the importance of SRH and family planning, and the need for government funding to support SRH services.

The project built on existing strengths, resources and experiences of lead CSOs in Uganda.
According to DSW Uganda, the initial team convened by DSW to lead the work covered CSOs with strength in district and national work (Reproductive Health Uganda (RHU)); in commodities supply (Marie Stopes Uganda (MSU)); and in communication (CDFU). MSU was the original lead organisation, but their limited involvement led the group to reassign the lead to CDFU in June 2011 to ensure that the project did not stall. MSU, which had less focus on advocacy, had limited involvement throughout. A mapping was carried out of potential partners and synergies with other activities underway, and of resources within the organisations with other programmes, particularly given the limited resources for the work, noted as a risk in the project document. By synergising with other work in RHU, DSW and CDFU, including in choosing districts to include regional representation, presence of coalition members and links to other advocacy projects being implemented by coalition members, Mityana, Mbarara and Gulu. No specific baseline was carried out but existing documentation was used to identify shortfalls in the SRH budget.

The project implemented the following steps in relation to the indicators set:

Activity	Indicators of success	Implementation
Prepare an action plan and implementation strategy (CDFU)	Action plan and implementation strategy developed	A planning meeting in May 2010 planned meeting with national political parties to secure commitment to SRH in their manifesto and to identify aspiring MPs to sign the pledge. A strategy was developed integrating with on-going work of DSW, CDFU. CDFU drafted an action plan which was reviewed in the coalition, finalized in June 2010 and used for coordination.
Strengthen RH advocacy coalition by bringing other	Percentage increase in RH sectoral CSOs working	After mapping CSOs and advocacy platforms DSW, CDFU and RHU held meetings to brief and bring on board PACE, UHMG, Reproductive Health Supplies Advocacy Network, Civic Coalition on Population and Development; BCC partners; UNHCO, Uganda Health Communication

CSOs on board	together	Alliance (UHCA); National Association of Women Living with HIV/AIDS; WHO, UNFPA, UNICEF, UNAIDS, UAC, Health Communication Partnership (HCP) (lead for AFP), Makerere University School of Public Health (MUSPH), Population Secretariat (PS) and NAWMP. A DSW/RHU orientation workshop held 26-28 May 2010 briefed 20 CSOs on AHEAD work. Coalition meetings provided advocacy materials to members.
Build media partnerships for advocacy	Number of media advocating for government funding for RH	The AHEAD Uganda coalition (with CDFU and UHCA in the lead) held a Media Dialogue in Kampala on 8th December 2010 which attracted 37 participants; mainly journalists (print, TV and radio) and health communicators from targeted stakeholders. It generated debate on SRH funding and partnership with media in coverage of the MPs pledge.
Prepare advocacy materials for different target groups (All) Package and disseminate target specific materials to the different decision makers and opinion leaders	Target specific advocacy materials available Percentage decision makers and opinion leaders accessing target specific information	DSW and CDFU compiled and got permission from the 'authors' to use materials in the AHEAD media partners meetings, dissemination forums and pledge signing. None were specifically produced under AHEAD- they were however reproduced and used by AHEAD, ie. i. CDFU (2010) 'Reproductive Health: fact sheet for leaders' and 'Family Planning: fact sheet for leaders': Family Health project ii. Population Reference Bureau, Gapminder Foundation and Makerere University School of Public Health (undated) 'Uganda on the Move: The role of family planning in achieving Uganda's development goals' multi-media presentations for policy makers iii. RHU (2010) 'The Impact of Reproductive Health Supplies Shortages in Uganda': an advocacy position paper. iv. RHU (2010) ''Leaders, act! A call to action on maternal health': a fact sheet v. Population Secretariat (undated) 'Media Advocacy Strategy: Guidelines for Media Partners in Support of Population and Development Issues: vi. DSW and RHU (2010) Health Budgeting in Uganda: A reality check
Identify key opinion leaders to champion the advocacy action plan (DSW, MSU)	Comprehensive list of key targets in place	During the planning phase coalition members identified opinion leaders to serve as advisors to the project, including Dr Miria Matembe (a strong proponent for and an advocate of women's rights in Uganda and MP); Dr Jotham Musinguzi (regional director of PPD) and Dr Olive Sentumbwe-Mugisha (RH director at WHO Uganda). It was a challenge to meet these opinion leaders, but they gave guidance to the project.
Build media partnerships for advocacy (RHU, CDFU-YEAH)	Number of media advocating for government funding for RH	The coalition (CDFU, UHCA leading) held a Media Dialogue in Kampala December 2010. It attracted 37 participants; journalists (print, TV and radio) and health communicators from targeted stakeholders. It aimed to generate debate on the advocacy goals and to build partnership with media for advocacy, and to give media coverage to the MPs pledge.
Securing MP support for the pledge (DSW)	MPs signing the pledge	AHEAD built on prior advocacy actions by DSW Uganda, RHU, UNFPA and Population Secretariat with MPs, and support from NAWMP. The pledge was signed by 90 MPs, district leaders, CSOs and media.
Hold dissemination forums for each target group	Number of dissemination forums conducted	The coalition members held 3 out of 4 planned regional forums on SRH all in January 2011, with District health officer (DHO) and MP presentations and pledge signing; in Gulu led by CDFU; Mabarara led by RHU and Mityana led by DSW. Coalition members worked with the parliamentary coordinators and DHOs. The forums and pledge signing ceremonies involved 189 existing and aspiring MPs, local leaders, CSOs and media.
Hold a high profile pledge signing ceremony	Number and category of signatories to the pledge	A high level signing meeting included Population Secretariat, Dr Latigo Mildred a SRH specialist and Barbara Among a renowned political journalist with the New Vision (a daily newspaper), with 53 existing and aspiring MPs and 37 local leaders signing the pledge. Media coverage was gained on 11 radio stations, 3 TV stations and 2 daily news papers.
Publicize list of signatories to the pledge	Number of media outlets publicizing signatories	The coalition held a press conference at Parliament of Uganda on 3rd March 2011 with support from NAWMP and MP coordinators to disseminate the national pledge signed by MPs and local leaders. 5 MPs spoke advocating for increased funding for SRH in the coming 9th Parliament spoke to 52 participants 39 of which were journalists from print, radio and TV and the rest coalition members (7) and the MPs (5).

Follow up activities: Support and monitor signatory activity, conduct annual review, disseminate results and inform MPs on gaps to address	Number of signatories utilizing information from the database; % signatories using RH information; % activities conducted; % signatories using progress review for action	The project ended in March 2011 before these activities could be implemented. They were assigned to NAWMP and included in their strategic plan through a NAWMP strategic planning process supported by the project and attended by DSW.
Evaluate and disseminate impact results (MSU, DSW)	5% increase in govt budget allocation for SRH	The 2011/12 budget was finalised in June-September 2011 after the project ended. The changes in SRH funding discussed in Section 2.3 indicates an increase in the SRH budget. MPs played a high profile role on SRH budget advocacy, discussed in Section 4.3

The project document noted the external risk of instability around the February 2011 elections. While this did affect timings, leading to some activities being delayed to January 2011 as shown in the table above, it did not stop the activities. By deliberately covering current and contesting politicians from all main parties and by working with the parliamentarians through networks such as NAWMP, the project was able to maintain continuity before and after the elections. According to CDFU, beyond issue of change of lead organisation and the election factor, including having to work to schedules suitable for the MPs, the selection of appropriate districts was delayed to September 2011 due to a national process of redefinition of districts underway. Further, given the the limited project resources, the CSOs had to co-ordinate with schedules for other projects and staff time to be able to 'piggy back' on their activities. While such co-ordination with other processes was noted to have maximized AHEAD resources, it was suggested it could have been better managed if partners had been brought into the design phase to align the work with other processes to take these contextual factors into account, or that budgets need to realistically fund processes less dependent on other programmes.

4.2 The inputs: capacities, strategies, tools and knowledge

Bringing CSO capacities and experiences together was a key resource for AHEAD: As noted earlier, the AHEAD project built on prior advocacy on RH. Jackson Chekweko, the Executive Director RHU, noted that this advocacy on SRH preceeded AHEAD and continues after. The RH supplies advocacy network was formed in 2008 to advocate for RH materials. RHU had engaged government together with Uganda Health Marketing Group (UHMG), Pathfinder International (PI) and MSU on resuming supply of contraceptives by NMS to CSOs providing RH services. They engaged USAID and UNFPA as external funders to support their campaign, with media to profile stories of mothers being turned away from facilities for lack of contraceptives; and made presentations at an international conference on RH commodity security involving government. Backed by the work by PPD described in Section 2.3, government changed policy on supplying CSOs. Mr Chekweko attributed the change in part to the credibility of the CSOs advocating the change, given that they played an important role in provision of up to 60% of family planning services in Uganda. CSOs have advocated further for inclusion of SRH and maternal health in the World Bank support to Uganda's health sector, and have worked to raise MP awareness on RH, including to have funds for RH supplies be allocated directly to NMS. While this brings significant CSO experience to the AHEAD project, it was also noted that different issue specific campaigns and coalitions have emerged, risking duplication if not well coordinated.

AHEAD drew on this base of CSO capacities and work but also enriched it. The mapping carried out of potential partners to identify synergies with other resources and activities underway described in Section 4.1 represented a significant asset for the AHEAD project, drawing in the wider resources and strengths of the consortium members. The CSOs directly involved in leading the work (CDFU, RHU, DSW), reported that AHEAD motivated and enabled them to reach to district leaders, to link their national level work with district level political and technical decision

makers and to strengthen their relationships and credibility with the parliament and politicians across the political spectrum. RHU is a longstanding national RH service provider, DSW has both national and international presence in RH policy and services, while CDFU has experience in communications on health. Individuals within the organizations (officers within RHU, DSW and CDFU; the chair and officer for NAWMP, the director of PPD ARO and district level champions) played important roles in bringing their organizational resources into the work.

AHEAD helped the CSOs involved to have a better understanding of each other's strengths and weaknesses and to benefit from and pool their different experiences, capacities and contacts. The work with PPD, the link with NAWMP and skills and information inputs from other CSOs involved in the project brought new technical expertise and information to the CSOs that was used in the project, the links with UHCA strengthened their connect with media, and the organisations were left with a more systematic appreciation of how to engage with the districts. That the experience was positive is indicated in the fact that it has not ended with AHEAD: Realising their need to work with MPs to properly understrand and track the budget, RHU and DSW are becoming more involved in budget advocacy and partnership and the work with parliaments and districts is being taken forward by the same CSOs working with others under new initiatives such as the AHEAD for World Bank (monitoring World Bank resources in health) and European Union supported Healthy Action partnerships. RHU has continued to use the same approach in working with MPs to reach out to other constituencies.

The strategy tapped opportunities and responded to demand: The project took as its specific advocacy target a pledge for a 5% increase in the budget for RH from 2011 and beyond. In interviews with RHU and DSW, they raised that prior advocacy had profiled the need for SRH services with policy and political leaders, but that this had not yet led to improved government budgets and and that SRH services were highliy dependent on external funding. The campaign to increase public funding for SRH was in part to bring new resources, but also to signal government leadership in and prioritisation of SRH. Given the political dimension of this budget decision, MPs were identified as central change agents, and the means to influence and hold government accountable for leadership and investment in SRH. However, low prioritisation of SRH in district budgets was seen to weaken demand on both MoH and MPs to motivate improved budgets. AHEAD thus added a new dimension to past work of building awareness and support from district leaders, and of enhancing communication between district and national leaders on SRH budgets. The media were identified as key in two respects, in levering the involvement of MPs and district leaders (given their role in raising their political profile) and in raising the profile of SRH through communicating message and information.

A number of opportunities existed for this strategy.

- A shift in the policy environment towards greater support for SRH, described in Section 2.
- Technical work had been initiated to improve procurement processes.
- Large international funders such as UNFPA and World Bank were willing to commit resources through the budget process, creating opportunities for improved budget resources.
- The Parliament Committee on Social Services, a key actor in the budget, had been involved in advocacy on SRH and health budget issues in the 7th (2002-2006) and 8th parliament (2006-2010), including on the Abuja commitment on 15% government funding to health, had included this in their strategic plan and had been involved in field visits to primary care level health facilities (Nambatya 2010). A private members bill, not enacted, was tabled in 2007 by the then chair of the health and social services committee, Hon Dr Chris Baryomunsi on the need to plan for the growing population and improve the quality of health service provision. Some local governments had passed by-laws outlawing female genital mutilation, early marriages and harmful traditional practices;
- NAWMP provided a consistent core of MP support for gender and SRH issues, providing continuity through a bipartisan institutional mechanism;
- Print and electronic media had already generated public dialogue and debate on family planning, maternal health, HIV and AIDs and female genital mutilation (Nambatya 2010).

> *"Interactions between MPs and CSOs make it possible for MPs to bring issues to the table, and CSOs help with research" Parliamentarian*

- MPs had begun to build and appreciate interactions with a number of CSOs on health and budget issues, including FOWODE on engendering the budget, DSW, RHU and PPD ARO, who had also held an orientation meeting for new parliamentarians. The interaction was reported to provide MPs with technical information on issues they were raising, while for CSOs it opened access to budget information.
- The election, while it created challenges for timing of events, created the opportunity of national and district politicians being more sensitive to their media profile and to social issues.

AHEAD packaged and communicated knowledge through a range of materials. While not producing new papers or evidence, as outlined in the table in Section 4.1, the CSOs in AHEAD made use of and widely disseminated a growing mass of technical and published information supporting the case on SRH need and for improved funding of SRH services. A leaflet produced by DSW in 2010 on 'Health Budgeting in Uganda: A reality Check': made the case for improved domestic financing for RH services, noting the gap between policy and implementation (DSW RHU 2010). In the foreword to the brief Hon Sylvia Namabidde Ssenabulya, MP states "*This study sounds a call to action for all parliamentarians to prioritise adolescent and maternal health in the national planning and budgeting process. Parliamentarians should sensitise their electorate to understand the impact and significant investment in reproductive health*". The project did develop a range of communication materials: media briefs, powerpoints, compilations of resources for CSO meetings, as well as the pledge to be signed by MPs and district leaders. While this was useful input for advocacy, there appears to be a gap in accessible accurate evidence on the specific budget figures for SRH, and on how budgets are being spent. SRH budgets were noted as difficult to identify and track, and there is limited information on expenditures against allocations for the different funding pools for SRH over time, at district and national level (DSW RHU 2010). While the PPD supported consultancy provided information on budget flows relevant to NMS, wider and deeper work is needed to include other on and off budget finances for SRH. A RH sub-accounts is proposed in the next national health account review. This will be critical to give clearer information on the sources and distribution of funds for SRH for future budget advocacy. Available evidence was also relatively focused on commodities. The interviews with district leaders and MPs, officials, technical agencies and CSOs all raised the range of other health system factors affecting delivery of SRH services that need to be included in future tools and knowledge for advocacy on SRH, such as access to emergency transport, and availability of trained health workers and incentives for their retention.

4.2 The mechanisms and processes: partnership, ownership, transparency and accountability

Effective, mutually supportive partnership between CSOs was central to the process: The partnership between CDFU, RHU, DSW described in the previous section was supported by processes within the project, viz: Clear workplans, roles, timelines and indicators of progress developed through mutual agreement of the partners, regular progress meetings (approximately monthly), phone and email communications across partners. The lower involvement of MSU, first as lead and then as partner was negative for the other partners. (We were not able to interview MSU and their lower involvement was attributed by the other CSOs to internal management changes). Partners noted that advocacy and engagement is a process not easily framed into a project, in that CSOs need to constantly scope and identify opportunities for quick wins, and respond to unexpected demands and activities not planned or resourced that are generated, such as the priorities for action raised by the districts, or the engagement with NAWMP on their strategic planning. These cannot easily be planned in advance and the progress meetings enabled shared thinking and action, while the meetings held with media and wider networks of CSOs were opportunities for brainstorming and enabled cross-fertilsation of ideas, networks and experience.

DSW and RHU pointed to the **importance and effectiveness of the role of the lead organization** (CDFU), in providing timely updates, following up each partner regarding planned meetings and activities; ensuring that each delivered on reports and met deadlines and that useful links from each partner were shared with the collective. CDFU was seen to have specific capacities for this and for media links because of its communications mandate. Implementing this role raised challenges that were noted by CDFU. A partnership calls for a large and selfless time investment in following up on partners, getting feedback, managing complex logistics and processes, particularly when political leaders and districts are involved. Organising processes within districts was highly

demanding, needing more resources, on the ground presence, more time for districts to plan for activities and more organisational involvement than were provided for in the project. While 'piggybacking' district level project activities on other activities of the organisations made them possible, it also made it challenging to align them to the time frames of the project. The low involvement of MSU, the complicated time frames due to elections, low levels of funding, and the turnover of personnel within partner organisations made the co-ordination even more difficult. CDFU suggested from the experience that processes that work with districts need from the beginning to engage people living within the districts to play stronger roles. Further, lead CSOs need the active involvement of their top management to make the higher level connections needed for advocacy work as well as to make resources such as personnel time available. Finally, it was suggested that given turnover and competing time demands in CSOs, it would be important to have more than one person actively involved from each of the partner CSOs.

Overall, **AHEAD built the credibility and increased leverage of the CSOs involved**, leading to fresh opportunities for them to work together. Even the difficulties were seen to have strengthened the relationship between the CSOs. However, across the interviews the most common feedback from all stakeholders to the question on '*how would you do things differently*' in the organization of the work was that those involved, CSOs, media, MPs and district leaders, should be brought in earlier in thinking through the design of the work, to strengthen process, partnership and ownership.

Transparency and accountability was built through processes that facilitated and informed interactions between forums of CSOs, media, MPs and districts: The information products described in the previous section were brought alive through the dialogue forums in districts, media and press briefings, and the opportunities raised for all groups, including officials, to input and exchange information and views. While the CSOs were largely acting as facilitators of many of these forums, AGHA and UNHCO, CSOs involved in the wider advocacy coalitions discussed in the next section also noted the usefulness of the orientation and the co-ordination meetings in sharing and exchanging information, UHCA offered forums for CSO access to media personnel, and NAWMP opened space for CSOs in parliamentary forums. This sharing of forums opened channels for information flow. Through their links with NAWMP, the CSOs were able to communicate with MPs and access information on the budget that they would otherwise find difficult to get, while MPs were able to use CSO networks to access useful analysis on budget information. Through the media networks, CSOs and political leaders were able to get coverage of SRH issues, This 'overlapping or joining of streams' is one of the means by which technical, political and social actors come together to produce change. **AHEAD uniquely made a further connect between district and national levels.** Through the district dialogue forums, CSOs were able to make a connect between national and district levels, with organised technical presentations and also presentations by district health officers and leaders to raise the profile of the situation on the ground, connecting this with national level processes through the MPs, and with accountability on the budget through the pledge.

> *"It hasn't been easy for CSOs to get information from the Ministry of Health, who seem to fear sharing information with CSOs. It is easier to get it from parliament".*
> Civil society respondent

While AHEAD strengthened budget transparency for CSOs, districts, MPs and media, **it could have created stronger dialogue with Ministry of Health to better understand their budget proposals**. As noted earlier, at both local and central level, Ministry of Health was concerned over co-ordination of the multiple actors involved in the sector. In RH this is compounded by the high level of off budget resources delivered through CSOs. Building stronger public leadership was a concern in framing AHEAD and a motivator for improved public spending on RH. CSOs reported frustration and difficulties in obtaining budget information from MoH and found their role with parliaments to have helped them to access information. However one CSO interviewed also noted a perception in MOH that the CSO relationship with parliament was 'behind their backs', and had not sufficiently involved them. Once consequence of this was in the budget outcome (discussed later), where CSOs, MPs and government officials concurred in interviews that better communication between the three groups in the run up to the budget could have yielded better explanation and less misunderstanding on the line items for training in the World Bank RH budget.

There was **little direct voice of or feedback to the community in the process**. This was not part of the initial design and the CSOs interviewed recognised that a critical next step would be to let the communities know what the politicians pledged, to work with the leaders to strengthen their communication with their communities and to support communities to hold the leaders accountable for what they signed. The Chief Administrative Officer in Mityana district noted that Health Unit management committees are functional in most of the facilities and could be used to make stronger links between communities and their health services.

Across the interviews with CSOs, MPs, district leaders, technical agencies and government there was a common view that AHEAD provided a 'jump-start', but that for real movement on SRH funding, more **work now needs to be done to support SRH advocacy *within* districts, and to monitor expenditure and use of the resources allocated, particularly in changes in access to services**. It was noted by AGHA, for example, that for accountability increased budgets need to be associated with improved access to and quality of services. This calls for stronger links with CSOs and technical expertise working on tracking resource use, and new processes to facilitate a follow through to community level to examine changes in access and quality, in ways that also involve communities more directly.

4.3 The outputs: advocacy coalitions, champions, communication channels and information flow

AHEAD processes tapped into wider CSO health advocacy coalitions: The strong and co-ordinated relationship between RHU, DSW and CDFU and their existing working links with other CSOs meant that AHEAD tapped into CSO health advocacy coalitions, such as on health rights, HIV budget advocacy and maternal health. These CSO coalitions provided an entry for AHEAD to widen CSO involvement in an advocacy coalition around the RH budget, through the orientation meeting held in May 2011 (See Section 4.1), and inclusion of CSOs in the media workshops and briefings,and in the district activities. Of these Uganda Heath Communications Alliance (UHCA) was critical in bringing media into the process and became a consistent partner on activities. CSO networks like UNHCO and AGHA also brought resources to the coalition, such as their relationships with Ministry of Health (UNHCO), budget advocacy capacities (AGHA), work in and evidence from districts. UNHCO worked with MPs on the health budget and in the same period as AHEAD advocating for increased support for recruitment of midwives and other health workers, contributing advocacy to the inclusion of budget support for a further 3000 midwives.

The coalitions provided a critical mass for CSO influence in budget advocacy. Partnering with other CSOs doing similar work appears to be a common feature of health civil society, and in budget advocacy is seen to provide the critical mass needed for impact and to avoid duplicating and fragmenting voice. CSO involvement in health and wider budget processes has been growing stronger through various advocacy platforms in the 2000s. The context seems to be encouraging for such coalitions. On the one hand new MPs have raised debates on transparency and accountability on state resources opening space for CSO advocacy on budgets. On the other hand CSOs are cautious about avoiding stepping into unintended political terrain. Legitimacy for CSO positions and voice is generally derived less from such political activity than from CSO experience on the ground, contribution to service delivery, technical capacities, information and grassroots linkages and the positioning of CSOs or their leaders. Networks provide opportunities to aggregate these features across different CSOs. The coalition around AHEAD bringing a mix of CSOs together provided a wide number of these features, giving strength to the coalition. Hence AHEAD was able in a short space of time to organize a strong and legitimate CSO coalition on RH. The strength of the coalition in sustaining advocacy for and tracking budgets at district level remains to be tested.

Coalitions are relatively dependent on external funds and focused on tracking on vs off budget funding. There is inherent competition between CSOs for visibility and funding, and a number of coalitions appear to be built around specific projects or funds. When AHEAD concluded, the coalitions were supported to track World Bank funding (AHEAD for World Bank) and others have been tracking GFATM funding. However while there is continuity in the institutions involved, it was not clear whether these specific projects allow for the wider advocacy and follow thorugh needed for accountability on SRH budgets. Many CSOs are tracking *on*-budget funding, and there

is limited focus on *off*-budget spending. There is also a gap, raised by the CSOs themselves, in tracking transparency and accountability in the *use* of RH resources, and in co-ordination and equity in the deployment of resources. As the absorbtion and uptake of SRH resources was repeatedly noted to depend on wider systems factors (health workers, transport, social determinants), this raises concern for how far issue based coalitions are raising wider systems advocacy. One interviewee suggested that no such broad based coalition exists. The closest was an emergent loose coalition of about 64 CSOs that formed initially around the court petition on maternal health (convened initially by UNHCO but now rotating the convening role for weekly meetings). This was reported to have begun to raise in its meetings wider health system issues, and to not be driven by any specific project, disease or health programme focus.

The CSOs in AHEAD identified and effectively worked with important champions for SRH. During the planning phase the coalition members identified key decision makers or opinion leaders that could serve as advisors to the project and guide it through the electoral period (noted in activity table in Section 4.1). These people were busy and their input was largely drawn through telephone calls or one on one meetings. Dr Musinguzi PPD played a role, for example, in bring SRH to high level attention, to have contributed to the consultancy that addressed bottlenecks in funding for RH commodities to NMS and from NMS to CSOs, and to have supported information for MPs.

The forums and pledge facilitated and made visible the individual and collective roles of MPs, NAWMP and district leaders. The activities that engaged these key groups are outlined in Section 4.1, including the three regional dissemination forums and pledge signing meetings in January 2011 in Gulu; Mabarara and Mityana districts and the national pledge signing ceremony. While it has been used in other processes, and appeared to be viewed with some cynicism by the media, the pledge, shown in Box 2, provided a focused tool to formalise and give visibility to the political leaders and to hold them accountable for their commitment.

Box 2: NATIONAL PLEDGE to increase government funding for Reproductive Health

The Government of Uganda is committed to achieving the Millennium Development Goals (MDGs) and has identified ill-health as the leading cause and consequence of poverty in Uganda. However, Uganda still has poor reproductive health indicators, with a high population growth rate of 3.2%, a low contraceptive rate of 24% and high unmet need for family planning at 41%, resulting in the highest total fertility rate in eastern and southern Africa (6.7%). While there is political will demonstrated by a number of national and international commitments, **only 9% of the overall country budget is dedicated to health.** If this under allocation of government funding for health and in particular reproductive health continues, by 2015 Uganda's attainment of the aspirations of the International Conference on Population and Development and Millennium Development Goals is not likely to be met. **Increased Government funding will ensure that adequate and quality reproductive health services and in particular family planning services are extended to the most vulnerable grassroots communities across Uganda.**

It is against this background that the undersigned existing and aspiring parliamentarians and district leaders have pledged to commit to lobbying and voting for an increment in government funding for Reproductive Health by 5% by 2011 and beyond.

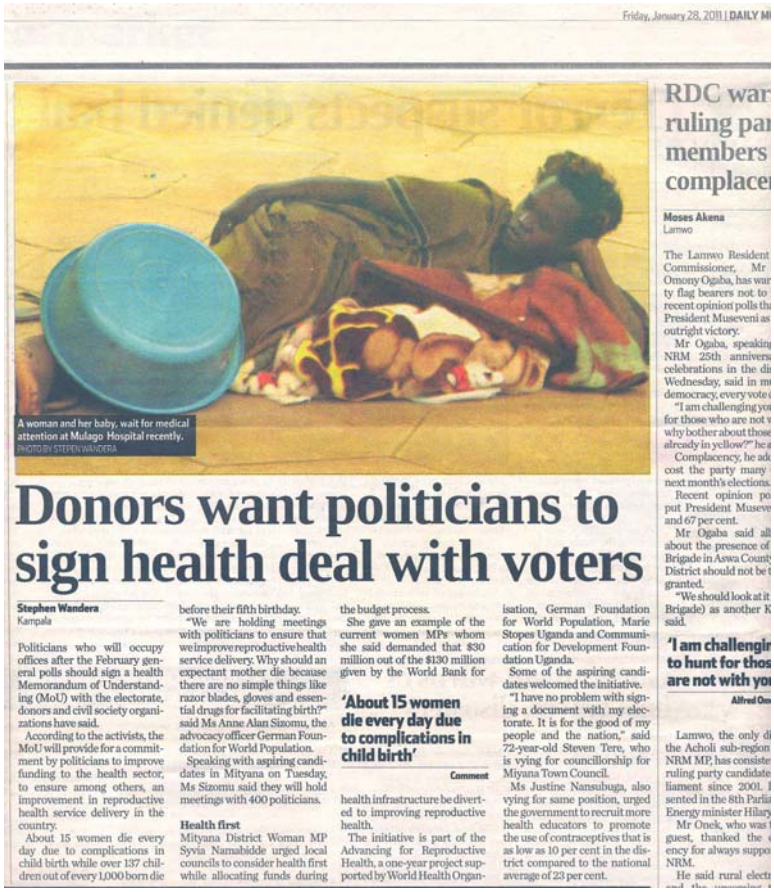
Name	Designation	Political Party / District	Signature	Date

'"we as Members of Parliament still pledge to advocate for increased funding for Reproductive Health in the coming 9th Parliament". . Hon. Namabidde Sylivia, Press conference, March 2011

The project took steps to use the pledge to publicly show the commitment of the 53 existing and aspiring MPs and 37 local leaders who signed it. The press conference to publicise the list of signatories to the pledge at Parliament of Uganda in March 2011 made the pledge, and its commitment to increase the budget public. The media noted that MPs have made previous pledges and questioned their influence in delivering on the pledge given the powers of the

executive. The MPs responded that their ability to ensure increased funding and proper use of funds depended on public support, which in turn needed media support. They indicated that they would continue to work with district leaders to ensure RH was prioritised (AHEAD 2011b). District leaders advocating SRH appeared to value this support from MPs, as those interviewed in Mityana specifically noted this as a key input in prioritising SRH in plans.

The MPs were reported to have played a role in 2010 ensuring that the World Bank loan included funding for SRH services, and in the 2011/12 budget debate they were vocal in successfully removing line items for workshops to reassign them to direct service support for SRH (See Box 3).



Friday, January 28, 2011 | DAILY M

A woman and her baby, wait for medical attention at Mulago Hospital recently. PHOTO BY STEPHEN WANDERA

Donors want politicians to sign health deal with voters

Stephen Wandera
Kampala

Politicians who will occupy offices after the February general polls should sign a health Memorandum of Understanding (MoU) with the electorate, donors and civil society organizations have said.

According to the activists, the MoU will provide for a commitment by politicians to improve funding to the health sector, to ensure among others, an improvement in reproductive health service delivery in the country.

About 15 women die every day due to complications in child birth while over 137 children out of every 1,000 born die before their fifth birthday.

"We are holding meetings with politicians to ensure that we improve reproductive health service delivery. Why should an expectant mother die because there are no simple things like razor blades, gloves and essential drugs for facilitating birth?" said Ms Anne Alan Sizomu, the advocacy officer German Foundation for World Population.

Speaking with aspiring candidates in Mityana on Tuesday, Ms Sizomu said they will hold meetings with 400 politicians.

Health first

Mityana District Woman MP Syvia Namabidde urged local councils to consider health first while allocating funds during the budget process.

She gave an example of the current women MPs whom she said demanded that $30 million out of the $130 million given by the World Bank for health infrastructure be diverted to improving reproductive health.

'About 15 women die every day due to complications in child birth'

Comment

The initiative is part of the Advancing for Reproductive Health, a one-year project supported by World Health Organisation, German Foundation for World Population, Marie Stopes Uganda and Communication for Development Foundation Uganda.

Some of the aspiring candidates welcomed the initiative.

"I have no problem with signing a document with my electorate. It is for the good of my people and the nation," said 72-year-old Steven Tere, who is vying for councillorship for Miyana Town Council.

Ms Justine Nansubuga, also vying for same position, urged the government to recruit more health educators to promote the use of contraceptives that is as low as 10 per cent in the district compared to the national average of 23 per cent.

RDC war
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Moses Akena
Lamwo

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Alfred Ou

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sented in the 8th Parli
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NRM.

He said rural electr

Box 3:
Daily Monitor Women MPs vow to block MoH budget

By Mercy Nalugo Tuesday, August 16 2011

Women MPs have vowed to block the Ministry of Health budget when it is presented in Parliament for consideration over the diverted maternal health money. The women have also threatened to petition President Museveni to intervene to ensure that the money meant for maternal health is put to proper use.Addressing a news conference at Parliament yesterday, the legislators under their umbrella organisation, the Network of African Women Ministries and Parliamentarians (NAWMP) announced they are moving jointly with their colleagues of the Uganda Women Parliamentary Association (UWOPA) to stop the diversion. Ms Rose Mary Muyinda (Gomba), the NWMP's Publicity Secretary, told journalists at a press conference yesterday that the country is a long way from achieving the Millenium Development Goal of reducing maternal deaths by three quarters and improved access to reproductive health. Government allocated Shs24 billion from this year's budget towards the improvement of maternal health in addition to a $130million (Shs390b) loan from the World Bank for the same. But over Shs2 billion has allegedly been diverted to seminars and workshops. The MPs vowed to block the Ministry of Health budget for the financial year 2011/2012 until they direct more resources to the purchase of medical supplies and also recruit more nurses and midwives. UWOPA chairperson, Ms Betty Amongi (Oyam South), condemned the action and said the government was not committed to reducing maternal mortality. The MPs also called on the government to make specific commitments to the global strategy for women and children's health ahead of the UN General Assembly summit scheduled for September 17-24.

When interviewed, MPs felt that they had been better positioned to lever improved spending on SRH in the national budgets over the past two years due to the shift in policy and social attitudes on SRH, on maternal health in the MDGs and on gender, particularly at national; as well as due to the championing of SRH by outspoken MPs leading to greater receptiveness of parliament to discuss and budget for SRH; the consistent voice and influence of NAWMP sustaining focus on SRH and maternal health, even with inclusion of a reported 60% new MPs in the parliament; and the supporting inputs from CSOs and technical partners.

"Politicians are here to help the system move" District respondent

MPs and district leaders felt that the district processes need more sustained support. The MPs greatly appreciated the work to connect MPs to the districts, but noted that women leaders at district level need to be organized the way they are organized at national level to see sustained improvements in district budgets for SRH and maternal health. This change they felt took more than one forum at district level. It needed capacity building of

councilors and women leader coalitions within districts on SRH and tracking of how district budgets are spent. District leaders in Mityana endorsed this view. MPs also noted that increasing the budget is necessary but not sufficient. While local radio and display boards can make information on budgets publicly available, but people need more support for informed participation. They raised concern that funds and supplies may not be effectively used without community level information and processes to support community uptake of services, and low uptake or poor use of resources could trigger a negative cycle of funding. District level leaders indicated that they needed to operationalise budgets through the system and needed advocacy on issues of improved staffing, retention incentives like housing, and skills in local health centres. The connect between the national budget and these local level concerns appears to be an unfinished agenda. Specific evidence on what the national and district signatories have done since signing the pledge is still to be collected by NAWMP, an activity in their strategic plan that was yet to be implemented at the time of the assessment. It would seem that CSOs need to call for this follow up, participate in it and as noted below involve media for public accountability. It may otherwise seem that the pledge was more a means to raising visibility of SRH than for raising social accountability over its contents.

The media played a key role both in coverage of political leaders and in raising social dialogue. The partnership with UHCA, an institution networking journalists that holds a monthly media dialogue for journalists based in the Kampala area, contributed to the inclusion of journalists at national and district level. UHCA has been supported to hold regular training for journalists on issues of health communication with the aim of getting the journalists to think about these issues. A Media Dialogue in December 2010 (reported in the activity table, Section 4.1), included a renowned political journalist with the New Vision, a daily national newspaper. The dialogue provided visual evidence, Google earth and motion pictures, punctuated by moderated open discussions to enable participants contribute to the deliberations and seek clarifications (UHCA 2010).

NEW VISION, Friday, January 14, 2011 9

Unsafe abortions on the rise in Gulu district

By CHRIS OCOWUN

Gulu district registers more than 1,600 cases of unsafe abortions carried out by mothers and school girls every year, Sister Jane Rose Okilangole, the assistant district health officer, has said.

"The Government must take action and increase funding towards reproductive health. Our parliamentarians should advocate for more funding to reduce maternal deaths ," she said.

Okilangole said statistics showed that in 2007/2008, a total of 1,982 mothers and school girls had abortions, in 2008/2009 1,160 aborted and in 2009/2010 1,681 aborted in Gulu district.

Okilangole said some of the abortions were as a result of health complications, while others were done deliberately by school girls. She said only 20% out of Gulu's population of 3,574,000, use family planning methods.

"Last year, only 16,096 couples enrolled for family planning methods, an increase from 12,975 in 2008/2009," she said.

Okilangole said few men had adopted family planning methods.

"Last year, 8 men enrolled for vasectomy, an increase from one in 2009," she noted.

Okilangole said women die of pregnancy-related problems every year in Gulu, adding that these deaths and abortions would have been avoided if the couples had sought family planning methods.

She revealed this while presenting a paper on the status of reproductive health and family planning in Gulu district during a half-day seminar with parliamentary aspirants and district leaders at Bomah Hotel on Tuesday.

While the media has itself been cticised for preferring to cover celebrities than health issues (UHCA 2010), the involvement of radio, TV and print media journalists levered media cover for alone led to media coverage on 11 radio stations, 1 TV station and 2 daily news papers. The media played a pivotal role in motivating political leaders and keeping issues in the public eye. Journalists themselves gained from accessing the information and analysis provided by the CSOs. UHCA monitors media coverage and the UHCA interviewee observed that there appears to have been an increase in both volume and controversy in media reporting of SRH issues. However issues affecting budget implementation, like health worker conditions, have not had as much media profile as issues like maternal deaths and the link between family planning and economic development issues is still not clearly presented. As for other actors, UHCA called for early involvement of media in designing advocacy interventions. Cautioning about media fatigue, he urged CSOs to keep media attention alive in acting as a watchdog to ensure that pledges and allocations are actually implemented.

4.4 The outcomes: SRH allocations, CSO participation in budget processes

The commitment was for MPs to vote for a 5% increase in government funding for RH by 2011 and beyond.

Funding for SRH and government prioritisation of SRH increased. The changes in SRH funding were discussed in Section 2.3, indicating that SRH budget resources did increase, even though it is difficult to measure whether the rise was 5%, given the lack of clear information on which baseline was being used. Beyond this, there is evidence of increased commitment to government leadership in SRH. Dr Ezati Director of planning in the Ministry of Health (MoH) indicated that health indicators

have demonstrated a clear public health need, so that MoH has internally reassigned funds to deliver on immunization and SRH, and that government intends to put more effort into coordination of on and off budget funds going to the districts. Off-budget projects were noted by MoH officials to be clustered in some districts while others do not have support, such as in relation to capacity support to service providers, affecting equity in service delivery. Dr. Jennifer Wanyana, Assistant commissioner for RH at MoH, noted that MoH with Engender Health is carrying out a mapping of RH services provided by non state actors in the country to inform efforts to co-ordinate more equitable distribution of inputs. District leaders in Mityana also reported that resources have been re-assigned at district level for SRH, such as for employment of midwives, although the changes implemented in all three districts after the pledge are still to be tracked.

The dialogue between CSOs and MPs offers a vibrant space for public engagement on budgets that has been sustained for several years. As noted in Section 2, this cannot be attributed to AHEAD alone. This project built on previous years of advocacy and technical support, including by the CSOs in AHEAD, around political commitments such as to the Road Map on maternal health, and through support from large international agency funders like UNFPA. Longer term relationships between CSOs involved in AHEAD and parliamentarians have been facilitated by institutions like NAWMP providing continuity, and supported by high level technical support, such as from PPD, to allow for the synergies to build across individual projects.

However three way communication could be further strengthened between CSOs, parliament and government. Some CSO respondents (RHU, UNHCO) suggested that communication with the Ministry of Health should be improved, despite difficulties sometimes encountered. In the 2011/12 budget , the MoH had included resources to train service providers on new family planning techniques (MVA, LTPM (minilap), Misoprostol, resucitation of the new born and for post internship induction of doctors newly recruited by government), but this was identified as "workshops" and refused by MPs, who were averse to resources going anywhere but to services. CSOs were themselves not informed and did not play a role in explaining or defending this line. While this training could be met through non state funds if better co-ordinated to overall needs, the experience suggests a need for stronger information flow between government, parliament and CSOs early in the budget process. This would help people to understand not just the budget amounts but what the funds are for.

The project outcomes at district level still need to be followed up and systematically documented. The lack of documented follow up in the three districts on the pledges makes it difficult to judge the outcomes across the three districts. Systematically documenting this would be important as the interview in Mityana showed that changes had taken place, and also showed the issues that need to be addressed to translate national budget advocacy into public engagement on changes within districts. The districts leaders in Mityana noted that AHEAD activities helped them to realize that there hadn't been enough focus on improving SRH. They identified their SRH priority as maternal health, and reported having since raised this in several council meetings to identify factors in the district that they could address. As a result the district had in 2011 reassigned resources to recruit two new midwives and to establish solar power at 12 facilities. It was not possible to ascertain the level of public engagement on these priorities and resource shifts at district level, despite social participation being an important to CSOs and in political decentralisation.

> *"AHEAD brought together the MPs and district leaders - but only once. That was not enough. It was a wake-up call, but needs to be followed up and more meetings need to be held between MPs and district leaders"*
> Parliamentarian

4.5 Challenges and likelihood of sustainability

The one year project faced a number of challenges. While challenges in the environment and process were responded to in strategic ways, they also demanded for personal and institutional commitment and resources from those leading the process:

- Competition from political campaigning activities led to reorganisation of the work, with dissemination forums held together with pledge signing in the districts to mobilize the aspiring and existing parliamentarians who were in the districts canvassing for votes.
- Delays in implementation explained earlier and lack of provision for a no-cost extension after March 2011 led to responsibilities for follow up on the pledge being integrated within NAWMPs

strategic plan. This may be seen as 'self monitoring' and both CSOs and media were raised as needing to follow up on the pledge for social accountability;

- There were many demands on the co-ordination of the work, including limited resources, tight time frames, competing priorities of coalition members, journalists and MPs, turnover of personnel and different work and reporting cultures in the CSOs, media, MPs and district leaders involved;
- Working with districts was reported to need more time to carry out courtesy meetings, build dialogue and involvement on the work and to co-ordinate with local actors;
- Working with media provided a positive input to social dialogue, but there were challenges, particularly at a time of heightened political tension. For example a radio programme used, "Ekimeza", at CBS raised social debate, but later became political as MPs who raised family planning issues were challenged by those raising land issues. The latter linked family planning to an agenda of land being taken from owners, to give profile to this land debate within wider political debates underway, complicating the discussion of family planning. Journalists had many competing demands, and themselves had issues with how family planning linked to concerns about food, housing and jobs. Technical information needed to be translated into short, clear messages, but this was complicated by the lack of clear budget information on SRH (UHCA 2010).

> *"The media raises the social demand for information. The issues that give rise to media soundbites are those the MPs raise"* CSO respondent

Advocacy for improved budgets needs to link with processes for budget accountability. The expectation is that there will be an increase in government funding for RH in future national budgets to the estimated level to meet demand outlined in Section 2.3. However, this cannot be assumed unless more is done to widen commitment at district level, and to ensure that resources assigned are used and produce change locally.

Ministry of health officials in planning and RH acknowledged that district capacities to absorb and use funds also needed to be strengthened to sustain increases in budgets. The interviews and background documents highlighted a range of bottlenecks to be addressed for SRH budgets to be effectively used, including:

- health worker numbers, skills, pay, conditions of service and supervision;
- the skills of frontline health workers to deliver innovations, such as new long term methods for family planning;
- anciliary services such as transport and communication;
- weaknesses in the push system of supply from NMS that delivers some commodities in excess, and inadequate supplies of others;
- procurement of contracted services;
- coordination among key non state actors providing anciliary inputs such as training or community awareness and uptake;
- transparency and accountability in CSOs on funding and on the business nature of their operations to avoid sale of public goods;
- activities to support service uptake, especially in vulnerable groups such as adolescents and women with disability;
- in tracking the results from increased funding, and
- in ensuring that accountability for service provision and outcomes is not limited to state services, but covers CSO, private, local and central government.

> *We need to improve health worker standards, capacities and pay to improve services. Dealing with the issue of health workers is not easy and we have no combined lobyy on it"*
> Technical agency respondent

It was suggested by CSO, government and parliament respondents that advocacy on the level of funding needs to be matched with advocacy on service delivery and uptake, and work to track the expenditure and use of resources allocated, including who is benefitting from these resources. District leaders and CSOs felt that leaders, personnel and communities within districts need to play a role in shaping this work. Alignment and co-ordination of off-budget spending remains a further significant challenge, particularly to achieve greatest impact with budget resources. While MoH stated concern for this most strongly, it is one shared by political leaders and CSOs, suggesting that all have a shared interest in ensuring the resources to implement the proposed RH sub-accounts are made available and that the information from it on the sources and distribution of all funds for SRH is shared.

5. Conclusions and lessons learned

In a context of evident public health need and low resource allocation, attitudes have shifted and policy support for SRH has grown at national level in recent years, although less so at local government level. National CSO and parliamentary advocacy, technical work to 'unblock' procurement challenges, increased on and off budget support from external partners have all raised demand and opportunity for increased public leadership and funding for SRH. While RH funding is in various 'pots' and thus difficult to track, it appears to have improved after FY 2009/10.

The budget process provides opportunities for public engagement and MPs, particularly those in NAWMP, have raised political attention on SRH. While there are challenges in the interaction between civil society and state in Uganda, CSOs have become increasingly involved in advocacy, policy dialogue and social accountability on health policies and budgets in the 2000's. Within this context, CDFU, DSW and RHU in the AHEAD project sought to mobilise parliamentarians to commit themselves to lobby and vote for increased government funding for SRH by 5% in 2011 and beyond. By August 2011, 5 months after the project ended, the budget for FY 2010/2011 showed that GoU, UNFPA and World Bank contributions to the budget had increased, and that parliament had actively engaged to negotiate and support these increases.

As a one year programme with limited resources, the AHEAD project built on prior engagement on SRH policies, budgets and interactions between civil society, technical agencies, government and parliament on SRH. It is thus not possible to simply attribute increased funding for SRH to the project. However, the evaluation highlights some lessons from AHEAD on civil society interaction and engagement on SRH budgets, and particularly in strengthening the foundation and co-operation between key actors and in bringing district level engagement into national advocacy.

Budget advocacy as a multi-actor, political process needs inclusive planning: The AHEAD strategy successfully identified important civil society, technical leaders, parliamentary, district and media actors needed to tap opportunities and address factors weakening demand for improved budgets. Each played a pivotal role. The lead CSOs combined service, technical, communication and advocacy capacities and experience, brought in institutional resources from existing programmes, and brought on board CSO networks with media, health and budget and other capacities. NAWMP provided an institutional mechanism for raising strong voice of women MPs, for involving MPs and ensuring continuity across sessions of parliament. The districts brought new impetus, information and legitimacy to the advocacy. Technical inputs made important contributions to unblocking resource flows through NMS. The process strengthened trust between these actors, an important issue for future access and collaboration. A shortfall identified was in creating stronger dialogue with MoH to better understand their budget proposals. Budget advocacy appears to benefit from this rich combination of actors, but CSOs, districts, MPs and media all suggested that it would work better if they were brought in early into planning in the design phase, to align the work with other processes, to take contextual factors into account and to synergise inputs.

Advocacy and engagement is a strategic process more than a project. The AHEAD work built on several years of prior interactions, including a growing appreciation by MPs of their interactions with CSOs on health and budget issues. While planned activities can create the conditions, interactions and produce information to support change, the CSOs raised that they needed to respond to changes, scope and identify opportunities for progress, brainstorm on unexpected demands and challenges and respond to issues raised by constituencies. In the AHEAD work there was evidence of such strategic response: Progress meetings enabled shared thinking, and meetings held with media, NAWMP and wider CSOs networks enabled cross-fertilisation of ideas and experience. The successful consultancy work to unblock procurement procedures in relation to NMS noted that the situation of competing priorities in health called for constant collaboration, in person communication and active follow up between the different institutions. The AHEAD work also pointed to the value of dialogue forums and media dialogues as a means not just to communicate 'the message', but also as a means to be used to open information flow between different kinds of actors. Kingdon (2003) points to such 'overlapping or joining of streams' through which technical, political and social actors come together as a means of policy change.

CSO coalitions bring significant resources to budget processes, but also demand significant institutional and individual resources for co-ordination Mapping coalitions and building synergies with and between existing networks and activities amplifies the outreach of civil society. Networking allows CSOs to aggregate their different capacities, including in service delivery, technical work and grassroots linkages, building a stronger and more influential coalition. It reduces the risk of duplication and fragmentation across different issue-specific coalitions. The RH budget advocacy successfully drew on a variety of CSO capacities and work, with the driving force for the coalition spread over three CSOs, and with many more involved. It also benefited the participating CSOs, provided them with new information resources, entry to new constituencies, new technical expertise, links with media and the shared and pooled resources of the network, strengthening legitimacy and impact. It was thus able, in a short space of time, to organize a strong, legitimate CSO coalition on RH budget advocacy that is now being sustained for other health advocacy activities. This demands significant investment, especially from the co-ordinating institution, to support the partnership, communicate with and following up on partners with different institutional cultures, and manage complex processes. CSOs involved are vulnerable to disruption from turnover if only one person is assigned to the work. It also calls for the involvement of top CSO management to make the higher level links needed for advocacy.

> *"I look at AHEAD as a success because of how we chose to make use of this time, who to target and the design. Our approach and choice of CSOs as a team and all other stakeholders was carefully thought through which to me says a lot about how we make use of what you have"* CSO respondent

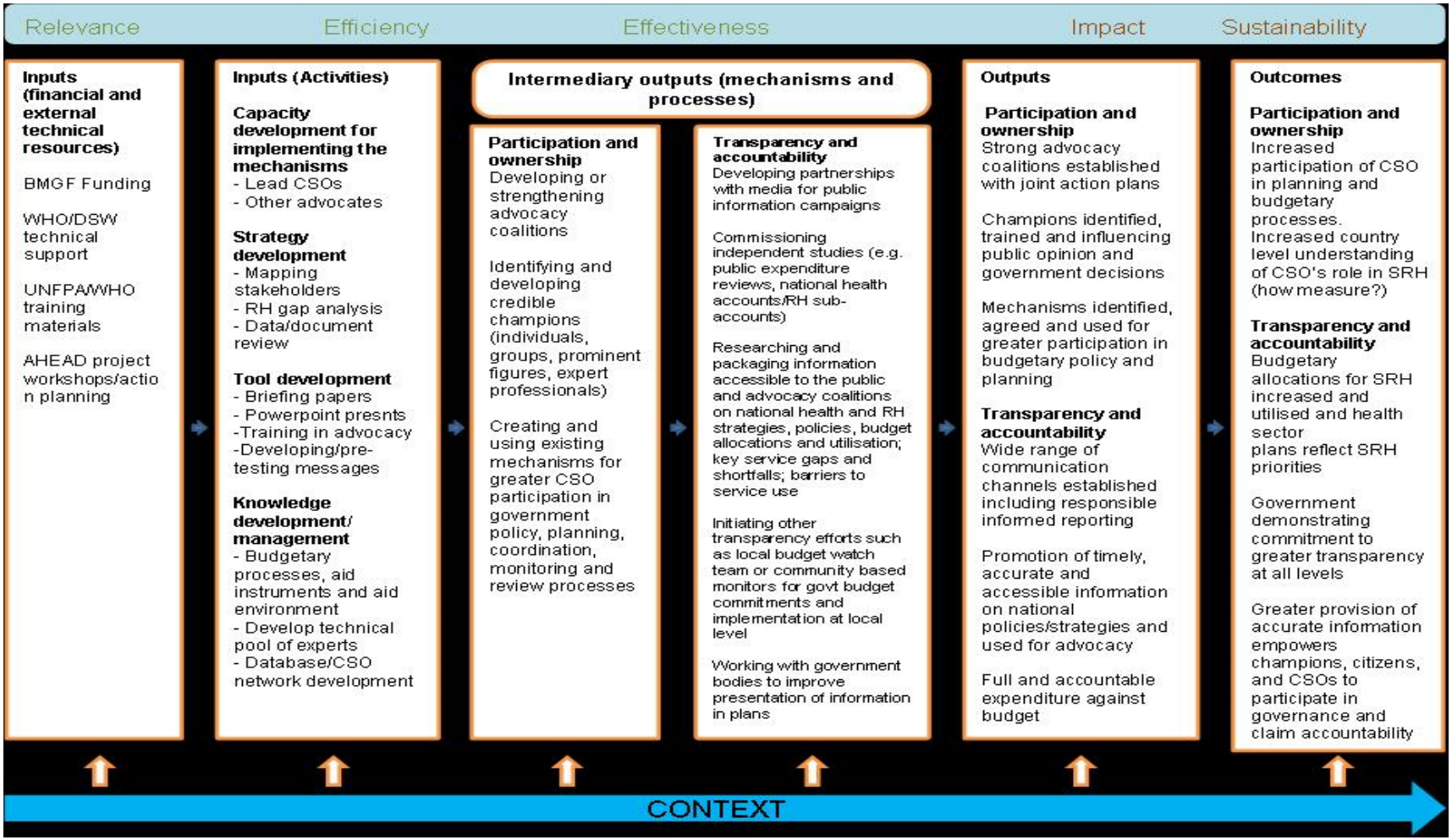
Advocacy for improved budgets needs to link with processes for resource uptake and budget accountability. The AHEAD work made an important connect between national and district levels, raising the profile of the situation on the ground and connecting this with national level processes through the MPs. It appears to have strengthened the link between MPs and districts on RH issues, and the pledge served an important means to link district and national levels on the budget. It has not been possibly to properly assess this experience given the lack of follow up in the three districts on what change has been achieved after the pledge. However MP, CSO and district participants to the process pointed to the need for more sustained work in districts if change is to take place, to build leadership, including with coalitions of women leaders as at national level, and with communities, to inform them of what the politicians pledged and to support communities to hold the leaders accountable for what they signed.

Increased budgets call for sustained advocacy and monitoring. It is possible for gains in one year to reverse, particularly if resources are not effectively used, even in the context of demonstrable need. Improvements in funding expose other constraints in the health system that affect delivery of specific services, in this case shortages of transport and of health workers, particularly midwives, and the accommodation, pay and incentives that retain health workers in districts. Further community level information and processes are needed to support community uptake of services, to avoid low uptake or poor use of resources that could trigger a negative cycle of funding. There was a strong shared perception amongst CSO, government and parliament respondents that advocacy to improve budget funding needs to be matched with advocacy on service delivery and uptake, and with work to track the expenditure and use of resources allocated, including who is benefitting from them.

CSO advocacy around government budgets may support and be necessary for, but is not sufficient in addressing aid effectiveness. The principles underpinning the Paris Declaration include local ownership, alignment to national priorities and partnership in overseas development aid. There was evidence that CSOs in partnership with parliaments and other actors can play an important role in advocating for budget allocations to areas of public health need. For external funders such as UNFPA and the World Bank, who direct resources through the budget, this can help to align aid resources to national needs, notwithstanding the various additional demands noted above. However, this left unaddressed the issue of alignment and accountability of the much larger share of off-budget spending for SRH. For MoH and districts, this was a significant challenge, particularly to co-ordinate the additional inputs needed to achieve greatest impact with budget resources. It was little affected by the budget advocacy work in AHEAD, which did not intend to collect information or advocacte on these resources, and which framed government as the target to be influenced rather than a partner in addressing the alignment of off budget resources. Transparency in and co-ordination of these significant resource flows for SRH is thus still to be addressed.

6. Annexes

6.1 Framework for the assessment



6.2 Project plan

Main Activities	Responsible Organization	Deadline	Desired output or outcome	Indicators of success
Prepare an action plan and implementation strategy	CDFU/YEAH	April 2010	An action and implementation plan developed	An action and implementation plan is in place
Utilize existing advocacy materials for different target groups (parliamentarians, UN agencies, CSOs, media, key opinion leaders etc)	RHU DSW/ CDFU/MSU	April 2010	Target specific advocacy materials gathered and adapted	5 target specific advocacy materials used in place, 2 press clippings in project file
Strengthen RH advocacy coalition by bringing other key CSOs on board	CDFU/YEAH RHU DSW MSU	May 2010	Number of RH sectoral CSOs working together	Number of CSOs working together increased from 4 to 7, minutes of coalition meetings, commitment letters to undertake specific activities in the action plan in place
Identify and list key decision and opinion leaders to champion the advocacy action plan	DSW MSU	May 2010	Consensus on target groups for advocacy built	3 key decision makers and opinion leaders in place
Build media partnerships for advocacy	RHU CDFU/YEAH	May 2010	A network of media for RH advocacy in place	Up to 39 journalists attended the AHEAD media dialogue, dissemination forum and pledge signing event and the press conference; (attendance lists of media in place); newspaper clippings in place
Solicit and securing support for the pledge from constituents	DSW MSU	June 2010	Support for the pledge secured	37 district leaders signed the pledge; signatures and attendance list of local leaders who support the pledge in place
Hold dissemination forums for each target group in partnership with key partners	CDFU/YEAH	July 2010	Dissemination forums held for each target group	3 dissemination forums held; list of attendees in place; signed pledges in place
Hold a high profile pledge signing ceremony	RHU CDFU/YEAH	August 2010	A signing ceremony held	Signatures from 53 existing and aspiring parliamentarians and 37 local leaders to the pledge in place ; pictures and press clippings in place
Publicize list of signatories to the pledge	RHU CDFU/YEAH	August 2010	List of signatories to the pledge publicized	Up to 11 radio stations, 3 TV stations and 2 daily news papers publicized the signatories
Support activities of the signatories	DSW MSU	August 2010 to Nov 2011	Monthly update issued to signatories	Not yet done
Monitor the activities of the signatories	CDFU/YEAH	August 2010 to February 2011	Relevant RH information being utilized by the Signatories	Not yet done
Conduct end of year review	MSU	March 2011	A documentation of progress and future action plans made	Completed report on progress with recommendations in place
Sensitize signatories on the annual progress made and remaining gaps to be addressed	MSU DSW	March 2011	Increased awareness about achievements and gaps among the signatories built	Not yet done

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6.4 People interviewed

Institution	Persons met	Comments
CSOs		
CDFU	• Catherine Kanyesigye	Lead CSO, AHEAD
DSW	• Mona Herbert • Ann Sizomu	AHEAD implementing CSO
Reproductive Health Uganda (RHU)	• Jackson Chekweko - Executive Director • Martha Songa - Advocacy Officer	AHEAD implementing CSO
Action group for Health, Human rights and HIV/AIDS (AGHA)	• Dennis Odwe – Program Officer	CSO involved in AHEAD
Uganda national health consumers organization (UNHCO)	• Jeff Opio – Program Officer for Advocacy and communications • Esther Nalujja – Program Officer	CSO involved in AHEAD
Advocacy champions targeted under the projects		
Parliament	• Hon. Emma Mboona, MP for Mbarara district • Hon. Komuhangi - MP for Nakasongola district • Hon. Betty Aol - MP for Gulu district • Hon. Matthias Kasamba – MP for Kakuto, Rakai • Hon. Kamateka – MP for Mitooma district • Lilian - NAWMP coordinator	National Association of Women Members of Parliament (MAWMP) MPs for districts involved in the project
Uganda Health Communications Alliance (UHCA)	• Richard Baguma - Coordinator	Media
Mityana District Local government	• Isiah E - District Public Health Officer • Betty Enzaro - in-charge maternal health at Mityana Hospital • Aloysius - District council Speaker • Ibrahim Mukanga - District councilor • Emmanuel Mugwanya - District Secretary for Finance • Dr. Kigongo - Acting District Health Officer • Salongo Asuman - Chief Administrative Officer	District local government and officials in a district involved in the project
Government officials and technical agencies		
Ministry of Health	• Dr. Isaac Ezati – Director for Planning • Dr. Jennifer Wanyana – Assistant commissioner for RH	Government agency
UNFPA	• Janet Jackson - Representative	Lead UN agency in FP
Partners in population and development – African regional office (PPD – ARO)	• Dr. Jotham Musinguzi, Director	Opnion leader and key technical agency

7. Acronyms

AFP	Advance Family Planning
AGHA	Action Group for Health, Human Rights and HIV&AIDS
AHEAD	Advancing Healthy Advocacy for Reproductive Health
ARO	Africa Regional Office
CDFU	Communications for Development Foundation Uganda
CSO	Civil Society Organisation
DENIVA	Development Network of Indigenous Voluntary Associations
DSW	German Foundation for World Population
FOWODE	Forum for Women in Democracy
GoU	Government of Uganda
HEPS	Coalition for Health Promotion and Social Development in Uganda
HIPC	Heavily Indebted Poor Countries
HPAC	Health Policy Advisory Committee
IHP+	International Health Partnership
MDGs	Millennium Development Goals
MoF	Ministry of Finance
MoH	Ministry of Health
MP	Member of Parliament
MSU	Marie Stopes Uganda
MTEF	Medium Term Expenditure Framework
MVA	Manual Vaccuum Aspiration
NAWMP	National Association of Women Ministers and Parliamentarians
NGO	Non Government Organisation
NMS	National Medical Stores
NRM	National Resistance Movement
PAF	Poverty Action Fund
PPD	Partners in Population and Development
RH	Reproductive Health
RHU	Reproductive Health Uganda
SRH	Sexual and Reproductive Health
SWAp	Sector Wide Approach
UDN	Uganda Debt Network
UHCA	Uganda Health Communication Alliance
UNHCO	Uganda Network of Health Consumer Organisations
UNFPA	United Nations Family Planning Association
UWOPA	Uganda Women Parliamentary Association
WHO	World Health Organisation