



# Mapping Maternal Health Advocacy

## A CASE STUDY OF UGANDA

# TABLE OF CONTENTS

I.	INTRODUCTION	3
II.	MATERNAL HEALTH IN UGANDA	4
III.	THE MATERNAL HEALTH POLICY ENVIRONMENT	5
IV.	MATERNAL HEALTH ADVOCACY STAKEHOLDERS	7
V.	ADVOCACY GOALS, MESSAGES, AND DISSEMINATION STRATEGIES	9
VI.	ADVOCACY OPPORTUNITIES AND CHALLENGES	12
VII.	THE PRIVATE SECTOR AND MATERNAL HEALTH	14
VIII.	CONCLUSION AND RECOMMENDATIONS	15
IX.	BIBLIOGRAPHY	16

## List of Boxes

BOX 1:	FAMILY CARE INTERNATIONAL'S (FCI'S) MATERNAL HEALTH ADVOCACY MAPPING	3
BOX 2:	PETITION 16	11
BOX 3:	ENGAGING GOVERNMENT ON MATERNAL HEALTH	12
BOX 4:	PAST AND PRESENT OPPORTUNITIES FOR ADVOCACY	13
BOX 5:	A CASE OF PUBLIC-PRIVATE PARTNERSHIP IN HEALTH	14

## List of Tables

TABLE 1:	KEY MATERNAL HEALTH INDICATORS FOR UGANDA	4
TABLE 2:	UGANDA'S NATIONAL, REGIONAL, AND INTERNATIONAL COMMITMENTS	7
TABLE 3:	MAP OF MATERNAL HEALTH ADVOCACY STAKEHOLDERS	8
TABLE 4:	MATERNAL HEALTH ADVOCACY PLATFORMS	9
TABLE 5:	MESSAGES AND TARGETS FOR MATERNAL HEALTH ADVOCACY	10
TABLE 6:	KEY PRIVATE-SECTOR STAKEHOLDERS	15

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## I. INTRODUCTION

The past two years have witnessed unprecedented global support and visibility for Millennium Development Goal (MDG) 5 and maternal health. A number of global and regional initiatives, most notably the United Nations (UN) Secretary-General's Global Strategy for Women's and Children's Health, Countdown to 2015, the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), and the UN Commission on Life-Saving Commodities for Women and Children, provide a platform for accelerating action to improve the health and well-being of women and their children.



Leading voices from UN agencies, major government and foundation donors, the private sector, developing countries, and civil society have come together to pledge commitments for achieving better health for women and children around the world.

Advocacy plays a critical role in ensuring that these commitments translate into concrete action, and civil society groups in particular can hold governments and other stakeholders accountable to global, as well as regional and national, commitments by demanding that policies are reformed, funds invested and tracked, and health outcomes measured and published. This report presents a summary of Family Care International's (FCI's) research on the maternal health advocacy environment in Uganda. It looks at Uganda's maternal health policy framework, outlines stakeholders working in maternal health advocacy in the country, and analyses opportunities and challenges for maternal health advocates. It describes the potential for engaging the Ugandan private sector on maternal health issues, and concludes with a set of recommendations for strengthening maternal health advocacy efforts in the country. Uganda has a robust and active civil society and maternal health has been a key area of advocacy. Like many countries, Uganda has made insufficient progress towards MDG 5. Still, the country has signed a number of international and national commitments to support maternal health, and advocates are actively striving for improved government accountability, as well as better access to quality maternal health services.

Data for this report were collected at national and district levels using a multidimensional qualitative model that triangulated data from key informant interviews, focus group discussions, and literature review. Respondents were identified via purposive sampling and included representatives from UN and government agencies, bi- and multi-lateral organisations, international and national non-governmental organisations (NGOs), health professional associations, advocacy coalitions, and private-sector organisations. Data were analysed using a thematic approach.

### **BOX 1: Family Care International's (FCI's) Maternal Health Advocacy Mapping**

FCI completed a comprehensive mapping activity in a number of African countries to gather information on the maternal health policy environment. The study assessed the organisations, partnerships, and networks currently and potentially engaged in maternal health advocacy, as well as the advocacy goals, strategies, resources, and core messages being used. It also sought to understand what role the private sector currently and potentially has in maternal health in Africa, and to identify points of engagement with potential private-sector partners.

## II. MATERNAL HEALTH IN UGANDA

Uganda has seen some progress on a number of its health-related MDGs. From 2006 to 2011, child mortality declined from 67 to 38 per 1,000 live births [1]. Over the same period, infant mortality dropped from 76 to 54 per 1,000 live births [1]. HIV/AIDS prevalence declined from 18.5% in 2004-05 to 7.3% in 2011 [3]. Incidence rates for tuberculosis have decreased from 410 in 2001 to 183 in 2011 per 100,000 [4]. In spite of the devastation brought by HIV/AIDS, life expectancy has been climbing steadily from 53.7 in 2010 to 54.5 in 2012 [5]. The country has also increased access to safe drinking-water sources, primarily in urban areas, from 66% to 69%; however, access in rural areas decreased from 66% to 62% between 2010-11 and 2011-12 [2].

Maternal health indicators have fared less favourably (Table 1). Between 1990 and 2000, Uganda's maternal mortality ratio (MMR) remained almost stagnant (527 and 505 per 100,000 live births respectively). Between 2000 and 2006, MMR declined to 435 per 100,000 live births. In 2011, according to the Uganda Demographic Health Survey (UDHS, 2011), the MMR reversed to 438 per 100,000, far off 2015 MDG target of 131 per 100,000 live births [1]. Only 48% of women receive antenatal care across the duration of their pregnancy, and skilled birth attendants are present at only 58% of all births [1]. The four most common contributors to maternal deaths in Uganda are haemorrhage (26%), complications from indirect conditions such as malaria or HIV (25%), sepsis (22%), and obstructed labour (13%) [4].

**Table 1: Key Maternal Health Indicators for Uganda and sub-Saharan Africa**

Platform	Uganda	Sub-Saharan Africa
Maternal mortality ratio (per 100,000 live births)	438	480
Population growth rate (%)	3.5*	2.4
Antenatal care coverage (%) at least one visit	94.9	74
Antenatal care coverage (%) at least four visits	47.6	43
Births delivered at a health facility (%)	57	--
Births attended by skilled health personnel (%)	58	48
Births by Caesarian section (%)	5.3	4
Post-natal care visit within two days of childbirth (%)	33	37
Total fertility rate (number of children per woman)	6.2	4.8
Pregnant women receiving IPTp <sup>a</sup> for malaria (%)	62.2	--
Pregnant women with HIV receiving antiretroviral medicines for PMTCT <sup>b</sup> (%)	86.2**	50
Unmet need for family planning (%)	34	25
Contraceptive prevalence (%)	30	24

**Source:** All statistics for Uganda are from 2011 Uganda Demographic and Health Survey, except \*Uganda Bureau of Statistics. 2012. Annual Population Growth Rate. <http://www.ubos.org>. Accessed May 22, 2013. \*\*Uganda AIDS Commission. 2012. Global AIDS Response Progress Report: Uganda. All statistics for sub-Saharan Africa are from World Health Organization. 2012. World Health Statistics 2012.

<sup>a</sup> Intermittent preventive treatment in pregnancy.

<sup>b</sup> Preventing mother-to-child transmission of HIV.

Sixteen women die every day while giving birth in Uganda [5]. High maternal mortality has been tied to a number of challenges, including health-system failures, financing barriers, and sociocultural issues.

Maternal health advocates cite nine key priorities for advocacy work. These priorities range from community-level promotion of high-impact interventions to high-level advocacy on health-sector financing and human resources. The priority areas are:

- Increase service provision, especially in rural areas.
- Improve general health-care financing.
- Train, recruit, motivate, and retain health workers, especially midwives.
- Increase availability of emergency obstetric and neonatal care (EmONC) at all facilities.
- Increase access to youth-friendly family planning and reproductive health services.
- Strengthen community empowerment and social accountability.
- Increase community awareness about causes of maternal deaths, birth preparedness, delivery by skilled birth attendants, facility-based births, and antenatal care.
- Support male involvement.
- Strengthen use of maternal death audits.
- Expedite the tabling of the National Health Insurance Bill before Parliament.<sup>c</sup>

These priorities are being advanced in a number of ways, by a range of stakeholders, and are supported by a strong policy environment that emphasises the integration and mainstreaming of maternal health.

### III. THE MATERNAL HEALTH POLICY ENVIRONMENT

Uganda has a number of policies, strategic plans, and guidelines that support advocacy for maternal health.

In 2013, the government launched the Sharpened Reproductive Maternal Neonatal and Child Health (RMNCH) strategic plan 2013-2017, to prevent an additional 40% of under-five child deaths and 26% of maternal deaths by 2017. Costed at \$682 million over the next four years, the plan identifies five forward-looking, strategic shifts for achieving integrated and sustainable improvements in RMNCH; these priorities include:

1. Focusing geographically on areas with the highest number of child and maternal deaths.
2. Increasing access to health services for vulnerable populations.
3. Emphasising evidence based high impact interventions.
4. Addressing the broader educational, economic and environmental context.
5. Strengthening mutual accountability for ending maternal deaths.

In 2008, the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda was launched as the primary national framework for reducing maternal mortality. The roadmap identifies a number of key strategies and interventions including:

1. Improving the legal and policy environment for maternal health.
2. Improving the availability of access to and utilisation of quality maternal and newborn care services at the community level.
3. Strengthening and building capacity for human resources for maternal health.
4. Advocating for increased resource allocation to maternal and newborn health.
5. Strengthening coordination and management of maternal health care services.
6. Empowering communities to ensure a continuum of care from household to hospital.
7. Strengthening monitoring and evaluation mechanisms for maternal and newborn health services.

<sup>c</sup>In 2012, a National Health Insurance Bill was drafted to facilitate the provision of accessible, affordable, acceptable and quality health care services; limit the cost of health care services; improve and harness private sector participation in the provision of health care services; provide a complementary mechanism for health care financing; ensure quality and equity of care, appropriate utilisation of services, fund viability, and patient satisfaction. The bill awaits Cabinet/Executive adoption before it can be brought before Parliament for debate.



The Road Map is supported by the *Third National Health Sector Strategic Plan (2010/11–2014/15)* (NHSSP III). The NHSSP III focuses on the improvement of overall health service delivery, but also emphasises that maternal and child health conditions account for 20.4% of the total disease burden in Uganda. The strategy prioritises EmONC, human resources for maternal health, improved supply of health commodities, and the development of better transport and communications for referral. Parallel to the NHSSP III, the *Health Sector Strategic and Investment Plan (2010/11–2019/20)* (NHSSIP) sets out the country’s medium- and long-term health agenda, with maternal and child health representing a key intervention area for investment. The NHSSIP sets out a 10-year plan for strategic interventions in: a) sexual and reproductive health and rights; b) newborn health and survival; c) scaled-up child-survival packages; and d) gender-based violence.

In 2013, a National Policy on Public Private Partnership in Health was enacted to provide a framework for institutionalising and guiding the implementation of working relationships between government and the private health sector on a wide range of services, such as ambulance services, family planning, and training of health workers, all of which are critical to maternal health service delivery. To-date, there has been limited collaboration between government and private health providers (especially for-profit) despite a large proportion of the population utilising private health services. This policy helps to establish the functional integration of public and private practitioners’ services, and optimise resources available from government and private sectors.



Below is a summary of the national, regional and global commitments to which Uganda is a signatory (Table 2).

Table 2: Uganda's National, Regional, and International Commitments	
Commitment	Targets and Resolutions Relevant to Maternal Health
Millennium Development Goals	<ul style="list-style-type: none"> <li>• Reduce maternal mortality to 131 deaths per 100,000 live births by 2015.</li> <li>• Reduce infant mortality by two-thirds from 88.4 deaths per 1,000 live births.</li> </ul>
Abuja Declaration	<ul style="list-style-type: none"> <li>• Allocate 15% of the annual budget to the health sector.</li> </ul>
UN Global Strategy for Women and Children's Health (Every Woman Every Child)	<ul style="list-style-type: none"> <li>• Increase comprehensive EmONC services from 70% to 100% in all hospitals, from 17% to 50% in all Level IV health centres,<sup>d</sup> and provide basic EmONC in all health centres.</li> <li>• Ensure skilled providers are available in remote areas.</li> <li>• Increase focused antenatal care from 42% to 75% with emphasis on PMTCT.</li> </ul>
Inter-Parliamentary Union Resolution on Securing Health of Women and Children	<ul style="list-style-type: none"> <li>• Resolution on "Access to Health as a Basic Right: The Role of Parliaments in addressing Key Challenges to Securing the Health of Women and Children" adopted on April 5, 2012.</li> </ul>
1995 Constitution of the Republic of Uganda, Objectives XIV, XV, and XX	<ul style="list-style-type: none"> <li>• Objective XIV: to fulfil the human rights of all Ugandans, including access to health services.</li> <li>• Objective XV: The State shall recognise the significant role of women in society.</li> <li>• Objective XX: to take all practical measures to ensure basic medical services to the population.</li> </ul>
Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Article 14: Health and Reproductive Rights	<ul style="list-style-type: none"> <li>• Ensure the right of women to control their fertility, choose contraception, access family planning information, and protect themselves against HIV/AIDS and sexually transmitted infections (STIs).</li> <li>• Ensure the right to be informed of one's own and one's partner's health status.</li> <li>• Provide adequate, affordable, and accessible health services.</li> <li>• Establish and strengthen existing antenatal, delivery, and post-natal health and nutritional services.</li> </ul>
Family Planning 2020 (The London Summit)	<ul style="list-style-type: none"> <li>• Ensure universal access to family planning and reduce unmet need to 10% by 2022.</li> <li>• Increase annual government allocation for family planning supplies to US \$5 million over five years.</li> </ul>

## IV. MATERNAL HEALTH ADVOCACY STAKEHOLDERS

The mapping activity identified 75 organisations, including private-sector entities, engaged in advocacy at national and sub-national levels. Many of these organisations, however, are focused on the implementation of interventions or on service provision. Additionally, most organisations are concentrated at the central level, with only a few stakeholders having links to districts and communities. The list includes international and local NGOs, advocacy groups and coalitions, and academic institutions (Table 3).<sup>e</sup>

<sup>d</sup> A health centre Level IV is the 4th level of care in Uganda's national health structure. In addition to services provided at Health Centres II and III, it provides emergency surgery, blood transfusion, and laboratory services.

<sup>e</sup> Professional organisations and private sector stakeholders are listed elsewhere in this briefing paper. A complete list of maternal health advocacy stakeholders — including government agencies and bi- and multi-lateral organisations — is available in the full mapping report.

### Table 3: Map of Maternal Health Advocacy Stakeholders

Category	Name of Organisation	Areas of Interest
International NGOs	<ul style="list-style-type: none"> <li>FHI360</li> <li>German Foundation for World Population (DSW)</li> <li>Partners in Population and Development (PPD)</li> <li>AMREF Health Africa in Uganda</li> </ul>	<ul style="list-style-type: none"> <li>Family planning, HIV/AIDS, nutrition</li> <li>Sexual and reproductive rights</li> <li>Reproductive health services and commodities</li> <li>Nursing and midwifery training, mentorship, health systems strengthening, sexual &amp; reproductive health (SRH)</li> </ul>
	<ul style="list-style-type: none"> <li>Marie Stopes</li> <li>Save the Children Uganda</li> </ul>	<ul style="list-style-type: none"> <li>Family planning</li> <li>Saving newborn lives, human resources for health, essential medicines</li> </ul>
	<ul style="list-style-type: none"> <li>IntraHealth International</li> <li>World Vision Uganda</li> </ul>	<ul style="list-style-type: none"> <li>Human resources for health</li> <li>Child Health Now campaign: Standing Up for Maternal and Child Health</li> </ul>
UN Agencies	<ul style="list-style-type: none"> <li>Unicef</li> <li>UNFPA</li> </ul>	<ul style="list-style-type: none"> <li>Mobilising commitments for child survival and improving maternal health through the RMNCH sharpened plan</li> <li>Universal access to SRH &amp; rights</li> </ul>
National NGOs	<ul style="list-style-type: none"> <li>Uganda National Health Consumers' Organisation (UNHCO)</li> </ul>	<ul style="list-style-type: none"> <li>Health and human rights</li> </ul>
	<ul style="list-style-type: none"> <li>Centre for Health, Human Rights and Development (CEHURD)</li> </ul>	<ul style="list-style-type: none"> <li>Health and human rights</li> </ul>
	<ul style="list-style-type: none"> <li>Action Group for Health, Human Rights and HIV/AIDS (AGHA)</li> </ul>	<ul style="list-style-type: none"> <li>Health and human rights</li> </ul>
	<ul style="list-style-type: none"> <li>Uganda Health Marketing Group (UHMG)</li> </ul>	<ul style="list-style-type: none"> <li>Quality, affordable health care, private sector, social marketing</li> </ul>
	<ul style="list-style-type: none"> <li>White Ribbon Alliance for Safe Motherhood Uganda</li> </ul>	<ul style="list-style-type: none"> <li>Maternal and newborn health, human resources for health, community social accountability, and health financing</li> </ul>
	<ul style="list-style-type: none"> <li>Reproductive Health Uganda (RHU)</li> </ul>	<ul style="list-style-type: none"> <li>Family planning</li> </ul>
	<ul style="list-style-type: none"> <li>Uganda Health Communication Alliance (UHCA)</li> </ul>	<ul style="list-style-type: none"> <li>Media and communications</li> </ul>
	<ul style="list-style-type: none"> <li>Women's International Maternity Aid (WIMA)</li> </ul>	<ul style="list-style-type: none"> <li>Quality health facilities, promotion of facility-based births</li> </ul>
	<ul style="list-style-type: none"> <li>International HIV/AIDS Alliance, Uganda</li> </ul>	<ul style="list-style-type: none"> <li>HIV/AIDS and maternal health</li> </ul>
	<ul style="list-style-type: none"> <li>PACE-Interventions for Health Impact</li> </ul>	<ul style="list-style-type: none"> <li>Expanding and strengthening private sector efforts to improve maternal health, social marketing of reproductive health supplies, and HIV/AIDS</li> </ul>
<ul style="list-style-type: none"> <li>Text for Change</li> </ul>	<ul style="list-style-type: none"> <li>Maternal health, health technology</li> </ul>	
Advocacy Groups/ Coalitions	<ul style="list-style-type: none"> <li>Civil Society Budget Advocacy Group (CSBAG)</li> </ul>	<ul style="list-style-type: none"> <li>Budget and policy advocacy</li> </ul>
	<ul style="list-style-type: none"> <li>Coalition to End Maternal Mortality</li> </ul>	<ul style="list-style-type: none"> <li>Maternal mortality</li> </ul>
	<ul style="list-style-type: none"> <li>CSO Coalition on MNCH<sup>f</sup></li> </ul>	<ul style="list-style-type: none"> <li>Maternal, newborn, and child health</li> </ul>
	<ul style="list-style-type: none"> <li>Health Works Uganda</li> </ul>	<ul style="list-style-type: none"> <li>Human resources for health</li> </ul>
	<ul style="list-style-type: none"> <li>Voices for Health Rights (VHR)</li> </ul>	<ul style="list-style-type: none"> <li>Health and human rights</li> </ul>
<ul style="list-style-type: none"> <li>Uganda Family Planning Consortium (UFPC)</li> </ul>	<ul style="list-style-type: none"> <li>Reproductive rights and commodities, budget tracking</li> </ul>	
Academic Institutions	<ul style="list-style-type: none"> <li>Save the Mothers – Uganda Christian University, Mukono</li> </ul>	<ul style="list-style-type: none"> <li>Human resources for health, training local leaders, degree courses in maternal health</li> </ul>
	<ul style="list-style-type: none"> <li>Makerere University / Mulago Hospital</li> </ul>	<ul style="list-style-type: none"> <li>Human resources for health, RMNCH service delivery</li> </ul>

<sup>f</sup>Maternal, newborn, and child health

## V. ADVOCACY GOALS, MESSAGES, DISSEMINATION STRATEGIES

The primary goal of maternal health advocacy organisations in Uganda is to ensure **that government adopts and implements a series of high-impact interventions to fast-track the reduction of under-five childhood and maternal mortality in order to achieve MDGs 4 and 5 by 2015.** To achieve this goal, maternal health advocacy stakeholders have focused on six strategic advocacy issues (Table 4). When comparing these issues to the priority areas identified in the Government’s Roadmap for maternal and newborn mortality, there is only partial alignment between government goals and objectives for maternal health, and those identified by civil society. Advocacy campaigns have sought to hold government legally accountable to global and national obligations and commitments, but have not necessarily tied their work closely to Ministry of Health plans and strategies.

**Table 4: Maternal Health Advocacy Priority Areas**

Priority Areas	Actions
1. Improving the legal, policy, and institutional frameworks for maternal health	<ul style="list-style-type: none"> <li>• Utilise existing constitutional and legal mechanisms to make government accountable for maternal health commitments.</li> <li>• Ensure that maternal health is better embedded in national planning, financing, and judicial institutions.</li> </ul>
2. Reviewing financing for both general health care and maternal health services	<ul style="list-style-type: none"> <li>• Strengthen budget-tracking mechanisms for maternal health financing.</li> <li>• Advocate for greater efficiency and effectiveness in the use of maternal health resources.</li> </ul>
3. Strengthening the community maternal health care system	<ul style="list-style-type: none"> <li>• Empower communities to understand their rights and obligations to demand and access quality services.</li> <li>• Ensure supply of medicines, supplies, and equipment for maternal health.</li> <li>• Improve maternal health worker/patient ratios.</li> </ul>
4. Addressing gaps in human resources for maternal health	<ul style="list-style-type: none"> <li>• Review human resources policy/strategy to address quality, recruitment, distribution, motivation, and retention of maternal health workers.</li> </ul>
5. Holding government accountable to national, regional, and international commitments	<ul style="list-style-type: none"> <li>• Ensure implementation of the Abuja Declaration that commits the Ugandan government to spending 15% of its national budget on the health sector.</li> <li>• Push government to commit funds to fast track the attainment of MDGs 4 and 5.</li> <li>• Push for transparency of expenditure and limitation of waste.</li> </ul>
6. Increasing access to family planning services and information	<ul style="list-style-type: none"> <li>• Monitor government commitment made at London Summit on family planning (see Table 2).</li> <li>• Address misinformation/negative attitudes.</li> <li>• Improve the method mix available for family planning, and ensure adequate financing for reproductive health commodities and supplies.</li> <li>• Fully implement a tax waiver on reproductive health commodities.</li> </ul>

The mapping found that organisations had elaborated advocacy messages aligned to their respective priority areas for improving maternal health (see Table 5 for a sampling of advocacy messages being used). However, these messages were not being shared among organisations working on maternal health advocacy, highlighting weak coordination and potentially weakening their power of influence.

**Table 5: Messages and Targets for Maternal Health Advocacy**

Organisation/ Individuals	Message/Ask	Target Audience
Save the Children	<ul style="list-style-type: none"> <li>• Health workers within reach of every mother and child.</li> <li>• No mother should die while giving life.</li> <li>• No child is born to die.</li> <li>• It is everyone's responsibility. Everyone is me.</li> </ul>	All stakeholders
CEHURD	<ul style="list-style-type: none"> <li>• Ensure essential health commodities in health facilities</li> </ul>	Executive and judiciary branch of government
Private Sector Health Common Fund	<ul style="list-style-type: none"> <li>• Partnership for care.</li> </ul>	Private sector
Uganda National Health Consumers Organisation	<ul style="list-style-type: none"> <li>• Ensure that there is sufficient logistical support for grass-roots health units, and village health teams.</li> <li>• Dispel myths about maternal deaths and strengthen care.</li> </ul>	Health sub-districts
Hon. Beatrice Rwakimari, Maternal Health Champion	<ul style="list-style-type: none"> <li>• Let's stop talking and walking in circles. Walk the talk.</li> <li>• Provide an economic model that links maternal mortality to economic loss in financial terms.</li> </ul>	Advocacy groups
Kigezi Healthcare Foundation	<ul style="list-style-type: none"> <li>• Disseminate policies for all to know.</li> </ul>	Political leadership
Eighth Parliament Sessional Committee on Health	<ul style="list-style-type: none"> <li>• Ensure money borrowed from the World Bank for the health sector includes maternal health.</li> </ul>	Political leadership
Coalition to End Maternal Mortality	<ul style="list-style-type: none"> <li>• Increase government funds to train additional health workers.</li> </ul>	Policymakers, Parliamentarians, Ministry of Finance, Ministry of Health
White Ribbon Alliance Uganda / UNFPA / Ministry of Education	<ul style="list-style-type: none"> <li>• Midwives save lives: Be smart... be a midwife.</li> <li>• Study and pass mathematics, biology, physics, and chemistry to study midwifery.</li> </ul>	Secondary school students
Association of Obstetricians and Gynaecologists of Uganda	<ul style="list-style-type: none"> <li>• Provide safe, respectful, culturally-sensitive care.</li> </ul>	Health workers, Service providers



Advocacy organisations have used a variety of strategies to disseminate these messages. A primary strategy is through mass media campaigns via radio, television, and print media (e.g. newspapers, magazines, and billboards). Media campaigns are also used to convey information, raise awareness, and call for government accountability. Respondents identified multimedia campaigns as the most effective means of dissemination in the country, as messages are able to reach the greatest number of people at the least cost. Petitions are also frequently employed, and have targeted politicians and government decision makers. Increasingly, these measures are piggybacked onto social media platforms such as Twitter, Facebook, blogs, and Google+. Budget tracking and maternal death audits have been used by civil society and non-governmental organisations to generate data for advocacy campaigns and to target messages to government.

Advocates have also used more direct advocacy measures, such as working within governmental structures (e.g. technical working groups, the Health Policy Advisory Committee), convening workshops to disseminate information, and carrying out public outreach via mass campaigns. Mass campaigns have been linked to national advocacy days (e.g. National Safe Motherhood Day, International Women's Day, International Day of the Midwife), or carried out independently via organised marches, rallies, community theatre events, or distribution of health-promotion materials (e.g. t-shirts, hats, posters).

Advocacy groups have also started to use strategic public litigation to highlight important topics in maternal health.<sup>8</sup> The hope is that, if litigation is successful, it will be used as a tool to fuel further advocacy efforts. The most well-known case – *Constitutional Petition No. 16 of 2011: Centre for Health, Human Rights and Development (CEHURD) and others vs Attorney General* – was complemented by other strategies, such as mass and social-media campaigns and marches. Petition 16 was a landmark case in Uganda, but was eventually rejected on legal technicalities, and is pending an appeal hearing. Advocates expressed disappointment by the court ruling, but acknowledged that it did create awareness among the general public that access to maternal health services is a human right (Box 2). Beyond Petition 16, very few organisations are actively measuring and evaluating their advocacy work, so the impact of most messaging and dissemination activities is unclear.

## BOX 2: Petition 16

In 2011, following the deaths of two women in childbirth, CEHURD launched a petition on behalf of the women's families against the Ugandan government. The petition and accompanying advocacy campaign were grounded in Uganda's 1995 Constitution, which defined access to health services as a human right and stipulated that the government should take all practical measures to ensure basic medical services reach all Ugandans. The petition argued that the government violated the constitutional rights to life and to health, and the rights of women in general. The campaign set about to educate Ugandans on their constitutional rights and to encourage them to demand better maternal health services. The Supreme Court eventually struck down the petition in June 2012, arguing that it was grounded in political rather than constitutional issues and that other legal avenues existed through which the injured parties could seek redress. Nevertheless, Petition 16 was a landmark for maternal health advocacy in the country.

<sup>8</sup> Strategic litigation is a rights-based approach intended to clarify the obligations of the State and to transform these obligations into implementable legal duties.

# VI. ADVOCACY OPPORTUNITIES AND CHALLENGES

## Opportunities

There is a strong enabling environment for maternal health advocacy in Uganda. The country has a large, active, and dynamic civil society. Clear routes exist by which to engage Parliament. There is political will among parliamentarians to take up maternal health issues, and there are explicit forums in place – at both parliamentary-level and within the Ministry of Health – through which to advocate for maternal health issues (Box 3). Finally, the government has signed a number of relevant international commitments that serve as benchmarks against which to evaluate budget allocation, health-sector planning, and programme implementation for maternal health.

BOX 3: Engaging Government on Maternal Health	
Within Parliament	Within the Ministry of Health
<ul style="list-style-type: none"><li>• Network of African Women Ministers and Members of Parliament – Uganda Chapter</li><li>• Uganda Parliamentary Forum on the MDGs</li><li>• Uganda Women’s Parliamentary Association</li><li>• Parliamentary Forum for Children</li><li>• Committee on Health</li><li>• Standing Committee on Budget</li><li>• Standing Committee on HIV/AIDS</li><li>• Office of the Speaker</li></ul>	<ul style="list-style-type: none"><li>• MNCH Technical Working Group</li><li>• Family Planning Technical Working Group</li><li>• Health Policy Advisory Committee</li><li>• Health Service Commission</li></ul>



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The Ugandan print and broadcast media are actively engaged in maternal health reporting. There are numerous civil society organisations, networks, and coalitions working on maternal health. This diverse array of stakeholders means that different organisations are able to create synergies by focusing on the specific areas of expertise to which they add value, such as service delivery or legal support. There are a wealth of health professional bodies, universities, and research organisations generating a strong base of evidence for decision-making on maternal health. The private health sector in Uganda is growing, and a number of private-sector associations and networks exist. Private providers have a history of partnering with the public sector on health initiatives, and now have a guiding legal and policy framework as a result of the National Policy of Public Private Partnership [see next section]. The country also has numerous events and opportunities that serve as platforms for raising awareness about maternal health issues (Box 4).

### **BOX 4: Past and Present Opportunities for Advocacy**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• International Women’s Day</li> <li>• National Safe Motherhood Day</li> <li>• National, District, and Local Budgeting and Planning Processes</li> <li>• National Joint Annual Health Sector Review</li> <li>• Maternal Mortality Court Case (Petition 16)</li> <li>• World AIDS Day</li> <li>• Maternal Health Private Members Bill</li> </ul> | <ul style="list-style-type: none"> <li>• Presentation on Commitment by Parliament to the Issues of Maternal Health</li> <li>• Release of national and global State of World Population reports</li> <li>• International Day of the Midwife</li> <li>• International Nurses Day</li> <li>• International Day of the African Child</li> </ul> |
|--|---|

## **Challenges**

A number of challenges for maternal health advocacy remain. Most organisations are understaffed and lack the basic capacity to carry out strategic advocacy. Advocacy organisations – especially in rural areas – often take on too many commitments and struggle to fulfill their work plans. Without the finances to carry out outreach visits and other fieldwork, organisations are overstretched and unable to ensure proper monitoring and evaluation.

Without proper monitoring and evaluation, advocacy organisations cannot effectively measure the impact of their work. Without the capacity for rural outreach, many organisations remain concentrated in the capital city and are often unable to capture community voices to amplify at the national level. The advocacy movement is not cohesive enough to generate collective messaging and asks. As a consequence, many important issues are not receiving widespread or equivalent coverage.

When maternal health advocacy organisations do work together in a coalition or network, they often lack clear terms of reference and a shared sense of roles, responsibilities, and obligations. For example, respondents noted that coalition members may seek independent funding for their own organisations’ activities, rather than leveraging resources on behalf of the coalition itself. Other important sectors – such as education – are left out of coalitions, even though they might add value.

Maternal health advocacy organisations also face challenges in conducting effective advocacy when national policies and strategies are not finalized and costed, and when they are not fully implemented or financed. In addition, national plans do not often have robust monitoring and evaluation for monitoring the implementation of these strategies. Advocates can call for strong monitoring and evaluation systems, which will help show progress and make a stronger case for the need to continue investing in maternal health.

## VII. THE PRIVATE SECTOR IN MATERNAL HEALTH

In Uganda, more than 60% of the population uses non-governmental services as their first point of health care, including 40% of those living within the lowest wealth quintile [7].

Presently, the private sector is regulated by governmental statutory bodies and non-governmental professional organisations. For maternal health, the most relevant are the Uganda Nurses and Midwives Council, the Uganda Nurses and Midwives Examination Board, and the Uganda Medical and Dental Practitioners Council, which provide oversight, regulation, and registration of practitioners in the country. Unfortunately, the reach of most of these organisations does not extend beyond the capital city.

### **BOX 4: A CASE OF PUBLIC-PRIVATE PARTNERSHIP IN HEALTH**

Implemented in four districts in mid-western Uganda, the Saving Mothers Giving Life (SMGL) initiative is an example where a public-private partnership (PPP) has demonstrated impressive improvements in maternal health. The SMGL initiative is a partnership between the MoH, global development partners (USAID, Merck for Mothers, Government of Norway, Every Mother Counts, American College of Obstetricians and Gynecologists, and Project C.U.R.E.), district-level governments, and private health service providers (Baylor College of Medicine, Makerere University Infectious Diseases Institute, Strides/Management Sciences for Health, Uganda Health Marketing Group, PACE, Marie Stopes Uganda, among others). In addressing the major delays that prevent women from accessing maternal health services i.e. delay in seeking services, delay in reaching services, and delay in receiving quality care, SMGL implemented a comprehensive set of interventions, including improving health facility infrastructure, strengthening the supply chain system, and establishing an integrated communication-transportation system. In just one year, SMGL has achieved dramatic improvements in maternal health indicators: a 30% reduction in maternal deaths; an increase in health facility deliveries from 46% to 74%. While the SMGL initiative provides lessons for scaling up public-private partnerships focusing on high-impact interventions for improving maternal health, greater attention needs to be paid to ensuring sustainability and national ownership.

The government recognises the importance of the private sector in the provision of services and has passed a National Policy on Public Private Partnership in Health. This policy regulates relationships between government and private health providers (private not-for-profit, private for-profit, and traditional providers, see Box 4). The coming into force of the National Policy and the National Health Insurance Bill lay the groundwork for expanding access to health services, and can help to address concerns that 'privatisation' of health services through health insurance may deny the poor access to quality health services. Therefore, as the government prepares to pass the Insurance Bill, it is imperative to identify innovative ways of ensuring equity in service provision and access.

There are a number of advantages and disadvantages to engaging the private sector in maternal health. On one hand, private providers help to alleviate congestion in public-sector antenatal clinics and maternity wards, improve quality of care through competition, diversify patient options for maternal health services and greatly increase access to and utilisation of maternal health services. However, there is also the risk that patients' increasing reliance on the private sector will lead to an escalation in out-of-pocket payments, higher costs, and a subsequent decrease in access to facility-based maternity services by the poor. Also, it is often difficult to regulate the private sector, so patients may find that quality of care by private maternal health service providers is no better than that of the public sector. These challenges, however, should be seen as opportunities for engagement with the private sector, rather than barriers. The following organisations are potential stakeholders for private sector engagement (see Table 6).

**Table 6: Key Private-Sector Stakeholders**

Organisation	Category
Uganda Private Midwives Organisation	Professional organisation
Uganda Nurses and Midwives Union	Professional organisation
The Reproductive Health Voucher Project	Financing for service delivery
Private Sector Health Common Fund (PSHCF)	Project support
Uganda Health Care Federation	Professional organisation
Health Works Uganda	Human resources for health
Uganda National Association of Private Providers	Professional organisation
Uganda National Association of Private Hospitals	Professional organisation
Reproductive Private Providers Association	Professional organisation
Family Planning Providers Network	Professional organisation
Ipsos-Limited	Media and research
Monitor Publications	Media
New Vision Group	Media
Orange	Telecommunications

## VIII. CONCLUSION AND RECOMMENDATIONS

Uganda has both an active health advocacy sector and a relatively robust private health sector. The number of maternal health advocacy organisations has risen considerably since 2000, and the country is committed to improving its progress towards MDGs 4 and 5. There is a strong policy framework in place for maternal health, and opportunities for maternal health advocacy abound.

However, the country continues to struggle with meeting its maternal health targets, and resources are not efficiently allocated to sustain focus on identified priority areas. Additionally, the focus on high-impact interventions sometimes comes at the expense of investing in the necessary health systems and infrastructural inputs that will sustain maternal health progress over time. Advocacy organisations are not coordinating their efforts, and the maternal health advocacy climate is fragmented. Maternal health advocacy organisations face critical resource constraints and have the tendency to focus on maternal mortality, poor maternal health service delivery, and other problems, rather than on the promotion of innovative solutions. The impact of advocacy work is not being measured in a rigorous or systematic way. This report therefore proposes the following recommendations:

- 1. Advocacy efforts should be focused on these priority areas:** a) the provision of support for maternal health service delivery via fully functioning health facilities with EmONC capacity; b) support for maternal health workers and other human resources inputs; c) the need for functioning communications and referral systems; d) the empowerment of communities to demand improved maternal health services.
- 2. Maternal health advocates should strive to ‘speak with one voice’.** There should be a coordinated mechanism by which the growing and diverse body of advocacy organisations in the country can work together, thereby promoting synergy, rather than fragmentation. Umbrella organisations for maternal health advocacy should help with advancing common messages, agendas, and strategies. One potential strategy would be for advocacy organisations to form an “issues and strategy clearing house;” this can take the form of

an ad-hoc coalition which allows members to come together in support of a common issue, agree on a goal and set of objectives, and work together on developing messages and strategies, and implementing activities.

3. **Advocacy should highlight the non-health sector systems** that support or enable improved maternal health. For example, organisations should ensure that infrastructure, education, and other systems that indirectly affect maternal health outcomes are part of their advocacy messaging.
4. **The emphasis of maternal health messaging should move from ‘problem-narratives’ to solution-centred strategies**, with an emphasis on innovations to support programme implementation.
5. **Organisations working on maternal health advocacy require technical and financial support**, including help with coordination, monitoring and evaluation, documentation and budget-tracking skills, and improving their institutional capacity to conduct effective advocacy. Monitoring and evaluation of maternal health advocacy initiatives, with an emphasis on measuring impact, should be made an immediate priority.
6. **There is a spotlight on advocacy for the private health sector:** With the passing of the National Policy on Public Private Partnership in Health, there is an opportunity to galvanize support and commitment of private health providers to push for sustainable partnerships that expand access to RMNCH services and programs. The passage of the National Health Insurance Bill also needs to be accelerated, as this bill deals, in part, with relationships between patients and private providers. There is need to push the Cabinet to expedite internal consultations on the proposed National Health Insurance Bill so that it can be presented before Parliament for debate and passage. Maternal health advocacy stakeholders should support such end-stage policy adoption efforts.

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