

**A Comparative Analysis of Health System Governance and its Impact on
Maternal Health Care in Post-Conflict Northern Uganda and Non-conflict East
Central Uganda**

Thesis submitted in accordance with the requirements of the University of Liverpool
for the degree of Doctor of Philosophy by Andrew Alyao Oceró

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For my late father Samson Abwang Otero

TABLE OF CONTENTS

1	INTRODUCTION	1
1.1	Research Question, Aims and Objectives	1
1.2	Setting the scene:	2
1.2.1	A brief political geography	2
1.2.2	Uganda's ethnic heritage	4
1.2.3	Gender relationships during Uganda's past and present	5
1.2.4	The role of women in governance	6
1.2.5	Uganda's coups and civil wars	6
1.3	The fragile state: health systems and governance	8
1.3.1	The period of transition	10
1.3.2	The maternal health situation in conflict affected countries	10
1.4	The rationale for maternal health care as the lens in this study	11
1.5	Justification for this study	12
1.6	The structure of the thesis	15
2	THE LITERATURE REVIEW	18
2.1	State fragility and conflict	19
2.1.1	Introduction - the fragile state	19
2.1.2	The post conflict period	21
2.1.3	The transition gap	22
2.1.4	Health and health care in the post conflict setting	24
2.2	Governance	26
2.2.1	Introduction - the dimensions of governance	26
2.2.2	Global development and good governance	27
2.2.3	Health system governance	29
2.2.4	Assessing health system governance	32
2.2.5	Good governance analysis frameworks	33
2.2.6	Political economy analysis	34
2.2.7	Political economy analysis frameworks	35
2.3	Decentralisation	38
2.3.1	Decentralisation - the public administration perspective	40
2.3.2	The role of the community in health system governance	42
2.3.3	The role of CPH in maternal health care	43
2.3.4	The role of social capital	45
2.4	Corruption	46
2.4.1	The corruption-health care relationship	46
2.4.2	Explaining corruption	48
2.4.3	Decentralisation and corruption	51
2.4.4	Political patronage	53
2.5	Maternal health and maternal health utilization	55
2.5.1	Introduction - maternal health and mortality	55
2.5.2	Maternal health care access and utilisation	57
2.5.3	Classifications of utilisation determinants	58
2.5.4	The determinants of utilization	58
2.6	Conclusion	70
3	Uganda: A Political Economical History	72
3.1	The era of national resistance movement governance	73

3.1.1	The beginnings of the NRM government.....	73
3.1.2	Constitutional provisions and its consequences.....	74
3.1.3	Economic policy reforms.....	78
3.1.4	The NRM and aspects of good governance.....	84
3.2	The status of maternal health care	100
3.2.1	Country status.....	100
3.2.2	Maternal health organisation and infrastructure.....	102
3.2.3	Factors affecting utilization.....	104
3.2.4	Delivery options in Northern and East Central Uganda.....	106
3.3	A review of Uganda’s healthcare expenditure.....	109
3.3.1	Out of pocket expenditure on health.....	109
3.3.2	Government allocations for health.....	111
3.3.3	Development partners.....	112
3.3.4	Financing the decentralized health system.....	113
3.4	Conclusion	115
4	- THE METHODS CHAPTER.....	117
4.1	Research Aims and Objectives.....	117
4.2	Research strategy and methodology	119
4.2.1	Applied Social Policy Research.....	119
4.2.2	Political Economy Analysis method.....	121
4.3	Study design.....	122
4.3.1	The use of the comparative method in subnational analysis	123
4.3.2	Retrospective nature of the study	124
4.3.3	Sampling method.....	125
4.3.4	Data collection.....	128
4.3.5	Public policy data.....	130
4.4	Study Site.....	131
4.4.1	Kampala	131
4.4.2	Northern Uganda	132
4.4.3	East Central Region.....	138
4.5	Methods.....	139
4.5.1	Policy documentary review.....	140
4.5.2	National level health system governance evaluation – in-depth interviews ...	141
4.5.3	Sub national level health system evaluation – in-depth interviews and documentary review.....	143
4.5.4	Service user and community evaluation – focus group discussion	144
4.6	Analysis.....	148
4.6.1	Framework Analysis.....	149
4.6.2	Political economy analysis.....	151
4.7	Quality Assurance	153
4.8	Ethics procedures.....	157
5	NATIONAL LEVEL RESULTS	159
5.1	Introduction.....	159
5.2	Contextual factors - policy documents analysis findings.....	160
5.2.1	Search strategy	160
5.2.2	The number and type of documents.....	160
5.2.3	Uganda policies influencing the period - 1987 – 2006.....	163
5.2.4	Uganda policies influencing 2006-2011	173
5.3	Institutional Factors - Interview Findings.....	178

5.3.1	The legislature and its power relationship with the executive and finance ministry	180
5.3.2	The prioritisation of Northern Uganda’s needs.....	189
5.3.3	Policy implementation challenges.....	194
5.3.4	Women and maternal health governance.....	201
5.3.5	The human resource challenge.....	204
5.4	Summary	208
6	SUB NATIONAL FINDINGS	212
6.1	Approach to this chapter	212
6.2	Institutional factors.....	213
6.2.1	The civil society role in maternal health care	214
6.2.2	“Supply side” issues and the utilisation of maternal health care.....	219
6.2.3	The role of women at sub national level in maternal health care	233
6.2.4	Community participation in health service delivery.....	238
6.2.5	Decentralisation	243
6.3	Summary	247
7	DISCUSSION.....	250
7.1	Central government governance relationships	251
7.1.1	Overview.....	252
7.1.2	Context	254
7.1.3	Formal institutions.....	254
7.1.4	Informal Institutions –	255
7.1.5	Incentives –	257
7.1.6	Discussion of Central Government Governance Relationships	260
7.2	Central health sector level to decentralised governance stakeholders relationship.....	266
7.2.1	Overview.....	266
7.2.2	Context	267
7.2.3	Formal institutions.....	267
7.2.4	Informal institutions	268
7.2.5	Incentives	268
7.2.6	Discussion – Health central ministry level	269
7.3	Decentralised health system to community relationship	271
7.3.1	Overview.....	271
7.3.2	Context:	273
7.3.3	Formal Institutions	273
7.3.4	Informal Institutions	274
7.3.5	Incentives	275
7.3.6	Discussion	277
7.4	Community relationships with central government and district government	283
7.4.1	Overview.....	283
7.4.2	Context	284
7.4.3	Formal institutions.....	284
7.4.4	Informal institutions	285
7.4.5	Incentives	286
7.4.6	Discussion	288
7.5	Summary	295
7.6	A reflection on the research methods	297
7.7	Limitations and constraints.....	299

7.7.1	Methodological limitations	299
7.7.2	Data collection limitations	301
7.7.3	Limitations to the interviews	302
7.8	Conclusion	303
7.9	Contribution to knowledge	305
7.10	Recommendations	306
8	References.....	313
9	Appendices.....	378

TABLE of FIGURES

Figure 1.1 Geo-political Map of Uganda	3
Figure 2.1 The Dimensions of Governance. Reproduced from EuropeAID (2008)....	27
Figure 2.2: The WHO Health System Framework 2007	31
Figure 2.3; The Sector & Political Arena Framework,.....	36
Figure 2.4: Socio-economic inequalities and maternal health care utilization.....	61
Figure 3.1. Place of Delivery in Northern & East Central Uganda - 2006 & 2011	108
Figure 3.2: Central Government allocation to the decentralized health sector.....	114
Figure 4.1 : The Research Concept Framework.....	118
Figure 4.2: Uganda administrative map and study sites.....	132
Figure 4.3 Problem Driven Framework for applied PEA (Harris 2013).....	151
Figure 5.1: Type of Document by Subject Area.....	161
Figure 5.2 : Document type by Era (<i>Pre = Conflict, and Post = Post conflict</i>)	162
Figure 5.3 Policy Development & Political Event Timelines 1987 to 2011	163
Figure 5.4: The Safe Motherhood Plan 1997 – 1999, Strategies and Costing.....	169
Figure 7.1. The study conceptual framework.....	251
Figure 9.1: Damaged HC IV - East Central Uganda	381
Figure 9.2: New HC III - Northern Uganda.....	381

TABLES

Table 3.1 The Evolution of Districts in Uganda since 1959.....	85
Table 3.2: Maternal Health Care Service providers in Uganda	103
Table 3.3: Primary Funding Sources as percentage of health expenditure.....	110
Table 4.1: Selected Profiles for Study Districts.....	128
Table 4.2: Summary of generated data collected relative to.....	129
Table 5.1: Mapping of stakeholders and respective citation codes	179
Table 5.2 Summary Table of the Study Policy Analysis	210
Table 5.3: Summary of Analysis from the National stakeholder Interview	211
Table 6.1: Actor Mapping and Citation Codes	214
Table 6.2 Summary Table for Sub National Research Findings.....	249

Abbreviations:

CBO	Community Based Organisation
CSO	Civil Society Organisation
FGD	Focus Group Discussion
FRELIMO	Frente de Libertação de Moçambique
HIV	Human Immunodeficiency Syndrome
HIPC	Highly Indebted Poor Countries
IFI	International Financing Institutions
IMF	International Monetary Fund
LRA	Lord's Resistance Army
MDG	Millennium Development Goal
MFPED	Ministry of Finance Planning and Economic Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOPS	Ministry of Public Service
MTEF	Medium Term Expenditure Framework
NGO	Non Governmental Organisation
NRM	National Resistance Movement
PEA	Political Economy Analysis
PEAP	Poverty Eradication Plan
PRDP	Peace Reconstruction and Development Plan
RENAMO	Resistência Nacional Moçambicana
SDG	Sustainable Development Goal
SWAp	Sector Wide Approach
UBOS	Uganda Bureau of Standards
ULRC	Uganda Law Review Commission
UNDP	United Nations Development Programme
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WHO	World Health Organisation

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ABSTRACT

Background:

Northern Uganda is recovering from a 23-year civil war that was largely confined to the region. During this period the rest of Uganda enjoyed a rapid GDP growth rate following wide-ranging macroeconomic reforms by the Ugandan government and its development partners. A post-recovery programme was implemented for Northern Uganda; however, the region still has the worst health status. This contributed to the country's failure to attain MDG five for maternal health. Limited research has been conducted to determine which national and health system governance factors influence performance and affect access and utilisation of health care in countries like Uganda that have witnessed the dual context of conflict and non-conflict. A better understanding of the governance and policy development process in such settings is required if health policy adoption and implementation is to be more appropriate to the needs of the country's entire population.

Methods:

A Political Economy Analysis framework was applied to compare governance factors at national and sub-national level in post-conflict Northern Uganda and in non-conflict East Central Uganda that had influenced the provision and utilisation of maternal health care. An analysis of constitutional, economic and health policies determined contextual factors, while data collected through in-depth interviews and focus group discussions with decision-makers, implementers and communities determined the institutional and agency features. The features were used to access power and accountability relationships and incentives that drove the actions of health system stakeholders in central government, health ministry, district local government and civil society as well as in the local communities during the post conflict period in the Northern and East Central Uganda.

Findings:

The post-conflict period in Northern Uganda coincided with evidence of increased national political commitment to addressing the healthcare needs of Northern

Uganda. However, the President, International Funding Institutions and Finance Ministry technocrats who were the dominant governance stakeholders pursued an approach to economic development that prioritised funding for the development of energy, transportation and defence sectors over that for healthcare. Women parliamentarians emerged as maternal healthcare policy champions but played a limited role in highlighting the special health needs of Northern Uganda. The Health Ministry lacked the political and technical capacity to adapt and implement maternal health care policies to specific sub-national needs. NGOs focused on human rights advocacy in Northern Uganda that enhanced the community's demand for appropriate healthcare while in East Central Uganda they mainly addressed supply-side issues. Political patronage at national and sub-national levels negatively influenced supply and demand for healthcare. In Northern Uganda donor funding, district-based development partner presence, and CSO health system demand-side activities moderated a more positive influence.

Conclusion:

Decentralisation offers greater opportunities for health system recovery in settings of confined conflict but is prone to elite capture and corruption in peaceful settings within the same national context. Women leaders are critical in the development of a national health system where there is confined conflict, but political and traditional norms limit their role in the promotion of universal healthcare coverage. Despite the presence of factors that portended better maternal healthcare in the post-conflict setting, the limited involvement of the health ministry in the recovery process diminished the impact. CSOs in collaboration with communities play an important role in enhancing the responsiveness of the health system but are prone to political intrusion. The comprehension of policies, economic processes and social institutions of a country recovering from confined conflict enables the identification of variables which, if addressed, will lead to versatile, equitable health systems for all citizens.

1 INTRODUCTION

This thesis examines how national and health system governance influenced health care in post conflict and non-conflict settings, during the period following the end of war in Northern Uganda in 2006. Maternal health service delivery is the lens used to examine governance, and maternal health care utilization is viewed as the health service delivery outcome. The thesis tracks policy agenda setting, decision-making and implementation at various levels of national and sub-national governance that influenced the state of maternal health care in post conflict Northern Uganda as compared to non-conflict East Central Uganda.

This chapter is a prelude to the study thesis. It discusses the thesis scope and background and then gives an outline to chapters' two to seven. It is structured as follows: section 1.1 provides the research question, the aims and objectives; section 1.2 provides the contextual background - the political and social history of the two regions studied; section 1.3 introduces the concepts of the fragile state and governance and their relationship with maternal health; section 1.4 and 1.5 provide the rationale and justification for the study respectively; while Section 1.6 outlines the structure of the rest of the thesis.

1.1 Research Question, Aims and Objectives

Research Question

What were the political, economic, and social factors that influenced Uganda's health system response to the health care needs of the vulnerable population of Northern Uganda during the immediate post conflict period, that is, 2006 to 2011? How different was the influence of these factors on the health system response to the needs of non-post conflict Uganda?

Aim

To evaluate the role of governance at national and sub national level in the performance of Uganda's health system as it provided for health care services in

post conflict and non-conflict regions of the country during the immediate post-conflict period using a maternal health care lens.

Specific Objectives

1. To examine national policy and health policy development and its impact on maternal health care in Northern Uganda as compared to East Central Uganda during the period 2006 to 2011.
2. To determine contextual and institutional factors that influenced the actions of health system governance stakeholders in Northern Uganda as compared to East Central Uganda during the period 2006 to 2011.
3. To determine how the actions of health system governance stakeholders affected maternal health care utilisation in Northern Uganda as compared to East Central Uganda during the period 2006 to 2011.

1.2 Setting the scene:

1.2.1 A brief political geography

Uganda is a land-locked country in East Central Africa and as represented in the map in Figure 1.1, it shares boundaries with five countries: Kenya to the west, Democratic Republic of Congo to the east; Sudan to the North; Tanzania to the South; and Rwanda to the Southeast. The country is situated on the earth's equator and is the source of the River Nile.

70% of the population according to the 2002 population census¹ report (UBOS, 2002).

The country has seven internationally recognised sub regions, Central (or Buganda), Western, Eastern, East Central (or Busoga), Northern, West Nile, Karamoja (UBOS and ICF International Inc, 2012). Uganda's capital city, Kampala is located in the Buganda region on the Northern shore of Lake Victoria. I discuss the regions of relevance to this thesis later in the methods chapter.

The country currently has the fifth highest population growth rate in the world at 3.24% as well as the third highest birth rate in the world at 43.79 births per 1000 population which reflects the total fertility rate of 5.89 children born per woman (CIA.gov, 2015). Uganda's economy has been growing in real terms at an annual average rate of 6.2% from 1987 to 2004. The proportion of Ugandans living in absolute poverty has reduced from 56% in 1992 to 35% in 2004. Uganda's literacy rate was 73% by 2010; an increase from 63% in 2006 (UBOS, 2010).

The Central region, excluding the capital city Kampala has the highest literacy rate of 83% while Northern Uganda has the lowest at 64% (UBOS, 2010). According to the Uganda National Household Survey 2010, the incidence of poverty was highest in the Northern region at 46.2%, followed by Eastern Uganda at 24.3%; the national average incidence of poverty was 24.5% (UBOS, 2010). The Central region had the lowest incidence of poverty at 10.7% (UBOS, 2010).

1.2.2 Uganda's ethnic heritage

The colonisation process commenced at a time when the different indigenous communities were at different stages of social, political and economic development (Atkinson, 1989). This had a direct bearing on the annexation and power sharing approaches that the colonialists used as they made contact with the different ethnic groups. This resulted in differential social and power relationships between the

¹ The population distribution in relation to ethnic group is thus: Baganda 16.9%; Banyankole 9.5%; Basoga 8.4%; Bakiga 6.9%; Iteso 6.4%; Langi 6.1%; Acholi 4.7%; Bagisu 4.6%; Lugbara 4.2%; Bunyoro 2.7%; and, with the other 55 ethnic groups constituting 29.6% of Uganda's population.

different ethnic groups by the time of independence that in turn guided the country's political and economic prospects thereafter (Amone and Muura, 2013).

The south and west of Uganda was inhabited by people of the Bantu ethnicity. The Bantu have for centuries inhabited the more fertile inter-lacustrine and Great Lakes regions of Central Africa. In Uganda they had attained a more centralised, stratified form of governance in the form of kingdoms, namely: Buganda, Ankole, Toro, and Bunyoro. The Basoga ethnic group of East Central Uganda that is of interest to this study are part of the Bantu ethnicity.

In the North and East of the country dwell the Nilotic, Sudanic and Nilo-hamitic groups who lived in non-stratified communities with clans as the basic unit of organisation. This group included the Acholi and Lango from Northern Uganda; the Teso, Karamajong, Sabin and Bagisu from Eastern Uganda; and Madi and Lugbara from the West Nile Region (Moncrieffe, 2004). The Lango and Acholi of Northern Uganda speak a similar dialect, Luo. Their political system was based on clans headed by a council of clan elders, though the Acholi later adopted a more regal style of administration probably due to influence from the Banyoro their westerly Bantu neighbour (Atkinson, 1989).

1.2.3 Gender relationships during Uganda's past and present

Though evidence is limited, early pre-colonial accounts suggest that women in Northern Uganda were considered assets. They did most of the menial work and were often used as a medium of exchange alongside ivory and other valuable barter items (Amone and Muura, 2013). However, Tosh (1978) suggests that in the Lango sub-groups of Northern Uganda, where food production was an important year round cultural activity, there were alternative arrangements: men acted as the backbone of the intense agrarian lifestyle of that community. In Lango, it was culturally a man's job to clear bushes, prepare land and carry out other menial tasks associated with food production (Driberg, 1921).

In East Central Uganda, the woman's position in society was no different to that described in Northern Uganda; amongst the Basoga, "*gentility and servitude*" among

the peasant women folk was culturally institutionalised (Sorensen, 1996). Fallers, 1965 cited in Sorensen (1996) epitomises this by stating that, “in Busoga, good women produce children, work hard around the house, and kneel for the husband while addressing him as “*ssebo*” (sir) or “*mukama wange*” (my lord)”.

Women in East Central Uganda were responsible for providing the basic food supply of the family (Sorensen, 1996). Mamdani, also notes that, in East Central Uganda, women and cattle were considered a medium of accumulating wealth (Mamdani, 1996 cited in Moncrieffe, 2004).

While education and modernity has infiltrated and altered some traditional norms in both cultures, the patrimonial nature of the traditional institutions still endure.

1.2.4 The role of women in governance

In 1954, almost half a century after Uganda became a colony the first African women gained a seat on the Colonial Legislative Council (LEGCO) but according to Tamale (1999) later in 1961, in the run up to Uganda’s first elections, there was still debate about whether women should be permitted to participate in elections and deliberate efforts were made to remove this position from parliament (Tamale, 1999). As Tripp (2001) notes, after Uganda’s independence, during the tumultuous years before the advent of the National Resistance Movement (NRM), women leagues were commonly formed in support of the regime. Through these groups women and their families were able to gain access to rare commodities and other political favours. It is noted that the NRM government ushered in a new era of autonomous women activism that often stood at odds with the regime-supporting women groups that still persisted (Goetz, 2002). Women often felt that the “no-party” system stifled free political expression and used

1.2.5 Uganda’s coups and civil wars

Uganda, like many African countries has been embroiled in civil wars right from 1962 when it gained instruments of self-governance from Great Britain (Collier, 2004). Uganda’s post independence conflicts are considered ethnically motivated, pitting the marginalised and militarised Northern ethnic groups and the Southern

affluent Bantu ethnic groups against each other (Nabudere, 2003; Wishart, 2010). According to Baker (2001), the civil wars and political instability in Uganda have been dependent on the degree of “suffocation” of particular groups at one period or another.

Before independence these tensions were not obvious. The transition from colonial to indigenous rule was relatively peaceful, with the King (or Kabaka) of the powerful Southern Kingdom of Buganda, Edward Mutesa II becoming the Executive President of Uganda, while Apolo Milton Obote, from Northern Uganda became the Prime Minister (Moncrieffe, 2004).

However, the Prime Minister abrogated the constitution, in 1966, after laying siege of the Kabaka’s palace. Nsibambi (1987), states that this was sparked off by Kabaka Mutesa, as Executive President, calling for the investigation of an ivory and gold smuggling racket that involved the Prime Minister. Following this event, Milton Obote overthrew the first post-independence government and rewrote the constitution in 1967 constitution that abolished kingdoms in Uganda (Moncrieffe, 2004).

Later in 1971, Milton Obote was overthrown in a bloody coup by his army commander, Idi Amin another Northerner (Brett, 1995). In 1972, a group of Ugandan exiles in Tanzania attempted to invade Uganda from its Southern border with Tanzania. They were repulsed but this sparked off a period of state-inspired blood letting as the army and civil service was purged of ethnic groups considered sympathetic to Milton Obote now in exile in Tanzania (Moncrieffe, 2004).

In 1978, Idi Amin attacked the Tanzanian town of Kagera, from where he was quickly repulsed but Tanzanian and Mozambican government troops and Ugandan rebels under the name the Uganda National Liberation Army (UNLA) proceeded into Uganda and eventually routed Idi Amin from power in 1979. The political arm of the UNLA, the National Consultative Council (NCC), appointed Professor Yusuf Lule as interim president for 65 days. He was replaced by Godfrey Binaisa who ruled from June 1979 to May 1980 before he was deposed and a Military Commission headed

by Paulo Muwanga took over the reigns of power. Later the same year Milton Obote was elected to power in a widely disputed general election (Brett, 1995).

In 1982, Yoweri Museveni embarked on an armed rebellion against Milton Obote from the infamous Luwero Triangle located within the Buganda region. In 1985, an army commander again overthrew Milton Obote; this time it was Tito Okello also from Northern Uganda. Tito Okello and Yoweri Museveni attempted a peace settlement in 1985 which failed to hold, eventually leading to Tito Okello's ouster by Yoweri Museveni in January 26th 1986 (Brett, 1995).

Following Museveni's take-over of government, there were a number of short-lived rebellions that were quickly quelled in the Northern and Western regions of the country. However in 1989, Joseph Kony commenced a 23-year-old conflict in Northern Uganda that led to the abduction of over 10,000 children, the displacement of up to 90% of the population and the death of hundreds of thousands of people in the region (Moncrieffe, 2004). In 2006, the signing of a peace accord between the Ugandan Government and the Lord's Resistance Army (LRA) brought an end to the war. During the period of war in Northern Uganda, the rest of the country was experiencing relative peace and economic development. The East Central Ugandan region in particular was reputed to rarely suffer from the effects of the larger nation-wide wars or coups that I have described (Rowley, Rubin and Kirk, 2006). I have provided more detail to this narrative in Chapter Three.

1.3 The fragile state: health systems and governance

The term "Fragile state" has been used by Western governments and International Organisations to describe nations where legitimacy, capacity and authority is declining or non-existent (Nay, 2013). According to Joyal (Joyal, 2015), the fragile state situation may be caused by political change, natural calamities, or deteriorating governance environments.

Health systems in fragile states are often dysfunctional and are associated with a decreased life expectancy, low maternal survival, and a decreased immunisation status as compared to health systems in more stable nations (Debarati and D'Aoust,

2011). Important fragile state health system deficiencies that portend poor health include: the inability of government to provide equitable services to its vulnerable populations; the lack of infrastructure; poor coordination, oversight and monitoring; and, inadequate policy frameworks to improve health care (Newbrander, 2007).

Fragile health systems are a concern to the international community because they lack the resilience and capacity to contain infectious disease outbreaks. For this reason, they have been the source of epidemics that have spread across borders and continents. The 2014/2015 Ebola epidemics that affected Liberia, Sierra Leone and Guinea are examples (Kruk *et al.*, 2015). It was anticipated that the heavy disease burden in these nations was going to stifle the world wide campaign to achieve the Millennium Development Goals (Bornemisza *et al.*, 2010).

The poor health service delivery that is typical of these settings can contribute to the sense of disenfranchisement, leading to political instability within nations and regions. Conversely, a rejuvenating health care system in a fragile state has a positive influence on strengthening national cohesion and this, it is recognised is dependent on the quality of national governance (Newbrander, 2007). Governance is a central theme throughout this dissertation.

Governance

The European Union (2008) considers Governance as a term describing power, power brokers (or stakeholders), their influences, relationships and the effects on society while governance *principles* represent ideals or benchmarks against which the impact of governance is measured. Whaites (2008) uses a state-building lens to consider governance in relation to the fragile state and makes a distinction between two functions of governance: i) a “survival” function – that is, the ability to maintain security, raise revenue and maintain the rule of law; and, ii) an “expected” function - that is, the promotion of citizen participation, service delivery and infrastructural development. Brinkerhoff (2007), additionally, reflects on national governance as the *effectiveness* and *legitimacy* of the sitting government. The discourse on governance in this thesis will reflect on each of these dimensions in relation to the fragile state; Uganda being a typical example.

1.3.1 The period of transition

The period of transition between war and peace is largely seen as an opportunity for appraisal and reform of political and social policies governing a population (Macrae, Zwi and Gilson, 1996). The period is also challenged by pre-empting changes in the political, economic and social landscape that have to be anticipated and appropriately managed. Failure to address these transition gaps can, amongst others lead to disastrous health-related consequences on the conflict-affected population and can contribute to the collapse of the peace process (Newbrander, 2007). I will discuss the different gaps in more detail in Section 2.1.3.

The end of conflict in Northern Uganda was soon followed by the withdrawal of humanitarian relief organizations that for much of two decades had provided for the basic needs of the displaced population. The return of peace also heralded the resettlement of the civilian population in their places of origin. Many of the returnees were immediately challenged by a lack of social amenities like health facilities, schools and safe water sources (UNOCHA 2007b). In the district of Lira where 83% of the population had returned to their places of origin within the first year of peace, there were reports of an increase in the incidence of global adult malnutrition (UNOCHA 2007b). Morbidity and mortality in the under-fives had increased as compared to population groups that had delayed their return (UNOCHA, 2007b). Reports state that Central government with the development partners were slow in addressing the basic needs of the resettling population (UNOCHA 2007a). I discuss the transition process in greater detail in chapters two and three.

1.3.2 The maternal health situation in conflict affected countries

While all the developed countries achieved 2015 MDG Five for maternal health, according to a World Bank Group report (2015) in sub Saharan Africa only Rwanda, Equatorial Guinea, Eritrea, Sao Tome and Principe, and Mauritius were reported as likely to meet their MDG targets. Developing countries in sub Saharan Africa and South Asia showed the least improvement in the maternal health indices with 86% of all maternal deaths occurring in these two regions.

It is generally recognized that sub Saharan countries with the poorest maternal health statistics are those that were recently embroiled in conflict (O'Hare and Southall, 2007; Debarati and D'Aoust, 2011). A review of health systems in conflict-affected countries in relation to maternal health report weaknesses in the policy and governance environment. It also notes that in these settings public expenditure on health is far below the Abuja target of 15% of the annual national budget. The less than adequate spending leads to inadequacies in human resources, in medicines and in equipment and supplies as well as in a weak information system (Tumusiime *et al.*, 2012).

Uganda did not meet its millennium development goal five target by 2015 (World Bank Group, 2015). This was in part attributed to low funding for health. Uganda currently allocates 10 per cent of government budget to health compared to the Abuja target of 15 percent and spends about US15\$ per capita compared to US28\$ per capita estimated as required to fully finance implementation of the Health Sector Strategic Plan. I discuss this further in chapter three.

1.4 The rationale for maternal health care as the lens in this study

The United Nations Population Fund, UNFPA (2012) considers maternal health indicators as a strong measure for the performance of the health system. Similarly, Ssengooba *et al.* (2007) in conducting a maternal health review for Uganda, distinguished maternal health as facilitating the gaining of a broader understanding of the effectiveness and efficiency of a health system. For over a decade, since maternal health was identified as one Millennium Development Goal, it has benefited from a relatively rigorous and accurate monitoring and evaluation effort.

More over, a number of sub-Saharan studies have shown robust associations between maternal health care access and utilisation with socio-economic status(Kiwanuka *et al.*, 2008). Borgi *et al.*(2006) state that, within a country or across countries, the variations in the utilisation of maternal health care closely mirror the disparities between the rich and the poor. These disparities, on the other hand, are strongly sensitive to "*wider national and local contexts*" (Kunst and

Houweling, 2001, p. 13). In line with these observations, an earlier World Bank report (1999), recommends that health reform endeavours should use skilled birth attendance as a short term performance measure, and maternal mortality as a longer term measure.

In Uganda's case, the Demographic and Health Surveys of 2006 and 2011 provide information on maternal health indices that are disaggregated by region and socio-economic status. Data shows that post-conflict Northern and Eastern Uganda that are the poorest regions of the country also have the worst maternal health care figures (UBOS and ICF International Inc, 2006, 2012). I use part of this secondary DHS data to highlight the relationship between delivery options and socio economic status in post conflict and non-conflict Northern Uganda.

1.5 Justification for this study

Uganda did not achieve its MDG Five, and the dismal state of maternal health in Northern Uganda significantly contributed to this. According to a UNDP report (2015b) the lack of national and district-level ownership of the process was a major obstacle to achieving this MDG goal for maternal health. In addition, Uganda's National Development Policy was noted to have followed financing, implementation and reporting frameworks that were not aligned to the MDG goals (UNDP, 2015b).

With the advent of the post-2015 agenda, Uganda is showing a greater commitment towards achieving the Sustainable Development Goals. The launching of the second National Development Policy (NDP-II 2016-2021) coincided with the Global adoption of the SDGs. The Ugandan Government used the opportunity to draft the NDP-II fully aligned with the SDGs; up to 76% of the SDGs and their targets are reflected in the policy document (UNDP, 2015b). A major challenge now recognised is how to ensure that the strategies that address the SDGs are localised and adapted to the different contexts across the nation (UNDP, 2015b). I intend to help provide some answers to this query.

In addressing the preceding issue, I concur with Siddiqi (2009) who notes that governance challenges have been a key determinant in affecting the MDG

attainment by low and middle-income countries. Health systems performance in these challenging environments has not been improved by stepping up health care financing (Feachem, Yamey and Schrade, 2010). A Transparency International Global Corruption Report (2006) suggests that the peculiarities of health systems in fragile states include: information asymmetry; massive uncoordinated funding; and, the vast mix of stakeholders that affects the quality of governance in place (Transparency International, 2006). It is on these grounds that I seek to comprehend the policies, rules and regulations as well as norms and traditions that might have influenced the actions of the numerous stakeholders that had a stake in the recovery of Northern Uganda's health system.

Long before the war in Northern Uganda was over, the Ugandan Government forecast failure in attaining the MDG goal five, attributing this to the prolonged insecurity in Northern Uganda (Carlson, 2004). Furthermore, Colombo and Pavignani (2009), underscored a stark contrast between health system performance in the peaceful parts of Uganda and in post-conflict Northern Uganda. However, a number of studies including the Uganda Demographic Health Surveys, and National Household Surveys that disaggregate selected health care outcomes by region show that peaceful parts of Uganda are still suffering a large burden of disease that is often comparable with that in the conflict-affected regions of Uganda (UBOS and ICF International Inc, 2006, 2012; UBOS, 2014). There is need to ascertain how both national and health system governance responds to and influences health system performance in contrasting national environments, in this case post-conflict and non-conflict Uganda.

This study's research question is of international relevance. A number of nations around the world have had to manage post conflict health system recovery at the end of a regional (or confined) conflict. Often health system recovery in these countries has been politically contentious (Colombo and Pavignani, 2009). Such nations in Africa include: Angola, Mozambique, Sudan and Nigeria. Examples in Asia include, Sri-Lanka, the Kashmir regions of India and Pakistan, the Philippines and Cambodia. While political, social and economic factors that might influence the

course of recovery of a health system are context specific, there are some broader lessons that can be gleaned from such findings.

The discussion chapter makes reference to Mozambique, a nation that suffered a 15-year civil war, which pitted the ruling FRELIMO regime against Rhodesian and South African backed RENAMO rebels. The war came to an end in 1992 following a United Nations brokered cease-fire. The RENAMO rebels had targeted the health system during the war and it was seen as a priority for rehabilitation when the war was over. As part of the peace process, the Mozambican government adopted and implemented a number of policies that prioritised the rehabilitation and strengthening of health systems in rebel held areas (Pavignani and Colombo, 2001; Domingues and Barre, 2013).

Another nation that this study alludes to is Sri-Lanka, a South East Asian nation that was engulfed in a 16-year civil war between the majority Sinhala that were backed in the conflict by the Sri-Lankan army, and the minority Tamil population that fronted the Liberation Tamil Tigers of Eelam (LTTE)(Sritharan and Sritharan, 2014). The Tamil Tigers were fighting for an independent state on the North and the East of the island. The conflict was confined to these areas while the rest of the country enjoyed relative peace and economic growth. The war was ended militarily after a series of failed peace talks in a similar way to that in Uganda. The Government has been accused of back-tracking on some of its post conflict recovery pledges which greatly influenced the performance of the health sector in conflict affected areas of the country (Athukorala and Jayasuriya, 2013).

Limited research has been conducted comparing the relationship between governance and health care outcomes in countries with the dual scenario of post conflict and non-conflict. There is insufficient understanding of what governance factors portend more robust recovery of the health system in such settings. A greater understanding of the context and of the governance and policy development process is required to ensure that the policy adoption and implementation is appropriate to the needs of that population (Macrae, Zwi and Gilson, 1996)

1.6 Positionality of this Researcher

The research question, the research design as a whole is guided by three important features of my personal background namely: i) my personal experience as a medical practitioner based in Northern Uganda since 1993; ii) my mixed Ugandan heritage, my father from Northern Uganda and my mother from Southern Uganda; and iii) my 20-year marriage to a senior manager of Uganda's health sector.

I grew up in the South of Uganda while my adult life to date was spent in the North. I initially worked in a private-not-for-profit setting, in a missionary hospital, and later dually employed in the public health sector as well as in the private-for-profit setting as a specialist physician. Immediately after the conflict came to an end I was employed for six years as a USAID health project technical specialist scaling up HIV services to hard to reach settings across Northern Uganda. Also important for my positionality in this research is my marriage to a paediatrician that ascended through the ranks from medical superintendent in the rural district hospital to senior consultant paediatrician, to Northern Uganda to Uganda's Director General for Health Services (an equivalent of UK's Surgeon General) and further to her current position as Minister of Health. I am well known to many within the political and medical fraternities across the country. My positionality may have significantly influenced the data collection exercise, analysis and key measures that I undertook to address ethical concerns as I elaborate in this thesis' Methods chapter.

1.7 The structure of the thesis

In order to address the objectives, the thesis has been divided into seven chapters. They are structured as follows:

Chapter 2: Literature review

The chapter explores peer reviewed and grey literature that addresses maternal health, health systems in disrupted environments, health system governance as well as accountability and corruption. The literature review applies a *systems thinking* approach to the study, viewing governance as one of the six building blocks of the WHO health systems framework.

Chapter 3: Background

This aim of this chapter is to profile the Ugandan historical context and how this influenced political, economic and social processes occurring during the National Resistance Movement political era, that is, 1986 to date. These processes in turn have had a bearing on maternal health care in post conflict and non-conflict Uganda. The Chapter also reviews maternal health related statistics from Demographic Health Surveys of 2006 and 2011 as well as health financing data from the period.

Chapter 4: Research methodology

This chapter details the objectives, the methods and design as well as the study sites selected for this study. The study conceptual framework is also discussed. Here I explain the rationale behind the selection of respondents in the in-depth interviews and the focus group discussions. The choice for methods of analysis, that is, the Political Economy Analysis Framework supported by Framework Analysis are discussed as well as ethics and reflexivity concerns.

Chapter 5: National level health system governance findings

The chapter presents data concerning maternal health care governance collected through two methods: An analysis of national and health policy; and, in-depth interviews held with individuals representing organisations that played a governance role in maternal health care service delivery in Northern Uganda and East Central Uganda during the immediate post-conflict period. The Political Economy Analytical framework, guides the application of policy analysis data in conducting a contextual diagnosis of governance issues, while the in-depth interview data is applied to diagnosing the institutional and agency related factors affecting governance. The organisations considered at national level are categorised into three groups: the President, the cabinet, the parliament that represent central government; funding and implementing agencies; and, relevant line ministries that include the health ministry that are mainly made up of technocrats. Thirteen interviews were conducted at this level.

Chapter 6: Health system governance at sub national level findings.

This chapter presents the analysis of the in-depth interviews and focus group discussions that were conducted at sub national or regional level with individuals or representatives of organisations that played a role in maternal health care governance in Northern and East Central Uganda during the immediate post conflict era. The In-depth interviews are conducted with three categories: the civil servants at decentralised government; health providers; and civil society organisations. The focus group discussions are also conducted with three categories: Women leaders; opinion leaders; and village health team members.

Chapter 7: Discussion

This chapter discusses the findings in relation to the literature and document reviews. The discussion is structured in line with the study conceptual framework that was first presented in Chapter Four. Socio political theories contribute to explanations for the different phenomena related to context and institution, and actions and relationships between the different maternal health care governance stakeholders. The limitations of the study, a reflection on the methodological approaches and a conclusion as well as recommendations are also presented in this final chapter.

2 THE LITERATURE REVIEW

This chapter is a review of current and past peer-reviewed and scholarly literature that broadly addresses health system governance and more specifically its associations with state fragility and maternal health care. This literature review acts as an introduction to the subject areas that are discussed further in chapter three in relation to the national-to-sub national maternal health care governance continuum with respect to post conflict and non-conflict setting in Uganda. Furthermore the literature review provides a basis for comprehending the findings, the discussions and conclusions of this study.

Section 2.1 sets the scene for the whole literature review by discussing state fragility and its relationship to health care. Section 2.2 defines both the broader and more specific governance concepts and expounds on the different approaches of analysis. Section 2.3 specifically discusses sub national governance; decentralisation, its merits and demerits and the role of the community in making decentralisation more functional. Section 2.4 is a discussion about corruption that is a good governance indicator with a strong impact on service delivery in the developing world. Section 2.5, discusses maternal health care and factors that influence its utilisation, while Section 2.6 is a summary for the chapter that highlights gaps in the literature that this study intends to address.

Search Strategy: A web database search strategy was applied to identifying articles that were relevant to the different sub sections. The PubMed and EBSCO databases were sourced for peer-reviewed articles while Google Scholar was used particularly for the non-peer reviewed material. From the databases, a small number of articles that were highly relevant to each sub section were identified. These articles acted as a nidus for a snowballing process through which additional articles of relevance were identified. For the governance and corruption sub sections, a few book sections were also identified through the web searches. Numerous search terms were used that were inclusive of the Boolean operators. Examples of the search terms included: “health system governance”, “stewardship”, “resource allocation”,

“social capital”, “decentralisation”, “devolution” and “community participation” for the governance sub section; “maternal health” , “antenatal care”, “maternal health care”, “health system”, “health care system”, “health care” for the maternal health care sub-section; and, “state fragility”, “post-conflict”, “conflict-affected” for the state fragility and conflict sub-section. The search considered research work conducted from 1990 to date. However there were a number of articles that were outliers; they were written in the 1970’s and 1980’s but were identified through a snowballing process from initially identified articles and found highly relevant.

2.1 State fragility and conflict

Much of the developing world has experienced war and violence or is prone to conflict. The health system is vulnerable to the ravages of such conflict but at the same time acts as an important tool for enhancing peace building and social cohesion. The following section discusses the relationship between state fragility, the post conflict setting and peculiarities associated with transition from war to peace and particular challenges that this pose to health and health care.

2.1.1 Introduction – the fragile state

The world is experiencing a series of events that emphasize the close connection between the developed and developing parts of the globe (Engberg-Pedersen, Andersen and Stepputat, 2008). The Western world is experiencing a rise in terrorism; the incidence of lethal viral infections due to intercontinental transmission from the developing world; and, mass migration often emanating from poorer more insecure nations. An official American government report captured this concern in the statement, *“When development and governance fail in a country, the consequences engulf entire regions and leap around the world”* (USAID, 2002, p. 1). This calls for the continued need for international engagement and support to these less secure developing countries (Zoellick, 2008).

Major international developmental agencies like the World Bank (WB) and the Development Aid Committee of the Organization of Economic Cooperation and Development (DAC/OECD) use the term “fragile state” to collectively describe this

group of developing nations that are recognised to have a populations that is adversely exposed to physical, social or economic shocks and lack protection of the state (Development Assistance Committee, 2008).

The term has been adopted by both academic and development aid fraternities (Canavan, Vergeer and Bornemisza, 2008; Stewart, Brown and Ukiwo, 2009). The aid community in particular premised it's understanding of the fragile state upon the absence or presence of two key criteria: *state legitimacy*; and *state effectiveness* – with respect to the provision or protection of its citizens from physical, social and economic shocks (Newbrander, Waldman and Shepherd-Banigan, 2011).

A widely adopted working definition proposed by DFID and OECD states that: “a state is fragile when it lacks political will or capacity to provide the basic functions needed for poverty reduction, development and for the safeguard of security and human rights of its population”(OECD DAC, 2007; Stewart, Brown and Ukiwo, 2009).

However, Engberg-Pedersen et al (2008), writing in a report for the Danish Institute for International Studies calls for the use of an alternative term, the “state situation” to allow for the recognition of non state actors in the causation and/or resolution of fragility. The recommendation is driven at widening the scope of related developmental agenda and counters a key recommendation of the OECD's Development Aid Committee laid down in their principles for good international engagement that encourages donor agencies to focus on “state building as a central objective”(OECD DAC, 2007).

From the human rights perspective, state fragility has been considered by many recipient nations as derogatory and inconsiderate of the on-going recovery trajectories (Piron and O'Neil, 2005). This has, in some cases, impacted negatively on the relationship between these states and the donor institutions (Nguyen, cited in Stewart, Brown and Ukiwo, 2009). Apparently in response to these concerns the United States Agency for International Development (USAID) has made attempts to promote another term “rebuilding states” in many of its official documents (Waldman, 2007).

Given all these understandings of fragility, a poor policy environment, weak institutions and poor governance characteristically underlie the failure of such nations to provide basic needs, like primary health care services, for their populations, leading to dire consequences (Joyal, 2015). A study conducted in conflict affected DRC Congo showed a strong link between the war-disrupted environment and poor health of its population (Waldman, 2007).

The incapacity of health systems in such environments to address the population's health needs are manifested by a number of deficiencies that include: lack of appropriate health infrastructure, personnel and drugs and a dysfunctional unresponsive health delivery system (Kruk *et al.*, 2010; Newbrander, Waldman and Shepherd-Banigan, 2011). Lack of leadership and governance capabilities that motivate the development of functional management systems are one of the first hurdles that have to be addressed during the post war recovery period (Joyal, 2015).

Numerically portrayed, up to 46 countries classified as fragile are reported as worse off compared to non-fragile nations with regard to key health and social determinant indicators (Branchflower *et al.*, 2004). Over 50% of these fragile states were conflict affected and their populations were significantly more disadvantaged compared to those in non-conflict but fragile settings (Ranson *et al.*, 2007; OECD, 2009). The 2011 World Bank Report shows that the development deficit is concentrated in fragile states and more especially in those that are conflict affected (World Bank, 2011). These states account for 77 per cent of children not enrolled in primary school, 61 per cent of people in abject poverty and 70 per cent of infants dying from all causes (World Bank, 2011).

2.1.2 The post conflict period

According to Canavan, Vergeer, and Bornemisza (2008) a country or an area is considered post conflict when active conflict ends and there is political transformation to post conflict governance. Following the end of the Cold War in 1989 the number of both inter state and intra state wars were reported to have declined with over 35 countries in the post conflict phase since then (Ohiorhenaun

and Stewart, 2008). However, the transition to post conflict status is not linear; many reverting back into war or taking several years for permanent peace to be established with this depending on a combination of factors that include the political settlement process (Collier, 2004; Ahonsi, 2010). Economic recovery and social transformation are critical requirements for addressing post conflict population needs and averting the risk of resumption of violence (Ohiorhenaun and Stewart, 2008). The rehabilitation of the health system in such a setting requires recognising it (the health system) as a complex adaptive system (CAS) (Anderson, Chaturvedi and Cibulskis, 2007). According to Piana and Peters, path dependence, feedback loops, emergent behaviour and phase transitions are behavioural phenomena typical of CAS and are crucial to put into consideration during the reconstruction phase(2012). I discuss the CAS features in detail under section 2.2.3. With reference to West African post conflict scenarios, Ahonsi (2010) proposes that the post conflict period falls into three broad phases: i) the emergency and stabilization phase - **0 to 11 months** post-armed conflict; ii) the transition and recovery phase - **12 months to 47 months**; and, iii) the peace and development phase - **4 to 10 years** after post-armed conflict. An analysis by Collier and Hoeffler (2004) of post conflict economic growth in 62 countries that experienced a post war situation between 1974 and 1999, suggests that in the first years of peace there is stagnated economic growth later giving way to “supra normal” growth from the fourth year. If peace is maintained beyond the tenth year the post war region goes into a catch up growth phase before levelling out to a long term growth rate (Collier and Hoeffler, 2004). Often humanitarian and development aid is not provided with cognisance of the peculiarities of the post war period (Vergeer, Canavan and Rothmann, 2009)

2.1.3 The transition gap

The transition from conflict to post conflict can be viewed from two contrasting perspectives: an “aid perspective” denoting transition from relief to development; and a “political perspective” meaning transition with regard to contextual level issues related to the shift from armed violence to peace (Canavan, Vergeer and

Bornemisza, 2008). The UN's Inter-agency Standing Committee (ISAC), cited in Suhrke and Ofstad(2005, p. 4), recognizes that post conflict periods are "*associated with gaps of one type or another*". In addition to ISAC's efforts, academics and developmental specialists identify a number of gaps in post war aid development and political transition (Suhrke and Ofstad, 2005; Chinitz and Rodwin, 2014).

Institutional gaps – these reflect poor cooperation between humanitarian and developmental agencies as a consequence of different methods of operation that are representative of different mandates and institutional cultures. Humanitarian activities are described as "micro-oriented" — focusing on providing for communities for a short term and on small scale as opposed to "macro-oriented" activities, typical of developmental agencies that have a national perspective and take into consideration national planning and institutional building (Kumar, 1997). A practical consequence of this is infrastructure like schools or clinics built during the emergency period in the refugee settings are often abandoned once humanitarian agencies pull out of the post conflict region (Petrin, 2002). In other words, humanitarian agencies disengage from an area given that actual violence and the humanitarian emergency is ended and hence they often have no mandate to stay until the reconstruction process commences (Porter, 2002).

Macro-funding gap – While humanitarian funding is based more on the premise of "saving lives", developmental funding might come from the same donor nation but from a different source and with an expanded, often more politically motivated agenda (Suhrke and Ofstad, 2005). In addition humanitarian funding is targeted at unstable parts of country while developmental aid goes to an entire country or to more stable parts of the nation (Canavan, Vergeer and Bornemisza, 2008).

The size of the funding gap is dependent on donor characteristics and interests. In a development aid study in six post conflict settings, DRC, Southern Sudan and Sierra Leone had discernable funding gaps while Afghanistan and Timor Leste did not experience a gap. Liberia had its funding gap averted by the post conflict government recognizing the threat and appealing for addition support to cover the transitional period. The absence of funding gaps in the three countries was

attributed ultimately to stronger donor political commitment and national leadership (Canavan, Vergeer and Bornemisza, 2008).

Authority gaps - refers to the weak administrative capacities of the host government at the commencement of peace, its varied political agendas, and challenges in communication and understanding as it relates with the developmental agencies that are coming in to provide support (Kumar, 1997).

Sustainability gap – this reflects the limited capacity of host governments to sustain the momentum of recovery, particularly by failing to cover some of the recurrent costs of services established by both humanitarian and developmental aid agencies (Kumar, 1997).

2.1.4 Health and health care in the post conflict setting

Kruk et al. (2010) argue that other than improving the health status of the vulnerable population, the post conflict health system is probably the most effective peace building tool at the States' disposal. Ensuring equity in service provision and fair financing for access, coupled with mechanisms that enhance institutional accountability and community ownership will lead to social cohesion and "*a greater sense of identity*" (Tibandebage and Mackintosh, 2005; Marmot, 2007). The government gains from enhancing its social contract, promoting state building and reducing the risk of recurrence of conflict (Pavignani and Colombo, 2009).

According to Jones, cited in Kruk et al (2010), elaborate efforts that promoted good health care services were at the centre of successes witnessed in the establishment of peace and state building in a number of post conflict countries including Germany and Japan after World War II, and, Haiti, Kosovo, Iraq and Afghanistan much later.

World Health Organization data on 23 major disease conditions indicate that armed conflict substantially increases the incidence and consequent mortality and morbidity due to contagious diseases (International Crisis Group, 2004a). In addition, the longer the duration of war, and the poorer and more vulnerable a country is, the greater the incidence of disease will be, with its effects transcending the end of conflict (Ohiorhenaun and Stewart, 2008).

A number of epidemiological studies conducted in conflict-affected countries that I enumerate below attest further to the relationship between exposure to conflict and disease:

Putzel(2004) showed the close relationship between armed conflict and the spread of the HIV virus. Prior to the period when Uganda became engulfed in several civil wars, the HIV virus was in quiescent existence in the population. The persistence of war was correlated with an exponential increase in the prevalence of HIV, a situation that continued into the years of political stability (Putzel, 2004).

The disproportionate incidence of stunting in children under-five years old is seen in poor conflict-affected countries (Save the Children, 2011). Infant mortality rates have remained unchanged 15 years after the end of war in the post conflict states of Angola, Liberia and Sierra Leone (Ohiorhenaun and Stewart, 2008). Poverty and lack of proper nutrition, poor education and health care services that are prevalent in such post conflict settings appear to be important factors leading to poor child survival (Ohiorhenaun and Stewart, 2008). Maternal mortality ratios in conflict-affected countries are high, often exceeding the average in least developed countries (LDCs) and in part resulting from insufficient skilled staff attendance at birth (UNICEF, 2008).

The preceding account is reflective of national health systems in post conflict settings suffering a number of deficiencies that make them incapable of addressing the great burden of disease (Newbrander, 2007; Kruk *et al.*, 2010; Newbrander, Waldman and Shepherd-Banigan, 2011). These deficiencies include: inability to provide equitable health care services for vulnerable populations; lack of referral services; lack of infrastructure, human resources, equipment, medicines and supplies; inadequate capacity building mechanisms; insufficient supervision, coordination and monitoring of health service delivery; lack of health policy implementation mechanisms; and poor governance and management capacities that impact on financing, human resource, procurement and other critical processes vital for the operation of the health system. Addressing these health system deficiencies requires prioritisation as part of nation building after conflict.

2.2 Governance

Governance is an intangible concept whose definition varies according to discipline and purpose. Governance has been recognised as an important element of the health system. Many stakeholders have endeavoured to distinguish quantitative measurable features of governance in order to analyse the relationship of governance and its relationships with other health system elements.

2.2.1 Introduction - the dimensions of governance

Governance is a key consideration in the policies and reforms that the European donors are targeting as they tackle poverty reduction, democratization and global security in the developing world (European Union, 2003). A number of organizations involved in development aid, for example DFID, OECD-DAC, the European Union and others, have adopted governance related approaches in their support to developing countries (OECD DAC, 2007; Ruger, 2007). Nevertheless, governance still has variations in definition and scope that are reflective of how each organisation is addressing governance (EuropeAid, 2008). Some definitions of governance just consider the technical and administrative functions of government. Other definitions include the political aspect as well (DFID, 2006; Brinkerhoff and Bossert, 2008).

The European Union gives governance a broad conceptualization of three interrelated dimensions that are schematically represented in Figure 2.1 below.

As the figure shows core governance issues are primarily about power, its actors, its influences and relationships and its effects on society while governance *principles* represent ideals or benchmarks against which governance is measured (EuropeAid, 2008). These principles are also known as Good Governance principles (UNDP, 1997). The governance clusters represented in the figure are long-term impacts of Good governance. In its aid development work the European Union suggests that

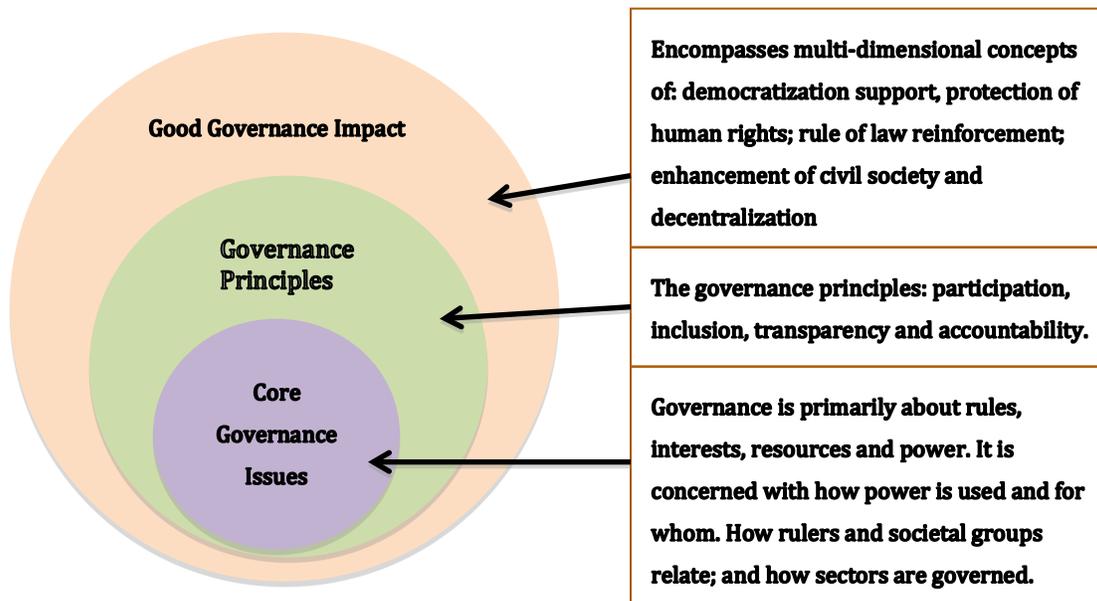


Figure 2.1 The Dimensions of Governance. Reproduced from EuropeAID (2008)

any dimension may act as an entry point when analysing or addressing the governance needs of a state, sector or specific programme (EuropeAid, 2008). The World Bank, on the other hand, defines governance as “the traditions and institutions by which authority in a country is exercised” (Kaufmann, Kraay and Mastruzzi, 2011). While acknowledging the importance of politics in governance, the World Bank has for long considered this outside its development agenda (Fritz, Kaisar and Levy, 2009). Despite several debates emanating from the Bank itself, the institution has maintained an apolitical stance and concentrated on supporting economic policymaking and implementation, service delivery, and accountable use of public resources and regulatory power (World Bank, 1991; Fritz, Kaisar and Levy, 2009).

2.2.2 Global development and good governance

A summary portfolio review for DFID shows, on the strength of research evidence, that there is a strong relationship between governance and national development (DFID, 2011). Improved governance is associated with the attainment of MDG goals;

and is also associated with greater socio-economic development in a number of middle and low income countries (Kaufmann and Kraay, 2008; Siddiqi *et al.*, 2009; DFID, 2011). Importantly as well, aid effectiveness is seen to improve in countries where “good governance” is observed (Lewis, 2006).

The association between governance and aid effectiveness is a reason a number of development agencies make recipient government governance reform a conditionality for aid (Brinkerhoff and Bossert, 2008). However, just as aid agencies are contending with working with each other given the varied concepts of governance, the list of Good Governance principles that aid recipients have to work towards have kept on expanding over the years (Grindle, 2004). As an example, while the 1997 World Bank Report advocated for aid recipient nations to address 45 good governance aspects, the 2002 World Bank Report had increased the number of indicators to 116 (World Bank Staff, 1997; World Bank, 2002; Grindle, 2004).

Accountability is a well recognised principle of Good Governance (Kaufmann and Kraay, 2008). However, Brinkerhoff and Bossert (2008) suggest that accountability is an offshoot of western political philosophy, gleaned off the concept of the social contract between state and citizen and not necessarily a governance value that aid recipient states in the developing world may identify with. Nevertheless, development experts argue that accountability is of universal relevance for national governance anywhere. Its features that draw on self-motivated integrity, on one hand and the more coercive feature of answerability on the other, have the potential of incentivizing individuals in responsibility into fulfilling the goals of the organizations or systems they represent (Lewis, 2006).

The relevance of Accountability and other Good Governance principles is still at the centre of debate. The concern is that after 20 years of the Governance agenda as a core component of development programming, there is no substantial improvement in the lives of the citizens in these developing countries (Piva and Dodd, 2009). Kelsall (2008) suggests that the Good Governance principles are not appropriate prescriptions for development in part because they are not in tune with political and societal realities of Africa. African indigenous concepts of politics and power that

are tightly linked to familial and paternal imagery are enduringly overlooked (Schatzberg, 2001). Similarly, Meisel and Ould Aoudia (2008) state that the Good governance principles are being used to force approaches to governance that are not in keeping with the stage of economic and socio-political development in the developing world (Meisel and Ould Aoudia, 2008).

To answer these concerns the DFID commissioned over 20 studies based on what is coined the “Drivers of Change” approach (DFID, 2011). The approach is based on the notion that effective development programming is best achieved by identifying and targeting economic, social and political factors that drive or stifle change (Warrener, 2004). The DFID studies have so far shown the relevance of considering the interplay between formal and informal rules, power structures, vested interests and incentives in development outcomes (Kelsall, 2008). A selection of these political economy analysis approaches is discussed in more detail in section 2.2.6 and 2.2.7.

2.2.3 Health system governance

Over time governance has become an important component of health system strengthening and analysis; it borrows all its definitions from the Good Governance principles (Fattore and Tediosi, 2013). Health system governance has gained more attention given that the health sector in low- and middle-income countries takes up a major proportion of spending of development aid (Piva and Dodd, 2009).

Governance was considered a key determinant in low and middle income countries attaining the MDGs (Siddiqi *et al.*, 2009). Increased health care spending has not elicited concomitant improvements in health system performance or population health (Feachem, Yamey and Schrade, 2010). Furthermore resource allocation factors alone fail to explain the variations in health outcome amongst nations that bear similarities in health care spending (Mikkelsen-Lopez, Wyss and de Savigny, 2011). Savedoff, cited in a Transparency International Global Corruption Report (2006) suggests that the peculiarities of health systems include: information asymmetry; massive uncoordinated funding; and, the vast mix of stakeholders. On these grounds, a more intense comprehension of formal rules and informal customs within a health system is justified (Mikkelsen-Lopez, Wyss and de Savigny, 2011).

The use of the governance concept in the health sector has been associated with the adoption of a number of adjunct health system conceptual frameworks that focus on the different elements and functions of the health system (Hsiao and Siadat, 2009). The frameworks apply different concepts and use a variety of terminologies to describe various health system objectives, processes and outcomes (Reich and Takemi, 2009). Many these frameworks have a limited utility because they address specific areas (Frenk, 2010). For example, while donors and implementing agencies may use particular frameworks for monitoring programme management, programme managers at country level may fail to find relevance in the tool (Balabanova *et al.*, 2010; Frenk, 2010). The aspiration amongst many stakeholders has been to have a framework that has the potential of promoting a more holistic picture of the functioning of a country's health system whilst also promoting better communication and coordination (Frenk, 2010; Fryatt, Mills and Nordstrom, 2010).

The 2007 WHO framework

The 2007 WHO framework (illustrated in Figure 2.2) is one that appears to fit with the aspirations described in the preceding section. It is an improvement of an earlier WHO health system framework (WHO, 2000) and describes the six health system building blocks, their aims and desirable attributes (World Health Organization, 2007).

The authors of the WHO Health System Framework report (2007) detail desirable attributes required of all the system blocks or elements of the WHO Health System Framework if it is to be perceived and managed as a complex adaptive system:

- There are multiple dynamic relationships between the six blocks that are enhanced by their connectedness. A change in one block will lead to concomitant changes in other elements as well.
- The system blocks together exhibit emergent behaviour. Health systems strengthening can take advantage of this feature through the application of technical and political knowledge to making alterations in each of the blocks and

managing the interactions between the six blocks with a view to forging equity and sustainability, access and coverage in performance.

- A set of appropriate indicators that can be determined that can measure change within the building blocks and within the system as a whole.

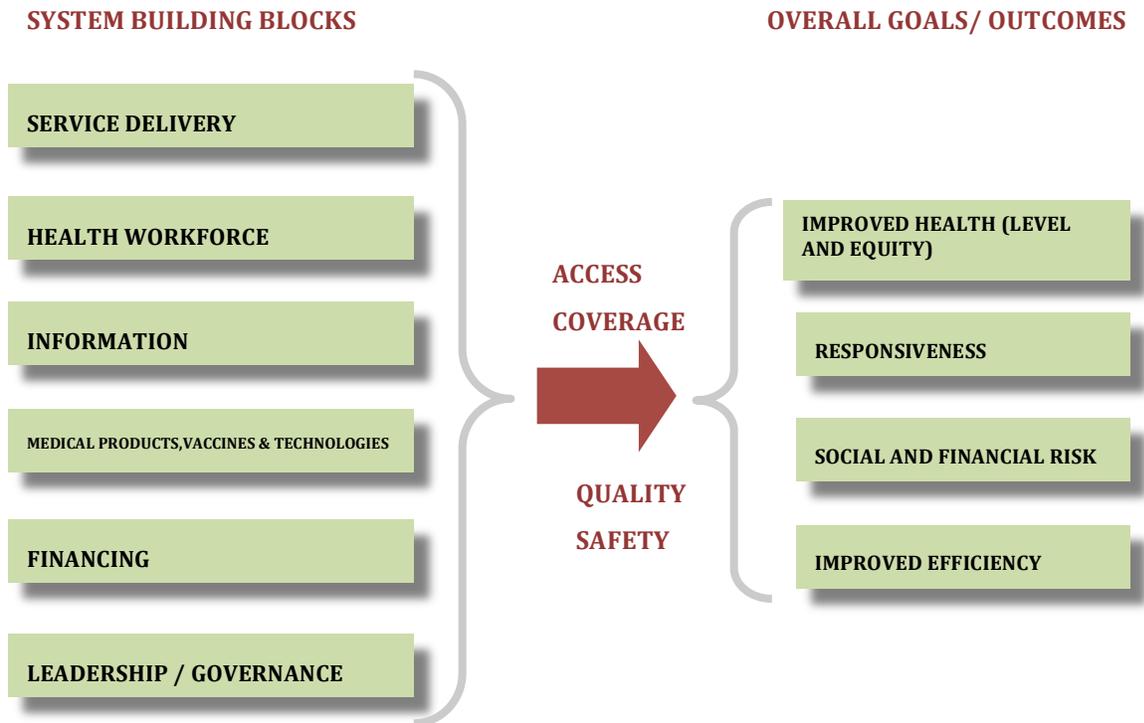


Figure 2.2: The WHO Health System Framework 2007

WHO employs the term *leadership* in its understanding of governance in the six building blocks health system framework (WHO, 2010). WHO states that to achieve the health system goals leadership as a governance role “ensures that strategic policy frameworks, effective oversight, coalition building, regulation, attention to system design and accountability are in place”(World Health Organization, 2007, p. 3).

Accountability

Accountability is also a prominent theme in health system governance just as it in national governance (Mikkelsen-Lopez, Wyss and de Savigny, 2011). It links all the different health system stakeholders together through power relationships and incentives - all within the context of institutional and structural features (Baez-Camargo, 2011). If well observed, accountability ensures that the health system

components are aligned to achieving the health system goal of improving health, distributing health care fairly and providing care in response to expectation (Molyneux *et al.*, 2012).

Brinkerhoff (2004) further identifies forms of accountability that are of relevance to the health system. These are: *political accountability* – related to the health care expectations of the citizens expressed through the politicians to the health systems planners and implementers (also referred to as “the long accountability route” in a World Bank report (2004)); *performance accountability* – related to the supervisory, monitoring and regulatory mechanism that support the production of health care; and, *financial accountability* – that involves budgeting and auditing to ensure appropriate use of resources for health care.

Answerability and the presence of *sanctions* are key defining features of effective accountability for health system stakeholders (Brinkerhoff, 2004). Answerability refers to the obligation health providers, health programme administrators and policy makers in general have to provide information and justification to the citizens either directly or through their agents (Cleary, Molyneux and Gilson, 2013). Sanctions may include punitive action like punishments, positive action like providing incentives or the application of ethics of conduct (Standing, 2004).

Decentralisation is one important reform of political governance that reduces the distance between the health care system governance structures and the communities and with the potential to enhance all the different forms of accountability. Strengthening the participation of communities in the public health system, it is believed, will enhance the quality and responsiveness of care and in turn improve its utilization (Cornwall and Pasteur, 2000). It is also for these reasons that accountability is an important indicator in the assessment of health system performance (Cleary, Molyneux and Gilson, 2013).

2.2.4 Assessing health system governance

The causality linkages between health system governance and health care outcomes are as yet poorly understood though governance is already considered a key

determinant for economic growth, and social advancement as a whole (Siddiqi *et al.*, 2009).

The development of theoretical frameworks and measurable indicators is considered a strategy that could create a shared reference for health system governance making it more understandable and actionable (Travis, Egger and Davies, 2000). Furthermore, Barbazza and Tello (2014), in a review of health system governance research, reemphasize the need for a clear more unified understanding of the governance concept. They highlight some world-views of governance that have important implications on health systems research.

For example, *Good Governance* alludes to governance ideals that are represented by a number of elements, while relational or *networked governance* refers to institutional relationships between health system stakeholders (Barbazza and Tello, 2014; Bodolica, Spraggon and Tofan, 2016). Assessment approaches for Good governance are premised on a variety of frameworks that incorporate principles like accountability, participation and consensus building (Cleary, Molyneux and Gilson, 2013). On the other hand, assessments for networked or relational governance are based on frameworks that analyse stakeholder power and influence relationships (Baez-Camargo, 2011; Cleary, Molyneux and Gilson, 2013). The frameworks from these two divergent approaches are discussed in detail below. This thesis focuses on the latter approach. In giving health system governance a more wholesome picture, I briefly discuss the Good governance frameworks before focusing on the political economy analysis frameworks.

2.2.5 Good governance analysis frameworks

This group of frameworks are categorized according to their scope. The three are:

- i) *Global health system frameworks* - derived by key international organizations that support cross-country comparison of governance capabilities (Siddiqi *et al.*, 2009). The frameworks include: (a) World Health Organization's (WHO) Domains of Stewardship; (b) World Bank's Six Basic Aspects of Governance; and (c) UNDP's Principles of Good Governance;

- ii) *National health system frameworks* – these frameworks are derivatives of the first group and therefore incorporate the good governance elements. The health system governance framework by Siddiqi et al (2009) is an example. It has been found useful for the identification of weaknesses in health system governance and highlights gaps and opportunities that decision makers could address (Abimbola et al, 2014). The tool has been tested in a number of health systems of LMICs including Pakistan; and
- iii) *Primary Health Care level governance frameworks* - these conceptualize governance at service delivery level and by doing this address the unique governance relationships between health provider and patients as well as the wider community (Brinkerhoff and Bossert, 2008). Examples of frameworks here are those by Cleary et al (2013), and Abimbola et al. (2014) who both underscore a duality of approaches required for analysing health system governance at primary care level. They consider: i) the *macro* or *hierarchical* level approach that look at the formal rules, norms and regulations governing the actions of employees and employers within a hierarchically arranged health system and; ii) *micro* or *relational* level - power, accountability and incentive led relationships between patient and health provider, influenced by ethical and rights related ordinances.

2.2.6 Political economy analysis

As alluded to earlier in section 2.2.2, a number of aid agencies over the last decade including DFID, DANIDA, EU, and the World Bank have revisited their approaches to planning, implementing and evaluating global programming (Moncrieffe and Luttrell, 2005). Tidemand (2010) states that it was previously commonplace for donors to offer aid with set conditionalities without due regard for constraints and opportunities created by the political environment. It is now more apparent that development aid is less effective, and does not reach to the most vulnerable in situations where power, politics and elitist interests are counteracting the goals of development programmes (Duncan and Williams, 2012). Tidemand (2010) again states that the challenge donors are facing in achieving positive impacts in

development in fragile and post conflict countries highlights how power and politics have a huge sway on the outcome of aid programmes.

It is on this premise that the agencies now promote, amongst their methods of programme evaluation, *political economy analysis (PEA)*. This methodology evaluates the performance and governance of country programmes in the context of relationships between economic processes, political policies and social institutions in these nations (Moncrieffe and Luttrell, 2005; Fritz, Levy and Ort, 2014). The PEA complements the conventional governance assessments that I earlier discussed by: providing a deeper comprehension about power, state capability, accountability and responsiveness and how these influence the health sector. The PEA, conversely also enables researchers to study the impact of a poor health system on state building or collapse in fragile or conflict affected environments (Mcloughlin, 2014).

The PEA approach considers: i) the interests and incentives experienced by different social groups in society (more especially the political elite) and how these interests and incentives lead to policy options that may deter or promote development; ii) the role that formal institutions (for example the rule of law) as well as informal institutions (for example social, political or cultural norms) play in influencing human interaction, political and economic competition; and iii) the impact of values and ideas, including political ideologies, religion and cultural beliefs on political behaviour and policy (Tidemand, 2010).

2.2.7 Political economy analysis frameworks

Political economy analysis has predominantly been a tool for development aid programmes rather than for researchers. For this reason the PEA frameworks that guide the assessment of contexts and institutions are tools that have been used across several sectors; they are versatile and adaptable across varied contexts and programme timelines (Collinson, 2003).

A number of frameworks have been developed during the last decade with terminologies and acronyms popularised by different organisations (Edelmann, 2010). Two frameworks are of relevance to this study: The framework by

Moncrieffe and Luttrell (2005) lays focus on the context and conducting stakeholder mapping; and the framework by Harris (2013) acts as a tool for addressing specific governance problems. This is discussed in more detail below.

The sector and political arena's framework (Moncrieffe and Luttrell, 2005)

Background and conceptual approach: The framework was designed in 2005 for the guidance of DFID country teams that were tasked to conduct analyses of the political economy of various sectors and policy arenas where DFID supported development programming. The framework supports a deeper understanding of local in-country sectors and gives answers to why health systems and their outcomes vary across different country contexts (Moncrieffe and Luttrell, 2005).

Methodology: The framework uses a three-stage process: a) a historical/foundational country overview; b) organisations, institutions, and stakeholders; and c) operational implications.

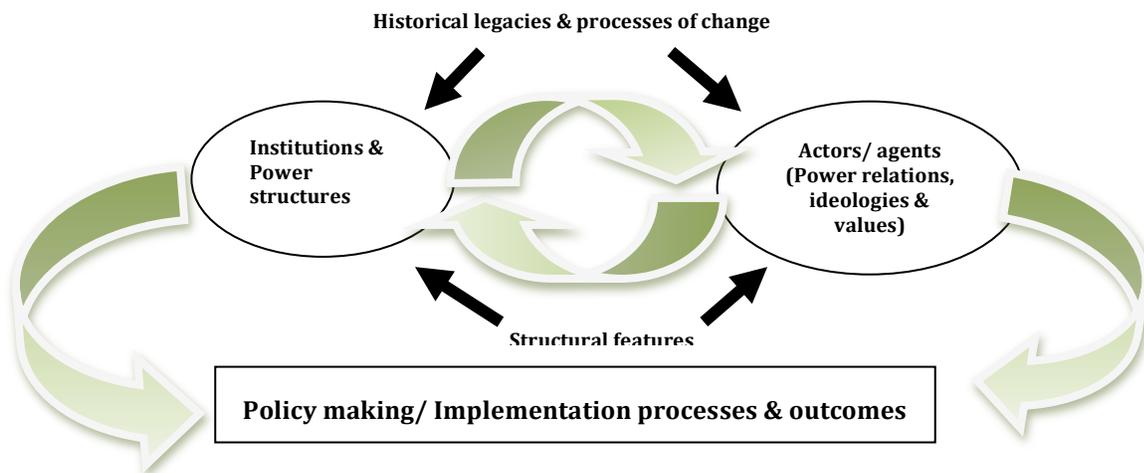


Figure 2.3; The Sector and Political Arena Framework by Moncrieffe and Luttrell, 2005

Stage I - constituted by a basic analysis that looks at broader historical and political in-country contexts. Historical legacies, processes of change and structural influences on relations between institutions and stakeholders and in turn on policymaking and implementation are also assessed at this stage. See the Figure 2.3.

Stage II - this involves gaining a closer understanding of the relationship between institutions and stakeholders; how institutions and stakeholders interact, with

regard to the sector, and how this impacts on the policy-making and implementation processes. Itself involves three activities: i) defining the sector - boundaries are defined and stakeholders are mapped; ii) political analysis of the sector – analysis of organisations in the sector takes place looking at the leadership structures, the roles and responsibilities, incentives and motivations for the different stakeholders therein; iii) relationships between the stakeholders within and across organizations and within and outside the sector (Moncrieffe and Luttrell, 2005).

Stage III – Involves looking at the operational implications. This will include: i) the donor reviewing the objectives and expectations of working in the sector; ii) determining the entry points – understanding the constraints, incentives and capabilities and the institutions and stakeholders that are most appropriate to engage; iii) identifying the mode of support in (ii) above.

The problem-driven framework for applied political economy analysis by D. Harris (2013)

The Health System Governance Framework by Baez-Camargo and Jacobs has been considered useful in the analysis of formal institutional influences on the performance of the health system. However it carries the limitations that plague the Good governance elements by failing to adequately capture the governance roles of non-state actors, and failing to account for the more informal institutions that may be of influence to the functioning of the health system (Abimbola et al, 2014).

On the other hand the framework by Moncrieffe and Luttrell (2005) has been considered robust because it uses multiple analytical tools to evaluate all aspects of a country's political economy. The approach however has been criticised for having the potential of generating a multiplicity of important factors influencing policy development and implementation but yet failing to determine the order of importance of these factors (Edelmann, 2010).

In view of these limitations, Harris (2013) developed a variant of the Moncrieffe and Luttrell framework that adopts a problem-specific approach to analysing governance. The framework uses three dedicated but related phases, namely: problem identification, problem diagnosis and a change process component (Harris,

2013). This is the PEA framework opted for in this thesis. As I later discuss under Chapters four and five the framework was found suitable for conducting a political economy analysis of the health system based on a specific research question and focused on a specific context.

2.3 Decentralisation

Decentralisation is a term that has been used in Europe for over two centuries; in France it was particularly recognised as one of the achievements of the French Revolution (Wagner, 2000). As early as 1789 the dismantling of large provinces that hitherto had been a symbol of centralized power and privilege, ensued. This allowed for the creation of a network of 83 semi-autonomous counties that had a say in tax revenue sharing (Tokes, 2013).

It was much later in the 1980's that a similar drive for greater government effectiveness in the developed world and more particularly in Latin America commenced (Campbell, 2003 cited in Faguet, 2004). Campbell states that by the end of the 1980's, "*as if by some signal*", several Latin American governments were transferring money and decision making powers to local municipalities and at the same time allowing the local governments to democratically elect their own leaders.

For the developing world, the adoption of decentralization was a radical shift in political ideology from the highly centralised ruler-ship that characterised the 1950s and 1960s early post-independence years (Rondinelli, Nellis and Cheema, 1983). Centralized systems, were at the time assumed more desirable for fostering social cohesiveness, nation building and economic development in countries where the diverse ethnic groupings did not come together out of choice but rather out of colonials sub dividing the continent between themselves (Maraka, 2009).

Decentralization is currently the preferred form of governance as governments grapple with making themselves more responsive, accountable and able in addressing the needs of the smallest homogeneous group in society (Shah and Andrews, 2003). One important trend that had been associated with decentralisation in many developing countries since the 1990's is the creation of

“new sub-national administrative units”. Green (2008, p. 1) states that decentralisation is seen as a “form of palliation” for a myriad of governance challenges that governments in the developing world contend with. While there might be a primary desire to enhance service delivery through the adoption of decentralisation, electoral and ethnic considerations have been proposed as additional factors driving the trend (Fitriani, Hofman and Kaiser, 2005; Malesky, 2005). I discuss the creation of new districts further under section 2.4.5 and later in chapter three under section 3.1.4.

The health sector was already functionally decentralised in a number of developed nations by the 1970s (Ball, Eiser and King, 2013). The National Health System of the United Kingdom, for example, was entrusted to the three devolved territory governments of England, Scotland and Wales. Mills et al(1990) in a WHO publication state that decentralisation in the health sector gained world-wide appeal in the late 1980’s as a promising strategy for attaining global health commitments, like “Health for All by the year 2000” and the Alma Ata Declaration on Primary Health Care. However, since health care is a function of government, health system decentralization has diverse drivers that are dependent on the political ideologies and administrative set ups of the state (Atkinson and Haran, 2004).

Generally, the driver of health system decentralisation in developed nations was pressure from grass root political entities upon the national governments (Mills *et al.*, 1990). In the developing world, decentralization was a theme adopted by national governments as a consequence of pressure from developmental aid partners who wished to ensure that the equitable distribution of limited health care resources takes place (Smith, 1997).

Decentralization is defined by Rondinelli, Nellis, and Cheema (1983) as the transfer of responsibility for planning, management and resource raising and allocation from the central government and its agencies to one of the following entities: (a) field units of central government ministries or agencies, (b) subordinate units or levels of government, (c) semiautonomous public authorities or corporations, (d) area-wide,

regional or functional authorities, or (e) nongovernmental private or voluntary organization.

Decentralization typically varies in the degree of decision-making authority divested from a central authority, varying from the simple adjustment of workload within central government to complete transfer of administrative authority to agents in the periphery (Shah, 1999). Bossert (1998) proposes four different approaches for defining, measuring and analysing the decentralization of national governance. These are: i) the public administrative approach; ii) local fiscal choice approach; iii) social capital approach; and the iv) Principal agent approach. The public administrative approach is of particular relevance to this thesis because it focuses more on the governance arrangements related with decentralisation as will be discussed in the following section. This approach will also be discussed further in relation to health system decentralisation.

2.3.1 Decentralisation – the public administration perspective

Governance arrangements in the health system are based on four types of power and responsibility distributions (Bossert, 1998). They may not necessarily reflect the varying degrees of decision-making autonomy but more consistently represent different degrees of accountability (Rondinelli, Nellis and Cheema, 1983). The typologies are: i) deconcentration; ii) delegation; iii) devolution; and iii) privatization.

Deconcentration involves the transfer of *some* administrative responsibilities from central government to peripherally located offices mainly for administrative oversight (Mills *et al.*, 1990; Hutchinson and Lafond, 2004) . This is recognized as the weakest form of decentralization and is a good example of one sided accountability from the decentralised office to its centralized institution (Mills *et al.*, 1990; Hutchinson and Lafond, 2004).

Deconcentration is exemplified by the role played by village extension workers that are common in both health and non-health related sectors, acting on behalf of the central organization to support implementation and identify issues for further

planning (Campbell and Graham, 2006; Percival *et al.*, 2014). According to Bossert and Beauvais (2002), the Ghana Health Service at the time had deconcentrated administrative authority to district health offices who then played a supervisory role for district health care services in addition to a limited role in decision-making and planning. Sumah, Bowan and Insah (2014) note that this arrangement was a handicap to health workers that had to contend with adverse challenges at the decentralised level for which central government supervisors were slow to provide solutions.

Delegation is the transfer of central government authority to private-for-profit or not-for-profit organizations at local level (Mills *et al.*, 1990). Delegation transfers administrative authority and provides accountability both to the community served as well as the appointing authority (Smith, 1997). The study by Bossert and Beauvais (2002) described the Zambian health system where the Central Board of Health appointed and oversaw operations of peripheral District Boards of Health and Hospital Management Boards during that period. In the case of delegation of power to hospital management boards, Bossert and Beauvais (2002) suggest that this was the greatest degree of autonomy possible. However, Ndiay 1990, cited in Smith (1997) recognised that such autonomy drew Senegalese hospital committees away from their designated mandates into local political factionalism; this is an example of the vulnerability of such decentralized entities to local elite capture. As this thesis will show elite capture was a key factor that was crippling the effectiveness of the decentralised health systems.

Devolution involves a central government institution creating sub national level structures of governance and shifting responsibility and authority to them on the premise of statutory or constitutional provisions (Hutchinson and Lafond, 2004). A devolved district, municipality or council, has a greater degree of autonomy — in terms of decision-making and implementation — as compared to other forms of decentralization. The decentralised government is accountable to the local population just as much as it is to the appointing authority (Mills *et al.*, 1990).

One key argument against devolution is that decentralized sector is often vulnerable to the local political climate with its decentralized functionaries easily caught up in political manoeuvrings at a cost to local service delivery (Atkinson and Haran, 2004). It is also documented that there is often a discrepancy between instruments provided to divest administrative, financial and technical authority to local authorities and the instruments used for monitoring, evaluation and keeping activities in check (Prud'homme, 1995). Health service delivery in a devolved government, is prone to suffering from funding priorities of the district authorities that may go against the health needs of the communities they serve (Newbrander, 1991 cited in Smith, 1997). As is reflected in this study this might be a reflection of procedural gaps in decentralized planning, in part stemming from information asymmetry and poor communication between the local health sector bureaucrats and the local decision makers (Atkinson *et al.*, 2000).

Privatization involves transferring administrative authority and operational responsibilities to private entities on the premise of a contract that defines the expected deliverables in exchange for public funding. A number of countries provide health care services through contractual arrangements with private health providers, including UK's National Health Service (Goddard and Mannion, 1998). Post conflict states like Afghanistan and Cambodia are among the developing nations that contract out health care (Loevinsohn and Harding, 2005). In 2002, Afghanistan with the support of numerous donor agencies, took on a number NGOs to provide a Basic Health Care Package of health care services for all its six provinces (Palmer, 2006). Concerns in Afghanistan abound with regard to sustainability of the contractual arrangement, as donor funding inevitably comes to an end (Pavignani and Colombo, 2009). There are also concerns about the maintenance of service delivery quality across the different contractors who often using different procedural guidelines (Alonge *et al.*, 2015).

2.3.2 The role of the community in health system governance

Alongside the drive for decentralised governance for the health system, following pronouncements at the 1978 Alma Ata Conference, there was a push for greater

involvement of communities in their health. The Alma Ata Conference situated community participation in health (CPH) at the centre of the primary health care strategy (Zakus, 1998).

A number of research efforts have been made to comprehend the bounds of community participation in health (CPH). Arnstein, cited by McCoy, Hall and Ridge (2012) allegorically represents the varied levels of CPH as a “ladder of participation”. The lowest rung of the ladder represents coercion of the community into participation; the second rung represents a “*tokenistic*” form of participation where communities are informed as a consequence of processes not necessarily related to their immediate health care system. The third and fourth rungs are “*consultation*” and “*delegated*” power respectively, both giving the community a voice but with the latter gaining additional decision-making powers.

Studies have shown community participation in health to be beneficial to participating community members as well as to the wider community (McCoy, Hall and Ridge, 2012). Community participation potentially enhances health knowledge and promotes health behavioural change (Zakus, 1998). CPH involves people in the assessment of their needs and enables them to express their local expectations according to local health needs (Zakus, 1998; Mubyazi *et al.*, 2007). In addition, there are far reaching benefits to the health system that include: the expansion of health care coverage (WHO, 2013); the enhancement of health system performance exemplified by an improvement in efficiency, effectiveness, equity and quality (Rodney and Hill, 2014); as well as improving the responsiveness to need and accountability to service providers (Mubyazi *et al.*, 2007).

2.3.3 The role of CPH in maternal health care

Community participation is recognized as vital for the promotion of maternal and new born health (Bhutta *et al.*, 2013). According to a systematic review of 43 studies conducted in diverse global contexts, community volunteers, community groups, women’s groups and representatives are now a core feature in strategies that promote maternal health at PHC level (Lassi *et al.*, 2014). As aptly stated by

Lassi et al(2014), *“the objective is to enable the community to provide support to pregnant women and their families throughout pregnancy and delivery”*(pg.3).

A number of community interventions that function at several levels and vary by context have been used to promote better maternal health. These include:

i) The engagement of community volunteers to provide maternal health promotion services within their communities. This works to enhance community awareness about maternal health care services available and provides community education about danger signs in pregnancy and the importance of seeking care from a skilled health worker for delivery (Campbell and Graham, 2006; Lassi *et al.*, 2014);

ii) The use of community health volunteers as auxiliary health workers at health facility level. The objective here is to provide health education to mothers, and conduct antenatal screening as well as handling uncomplicated deliveries in the primary care setting (The Partnership for Maternal Newborn & Child Health, 2006 c);

iii) The formation of health facility committees that work as part of the formal administrative structure of a community level health establishment with a view to ensuring appropriate and acceptable maternal and new born health care services (Mubyazi *et al.*, 2007; McCoy, Hall and Ridge, 2012);

iv) As a more overt governance role, the communities can participate through the engagement of grass root women’s groups, community coalitions and politicians so as to influence local and national policy makers as well as donors in providing for more equitable maternal health care services (Shiffman and Smith, 2007).

In recognition of the potential communities can play in supporting governance and equitable maternal care, a number of international organizations have been at the fore in supporting and collaborating with national governments, particularly in the LMICs to empower local communities for health and with a focus on maternal health in particular (UNFPA, 2012c; Family Care International, 2014).

2.3.4 The role of social capital

Social capital, according to Putnam (1995), refers to “*features of social organisation such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit*”. Described as a relational consequence of people coming together by association or by networking, social capital is also considered a public good that has positive externalities that can steer a community into achieving a common good (Kawachi *et al.*, 1997).

Bowles and Gintis (2001) consider social capital as the enterprise behind “*community governance*”, largely dependent upon informal behavioural attributes that have been internalised by individuals in a society and traditionally regulate relationships at community level. These include: trust, solidarity, reciprocity, reputation, personal pride, respect, vengeance, and retribution (Bowles and Gintis, 2001). Through community governance social capital contributes to the upholding of Good governance principles and this complements and at times substitutes the role of markets economic forces in safeguarding these principles (Vatn, 2005).

Social capital can be considered as having two complementary components: cognitive and structural (Islam *et al.*, 2006). Cognitive social capital considers an individual’s norms, values, attitudes and beliefs: these explain interpersonal trust, sharing and reciprocity which in turn determine risk behaviour, mutual aid and support and informal communication (Story, 2014). Structural social capital considers the more externally perceived concepts of association, social networking and civic participation: these explaining the shaping of institutions, policies and culture (Kawachi *et al.*, 1997; Islam *et al.*, 2006).

Of interest to this thesis is the relationship between social capital and health care utilization. A study in India by Story (2014) used the 2005 India Human Development Survey to show that other than individual (or compositional) characteristics, there were contextual factors related to community and geographical location that were influencing health-seeking behaviour. The study particularly shows that health care utilisation was positively associated with individuals that are: i) part of bridging-intergroup relationship (that is, the

members hail from diverse heterogeneous groups within a community) and ii) are part of a social network where the members leverage relationships with people of power and influence. In the study individuals from communities with strong intragroup bonding (relational ties according to family, religious affiliation or caste) had lower odds of utilizing antenatal care services, while it had higher odds of using a doctor, nurse or midwife during delivery (Story, 2014). The negative association with antenatal care is supported by the view that collective action premised on group traditional beliefs and norms can negatively influence utilisation behaviour (Portes, 1998).

By participating in healthcare, local communities are able to adapt the health care services to their needs and in doing this strengthen relationships with the service providers and the wider health system (Needham, 2008). It has indeed been argued that the lack of involvement of communities in Ebola prone parts of West Africa was a critical factor in the spread of the Ebola epidemic. The lack of involvement of local communities in addressing a number of important risk factors may have played a critical role in the perpetuation of the epidemic. (Chan, 2014; Shrivastava, Shrivastava and Ramasamy, 2015).

2.4 Corruption

Corruption has been characterized as endemic in many health systems around the world, and has deleterious effect on the Good governance in the health sector. The following sections expound on the definitions and various features of corruption, concluding with political patronage, which under other circumstances can be perceived to be institutionalized corruption.

2.4.1 The corruption-health sector relationship

The World Bank amongst other global financiers recognise corruption as a governance concern; it is indeed one of the indicators of Good governance just as I allude to in section 2.2.5. With governance as its central theme, Factor and Kang (2015, p. 634), propose a broad definition stating that: “*corruption is the misuse or abuse of one’s office or position in either the private or public sector*”.

Corruption has been recognised as a threat to global health outcomes, leading to financial waste and adverse health consequences (Mackey and Liang, 2012; Factor and Kang, 2015). Corruption is endemic in health systems all over the world; both in developed and developing countries. During the last two decades substantial work has been carried out to provide empirical evidence for the adverse relationship between corruption and health outcomes in a population (Factor and Kang, 2015).

There are two ways of relating corruption to the health sector. The first relates to corruption affecting the nation's ability to respond to the health needs of its people (Factor and Kang, 2015). This may occur by corruption reducing government revenue available for the population's health needs (Akçay, 2006). Corruption causes a distortion in economic benefits to society, with the more powerful social groups gaining better social services, and through this creating a less equitable nation, poverty, as well as a risk posed to national security (Målqvist, Hoa and Thomsen, 2012). Studies by Gupta et al, (2002), Shelley (1979) and Mackey and Liang (2012) have consistently shown a relationship between corruption and lower standards of education and reduced health care spending (Mauro, 1998).

The second way that corruption affects the health sector is by processes that take place within the sector itself. Corruption here may be in the form of embezzlement, bribery, kickbacks, theft and failure to deliver services (Scott *et al.*, 2011; Novignon, 2015). According to Factor and Kang (2015), these processes highlight failures in three important health system areas, namely financial resources, medical supplies and health worker-patient relationships.

Corruption in the financial resources area includes: the diversion of public funds from allocated budgets; or bribes made to influence regulatory or procurement decisions. Corruption in the medical supplies area includes the theft of pharmaceuticals during procurement and distribution. Examples of corruption in the human resources area include: absenteeism by health providers; or informal payments by patients seeking more appropriate care (Factor and Kang, 2015).

Absenteeism is of particular interest to this study given that health workers are probably the most important element of health service delivery (Lewis, 2006). It limits access to care and reduces the quality of health service delivery (Asiimwe *et al.*, 2006).

According to Lewis (2006), absenteeism is symptomatic of an unaccountable health care system and ineffective government. The ineffectiveness of government is exhibited by its inability to provide a living wage for the health worker, exposing them to various coping strategies, some of which involve staying away from the station of duty for long periods. Because the poor performance of health workers is easily recognised but yet ignored by those in authority, it quickly leads to contempt for the systems of governance and the policies that they follow (Lewis, 2006).

Lower levels of corruption also portend greater efficacy in health care spending and a reduction in child deaths. This was the conclusion of a study by Rajkumar and Swaroop (2008), based on World Bank annual reports that looked at the relationship between governance, public spending and health outcomes.

A meta-analysis of 42 empirical studies on corruption by Judge *et al* (2011), determined a correlation between the level of national corruption and three groups of “*macro-environmental antecedents*” namely, political, economic and socio-cultural antecedents (Judge, McNatt and Xu, 2011). The study suggests that low levels of corruption are a function of political openness, economic progress and high levels of education.

2.4.2 Explaining corruption

A number of theories have been advanced over the years to explain the basis of corruption and areas that might be responsive to remedial action. Rose-Ackerman (1999) is one of the proponents of the principal-agent model that considers corruption as criminal behaviour. The designation of who is principal or agent may differ from one researcher to another. Becker and Stigler (1974) in their model denote political rulers as the principal and the potentially corrupt bureaucrats as agents. According to Aidt (2003), the limitation of the model proposed by Becker

and Stigler is its assumption that the principal — the politician — is “*benevolent*” and willing to take punitive action against errant agents.

More commonly, rulers are modelled as agents and citizens as the principals. Corruption in the agent is dealt with here by the establishment of institutions: like electoral systems or government ombudsmen that enhance vertical accountability (Persson, Tabellini and Trebbi, 2003).

Teorell (2007) faults the principal-agent approaches that I have highlighted for considering corruption as an “*illicit behaviour among agents*”. She notes that in reality the principals, be it a leader in the top-down model, or the voter in the bottom-up model are not necessarily willing participants in controlling corruption. They are influenced by external factors that the models do not take into consideration.

It is on this premise that Teorell (2007) and Collier (2002) amongst other researchers advocate for the appreciation of corruption as an institution in its own right. In keeping with North’s (1991) definition of an institution, corruption would then be seen as a “rule of the game”, as opposed to an act. It is in line with this argument that Collier (2002) uses an institutional choice analytical frame to illustrate how political corruption is an institutionalised social behaviour bound by culture and social institution.

Culture holds a central position in Collier’s treatise on corruption. He argues that it is from Western culture that principles of Good governance evolved with an anti-corruption tenet emerging as part of it, making it a norm for public officials to separate their public duties from their private interests. However, as he notes, *cultural relativity* stipulates that the norm is not applicable everywhere. To further rationalize his argument, Collier argues that there are three principal world political cultures — *collectivist*, *individualistic*, and *egalitarian* — each with its own unique mix of social rules that determine the gravity of political corruption in that society. According to Collier *collectivist* cultures are segregated into clans, tribes, ethnic, religious or other social groupings. Leadership in these cultures is patronage based

with the citizens offering political and economic allegiance to the ruler for access to Government resources. In such settings, the rule of law is weak and rule is mainly by hegemony. There is a large level of permissiveness towards many forms of political and bureaucratic corruption in this culture. Examples of collectivist cultures are developing states in Eastern Europe, Latin America, Asia, Africa, and the Pacific.

The Individualistic culture on the other hand, is segregated along political and socio-economic class. Social and economic transactions are conducted between the different groups. Contracts are primarily enforced through formal legal and specialised organisations such as courts. Individual self-interest is the governing rule in this culture. Here the political culture of this group is utilitarian; politics is seen as business. Powerful political elite engage the community in decision-making through party structures and interest groups. There is a moderate level of permissiveness towards corruption as compared to the collectivist group. Examples of this culture according to Collier are non-Puritan sections of England, Wales, the United States, Australia, New Zealand; Ireland; Central Europe; and French-speaking Canada (Collier, 2002).

Again according to Collier, the egalitarian culture is the most integrated and complex. Individuals in this cultural category belong to a wide array of political, economic and social groups, but are still able to conduct social and economic transactions across the groups. In this group both formal and informal mechanisms of enforcing contracts are functional across the groups. Egalitarian political cultures are seen as focused for the public good and are devoted to the advancement of public interest. Therefore politicians vie for power for the advancement of society. Their political parties are less influential and the community have platforms that enable them to engage in politics from a horizontal rather than vertical arrangement. There is a high level of disdain for all forms of corruption in this culture. Puritan sections of England, Wales, the United States, Australia, New Zealand; Ireland; Central Europe; and English-speaking Canada (Collier, 2002).

Collier's work may have some condescending undertones but it has nonetheless been appreciated for highlighting the institutional nature of corruption (Pillay and

Dorasamy, 2010). Rudel and Xin (2004) assert that there are yet other equally important variables other than culture that influences the intensity of corruption in a nation. These include: national wealth, political legacies and population size (Rudel and Xin, 2004).

2.4.3 Decentralisation and corruption

Much work has been done to evaluate the relationship between corruption and decentralisation (Peixoto *et al.*, 2012). It has been suggested that the decentralisation of public service provision can enhance voter accountability and reduce corruption practices among bureaucrats and local politicians. It reduces the monopoly of central government and entrusts governance in the hands of leaders that are directly accountable to the voters (Aidt, 2003). Brennan and Buchanan (1980) report a negative correlation between decentralisation and corruption. According to these researchers, there is competition between decentralised districts to provide appropriate service delivery. This sets in place standards of service delivery, restricting impunity amongst local bureaucrats that would have diverted the revenue.

Bardhan and Mookherjee (2000) also suggest that improved service delivery that comes with decentralisation occurs because information asymmetry between the service providers and the population is reduced. However, at the same time the decentralised service delivery is prone to capture by the local elite. The success of decentralisation is therefore dependant on the trade-off between these two factors (Conning and Kevane, 2000). The conclusion of a theoretical evaluation of factors affecting the effectiveness of decentralisation by Bardhan and Mookherjee (2000) suggest that that local elite capture and therefore corruption is a likelihood where: i) local interest groups are highly cohesive; ii) local ignorance is high; and, iii) there are high levels of inequality.

Still, Careaga and Weingast (2000) note that the decentralisation of expenditure without the decentralisation of revenue generation and management makes controlling corruption futile. This occurs because the “*process of fiscal transfer leads to underestimation of the fiscal effort*” (Peixoto *et al.*, 2012, p. 1885). Fan, Lin and

Treisman (2009), used a large trans-national dataset to determine that there was an increased incidence of bribery where there was an increase in the tiers of governance at sub-national level. The researchers cite as an example the discrepant levels of bribery in Uganda with six tiers of sub national government as compared with Slovenia with only two tiers of sub national government. However, such a conclusion is open to argument given the marked variance in culture and GDP status.

It was significant also that a Brazilian study by Peixoto *et al.* (2012) using immaculately managed administrative and audit databases found no relationship between decentralisation and corruption regardless of whether they used administrative or fiscal measures for corruption.

Many studies using both subjective and objective indices for measuring corruption have come up with conflicting results regarding the relationship between corruption and political and fiscal decentralisation. An important factor for these discrepancies is the differences in political, economic and sociocultural contexts as is evident from Collier's (2002) behavioural perspective on corruption that I discussed earlier in section 2.4.2.

Health service provision in the decentralised setting is dependent on Good governance and sound *institutions*. These act as critical factors working hand in hand to ensure that the health system mobilizes and distributes resources, processes information, acts upon it, and motivates providers' appropriate behavior by individuals, health care workers, and administrators (Kaufmann, Kraay and Mastruzzi, 2006). Having in place democratic processes that promote accountability of office bearers and effectiveness of the citizen's voice are associated with greater incentives for these public servants to avoid corrupt practices. (Lewis, 2006). Rijckegham and Weder's (1997) "*shirking*" hypothesis explains the mechanisms behind Good governance and appropriate institutional change curbing corruption. From their hypothesis, it is notable that in curbing bribery increasing the wages of public servants is not a necessity. In low wage settings, corruption can be constrained by: i) minimising the contexts that promote bribery - for example, by

adopting fiscal decentralisation so as to reduce on central government monopoly and patronage; ii) strengthening local auditing and law enforcement capabilities that ensure high levels of detection and high penalties; and iii) harnessing social capital, as previously discussed, by raising the level of awareness of the citizens through, education and information sharing so that bribery is socially unacceptable (Rose-Ackerman, 1999; Kaufmann, Kraay and Mastruzzi, 2011).

2.4.4 Political patronage

Political patronage is a cross-cultural phenomenon that has been defined as an informal contractual relationship between persons of unequal status and power that imposes reciprocal obligations of a different kind on each of the parties. It is a continued, personalized relationship that often involves favour and protection being offered by a patron for loyalty by a client (Silverman, 1965).

Other terms like, “patrimonialism”, “clientelism”, “neopatrimonialism”, and “presidentialism”, are terms whose definitions focus on peculiar features of patronage, which itself is considered a principal mechanism regulating political and economic life in a number of African countries (Bratton and van de Walle, 1999).

Patrimonialism originally referred to the pre-modern forms of organisation where patrons and their clients, who might be political supporters or rivals constitute a system from which the rulers as patrons opt whom amongst the clients they will show favour in exchange for loyalty (Theobald, 1982). With reference to the modern day setting, Arriola (2009) recognises that such favour comes with access to perquisites that cannot be readily attained in a weak formal economy. According to Hyden (2008), the state is therefore “a venue” set under conditions of economic scarcity where political actors determine the allocation and consumption of vital resources. Other than the more traditional forms of patrimonialism associated with the third world, Theobald (1982) recognises patrimonialism in the industrialised societies, giving an example of the United States where family relationships and other personal linkages are important factors guiding political recruitment and elite cohesion.

On the other hand, Bratton and van de Walle (1999) describe Neo-patrimonialism as a hallmark of African regimes since independence. Considered a more modern form of patrimonialism, more informal forms of ruler-ship pervade formal institutions of governance that were constitutionally put in place. The distinction between public and private office is blurred as the chief executive uses his office to acquire wealth and status.

Clientelism is a definition that illuminates the personalised and reciprocal relationship between an inferior and a superior. In the political sense, the relationship may be less personal or affable but involves a reciprocal relationship between a set of actors who have unequal command over resources and become involved in mutually beneficial transactions that have political implications beyond their immediate sphere of influence (Lemarchand and Legg, 1972).

Political clientelism foments a vertical isolationist relationship between a ruler and privileged individuals. This defers from, and is antagonistic to all forms of collective action, which by harnessing social capital, drive towards more horizontal inclusive social movements. It is such social movements that counteract clientelism and have fomented political, economic and social change in many nations (Auyero, Lapegna and Poma, 2009).

Patronage can be considered as a spectrum of patron-client related acts that range from the benign to overtly corrupt forms (Tripp, 2001). The benign forms are cited to include patrons extending access to vital social services to their clients, by building schools, clinics, low interest loans or supporting rural voters to access licences that they would have otherwise failed to access (Tripp, 2001). The creation of new districts in rural underserved areas can also be perceived as a benign form of patronage (DENIVA, 2011). The more corrupt side of the spectrum includes examples that portray the unfair grabbing of scarce resources by the powerful. Another example is that of those in authority overlooking actions by their supporters like: bribery, kickbacks, blackmail or outright theft of government funds (Arriola, 2009).

It is stated that the adoption of structural adjustment programmes and aid conditionalities by International Financing Institutions in the 1980s and 1990s were attempts at controlling the wanton wastage and misappropriation of state resources by states that were engaged in patronage (Mwenda, 2005).

The new millennium however saw a reversal in that donor-recipient nation relationship. A number of donor-dependent nations, in particular, Mozambique, Tanzania, Uganda, Rwanda and Ghana, were being heralded for exhibiting rapid growth and had undertaken ground breaking pro-poor reform that the World Bank and other agencies were showcasing. It was at this time that the donors shifted to a new model of financing, also referred to as post-conditionality funding (Harrison, 2001). For these favoured states, many of them highly indebted, their debts were written off and the funding agencies became more embedded in the day-to-day workings of the economy. Mwenda (2005) asserts that these actions have legitimised the patronage systems in many of these countries, providing the patronage system with more resources to distribute to its clients and further excluding the poor and voiceless from having their basic needs addressed.

2.5 Maternal health and maternal health utilization

2.5.1 Introduction - maternal health and mortality

The World Health Organization defines maternal health as the health of women during pregnancy, childbirth and the post-partum period. Maternal health is addressed through the health care dimensions of family planning, preconception, prenatal, delivery or labour and postnatal care; they are provided in a bid to reduce maternal mortality and morbidity (WHO INT., 2015). In 2000, world leaders came together to adopt the United Nations Millennium Declaration committing their nations to work in a global partnership to reduce extreme poverty, through a series of targets by 2015 (United Nations, 2015). One of these goals is to improve maternal health; *maternal mortality* was chosen as the outcome with which to monitor progress towards this goal (Ronsmans and Graham, 2006; United Nations, 2015). Only 10 countries, achieved MDG 5 by 2015 (Kassebaum *et al.*, 2016).

In September 2015 the global community adopted a new set of 17 Sustainable Development Goals (SDGs) that provided benchmark targets for global development between 2015 and 2030 and built on the momentum generated by the MDGs (Kassebaum *et al.*, 2016). While MDG 5 set a target reduction of 75% in maternal mortality for the period 1990 to 2015, SDG 3 sets specific targets for all countries to lower maternal mortality by 70% by 2030. Unlike MDG 5, SDG 3 is a global target that requires every country to reduce its national mortality ratio by two thirds within the given timeframe (Boldosser-Boesch *et al.*, 2017).

In many countries maternal mortality is the leading cause of death in women of reproductive age (McCarthy and Maine, 1992). World Health Organization estimates indicate that in 2013, 289 000 maternal deaths occurred between the periods 2003 to 2009 representing a decline of 45% from 1990 (WHO *et al.*, 2014). Most of these maternal deaths occur in the developing world with the maternal deaths in Sub-Saharan Africa representing about 62% (179 000) of all global deaths related to childbirth (WHO *et al.*, 2014).

A 2014 systematic review on global causes of maternal death established that about 73% of all maternal deaths worldwide between 2003 and 2009 have been due to direct obstetric causes. Haemorrhage, hypertension and sepsis have contributed to more than half of the direct causes (Say *et al.*, 2014). Furthermore, up to 70% of indirect causes of maternal death have been a consequence of pre-existing medical conditions, with HIV related medical conditions being the major cause of death (Say *et al.*, 2014). Most of these deaths are preventable by interventions that are implementable at primary health care level and mainly involve improving women's access to: information, quality health care coupled with appropriate support from their families and communities (Adam *et al.*, 2005; Wang, 2013).

Maternal morbidity and mortality indices, more closely than any other national health index, reflect the functionality of a country's health system (Jamison, 2006). Just like other MDG goals that include poverty, gender relations and education, maternal mortality is a robust marker for wider developmental disparities at global, national and at sub national levels (Ronsmans and Graham, 2006; UNFPA, 2012b).

Other than being solely affected by health system or “supply-side” determinants, national maternal health statistics are also influenced by broader social, economic and geographical contexts. For example, conflict-affected countries carry the highest burden of maternal death (Kruk *et al.*, 2010). The highest maternal mortality ratio ever recorded is from a province in Afghanistan that has had a long history of armed conflict (Bartlett *et al.*, 2005). An analysis by Kruk *et al.* (2010) also shows that out of 14 sub Saharan countries with the highest maternal mortality ratios in Africa, 10(71%) had been in conflict during the period 1990 to 2005.

The importance of socio-economic contextual influences on maternal health outcomes is seen in the significantly worse maternal mortality among poorer or less affluent women as compared to those that are more privileged irrespective of level of national wealth (Ronsmans and Graham, 2006). Differences in antenatal and delivery service uptake by the rich and the poor is directly reflected in the disparities in maternal health outcomes (Kunst and Houweling, 2001). For instance by 2006, despite having higher gross national incomes per head and higher public health sector spending, Cote d’Ivoire and Yemen had higher maternal mortality rates than their poor counterparts Vietnam and Sri Lanka. This was attributed to steeper socio economic gradients, or in other words, the wider gaps between the rich and the poor with regard to uptake of maternal health care services in Cote d’Ivoire and Yemen (Ronsmans and Graham, 2006).

2.5.2 Maternal health care access and utilisation

It is understood that maternal health is dependent on women being able to *access* and *utilize* services in two key areas: i) family planning services that can reduce the frequency of maternal risk, and ii) prenatal and delivery services to reduce on pregnancy related health risks (Gertler *et al.*, 1993). According to Kiwanuka *et al.* (2008), *accessibility* is the degree to which an individual is facilitated or deterred from gaining entry to, and making use of the health care system, while *utilisation* describes the actual consumption of a service. Access may be: geographical – referring to for example number of facilities providing maternal health care services; financial – referring to, for example, pre payment schemes for services;

transportation access; social; and organisational (Peters *et al.*, 2008; Glick, 2009). Utilization is a more exact proxy measure for the gap between satisfied and unfulfilled maternal health care need (Culyer and Wagstaff, 1993; Glick, 2009). This was my rationale for opting to use utilisation as the measure of effectiveness of the maternal health care service delivery in Uganda.

2.5.3 Classifications of utilisation determinants

There are a number of epistemological classifications of factors that influence utilization of maternal health care services, many of these factors are relevant to maternal health care in the developing world (Kiwanuka *et al.*, 2008; Peters *et al.*, 2008; Matsuoka *et al.*, 2010; Béhague and Storeng, 2013). These include: the economics-based “demand and supply” classification (Ensor, 2004); a sociology based classification focusing on the roles of individual, family and community in determining utilization of maternal care services (Thaddeus and Maine, 1994; Kiwanuka *et al.*, 2008) ; and, more socio-political classifications by authors like Lule *et al.*(2005) and Moyer and Mustafa(2013). These three taxonomies are of direct relevance to this thesis because they all consider the individual, societal, health system and wider national level determinants. I will apply them to my discussion about the determinants of utilisation in the following sections.

2.5.4 The determinants of utilization

Demand side factors

Health-seeking characteristics – According to Thaddeus and Maine’s (1994) three delays model health care utilization is strongly influenced through the individual’s health seeking behaviour — itself a complex product of personal, family and community identities that are also in turn determined by a mix of social, personal, cultural and experiential factors (Mackian, 2003).

Anderson, cited by Chakraborty *et al.* (2003) proposes a model to explain the role of health seeking in utilization of maternal care services based on three sets of individual characteristics. They are: i) predisposing characteristics - that include age, marital status, education status, parity and health-related attitude; ii) enabling

characteristics – for example, income status, perceived health system effectiveness, availability of health care, passable roads; and iii) need characteristics – that is, the individual's perception of the severity of illness and the expected benefits of care.

According to the model, need which is recognized as a self-perceived health status is the most immediate driver for health care use (Fosu, 1994; Chakraborty, 2003). It follows therefore that a pregnant woman's perception of risk will be in consonance with that of her community or social grouping which will in turn influence her health-seeking behaviour (Mackian, 2003). Many cultures, for example, regard pregnancy as a normal event not requiring medical attention. Furthermore, some belief systems have it that a pregnancy related abnormality suggests infidelity, acting as a strong deterrent for many pregnant women that would have otherwise sought care (Thaddeus and Maine, 1994).

Maternal age – A study by Stephenson et al (2006) shows that in Kenya women of ages 30 to 39 and 40 to 49 years are more likely to deliver in health facilities than women 20 to 29 years of age. It is notable however that the same study found that the difference was insignificant for women that had delivered in a health facility before. Age may be associated with marital status, “*wantedness*” of a pregnancy, socio-economic status and decision-making power (Magadi, Agwanda and Obare, 2007).

Parity – the first and lower order births are more associated with facility based delivery than higher order births (Gabrysch and Campbell, 2009). This may be explained by high parity being a reflection of low socio economic status, strong adherence to traditional attitudes, or bad previous experiences with the health system which in turn act as deterrents to health facility delivery (Stephenson and Tsui, 2002).

Marital status – The association between utilization of health facility services and marital status may go in either direction and appears to be context specific, according to a number of studies (Gabrysch and Campbell, 2009). A Zambian study that looked at maternal characteristics related to institutional deliveries in a rural

district found that unmarried women are more likely than their married counterparts to deliver in a health facility (Stekelenburg *et al.*, 2004). This is taken to signify higher levels of financial and decision autonomy in the unmarried women. Again a study across six African countries by Stephenson *et al.* (2006) showed that in two of the countries (Ivory Coast and Kenya) monogamous women were more likely to seek care. However, three of the countries (Tanzania, Ghana and Burkina Faso) showed no association, and Malawi had more women in polygamous relationships and divorced women delivering in health facilities. An argument that is maintained by many authors is that modifiers like age, socio-economic status, and culture might be behind such divergent outcomes. Thus a non-marital status in some cases might imply youthful age and residence with natal family portending therefore hospital delivery (Gabrysch and Campbell, 2009). Counter arguments suggest that the married status implies a better social and economic standing and therefore greater access to facility based care (Stephenson *et al.*, 2006)

Attendance of Antenatal Care Clinic – a systematic review by Moyer and Mustapha(2013) found that out of 13 studies, 11 using household survey data, establish a positive association between antenatal care use and facility based delivery. Other studies also show that earlier and more frequent antenatal care attendance is linked to a stronger likelihood of facility-based delivery (Spangler and Bloom, 2010; Akazili *et al.*, 2011). The quality of antenatal care has been shown to be a strong predictor for facility-based care as well (Adanu, 2010). Two qualitative studies showed that poor quality of counselling services at antenatal clinics as well as “normalcy” of a pregnancy as pronounced during antenatal care led to less facility-based delivery utilization (Amooti-Kaguna and Nuwaha, 2000; Magoma *et al.*, 2010).

Socio-economic status – this is one of the important determinants for use of maternal health care services (Defo, 1997; Gwatkin *et al.*, 2000). A conceptual framework by De Brouwere and Van Lerberghe (2001) depicts the complex pathways through which a woman’s socio economic status influences utilization of health care services (see figure 2.4 below). The framework indicates that socio

economic status is a product of material and other non-material resources that are unevenly distributed within each population group. Resources like income, education or physical assets position individuals along a social ladder or social position laying the basis for inequality.

The conceptual framework shows how age or place of residence influence health care utilization by acting as confounders (De Brouwere and Van Lerberghe, 2001). As the arrows denote, some of the factors perceived as confounders are influential enough to act independent of socio economic factors.

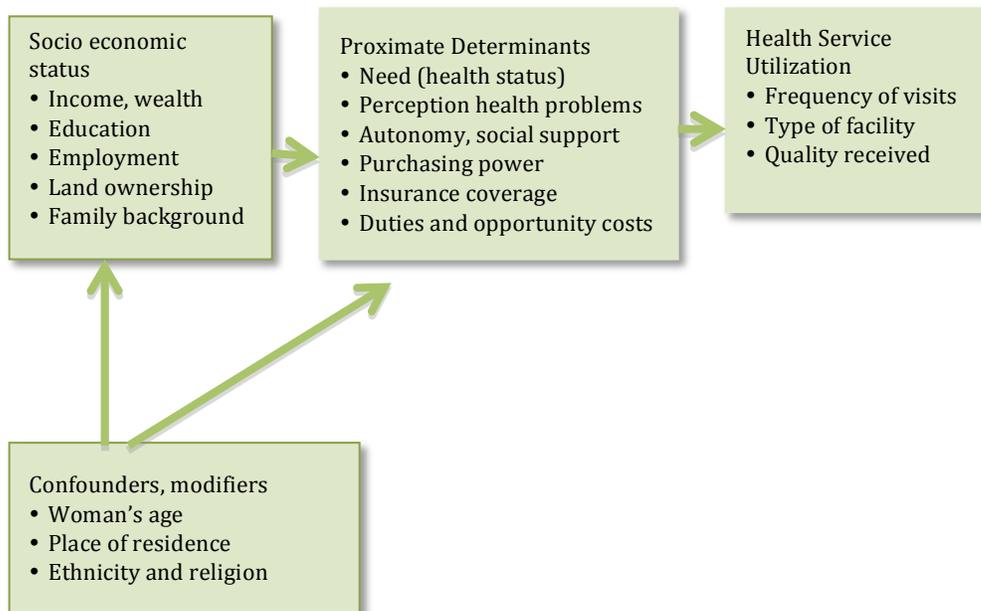


Figure 2.4: Socio-economic inequalities and maternal health care utilization

As an example, a study in Turkey found that geographical factors such as region and urban versus rural residence, as well as ethnicity and age are important factors influencing the utilization of maternal health care services (Celik and Hotchkiss, 2000). In concurrence, a study conducted in Cameroon suggests a high maternal mortality burden coupled with low utilization of health care services lies with women that are economically disadvantaged and of low social status in society (Defo, 1997).

A number of studies show that income and wealth are probably the most important determinants amongst all the socioeconomic factors and show independent

influence even after controlling for other factors in a multivariate analysis (Defo, 1997). To enable greater understanding of this relationship Macro International and the World Bank in 2000 applies an analytical approach that makes possible the study of the relationship between socio economic status and; i) health and nutrition status, and ii) burden of disease and, iii) service access (Gwatkin *et al.*, 2000). The analysis makes use of data collected from a series of demographic health surveys under the Macro International DHS program. In the World Bank and Macro International approach, women in a given population are classified into five quintile groups according to household wealth. This makes possible the examination of the patterns of wealth distribution within the surveyed population. Household wealth in this case is determined by an asset index that is based on the *principle component analysis* method that uses various household asset variables to determine wealth (Gwatkin *et al.*, 2000). In Chapter three, Section 3.2.4, as part of profiling Uganda, I review maternal health care utilisation by the socio economic status of post-conflict Northern and non-conflict East Central Uganda.

Education – together with literacy and knowledge are important human assets for the woman as well as the rest of the household (Gwatkin *et al.*, 2000). The asset enables members of the household to acquire knowledge about their health and about health related opportunities available. The systematic review by Moyer and Mustafa (2013) established consistent evidence of maternal education being associated with greater access to facility based delivery and skilled birth attendance. In addition, women with better educated husbands are more likely to utilize facility-based delivery services (Moyer and Mustafa, 2013). A descriptive study in Turkey reports that education attainment and lower parity is associated with preference for modern medical home delivery methods as opposed to traditional options (Celik and Hotchkiss, 2000). A study in Punjabi India suggested that education enhanced the confidence of women and improved their maternal skills, in turn increasing their exposure to information as well as their response to it (Gupta, 1990).

Community factors

Culture - Claeson, Griffin, and Johnston (2001) with focus on sub Saharan Africa state that poor communities are often traditional as well, and therefore have norms and cultural beliefs that deprive women of education, assets, and autonomy to make decisions. In such settings, the gender norms infiltrate the household dynamics and often impede the capacity of women to seek reproductive health care services (Claeson, Griffin and Johnston, 2001). The predicament is made worse by men, who as the decision-makers on whether and when to seek care, lack an understanding about the potential risks associated with pregnancy and delivery (Tolhurst, Raven and Theobald, 2009).

Still related to culture are gender norms that promote the notion of a female child as both a burden as well as an asset. Girls in these contexts are often given-away in youth for a bride price, this often dictating that a girl enters into a marriage on unequal footing and with a set power relationship favouring the men. The pattern of who makes the decisions about child birth is often set (School of Women and Gender Studies, 2013).

Furthermore, in many cultures the preference of male infants influences a woman's fertility choices and indirectly deters her from the use of medical delivery care given that access might be associated with prohibitive costs and disapproving attitudes of the health providers (Chakraborty, 2003). In other societies women have been driven into the practice of sex-selective abortions that, in itself, puts the health of a woman at risk (Ganatra, Hirve and Rao, 2001; Junhong, 2001).

In some settings, growing female children and women are prohibited from eating nutritious foods that are essential for their development and preparation for parturition (Tolhurst, Raven and Theobald, 2009). Important consequences of this under-nutrition include iron deficiency anaemia and stunting that have a profound effect on the delivery outcomes.

Another study in Mali established that women in similar rural settings and of similar social economic status still had variations in the utilization of facility-based services

, which were dependent on the health seeking “culture” of different sub localities or neighbourhoods. According to these researchers, it mattered who a pregnant woman’s neighbours were this influenced her decisions to opt for facility based delivery (Gage, 2007).

Community Institutions – Community associations like women’s self-help groups and village health teams are vital in influencing good health seeking behaviour by women (Lule *et al.*, 2005). The community associations can also positively influence health service provision, according to Claeson, Griffin and Johnston (2001). They argue that the community groups can mobilise resources for better health. See also discussions on social capital and community participation in health in Section 2.3.4.

Supply side (health system) factors

A country’s health system is under obligation to ensure that women have access to comprehensive health care that improves their overall health and mortality outcomes as envisaged by the MDGs (Lule *et al.*, 2005). However a number of challenges have persisted over the years that have contributed to limited utilisation of health care by especially the poor and underprivileged (Gwatkin, Bhuiya and Victora, 2004). The factors contributing to this inappropriate access can be categorized for the sake of systematically discussing them into four distinct areas namely: quality of care, accessibility, availability and affordability (Lule *et al.*, 2005).

Quality of Care - According to Srivastava et al (2014), quality is by far the most important supply-side influence on maternal health outcomes, affecting the decision to seek care, the time taken to reach appropriate care and the ultimate outcome of care. However according to Hulton, Matthews and Stones (2000), the degree of influence of quality of care on health care utilization is related to the wealth status of a country. In the developed world the association between quality of care and health care utilization is weak. In a few instances where there is an association between the quality of care and health care utilisation the levels of convenience and comfort of care are the main issues of concern to the client (Bago d’Uva, Jones and van Doorslaer, 2009; Quast, 2015) On the other hand, in the developing world at any given income level, the responsiveness, availability and

appropriateness and the competence of the health workers are important quality of care parameters that clients consider (Uzochukwu, Onwujekwe and Akpala, 2004).

A study in Sri Lanka by Akin and Hutchinson (1999) looked at reasons why both rich and poor patients by-pass free or heavily subsidized health facilities in search of care in private more expensive facilities. They discovered that poor and more severely ill patients are more likely than the rich patients to opt for health facilities irrespective of cost, provided that there is a perception or knowledge of more doctors, better services and treatments available in the preferred facility. Similarly a qualitative study conducted in Orissa India, one of the poorest and least developed areas of that country found that perceived quality of care is more important than cost or distance when patients need care (Ager and Pepper, 2005). This finding concurs with that of the systematic review by Moyer and Mustafa(2013) that suggests that perceived quality of care, health provider attitudes, behaviour and cost are the main facility related factors that influence utilization of facility based deliveries. Again, a study in Senegal reported that women that initially delivered in a health facility but in subsequent pregnancies delivered at home stated poor quality of delivery services or delivery by a male provider as the main factors behind their change of delivery option (FAYE, NIANE and BA, 2011).

It is important to note that client satisfaction is of particular relevance(Hulton, Matthews and Stones, 2000; Uzochukwu, Onwujekwe and Akpala, 2004). The final decision against or for an obstetric referral depends on the perceived quality of care, the perceived severity of the condition, which in turn may be influenced by the woman and her household's cultural beliefs, understanding, and levels of education (Dar Iang, 2000). As De Brouwere and Van Lerberghe (2001) state, hospital based care is often avoided because of poor interpersonal skills and attitudes of the health workers, rural women particularly being subjected to stigmatization and discrimination. Overall health-related quality of care can be conjectured to be a consequence of health-related processes taking place at three measurable levels: policy level; service delivery level; and, client or outcome level (Uzochukwu, Onwujekwe and Akpala, 2004).

Accessibility – Here I make specific reference to geographical accessibility; distinct from the accessibility definition by Peters et al (2008) that defines it as, “*the timely use of service according to need*” and encompasses affordability, availability and acceptability that I discuss individually in the following sections. Geographical coverage of health facilities usually reported as the distance or time required to reach a health facility is an important determinant for utilization (Lule *et al.*, 2005). Thaddeus and Maine (1994) state, with reference to the *Three Delays* model, that a “Phase II” delay almost entirely has to do with accessibility which might imply difficulties in reaching a health facility on the premise of distance, terrain or transport availability.

A study in the Netherlands by Ravelli et al (2011) shows that accessibility to maternal health care services is still a pertinent challenge in the developed world. In that study, accessibility is measured as travel time using a geographical information system package that takes the transit network into account. The authors explain that travel time is a preferred measure because the same travel distance might require different travel times given the complexities of the Dutch road network system (Ravelli *et al.*, 2011). The researchers found a positive relationship between travel time when more than 20 minutes long and total mortality (OR 1.27, 95% CI 1.17–1.38) (Ravelli *et al.*, 2011). An example of similar challenges are seen in a middle income country Brazil where in urban Rio de Janeiro, a geographical information system package was also used to determine home-to-health facility distance for women that required emergency obstetric care. The study established that the travel distance measured through the transit networks is an important risk factor for death in the studied population [death odds ratio for women who travelled 5–10 km - 3.84 [95 % CI (1.96–7.55)] (Simões and Almeida, 2014).

In sub Saharan Africa’s poor nations, the impact of poor access is even more profound as exemplified by interviews with women in a Kenyan study by Voorhoeve (1984) revealing that a number of them were intent on delivering in a hospital. This group of women had received prenatal care and, along with their relatives, understood the risks associated with traditional delivery methods. Only 36% of

them actually delivered in a health facility. The 64% that delivered at home expressed inability to access the health facility in time because they had to walk or wait for a passing lorry. Similarly, a study conducted in Tanzania established that maternal deaths were higher among women that resided at a distance greater than 10 km from a main highway, post partum haemorrhage being the most common cause of death (MacLeod and Rhode, 1998).

These studies suggest that more vulnerable women face greater challenges in accessing care (Rahman *et al.*, 2008). A study by Chowdhury *et al.*, (2006) suggests that even after excluding geographical barriers by providing skilled home-based delivery services, maternal health care services are still less utilised by women of poorer socioeconomic status.

Availability - even when a health facility is geographically accessible, other factors may be of influence, for example, essential inputs like drugs, vaccines, contraceptives, delivery supplies and sundries might be in short supply hampering actual utilization of facility delivery services (Claeson, Griffin and Johnston, 2001). Lule *et al.* (2005) state that in the developing world, it is often public services serving poor or remote communities that lack skilled health workers who can provide necessary intrapartum care and emergency obstetric care when required.

A set of interventions, also called *signal functions*, need to be available and functional in a health facility if it is going to directly treat the obstetric complications that cause up to 80% of maternal deaths (Bailey *et al.*, 2006). These eight interventions (or signal functions) together constitute what is called emergency obstetric care (EmOC). The signal functions when put together as a strategy significantly avert maternal death by managing most of the obstetric emergencies that occur in hospitals and health facilities in resource poor settings (Maine *et al.*, 1997; WHO, UNFPA and UNICEF, 2009).

The eight EmOC signal functions are: 1) Parenteral antibiotics; 2) Parenteral oxytocic drugs; 3) Parenteral anticonvulsants for pregnancy-induced hypertension; 4) Manual removal of placenta; 5) Removal of retained products; (e.g., vacuum

aspiration); 6) Assisted vaginal delivery (e.g., vacuum extraction, forceps); 7) Caesarean delivery; and 8) Blood transfusion services (WHO, UNFPA and UNICEF, 2009). If a health facility performs the first six functions routinely it qualifies as a basic EmOC facility and if a health facility performs all the eight functions routinely it qualifies as a comprehensive EmOC facility (McCarthy, 2010). WHO, UNICEF, and UNFPA(2009) recommend that for every 500,000 people, there should be at least one comprehensive and four basic EmOC facilities with 15% of all births taking place in the EmOC facilities (WHO, UNFPA and UNICEF, 2009).

A global assessment of EmOC capacity in 24 national health systems found that all of them apart from the United States and Benin had an inadequate number of basic EmOC-ready health facilities relative to the proportion of their rural based populations (Paxton *et al.*, 2006). Despite the study showing an adequacy of EmOC sites in Benin, other researchers report about the grave staffing shortages and serious quality of care issues in that country that are affecting the actual utilization of facility based care (AMDD, 2004). Paxton et al (2006) argue that inadequate basic EmOC coverage across the globe goes to reflect the priority of most governments, preferring to invest in comprehensive EmOC and therefore in larger and often urban based hospitals as opposed to primary health care level health facilities. Community based basic EmOC health facilities are often incapacitated due to irregular maintenance and supply of equipment, inadequate medicines and understaffing of health workers (Paxton *et al.*, 2006).

Affordability - Health care costs in low and middle-income countries are a prominent cause of impoverishments to the population (Jacobs *et al.*, 2012). The degree of protection of a population from the risk of financial catastrophe whenever faced with ill health is dictated by the health system's financing arrangements (Roemer, 1993). In much of the LMICs, *entrepreneurial* or out-of-pocket oriented health systems are commonplace (Roemer, 1993). They are characterized by a pluralistic structure with both private and public sources of care sharing the health market place, often sharing the human resources (Mcpake, Blaauw and Sheaff, 2006). On average about 50% of total health financing in low-income countries

comes from out-of-pocket payments as compared with 30% in middle-income countries and about 14% in the high-income countries (Mills, 2014). In LMICs, families that are already too poor to meet the cost requirements for a normal medical delivery will face financial catastrophic consequences in the event of the obstetric complications (Lule *et al.*, 2005).

Other national health systems protect their citizens from financial catastrophe by comprehensive funding for health. For example, out-of-pocket spending represents less than 20% of total health expenditure in Canada, Denmark, Germany and the UK (Savedoff and Carrin, 2003). The UK and former socialist states like Cuba promote equal access to care for all their population by financing health care through general revenues (Lule *et al.*, 2005). Canada, Germany and Japan have achieved the same goal by providing comprehensive insurance coverage for all their citizens ((Hsiao, 1992)). These measures have supported the reduction of maternal mortality to a minimum. Cuba is an example of a developing country that has reduced maternal mortality to less than 30 per 1000 live births by ensuring 100% institutional delivery rates (Lule *et al.*, 2005).

The entrepreneurial type of health system, that are commonplace in the LMICs, have been undergoing a series of health financing reforms over the past two decades, heavily influenced by the donor countries and aid agencies (Okunzi and Macrae, 1995). An important reform sponsored by the World Bank and the IMF, in the mid 1980's and 1990's, introduced Structural Adjustment Programmes that included the scrapping of government subsidies and the introduction of user fees. The earnings from the user fees were used for financing recurrent expenditure (Bennett and Gilson, 2001). However, there was evidence the introduction of user fees negatively influenced, amongst others, the utilisation of maternal health care services (Hotchkiss *et al.*, 2005; McIntyre *et al.*, 2006). It also caused a negative impact on household incomes in poor countries with many being pushed further into poverty (McIntyre *et al.*, 2006). While Ridde and Morestin (2011) observe that the user fee policy has largely been abandoned by several countries, another study by Witter (2010) indicates that only six (mainly post conflict) out of fifty 50 health systems in

Africa and Asia have no form of user fees in the public sector. It is notable that a common feature among these six nations is that they were recently post conflict. Many LMICs are attempting to address the challenges associated with out-of-pocket payment by exempting vulnerable groups and those requiring infectious disease management from user fee payments (Witter, 2010). Some countries are adopting prepayment health care schemes as a means of financing health care (McIntyre *et al.*, 2006).

According to Thaddeus and Maine (1994) in the developing world cost for care includes transport costs, the costs for medicines and supplies, official and unofficial provider fees as well as opportunity costs of travel time and waiting time away from productive activities. Costs rise further because a pregnant woman often has to travel with one or more members of her household, multiplying costs in terms of lost production time and upkeep (Thaddeus and Maine, 1994). There are other hidden costs that include, the purchase of surgical gloves, syringes and out of stock drugs (Nahar and Costello, 1998). The above findings still closely resonate with the conclusions of a recent synthesis of qualitative evidence for factors influencing facility-based delivery in low and middle income countries conducted by Bohren *et al* (2014).

2.6 Conclusion

This chapter brought together research evidence on key issues of concern to this study. The State fragility concept and its impact on the post-conflict health system have been defined. A converse causal relationship has also been highlighted elucidating the effect of a weak health system on the stability of the state. This chapter also portrays governance as a decision-making and implementation process undertaken by various stakeholders at different levels of government, the health system being one of those levels. Decentralization is often a feature of political governance; it offers the community an opportunity to participate in the planning and implementation of their health care. The mode of decentralization has a strong influence on the nature of health service delivery. Corruption and weak

accountability are one of the manifestations of ineffective governance, with adverse consequences on health care. Maternal health remains an important indicator of the effectiveness of the health system. The access and utilization of maternal health care are affected by both supply-side and demand-side factors. There is an apparent gap in research literature linking governance of the health system to the capacity of the health system to provide appropriate maternal health care in the fragile state and more still in environments disrupted by conflict. This study provides evidence on the relationship between these factors.

3 UGANDA: A POLITICAL ECONOMICAL HISTORY

This chapter profiles Uganda's more recent history focusing on political, economic, and social factors and their relationship with maternal health care governance in post conflict Northern Uganda and the rest of the country.

The chapter is organised along the structure of political economy frameworks as described by Daniel Harris (2013). The PEA framework by Harris lays prominence on recognising issue-specific contextual, institutional and agency related governance phenomena. The introductory chapter, chapter one, discussed the contextual issues of concern to this study. This chapter focuses on the institutional concerns and commences with section 3.1 that looks at the advent of National Resistance Movement government. It also focuses on the formal and informal institutions that fomented the Northern Ugandan conflict and other events that have had an influence on health system governance and maternal health care. Section 3.2 is an appraisal of Uganda's maternal health care service delivery and its utilisation as well as important regional maternal health demographic statistics for Northern and East Central. Section 3.3 reflects on the Governments actual policy prioritisation by reviewing the health financing arrangements. The content of key policy documents mentioned in this section are examined further in the policy analysis conducted in Chapter five.

The chapter is based on peer reviewed and grey literature from the realms of political science, sociology, and economics. The literature search here follows the approach used in Chapter two with some additional search terms including "Buganda, Acholi, Lango, Busoga, Idi Amin, Milton Obote, Yoweri Museveni, National Resistance Movement, Lord's Resistance Army, Alice Lakwena, National Health Accounts, Maternal Health care,". The search considered research work conducted from 1990 to date. However there were a number of articles that written in the 1970's and 1980's were identified through a snowballing process and found very relevant to the review in this chapter.

3.1 The era of national resistance movement governance

This section focuses on the period 1986 till 2011. This was when Uganda underwent governance and policy reform during the reign of the National Resistance Movement (NRM) headed by Yoweri Kaguta Museveni. This is the period of direct relevance to the conflict in Northern Uganda and in turn, maternal health care in that region and Uganda at large. The section in line with the Political Economy Analysis framework considers both formal institutions – the “rules and regulations” of governance set by the NRM government, as well as informal institutions - the “norms and traditions” that are at play. The discussion draws attention to the governance processes influencing health policy-making and implementation during that era.

3.1.1 The beginnings of the NRM government

The National Resistance Movement (NRM) of Yoweri Museveni came into power after a protracted guerrilla war against the regimes of Apollo Milton Obote and General Tito Lutwa (see Chapter One, Section,1.2). The NRM inherited the governance of a country that was riddled with complex political, economic and social relationships which each regime assuming power made worse (Kasfir, 1998). Though initially perceived by Northerners as a popular revolt by Southern Ugandans against them, various reconciliatory overtures by Yoweri Museveni gradually won him support from the North as well as other parts of the country (Dicklitch, 2002).

According to Odonga-Ori 1998, cited in Okuonzi (2009) and Kasfir (1998) the NRM guerrilla movement represented a multi-ideological alliance of freedom fighters who considered political parties as a perpetuator of “sectarianism” and instability in Uganda’s historically fragmented society. This warranted the establishment of a no – party or “movement” political system that advocated for: grass root elections on personal merit, rather than by political affiliation, for all office bearers (Okuonzi, 2009). The no – party approach (or Movement) to national governance continued until 2006 when the first multi party election was conducted as a consequence of incessant donor and internal political pressure (Carbone, 2003).

3.1.2 *Constitutional provisions and its consequences*

The Uganda 1995 Constitution

Formal Institutions: As a basis for unifying Uganda’s “social and political forces”, the NRM right from its formative years in government strove to implement its Ten Point Programme, a political manifesto conceived by NRMs guerrilla leaders while still in the bush (NRM, 2000). The implementation was initiated by the setting up of a 21-member consultative review committee that assessed Uganda’s 1962 Independence Constitution. Through a highly consultative process the committee also incorporated into its own analysis representative views of Ugandans of all persuasions including those from the political opposition (Watson, 1994; Kasfir, 1998). The review process paved the way for the national elections of a 280-member constituent assembly in 1994 that would work to create the 1995 Uganda Constitution. The promulgation of the new constitution itself was followed by presidential and parliamentary elections in 1996 and again in 2001 using the “no-party”- personal merit formula (Watson, 1994; Carbone, 2003; Moncrieffe, 2004).

Informal Institutions: Since independence, Uganda’s constitution of 1962 has been re-written in 1966, 1967, and 1995. The current 1995 constitution, alone, has since had six major amendments, which Ogwang (2012) says is an indicator that even after the 1986 NRM revolution, the culture of bending the supreme law of the land by the incumbent government in a bid to consolidate longevity in power still endures². Nevertheless, one key amendment was a consequence of international and local pressure, and that was: the restoration of multi-party democracy (Golooba-Mutebi, 2004). This followed a national referendum that voted for the restoration of the multiparty political system. Carbone(2003), suggests that it was bound to happen: the NRM government that was supposed to be an all-inclusive umbrella arrangement was already informally playing party politics. This was evident in the politicking that characterised the no-party elections held in 1996 and 2001.

² In an article written in Uganda’s state owned newspaper Ogwang (2012), decries the fact that since independence Uganda has had four constitutions written, making comparison with the United States that has had to make only 27 amendments in the same constitution that nation has had over its 200 year history.

The executive and legislature

Formal Institutions. According to the Uganda's 1995 Constitution, the President is Head of State, Head of Government, and Commander-in-Chief of the Uganda People's Defence Forces (UPDF)³, and was to hold this office for a maximum of two five-year terms (Government of Uganda, 1995). The constitution also provides for a unicameral parliamentary system, operating independent of the executive and composed of Members of Parliament directly elected into office by their respective constituencies. This included one woman representative from each constituency, as well as representatives from the army, youth, workers and persons with disabilities (Government of Uganda, 1995). The parliament was to: pass laws on "good governance" and ensure government accountability in expenditure and policy management; debate topical issues; and, monitor government appointments. The parliament was to also work through committees that included those for Public Accounts, Budget, Local Government Accounts health and social welfare that would play a monitoring role (Government of Uganda, 1995).

Informal Institutions. The relationship between the executive and the legislature, as observed by Kasfir and Twebaze (2005) has to be understood in the context of Uganda's political history and the choice between the desire for democracy and the importance of building an alliance to entrench rule. While Uganda's 6th parliament⁴, the first parliament under the NRM government, was widely credited as having been the most effective parliament in Uganda's political history, subsequent parliaments were considered more subdued and eager to respond to the Chief Executive's beck and call (Hickey, 2003; Piron and Norton, 2004). Functioning under the no-party movement dispensation was advantageous for the 6th parliament; there was no obvious demand for "party discipline". This made it easy for the Members of Parliament to resist disagreeable demands made by the President. Both movement and "old" party leaning Members of Parliament created issue-based non-partisan

⁴ The 6th and 7th parliaments were constituted after the general elections held in 1996 and 2001 under the no-party system. The 8th and 9th parliaments were constituted after general elections under the multi-party dispensation.

coalitions that recorded ground breaking political successes (Piron and Norton, 2004).

One incident of note was the successful censure of two cabinet ministers, that forced the President to remove them from office (Moncrieffe, 2004). Another incident involved the passing of the Budget act by a majority parliamentary vote despite strong contestation by the President. The bill provided for the mandatory scrutiny of government budgets by an appropriate committee of parliament before its sanction (Carbone, 2003). The coalitions later developed into institutionalised caucuses that had a more permanent membership (Kibandama, 2005). Through these caucuses, the Members of Parliament from Northern Uganda were able to mobilise other Members of Parliament to force the President to declare Northern Uganda a disaster area after 20 years of war, the consequence of which was the attraction of greater international support for both the region's humanitarian needs and conflict resolution efforts (Carlson, 2004; Kasfir and Twebaze, 2005).

The legislative successes of the 6th parliament are said to have disconcerted the President and measures were taken to curb the legislative independence that the no-party parliamentary system was fomenting (Tripp, 2010). According to Carbone (2003), such measures included "*over-zealous, illegal interventions*" by the Movement secretariat to sponsor favoured candidates against the trouble makers in subsequent parliamentary elections. Through this process, in the 2001 General elections the parliament was purged of errant movement-leaning MPs; only about 43 per cent of them made it back to parliament (Kasfir and Twebaze, 2005).

Once the new parliament resumed business, a Parliamentary Movement Caucus was formed that became a mechanism through which the President could monitor the voting patterns of the movement-leaning MPs. This was considered a shift towards party-style politics during the no-party era (Piron and Norton, 2004). Notable bills that were easily passed during this new dispensation included: an amendment lifting presidential term limits and allowing the incumbent president to stand for re-election more than once (Moncrieffe, 2004). It also included an amendment

removing the secret ballot voting method for parliamentary business (Kibandama, 2005).

The political system

Formal Institutions: NRM's no-party system was provided for by the 1995 Constitution (Moncrieffe, 2004). The system was considered different from a one party system, multi-party system or any other in existence (Dicklitch, 2002). Its proponents articulated it as a broad based, inclusive and non-partisan political system where anyone could stand for elections based on personal merit and independent of party affiliation (Okuonzi, 2009). The 1997 Movement Act specifies the Movement's structure, functions and provisions for financing. The Act also stipulates that the National Executive Committee, Secretariat, and District through to Village Committees are answerable to the National Conference, which convenes biannually. The Chair of the Movement (who is also the President of Uganda) is the Head of the Movement, Chairperson of the National Conference and of the National Executive. He presides over the election of the Vice-Chair and nominates candidates for the National Political Commissar. At district level the Movement structure is made up of a five-tiered interlocking format of political administrators from village level, to parish, sub county, county, and district levels (Watson, 1994; Golooba-Mutebi, 2004).

Informal institutions: According to Golooba-Mutebi (Golooba-Mutebi, 2004) the village level council leaders gained popularity countrywide because: i) they were quickly at the centre of the populations livelihood as custodians and distributors of essential commodities that remained in short supply for a while after the NRM came into power; ii) they provided protection and acted as arbitrators for community level issues before the police were called upon; and, iii) they acted as valuable intermediaries between higher authorities in government and the local community, providing feedback on community concerns about the quality of health care .

Kanyinga, Kiondo, and Tidemand (1994) also state that the judicial role that the local councillors played extended to protecting the population from the police force and formal justice system that was considered corrupt and intimidating.

The influence, popularity and perks that came with the office of the local councillor at village level became highly coveted and contested for throughout the 1980's and 1990's. According to Berkley 1991, cited in Golooba-Mutebi (2004) the position was soon perceived as a source of self-enrichment and fell prey to vote buying practices. Local elite capture quickly crippled the local council chairperson's primary purpose of affording self-governance to the community. Golooba-Mutebi's (2004) notes that the more powerful and enlightened began to dominate proceedings of local council meetings. Similarly, a village census conducted by the Ministry of Finance and Economic Planning and Development found that women, and the poor were less represented by their leaders as compared to those considered rich in the community (Piron and Norton, 2004).

3.1.3 Economic policy reforms

Formal institutions: The Ugandan government's economic reforms were undertaken in three activity areas: macroeconomic activities; revenue management; and, public expenditure management (Kuteesa *et al.*, 2009). Whitworth and Williamson (2009) further classify the development and implementation of the economic reform policies into four phases:

- i) **1986 to 1990** – the pre-reform period when the new NRM government was still debating whether to opt for state controlled economic development or liberalization;
- ii) **1990 to 1995** – commencement of economic reform, sponsored by the World Bank and IMF and spearheaded by the merged Ministries of Finance, Planning and Economic Development (MFPED) that led to the subsequent achievement of macroeconomic stability;
- iii) **1995 to 2002** – continuation of reforms following promulgation of the new constitution. The most important fiscal reforms being the Poverty Eradication Action Plan (PEAP), the Medium Term Expenditure Framework (MTEF), the budget formulation process, and decentralization;
- iv) **2002 onwards** - the period of consolidation and adjusting to political and donor related changes. During this period there was less emphasis on poverty

eradication, and more on economic growth with government playing an interventionist role.

The poverty eradication action plan

In line with the Ten-point programme, poverty alleviation was the major political project pursued by the NRM government in its drive towards state building and national unity (Piron and Norton, 2004). The Poverty Eradication Action Plan (PEAP) that was formulated in 1997 was, as Piron and Norton (2004) put it, Uganda's home-grown poverty reduction strategy that could collocate national development priorities and international donor funding strategies. Uganda's effort did not only substantially contribute to the design of Poverty Reduction Strategy Papers for other low-income countries globally, but it made the country the first beneficiary of Highly Indebted Poor Countries (HIPC) debt relief and saw a shift from project aid to budget support (Reinikka and Mackinnon, 2000). Harrison (Harrison, 2001) refers to this as Post-conditionality donor funding which is reflected in this study's research findings as discussed in Chapter 7, Sec. 7.1.6

Uganda's government through MFPED used the PEAP to initiate reforms in policies and strategies that, at least in the eyes of international stakeholders, steered the impressive economic growth experienced over a number of years (Piron and Norton, 2004).

Whitworth and Williamson (2009), state that the introduction of Universal Primary Education from 1997/1998 was the centrepiece of PEAP. A countrywide evaluation of the UPE programme indicated that the index enrolment in primary schools doubled from 2.6 million to 5.2 million between 1997 and 1998, and tripled in ten years to 8.3 million in 2009 (UBOS, 2009). In addition, the UPE programme had achieved a 50% enrolment for both boys and girls, which has been commended as achieving 90% of MDG-2. However, over the last decade the programme has been plagued with a high primary-level school drop out rate of 68%⁵ (Mwesigwa, 2015). These dismal statistics reflect the scheme being challenged by gender related biases,

⁵ Chad has the highest primary school drop out rate in Africa at 72%. Uganda's neighbour Kenya has a dropout rate of 16% (Mwesigwa, 2015).

child labour, early marriages, less motivated teachers, and lack of awareness among parents, nevertheless the most important predicament is widespread poverty that deters parents from buying scholastic requirements that the government does not provide (ODI, 2006; Mwesigwa, 2015).

While the PEAP is praised for successfully reallocating resources towards pro-poor priorities it has faced the persistent challenge of poor local participation and inadequate state responsiveness (Piron and Norton, 2004). Local government officials are reported to avoid implementing PEAP programmes that, due to weak technical support and inadequate funding, exhibit poor outcomes and expose these local officials to the public wrath. The bureaucratic processes associated with the Uganda's PEAP system and related instruments like the Poverty Alleviation Fund (PAF) are said to be diverting the priorities of decentralised local governments from responding to the needs of their constituencies to ensuring accountability to central government (Craig and Porter, 2003). Piron and Norton (2004) conclude that this situation precludes any incentive for elected officials to represent the interests of their poor constituents and instead perpetuates buying votes from the disenfranchised electorate.

Medium term expenditure framework

Uganda was again one of the first amongst developing states to introduce a medium term expenditure framework, a tool that was to help budget planners to improve the allocative efficiency of scarce budget funds while maintaining macroeconomic stability. At sector level for example, this meant that budget planners were required to identify their priorities, and draw up a rolling three year expenditure plan detailing how these priorities would be delivered (Kuteesa *et al.*, 2009). The MTEF helped counter the problem that the country's annual budgets had been based on incremental changes; it made possible the re-alignment of public expenditure with the political priorities set out in the PEAP (Brownbridge, Federico and Kuteesa, 2009)

The MTEF proved to be an effective macroeconomic stabilization and budgeting tool. This was particularly appreciated in the earlier years of the NRM government

when, according to Whitworth and Williamson (2009), budgeted aggregate government expenditure was determined by the maximum amount of resources (domestic and foreign) that could be mobilized with adjustments made to address domestic borrowing targets. However by 2000, as more donor aid was directed towards budget support in a bid to enhance pro poor public spending, it began to have the untoward effect of crowding out private sector growth and export competitiveness (Brownbridge, Federico and Kuteesa, 2009). The MFPED responded to this by controlling the fiscal deficit (before grants) through a phased reduction from 11.6 per cent of GDP in 2001/02 to 6.5 per cent by 2008/09 (Brownbridge, Federico and Kuteesa, 2009).

The implication of this action was that if projected aid disbursements exceeded the budget ceiling as determined by the deficit target, government would save the excess resources with additional monies being added to Uganda's foreign reserves (Brownbridge, Federico and Kuteesa, 2009). The downside of this intervention was that necessary increases in the health sector budget funding by spending agencies and donors alike would not guarantee an increase in health expenditure (Odaga and Lochoro, 2006) . This did not augur well for vulnerable Ugandans — and especially those from post conflict settings like Northern Uganda whose health care needs could only be met by availing additional resources; this was in part a motivator for the resurgence of off-budget donor financing (Namakula, Witter and Ssengooba, 2014). Additional discussions related to this section are in the policy analysis section in Chapter five, section 5.2.3 and 5.2.4.

Budget formulation

The national budget process, which is led by MFPED, runs from October to the reading of the budget in June the following year (Williamson, 2003). The process is consultative and there are several stakeholder conferences, with involvement from communities, Local Governments, civil society and donors, as well as central ministries and agencies. Following a successful and highly contentious vote for a bill that enabled parliament to vet government budgets, from 2001 the parliament has become more involved in the process.

While Uganda's budgeting process has gained acclaim for providing an example of the institutionalisation of fiscal discipline, it is as yet unable to protect public expenditure from the excesses of patronage practices that are increasingly commonplace in Uganda's mode of governance (Hickey, 2003; Maraka, 2009). In-year reallocations of funds for the State house and Defence regularly occur at the expense of other sectors given the budgetary ceilings on spending. PEAP's Poverty Action Fund attempts to ring fence some critical sectors, such as, education, health and local government from these ad hoc practices (Piron and Norton, 2004)..

Decentralization

NRM's successful experiment with the creation of Local Councils, as I earlier mentioned, showed the effectiveness of grass root participatory democracy. The Local Council, a product of NRM's popular armed resistance, is considered a key motivator for the push for the decentralisation policy that was enacted in 1993 (Kuteesa *et al.*, 2009). The plan was to progressively devolve the provision of public services to district governments and local councils (GOU, 1997). Though actions to rollout the reform commenced in 1994, legal frameworks providing for fiscal and administrative decentralisation were stipulated later in the Uganda 1995 Constitution and the Local Government Act of 1997 (GOU, 1997). The major areas that immediately benefited from district local government-led service delivery were primary and pre-primary education, district hospital services and primary health care, district and community roads, rural and urban water and sanitation, as well as agricultural extension and advisory services (Piron and Norton, 2004).

Whitworth and Williamson (2009) state that initially, a high degree of discretion was used in deciding the channels and amount of funds provided for district level service delivery. The channels opted for included unconditional grants, supplemented by equalization grants as in the case of Northern Uganda, and conditional grants for jointly agreed programmes funded by central government. Central government ministries maintained responsibility for setting service delivery policies and standards, and for monitoring their implementation (Kuteesa *et al.*, 2009).

To date, a Central government mediated incentive framework provides for the regular assessment of local government planning and financial management performance. Poorly performing local governments lose out on receiving development grants while better performing districts get 10% increases in their grant allocations (Williamson, 2003; Wokadala *et al.*, 2007)

In principle, the local government mirrors the central government budget formulation process by developing annual district level budget framework papers (BFPs) through a participatory process beginning at village level, to sub country, and district level. District level BFPs are incorporated into the national budget documents through the local government Sector Working Group (Williamson, 2003; Piron and Norton, 2004).

Contrary to the original plans, in a bid to ensure that basic service delivery prioritizes areas for poverty reduction as stipulated in the PEAP, decisions on the allocation of resources by the local governments are still driven by the central government's policy agenda spearheaded by the MFPED and the sector ministries. The use of earmarked conditional grants remained an attractive option for MFPED and sector ministries so as to ensure the achievement of their policy objectives. Locally based sources of revenue are too small to counterbalance the centralising impacts of the PEAP and Poverty Alleviation Fund (PAF), and don't encourage local accountability mechanisms between citizens and their local institutions (Craig and Porter, 2003). The government's abolishing of graduated tax collection that was the main local district tax revenue has further damaged any responsiveness that the councils had to addressing the actual needs of their communities, and in turn any obligation felt by the communities to their local councils (Craig and Porter, 2003; Petersen, 2006; Muriisa, 2008). The exclusion of local priorities that fall outside sectoral guidelines is a limitation in the present arrangement and reflects a conflict between the top-down PEAP pro poor priority driven system, as stipulated in the MTEF, and the bottom-up budget-cycle-driven agendas (Piron and Norton, 2004)

3.1.4 The NRM and aspects of good governance

Political and bureaucratic corruption

According to Amundsen (2006), Uganda is plagued with both political and bureaucratic corruption that are systemic and endemic. Transparency International suggests that corruption in Uganda's case is due to the lack of separation between public and private spheres (Maira Martini, 2013). Many authors describe corruption in Uganda as being deeply institutionalised (Flanary and Watt, 1999). There have been some attempts to address the problem. Basic control mechanisms and legal frameworks have been set up, for example, the development of a National Anti-corruption strategy and the signing of relevant international conventions (Amundsen, 2006). An evaluation of supreme audit institutions in Malawi, Tanzania, and Uganda by Wang and Rakner (2005) suggests that the Parliamentary Public Accounts Committees (PAC) in Uganda is better capacitated than its Southernly neighbours and has better exploited the opportunity to hold the executive accountable.

In 2001, Uganda was ranked the third most corrupt nation in the world after Nigeria and Bangladesh (Thai Khi V, 2008). Furthermore, according to Kaufmann (2006), World Bank Institute indicator datasets for the period 1996 to 2004 show that Uganda has had a negative trend in all the governance indicators except the *control of corruption*. Self-enrichment and the use of patronage for power preservation are two forms of political corruption described in Uganda (Tangri and Mwenda, 2003; Amundsen, 2006). Self-enrichment is seen in the involvement of political figures, their families and associates in state contracts in disregard of procurement principles as is often reported in the media (Tangri and Mwenda, 2003). With regard to political patronage, Tripp (2010) cites a widely acknowledged story where movement-leaning Members of Parliament (about 70 per cent of the Ugandan parliamentarians in the 8th Parliament) received cash payments from the state and a few days later voted with a two-thirds majority for the lifting of presidential term limits. Amundsen (2006) asserts this unclear payment of money to the legislators

was the strongest demonstration yet of the use of political corruption to sustain and strengthen the hold on power.

Ugandan Members of Parliament, in turn, are known to live in perpetual debt because of the costs that they incur in vote buying during political campaigns. Even in between elections Uganda’s Members of Parliament remain trapped in an implacable phenomenon of paying out gratuities to numerous individuals perceived as kingmakers within the electorate (Amundsen, 2006).

The creation of new districts

Right from Uganda’s pre-independence period, the creation of new district administrative units was taking place. However, after the NRM government came into power in 1986 there was an exponential increase in the proliferation of districts as table 3.1 illustrates.

Table 3.1 The Evolution of Districts in Uganda since 1959

YEAR/DATE	No. of Districts
1959	16
1962	17
1968	18
1971	19
1974	38
1979 (January) 1979 (May)	40
1979 (May)	22
1979 (August) 1980 (August)	33
1980 (August)	33
1991(March 15th) 1997 (March 20th)	39
1997 (March 20th)	45
2000 (November 28th) 2007 (July)	56
2007 (July)	80
2009 (December 22nd) 2010 (July 1st)	97
2010 (July 1st)	111
2016	112

Source: Ministry of Local Government

Political patronage and gerrymandering have been described as major reasons for the proliferation of districts in Uganda during the NRM era (Malesky, 2005). Political patronage was recognised in the government creating new districts at the behest of

different interest groups across the country that were known for their support for the ruling party, NRM (Green 2008).

Some scholars saw gerrymandering particularly occurring just before general elections as the main reason for new district creation. The intention was to increase the number of districts that could generate additional party leaning MPs; beefing up NRM's representation in parliament in the process (DENIVA 2011).

The districts of Kamwenge and Kanungu, for example, located in well known NRM political strongholds, were created a few months prior to Uganda's 2001 elections and indeed provided a set of new NRM MPs (Piron and Norton, 2004). However, it is notable that the NRM government also created new districts in Northern Uganda, a well-known enclave of opposition support. The opposition went on to win massively in these newly created districts in Northern Uganda (ACCS, 2013). This latter finding went against the gerrymandering argument for district creation.

A survey by DENIVA (2011) established that by 2010 up to 60% of Ugandans were still calling for more districts to be set up to address the needs of marginalised and underserved communities. The creation of new districts did cause dramatic political, economic and social changes in these localities (GROSSMAN and LEWIS, 2014). There was a notable increase in ethnic homogeneity within the new districts that went on to create a greater sense of control over resources and political leadership among Uganda's different ethnic groups (Green 2008). The new districts gained from an increase in allocations from central government as the locus of social services was drawn closer to communities (Piron and Norton, 2004).

It is considered by some researchers that Uganda's incessant creation of new districts has eventually diminished its intended benefits to the local population. It is now primarily the local political elite that are gaining from the process (GROSSMAN and LEWIS, 2014). The large number of new districts has also created administrative challenges that is causing a recentralisation process to take place in three major governance areas (Lewis, 2014).

Firstly, as the districts, or administrative units become smaller and more numerous the management of disbursed funds is more complex, motivating closer control by central government; hence fiscal recentralisation (Lewis 2014).

Secondly, many of the new districts lack the appropriate political and technical human resources to manage the transition and development of the human resource in the new entities. The recentralisation of key governance and administrative functions to central government, for example the hiring and firing of health workers becomes a necessity (DENIVA 2011).

Thirdly, for each district created, the President's office deploys a district administrator to head a team of district-level apparatchik who become the eyes and ears of the political wing of central government. Decentralisation in essence is making it possible for the NRM government's security and political apparatus to infiltrate and monitor the security of more remote parts of the country that were hitherto ignored (Lewis, 2014; Green, 2008).

While the new districts often appear to have a favoured status with government by receiving a larger proportion of central government disbursements, they tend to remain significantly dependant, for a while, on their mother districts for both administrative and technical support (DENIVA, 2011). The annually prepared health sector district league tables continue to show poor health system performance in the newer districts as compared to the older ones, with only a few exceptions (MOH, 2014).

Relationship of government with civil society

While previous regimes restricted the activities of civil society, from 1986, the NRM government allowed press freedoms and the emergence of Non Governmental Organisations (NGOs) and Community Based Organisations (CBOs) (Moncrieffe 2004). Piron and Norton (2004) state that Uganda's civil society played a prominent role in the development of the PEAP; their role in policy making and monitoring of the PEAP was evidence that Civil Society Organisations (CSOs) were now institutionalised and were provided for in the Constitution. The consultative process

that led to the development of the PEAP was also said to be a reflection of the level of inclusiveness of the Movement system (Piron and Norton, 2004).

Civil society organisations in Uganda have been functionally classified by Makara(2003), into six categories: i) **Umbrella NGOs** – for example the Uganda National NGO forum; ii) **Advocacy organisations** - for example those that carry out advocacy activities for women’s as well as other forms of human rights; iii) **Lobbyists** – an example being the Uganda Debt Network, a consortium of NGOs and individuals that lobby policy makers and donors on the reduction and writing off of some of the country’s debts; iv) **Civic organisations** - that educate the citizenry about their political and democratic rights and freedoms as enshrined in the constitution. They also monitor how civil liberties are upheld and in this also play an advocacy role; v) **Developmental oriented CSOs** – these include international and local NGOs; they mushroomed and gained prominence as a consequence of the “*state-avoidance*” off-budget mode of financing that many Development and Humanitarian Aid agencies opted for particularly in response to the HIV/AIDS scourge and conflict in Northern Uganda⁶; and, vi) **grass-root organisations** - these have become commonplace in what Maraka (2003) calls rural and often marginalised areas where they form associations of all kinds, including burial associations, cultural associations and revolving credit schemes.

A USAID sponsored technical report on Civil Society Organisations in Uganda, describes them as numerically strong, but organisationally weak (USAID, 2005). A majority of these organisations are Kampala-based with tenuous linkages into the countryside; most have mandates that focus more on service delivery than on advocacy (USAID, 2005). According to the report, these characteristics are more a consequence of government’s selective tolerance and promotion of some CSO types and greater restrictions on others. For example, the state promotes and patronizes women-based CSOs and is permissive of the more urban-based democracy and governance related CSOs (USAID, 2005). On the contrary, CSOs that provide a

⁶ Makara (2003) refers to Brief case NGOs falling into this category, often fraudulent, hastily set up legal entities that tap into funding opportunities as was the case in Northern Uganda after conflict.

platform for workers, farmers, teachers and other salaried workers are heavily restricted by state legislation. Autonomous rural based CSOs are deemed non-viable given the robust functional state-run grass root Local Council system (USAID 2005).

Gender Based NGOs - Women-based NGOs are recognised to have thrived in this era, taking advantage of the NRM's progressive record on gender empowerment. Tripp (2001) observes that as is the trend across Africa, women-centred CSOs in Uganda have evolved from associations that were strongly linked to the machinations of a ruling party to autonomous organisations that are working to organize and mobilize women around legislative changes regarding issues of inheritance and property rights, domestic violence, rape, female genital mutilation, and the rights of disabled women. It is argued that unlike other African countries where the representation of women in the legislature was increased to create new lines of patronage, in Uganda this was more in response to pressure from a vibrant women's movement (Tripp, 2003).

However other authors still assert Uganda's women-based NGOs, especially those at district and community level, are motivated to maintain a symbiotic relationship with the NRM government. They are invariably exploited for garnering support for the ruling party for the Movement during election season (Hickey, 2003; Maraka, 2009). Indeed, more aggressive, autonomous Women-based NGOs, such as Forum for Women in Development and the International Federation of Women's Lawyers that have done significant advocacy work, are urban-based and are far removed from the grass root communities that represent the Movement's political strongholds. For this reason, these urban-based entities, according to a USAID report, have proved ineffective in mustering adequate leverage to cause change in a number of contentious gender-related issues (USAID 2005).

CSOs in Northern Uganda - During the period of conflict, NGOs in Northern Uganda played a critical role in addressing the population's basic needs given the limited capacity that the government had in providing for the displaced population (Carlson, 2004). A compilation of NGOs operating in Gulu in 2003 by Omona (2008) gives a picture of the diversity of civil society organisations that were bridging the

gaps the public service delivery system couldn't contend with on its own. They were classified into six broad categories, namely: i) the UN family of organizations; ii) International NGOs; iii) National NGOs; iv) District or municipality level NGOs; v) Community-Based Organizations, and vi) Self-help initiatives.

The UN family of organisations notably included the World Food Programme (WFP), the International Labour Organization (ILO), United Nations Office Coordination of Humanitarian Affairs (UNOCHA), UNHCR and UNICEF (Omona, 2008). For most of the 1980s and 1990s, UNICEF was the *de facto* Ministry of Health for the war torn region running many programmes in line with government policy and providing a level of support for human resources for health (DFID, 2002; Namakula, Witter and Ssenooba, 2014). Also notable was that while over 200 International NGOs had representation on the ground, some only working remotely in the Western World, for example Gulu Walk and Action for Stolen Children of Uganda carried out vital advocacy and fund raising campaigns that were supporting both the immediate needs as well as the peace effort (UNOCHA, 2007b; Omona, 2008).

The Northern Peace Process saw 43 local and international Gulu-based NGOs come together to form the Civil Society Organizations for Peace in Northern Uganda (CSOPNU) that actively influenced the agenda of negotiations that paved the way to the peace pact. These included the rights of the IDPs, economic empowerment opportunities for the post conflict population and the provision of basic needs (Lomo and Hovil, 2004). Despite these efforts, prominent women-based NGOs raised the concern that the parties negotiating the Northern Ugandan peace process trivialised gender concerns. Women participants were, in effect, muzzled from forwarding their interests on the basis of patriarchal and sexuality based sentiments (Nabukeera-Musoke, 2010). For instance, the peace talks almost unanimously opted to adopt a mode of traditional justice, for the purposes of reconciliation that in the pre-modern times, amongst other rites, saw belligerents exchanging women to cement peace.

After the conflict there was a mushrooming of national and district level NGOs, as well as CBOs and self-help initiatives that were working to support the resettlement

process. They were tapping into the massive interest and inflow of funding for Northern Uganda (Omona, 2008). It was also a time that the government passed a policy in 2010 providing for Districts to form District Disaster Management Technical Committees (DDMTC) that brought together the district administrative and technical heads, UN Agencies and international, national and district NGOs active in the area to address preparedness, response, recovery and development in a more coordinated and holistic manner (UNOCHA, 2010). The DDMTC's for Northern Uganda were ideally picking up from the coordination and monitoring role that was provided by UNOCHA during the war period(UNOCHA, 2010).

In the section that follows I discuss the conflict in Northern Uganda in greater depth, given that this may have influenced the negative trends in health care in the region.

Background to the war in Northern Uganda

Explanations for the conflict in Northern Uganda are complex, however there is consistent discourse alluding to: i) grievances in the North as a consequence of the socio-economic North-South divide favouring the South (Moncrieffe and Luttrell, 2005), and ii) the Southerners holding the Northerners responsible for all the post-independence violence that the country has suffered (Esuruku, 2011). Historians assert that this divide is itself etched in Uganda's colonial and pre-colonial past. The country's post independence leaders inherited an army and police force predominantly composed of Northerners and a civil service mainly made up of the more educated population of Southern Uganda (Byrnes, 1990; Gersony, 1997) .

Following its assumption of state power in 1986, the NRM government was credited with having a highly disciplined army that initially exhibited restraint as it pacified Northern Uganda. The armies of the past regimes, mainly composed of soldiers from Northern Uganda were held responsible for the pillage and killing meted out on Central Uganda's population during Yoweri Museveni's guerrilla struggle (Moncrieffe and Luttrell, 2005). The Southern dominated National Resistance Army (NRA) acted quite contrary to the Northern Ugandan population's expectations, who feared that they would be the victims of reprisal attacks as had been the practice in Uganda's violent past (Esuruku, 2011).

However, soldiers of the deposed regime soon took up arms against the National Resistance Army. The response was what quickly tarnished the NRA reputation. A number of reports began to emerge of human rights abuses against the region's civilian population. There were widely held rumours that the State orchestrated the cattle raids that swept across Northern Uganda, destroying the source of livelihood for the population (International Crisis Group, 2004b; Lomo and Hovil, 2004). At the same time, it was felt that in government, the civil service was systematically purged of employees who were from Northern Uganda. These were some of the key grievances that led some ethnic groups from Northern Uganda to rally behind a series of armed uprisings, all of which were quickly placated (Moncrieffe, 2004).

Two rebel groups of note had an impact that spread from the Acholi region to other parts of the country (Branch, 2010). The two groups: the Holy Spirit Movement led by Alice Auma Lakwena from 1986 - 87; and, the Lord's Resistance Army of Joseph Kony from 1987 to 2006, both based their political agenda's on a mixture of African and Christian spiritualism.

Alice Lakwena, a young woman that had worked as a spiritual medium previously, according to Branch(2010), had her agenda driven by a redemptive spiritual discourse that sought to expunge the spiritual corruption and misdeeds of the Uganda National Liberation Army (UNLA) ex-soldiers and the Acholi community after which she could then lead them back to power. Lakwena mustered significant support, winning over conscripts from other ethnic groups along her march towards Kampala. However, her campaign was brought to an abrupt end in October 1987 just 100 kilometres from the capital city when the NRA staged a decisive ambush at Magamaga Bridge just outside Jinja town that repulsed and summarily decimated the invading force (Branch, 2010).

Joseph Kony also had a religious background. He had a two-fold mission of violently purging the Acholi community of NRM collaborators and taking over government. For 23 years, as Kony waged war against the NRM government, he caused untold suffering to the Acholi civilian population, maiming and killing those that he considered compromised by the enemy. He soon lost popular support amongst the

Acholi. Kony spread his violence into the neighbouring regions of Lango and Teso where he regularly overrun villages abducting children and looting food and property. By the end of the war, it is estimated that Kony was responsible for the abduction of over 10,000 children whom he turned into sex slaves or child soldiers (Esuruku, 2011).

In a bid to isolate the rebels and protect the civilian population, the NRM government opted to encamp the populations in Acholi and later in parts of Lango and Teso. By the end of the war, up to 90% of the population in the districts of Gulu, Kitgum and Pader were camp dwellers; in Lango and Teso the number was estimated at about 40% of the entire population (UNOCHA, 2007). The long-term internment of the civilian population had its consequences and drew significant criticism from various quarters; over one million people were wholly dependent on food aid and within the camps the mortality rate had soared. By 2005, almost 1000 people every week were dying of AIDS, Malaria and the continued LRA raids (Norris, 2014).

During the war, the government for a while censored media reports about the region, and was reluctant to declare the area a disaster area. This approach came to an end about two years before the peace accord was signed (Carlson, 2004). Carlson (2004) attributes this to pressure on the President from legislators and civil society at national level as well as from key international stakeholders. The United Nations Under Secretary for Humanitarian Affairs Jan Egeland who visited the region during that period is famously quoted as having described the Northern Ugandan situation as the “world’s most forgotten crisis” (International Crisis Group, 2004b).

After a series of failed attempts at ending the war, in 2006 there was a Cessation of Hostilities agreement in Juba between the Ugandan Government and the Lord’s Resistance Army (Branch, 2010). The agreement brought peace to Northern Uganda though a final peace accord that was to be signed later in 2007 never materialised. The NRM government and LRA resumed war but this time in foreign territory: in Southern Sudan, the Congo and the Central African Republic where they continue to steal, abduct and kill innocent civilians.

Northern Uganda's health sector suffered adversely from the conflict: health workers were forced to abandon their stations of duty; essential medical supplies and support supervision were not provided to the health centres; a number of health facilities had their equipment vandalised and the rebels would raid health units in search of medicines and supplies (Rowley, Rubin and Kirk, 2006). It is notable that up to 70% of women that delivered during the period of encampment did so with the assistance of a traditional birth attendant despite the preponderance of NGO's (UBOS, 2006).

Government Programmes during the conflict period

As early as 1990, when the Northern conflict was still going on, with support from the World Bank and other relief agencies, the NRM government was already implementing a number of reconstruction and development initiatives for the whole of Uganda given that the entire country itself had recently emerged from conflict. During the period, 1988 to 1995, the World Bank's financed national projects like the IDA Project to Alleviate Poverty and the Social Costs of Adjustment (PAPSCA) that were targeted at vulnerable populations and women all across the country (Kreimer *et al.*, 2000; Makokha, 2001). Northern Uganda also benefited from World Bank projects like the First World Bank Health project that focused on the rehabilitation of health facilities across the country (Okuonzi, 2004).

Kreimer et al (2000) state that the Ugandan government recognised that Northern Uganda's districts were disadvantaged from the beginning, suffering the double penalty of being rural and being the bedrock of opposition to the NRM government (Branch, 2011a; Bertasi, 2013). Some projects specific for Northern Uganda were set up but were considered ineffective (Kreimer *et al.*, 2000). The projects came at a time when up to 90% of Northern Uganda's population were dwelling in IDP camps and could not appropriately benefit from them (Branch, 2011a). This drew strong criticism from numerous quarters nationally and internationally; it reflected the World Bank's compromised position in favour of the Ugandan Government whose relative economic success was heralded as a model of development and was sold as evidence of the efficacy of World Bank's strategies (Hickey, 2003). Key amongst

these projects was the Northern Uganda Reconstruction Programme (NURP) and Northern Uganda Social Action Fund (NUSAF).

The Northern Uganda reconstruction programme

The Northern Uganda Reconstruction Programme (NURP), commenced in 1992 and lasted for six years. According to both an Office of the Prime Minister (OPM) report and statements by a Parliamentary Committee on the North, NURP was considered a failure (Kreimer et al, 2000). Three key areas of failure were identified: i) there was rampant internal corruption; ii) the escalation of conflict halted the rebuilding efforts and dispersed the communities; and, iii) the desperately poor and illiterate communities were incapable of making good use of the soft loan scheme to support income generation. This reflected on NURP's weaknesses in addressing capacity building. The project was implemented by donor agencies. Only USD 94 million of the USD 600 million planned was actually spent. The programme was succeeded by the NURP II in 2001.

The Northern Uganda social action fund

This was a project that was launched in 2001 was considered part of the Northern Uganda Reconstruction Plan II. It was funded by the World Bank and covered 18 districts in Northern and Eastern Uganda (This does not include North Eastern Uganda). NUSAF was premised on a demand-driven approach in which local communities identified, planned and implemented sub-projects that were to improve local infrastructure, promote livelihood opportunities, and resolve conflict. The \$133.5 million project was funded by an IDA loan of \$100 million, together with a government commitment of \$13.5 million, and local contributions of \$20 million. NUSAF was initiated in mid-2002 after an intensive two-year design process with three main objectives: reducing poverty, improving governance, and promoting positive spill over effects through conflict mitigation (Robinson, 2005). As part of its final evaluation, the project failed to attain its objectives as a consequence of inappropriate procurement mechanisms, as well as poor supervision and monitoring practices (Robinson, 2005).

The Peace Recovery and Development Plan (PRDP)

The first phase of the Peace Recovery and Development Plan (PRDP) was launched after the war in September 2007 as a three year Government of Uganda plan for the recovery and development of Northern Uganda. NUSAF (still on-going) became part of PRDP given that it commenced as NURP II came to an end. The PRDP was extended till it ended in 2012 and in the same year its successor PRDP II was launched. The Plan initially covered 55 districts and 9 municipalities of Northern Uganda, though PRDP II incorporated additional districts from Western and Eastern Uganda. The PRDP was considered a key cornerstone to the signing of the Juba Peace Accord. It was formulated by the Ugandan Government as a comprehensive stabilisation plan that provided a mechanism for disaggregating northern Uganda from the national sector plans and addressing its special needs as a historically marginalized, conflict-affected setting. This was to be achieved through interventions that fell into four major strategic objectives, namely: i) the consolidation of state authority and strengthening of the rule of law and access to justice; ii) rebuilding and empowerment of communities; iii) revitalisation of local communities; and iv) peace building and reconciliation (OPM, 2007; Esuruku, 2011). The PRDP was harmonized with the national Poverty Eradication Action Plan and the latter was used as a benchmark for evaluating its effectiveness.

While the Department of Pacification and Development in the Office of the Prime Minister managed and coordinated the PRDP, governmental and non-governmental organisations were expected to align their interventions in Northern Uganda to the PRDP framework (OPM, 2007). This meant that the health sector for example, ensured that technical planning and coordination would continue in accordance with the procedures of implementation of sector programmes and district developmental planning. This also meant that the Chief Administrative Officers of the local governments in the PRDP-supported districts were responsible for the planning and overseeing of programmes being implemented by both governmental and non-governmental organisations (Esuruku, 2011).

The estimated cost of implementing the PRDP over the three-year period was US\$ 606,519,297 (£ 392,366,000) which was distributed into 31% in the first year, 30% in the second year and 39% in the third year of implementation (OPM, 2007). While government committed to funding 30 per cent of the PRDP overall cost, the international community was requested to fund the remaining 70 per cent (NRC and IDMC, 2010). The planned PRDP allocations with respect to the strategic objectives were: consolidation of state authority 23.8%; rebuilding and empowering communities 47.4%; revitalization of the economy 23.2%; peace building and reconciliation 2.7%.

Evaluations of the PRDP criticised it for lack of clarity because while to some it was a policy framework stipulating how additional resources will be channelled to Northern Uganda, to other stakeholders it actually represented a conventional programme or master plan for Northern Uganda (Claussen *et al.*, 2008). It is also stated that the PRDP focused mainly on “hardware” (buildings, infrastructure) at the expense of developing the human capacity of the education, health care, local government, security and justice sectors (NRC and IDMC, 2010).

It was also revealed that the planning of PRDP-related activities in Northern Uganda’s districts remained separate from existing national and district planning cycles, and existing district development plans did not reflect the PRDP recovery component (Claussen *et al.*, 2008). The on-going process of subdividing existing districts created additional problems, with newly created districts lacking the capacity to discharge their responsibilities as regards the PRDP (NRC and IDMC, 2010).

An analysis of the PRDP by School of Law at Makerere University commended the NRM government for following through with implementation of the PRDP though the formal signing of the Juba Peace Process didn’t materialize (Marino, 2009). Additionally, a DFID funded study showed that the implementation of the PRDP had significantly helped to counter real and perceived neglect and marginalisation of Uganda’s North by the South (International Alert, 2013).

The government came under criticism for including some districts in the Western and Easter regions of the country that were not post-conflict by the definitions of the Juba Peace Accord. The government, as it was stated, was using the PRDP to appease or make political gains in non-conflict communities around the country (International Alert, 2013).

Donor support for the PRDP was mainly budget support. It was generally poorly coordinated, with limited involvement of the sector working groups in its disbursement. It was argued that the off-budget or parallel funding approach that USAID had insisted on using, had delivered better outputs within the three years (Midling *et al.*, 2014). However, USAID's funding approach also drew significant criticism for failing to adequately recognise the central governance role of central and government as they worked through district level projects. Furthermore, USAID was criticized for imposing ideological beliefs on their recipients and impeding programmes with extensive bureaucracy⁷ (Norris, 2014).

The limited impact of the PRDP on the health sector is manifested by the human resources of health care challenges that persist, reflecting the poor coordination and coherence in strategies adopted by various stakeholders as they addressed the rehabilitation of Northern Uganda's health system (Bertasi, 2013; Namakula, Witter and Ssenooba, 2014). Both the OPM, by its own admission, and the population of Northern Uganda recognise that the health sector benefited to a limited extent from the PRDP (International Alert, 2013; ACCS, 2015).

A gender perspective of the conflict

While the men folk in Northern Uganda had more say in resolving or perpetuating the conflict in Northern Uganda, women and children were known to be the major victims of displacement, abduction, maiming or massacre over the 20 years of conflict (Gersony, 1997). Omona (2008) estimates that at the peak of displacement, up to 80% of the IDP population were women and children. During the two decades of war, children were brought up under squalid camp conditions, missing out on a

⁷ USAID's approach to HIV prevention in Uganda was influenced by the Bush administration's ideological stance on prostitution and abstinence from sex amongst others.

formal education and the girl child was exposed to early sexual debuts and pregnancy. The girls were forced into marriage so that poverty stricken families could gain some wealth through the payment of dowry. This augured well for the families of the suitors that were in a similar haste to dispose of their livestock before they were looted by cattle rustlers (Lomo and Hovil, 2004).

Women were targets of rape by the different combatants and other lawless individuals. In the camp environment, women remained active tending for the family while the men fell redundant and resorted to alcoholism and gambling as agricultural activities were on hold (Branch, 2011b). It was in the execution of their daily chores that women became more prone to the anti-personnel mine injury (Dolan, 2002).

Nabukeera-Musoke (2010) reports that during the protracted negotiations between the government and the rebels for peace, women and their concerns were not adequately represented. One enduring proposal for effecting peace and reconciliation between the LRA, the Acholi people and the government, was the adoption of an Acholi traditional justice ceremony, which according to concerned feminists, had poor regard for position of the Acholi woman. Part of the peace pact entailed young women from each of the warring factions being exchanged for betrothal (Nabukeera-Musoke, 2010).

A 2012 study reports that the gradual return of families from the IDP camps to their homes did not lead to an end of sexual and gender-based violence (International Alert, 2013). This was corroborated by a later evaluation that revealed that there was a persistence of domestic violence in the communities (ACCS, 2013). The evaluation nevertheless recognised that, in general, PRDP-supported conflict resolution institutions at community level were accessible and effective and had made a significant impact on peace and security (ACCS, 2013). PRDP programmes technically and financially facilitating local traditional institutions so they could effectively deal with local disputes exemplified this. The PRDP programme was reckoned as gender-insensitive, failing to adequately address SGBV in its peace building efforts (International Alert, 2013). The Uganda Women's Parliamentary

Association criticised the project for “*not being aligned with accepted national, regional and international gender instruments, including the UN Security Council Resolution 1325 on Women, Peace and Security*” (Claussen *et al.*, 2008, p. 30).

The PRDP was also considered to be empowering women in a “conflict insensitive” manner. Government and its donors were availing women with more opportunities for wealth creation oblivious of the consequences on the menfolk in this highly patriarchal setting where displacement had negatively impacted the male role and status in society (International Alert, 2013). Dolan(2002) suggests that men, as a consequence, have frustrated expectations that have significantly contributed to all forms of violence against women as well as the perpetuation of armed conflict.

It was also acknowledged that twenty years of exposure to violence and encampment had significantly damaged the lifestyle and social values of the people returning to pre-displacement sites (Esuruku, 2011). Any customary instrument that could have ensured security of tenure to widows, divorcees, child-headed families and single mothers had been eroded leaving many of such individuals destitute and resorting to desperate means for survival (ACCS, 2013). This was not adequately addressed by the PRDP (International Alert, 2013).

3.2 The status of maternal health care

In the following sections, I provide an update on the status of Uganda’s health system performance in affording maternal health care. My review here places extra emphasis on Northern Uganda given its unique challenges and the impact that these challenges have had on the health system. I also consider the utilisation of maternal health care services amongst the poor in Uganda in Northern and East Central Uganda making use of UDHS data that I reanalysed for the purpose.

3.2.1 Country status

Though maternal health care in Uganda has been a major beneficiary of the health reforms that have characterizing NRM’s political era, the country did not achieve its MDG targets for maternal health by the end of 2015 (Kassebaum *et al.*, 2016). A recent joint UN report puts Uganda’s MMR at 360 per 100000 births in 2013 (WHO

et al., 2014). Northern Uganda by 2007 had been estimated to have an MMR of between 650 and 700 per 100,000 live births; this was directly attributed to the disruption of health service delivery in Northern Uganda (Tweheyo *et al.*, 2010). A 2015 report for Iganga a rural district in East Central Uganda cited an MMR of 421 per 100000 live births for the district.

According to the Uganda Demographic Health Survey (2006) the high maternal mortality in both regions is attributed to a disproportionate number of women delivering without skilled attendance. In that survey only 58% of women in Uganda delivered with support from a skilled birth attendant (UBOS and ICF International Inc, 2006). The figure reduced to 48% in 2011, according to results of a subsequent demographic health survey (UBOS and ICF International Inc, 2012). In Uganda, while antenatal care (ANC) is attended at least once by nearly all pregnant women only 48% achieve four or more visits (UBOS and ICF International Inc, 2012). Key factors that contribute to the high maternal rate in Uganda include:

- *Adolescent pregnancies, short pregnancy intervals, a high fertility rate and low use of contraceptives coupled with supply side challenges of an inadequate supply* (Ssenooba *et al.*, 2003). About 33% of all women 20 – 24 years gave birth to their first child before 18 years, making Uganda one of the countries with the highest adolescent pregnancy rate globally (UNFPA, 2013).
- *Complications arising from abortions and miscarriages with inadequate access to care.* According to Singh *et al* (2005), an estimated 297,000 induced abortions are performed every year, equivalent to a Uganda national average rate of 54 per 1000 women aged 15 – 49 years. In that study, Northern Uganda was noted to have the highest abortion rates at 70 per 1000 women (Singh *et al.*, 2005). The strong association between the high prevalence of intimate partner violence occurring in the North and its influence on pregnancy intention might be contributing to this high abortion rate (Kaye *et al.*, 2006; UBOS and ICF International Inc, 2006; Saile *et al.*, 2013).
- *The high HIV prevalence amongst rural pregnant women.* A study by Reuschel, Tibananuka, and Seelbach-Goebel (2013) compared HIV sero-prevalence data

for a rural cohort of antenatal care attendees in 2007 and 2011 and established that the HIV prevalence in that setting at 25.1% in 2011 represented a dismal 3.5% decline from the 2007 figures. This contrasted with the urban areas where the HIV prevalence amongst pregnant women has witnessed a significant decline (Reuschel, Tibananuka and Seelbach-Goebel, 2013). A 2010 study reported post-conflict Northern Uganda to have the highest HIV prevalence rate of 12.8% (Patel *et al.*, 2014)

- *Malaria as a leading public health problem in Uganda and a major cause of morbidity and mortality* (Ssenooba *et al.*, 2003). A study of 1,218 pregnant Ugandan women in Southwest Uganda established laboratory evidence of malaria infection in 27% of the women, most of whom were young, HIV infected, less educated or living in rural areas (De Beaudrap *et al.*, 2013).

3.2.2 Maternal health organisation and infrastructure

As is specified in Uganda’s first National Health Policy health facilities are organized into seven hierarchical levels, each with a defined capacity to provide health care on the basis of a catchment population within the specified administrative boundary (Uganda Government, 1999). Table 3.2 displays the levels of care with reference to maternal health services provided at each level.

Table 3.2 The Seven Levels of Health Service Delivery in Uganda

Level of Health Unit	Target Population	Services Provided
Health Centre I (Village Health Team)	1000	Community based preventive and promotional health services. Identification and follow-up for expectant mothers
Health Centre II	5,000	Preventive, promotional and basic outpatient, emergency, and curative care. Emergency deliveries in some cases
Health Centre III	20,000	Preventive and promotional care. Outpatient curative, maternity, inpatient services and laboratory services, basic emergency obstetric care ready
Health Centre IV	100,000	Preventive and promotional care. Outpatient curative, maternity, inpatient services, blood transfusion, emergency and laboratory services. Comprehensive emergency obstetric care ready
General Hospital	500,000	Services provided at level IV plus other general services, in service training, support for community based programmes
Regional Hospital	2,000,000	Services provided at general hospital level plus additional specialist services, e.g. psychiatry, ENT, ophthalmology, dentistry, intensive care, radiology, pathology, high-level surgical services and medical services.
National Hospital	10,000,000	Comprehensive specialist services, teaching and research

Source: MOH (2013) Annual Health Sector Strategic Plan

MOH and WHO Service Provision Assessment survey (Uganda MOH, 2008) indicates that out of 5,229 health facilities country wide only three and four per cent are hospitals and health centre IVs respectively. The survey also shows that 24% of the facilities are health centre IIIs and 69% health centre IIs. Though ownership of the health facilities is 55%, 17%, and 28% for government, private-not-for-profit, and private-for-profit respectively, there is a 50/50 split in ownership of hospitals between government and private-not-for-profit hospitals organisations (Uganda MOH, 2008). In table 3.3 below the actual availability of maternal health care services relative to health care level and ownership is displayed.

The table shows that basic maternal health care services are now available almost universally up to Health centre III level, however caesarean births are limited to the higher-level health facilities at present. Transportation services that would refer mothers to these more specialised units from the health centre III and II levels are limited. Further analysis shows (not displayed in the table) that only 47% of health facilities that provide emergency services actually have emergency transportation in place; facilities in Northern Uganda are the ones least likely to have an ambulance in place (Uganda MOH, 2008).

Table 3.3: Maternal Health Care Service providers in Uganda

Background	Antenatal Care (%)	Normal Delivery Services (%)	Caesarean Section (%)	Basic EmOC ¹	Comprehensive EmOC ²	Transportation for Maternity Emergencies (%)
Type of Facility						
Hospital	95	97	84	26	23	91
HC-IV	100	99	24	1	-	92
HC-III	96	90	2	-	-	61
HC-II	52	25	0	-	-	33
Ownership						
Government	69	53	4			45
Private	74	54	10			54
¹ Facilities that applied all six Basic EmOC functions in the three months preceding the Assessment ² Facilities that applied all the basic EmOC functions plus blood transfusion and Caesarean sections in the three months preceding the study.						
Source: MoH (2007) Uganda Service Provision Assessment Survey						

The Ugandan policy on health infrastructure development aims to provide a network of functional, efficient and sustainable infrastructure that can provide maternal health care services within a five kilometre walking distance (Ministry of Health, 2012). The 2009/10 National Household Survey has established that this has been achieved in part; government health facilities are indeed on average about five kilometres away from the communities, however traditional birth attendants are even closer at an average of three kilometres away (UBOS, 2010). Central Uganda (Buganda) and Kampala saw the greatest reduction in distance to health facility (UBOS, 2010). As illustrated in table 3.3, the proximity of government health facilities to the communities does not, as yet, translate into accessible maternal health care.

3.2.3 Factors affecting utilization

The Uganda Health and Demographic surveys of 2006 and 2011, reveal statistically significant inter regional differences in the utilisation of maternal health care services. Kampala and its surroundings of Central Uganda utilised maternal health services best while the Karamoja, Northern and West Nile regions exhibited the poorest utilization of both public and private maternal health services. These latter three regions are the least developed, and more remote regions of the country (UBOS and ICF International Inc, 2006, 2012). Rutaremwa et al (2015) explains that regional differences in maternal health care services utilisation in Uganda is due to differences in access to maternal health care services, education and economic opportunities as well as variations in cultural practices and norms.

A study by Rutaremwa (2015) based on a secondary analysis of 2011 Uganda Demographic Health Survey data representing 1728 women of reproductive age shows that only 10 % of mothers actually utilize the full complement of delivery related services as recommended by the Ugandan Ministry of Health guidelines. The full complement of delivery services according to the guidelines is: at least four antenatal visits; delivery at health facility; and, a postnatal visit.

In line with discussions on maternal health care utilization in Chapter two, Rutaremwa et al (2015) in addition to a number of earlier studies conducted in

Uganda reflect the influence of individual, community and health system factors on the uptake of these facility-based services. Individual factors strongly associated with the utilization of the full complement of maternal health care services are: women that live in Kampala, Uganda's capital city; women from wealthy households; and, women that had attained secondary or tertiary education. In that study, married women, women of Muslim faith, or those living in rural areas were less likely to deliver with assistance from a skilled birth attendant (Rutaremwya *et al.*, 2015).

A field based study conducted in the rural Eastern Ugandan district of Busia further indicates that personal choice backed by greater autonomy and traditional belief led women to shun the health facilities which amongst other concerns were inflexible about their preferred birthing positions (Anyait *et al.*, 2012). The significance of a community's traditional beliefs and norms in maternal health care utilization is also reported by other studies conducted amongst the ethnic groups of South, West and Central Uganda, that is the Banyankole, Banyoro and Baganda, where childbirth at home is admired and shows a woman's self-efficacy (Amooti-Kaguna and Nuwaha, 2000; Kyomuhendo, 2003). Indeed, in some of these cultures, women that deliver by caesarean section are deemed lazy and are not congratulated. Such dynamics lend to a degree of self-stigma amongst women that delivered through surgical means (Kyomuhendo, 2003).

The dismal involvement of the male gender in women's pregnancy and childbirth is highlighted in a number of Ugandan studies. According to Uganda's health management information system data for 2006 male attendance of antenatal care alongside their expectant partners was at 3% (Tweheyo *et al.*, 2010). This might be explained, in part, by another study in Southwest Ugandan that reports that rural men generally perceive it as their role to financially provide for the prenatal needs of their expectant spouses. Nevertheless, they are unwilling to escort their wives to hospital because: it involves long waits; interferes with their daily earnings; and, generally goes against traditional norms (Singh, Lample and Earnest, 2014).

Where male involvement has been encouraged in Uganda, there have been significant improvements in the attendance of at least four antenatal care clinics amongst women, this in turn portending safer childbirth (Tweheyo *et al.*, 2010). Another study looking at the factors that influence birth preparedness, Kakaire et al (2011) highlights the association of age, education level and occupation of a woman's *spouse* with having a birth plan, and this, in effect, determining maternal health care utilisation.

With regard to health system determinants at service delivery level that influence the utilization of ante-natal services in Uganda, a study by Konde et al (2011) reports three factors associated with the use of antenatal care: prior attendance of antenatal care at the site; affable services offered at the site; and, distance from health facility. This corroborate the findings of Kyomuhendo (2003) and Amooti-Kaguna & Nuwaha(2000) who suggest that despite a favourable policy environment, health worker attitudes, poor service quality and the distance to care deter rural women from utilizing the full range of maternal health care services. It is therefore significant from the Rutaremwa et al (2015) study that 44% of Ugandan women report distance as a factor affecting their use of facility based care. A study by Mbonye (2001) found that most maternal deaths occurred amongst rural women and 57.1% of these mothers had been transported over 20km to access the health units where they died. Nevertheless, Parkhurst and Ssengooba (2009) in reporting a study in rural district in Northwest Uganda, health facility quality of care considerations were deemed more important than distance and transportation concerns as women sought maternal health services. The researchers describe a phenomenon of poor pregnant women bypassing one maternal care setting to access care in a more distant health facility that is perceived to provide a better quality of care. This phenomenon was previously discussed at greater length in Chapter two, section 2.5.4 of this thesis.

3.2.4 Delivery options in Northern and East Central Uganda

Following is a review of delivery options made by women in Northern and East Central Uganda relative to socio economic status during two time frames, 2006 and

2011, that coincide with the period of interest to this study. This review is based on an analysis I conducted on secondary data from Uganda Demographic Health Surveys for 2006 and 2011.

These surveys are part of a multinational USAID funded DHS project that uses internationally standardised questionnaires to collect data from sampled households on socio economic status, marriage, fertility, family planning, maternal health, child health, and HIV/AIDS. Additionally, the DHS data is disaggregated by the nine sub regions of Uganda, namely: Central I, Central II, Kampala, East Central, Eastern, North, West Nile, Western, Southwest, and Northern regions. The surveys focused on women of reproductive age, that is, 15–49 years of age.

From the analysis, the social status of households of women of reproductive age, and their respective childbirth choices were determined for both post conflict Northern Uganda and non-conflict East Central Uganda in the years 2006 and 2011. This provided important contextual information about the study population and lent to the arguments of political, economic and social dynamics that influenced maternal health related governance and utilisation in the post-conflict and non-conflict regions.

Figure 3.1 displays a chart derived from the DHS data depicting the delivery preferences of women in the two sub regions during the survey periods, 2006 and 2011. The options considered are: women opting to deliver at home (represented as “home” in the figure); women that delivered in a government hospital (represented as “Govt” in the figure); women that delivered in a private not for profit, or private for profit health facility (represented as “private”). According to the DHS, a skilled birth attendant assisted 4% of women that delivered at home.

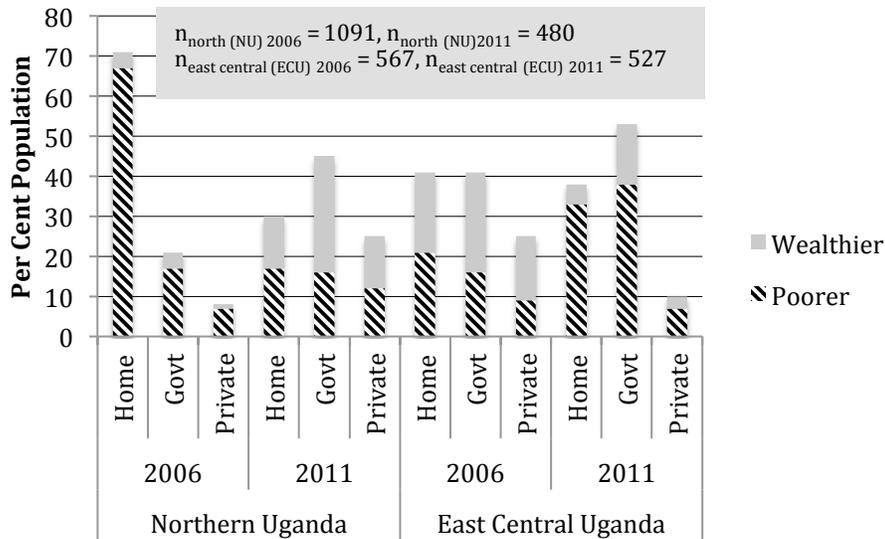


Figure 3.1. Place of Delivery in Northern and East Central Uganda in 2006 and 2011

Figure 3.1 is indicative of two important dynamics at play: i) there was a shift in preference of delivery options from 2006 to 2011, and ii) there were significant transitions in socio-economic status of the women giving birth across that period.

In Northern Uganda there was a decrease in home delivery and a concomitant increase in public and private health facility deliveries and more of the women giving birth belonged to the wealthier fourth and fifth quintiles. While in 2006, 71% of women delivered at home, only 2.8% of these by a skilled birth attendant, in 2011 there was a two-fold reduction in the proportion of women that delivered at home compared to 2006. There was a concomitant increase in the proportion of women that delivered in a government health facility according to the 2011 survey.

In 2006 only 4% of those that delivered without skilled assistance were from the fourth and fifth (wealthier) quintiles. 21% of women delivered at government hospitals during that period, with again only 4% categorised in the fourth and fifth quintiles. In 2011, a significant percentage of women that delivered at home belonged to the wealthier quintiles suggesting that other than out-of-pocket constraints there were other factors that motivated women to prefer this option. The majority of women that delivered in the health facilities (64%) belonged to the fourth and fifth (wealthier) quintiles. There was also a significant increase in both

poor and possibly wealthy women that chose to deliver at the private health facilities, the finding corroborating the “by-pass” phenomenon - women spending more to seek health care in health units further away – that was discussed in the previous section and previous chapter (Section 2.5.4).

In East Central Uganda an analysis of the two surveys shows a decrease in home and private facility deliveries and an increase in the utilisation of public facilities. In 2006, 41% of women delivered without skilled birth attendance. An equal proportion of women (41%) opted for skilled birth attendance at the government health facilities. A smaller number of women delivered in private health facilities. Compared to 2006, the 2011 DHS reflects overall a poorer population delivering by all the three options. This might be explained thus: between 2006 and 2011, Eastern Uganda, like the rest of peaceful Uganda was affected by the International Financial Crisis that reduced the demand for Uganda’s agricultural produce and hiked Bank lending rates, severely affecting household incomes in rural Uganda (Ssewanyana *et al.*, 2009).

3.3 A review of Uganda’s healthcare expenditure

Eleven years after signing up to the 2000 Abuja Declaration and akin to other sub-Saharan developing nations, a 2011 report showed that Uganda had fallen short of fulfilling its pledge to allocate at least 15% of annual government budget to health; public funding to the health sector has on average accounted for up to 9% of the country’s budget (Knoema, 2015; Kwesiga *et al.*, 2015; Worldbank.org, 2015). Out-of-pocket spending continues to represent the bulk of expenditure on reproductive health in Uganda. Other than donor contributions, the government funding is the other main source of financing.

3.3.1 Out of pocket expenditure on health

Data sourced from compilations of Uganda’s National Health Accounts (Table 3.4) shows the contribution of the various entities to health care spending from financial year 1997/8 to 2011/2012 (Ministry of Health, 2011; MOH, 2013b).

Table 3.4: Primary Funding Sources as percentage of total health expenditure for 1998/1999-2011/2012

SOURCE	Financial Year							
	98-99	99-00	00-01	06-07	08-09	09-10	10-11	11-12
Public Funds (%)	17	16.7	18.2	15	16	15	12	9.6
Household (%)	46	45	40.5	51	43	42	58.2	43.2
NGO (%)	8	10	13.6	6	4	4	5	1.16
Private Firms (%)	1	0.3	0.3	-	2	2	0.3	0
Rest of the World (%)	28	28	27.4	28	34	37	24.6	45.6

Compiled from four National Health Accounts reports (2000a, 2011; 2004; 2013b)

The table indicates that Ugandan households have from 1998 to 2011 sustained the bulk of health expenditure, their contributions remaining more or less stable during this time frame despite the interventions instituted by government. Government contributions continued to drop while donor contributions showed a rising trend, becoming the dominant source of health care funding by 2011. On average between six to nine per cent of household expenditure went to accessing health care, during that 14 year period (1998 to 2012) representing a contribution of between 46% and 58% to the total health expenditure (Mugisha and Nabyonga-Orem, 2010). Other private funding sources include employer re-imbursments and pre-paid insurance arrangements (MOH, 2013b). Table 3.4 also corroborates a Orem and Zikusooka (2010) report showing that out-of-pocket expenditure continued to rise despite the abolition of user fees and the provision of free health care services over the decade and a half. Nevertheless, the World Bank still considers Uganda's out-of-pocket expenditure as lower than that of other lower income countries (Knoema, 2015).

A World Bank analysis of data from 2006 Uganda National Household Survey data suggests that an average of 28% of the households sampled sustained health expenditures that could be deemed catastrophic (Okwero *et al.*, 2010). Furthermore, though the poor spent a smaller proportion of their savings on health care (that is, 7.8 per cent for the lowest quintile versus 8.9 per cent for the highest quintile) the incidence of catastrophic spending was still higher in the lowest quintile as compared to the wealthiest quintile (28.3 per cent and 24.8 per cent respectively). Orem and Zikusooka (2010) estimate that about 50% of the total household expenditure on health goes to the purchase of drugs that are often out of stock at the

health facilities. A Ministry of Health Financing Review (2010b) reports that the predominant source of money for household health expenditure are loans from informal money lenders, often with a repayment interest rate of up to 3000%. Other sources include: using past income (about 20%), selling assets; and, borrowing from microfinance institutions (Ministry of Health, 2010b). Like the rest of its East African neighbours⁸, Uganda has gone through a number of phases in a bid to set up a universal health insurance scheme although, as stated by Basaza, O’Connell, and Chapcakova (2013), this has not yet culminated into its implementation.

The Uganda National Household Survey of 2009/10 reports that the share of household expenditure on health care remained unchanged for Kampala and Northern Uganda over five years but increased for urban Eastern and Central Uganda and declined for rural Eastern and Central Uganda as well as rural and urban Western Uganda (UBOS, 2010).

3.3.2 Government allocations for health

Table 3.5: Sector Contribution of Government funds - both expended and planned

	2008/09 % of GGE	2009/2010 % of GGE	2014/15 % of TGB	2015/16 % of TGB
Accountability	6.4	6.4	8.0	8.0
Agriculture	3.5	3.9	3.0	3.0
Education	17.4	17.4	14.0	14.0
Health	8.3	8.1	9.0	7.0
Interest Payments	8.4	6.9	7.0	12.0
Justice/Law and Order	5.9	6.4	5.0	6.0
Parliament	2.5	2.3	2.0	2.0
Public Sector Management	8.7	8.9	8.0	5.0
Public Administration	3	4.1	4.0	5.0
Roads	16.3	16	16.0	17.0
Security	10.5	9.1	8.0	8.0
Social Development	0.5	0.5	0	1.0
Tourism, trade and industry	0.6	0.8	0	1.0
Water	2.2	2.3	3.0	3.0
Energy and mineral development	5.6	6.6	12.0	6.0
Lands Housing/Urban development	0.3	0.4	1.0	1.0
GGE = General Government Expenditure (<i>spent</i>); TGB = Total Government Budget (<i>planned</i>)				

⁸ The country is currently the only country in the region without a National health insurance system in place (Basaza, O’Connell and Chapcakova, 2013)

Table 3.5 reflects resource allocations by government to various areas including the health sector between 2008 and 2010. The table also shows budget projections for 2014 to 2016. The General government health expenditure (GGHE) as a percentage of total health expenditure at 8.3% and 8.1% in 2008/09 and 2009/10 respectively fell below the Abuja Target set is 15% and according to the projections there was no plan to have it increased in the subsequent financial years. The Health Sector Development Plan 2015/16 - 2019/20 states that this represents £7.7(US\$9.5) yet about £18.6 (US\$28.0) is required to fully implement the country's Minimum Health Care Package (Uganda Ministry of Health, 2015).

According to a Ministry of Health report (2010), the prioritisation of health has remained the same over a number of years, with the value of Government allocations to the health sector coming fourth after security, education and roads. Many donors reverted to off-budget funding in response to the corruption scandals that continue to plague key Government ministries. This corruption has been a major hindrance to development despite, 6.4% of government allocations going to strengthening institutions that enforce accountability, for example, the office of the Inspectorate of Government as is reflected in the table. The limited increase in funding to the health sector is also a reflection of the budget ceilings dictated by the MTEF that I described earlier in Section 3.2.3. The donor investments in the health sector are discussed further below.

3.3.3 Development partners

The development partners continue to be important funders of the Ugandan health sector with their contribution over the last decade representing about 11% of total overseas development assistance (ODA) and representing 1.5 – 2% of Uganda's GDP (MOH, 2014). When considered as a proportion of the country's total health expenditure it fluctuates between 28 and 45 %, making ODA the second largest funding source for health after the Ugandan household (Ministry of Health, 2010b; MOH, 2014). The reports on donor contributions relative to total health expenditure are highly variable and unreliable, given the challenges of tracking the various

funding streams: the off-budget and on-budget funds as well as funds supporting multi-sectoral interventions (Ministry of Finance Planning and Economic Development, 2013). For example, Okwero et al (2010) describe the inadvertent bundling of all HIV/AIDS related expenditures under the health sector budget, yet significant amounts of this money targeted HIV related interventions outside the health ministry's mandate. A Ministry of Health survey report, also cited in Okwero et al (2010) reveals that 56 per cent of the donor project funds attributed to the health sector was actually spent on non-Health Sector Strategic Plan related inputs, most of them overhead costs that included: expatriate hiring costs; motor vehicle purchasing and running costs; and, renting office space.

Reproductive and maternal health services have generally benefited even less from donor funding. A 2010 study on health financing in Uganda provides statistical evidence to show that funding for sexual and reproductive health was re-allocated to STI and HIV/AIDS treatment and preventions programmes (Action for Global Health, 2010). A MFPEd report (2013) highlighted renewed government and donor commitments to increasing donor funding for reproductive health (including maternal health) by 122% from £6.7m (US\$ 10.4m) in FY 2011/12 to £14.8m (US\$ 23.0m) in FY2013/14. An updated evaluation is awaited.

3.3.4 Financing the decentralized health system.

The decentralization of governance to the districts in the 1990s was accompanied by plans to devolve powers that allocated resources and deliver health care services. Amongst the key objectives of decentralisation was to minimize duplication, increase accountability and enhance the cost effectiveness of health care delivery (Ministry of Health, 2010b). Later in 2000, direct financing to Health Sub Districts (HSDs) from central government was implemented. So rather than funds being disbursed to the district management team, the health sub districts received funds against plans they developed, for their operations. This reduced on the transaction time.

As depicted in figure 3.2, the central government provides grants to the district public sector using an allocation formula. These grants fall into three major

categories: i) the recurrent wage; ii) the non-wage recurrent; and, iii) the development grant. All government-run district hospitals and health centres are beneficiaries of the PHC grant. The central government, in addition, offers a block PHC grant to NGO (or PNFP) hospitals that is not delineated as is the case for district public health sector funding.

An analysis by Mugisha and Nabyonga-Orem (2010) (see Figure 3.2) shows that while the recurrent PHC *wage* bill increased by 70 times over the last ten years from 2001, the PHC recurrent *non-wage* bill did not benefit from a concomitant increase but recorded a decline from 2004/05 that continues till date.

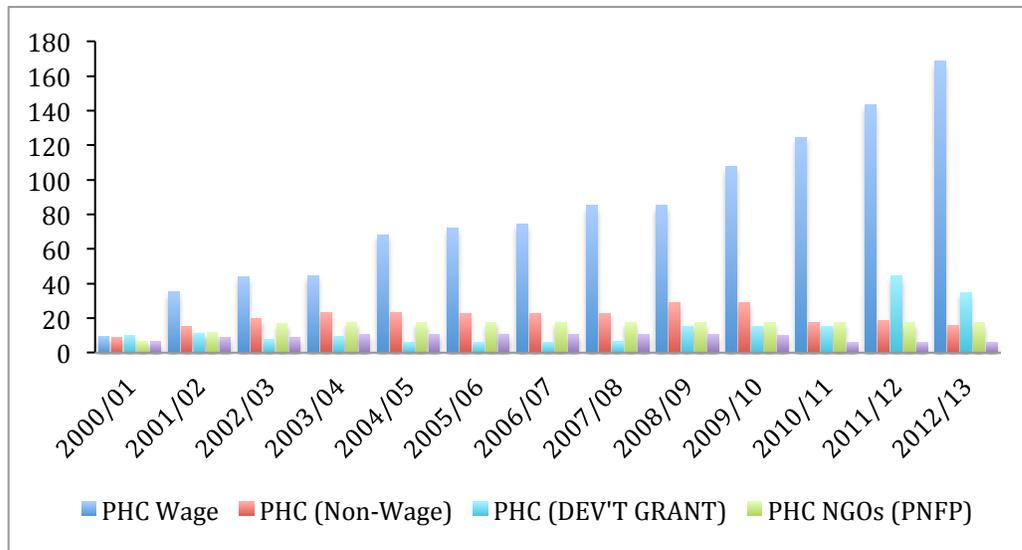


Figure 3.2: Central Government allocation to the decentralized health sector. Source: National health accounts

The recurrent wage and non-wage bills for government and NGO hospitals have remained more or less constant despite an increase in the catchment populations, in administrative costs and in investments made in service delivery technologies at these health facilities (Ministry of Health 2013). These bills do not include the cost of drugs whose supply has been centrally controlled by the National Medical Stores that uses a separate population-based formula. The state of affairs in units that act as referral units is worsened by congestion with patients that ideally should have been handled in the lower level PHC facilities. The PHC facilities themselves are suffering a decline in the scope and quality of services as a consequence of the

limited non-wage funding as I previously mentioned (Mugisha and Nabyonga-Orem, 2010). The decline in non-wage funding is reported to have adversely affected the quality of maternal health care at PHC level (Uganda MOH, 2008).

The non-wage grants for the districts are allocated on the basis of an allocation formula based on the following attributes: i) population (85% weight after the deduction of mandatory and basic allocations; ii) infant mortality rate; iii) crude birth rate; iv) number of live births; v) a basic amount allocated to all districts for health service delivery; vi) a special and fixed allocation for hard-to-reach areas (Ministry of Health, 2010b)

3.4 Conclusion

This chapter profiled wide-ranging constitutional, economic, and health care reforms that commenced shortly after the National Resistance Movement took over power in 1986. These reforms acted as a framework for further review of the performance of the Ugandan health care system as it catered for the health needs of the populations in both conflict-affected and peaceful parts of the country.

Key amongst the constitutional reforms was the promulgation of the 1995 Constitution that stipulated the Movement or no-party political system. However, later in 2005, a constitutional amendment paved way for the return to the multiparty political dispensation. The economic reforms initially entailed the adoption of World Bank and IMF sponsored Structural Adjustment Programmes (SAPs) but in 1999 the nationally developed Poverty Eradication Action Plan superseded them. Fiscal instruments that on one hand enhanced the participation of a wide range of stakeholders in the budgetary formulation process and on the other, set expenditure ceilings for all sectors including health complimented the PEAP's implementation.

Though the NRM government in its infancy broke ranks with Uganda's history of political and bureaucratic corruption and internal strife, soon a number of reports showed an increase in institutionalised corruption often for the purpose of personal enrichment and political patronage. Internal strife, itself acting as evidence of

Uganda's lack of national cohesion, was soon manifested by a twenty yearlong rebellion in Northern Uganda by the Lord's Resistant Army rebels. The rebellion led to the prolonged internment of Northern Uganda's population, the loss of lives and livelihoods, and the abduction and abuse of women and children. The war also led to the destruction of health, education and justice systems in Northern Uganda.

A review of Uganda's health financing modalities indicates that out-of-pocket funds and donor aid have remained the main sources of funding for the health sector. Government allocations for defence, internal security, education, and road construction are prioritised over the health sector. This poor prioritisation of the health sector is reflected in the pattern of primary health care funding, despite population growth and an increase of equipment and infrastructure (largely supplied through donor funding), there has been no appreciable increase in the different allocations to the decentralised district.

Many of these factors have influenced maternal health care access and utilisation through their impact on important supply- and demand-related factors. Data shows that many of these factors are more prevalent in conflict-affected Northern Uganda.

4 - THE METHODS CHAPTER

This chapter provides an overview of the methodological approaches that include the data collection, and analytical techniques that were applied to this thesis. The aims and objectives are explained in section 4.1 while section 4.2 describes the underpinning strategy and methodology. I then discuss the study design in section 4.3 followed by section 4.4 that provides details about the study sites. Sections 4.5 and 4.6 describe the methods and analysis chosen. Sections 4.7 and 4.8 describe the quality assurance issues, reflections on my role and positionality as a researcher and the ethical considerations respectively.

4.1 Research Aims and Objectives

The aim of this thesis as mentioned in chapter one, section 1.1 was to understand how governance and its underlying drivers contributed to Uganda's health system performance, as it delivered health care to a vulnerable population that was recently post-conflict as well as to a similarly vulnerable population in Uganda that had enjoyed relative peace of over 20 years. I refer to the latter population as non-conflict or non-post conflict.

More specifically, the research studied two processes, as well as actions and interactions of stakeholders that influenced maternal health outcomes. One process was the governance process that had a bearing on the strategic direction of health policy development and its implementation. The second process was the governance processes that influenced the maternal health care services utilisation by vulnerable women in a Ugandan post conflict setting in comparison with women from other rural, poor, but more peaceful environments within Uganda. Political, social and economic lenses were applied in understanding the actions and interactions through which these two processes influenced health system performance in the two contrasting settings.

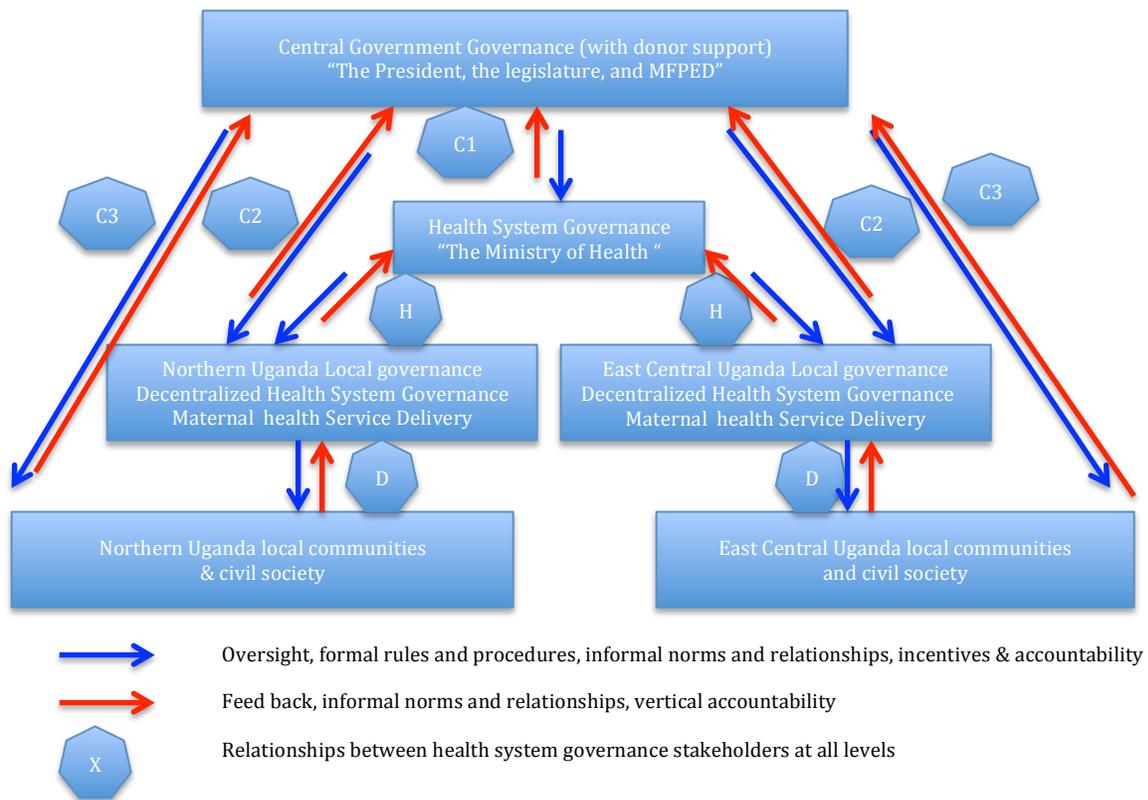


Figure 4.1 : The Research Concept Framework

Figure 4.1, the study’s conceptual framework depicts the linkages between Central government, the health sector ministry, the decentralised government and health system, and the community. The blue uni-directional arrow depicts the policies, the rules and procedures as well as the informal norms working at three levels: central government, health ministry and district level that shape the maternal health care provided to the communities.

The red arrows show the upward relationship representing: service uptake (at community level), response to the service, for example, feedback, protest, voting patterns. The red arrows at higher governance levels depict the provision of information in the form of reports and accountability (see discussion on accountability on Section 2.2.3).

The labelled hexagons depict the stakeholder relationships and in this case “C1”, “C2” and “C3” represent Central government relationships with the health ministry, the decentralised health system and the communities in Northern and East Central

Uganda respectively. The label “H” represents the relationship between stakeholders at MOH and the district local governments. The label “D” represents the relationships between the district health system and the communities in Northern Uganda and East Central Uganda respectively.

Maternal health care, one of the components of Uganda’s minimum health care package and an important millennium development goals was opted for as a tracer for health system performance because it made possible the scrutiny of the impact of health system governance on the equitable utilisation of care, a desired health system outcome in accordance with the WHO’s health system framework (2007)(McPake *et al.*, 2013).

This study entailed the collection of data relevant to maternal health care in Northern and East Central Uganda through a policy document review and through the collection of qualitative data from in-depth interviews and focus group discussions. The major focus of these investigations was to determine underlying power relationships; actions and incentives influenced by institutional and contextual factors and ultimately having a bearing on health sector performance.

4.2 Research strategy and methodology

I opted to use an Applied Social Policy Strategy that provided a suitable platform upon which the Political Economy method of analysis was applied.

4.2.1 Applied Social Policy Research

Applied Social Policy Research (ASPR) is a term used in social enquiry to denote studies that aim at monitoring and evaluating the effectiveness and utilisation of policy and procedure (Srivastava and Thomson, 2009). This form of qualitative research is seen to differ from basic or theoretical research because it “uses knowledge acquired through research to contribute directly to the understanding or resolution of a contemporary issue” (Ritche, 2004, p.24). According to Bulmer, 1982 cited in Ritchie and Spencer (1994), a perception initially held by many policy makers and researchers alike that hard evidence has to be of the quantitative form was changing to an appreciation that qualitative research provides added value in

applied social policy research (Ritchie and Spencer, 1994). Depending on the audience and the research question, the qualitative method can have a significant stand-alone value of its own (Theobald and Nhlema-Simwaka, 2008).

The Applied Social Policy Research strategy was suited for this thesis on the basis of the following: it addresses policy-related research questions; it uses samples that can be pre-determined; it is suited for research into *a priori* issues; and it is suitable for research limited by time (Ritchie and Lewis, 2003). Other researchers corroborate my choice of strategy; they recognise the suitability of the ASPR strategy for raising the perceptions and experiences of marginalised and vulnerable populations to the formulators and implementers of health policy (Theobald and Nhlema-Simwaka, 2008).

While a distinction is made between *applied* social research and *theoretical* social research, they are recognised as complimentary in applied social policy research (Ritchie and Lewis, 2003). These authors also state that policy-related research objectives, like mine, tend to have a broad agenda that draw in social and culturally contextualised issues in an attempt at relating their influence on specific services, interventions or legislations being made (Ritchie and Lewis, 2003). Further more, applied social research is not limited to a single data collection or analytical method but is an interdisciplinary confluence of research approaches that are put together to address the research question (Ritchie and Spencer, 1994). It was on the strength of these salient points that I co-opted methods from the disciplines of sociology, economics, and political science and applied them using both the inductive and deductive approaches as I am to explain.

Ritchie and Spencer (1994), conceptualise the research objectives that applied social policy research responds to under four distinct categories, namely: the *contextual category* – representing studies that look at the form and nature of what exists; the *diagnostic category* – that look at the reasons for, or the causes of what exists; the *evaluative category* – that appraises the effectiveness of what exists; and, the *strategic category* – that identifies new theories, policies, plans or actions.

My thesis predominantly featured the evaluative and diagnostic categories. The research objectives are *evaluative* because it looks at the relationship between health system governance and maternal health care utilisation in the two contrasting contexts of Uganda. The objectives are *diagnostic* in nature because they seek to determine factors that influence the health system performance outcomes of governance decisions made for both the conflict and non-conflict affected environments.

While I use the applied social policy research strategy as the overarching research approach, it primarily makes use of the political economy analysis (PEA) framework for data analysis complimented by the Framework analysis method. The PEA framework supports an intensive analysis of emerging themes on the basis of economic processes, political policies and social institutions. The Framework Method is an analytical approach that acts as a tool for the generation of themes that are subsequently applied in the PEA. The themes are generated through the systematic organising, summarising and analysing of qualitative data, with the themes created being arranged by case, and by code. In subsequent sections I expound further on the rationale behind choosing this approach.

4.2.2 Political Economy Analysis method

This method is of particular importance to the thesis because while an inductive approach was the pre-dominant driver in the generation of themes, the subsequent use of the political economy framework represented the introduction of pre-existing theory to enhance theme refinement as I alluded to previously.

To reiterate, the *deduction* process narrowed the analysis to focus upon economic processes, political policies and social-cultural dimensions of the contexts that influenced the manner in which organisations addressed health system governance and maternal health care delivery in Northern Uganda as compared to East Central Uganda (Harris, 2013). The *induction* process through its case based approach initiated the generation of themes and provided additional a *posteriori* factors, particularly at community level that played a role in health system governance that

otherwise could have been ignored (Srivastava and Thomson, 2009; Gale *et al.*, 2013; Harris, 2013).

The Framework Method

The Framework Method that supported the development of themes in the PEA was developed by Jane Ritchie and Liz Spencer from the Qualitative Research Unit at the National Centre for Social Research in the United Kingdom in the 1980s for use in large-scale policy research (Ritchie and Spencer, 1994). It belongs to a group of analytical approaches, referred to as thematic or qualitative content analytical methods, that identify “*commonalities, differences and relationships*” in qualitative data that can then be used to draw explanatory conclusions that cluster around themes (Gale *et al.*, 2013).

Details on how the political economy approach was effectively complimented by the framework analysis method are discussed in the next section.

4.3 Study design

This study was designed to capture information about health system governance factors that had a bearing on maternal health care services utilization amongst women in two sub national populations that differed with respect to exposure to conflict in the recent past. As defined by the research objectives, the study employed a comparative analytical approach, collecting predominantly retrospective data through a single episode of interviews, focus group discussions and policy documentation. Summary table 4.2 (in Section 4.3.4) indicates how the study conceptual framework guided the collection of research data according to governance stakeholder category at national and sub national level. I describe important features that are unique to this study and provide a rationale for the design opted for. Further elaboration is provided when I describe the study procedure in section 4.5.

4.3.1 The use of the comparative method in subnational analysis

Opting for an approach that compares governance and its impact on maternal health in the population of Northern and East Central Uganda resonates with the views of Collier (1993), and more recently Jacob (2015) who argue that comparative analysis holds a central goal of assessing and clarifying rival explanations.

Ritchie and Lewis (2003) and Walliman (2006) argue that comparative research portends a more robust understanding of relationships between a “controlled variable” and social phenomena. In my research objective, the controlled variable is health system governance and the social phenomenon is maternal health care and its utilization. As these authors clearly state, the use of a control variable is not purposed at measuring or quantifying impact of an intervention as would be the case in quantitative research, but is rather purposed at understanding the phenomena (Ritchie and Lewis, 2003; Walliman, 2006).

In line with suggestions by Ritchie and Lewis (2003) therefore, I use the comparative approach for the purposes of: i) determining health system governance characteristics that impacted on maternal health care utilisation in post-conflict and non-post conflict Uganda during the immediate post conflict period; ii) identifying the absence or presence of particular Good Governance characteristics in health system governance; iii) exploring how governance influenced supply-side and demand-side health system determinants, in turn causing variations in maternal health utilisation in the two study populations; iv) determining how the different characteristics identified influenced other important parameters of health system performance in the two regions including: equity, quality and responsiveness.

My study's quest is to consider factors influencing maternal health care in two contexts: post conflict and non-conflict. In line with a discourse by Miles, 1994 cited in Freeman(2006), using the non-conflict health system as comparator also provides opportunity for testing the validity of assumptions that are considered unique to post-conflict health systems.

The comparative approach to qualitative research has not been without criticism however. Walliman (2006) recognises that in a cross cultural study, contextual differences are easily ignored in the quest of identifying contrasts between cases. Indeed in this study there are important cultural differences between the Luo and the Bantu living in Northern and East Central Uganda respectively. As will be seen in chapter 7, these cultural differences are duly considered during the discussion.

4.3.2 Retrospective nature of the study

The fieldwork of my research study was conducted between June and September 2014, seven years after the signing of the peace accord. The study required the collection of mainly retrospective accounts from respondents to explore governance and maternal health care utilisation during the immediate post conflict period. Further more the data collection process involved a single episode of fieldwork⁹. A number of researchers, for example Dex (1995) and Silverman (2000) highlight the limitations associated with retrospective questioning, citing a high likelihood of a deterioration in the data quality through problems with recall, distortion and post event rationalisation. However, from a review of studies that evaluate the validity and reliability of recall data, Dex (1995) reports that recall data associated with *salient events, health service usage and health related events* tend to be consistently reliable. In addition the researcher proposes methods that enhance the reliability of recall data which include conducting face to face interviews, using open-ended questions and “land-marking” events (Dex, 1995). My study collected recall data by making use of open-ended questions that encouraged narrative style responses on governance and health care usage issues during salient moments in Uganda’s history when Northern Uganda was gaining peace after 23 years of turmoil and for the rest of Uganda I used the 2006 general election as the point for recall.

As will be described in the section 4.5 the retrospective questioning occurred more in the in-depth interviews that sought detailed information about health system governance and maternal health care during the immediate post conflict period. The

⁹ In this includes three of the respondents that I visited more than once to seek clarifications on a number of emerging issues.

focus group discussions addressed more attitudinal issues and entertained responses to questions about governance and maternal health care that were more in the current situation. I discuss the rationale for these options in the following sections.

4.3.3 Sampling method

I identified the stakeholders that I interviewed in three settings: Kampala, Uganda's capital city, Northern Uganda, and East Central Uganda. They were identified on the basis of their governance roles in decision-making and programme implementation as represented in the conceptual framework in Figure 4.1. While in the field conducting the interviews, the respondents on many occasions identified – *snowballed* – other potential respondents that held information in areas of particular interest to my research.

The overarching rationale for my sampling approach is in consonance with the aim of qualitative research, which is to gain an understanding about the nature and form of phenomena; deriving meaning and explanations; and, generating concepts and theories (Ritchie and Lewis, 2003). In this regard, purposive or criterion based sampling techniques as defined by Patton (1990) best describe my approach; the sample units chosen having particular features which enable a “*detailed exploration and understanding of the central themes and puzzles which the researcher wishes to study*” (Ritchie and Lewis, 2003, p. 78). Burgess, 1984 cited in Ritchie and Lewis (2003), further applies the term *judgement sampling* on the method of selecting individuals on the basis of specific information that they will provide on socio-demographic characteristics or on particular behaviour, roles and experiences.

I also predetermined the number and composition of individuals (or sampling units) that were engaged in in-depth interviews and focus group discussion on the basis of information that I needed to capture on governance. Thirty-one individuals were interviewed, and another 61, that is, an average of 8 people per focus group, were engaged in focus group discussions.

The relatively small sample size is justified by Collier (1963). He states that a small sample size (“*small-N analysis*”) is appropriate in comparative analysis for political science-oriented research questions. This smaller sample size and approach allows for more intensive analysis and hypothesis testing.

Selection of individuals for in-depth Interviews

Individuals working with organisations that had a stake in maternal health governance in Northern and East Central Uganda during the 2006 to 2011 timeframe were identified using the study’s conceptual framework (see Figure 4.1). As the framework indicates stakeholders at central government and central health sector levels were accessed in Kampala, Uganda’s capital city. These stakeholders included individuals that worked or were still in active service in government or in key donor agencies and NGOs working with government at national level.

The stakeholders at the decentralised and community levels, who were representatives of government, NGOs and CBOs were accessed for interviews at their organisational offices in their respective locations in Northern and East Central Uganda. In Northern Uganda the in-depth interviews took place in the districts of Gulu — which is the region’s main city, Kitgum and Apac. In East Central Uganda the in-depth interviews occurred in the two districts of Iganga and Luuka (see the districts in the map in Fig. 4.2 below).

Selection of the Districts for focus group discussions

I selected three out of the four study districts in Northern Uganda for the focus group discussions on the basis of: i) degree of displacement during the war; ii) degree of “rurality”¹⁰; and, iii) “age” of district (see relative challenges of old and new districts in section 3.1.4).

¹⁰ My search for an appropriate definition and measure for the rural taxonomy or “rurality” was futile. I realize that for the developing world *rurality* is appreciated as the norm. In contrast, the urban settings are relatively fewer, rapidly changing but still harbor a smaller percentage of the population. Most research work has gone to defining urban and therefore rurality through exclusion. For the Western world, where most people leave in urban settings, the converse seems to be the case, there is an abundance of research work that defines what “rural” is in measurable terms. I therefore opted to use the degree of remoteness or distance from the nearest urban centre as main measure of rurality. Note the distances from the closest urban centre in section 4.4.

Kitgum and Apac are older peri-urban districts that came into existence at the same period during the *pre*-NRM government years. Kitgum experienced massive displacement with about 90% of the population displaced at the height of the war. Apac is a district on the southern fringes of the region; it suffered transient spill overs of violence. Only about 40% of the population suffered displacement and this towards the war's end.

Lamwo and Nwoya districts represent the newly created districts in the region both coming into existence during the immediate post-conflict period. They are both significantly remote. (See the description of the districts under section 4.4).

I selected two districts in East Central Uganda as comparators on the basis of i) being non-conflict districts; ii) population size (see table 4.1) iii) "Age" of district matching that in Northern Uganda; and iv) relative degree of "*rurality*" also matching that in Northern Ugandan districts.

On the basis of the parameters described under section 4.4 Iganga district compared closely with the older peri-urban districts of Kitgum and Apac. Luuka district compared with the newly created, remote districts of Nwoya and Lamwo districts (also see table 4.1). Focus group discussions were not conducted in the unmatched district of Gulu. It was a location for some of the important in-depth interviews that were conducted at sub national level.

Focus groups were held within or close to health facilities that I had selected to represent the tiered decentralised health care delivery system. Therefore for each region, communities in the service areas of i) a district hospital; ii) a health centre level IV, and iii) a health centre level III, represented the eligible sample population. I applied the purposive or criterion-based sampling procedure to select three homogeneous groups: the village health team members; women leaders; and opinion leaders. Additional definitions and details on procedure are further discussed under sections 4.5.3 and 4.5.4.

Table 4.1: Selected Profiles for Study Districts> Source: MOH HMIS Reports (2012-2014)

Region	District	Population	Number of Health Facilities (HF)				HF Deliveries %	ANC Complete %	Ranking (out of 132) 2012/2013
			Hosp.	HC IV	HC III	HC II			
POST-CONFLICT NORTHERN UGANDA									
Acholi	Gulu (Ur)	407,500	4	2	14	53	79.5	41.1	1
	Lamwo (Rr)	178,100	0	2	8	13	45.3	25.6	86
	Kitgum (Rr)	257,600	2	1	8	11	54.4	30.9	54
	Nwoya (Rr)	54,400	1	0	3	13	111.6*	54.8	3
Lango	Apac (Rr)	360,500	1	1	11	19	32.1	20.4	67
NON-CONFLICT EAST CENTRAL UGANDA									
Busoga	Iganga (Ur)	517,000	1	2	14	40	48.7	24.3	20
	Luuka (Rr)	269,800	0	1	7	20	17.2	11.0	96
Key : Ur = Urban; Rr = Rural; * as recorded in HMIS report									

4.3.4 Data collection

The data collection method applied to this study involved a combination of in-depth interviews, focus group discussions, and a policy document review, each method playing a distinct role. As represented in the summary table 4.2, the data collection exercise was guided by study conceptual framework with regard given to governance level and the category of respondents. Table 4.2 also indicates the data collection period and the number of respondents reached.

In line with suggestions by Ritchie and Lewis (2003), the choice of data collection method was dependent on: i) the type of data sought; ii) the subject area; and, iii) the nature of the study group. The in-depth interview was suited for the collection of detailed technical information from policy makers, government or donor agency bureaucrats or health providers about their roles and that of organisations with regard to maternal health care governance. Additionally conducting a focus group discussion with such individuals would be difficult considering their conflicting time schedules.

Table 4.2: Summary of generated data collected relative to governance level, time frame, and gender and number of sessions

Stakeholder Category	Governance Level	Interview Period	Data Collection Method	Female	Male	No. of interviews/FGDs
National Stakeholders	Central Government level					
	Legislators	Sept 2014	KII	1	1	2
	Ministry of Finance	Jun 2014	KII		1	1
	Donor Agency Reps	Oct 2014	KII	4	2	6
	Ministry of Health Level					
	Health Ministry officials	May 2014	KII	2	4	6
Sub-national Stakeholders	District Level					
	<i>District Administrators</i>					
	North	July 2014	KII	1	2	3
	East Central	Jun 2014	KII		4	4
	<i>Health providers</i>					
	North	Aug 2014	KII	1	0	1
	East Central	Jun 2014	KII	1	0	1
	Community Level					
	<i>CSO representatives</i>					
	North	Aug 2014	KII	2	1	3
	East Central	Jun 2014	KII	4	1	5
	<i>Community interest group reps*</i>					
	North					
	Opinion Leaders	Aug 2014	FGD	0	11	1
	Women Leaders	Aug 2014	FGD	10	N/A	1
Village Health Team	Aug 2014	FGD	4	7	1	
East Central						
Opinion Leaders	July 2014	FGD	10	0	1	
Women Leaders	July 2014	FGD	9	N/A	1	
Village Health Team	July 2014	FGD	5	4	1	
			54	38	38	

*One focus group discussion held for each community level category
KII = Key informant interviews, FGD = Focus group discussions

My choice was in consonance with the opinions of DiCicco-Bloom and Crabtree (2006) that stated thus: “*in-depth interviews are widely used by health care*

researchers to co-create meaning with interviewees by reconstructing perceptions of events and experiences related to health and health care delivery”.

On the other hand, focus group discussions played a separate role in the study and focused on breadth through observations, perceptions and attitudes of members of communities in the two sub regions, people that were predominantly beneficiaries of the health system, and were voters and consequently influencers of policy. In agreement with the writings on the focus group method by Kitzinger (1994), I was not only interested in *what* the communities thought about health system governance and maternal health care, but also about *how* and *why* they thought the way they did.

Beyond issues regarding the suitability of the focus group, Freeman’s (2006) comparison of the realist versus the contextual constructivist epistemologies best captures the considerations that I contended with as I planned the constitution of the focus groups. I consider my approach more in keeping with Kitzinger’s (1994) methodological tradition of contextual constructivism which seeks to glean data from “naturalistic” exchanges between members of pre-defined groups. Unlike Freeman (2006) who considers information gained from pre-defined groups as weak in transferability, I found it useful to purposively select individuals from well recognised community structures, that is, women’s groups, opinion leaders and village team members who could provide data representative of each sub region but also more suitable for comparative analysis.

4.3.5 Public policy data

According to Kaufman and Kraay (2008), there are two useful approaches to measuring health system governance. These are the rules-based and out-come based approaches. The rules-based approaches measure whether countries have appropriate policies, strategies and mechanisms for governance of the health sector. The out-come based approaches ensure rules and procedures are effectively enforced or implemented based on the experience of relevant stakeholders (Kaufmann and Kraay, 2008; World Health Organization, 2008). While the in-depth interviews and focus group discussions provide for the out-come based approach,

the rules-based approach was determined by the in-depth interviews in part and reinforced by a review of policy related documents that I undertook.

The aim of the policy documentary review was to evaluate all policies written during the NRM movement era that had a bearing on maternal health care utilisation in both regions. In the policy analysis I considered two important areas as described by Morestin (2012): i) the effects of policy; in other words: the effectiveness, unintended effects, and equity of policy implementation; and ii) the cost, feasibility, and acceptability of policy. The procedure of review is described in detail under section 4.5.1.

4.4 Study Site

Data collection took place in the three regions of Uganda: i) Central Region - Kampala; ii) Northern Uganda – districts of Kitgum, Lamwo, Gulu, Nwoya and Apac; and iii) East Central Uganda – districts of Iganga and Luuka. See map in Figure 4.2.

4.4.1 Kampala

Kampala is the capital city of Uganda and also a metropolitan district within Buganda or Central Uganda. Kampala is located on the Northern shores of Lake Victoria and is surrounded by Wakiso and Mukono districts (see figure 4.2). The district has a population of 1.5 million according to the latest National Housing and Population Census(UBOS, 2014). It hosts the Ugandan parliament as well as the headquarters of the ministries of government, foreign missions, and donor agencies and is also headquarters to leading non-governmental organisations.

I conducted interviews in Kampala with Members of Parliament, senior technocrats in government and with representatives from non-governmental organisations.



Figure 4.2: Uganda administrative map and study sites

4.4.2 Northern Uganda

As shown in the map in figure 4.2, Northern Uganda consists of two ethno-politically distinct sub regions; the Acholi sub-region with seven districts, and Lango sub-region with eight districts. All the districts of the Acholi sub-region were exposed to the conflict for over 20 years. In the Acholi sub region, the data collection exercise took place in Gulu district where the regional capital of the sub region is situated as well as in the rural districts of Kitgum, Lamwo and Nwoya. Lamwo and Nwoya are newly created districts that were formed after the restoration of peace in the region. In the Lango sub region, the data collection was conducted in the rural district of Apac. The district was one of that suffered from spill overs of conflict, however the

counties that were most affected by the war more recently become independent districts themselves, these are: Kole and Oyam districts. The study districts are represented in the administrative map in figure 4.2.

Gulu District

Gulu is a peri urban district of the Acholi sub region and is named after its town. It is recognised as the regional administrative headquarters for Northern Uganda. The district is located 320 kilometres north of Kampala Uganda's capital city by road. As of May 2011, Gulu consisted of two counties, Achwa and Omoro with a population of about 298,500 people. This district was the epicentre of major battles between the Ugandan Army and the Lord's Rebel Resistance Army that led to the maiming, abduction and death of the civilian population over the 23-year period. Over 90% of the population of the district was displaced into IDP camps by 2006 when the Cessation of Hostilities Agreement was assented. By 2009, about 80.7% of the 1,840,000 internally displaced persons had returned to their homes, many located outside Gulu District (UNOCHA, 2010). A number of youth, widows, the elderly and sickly individuals decided to remain behind in the IDP camp settings which have slowly transformed into townships. Nwoya district, another site for this study was still part of Gulu district during this period of interest, that is, 2006 to 2011.

Gulu district hosts a number of major health facilities. These include two referral hospitals: one government, and the other private-not-for-profit. It also hosts two medical schools for the training of doctors and clinical officers that are run in close collaboration with the referral hospitals. The district has a number of level III and level IV health centres providing maternal health care services.

Gulu town accommodates the headquarters or regional offices of international and national NGOs that have varied levels of involvement in maternal health care for Northern Uganda. A significant number of these emergency relief organisations gradually closed their operations in Northern Uganda once the war came to an end.

In Gulu, I conducted three in-depth interviews, with a senior officer in the health sector, and with two senior NGO personnel whose organisations were active during the immediate post-conflict period.

Gulu District reported 79.5% of maternal deliveries being conducted in government or private not for profit health facilities in 2011 (MOH, 2013a). This ranked Gulu first at district and national level in the Uganda Ministry of Health league tables for financial year 2012/2013 (MOH, 2013a). Gulu has on many occasions topped the District Performance League Tables¹¹ both during the conflict and post-conflict periods. Various reasons have been entertained for Gulu's unexpected performance that is not replicated in other conflict-affected districts. One postulation hinges on the fact that up to 90 % of the population were displaced into camps. These congregate settings provided better access to high quality medical care provided by the numerous NGOs that have been active in Gulu (Nattabi et al. 2011; Orach & De Brouwere 2004). Another reason offered by Komakech (2005) suggests that the league tables are based on process indicators, for example, timeliness and completeness of health management information reports, the number of outpatient visits in government and NGO hospitals, or immunisation coverage and or health facility deliveries. It does not capture data on health outcome indicators like maternal mortality and infant mortality rate amongst others. Again Komakech (2005) suggests that Gulu's figures only reflected the efficiency of a well-established, experienced health team. Indeed these league table figures do not tally with the Uganda Demographic Health survey reports of 2011 that suggest health facility delivery rates for Northern Uganda of 51.9% (UBOS and ICF International Inc, 2012). UNICEF specifically reported a maternal mortality of 1000 per 100000 life births for the districts of Gulu and Kitgum (Komakech, 2005).

I had worked in Gulu for a total of eight years at different times, first as an intern doctor at a faith-based private-not-for-profit referral hospital and later as a

¹¹ The District League Tables (DLT) is a tool used for assessing the performance of district local governments in the health sector. Twelve indicators are used to evaluate and rank district performances that include: eight coverage and care indicators (score weight 75%) and four management indicators (score weight 25%) (MoH 2013a).

technical staff with a USAID health programme based in Gulu. I will discuss further in section 4.7, how this affected my role as the researcher in this study.

Lamwo District

Lamwo is a newly created rural district in the Acholi sub region carved out of Kitgum district by an Act of Parliament, becoming functional on the 1st July 2009. The district is bordered by Southern Sudan to the north, Kitgum District to the east and southeast, Amuru District to the west and Pader District to the south (see figure 4.2). It had a population of 178,100 people by 2011. Padibe town is the main political, administrative and commercial centre and is located approximately 150 kilometres northeast of the regional town of Gulu and approximately 450 kilometres north of Kampala the capital city.

The district has no district hospital, but has four health centre III's and two health centres IV's that had the capacity to provide emergency obstetric care (EmOC). The referral centre for the new district is Padibe Health Centre Four located in Padibe town council. According to the financial year 2012/2013 Ugandan Ministry of Health League table, Lamwo district ranked 12th out of 15 Northern Ugandan districts, and 86th out of 132 districts country wide (MOH, 2013a). The league table further indicates that 25.4% of pregnant women delivered in the health facilities and 25.4% of pregnant mothers completed four antenatal visits in 2011 (MOH, 2013a). Lamwo district continues to gain news coverage on the grounds of its population suffering outbreaks of largely preventable epidemic prone diseases like yellow fever, cholera, typhoid fever and hepatitis E. Lamwo district also harbours the largest number of children suffering from Nodding Disease a neurological disease of unknown aetiology. I conducted one in-depth interview here with a district health team member at the health sub district head quarters. As will be noted in chapter six, my study findings suggest that the health system in Lamwo District is witnessing great improvement though this is not reflected in the data profiled above.

Nwoya District

Nwoya is a rural District, also part of the Acholi sub region and one of the newest districts in Uganda carved out of Amuru district, becoming functional on the 1st July 2010. Amuru district was itself part of Gulu district in 2006. Nwoya district is bordered by Amuru District to the north, Oyam District to the east, Kiryandongo District to the southeast, Nebbi District to the west, Bulisa District to the South West and Masindi District to the south. Anaka is the main political, administrative and commercial centre that served a population of 54,000 by 2011. The town grew out of a disbanded IDP camp that once surrounded Anaka hospital. The town is located approximately 44 kilometres southwest of the regional town of Gulu and approximately 330 kilometres north of Kampala.

In the centre of Anaka town is a 100-bed hospital, one of 22 hospitals built by the first post independent government. According to the District League Tables for 2011/12 and 2012/13, Nwoya's health sector performance ranking improved from 17th country wide to 3rd and was ranked as the best performer amongst the newer districts of Uganda (MOH, 2013a).

I conducted interviews with members of a woman's self-help saving scheme as well as with a group of opinion leaders. I conducted my interviews outside the hospital grounds, this seemed to have a bearing on the quality of the discussion as compared to the focus group discussions held in Kitgum, Luuka and Iganga that were held within the hospital grounds. I will discuss the implications of this in section 4.7 and later in chapter 7.

Apac District

This rural district is part of the Lango sub-region and is named after the main administrative town of the district, Apac. It is bordered by Oyam District to the North East, Kole District to the north, Lira District to the northeast, Dokolo to the east, Amolatar District to the south, Nakasongola District to the south east, and Kiryandongo District to the west. In 2006 and 2010, Oyam and Kole districts, respectively, were carved out of Apac District.

Five sub counties of Apac district suffered the brunt of the conflict in Northern Uganda with a large number of children abducted by the rebels from these areas during the period. One of the highly publicized abductions was of 139 schoolgirls that were kidnaped from St Mary's Girl's school in Apac on the 10th of October 1996 (De Temmerman, 2001)¹².

The district has a 100-bed government run hospital. The district has in addition four health centre level IVs and eight-health centre level IIIs that provide maternal health care services. Apac is host to a number of prominent community based organisations. With health facility related deliveries at 31.5%, and four antenatal visits at 20.4%, Apac is ranked 67th nationally and 11th out of the 15 districts of Northern Uganda in MOH league table for financial year 2012/2013 (MOH, 2013a).

I conducted in-depth interviews with respondents representing community-based organisations active in the Lango sub region during the immediate post-conflict period.

Kitgum District

Kitgum is a rural district of the Acholi sub region of Northern Uganda is one of the older districts from which the two districts of Lamwo and Pader were created. The district has a population of 44,604 and shares boundaries with Gulu on the west, Southern Sudan on the North, Kotido on the east and Pader in the north. Kitgum town is 108 kilometres Northeast of Gulu and 460 kilometres north of the capital city Kampala.

Kitgum has a 200-bed government district hospital and a 300-bed missionary hospital both acting as referral units for that catchment area. I conducted in-depth interviews with some members of the district team and a focus group discussion with village health team members at one of the health centres in Kitgum.

¹² By 2006, 132 of the Aboke girls had either been rescued or escaped from captivity. Two girls died in rebel hands and five remain unaccounted for.

4.4.3 East Central Region

This sub-region is also called Busoga, after one of the ancient Bantu states. It is one of the four constitutionally recognised traditional monarchies in Uganda. The Basoga (singular: Musoga) are the ethnic group indigenous to 10 districts that make up the sub-region. Busoga is probably the only region in Uganda that has been spared from effects of the numerous waves of violence that characterised Uganda's chequered past (Ngobi Miti, 2012). Jinja, where the source of the River Nile is located, is the regional city for East Central Uganda. The region is however recognised to have one of the highest levels of poverty and has consistently performed poorly in many health surveys (UBOS and ICF International Inc, 2006, 2012).

Luuka District

Luuka is a rural district that was originally a county within Iganga district until it became a district on the 1st of July 2010. Luuka District borders Buyende district in the North, Iganga district to the southeast, Mayuge district to the south, Jinja to the southwest and Kamuli to the Northwest. Luuka the chief town in the district is 33 kilometres south west of Iganga town, and 77 kilometres from Jinja.

The district had an estimated population of 269,800 people by 2011. It has no hospital but is served by one health centre IV that provides essential maternal health care services. Luuka was ranked 96th out of 132 districts in health care performance for financial year 2012/2013, with 17.2% of women delivering in government or private not for profit health facilities in the district and 11.0% of pregnant women completing four antenatal clinics (MOH, 2013a).

At Luuka, I conducted interviews with respondents from the district council, and focus group discussions with women leaders of community based organisations, and opinion leaders.

Iganga District

This is a peri-urban district in east central Uganda named after its main town, Iganga and is bordered to the northeast by Namutamba District, Bugiri to the East,

Mayuge to the South, Jinja to the South East and Luuka District to the West. The district population was 517,000 by 2011. The district headquarters are located approximately 44 kilometres by road from Jinja. The town lies astride the Kampala – Nairobi highway, and is 50 kilometres away from the Kenyan Ugandan border. Iganga has a district hospital, four health centre level-IV and eight health centres level-III. The district was ranked 20th in MOH league table for financial year 2012/2013 with 48.7% of deliveries conducted in government or private not for profit health facilities (MOH, 2013a).

I conducted in-depth interviews with respondents from the district local government and district based non-governmental organisations, and held focus group discussions with village health team members.

Refer to table 4.1 that summarises the key administrative and health system related features of the districts that made up the study sites for this research (except Kampala). In the table note the un-equal distribution of health facilities between the rural and peri-urban districts. It is also notable that the health facility deliveries, antenatal attendance and overall ranking are similar or even better in the post conflict setting compared to the non-conflict setting.

4.5 Methods

This involved a documentary review, in-depth interviews at national and sub national levels, and again at sub national level, and focus group discussions. I considered this a suitable approach to gaining a rounded interpretation of factors that influenced health system governance for maternal health care. At national and sub regional level the in-depth interviews targeted representatives of organisations, while focus group meetings were used to collect data from different community groups.

Combining the interviews and meetings with the policy analysis process is in line with recommendations by Ritchie and Lewis (2003), who consider the triangulation of *naturally occurring data* (documentary reviews), and *generated data* (in-depth and focus group interviews) as suited for qualitative inquiry. The generated data in

this study ensures that details about governance for maternal health contextual and institutional issues in Northern and East Central Uganda, albeit retrospective in nature are captured. The naturally occurring data, that is, the policy documents corroborate and enhance the linkages and accuracy of the retrospective data.

4.5.1 Policy documentary review

As earlier mentioned, accessing the documents involved a review of national level and health sector policies that had a bearing on maternal health care and its utilisation. Hard copies of the documents were sourced from the Uganda Ministry of Health library as well as from in-depth interview respondents at organisations visited. Soft copies of the documents were accessed from MOH website as well as other related websites. A snowballing approach was used to access grey literature as well as peer-reviewed articles that evaluated these policies at formulation and implementation level. This supported the effort to gain a clearer picture of issues surrounding the maternal health policy environment.

The document review proceeded through three recognisable steps:

Step One: An inclusion criterion was created that set a boundary for the search. The criteria included the following:

- Documents from 1987 to 2011;
- National Policy documents addressing political governance, macroeconomic policy and pro-poor reform and decentralisation;
- Health sector policy documents including the national health sector strategic and investment plans, the health financing and human resource for health plans;
- Specific programme policies for maternal health, reproductive and adolescent health;
- Mid-term and end-of-programme reviews;
- Grey and peer-reviewed literature written during any timeframe assessing the formulation and implementation of these policies.

Step Two: The documents selected were then reviewed and data was extracted and categorised according to the following parameters (Sections 5.2.3 and 5.2.4 in chapter five were derived from these parameters):

- Document description - the *title, source* and *intervention context*;
- Scope – National, health sector, and Northern Uganda;
- Period - when the document was written and period covered;
- Content – whether Northern Uganda was implicitly or explicitly catered for in the policy implementation plan.

Step Three: The data from these documents was then analysed to determine links, power relationships and influences between the different national and health sector policies and implementation guidelines.

4.5.2 National level health system governance evaluation – in-depth interviews

At national level, the in-depth interview was the data collection tool of choice for gaining information from decision-makers and technocrats. A topic guide steered the interview process at this level ensuring that the information obtained was of appropriate detail considering the comparative nature of the study. It had the potential of unravelling the complex and in many cases sensitive issues that were influencing the actions of health governance stakeholders and impacting on health system performance and outcome (Ritchie and Lewis, 2003).

Procedure

I made physical or phone contacts with potential respondents prior to the date of the interview for purposes of scheduling an appointment. Most of the interviews took place in their office premises. Two of the interviews were held in a public venue and three eventually had to be conducted by Skype. These three individuals were not accessible during the data collection period. I maintained contact with them and an opportunity to conduct the interviews arose while back in the UK. It was often difficult to maintain a stable Skype video link hence the decision to conduct the interview by the Skype voice call facility alone. This was synonymous with a telephone interview.

Lewis and Ritchie (2003) offer caution on the limits of the telephone interview, as compared to the face-to-face interview; the interactive encounter where meaning and language is explored in depth is lost. The Skype interviews were the last three in-depth interviews that I was conducting and mainly played a validating role for information that I had already been reviewing as part of iteration (as I explain in section 4.6.1.). A review of the telephone interview method by Opdenakker (2006) indicates that it was sufficient for the clarification role that these latter interviews played in this study. The Skype interview questions set to the respondents were focused and were expected to draw direct responses. Seeking social cues to augment the information that the respondents provided was of minor importance in these circumstances.

Many of the respondents were individuals that had moved on from positions they held in organisations that were of relevance during the immediate post-conflict time frame (Such respondents were no longer bound to these organisations and were assumedly more able to discuss more contentious issues). The interviews focused on policy makers and implementers that included: legislators, senior bureaucrats, managers in donor agencies and academicians.

I conducted the interviews singly without an assistant and used both a recording device and short notes to capture the proceedings of the interview. An interview guide that was pre-tested earlier in the study provided direction for the process. The interview took on average about one hour and 10 minutes and ended with the respondent being requested for policy documents, briefs or reports that were related to activities carried out in Northern Uganda and East Central Uganda that had a bearing on health system governance, maternal health care and its utilisation. I had the opportunity to conduct a repeat interview with two of the respondents in an effort to clarify the data that I was reviewing as part of iteration.

The data collected focused on: i) individual and organisational perspectives of the political, economic and sociocultural factors that influenced the course of governance for maternal health service delivery during the immediate post conflict period in Northern Uganda and during that same time frame in East Central Uganda;

and, ii) a review of processes related to policy formulation and implementation with regard to health system governance and maternal health care utilisation. The topic guide used here is included in appendix IV.

4.5.3 Sub national level health system evaluation – in-depth interviews and documentary review

The in-depth approach was also adopted for district level politicians, members of the district health teams and NGOs, as well as health workers. My rationale for opting for the in-depth interview approach is similar to that in section 4.5.2 above. The initial plan to conduct a focus group discussion with health workers was shelved; the approach was not feasible given health worker work schedules and the potential logistical challenge of bringing them together from the various units and locations.

In one interview, the key informant decided to co-opt her technical assistant into the interview and insisted on having it conducted this way. She felt that the assistant was more conversant with Ugandan health policy issues in case questions in this area arose. I considered the data collected through this interview as quite robust.

Though there is a paucity of literature discussing such a scenario, I gained support for my decision to include this data from the conclusions of a study by Bjornholt and Farstad (2014). They showed that data of a richer quality could be obtained from in-depth interviews with paired respondents that are interrelated: in that author's case couples or families; in my case — employer and employee. My respondents were related to each other through the supervisor-subordinate relationship and provided views that were closely linked (Fern, 1982; Ritchie and Lewis, 2003). Like Bjornholt and Farstad (2014) argues the pair did not constitute the recommended minimum of four persons to be considered as a focus group. More still I was less inclined to collect data from listening and observing the relational interaction, as a focus group discussion would have it. It was therefore in the spirit of *critical realism* that I added this interview to my data.

Procedure

The process was similar to what occurred at national level. I was guided by a continually updated list of respondents that I had developed with the help of the district health teams and health facility in-charges. The continuous updating was a necessity considering that after an interview, respondents now with a clearer understanding of my research objectives, more accurately directed me to potential respondents that were more relevant.

A topic guide that I pre-tested in Iganga steered the interview process; the data obtained during the pre-test was included as well. The sub national level topic guide differed from the national level version by including discussions about health care service implementation, district politics in relation to health care and community participation in maternal health, gender and health care utilisation (See Topic guide sub national in-depth interviews in Appendix V).

In-depth interviews were conducted with district politicians, senior civil servants employed by the district council, members of the district health management teams and representatives of non-governmental organisations working in those districts. All the interviews, except one were conducted in the organisational premises. I personally conducted the interviews and they lasted between 60 and 90 minutes.

I took notes and made audio recordings of the proceedings except in one case where a district health team member declined being recorded. I had a repeat interview with two respondents in this category as well.

4.5.4 Service user and community evaluation – focus group discussion

I considered the focus group discussion as most suitable for gathering data from the community for a number of important reasons: Firstly, the participatory nature of the group discussion had the potential of encouraging stimulating responses from people that assumed that they “knew nothing” on the subject (Kitzinger, 1995; Ritchie and Lewis, 2003; Theobald *et al.*, 2011).

Secondly, the focus group discussion enhanced the validity of data collected by retrospective approaches; the participatory role had an effect of stimulating recall of the participants (Grusin and Stone, 1992).

Thirdly, and in relation to the second point, the interviewer was at will to probe, seek clarification and use recall techniques that could enhance the quality of the data (Dex, 1995).

Fourthly, there was less chance of *satisficing* taking place, that is, respondents offering the next best answer just to please the interviewer (Krosnick, 1991). Satisficing was minimised by the use of check questions and by ensuring that the data collected was not from direct responses to the questions, but rather to interactions between respondents (Krosnick, 1991; Kitzinger, 1994). (Compare this with my discussion about the in-depth interview of two persons scenario in section 4.5.3).

I opted to *pre-define* the composition of the focus groups, which was, again, more in keeping with the contextual constructionism tradition (Kitzinger, 1994). My contention here was that though the findings of a pre-defined focus group were more specific to the discussion group and *probably* had limited external validity as compared to the realist approach that advocated for probability sampling. The findings of the pre-defined group contributed to the more important higher-level concepts and theories that augmented the kind of comparison that I was undertaking.

However, with regard to constituting the groups, in keeping with recommendations by Theobald et al (2011), I addressed concerns about homogeneity by ensuring that respondent participation was not dampened by cultural or social hierarchical considerations amongst the group. Ensuring homogeneity also worked towards greater external validity and comparability between community groups within and across the regions being studied (Freeman, 2006; Krueger and Casey, 2009). In essence by this, I was co-opting an approach from the realist epistemologies that enhanced regional comparison.

I created the initial lists of groups and the cadre of the group constituents, given my prior experience working with similar communities in Uganda and in Kenya. My choice was then corroborated through consultations with my supervisors, with colleagues, with experts in government, in the Ugandan academia, and later in the field with the district health team of Iganga district. I opted to conduct the focus group discussions with women leaders of community-based organisations, opinion leaders, and with community level health providers.

The opinion leaders were people recognised to hold sway on the attitudes, beliefs, motivations and behaviour of their communities (Flodgren *et al.*, 2007). The opinion leaders were selected using the “positional approach” as described by Valente and Pumpuang (2006). In applying this method, I requested members of the DHT, or health facility in-charges to identify people who held key positions of leadership in the community and were additionally recognised for supporting health promotion related activities in the setting. The opinion leaders identified included, clergy, appointed clan or kingdom leaders, elected officials and retired schoolteachers.

I used a topic guide to ensure a systematic sequence to data collection though I ensured at all times that the interactions were conversational and contextual (Patton, 1990). The key areas of focus in the planned discussions were perceptions, beliefs and attitudes with regard to: i) the state of maternal health care in the respective settings ii) changes in the quality and responsiveness of the health system to maternal health care needs from 2006 to date; iii) the community’s capacity to influence governance iii) the role of women in enhancing maternal health care utilisation; iv) awareness and actions related to rights to appropriate health care.

As previously mentioned, the end of the war in Northern Uganda in 2006 that also marked the commencement of the resettlement process as a landmark event acted as a recall aid. For the interviews in Eastern Uganda, the recall aid was the election cycle, and in particular the 2006 presidential elections. These were Uganda’s first multi-party election since the NRM government came into power.

Procedure

In both regions, I worked with the district health educator to invite potential participants for the focus group discussions. In Luuka District, East Central Uganda, the district secretary for health¹³ took personal interest in ensuring that the invitations received positive response. Village health team members in both regions, on the other hand, were mobilised for the meetings by the health facility in-charges. The invitations were made one day prior to the event. As I later mention in the ethics procedures in section 4.8 to ensure that these potential respondents came out of their freewill and not out of the coercion of these senior level health workers, I emphasised to them the voluntary opt-out nature of the exercise.

Group discussions were held within the vicinity of health facilities where maternal health care was being provided. In Eastern Uganda, the women leaders and community opinion leader group discussions took place within the grounds of Kiyunga Health Centre IV, Luuka District. The village health team group discussion took place at Nambaale Health centre III, Iganga district. In Northern Uganda, the women's group and community opinion leader group discussions in Nwoya district took place outside the hospital grounds. The village health team group discussion was held within the premises of Kitgum Matidi Health Centre III, Kitgum District. The groups ranged between 10 and 12 participants. I discuss the potential implications of the location of interview later in the Discussion chapter section 7.7.2.

I had initially selected research assistants from Kampala on the basis of proficiency in Luo and Lusoga, the languages spoken in each of the two regions. However, later I found it more prudent to identify facilitators from within the researched communities. The comparative nature of my study and the constructivist epistemological approach warranted the identification of facilitators that were contextually grounded and could capture subtle issues that would be important for analysis. Good facilitation skills coupled with good local contextual knowledge were pivotal for the success of a group discussion (Theobald *et al.*, 2011).

¹³ The district secretary for health is an equivalent of the minister of health in the decentralised district council cabinet.

In East Central Uganda a district health educator with recent research moderation experience in that setting was identified. In Northern Uganda, a female social worker working with the community development office in Nwoya was similarly found suitable for the task. I had some concerns with regards to the male moderation of a women's FGD in the East Central Ugandan community that had strong patriarchal leanings. However as it will be shown, the outcome of that FGD's in particular was one of the more informative ones. Amooti-Kaguna and Nuwaha (2000) who reported similar challenges in conducting research in another rural setting in Uganda, found that facilitation skills as opposed to gender differences were more critical in cross-gender focus group moderation. Interestingly, my all-male facilitated interviews gained responses similar to what Amooti-Kaguna and Nuwaha (2000) described in their study: the women participants appeared uninhibited when discussing gender related issues. The FGD appeared to have given the women participants the opportunity to talk back to "us" the men. For instance, during the FGD they would often use the phrase "you men!" whenever referring to the male gender.

The focus group discussions lasted between 60 to 90 minutes. A soft drink was offered to the participants during the meeting as well as a transport refund at the end. After each group discussion, I had a discussion with the facilitator so that she or he could give me their personal impressions and provide additional clarification on statements, social constructs and actions that were recognised during the meeting. The transcribing of the recordings was carried out in a separate setting.

4.6 Analysis

As previously mentioned the Political Economy Analysis framework incorporated approaches of the five-stage Framework Analysis Method as described by Pope and Mays (1995) so as to generate key themes linked to concerns portrayed by the research question. The data was analysed using NVivo software (version 10). I describe the analysis by explaining how the themes were generated by the Framework Analysis method.

4.6.1 Framework Analysis

A defining feature of the framework method is the matrix output used for systematically summarising and structuring qualitative data by case and by code (Ritchie and Lewis, 2003). A key advantage of the method is that it provides for the use of either or both the deductive or inductive approaches; “*where the research sits along this inductive-deductive continuum depends on the research question*” (Gale et al., 2013). Combining the inductive and deductive approaches makes possible an in-depth analysis of issues that are central to the research objective (Ritchie and Lewis, 2003). Secondly, the method also allows for data collection and analysis to occur concurrently as an iterative process (Srivastava and Thomson, 2009).

As part of the analysis stage the gathered data is sifted, charted and sorted in relation to key issues identified and from this, with relevant *a priori* theories considered, themes are generated and refined so as to enhance the process (Ritchie and Spencer, 1994). In practical terms the analysis involves a five-stage process, namely: i) familiarisation; ii) identification of a thematic framework; iii) indexing; iv) charting; and, v) mapping and interpretation (Pope and Mays, 1995). I expound on each stage in relation to the procedure that I undertook in this study and also in relation to the Nvivo software that I applied to the analysis.

Familiarisation with the data collected was undertaken by listening to the audio recordings, and reading the transcripts and policy documents. By this, I was able to gain a broader idea of commonalities and contrasts within the data that could later be examined in depth. This remained an on-going process that transcended the completion of the field exercise. As described by Ritchie and Spencer (1994) by continuous interaction with the data during this initial stage, I was already able to recognise possible themes that made subsequent interviews more focused.

Identification of a thematic framework, an important component of the analytical process entailed importing the prepared transcripts into the NVivo 10 Qualitative Software Package. In conducting the coding process I opted to develop a thematic framework that had a combination of pre-defined and emergent categories.

I coded the source files into two categories representing in-depth interview data and focus group discussion data. Each of these categories had three “child” nodes. The in-depth interview data category contained the child nodes: governance; policy; and technical information. The focus group discussion data category contained the child nodes: community; attitudes; and perception (see Appendix VIII and IX). These pre-defined codes then provided the basis for the generation of emergent themes or codes from the respective data sources which were then collated in subsidiary nodes under each of the predefined nodes. In many cases the an emergent theme featured in more than one of the pre-defined nodes.

Charting was conducted using NVivo. Each case was indexed using the thematic framework developed. This process identified data from each case that spoke to the codes. Key excerpts from the data were then extracted and placed in the designated nodes. The indexing process also entailed identifying more potential themes. Data obtained from Northern and East Central Uganda were indexed against the same codes and places within the same nodes. This was in line with a suggestion by Ritchie and Lewis (2003) stating that, unlike quantitative research that seeks for reduction and measurement, comparison in qualitative research is aimed at gaining an understanding of the presence, absence or variations and consequences of specific phenomena by the accounts given by compared groups when considered together.

Mapping and interpretation was a process undertaken by a review of the indexes compiled. A framework matrix that was represented in Nvivo as an intersection of rows of case nodes versus columns of thematic nodes was useful in linking themes with the cases and with context. The matrix was also key in seeking out associations with regard to the attitudes and perceptions by stakeholders role or level and by region – Northern Uganda and East Central Uganda.

To a significant extent the research questions provided the a priori issues that in turn guided the adoption of pre-defined themes. The political economy analytical framework contributed theoretical concepts that enabled the generation of

emergent themes and the final structure of the nodes or index (the process of theme generation shown in Appendix VIII and IX).

4.6.2 Political economy analysis

I opted for a PEA framework by Harris (2013) that is structured into three phases: problem identification, problem diagnosis and “change process” which guided the refining of themes into structural and agency features as represented in the figure 4.3 below (Harris, 2013).

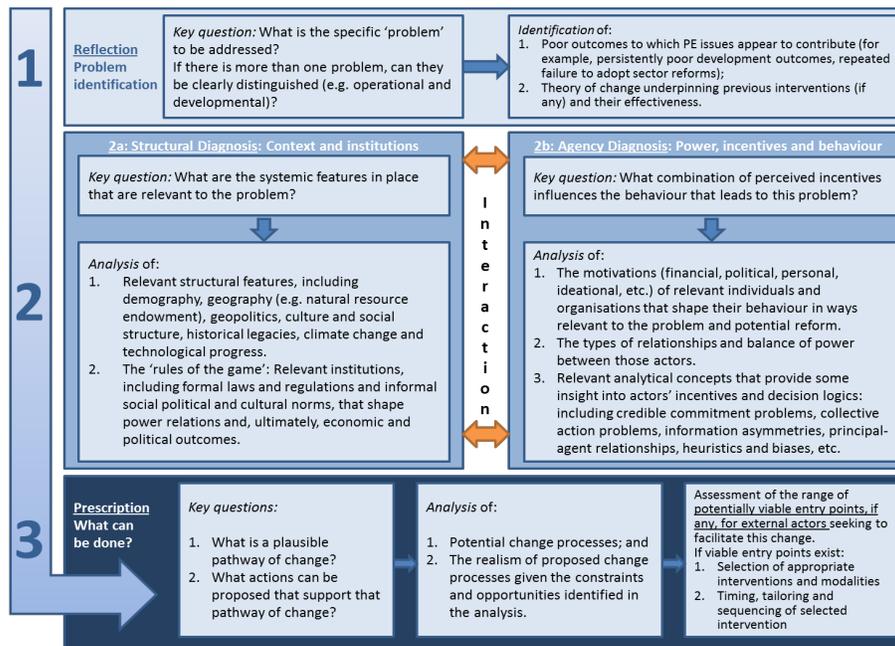


Figure 4.3 Problem Driven Framework for applied PEA (Harris 2013)

Step 2(2a and 2b) of the framework is of particular relevance to this thesis. The *structural features* (2a) represent: **contextual characteristics** - that are fixed or very slowly changing, these were represented by themes that alluded to political climate, historical legacies, national economic status; and, **institutional characteristics** - that are more amenable to change and include *formal institutions*, in this study exemplified by themes related to legislature, policies, laws and regulations and, *informal institutions*, for example, neo-patrimonialism, clientelism, “tribalism” and corruption.

The *agency feature* (2b) represents individuals, organisations with which these identify. The agency feature also highlights the motivations (for example, financial,

non-financial, political, personal, ideation), the types of relationships, and the balance of power between them. It is at this point that the analytical concepts and theories can be applied to provide insight into actor's behaviour and decision logics.

In order to recognise the contexts, the structures, and the institutions constituting the elements of the political economy framework, I co-opted a systematic approach as described in another political economy analytical framework that was described by Moncrieffe and Luttrell (2005). I used it to systematically: i) identify and stipulate Uganda's historical and foundational legacies; ii) define the sector boundaries and map the stakeholders within the sector; iii) define the roles and responsibilities, organisational structure, management and leadership, financing, and incentives for each of these; and iv) define the relationships between the stakeholders and how this influenced governance with regard to maternal health care.

As an example, a broad representation of the boundaries and stakeholders considered (as reflected in the conceptual diagram in Figure 4.1) guides the structure of the findings chapters:

i) National level stakeholders that include: the policy decision maker at legislative level and at line ministry level as well donors and implementers. The implementers at national level include administrators and technical staff of various cadre in the ministries of health, finance, public service, gender, internal affairs and local government.

ii) Sub National level stakeholders that include: District level decision makers that are made up of district council legislatures, local government administrators and technical staff in local government departments of health, local government, finance, gender and social affairs, and education; health care providers that include health workers within the health facilities and in the communities.

iii) Community level stakeholders, that include: both formal and informal community level organisations as well as consumers of maternal health care

services and their families. The women groups and the opinion leaders that I interviewed to a large extent represented the consumers.

As previously mentioned, the political economy approach draws in a number of theories from the fields of economics sociology and political science to support the generation and analysis of themes. It does this by explaining the social phenomena in relation to economic processes, political policies and social institutions that are influencing maternal health care governance and its impact on the outcome, maternal health care utilisation in the contrasting environments of Northern Uganda and East Central Uganda (Moncrieffe and Luttrell, 2005).

Some of the theories that I found relevant to the study included the rational choice and public choice theories, which in turn are basis of other results of similar abstraction including the social choice theory and the theory of asymmetric information. I describe the rational choice and public choice theories in the discussion chapter.

4.7 Quality Assurance

Data management

The research methods used for this thesis are designed to ensure the reliability and validity of the information presented. Methods of quality assurance include an active search for bias among the data sources; transparency in the presentation and justification of methods; ensuring that the perspectives of all participants had the chance to be heard; and an elaborate consideration for reflexivity throughout the process. In addition the review of policy documents also provided a check mechanism that corroborated the more technical and historical information sought from the policy makers and implementers. A systematic and rigorous approach went into designing, sampling and applying the methods that are central to the qualitative aspects of research design and by so doing, credibility and internal validity were addressed.

Further more, I recorded (except one – see reasons in following sub-section), transcribed and translated the interviews that were in Acholi and Lusoga (the

languages spoken in Acholi and Busoga respectively); some were sampled for accuracy. I reviewed the interview content the same day and took notes of issues that arose. The recordings and transcripts were stored securely.

Reflection on the role and position of the researcher

In an approach similar to that for studying policy stakeholders, Walt et al (2008) emphasize the importance of taking into account, the research team's institutional power and resources, as well as the positionality of the individual researchers in the team. The process of reflexivity is deemed necessary given the influence that the researcher has on the research agenda setting, on the quality of data collected, and on the analytical process (Walt *et al.*, 2008).

In regard to the above, my personal background that I consider had a bearing on this study is as follows. I hail from Northern Uganda where I worked initially in the civil service as a medical officer and then later as an NGO project staffer in Gulu. I have also maintained close ties with other health professionals through a number of bodies including the Uganda Society of Health Scientists where I was an executive board member, the Palliative Care Association of Uganda where I am a longstanding board member amongst others.

I spent my formative years and completed my primary education in Kampala, Central Uganda where my parents worked as civil servants. My parent's marital union was a rare one— of a Northerner and Southerner—that transcended Uganda's ethnic discord; they first met as students in the UK at Uganda's High Commission on the 9th October 1962, on the day Uganda became an independent nation. For this reason, I am conversant with, and identify myself with both the Nilotic culture of Northern Uganda and the Bantu culture of Southern Uganda. I have close blood relatives from both regions.

In addition, at the time I was conducting research it was known by many that I was the spouse of Uganda's Director General for Health Services (she is now the Uganda's Minister for Health). My being of the male gender and conducting this

research as part of a university in the UK also had a strong bearing on my positionality.

My positionality enabled me to gain access to many offices and key personnel in both national and district offices of government than would have been the case. I had to be cognisant of the fact that civil servants in national and sub-national government that were readily giving me audience felt under pressure to do so and would not be forthcoming with reliable information. Indeed, one respondent at sub national level requesting not to be voice-recorded and another requesting to make an off-record remark. These might have been manifestations of potential interviewees being concerned or all together influenced by my spousal relationship.

Seidman(2013), describes similar power dynamics between teachers interviewing students, or employers interviewing employees that I identify with. Akin to Seidman's recommendations to address such a scenario, I worked pre-emptively to address any sense of intimidation: I undertook *not* to enlist the help of my wife in contacting the potential respondents; I reassured the respondents of my obligation to ensure their confidentiality and autonomy; I emphasised the voluntary nature of their participation and their right to withdraw consent at any moment to the use of information that they provided.

From the outset as I made initial contact with the potential interviewees, I explicitly explained the purpose for my study and potential areas of discussion. I repeated these rights to consent prior to the actual interview before the consent form was signed.

Reciprocity issues arose with regard to my being a UK based doctor. Many of the focus group discussion participants considered this a unique opportunity to gain a free consultation, particularly about reproductive health issues, for example, family planning and lifestyle diseases, for example diabetes. According to Anderson(1991), the establishment of such a health worker-patient relationship may compromise the objectivity of the interview process. Nevertheless, I was caused to appreciate that in environments such as these, this was probably a rare opportunity for the

community to have a doctor interacting and asking for help from them on their own terms. As DiCicco-Bloom and Crabtree (2006) note, many researchers – feminists and those using the participatory approach consider it only fair that the time, energy and information offered by the community be reciprocated to a measured degree. Again, I identify with this stance.

My mixed ethnic heritage and professional background motivated the research question and the comparative research design but in addition influenced the design of the study conceptual framework and the interpretation of results. Some researchers consider a situation such as mine as compromising objectivity and the quality of the data and should rather be treated as a confounding bias that has to be controlled (Freeman, 2006). However, researchers like Kitzinger and others from the feminist tradition, consider the role of the researcher as critical, from a contextual constructivists vantage point; the subjective interpretation of research data is unavoidable and can be harnessed to generate information that is unique and contributes to knowledge construction (DiCicco-Bloom and Crabtree, 2006; Freeman, 2006). A case in point was my capacity to delve into nuanced differences and similarities in governance related constructs in the post conflict and non-conflict regions. This was critical given the fact that the cultural differences between the two regions were important confounders to consider in this study.

As I disseminate the findings of this research nationally, my links with other health care professionals, and through professional bodies that I previously mention will be important. My connections with the Health Ministry make it possible for my work to be presented at forums that annually take place to review the implementation of policy. National Dissemination exercises by the ReBuild Consortium and Makerere University have already been forums that I have used to share excerpts of my research findings with both researchers and Ugandan policy makers.

Internationally, my links with Alumni Associations for the Commonwealth Scholarship Commission, the University of Liverpool, and Liverpool School of Tropical Medicine as well as my membership of Health Systems Global will be

starting points for sharing important lessons learnt with policy makers, development experts and academicians.

4.8 Ethics procedures

Ethical approval was granted for the methods detailed above by the Liverpool School of Tropical Medicine Ethics Committee (Research Protocol 14005) prior to the commencement of fieldwork. I later also gained approval from the Uganda National Council for Science and Technology Registration Number HS 1600. (see appendix I)

I was given permission by these boards to offer some refreshments as well as a nominal transport refund to participants that attended the focus group meetings. This included the two instances where the respondents choice of venue for the in-depth interview was in a public eatery; I paid for the refreshments.

Three in-depth interviews had to be conducted by a Skype call after I had returned to the UK from Uganda, because scheduled meetings could not take place at the time. I was still able to share consent documents with these interviewees by email and had them endorsed. I informed the Liverpool School of Tropical Medicine Research and Ethics Committee and gained permission to use this information.

For the informed consent, I used a translated format of the Liverpool School of Medicine consent form that had additionally been approved by the Uganda National Council of Science and Technology. This was administered to all the respondents of the in depth interviews and each participant of the focus group discussion. The participants were assured of complete anonymity. Participants were also reminded of their right to withdraw from the interview at any point. It was standard practice on issuing out the consent form to all participants of the focus group discussions to have the content additionally read out to them before they appended their signatures or thumbprints.

Participant data was duly anonymised with identification code only known to me used to link the audio record, interview sketch notes and later the written transcripts. Persons representing organisations were identified by sector and

quotations that were directly attributable to an individual were not used. Some of the data that I was provided may be deemed of politically sensitive nature. In such cases, where I have used such information in the results section of this thesis, it is ensured that the source of the information is untraceable by in some cases reducing on the level of detail of findings reported.

5 NATIONAL LEVEL RESULTS

5.1 Introduction

As mentioned in the methods chapter, this thesis seeks to establish the influence of governance at national and sub level, on the performance of the health system and maternal health care and its utilisation at community level in post conflict Northern Uganda and non-conflict East Central Uganda. This chapter presents the findings of: i) policy analysis and, ii) of in depth interviews at national level.

The policy analysis considers Ugandan policy and related documents in relation to maternal health governance for Northern Uganda and East Central Uganda as comparator. The interview analysis details the perceptions, attitudes, and behaviour of key governance stakeholders in relation to governance as well as maternal health at national level in the period 2006 to 2011.. Interviews and focus group meetings at the decentralised level will be discussed in the next chapter.

As mentioned in the methods chapter, the analysis of the results is primarily based on the political economy analytical framework (Harris, 2013). However, the framework method is applied in the early stages of analysis to aid the identification of themes; themes that are coalesced and subsequently structured according to the dictates of the political economy approach. Figure 4.3 in the previous chapter depicts the PEA framework by Harris (2013) that I adopted for this thesis.

Considering steps 2a and b in Figure 4.3:

- Step 2a structural diagnosis: Relating this to the research question, this will be represented by contextual and structural factors that are derived through the analysis of national political and maternal health policy documents,
- Step 2b structural diagnosis: The rules of the game, that is the formal and informal institutional factors that were derived from key informant interviews,

- Step 2b agency diagnosis: The motivations, the relationships and balance of power that were derived through further analysis of both the policy documents and interviews as will be shown in both the results and discussion thereafter.

5.2 Contextual factors - policy documents analysis findings

Uganda's national and health sectoral policies provided the context for maternal health care delivery. The analysis focuses on the health system, maternal health and Northern Uganda. The broader national level issues are first scrutinised, before narrowing down to sector specific features.

5.2.1 Search strategy

The policy documents were sourced during key informant interviews conducted at the various government ministries, donor agencies and a number of civil society organisations during the periods from May to September 2014. Other policy documents were sourced through an internet search of websites for: the Uganda Legal Information Institute; the Uganda Ministry of Health; MFPED; the Ministry of Local Government; Local Government Finance Commission; the World Health Organisation; and, the World Bank. An Internet search for grey and peer-reviewed literature was also conducted in search for material that would further inform the analysis of the policy documents.

5.2.2 The number and type of documents

An initial 101 documents were collected through the various approaches described. As is detailed in section 4.5.1, excluding those that were not national, health sector and maternal health specific policy documents, policy reviews and research articles further refined the selection. The documents selected spanned the period 1987 to 2011 with national policy documents addressing political governance, macroeconomic policy and pro-poor reform and decentralisation and health sector policy documents including national health sector strategic and investment plans, health financing and human resource for health. Specific programme policies for maternal health, reproductive and adolescent health was selected as well as grey

and peer-reviewed literature written during any timeframe assessing the formulation and implementation of these policies were also included.

42 documents were finally selected for the analytical process on the basis of relevance to the research question. As represented in figure 5.1, 25% of all the documents were research articles, 35% were policy documents, 26% were government reports, and ten per cent were donor documents. The government documents included demographic health surveys and other government sponsored evaluations. Some important older documents were not accessible, however in such cases, evaluations or reports related to these policies were used.

With regard to the subject matter, eight (18%) documents that were finally selected addressed general health policies and strategies; six (14%) focused on maternal health policy and strategies; six (14%) were documents on wide ranging policies related to Northern Uganda; Only two documents (5%) discussed policy and the state of maternal health in Northern Uganda; nine (21%) documents addressed finance policy and strategy; and, five (11%) addressed national governance.

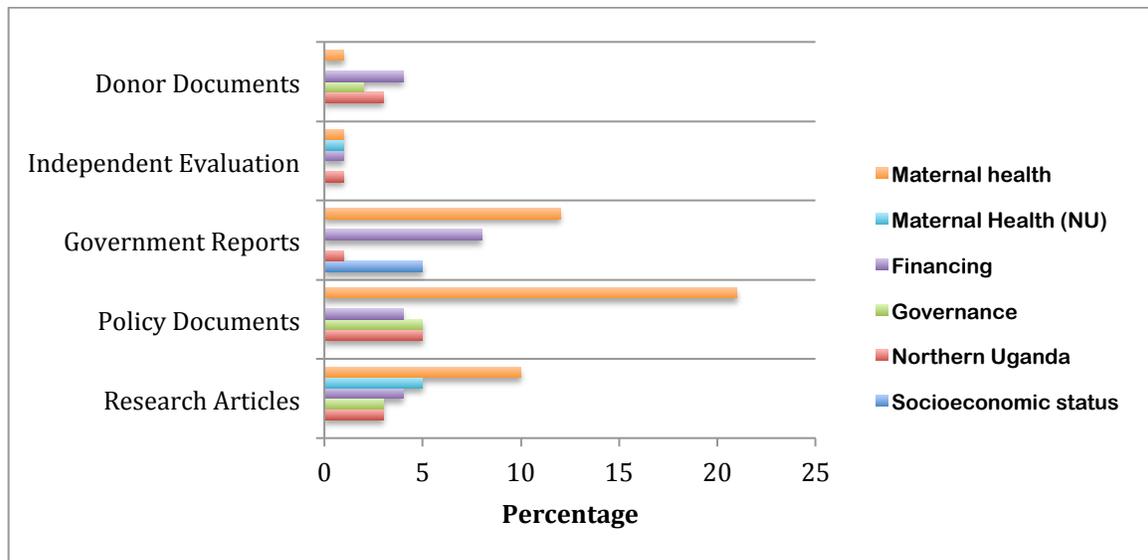


Figure 5.1: Type of Document by Subject Area

Given the focus of this study, three points in time act as references for two key periods covered by this policy analysis. The reference points are: i) NRM's ascension to power in 1986 representing the starting point; ii) the cessation of Hostilities

agreement in November 2006 representing the end of the conflict period and commencement of peace (the intervening era denoted as “pre” in figure 5.2 below); and, iii) 2011/2012 representing the end of the five years after commencement of peace (the intervening era denoted as “post” in figure 5.2 below). Therefore the 2006 Cessation of Hostilities agreement acted as a demarcation point between policy documentation developed during the conflict-period, and policies developed in the immediate post conflict period.

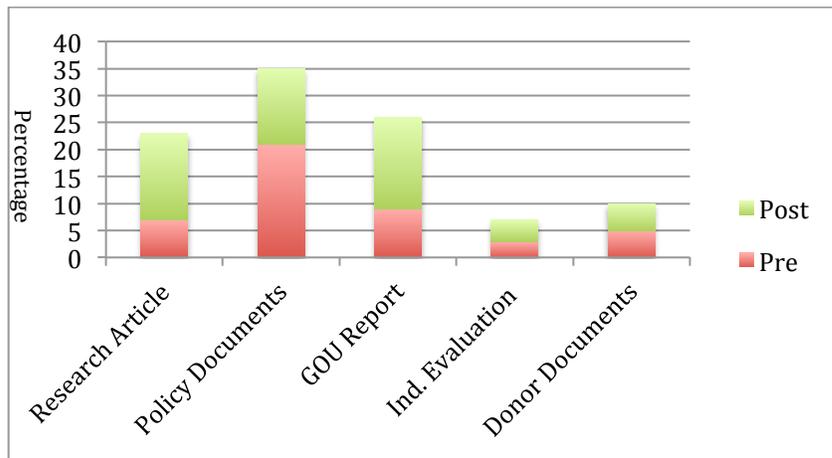


Figure 5.2 : Document type by Era (Pre = Conflict, and Post = Post conflict)

Procedure of Analysis

The selected documents were analysed with an aim of determining the overarching policy environment that was influenced, and was also influencing political, economic, and social processes at national and sectoral level. The political economy analysis framework by Harris (2013) described above guided the analysis. The analysis considered: i) the objectives and approaches for national political policy; ii) objectives and approaches for health policy; iii) objectives and approaches for maternal health policy; iv) the objectives and approaches for health related policies on Northern Uganda; iv) the financing and implementation of policy; and iv) the drivers of policy trends.

Figure 5.3 below is a schematic representation summarising the important policies and policy categories relative to their approximate launch and implementation timeframe. These policy relationships are analysed in sections 5.2.3 and 5.2.4.

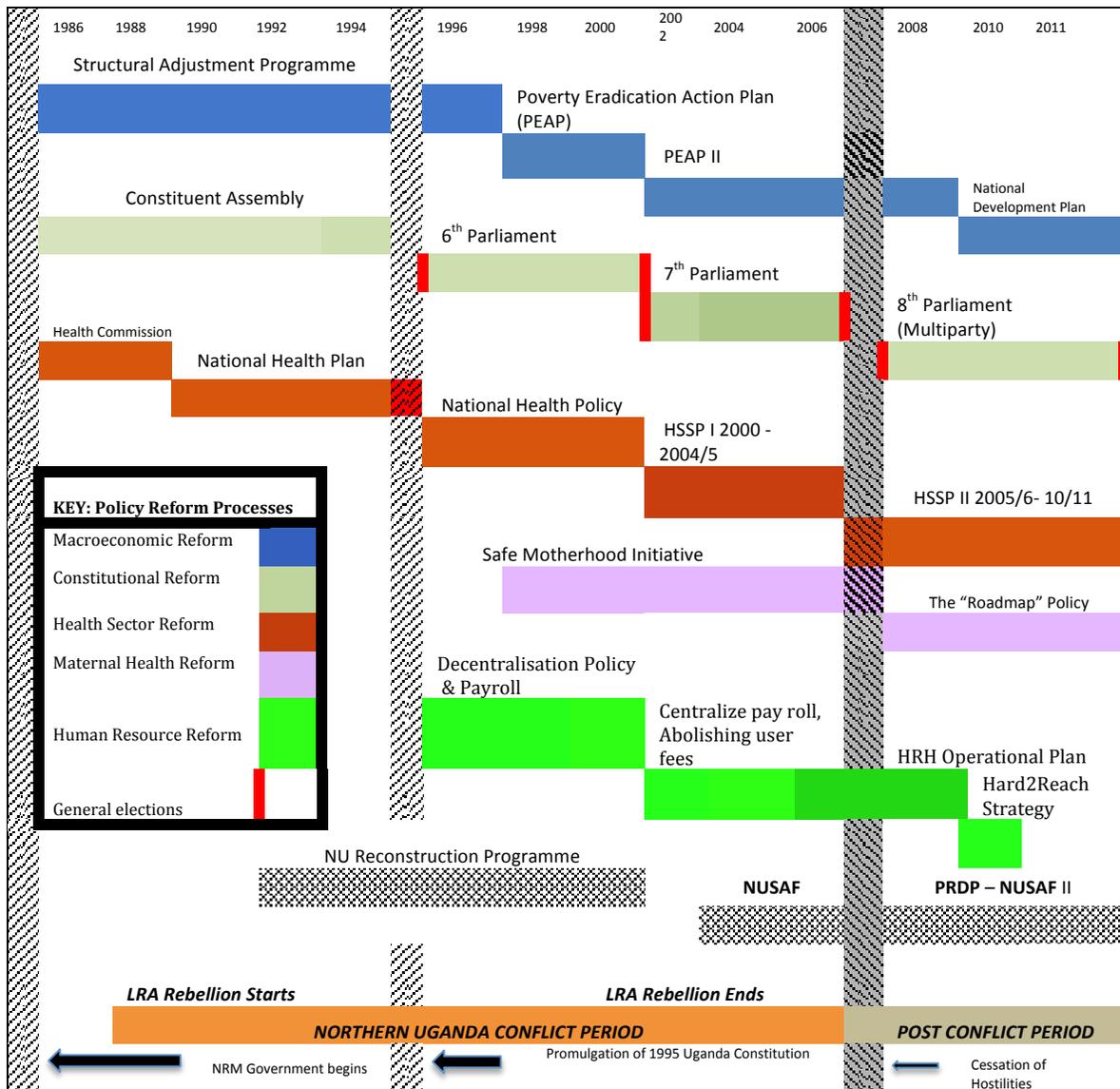


Figure 5.3 Policy Development and National Political Event Timelines 1987 to 2011

5.2.3 Uganda policies influencing the period - 1987 – 2006 (Period of Conflict in Northern Uganda)

Governance policies – objectives and approaches

The *NRM Ten point programme*(2000) is considered to have been conceived by the National Resistance fighters while still in rebellion (see Section 3.2.1). Yoweri Museveni is reputed to have authored the 16-page document while still in active combat. It reflects the political and development strategy that the NRM government has closely adhered to. Its points of emphasis include: democracy, security, developing a mixed economy, and the elimination of corruption and power misuse.

The sixth point in the document proposes, in part, the redress of human resource and drug supply gaps as well as the elimination of corruption as critical prerequisites for the development of the health sector. I observe that references to women's rights and equity are only indirectly implied under the documents points six, eight and nine which discuss: i) the restoration and improvement of social services and rehabilitation of war ravaged areas; ii) redressing "errors" that have resulted in the dislocation of members of society; and, iii) cooperation with other African countries in defending human and democratic rights in other African countries.

The *1995 Uganda Constitution* (Government of Uganda, 1995), described as one of the longest in the world with 287 articles and seven schedules is a product of a prolonged multi-tiered process of extensive countrywide consultations with different communities. The constitution amongst other important declarations affirms health as a right for all Uganda's citizens and stands for the protection and promotion of gender balance and fair representation of marginalized groups. It also recognises the rights of women and their role in society.

The document articulates the integration of all Uganda's peoples articulating the role of Government in providing a peaceful, secure and stable political environment necessary for economic development. It recognises Uganda's ethnic, religious, ideological, political and cultural diversity and stipulates the establishing of nurturing institutions and procedures that address the resolution of conflicts fairly and peacefully. Chapter 16 of the document lays out provisions for traditional leaders who "*may exist in any area of Uganda in accordance with the culture, customs and traditions or wishes and aspirations of the people to whom it applies*" (Pg 153). It is on the basis of this that Northern Uganda has cultural chiefs in Northern Uganda while there is a traditional kingdom in East Central Uganda. These leaders do not hold any political power.

The 1995 Uganda Constitution banned the *one-party* political system but provided for a referendum in which Ugandans could democratically choose between the *no-party* movement and multiparty systems of governance. The constitution also

stipulates a unicameral parliamentary system, operating independent of the Executive and composed of Members of Parliament directly elected into office by their respective constituencies. In addition, women district representatives as well as representatives from the army, youth, workers, and persons with disabilities are provided for. The role of women representatives' features prominently in the interviews discussed under Section 5.3.4 and Section 6.2.3.

The Movement no-party system was later opted for by referendum as was enshrined in the constitution. This paved the way for the adoption of *the 1997 Movement Act (1997)*, a document that spelt out the Movement's political structure, functions and provisions for financing (Movement Secretariat, 1997). The act stipulates that the President of Uganda is the Head of the Movement and the Head of its National Executive Committee. Of relevance to this thesis is that the Movement Act defines the political structures at the district level: making up an elaborate five-tiered interlocking structure of political administrators at village, parish, sub county, county, and district levels. This sets the context for the *Local Government Act 1997* (GOU, 1997), a legal policy and regulatory framework whose objective is to “*give full effect to the decentralisation of functions, powers, responsibilities and services at all levels of local government*”(pg.9). Amongst others, the Local Government Act elucidates the role of the district political leadership, the civil service, and the district service commission in supporting the functioning of the decentralised health system. However, the Local Government Act remains a vacillate document; it has seen a number of policy statements amended or withdrawn. These include a number of statutory provisions within the local government that had to be altered to operationalize the abolition of user fees at first level public health facilities in 2001, and the abolition of graduated tax in 2006 (Manyak and Katono, 2010; Moat and Abelson, 2012).

Another important area addressed in the 1995 Uganda Constitution relates to Civil Society Organisations which through articles 19, 38, 43, 50 and 51 aim to protect, promote and enforce civil rights and liberties of all people. This reflects Uganda being signatory to key international and regional human rights charters that

include: the International Covenant on Civil and Political Rights – ICPPR (1995), the Convention Against All forms of Discrimination Against Women – CEDAW – (1985), and the African Charter on Human and People’s Rights (1986). Civil Society Organisations also called Non governmental organisations are supposed to be registered and regulated by the state according to the Non governmental act(1989) and its amendment (2006b).

The *Health Sub District policy* (MOH Uganda, 1999) draws from the Uganda *Constitution*, and *Local Government Act* by defining how health service delivery is structured around the decentralised structures of political governance. The *Health Sub district* policy aims to bring health service provision and decision-making closer to the community by making the Health Centre level IV the referral unit for the lower level health care structure (p.6). The document elaborates on how the health system is organised so as to ensure equitable health service delivery, describing the number of health sub districts, expected catchment populations, and the anticipated operational costs (p.11). The cadres of health providers in the lower level health facilities that will be engaged with the health of communities are well described but the document falls short of describing strategies that could cement the health facility – community interface. As I discuss later, such possible strategies are mentioned in a larger document the Health Sector Strategic Plan I that was written during the same time and proposes the creation of Village Health Committees and Health Unit Management Committees.

The peculiarities of the different parts of the country, and Northern Uganda in particular are ignored in the Health Sub District policy. The year 1999 was close to the period when the LRA rebellion was at its peak in terms of battles, civilian deaths, and population displacements. Over 90 per cent of the population in Gulu and its neighbouring districts had congregated in IDP camps, many of which were within Gulu municipal area (MOH Uganda and WHO, 2005). However, the document uses a projected figure for Gulu municipality of 48,000 people (*Annex 2, Pg. II*) yet the number was actually close to 100,000 in Gulu town and 462,580 for Gulu District according to a WHO report (2005). The implication was that attempts made at

costing health worker recruitment and retention at health sub district level ignored the additional human resource requirements for these settings. All these omissions appear to reflect inadequate planning for the implementation phase of policy (also see discussion on “*Good maternal policies – poor implementation*” in Section 5.3.3).

Maternal health policy – objectives and approaches

Macrae and Okuonzi (1995) state that between 1987 and 1991 there was no clear health policy framework in Uganda. It was in 1999 when the first *National Health Policy* (1999) was formulated “*within the context of the provisions of the Constitution of the Republic of Uganda 1995 and the Local Governments Act, 1997 which decentralised governance and service delivery*”(p.5). Guidance was provided by the Poverty Eradication Action Plan, which I describe in the Financing and Implementation policies section below.

Amongst the National Health Policy’s ten guiding principles, the ones of relevance to this thesis are: the focus on Primary Health Care through the provision of the health care package; the aspiration to provide equitable distribution of health care services all over the country through the decentralising of health care; greater attention to health promotion and empowerment of communities in health development; and, a gender sensitive and responsive national health system achieved through mainstreaming gender considerations in planning and implementation of all health programmes (Uganda Government, 1999, p. 5).

The document’s elaborate situational analysis does not highlight the health related trouble spots that include conflict afflicted Northern Uganda, where the populations are vulnerable but yet contending with major impediments to health service delivery.

The Health Sector Strategic Plan I (HSSP - 2000/1-2004/5) was launched by MOH in 2000 on the heels of the National Health Policy providing greater detail on major health programmes, on support services, on the role of national and international stakeholders and their outputs (Ministry of Health, 2000b). The document aligns itself to the PEAP and the Mid Term Expenditure Framework (MTEF) that provides

a framework for three-year rolling plans at all levels. The MTEF made possible the estimation of costs of the various interventions across the five years covered by the HSSP. The plan also marked the commencement of the *Sector-wide Approach policy* (Ebanyat, 2002), where all stakeholders within the health sector signed up to using one programme of work.

The nexus with the 1997 *National Gender Policy* (Government of Uganda, 2007), provides for gender mainstreaming and the gender-sensitive programming in all the health system intervention areas. The HSSP I articulates the Minimum Health Care Package that addresses the needs of the poor. It is notable though that the document identifies the North and East of the country as harbouring populations with the greatest levels of poverty, but it falls short of discussing strategies that will address the burden of disease in these settings. Furthermore, while the Poverty Eradication Action Plan (PEAP) pillars one, two and four are alluded to in the HSSP I document, however, the third PEAP pillar that addresses conflict and security needs, is missing from the narrative (Ministry of Health, 2000b, p. 9).

The three year *Safe Motherhood Strategic Plan*(1999) is described in the National Health Plan as an instrument that will guide the improvement of maternal health care all over the country. As depicted in Figure 5.4, the Safe Motherhood Strategic plan focused on amongst others improving obstetric care and redressing social inequities confronting the status of women.

The Uganda Safe Motherhood Strategic Plan 1997-1999 Total Cost (US\$)

	Total
Strategy 1: Ensuring Sustained Political Commitment to Safe Motherhood	969,800
Strategy 2: Improving Quality and Accessibility of Maternal Health and Obstetric Care	21,260,000
Strategy 3: Developing Human Resources for Safe Motherhood	2,452,867 * Items 1-24c o
Strategy 4: Ensuring Access to Family Planning	1,531,000
Strategy 5: Strengthen Research for Safe Motherhood	428,300
Strategy 6: Strengthen IEC and Advocacy for Safe Motherhood	473,000
Strategy 7: Strengthen Health Management and Management Information System	944,000
Strategy 8: Redressing Social Inequities Confronting the Status of Women	931,000
TOTAL	28,989,967
Minimum Equipment Package for Implementation of the Mother-Baby Package	12,150,372
Adjustment for items listed, but not costed (approx. 25%)	3,849,628
Total Equipment	16,000,000
Total Cost	44,989,967

Figure 5.4: The Safe Motherhood Plan 1997 – 1999, Strategies and Costing

As seems to be the general pattern in policy documents during that period, and particularly under strategies, 1, 3 and 8 (**Error! Reference source not found.**) of the Safe Motherhood Plan, there is no provision for activities that address the needs of the communities affected by conflict or disrupted environments.

In 2000, MOH released the *National Policy Guidelines and Service Standards for Reproductive Health Services* (Ministry of Health, 2001) and the *National Adolescent Health Policy* (Ministry of Health, 2004b). The adolescent health policy is a re-emphasis of the former document that discusses adolescent health policy under its Chapter six. The approach to the different aspects of reproductive health is discussed by these documents. They advocate for the youth as a priority target group and advocate for an intensification of efforts that address the special sexual and reproductive health needs of the group. The documents identify the unique needs of the populations in Northern Uganda, recognizing them as a priority target group with regard to Sexual and Gender Based Violence. Though the documents are more inclusive they lack detail with regard to strategy, targets or indicators considering that they call for the observance of a minimum set of standards.

The *Health Sector Strategic Plan II (HSSP - 2005/6-2009/10)* (Ministry of Health, 2004a) is a complete departure from the approach used in HSSP I. The five-year

strategy document is logically written with constant reference to empirical evidence sourced from Ugandan health management information system and demographic health survey data. An entire section (pg. 91) is dedicated to discussing strategies that would address the maternal, child and adolescent health concerns of Northern Uganda's population (Ministry of Health, 2004a). It is notable that amongst the strategies described in the document are the psychological and physical needs and the rehabilitation of victims of conflict. In addition, sexual and gender based violence (SGBV) support for women and girls amongst the returnees is discussed (p.44). I discuss the drivers of these changes in the "*drivers of policy trends*" section below.

In defining the government's health sector plans for Northern Uganda, and in contrast to the approach in HSSP I, the HSSP II clearly relates its approach to the PEAP Pillar three on security, conflict resolution and disaster management, the *IDP policy* (Government of Uganda, 2004) and to the *Peace and Recovery Programme for Northern Uganda* (NURP) (MFPED and OPM, 2003). The authors of the document also carefully consider cross-linkages with other sectors including the Northern Uganda Social Action Fund (NUSAF) and the National Agricultural Advisory Services (NAADS) as approaches to enhance community empowerment.

I was not able to access any stand-alone human resources for health policy covering this period, however the National Health Policy and HSSP I, and II highlight the challenges facing the country's human resources and restate strategies that largely remain unachieved, according to a recent *Human Resources for Health Report* (Government of Uganda, 2011). The National Health Policy candidly states that, "*the mal-distribution of human resources, low staff morale arising out of poor remuneration and an over-dependence on untrained personnel in the primary health care facilities, pose major structural problems to effective implementation of health programmes. Furthermore, weak management and support supervision systems, insufficient collaboration between the public and private sectors, together with inadequate co-ordination of development partners, have resulted in a poorer health outcome than would have been expected*"(Uganda Government, 1999, p. 3).

Discussed in HSSP II, two human resource policy strategies that may have promoted the attraction and retention of health workers during the period Northern Uganda was still in conflict period were: the *lunch allowance*; and, the maintenance of the *multi-spine salary structure system* that guaranteed health workers a slightly higher pay structure compared to other employees of government (Ministry of Health, 2004a, p. 75).

Nevertheless, the embargo on the recruitment of health workers since 1996¹⁴, the wage bill ceiling in line with the country's macroeconomic policies and the weak functionality of the district service commissions adversely stifled health care improvement in the more underserved districts of the country (Kanyesigye and Ssendyona, 2003; Namakula, Witter and Ssenooba, 2014).

Financing and implementation of policies

With a view to stabilising the economy and stimulating economic growth, Uganda adopted a set of Structural Adjustment Policies (SAPs) from the World Bank and IMF in 1987, just a year after the NRM government assumed power. The policies guided the implementation of seven structural adjustment processes grouped into two namely: (i) The Economic Recovery and Structural Adjustment Programmes of the World Bank and IMF; and (ii) The Sectoral Lending Operations of the World Bank. According to an assessment report, only the finance ministry was involved in the negotiations that led to the adoption of these policies; line ministries of health, agriculture and education were only implementers of the SAPs (Makokha, 2001).

I was not able to obtain original policy documents for the Structural Adjustment Policies (SAPs) that came into force at a time when the conflict in Northern Uganda was intensifying. However, a Structural Adjustment Participatory Review Initiative (SAPRI) impact assessment (Makokha, 2001) suggests that much of Northern Uganda did not benefit from the economic liberalisation ushered in by the policies. The region experienced worsening poverty levels as opposed to the improvement in

¹⁴ New medical personnel have been recruited to replace those that have gone out of service. However, in 2006, 2009 and 2011, the ban was temporarily lifted to recruit particular cadres.

poverty levels registered elsewhere in the country (Government of Uganda, 2008). Common to all parts of the country, the uptake of maternal health services did not improve despite government policy exempting maternal health care services from cost sharing. Many health providers did not follow this policy guidance and continued to demand for payments from expectant mothers (Makokha, 2001). Nevertheless, vaccination services led to a 60% increase in immunisation coverage during the period. This was recognised as the only preventive service that the poor and vulnerable could benefit from given that much of government health care spending was skewed towards curative services (Makokha, 2001).

In 1997, the *Poverty Eradication Action Plan (PEAP)*, a broad based planning framework that would be revised every four years, was developed by the Ugandan Government as a medium-term planning guide for sector, district, and budgetary processes. This was so that all government planning could be guided towards planned action addressing the needs of the poor given the public purse constraints (MFPED, 2000; World Bank., 2006). I accessed the 2000 revision of the 1997 PEAP document. It was specifically re-written for its adoption by the IMF as Uganda's Poverty Reduction Strategy paper (MFPED, 2000).

The PEAP was originally based on four pillars: (1) economic transformation and growth; (2) good governance and security; (3) ability of the poor to increase their incomes; and (4) quality of life of the poor (MFPED, 2004). Crosscutting issues such as gender were incorporated in the 2004 revision of the PEAP after evaluations focusing on the gender dimensions of poverty at household and community level revealed the persistence of large gender and region-related inequities (IMF, 2005; Government of Uganda, 2008).

The geographical targeting approach advocated for by the PEAP proved an effective premise for the creation, in 2003, of the Northern Uganda Social Action Fund by the Ugandan government, a \$100 million dollar initiative that aimed at addressing the *self-identified* needs of the rural poor in 18 districts conflict affected districts of Northern and North-eastern Uganda and West Nile.

According to the PEAP document, the three-year rolling budget of the Mid Term Expenditure Framework is aligned to the PEAP so that funds to the health sector, amongst others are allocated with a pro poor focus on the basis of an allocative share predetermined by MFPED. More still, because health is a priority sector from the poverty eradication perspective, it gains additional funding from the Poverty Action Fund that bolsters district level health care spending.

An independent evaluation of the PEAP states that the health and education sectors were the main beneficiaries of pro poor sectoral targeted funding through the Poverty Action Fund (Government of Uganda, 2008). In addition the PEAP supported geographical targeting, NUSAF being evidence of such efforts as I discuss in the Health and Financing section below. Additional details are also in the Uganda Chapter, section 3.2.4. The trends in health financing during the period of conflict for health care are also discussed in more detail in the Uganda Chapter, under the Health Financing and Resource allocation (section 3.4.2).

5.2.4 Uganda policies influencing 2006-2011 (Post conflict Period in Northern Uganda)

Governance policies – objectives and approaches

Uganda's 1995 Constitution was amended in 2005 to allow for the adoption of a multiparty political system and for the lifting of presidential term limits. The amendment meant that Ugandans could choose their political leaders along party lines; it also allowed for the incumbent President to seek for another term in office.

As the war drew to an end in Northern Uganda, the government of Uganda launched the *Peace, Reconstruction and Development Programme I* (OPM, 2007), "*a national program with the overarching goal to stabilise the North; a stabilization plan which aims to disaggregate the North from national sector plans. It establishes targets that are sensitive to needs of the population and its targets and objectives contribute to the overall objectives of the PEAP* (p.17).

Following the 1997 PEAP, as I mentioned previously, another three four-year PEAP's were implemented before they were replaced, in 2009, by the National

Development Plan whose new emphasis is on socio-economic development and transformation as a stimulus to poverty reduction (Government of Uganda, 2010).

A number of key amendments to the *1997 Local Government Act* (GOU, 1997) occurred from around the national pre-election period, also coinciding with the period just prior to the establishment of peace. One of the amendments saw the creation of new districts taking place, increasing from 78 in 2005 to 111 districts by 2011; for Northern Uganda the number increased from 7 in 2005 to 15 by 2011. Green (2010) explains the proliferation of new districts as a consequence of the Ugandan President playing political patronage. On the basis of research conducted elsewhere in Africa, Green argues that like much of sub Saharan Africa, Uganda underwent a series of political and economic reforms that had restricted patronage opportunities available to the President. Political and fiscal decentralisation, and the Structural Adjustment Programmes are examples of such reforms. See sections 3.1.4 and 7.1.5 for further discussion about the creation of new districts.

Another amendment closely related to the proliferation of new districts was the recentralisation of senior civil service positions in the district administration¹⁵. According to Manyak and Katono (2010) this was made necessary to protect the public servants from local political interference, and to address competency and quality issues, which was particularly a problem in the newly created districts all across the country.

Maternal health related policies – objectives and approaches

The *Second National Health Policy* (2010) was a document designed to echo the National Development Plan. Its central theme emphasised universal health coverage through the enhancement of the minimum health care package. To make this possible the policy elaborates human resource development as well as equitable and sustainable financing. It was operationalized by the *Health Sector Strategic Plan III 2010/11 – 2014/15* (2010a), whose aim was to “*improve efficiency and equity in*

¹⁵ The administrative positions were for the chief administrative officer, the deputy chief administrative officer, and the town clerk of Municipalities,

health service delivery through health sector reforms, donor coordination, improved allocation of resources and better reporting (Ministry of Health, 2010a, p. 24).

The findings of Ministry of Health's *Mid Term Review for HSSP II* are a platform for *HSSP III's* agenda. Poverty and low literacy are identified as some of the factors causing Northern Uganda to lag behind in a number of health care indices. The HSSP III strategy therefore emphasises: emergency obstetric and neonatal care; midwife training and recruitment; improved supply of health commodities; ambulance services and referral communication modalities as some of the interventions that require investment.

Another poor outcome of the HSSPII period that the HSSPIII document was to address was the lacklustre SGBV response; this was attributed to poor coordination between donor agencies and the various government ministries. Nationally, again, poor literacy and the persistence of a poor social economic status were considered to have further limited the impact of the response (Ministry of Health, 2010a). In Northern Uganda, the weak response to SGBV experience by women and girls was further perpetuated by human resource constraints, particularly a paucity of medical officers to handle the medical and medico-legal aspects of SGBV. The Strategic Plan failed to follow up this revelation with specific interventions addressing Northern Uganda's specific needs. However, one of HSSP III's objectives is to strengthen the health systems SGBV data collection capabilities so that the prevalence and pattern of distribution is established, so that more targeted interventions are developed to address them. All this spoke to a lack of technical capacity to address SGBV amongst MOH planners. A 2013 report commissioned by Reproductive Health Uganda concurs with this finding, highlighting the continued failure of policy planning and implementation in addressing Northern Uganda's SGBV needs. The report also highlights the poor linkage between the health system and law enforcement and justice systems (School of Women and Gender Studies, 2013).

The second *National Health Policy* and the *Health Sector Strategic Plan III* provide a foundation upon which the objectives of the *Roadmap for Reducing Maternal and*

Neonatal Morbidity and Mortality in Uganda (2007) are laid. The document is considered to be the primary national strategic framework upon which the Ugandan Government and its partners base actions aimed at reducing maternal mortality. It lays out a number of strategies and interventions that include: i) improving the legal and policy environment for maternal health; ii) improving the availability of access to, and utilisation of quality maternal and new-born care services at community level; iii) strengthening coordination and management of maternal health care services; iv) empowering communities to ensure a continuum; and, v) strengthening monitoring and evaluation mechanisms for better decision-making and service delivery.

However, unlike the HSSP policy documents, the *Roadmap for Reducing Maternal and Neonatal Morbidity and Mortality in Uganda* does not allude to prioritizing special groups, nor does it explicitly discuss the maternal health care needs of returning populations like those of Northern Uganda. In more general terms the equitable distribution of resources for maternal health care is inadequately addressed. The policy probably holds an assumption that appropriate health management information system and demographic survey data will ensure that the interventions target the more vulnerable populations.

A Human resources for health policy (Ministry of Health, 2006) was launched in recognition of the crucial role Human Resources for Health plays in health service delivery. Though the document is limited in detail, amongst other action points, it emphasises that staff distribution be determined by a number of criteria including: data from essential needs assessments; socio economic; and, population density data. The document also recommends affirmative action in the training, recruitment and distribution of health workers to disadvantaged areas and vulnerable groups.

Other policy documents produced during the post conflict period that complement the reproductive health strategies include, the *Communication Strategy to Accelerate the Implementation of Reproductive Health*(2009), and the *Family Planning Campaign Strategy* (2006). Again all these documents failed to provide concrete

strategies proposals that address sexual and reproductive health needs in Northern Uganda (Kafuko, 2009).

Financing and implementation of policies

The *Health Sector Strategic and Investment Plan (2010/11–2019/20)* (NHSSIP) (2011) sets out Uganda's medium and long term health agenda recognising: sexual and reproductive health and rights; new born health and survival; scaled-up child-survival packages; and gender-based violence, as key intervention areas for health investment. A review of the investment plan recognised that its situational analysis approach was based on sound evidence and led to the generation of feasible interventions (Walford, 2011). A failure however was its inability to appropriately address variations by region, urban versus rural, conflict versus non-conflict amongst others. This weakness, it is anticipated, led to the perpetuation of the previously ineffective interventions (Walford, 2011). More was discussed in regard to Uganda's health financing policies in Chapter three, section 3.1.3 & 3.4.

Drivers of policy change

There were overt political and economic process that took place between 1986 and 2006 that had an influence on the health policies during the conflict and post conflict periods in Northern Uganda and in the rest of the country.

The elaboration of Northern Uganda's special needs in the HSSP II stand in stark contrast with the lack of mention in HSSP I reflect these political and economic transitions.

From the political front, the intervening period between the launching of HSSP's I, and II coincided with the resumption of multiparty politics in Uganda. Robinson (2005), suggests that the ruling party needed to garner votes from the North and was therefore motivated to act in the interest of the population.

The relationship between a number of policies that had a bearing on the health sector and in the electioneering process is exemplified by the amendments made to the 1997 Local Government Act abolishing health care user fees. The abolition of user fees occurred "*10 days before Ugandan citizens went to the polls,*" for the 2001

Presidential elections (Moat and Abelson, 2012, p. 579). Similarly, the abolishing of graduated tax during the 2006 pre-election period still supports the argument of politically expedient policy amendments taking place (Manyak and Katono, 2010). Again, the adoption of Universal Primary Education was put on hold until 1996 when it was adopted into the President's election manifesto despite having been mooted by the Education review commission four years before (Williamson, 2003).

Other than electioneering, there was significant political pressure for more to be done for Northern Uganda. The donors that were funding the government's health budget under the Sector Wide Approach had greater premise to scrutinise whether government expenditure was equitable. Secondly, there was local political pressure from parliament to declare Northern Uganda a disaster area so that the population in the region could gain better humanitarian support (Kasfir and Twebaze, 2005). This was shortly after UN's Under Secretary General for Humanitarian Affairs Jan Egeland, visited the region and drew international attention to the crisis.

From the economic viewpoint the transition from the SAP driven economy to a pro-poor PEAP based financing approach provided for the bolstering of the health sector by the Poverty Alleviation Fund, attracted additional funding to the health sector, both from Government and from its donor funders. The Northern Uganda Recovery Programme, NUSAF and later PRDP were all modelled around the PEAP objectives (MFPED and OPM, 2003; OPM, 2007). In the same vein the adoption of the MTEF and the elaborate annual budgeting process that permitted the scrutiny of multiple stakeholders from district to National level contributed to policy change (Brownbridge, Federico and Kuteesa, 2009).

5.3 Institutional Factors - Interview Findings

Reported in this section are the perceptions and attitudes of individuals and organisations at national level that played a role in health system governance and maternal health care provision and utilisation in both Northern and East Central Uganda during the years 2006 to 2011; this represents the immediate post-conflict period.

Like the policy analysis, the problem driven framework for political economy analysis (Harris, 2013) is applied here to analyse the voices of key informants that relate to political, economic and social processes, categorizing them into institutional and agency related themes. The Institutional factors reported here may be: i) formal - representing rules and procedures that direct the implementation of policy, and ii) informal - representing norms and traditions that influence the behaviour of organisations and individuals.

Agency related themes reflect additional analysis to determine the incentives or motivations that may be financial or non-financial, political or economic influencing the organisational or individual behaviour. The agency themes also consider power relationships between stakeholders in regard to governance and maternal health care.

The policy actors or stakeholders that were interviewed were categorized into three groups according to the type of organisation they represented and these were:

- i) Decision makers (the legislators and top government officials in the health and finance ministries and the office of the prime minister);
- ii) Donor agencies - those involved in providing government with technical and financial support; and
- iii) Civil servants – senior technocrats involved in policy planning and implementation.

Table 5.1: Mapping of stakeholders and respective citation codes

Policy Actor Map and Citation Codes			
Category	Female	Male	Notes
Decision Makers (Legislators)	Legislature.F.1	Legislature.M.1	Members of Parliament during the periods 2001 - 2006, 2006 -2011
Civil Servants (Senior Technocrats)	Technocrat.F.1, Technocrat.F.4	Technocrat.M.1, Technocrat.M.2, Technocrat.M.3, Technocrat.M.4	Civil Servants in the Central Ministries of Health, Finance and Office of the Prime Minister during the Post conflict period
Donor/NGO Representatives	Donor.F.1, Donor.F.2, Donor.F.3, Donor.F.4	Donor.M.1, Donor.M.2,	Donor agency and Implementer NGO employees during the conflict and post conflict periods

At national level, fourteen policy stakeholders were interviewed as key informants. As depicted in Table 5.1 all the policy stakeholders interviewed were individuals that worked in organisations that had a stake in governance and maternal health care in Northern and East Central Uganda during the immediate post conflict period. 54% of the respondents were female. The majority of the women interviewed worked in the donor agencies during the immediate post conflict period. Conversely, most of the men interviewed were civil servants during the immediate post conflict period.

Below are themes that capture the perceptions of individuals as they discussed issues that addressed: formal institutions; informal institutions, and agency issues or incentives. The formal and informal institutions represented the “rules of the game” ultimately influencing maternal health care utilisation as an outcome. The incentives were processes that derived from the institutional direction.

The discussions here focused attention on the impact of three important decision makers: i) the executive, representing mainly the President and occasionally members of his cabinet; ii) the legislature, or the parliament; and, iii) MFPE representing mainly senior technocrats in the ministry that played a primary role in determining Uganda’s macroeconomic environment during Northern Uganda’s immediate post conflict period.

5.3.1 The legislature and its power relationship with the executive and finance ministry

Ten out of 14 respondents made substantive references to the effectiveness of the Ugandan National parliament in its legislative and policy-making role.

Formal institutional related responses

Out of the wide-ranging functions of the Ugandan parliament some discussions alluded to the parliament’s role in the formulations of policies that had a bearing on health and social welfare. Most attention focused on Parliament’s role in health

financing and government accountability. The executive and MFPED were perceived to have significant and often-conflicting interests in that area.

As compared to other respondents, the legislators provided explicit responses to questions raised about the role of parliament in supporting the functioning of the health sector which was indicative of legislators appreciating their important role in health system governance,

“Functionally it may not be an effective parliament, but structurally we have good institutional arrangements that can guarantee some checks and balances... With health, if a loan for example is required for building a hospital for example, or buying equipment or running any project, still it is parliament that approves all that” (Legislature.M.1)

Three interviewees illustrated the parliament’s effectiveness within its limited power, citing the 2004 unanimous bipartisan vote by parliament that successfully passed a bill declaring Northern Uganda a disaster area. Despite this effort, the President tarried to ratify the bill until the following year, manifesting complex dynamics associated with Northern Uganda that the President had to contend with as well as constitutional limitations of parliament. One respondent felt that the Executive’s reluctance was mainly driven by concerns about the financial implications on government and the strain that this would cause to the financing of on-going programmes in other parts of the country.

Declaring disaster in the region, it was stated, reflected mounting donor pressure on a reluctant Ugandan government. It also reflected how the donors could influence the balance of power between parliament and the executive; the declaration was made after twenty years of conflict and only after the suffering of the civilian population had gained increasing international attention¹⁶.

¹⁶ A visit to Northern Uganda in 2003 by Jan Egeland, who at the time was the UN Under Secretary General for Humanitarian Affairs and Emergency Relief was considered a game changer. The international community was alerted to the dire existence of the civilian population of Northern Uganda through important pronouncements that he made (Agence France-Presse, 2003).

“remember that it also took a while for government to accept the North as a disaster area. It was pressure from international funders that made them declare it. Because you know declaring it a disaster zone automatically needs special attention budget-wise and all that.”¹⁷ (Donor.M.1)

In articulating Parliament’s role in budgeting and ensuring accountability within government, most of the respondents acknowledged that the Members of Parliament had carved out for themselves, a significant oversight role¹⁸ in the budgetary process. As an African country, it was argued, Uganda is not exceptional in the President having final say over the budget. What is unique to Uganda, however was that its legislature is more deeply involved in the budget planning process, scrutinising and amending the annual draft budget before it is passed; this was being emulated by other African nations,

“this culminates into the draft budget in May and the ministerial policy statement which is presented to Parliament for approval in June and of course between July and September, Parliament passes through these budget proposals and they make amendments because they have the powers. They do amendments and do reallocations and corrigendas if there are changes to be done and then the budget is approved by end of September.”(Technocrat.M.1)

However, respondents from the donor fraternity, in reflecting on the balance of power between the executive and parliament, underscored the role of senior technocrats at MFPED. The technocrats in MFPED had what was considered, *undue* influence on the budget planning process and on its implementation. The impression was that they had the latitude to deviate from a budget sanctioned by parliament during the implementation phase, justifying their actions on the basis of

¹⁷ This was in reference to an event in 2003 when the Ugandan parliament passed a vote declaring Northern Uganda a disaster zone, however the executive tarried to ratify the bill until a year later. Extensively discussed in Carlson (2004).

¹⁸ The Budget Act of 2001 provided for the setting up of the Budget Committee and a Parliamentary Budget Office that gave the parliament mandate to provide on-going scrutiny during the budget planning process unlike previously where there parliament was required to approve a budget draft during reading of the budget.

the country's fiscal policy instruments¹⁹. One donor respondent and one legislator interviewed felt that the actions of the finance ministry had made the elaborate budget planning process more of a facade,

“most of the time the minister of finance just comes with ceilings for each ministry! You know! Saying, “this year you are just going to budget up to this amount... up to this amount! I mean... arbitrarily like that and the ministries that then take the lion's share are well known. The culprits are defence [the ministry of,] and all that!”(Legislature.M.1)

Another donor respondent asserted that MFPED used its powers to flaunt the principles of additionality, erratically withdrawing money for health care and other social services from Northern Uganda on the premise that the region was already benefiting from massive donor funding during the post conflict period.

“We were even getting a lot of money and putting it in the North. So policies like trying to encourage health units to capture all these resources in their work plans and their books were so that the health people know what is going in. At the end of the day the individual health units got short-changed because government used this information to withdraw its money smartly. During preparation of the budget, there will be some places that are stressed so the government has got to cut the North, however they were denying predictable fungible resources to the North. (Donor.M.1)

This opinion was refuted in further discussions with other donor and technocrat respondents. Nevertheless, these discussions did reveal that the finance ministry's role in prioritisation and planning was perceived as that of: i) undue influence; arbitrariness in action — though within the bounds of the macroeconomic policy; ii) information asymmetry with regard to the rationale for their actions; iii) powerlessness of the legislature and line ministries in the face of the finance

¹⁹ The government of Uganda spends public resources on the basis of a 10-year Long Term Expenditure Framework (LTEF) and a 3-year Medium Term Expenditure Framework (MTEF). Both of these instruments are used for deriving budgetary ceilings for allocations to various sectors in a bid to staying within the bounds of the government's economic policy objectives.

ministry's actions; and, iv) MFPED working for the executive and against the legislature.

“One of the biggest problems we have in Uganda is that we have a very powerful Ministry of Finance. If you go to other places for example even Kenya and Tanzania; the user ministries determine the amount of money they want and most importantly determine how that money is allocated in the sector. But your Ministry of Finance goes ahead to allocate money even in [within] the sector!” (Donor.M.1)

One donor respondent and another from the civil service had more positive stances of the finance ministry's role, feeling that they exhibited astute technical skills, given Uganda's fiscal constraints. These respondents felt that, as it funded the health sector, MFPED was proactive and transparent enough in their dealings with parliament, MOH and the Ministry of Local Government. The challenge was that other stakeholders had a limited understanding of the technical criteria or allocation formula that MFPED used in making its budgetary allocations and disbursements. The tight control over the disbursement of funds was considered protective of the decentralised health sector given the tendency of line ministries and district local governments to divert funds whenever given the opportunity. However, another donor respondent was later to argue that government had long since abandoned the use of the resource allocation formula and was using an arbitrary allocation method that was prone to political intrusion.

Despite the drawbacks to their effectiveness, the legislators interviewed felt that they had gained significant mileage in their accountability function. They had put on hold questionable public spending, had alerted the general public about corruption going on in government, and had enhanced systems that could ensure the fair distribution of public resources,

“It has not been easy, but once parliament puts its feet down... and I am not talking blackmail here... but you know when parliament refuses to pass the

budget for any sector or the entire budget then it becomes problematic for the powers that be.” (Legislature.M.1)

Maternal health was a beneficiary of parliament’s influence on government’s financing priorities. The respondents representing the legislature expressed satisfaction in the fact that more than once they had pushed for the funding of a number of maternal health programmes. They did this by using the powers they had to impose moratoriums on the overall budgeting process until their interest was addressed. MFPED was caused during such occasions to allocate additional funds to maternal health. It was notable that whenever positive references about the effectiveness of the Ugandan parliament were made, it was often in relation to these achievements that supported social welfare,

“in regard to maternal health there was a World Bank grant released for health systems strengthening in Uganda. The Members of Parliament insisted \$30million of that should be exclusively used for maternal child health. If the Government didn’t do that then parliament would not approve the grant. I think that was a very explicit example of governance by Parliament driving donor priorities.” (Donor.F.3)

Nevertheless, legislators had limited provisions to follow up the impact of such funding at health service delivery level. If an MP had concerns about programme implementation within their own constituency, queries could be raised in parliament: i) through *question time* sessions with the prime minister, ii) through raising a private member’s bill, or iii) more drastically by leading constituents in a protest petition in parliament. Such a protest petition was done in relation to the Nodding Syndrome that I have detailed in section 5.3.4. There were other approaches through which legislators could address concerns about questionable programming in the health sector, however these were considered rather ineffective,

“Unfortunately, the way that parliament also works... and it is not their fault really, they cannot initiate action. They have to wait for the auditor general to

do their audit and then report. Once the report is provided to parliament that is when the public accounts committee takes interest and investigates. The parliament's investigations often stop at reviewing the papers that the auditor general has written. They are not mandated to go and do on spot checks. The best that they can do is to refer the matter to police and to the CID to investigate further and make arrests if any." (Legislature.M.1)

Informal institutional related responses

The majority of the respondents interviewed felt that MFPED was working on the behest of the country's president. While it wasn't clear whether this influence of the executive was unconstitutional, many of the respondents felt that decisions made by the executive on the use of public funds was less open to scrutiny.

"Those budgets out of necessity emanate from cabinet. But then MFPED again has a big say in it. But as you know it's the president that really...really controls the budget. The Minister of Finance only does it on his behalf. I mean, even when it comes to reading the budget it is the President that presides and just delegates the finance minister."(Legislature.M.1)

It was also considered that this influence over the country's finances by the Executive, was disadvantageous to the health and education sectors given that the ruling party's economic and social development ideologies as enshrined in the Ten Point Programme (also discussed in section 5.2.3) continued to give these sectors secondary priority relative to the energy, road construction and security.

Respondents from the finance ministry countered the opinion held by the legislators, stating that the Ugandan parliament actually had more say in the allocation of the national budget than any other actor working on the annual budget planning cycle. An example was cited of how the MPs continued to smuggle into the slim budget every passing year new types of emoluments for themselves. Another example drew attention to the fact that the legislators even had the audacity to cut down the budget allocations to the state house budget, which as it was stated, directly affected the operations of the President's office.

A number of alliances were created that allowed the parliament to retain a significant level of function, given the influence of the President and MFPED. One alliance of note was that involving cabinet ministers and the parliament. One would have assumed that cabinet ministers were part of the Executive arm of government and were therefore party to budgeting decisions as represented in the ministerial policy statement. However, it was reported that the ministers heavily depended on Members of Parliament to get programmes in their respective sectors funded,

“So usually we do that in support for the sector ministers because they the ministers may not be able to push for themselves for any increment yet they need the money. So when we rise up and speak for them they are also happy... they may secretly release to us information about what is really pressing and we use such information and they would be happy. This is something that they cannot do by themselves in cabinet!” (Legislature.M.1),

Another dynamic that had evolved in parliament, according to one respondent, was how membership to particular parliamentary committees was coveted given the associated potential for monetary gain. The Committee on the National Economy was cited as one of those coveted ones. It was divulged that members of such committees receiving generous payments from some government projects that were vying for extra funding. Outright demands for kickbacks were negotiated in some instances,

“We learn that someone goes to the ministry that is going to be beneficiary saying, ‘ha! you know, members are very hard! They may not pass this loan... you need to do something!’ And you know, a lot of money is released to these persons, we hear even to the tune of one hundred million which they say they are going to share out to these 20 - 30 members of that parliamentary committee.”(Legislature.M.1)

The respondent found it inconceivable that, as was stated in that interview, departments of government had the capacity to mobilize 100 million shillings (about £20,000.00) to make such illegal payments. It raised even more questions

about the fate of the borrowed funds once approved. The assertions from that interview were directly corroborated in another interview and vaguely alluded to in interviews with two other respondents.

Two respondents also shared their concerns about the late release of disbursements by MFPED to the different sectors. They both considered that an ulterior motive was behind this habitual occurrence given that such monies were reportedly “returned” to the government’s consolidated account but were never declared in Government’s revenue projections for the subsequent year’s budget.

It was also divulged that there were some central government purchases that were not subjected to the resource allocation formula for their distribution to the different decentralised districts. One donor respondent described their eventual distribution as highly politicized. A legislator portrayed such distribution modalities as blind to the needs of the vulnerable and deliberately designed to coerce the Members of Parliament and the electorate into political acquiescence,

“You see that there are these nice ambulances that are only distributed by the President according to some criteria that you really don’t know! It makes some of us feel out of place because he keeps saying to the voters, “you people made a mistake by voting an opposition that can not reach me... that is why you are missing good things! (Legislature.M.1).”

The opinion of the respondents from the donor agencies and the legislature was strongly refuted by a technocrat in the health ministry who explained that while the President during his up country tours might pledge an ambulance, it remains for the line ministry in collaboration with MFPED to plan and schedule how to equitably honour these numerous pledges.

It was notable that the Members of Parliament interviewed, hailing from different political parties and belonging to different parliamentary eras displayed the same air of achievement as they animatedly described the political manoeuvrings preceding successful votes that would enhance maternal health care.

“We know what we did was crazy! We realized, that is, our network realised that Finance was getting different loans and we knew it was us and our children to pay! Then we made ourselves ready. When they brought the loan for approval, I remember very well it was for local Government, we mobilized ourselves in parliament and we threw it out until they included maternal health.” (Legislature.F.1).

And,

“I remember also one time we refused to pass the entire budget of the country unless the health sector budget was increased and health workers were taken into consideration in terms of enhancing their pay and it was done!!”

(Laughter) (Legislature.M.1)

In many of these discussions, the legislators kept comparing the effectiveness and impact of their parliamentary era with other eras. This suggested that the desire amongst the parliamentarians to outdo the legacy of their predecessors was an important motivator for important legislations that had been passed in parliament.

5.3.2 The prioritisation of Northern Uganda’s needs

This was another commonly discussed theme. It reflected Central government’s commitment to establishing peace, security, social development and health in Northern Ugandan. The PRDP turned out to be the most common issue discussed.

Formal institutional related responses

There was a strong perception amongst the respondents, interestingly including those in political opposition, which suggested that during the period leading to the Cessation of Hostilities Agreement signed in Juba in November 2006, the President had exhibited a commendable commitment to peace, security and development in Northern Uganda. The launch of the Peace, Reconstruction and Development Plan (PRDP) the following year was described by one respondent as confirmation of the President’s interest in supporting the region’s social economic development process. Other than being a Presidential prerogative the PRDP, according to another respondent, was more a reflection of donor concern,

“I participated just at the beginning of the PRDP, what I know about it is that it became like a department in the OPM. It actually became like a pool funding; basket. What gave birth to the PRDP was that the donors were complaining that they were not seeing the results of funding different projects in the North through individual ministries.”(Technocrat.M.2)

Underscoring the level of government involvement in Northern Uganda’s recovery process, two respondents highlighted the fact that even before the PRDP was conceived there were other recovery programmes being run by the Office of the Prime Minister (OPM) for Northern Uganda. The OPM was an active participant in coordination and humanitarian relief work during the war. OPM had also supported the population during the early transition and recovery period. It had worked in liaison with a number of UN agencies like UNOCHA, UNDP, UNICEF and WHO. One of the better-known projects that was in existence before and after the war was the Northern Uganda Social Action Fund II that focused on education and health infrastructure. However according to the respondents the impact of these efforts were hampered by limited leadership capacities in the districts,

“Government put in a lot of interventions through NUSAF and NURP, in which health facilities in the North received money to construct staff houses, to expand the maternity wings, and improve on them as well as improve on equipment. Again here the challenge was leadership. Most of the Chief Administrative Officers and DHOs were not pushy enough to acquire the funding, and it took Central government to go down on the ground to remind them. Yet the Ministry of Education and district education departments were utilising the money.”(Technocrat.F.2)

Akin to findings at sub-national level (discussed in the next chapter, section 6.2.5.), some respondents recognised leadership challenges at district level rather than poor prioritisation of the North by Central Government as the cause for poor health service delivery in the region,

“It is not a rule of thumb, but at least you find that areas with very strong leadership, good management practices, they are able to coordinate their implementing partners within the district as well as the political leadership within the district. That impacts a lot on the performance of the system and therefore the people benefit.”(Donor.F.1)

Concerns were raised about the attitude of line ministries; they had failed the programmes by refusing to participate with OPM in the PRDP roll out. In addition, respondents revealed that the PRDP was mistaken to be a funded equalisation programme that had separate sources of funding to address the special needs of the region. By many it was not perceived to be a plan to streamline and coordinate the activities of all stakeholders that were investing resources in the region. The lack of information about PRDPs role might explain why technocrats in MOH continued with their routine programming approach in Northern Uganda,

“I would think honestly there was nothing specific for war torn areas and one thing which was brought to our attention was that we had Programmes like NUSAF, PRDP in those areas and there was an element of health within the component... according to MOH you draw up a programme and each region should benefit and that was in line with the implementation with MOH”(Legislature.F.1)

Similarly, MFPEDs resource allocation formula for the decentralized health sector had no provision for the special needs of Northern Uganda though according to one respondent the “degree of deprivation” was factored into the formula and this automatically guaranteed the North additional resources.

Nevertheless, the PRDP had a monitoring committee in place whose membership was constituted by various sectoral ministers, heads of donor agencies and missions. It was purposed at ensuring that the reconstruction efforts undertaken by the PRDP were aligned to all the government’s developmental aspirations. That, the PRDP “wandered off on its own” to invest in infrastructure rather than in recruiting health workers, for example, was strongly repudiated by respondents from the OPM.

Statements made by the OPM respondents, corroborated by two other respondents suggested that monitoring meetings were actually held with representation from MOH, however with some challenges,

“You would have expected very senior people from MOH and Ministry of Education to come and have a very strong engagement in the OPM meetings. You wouldn’t find them! You would find junior officers coming to attend such meetings, people who don’t even take decisions. To me I even thought they were not even giving feed back to their ministries for their senior people to take action. I saw that as a big problem.”(Technocrat.M.2)

One of the respondents revealed that the health ministry did eventually engage with the OPM at senior managerial level, seeking to halt the construction of new health facilities while MOH sought avenues of equipping and functionalising the ones already built.

Informal institutional related responses

There was a general acknowledgement amongst the respondents that though social services for the entire country - including that for health - were adversely affected by underfunding, Northern Uganda after the 20-year war was deserving of some additional attention.

“A number of Ugandans who were not coming from the Northern part of Uganda ... were sympathetic to what was happening up there in the North but of course there were a few disgruntled people who were maybe coming from the time when we had Presidents coming from the North that terrorized a number of people.”(Technocrat.M.2)

Nevertheless, considering that the war in Northern Uganda had lasted over 20 years, the limited amount of knowledge that many respondents from the rest of the country had of the health related challenges of the region was remarkable.

It was stated that the President being able to repudiate his belief in a military solution to end the Northern Uganda conflict was considered critical in eventually getting the elusive Lord Resistance Army rebels into signing the Cessation of

Hostilities Agreement. The President was also considered personally responsible for the stabilisation and reconstruction efforts that ensued thereafter. There were mixed opinions about the commitment of other officials of government, planners and implementers particularly at the OPM and in the respective districts of Northern Uganda. Some instances were given of senior OPM officers getting involved in corruption. It is believed that this had a profound effect on OPM's efficacy in addressing the different sector specific needs in Northern Uganda,

“all this is due to corruption, embezzlement and mis-appropriation! It has compromised the expected outcomes; and also the people there [in Northern Uganda] are not aware of their rights and dues. The monitoring aspect has not been strong; and the people get to miss what they are supposed to get. Do you remember at one time they supplied “paper” machetes and seeds that don't germinate?”(Legislature.M.1)

Two interviews offered contrasting views on where corruption related to the PRDP was more predominant. One legislator felt that in many of the PRDP supported districts the district leadership had dealings with local contractors through whom they would pilfer massive amounts of PRDP funds. The other view by a respondent that was conversant with the internal workings of the OPM at the time suggested that the checks and balances at district level were stronger and more functional than those at central government level. The steering and procurement committees in the districts were inclusive and transparent and were closely monitored by the OPM and donors. The corruption, according to this respondent, was taking place in the higher echelons of power in the OPM,

“I think it goes back to the top because even in the PM's office, there were officers there that were dishonest. It may not have gone to the level of the minister or Permanent Secretary but then there are those powerful people who make decisions around procurement within the Ministry. I think that is where the problem was rather than affect the district level.”(Technocrat.M.3)

One respondent representing the academia considered that political patronage was behind the Government's amending of the PRDP's coverage from an original 18-post conflict Northern Ugandan districts, to a total of 55 districts in West, East, North and North-eastern Uganda. An interview with a donor respondent provided an alternative explanation,

"Now, although the war and the LRA impact and conflict occurred in high levels in 18 districts, the consequences spread and overlapped beyond the boundaries of the 18 districts either in terms of incursions or in migrations and people running away. So that led to a wider analysis of the geographical area that required PRDP interventions." (Technocrat.M.2)

The donors on many occasions failed to adhere to PRDP's terms of support to Northern Uganda because by channelling their funds through the PRDP basket they would lose credit for their efforts.

"They [the donors] were stubborn. And the PS [Permanent Secretary] at the time, with all his mistakes, was one of the people that pushed the PRDP through. He would take donors to account. Those who would try to put money under wraps; he would tell that, "We are not that kind of people"! He would bring them back into line. That PS liked a coordinated approach. And as I told you that they [donors] did not like the issue of no attribution; they don't like it!"(Donor.M.1)

5.3.3 Policy implementation challenges

Over the years Uganda had produced a number of commendable maternal and reproductive health policies but this was not translating into significant reductions in the death of women due to childbirth particularly in Northern Uganda. This was a theme commonly discussed by the policy stakeholders. Inequitable outcomes and a lack of leadership were some concerns illuminated by these discussions.

Formal institutional related responses

A common theme voiced by the donor cadre of respondents was the meticulous effort put into the adoption or formulation of new policies and strategies by Government, but yet most of them remained poorly implemented,

“in Uganda that health ministry spends so much time on policy and strategy formulation, like now they are in the process of preparing the next health sector strategic plan ... so that might take another two years. Then before they even start implementation they want to do midterm review ... so that is the dilemma!”(Donor.M.2)

Other than the health sector strategic plan, other overarching health policy documents that were regularly re-written included the midterm reviews, annual reviews and the five yearly strategic plan revisions; this all appeared unconnected to the implementation process. Maternal health was experiencing a similar situation; according to one respondent, due to lack of funding the *Roadmap for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality in Uganda*, had achieved only 30% of its targets. However, it was soon to be superseded by another policy document, *Ending Preventable Maternal and New-born Deaths: A Promise Renewed*, which had just been launched by the Health Ministry, targeting maternal health through similar strategies²⁰. It was soon to be tabled in parliament for funding.

As a rebuttal to the above statement by a donor respondent, a government respondent stated that the *Ending Preventable Maternal and New-born Deaths: A Promise Renewed* policy document was imposed upon MOH by a key donor agency that was launching the same programme globally. The respondent absolved government of this perceived “*policy writing obsession*”. As the respondent put it, *in all these cases really, it’s the donors who push for the new policies because they wish to*

²⁰ Ending Preventable Maternal and Newborn Deaths: A Promise Renewed that brings together public, private and civil society organisations as well as individual citizens committed to acting and advocating on behalf of women, new-borns and children. UNICEF, USAID and WHO sponsor the campaign. On the other hand, the *Roadmap for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality in Uganda* was launched in 2007 providing multi-stakeholder guidance for advocacy and implementation of Maternal health care. It was created with technical support from WHO and financial support from UNFPA and WHO.

show the world that they are supporting Uganda ... our challenge is that we are unable to say no!" Discussions with other respondents provided explanations why the MOH technical team was unable to decline taking up these new policies. This is presented in the informal institution part of this section below.

In Northern Uganda's case, inadequate attention was given to the critical requirements that could guarantee the successful implementation of health policy despite the affirmative action provided to the region. The consequence of this according to one respondent from the academia was that, while the country generated numerous health policies that were in tandem with international agreements, they were not adapted to ensure equitable health care. In reality, PRDP money was wasted on projects that were non-sustainable and fragmented and could not make a useful impact on the maternal health needs of the most vulnerable in Northern Uganda,

"I think that there is entirely nothing that has improved equity for the poor or vulnerable, nothing! If you look at what the PRDP was supposed to address ... and that's where the paradox came in during the conflict, all of those guys who were in the camps had the same amount of better service, all those that were within the camps therefore that kind of sense that all things are better"

(Technocrat.M.4)

Implementing maternal health policy in Northern Uganda required recognising the myriad of challenges that had to be addressed before health service delivery was effective. It even suggested that addressing the complexities involved in implementation of maternal health care services had overwhelmed the health system planners,

Those issues are thought through but we never complete our thought processes at planning. I think it overwhelms the system... because when it is articulated like this, I have been here long enough to see people switching off... because we are going through the nitty-gritty. And yet if you don't go through it, you are providing something but it is not working for the women..."(Donor.F.2)

Similar sentiments were voiced by another donor respondent: the wholesale adoption of policies generated by WHO and other international agencies without considering the implications at the rollout phase was suggested as evidence of a lack of health planning skills in the country,

“to ensure that you implement your priorities you need capacity to define your policies and strategies in a manner that is consistent with your implementing structures. Now if they are not, we should be able to tweak the strategies so that they cater for the realities of the structures that are on the ground.”

(Donor.M.2)

However, a respondent from an international NGO working in Northern Uganda was appreciative of the efforts that MOH had put into the policy development process. She felt that multiple stakeholders had worked hard to develop policy guidance and operational tools. In her opinion the responsibility for the failures lay with the funders of policy,

*“The way programs were implemented always remained the main challenge. I think an important step was ownership in the sense that people would develop and implement it together. But there seemed to be some issues over its funding;”***(Donor.F.4)**

Other discussions also appeared to absolve MOH of responsibility for the policy implementation failures. Respondents from government felt that it was mainly financial constraints at fault. The MFPED and the donor partners held the purse strings and were more answerable. The perception in this case was that MOH had no control over the finances required for health service delivery. Both government and donor funding to the health sector had become *equally unreliable*. For the government, MFPED was not adhering to approved health sector budgets, in terms of the timing and amounts released. The donor partners, on the other hand, funded interventions of their own interest; the projects tended to be time bound, often duplicated and limited in coverage.

A particular example was given of MFPED opting not to increase funds necessary for the ministry to fulfil its monitoring role, this was stifling proper policy implementation, and was directly affecting the quality of maternal health care service provision,

“...We need more money for service delivery, even for routine supervision and administration. That money has remained the same by the way for the last 10 years. What we call the non wage; the one for supervision, for monitoring, for administration has remained the same but population has increased, number of health infrastructure has increased, number of staff has increased but resources to facilitate their work to some large extent remained stagnant so that is a challenge.”(Technocrat.M.1)

There were incidents where funds were arbitrarily withdrawn from the health sector’s account by MFPED to fund the emergency responses to disease outbreaks and natural disasters that had occurred in Northern and Eastern Uganda. As stated previously government funding was now considered as unpredictable as donor funding,

“You might have heard when they announce, ‘budget cuts are going to be made across several ministries’ or ‘we require this percentage back!’ Even when the money is already in the ministry account! [Laughter]. So MFPED holds a lot of sway!” (Legislature.M.1)

These incidents reflected the power relationship between MFPED and MOH. As a consequence the health sector’s modus operandi during the post conflict period (for both post conflict and non-conflict Uganda), as one technocrat put it was of, *“interventions that were just picked and implemented on an adhoc basis”*.

Informal institutional related responses

The actions of the policy makers at national level were also perceived to have an informal institutional dimension.

According to the respondents, while various international organisations were under pressure to have their new strategies disseminated and adopted, the Ugandan technocrats were simply lured by the

“generous honoraria and lavish retreats”[Technocrat F.1]

that the national dissemination and adoption process came with. This was proposed as the key reason why government technocrats were not turning away policies that the country was not yet unprepared for. Once the adoption process was accomplished, many of such policies were,

“launched and abandoned after an attempt at implementation at best, or simply shelved and forgotten”[Technocrat M.4]

According to one donor respondent, the areas of reproductive health and HIV prevention, treatment and care were particularly prone to this phenomenon. These were areas that were gaining significant international attention and witnessing a rapid turnover in terms of strategy guidance.

This interest in personal gain, some of the discussants argued, explained the lack of coordination across the health ministry’s departments. Some units within the ministry were running semi autonomously because they were handling projects that attracted more donor funding. Such departments were known for generating policy proposals that often lacked coherence with the capacities of other components of the health system.

Some discussions about implementation challenges made reference to corruption scandals affecting MOH, the Office of the Prime Minister and other important institutions of government. The pilferage of public funds had led to a reduction in the resources available to the implementers - the maternal health service providers, furthermore it made the donors less willing to pool their resources in the PRDP basket fund,

“I think tragically, tragically I think the implementation has been and remains wanting, very, very wanting. If you look at funds brought in, the funds that were meant for the north that were swindled from within the Office of the Prime

Minister, what would you expect? Uhm ?! So I will just state it categorically, the implementation of these policies has been extremely wanting!"

(Technocrat.M.4)

One national level respondent decried the impact of district level politics on health service delivery, an example was given of how the district administration in Luuka District, East Central Uganda failed to repair their maternity ward for over four years, despite central government providing extra funding for the renovation of the facility. Overt political interests had led to the diversion of these development funds²¹ to financing less urgent but politically expedient projects within the district (Other governance implications of the Luuka district maternity ward scenario are discussed in Sections 5.3.5 and 6.3.2),

"I think for some of these things politics plays into it. You give money and guidance that 'please make this facility functional!' but when it [the fund] reaches the local Governments there are so many interests; the chairman LCV has an interest, the speaker has an interest, the councillors have an interest, the secretary of health..." (Technocrat.M.1)

Equal blame was apportioned to national level politicians that would on occasion extend their influence and interfere with the district health planning processes. They often pressurised the local governments and lobbied MOH so that district resources and medical supplies were diverted to developing and supplying the smaller parish level health centres. Though they were not providing delivery services, one legislator defended her interest in advocating for them,

"There is one health centre II at Parish level, though it doesn't have a maternity, that I built in my parish; and it is wonderful. Ministry of Health had a new plan where they were to create a certain small room to serve as a maternity room though there is no for accommodation for a midwife yet. I was there last weekend and felt good. I think the District leadership and the health worker

²¹ The roof of the maternity ward of Kiyunga Health Centre IV, Luuka District got damaged in a fire. Central government disbursed to the district an extra £ 23,000 on top of its regular development grant. The roof still remains unrepaired, however it was reported that a health centre II and a classroom block were erected in other parts of the district on the insistence of the districts political leadership.

have managed it well. They are saying National Medical Stores is putting medicines there more than in the hospital! So I was like if the system could change, health centre II's should be designed with a maternity wing and put in places that are heavily populated. The problem we have is we wake up and build here, there... everywhere! I still think that a level II facility would address the problem as long as it is placed right among the people who need it most.

(Legislature.F.1)

This legislator was not from Northern Uganda but the picture was similar across the country. She later admitted that there was significant pressure from the population to have these small health units set up within their vicinity even when they lacked maternity functionality.

5.3.4 Women and maternal health governance

The interviews highlighted a critical role women played in maternal health care in post conflict and non-conflict Uganda by their participation in national governance in Uganda. Women leaders in the legislature were recognised as effective advocates for maternal health because they drew from their personal experiences and collaborated across the political divide.

Formal institutional related responses

During the 7th and 8th Parliaments that coincided with the post conflict period, women parliamentarians were able to raise national awareness about the plight of women in childbirth. Respondents stated that the awareness campaigns were spearheaded by women parliamentarians acting under the umbrella of the Parliamentary Forum on Maternal Health, which was later referred to as the Network for African Women Ministers and Parliamentarians – Uganda Chapter (NAWMP). Through this body additional funding was solicited for the dire state of maternal health care across the country.

A majority of respondents appreciated the role played by the women parliamentarians. They had effectively used their legislative roles and political

muscle to raise funds that would enable Northern Uganda like the rest of Uganda to gain additional health workers and equipment for emergency obstetric care,

“the motivation came out of the realization that, you know... women go through a lot and no woman should die giving birth! This has nothing to do with politics and the advocacy that came through these women parliamentarians was critical. There are times when people do not know that there is an issue that needs attention and it will be obscure. But the moment some people raise the flag and persist on advocating then people become aware. So that advocacy really helped and genuinely without any selfish interests or motives all Members of Parliament were unanimously supporting the cause.”(Legislature.M.1)

According to the legislators, the activism for maternal health was unfortunately not a continuous process though NAWMP attempted to keep the issue on the agenda. Other political priorities, for example, contending with upcoming election seasons kept interfering with their work. Some women politicians that had left parliament had made efforts to continue the advocacy work outside the House but conceded that without the mantle of political power it was challenging,

“As you push on an issue then elections come in and then you are not in... though I continued even after parliament ... but the authority and power when you are in as a Member of Parliament is quite different, I have not achieved that much. I am now working with other alliances, but things move slowly”
(Legislature.F.1)

Male legislators were recognised to have shown a level of interest in maternal health care; they readily supported maternal health related legislation. Nevertheless they lacked the tenacity and persistence that the women members of parliament exhibited.

Informal institutional related responses

The women parliamentarians had set a precedent by co-opting the various stakeholders into a mutual relationship that transcended gender and political

divide. Through this the women parliamentarians mustered enough support to draw support for the country's maternal health care needs,

“we were stagnant and things didn't seem to be moving or changing but we tried hard and at least got everyone as a country to really appreciate the maternal health situation in the country compared to elsewhere in other countries. We really made good noise that was appreciated by everyone we thought was concerned...the stakeholders! The ministries were also good to us, they were not against us; now that policy makers are in the thing then maybe it would cause change, but I don't know; there are things which come in along the way and sway us” (Legislature.F.1)

That the women parliamentarians were strong advocates for maternal health issues, was probably driven by their own experiences as individuals that had to go through the rigors of childbirth,

“We formed a group of other Members of Parliament, a network; Uganda women parliamentarians and men and it was focusing on maternal health improvement in our country. Many of us that started it are mothers, married, or midwives as a background. Yes! Medical workers... midwives by training;” (Legislature.F.1)

The women parliamentarians had developed strong mutually beneficial collaborations with civil society organisations. The CSOs provided them with well-packaged, well-informed advocacy messages that proved effective in maintaining the pressure on other legislators and technocrats in the finance ministry and on the executive,

“The analogy was that everyday a matatu (commuter taxi) full of women is crashing and killing all of them daily. You know that painted a very sordid picture which made people realize that there is a problem.” (Legislature.M.1)

None of the respondents was able to recall advocacy efforts by the women MPs that was specific for maternal health in Northern Uganda. The lack of technical guidance

to the parliamentarians on the need to advocate for interventions targeting specific needs across the country, and in Northern Uganda in this case was evident.

However, in a discussion over a separate issue, one respondent recalled the actions of the Woman Member of Parliament of Kitgum District in Northern Uganda that bussed 25 children suffering from the mysterious Nodding Syndrome disease²² to Kampala, 436 kilometres away in a bid to get their plight recognized. Her actions gained the condition both international and local attention. Again, the maternal health care needs of Northern Uganda did not benefit from similar advocacy efforts.

5.3.5 The human resource challenge

The majority of respondents were consistent in identifying the lack of health workers as the one critical factor deterring a reduction in maternal mortality in post conflict and non-conflict Uganda. In spite of this recognition, governance stakeholders at national and health sector level were unable to channel resources to addressing the gaps in this health system element.

Formal institutional related responses

The majority of respondents felt that, all supply and demand side factors considered, Northern Uganda's human resource challenges were the main cause for the region failing to gain an improvement in maternal health. During the war and again during the post conflict period in Northern Uganda, the government had delegated significant levels of responsibility to the development partners. However given their varied interests and strategies the human resource challenges were inadequately addressed. Donor partners were less willing to fund the recurrent costs associated with the recruitment and retention of health workers

“One of the key challenges was health worker availability. I think it [Northern Uganda] had the least number of health workers across the board...they are coming from a war situation and they needed a boost for the health system to

²² According to a CDC.Gov website, Nodding syndrome is an unexplained neurologic condition characterized by episodes of repetitive dropping forward of the head, often accompanied by other seizure-like activity, such as convulsions or staring spells. The condition predominantly affects children aged 5–15 years and has been reported in South Sudan, Northern Uganda and southern Tanzania.

be functional. Then of course the other thing that they faced was the multiplicity of partners, each with their own agenda. So you would never really know collectively, what you have achieved.”(Technocrat.F.2)

The deficiencies in human resources for health was not uniform across Northern Uganda, some of the districts that were further away from the epicentre of the conflict were reported by some respondents to have recruitment levels comparable with urban centres in the south of the country,

“Yes you may say that there was heavy leaning towards infrastructure. But infrastructure was also badly off. For the human resource at some point actually, Lira in Northern Uganda had the best proportion of approved posts filled by health workers because there was support to the recruitment of health workers – yes I think it was Lira. Also the issues of medicines, there was deliberate targeting.”(Donor.F.1)

Neither was the government able to implement its human resource strategies as portrayed in national health policies. According to one respondent, the government recruited an average of 500 health workers annually, mainly as replacement for positions recently vacant. The respondent described the government as using ad hoc, fire-fighting approaches to responding to the national human resource gaps. Northern Uganda was not a specific beneficiary of this ad hoc approach,

“The government recruited about 7000 health workers to cater for health centres III and IV across the country. The other thing that was done was to facilitate and support the village health teams, so that they could mobilise mothers - pregnant women to deliver at the health facilities. (Technocrat.F.1).

This was in reference to the one off release of \$20 million by the Ministry of Finance, increasing the health wage bill by 16% and subsequently funding the recruitment of 7211 new health workers and doubling the salary of doctors working at sub district level in the rural areas of Uganda.

Uganda’s stringent macroeconomic policies were also cited as motivating health workers to seek employment outside government. Some policy decisions that were

adopted as an effort to ensure fiscal stability had an adverse impact on the health sector wage bill. The Government maintained its embargo on the recruitment of new health workers (that is, until the one-off recruitment exercise above). Again in 2009, the Government decided to cluster health workers together with other employees of government on a *single spine salary structure*.

These actions it was felt indicated that there was poor prioritisation of health care and the government was not taking into consideration the special circumstances associated with health worker training and employment,

*“And you know...the challenge with Uganda, in 2009 the single spine salary scale was started ... all health workers went on a single spine. Now this means that all civil servants are on that same salary scale. If you want to increase salaries for health workers then you will have to increase salaries all across the board, which means never! Now, for me that was a gross mistake although finance thought that they were saving money, they were making it more difficult to address health worker’s needs”**(Technocrat.F.4)***

The PRDP received much criticism from a majority of respondents for not using their funding for addressing the human resource challenges. Nonetheless, two respondents argued that the massive investment in infrastructural development actually addressed the human resource question. The planners, it was explained, had recognised that most of the health facilities in Northern Uganda were run down, and the few health workers that had ventured to work in these settings were living in nearby trading centres or towns given the lack of housing and security fencing. This made it difficult for emergency obstetric care to work,

“the ability to attract and retain the health worker has a lot to do with a decent house and decent accommodation. PRDP is putting tremendous priority there. Ministry of Health now has an opportunity to aggressively deploy people to these units because accommodation is available. So we now have an opportunity for reprioritization. Now we can revisit and say, ‘this mortar and cement we have been piling in there. Can we now say we have reached 80%?”

Can we now say we should now look at staffing? Can we say now more equipment? Can we say something else that people can see and say is needed?
”(Technocrat.M.3)

In addition, according to these respondents, the infrastructural support that went to medical training institutions in the region met a dire need in the classrooms and training equipment that were run down and in need of an urgent facelift.

In this light, the respondents that were “*pro-infrastructural investment*” identified the lack of effective political, administrative and technical leadership in Northern Uganda as having caused the districts to lose out on a number of funding opportunities that could have enhanced the region’s capacity to attract and retain health workers. Some of this funding would have come through some of the PRDP’s projects as well as through the multiplicity of donors that were active in the region. There were a few success stories, of districts that had managed to galvanize funders into addressing their specific human resource challenges,

*“So there have been some successes, in human resource recruitment; I think the same goes for St Joseph [hospital]. There was a time it was also going well in Kitgum government, though I know now its down again - they do not have a doctor. So I think it all happens in phases and depends a lot on the person in management and the DHO”.***(Donor.F.4)**

However as stated before, the donor funding was available for a short duration, was not reliable and was noted to have led to divisions within the health facilities. The donor-paid health workers were often left to do the bulk of work because their counterparts employed by government considered them more regularly and more highly paid.

Informal institutional related responses

It was stated that although health workers preferred to work elsewhere in Uganda other than in the North, this had not made the human resource situation in these contexts any better. In East Central Uganda, health workers were described as partially committed to their duty stations; many had a second job in the private

sector. The region was a popular destination because it would guarantee access to urban centres where health workers could engage in dual practice. This was affecting the quality of health care,

“Luuka, Kamuli [towns in East Central Uganda] where there is no active concentration on the issue, things have been left to happen...business as usual! There is no special organization. The system in general is not up to where you want it; the service providers are deserting work and coming here to Kamwokya [a suburb in the capital city Kampala- 120 km from duty station] to do private practice”,(Donor.F.2)

5.4 Summary

The Political economy analysis framework was applied to analyse key national and health sector policy documents, and in-depth key stakeholder interviews. This made possible the identification of contextual, structural and agency related issues that influenced maternal health care governance at national level.

The analysis of national and health sector policies indicated that there were important political and economic changes occurring towards the end of Northern Uganda’s conflict in 2006; these changes had a bearing on maternal health care.

The political changes included a transition from no-party democracy to multiparty democracy and the adoption of the decentralised system of government.

International sentiments about the war and its impact on the civilian population also influenced Uganda’s governance decisions during that period.

On the economic front, an important policy shift was the abandonment of the Structural Adjustment Programmes and the adoption of the Poverty Eradication Action Plan. The Mid Term Expenditure Framework and the Annual Budgeting Cycle were tools that guided the financing modalities of the PEAP.

Uganda’s overarching health care policies mirrored the changes in the national policies and were more cognisant of the special needs of Northern Uganda as efforts to end the conflict intensified. However, more technical policy documents like

Uganda's maternal health care policies did not reflect these policy shifts and continued to advocate for a "one-size-fits-all" approach to service delivery.

As represented in the summary 5.2, from the analysis of stakeholder interviews five broad themes were derived; each theme had a formal and informal institutional component. From the formal and informal areas within each theme, agency related drivers were identified for further analysis later in discussion.

The five themes reveal that the President, MFPED and the Aid donors acted as a powerful alliance that with regard to health service delivery, shared policy interests that limited the effectiveness of Parliament supporting the improvement of maternal health care. To a notable degree, women parliamentarians' mustered political support from key stakeholders within and outside parliament and pushed for the occasional release of funding for maternal health care. This funding never targeted maternal mortality hotspots, for instance, Northern Uganda where the population was in transition.

The creation of the PRDP manifested the recognition and prioritisation of Northern Uganda's needs by the President, MFPED and the donors, however national level technocrats failed to direct this funding opportunity to the regions health sector. Maternal care policies were not well adapted to the local context and the lack of appropriate funding limited the impact of these policies.

The tables below summarise the findings from the policy analysis and the qualitative interview.

Table 5.2 Summary Table of the Study Policy Analysis

Theme	Sub-themes	Uganda	Specific to Northern Uganda
Contextual Factors			
National Governance Policies	Policies characterising the conflict period	No-party Movement System. Decentralisation Policy. Primary prioritisation of infrastructural development, fiscal structural adjustment and defence. Secondary prioritisation of the health sector. National Gender Policy	Military solution to pacifying Northern Uganda. The encampment of the civilian population in IDP camps. Later development of IDP Policy
	Policies characterising the post conflict period	Military dispensation. Reserved parliamentary and local governance seat policy for women. PEAP. National Development Plan with new emphasis on socio-economic development and transformation	PEAP promoted geographical targeting implemented through the PRDP and NUSAF. Humanitarian disaster declaration, Northern Uganda reconstruction programmes. Decentralisation policy.
Health Sector Governance Policies	Policies characterising the conflict period	Minimum health care package key emphasis of the Health Sector strategic plan I. Health sub-district policy stipulating health care investment at community level	No specific health sector policies for Northern Uganda. HSSP I does not mention the PEAP pillar addressing conflict and security.
	Policies characterising the post conflict period	Health Sector Strategic Plan III aim was to improve efficiency and equity in health service delivery through health sector reforms, donor coordination, improved allocation of resources and better reporting	HSSP II identifies poverty and low literacy as a cause of limited health care benefits in Northern Uganda. HSSP III identifies but does not specify strategy for addressing Northern Uganda EmOC needs
Maternal Health Policies	Policies characterising the conflict period	Safe Motherhood policy advocacy for political commitment and redressing social inequities affecting women. National Adolescent policy 2004. HR Policy – lunch allowance and special salary structure favouring HCWs	No specific maternal health or human resource provision for Northern Uganda during the period of conflict.
	Policies characterising the post conflict period	Roadmap for Reducing Maternal and Neonatal Morbidity and Mortality in Uganda (2007) was Uganda's primary MNCH strategy's Communication Strategy to Accelerate the Implementation of Reproductive Health (2009) and the Family Planning Campaign Strategy (2006)	No specific maternal health provision for Northern Uganda during the resettlement process. Human Resource Policy advocates selective HR investment for disadvantaged population but not implemented. Reproductive health policies not specifying strategies for post-conflict setting.
Financing and Implementation	Policies characterising the conflict period	Structural Adjustment Policies and later the Poverty Eradication Action Plan introducing MTEF that limited changes in sectoral budgets and ring fenced funding for the health sector.	Health workers in Northern Uganda benefited from the Hard to Reach allowance for Health workers in rural areas.
	Policies characterising the post conflict period	Health Sector Strategic and Investment Plan (2010/11 – 2019/2012) emphasising investment in SRH rights; MNCH survival and SGBV as key intervention areas for health investment.	Inability of strategic investments to address region specific needs affected in Northern Uganda.
Policy Drivers for Maternal Health	Conflict period	NRM Manifesto, Structural Adjustment policy	PEAP, Northern Uganda Reconstruction Programme, IDP policy
	Policies characterising the post conflict period	1995 Constitution amendment adoption of multipartyism, PRSPs (PEAP II). Abolition of cost sharing	PRDP, Humanitarian Crisis declaration, Cessation of Hostilities, hard to reach allowance, quota provisions for women MPs

Table 5.3: Summary of Analysis from the National stakeholder Qualitative Interview

Theme	Sub themes	Uganda	Specific to Northern Uganda health sector
Institutional Factor			
Legislator and Power balance	Formal	Legislature scrutinises and passes health sector budget but MFPED dictates itemised implementation. MFPED actions reflect presidential priorities. MTEF and budget ceiling.	
	Informal	Alliances are formed among the elite stakeholder so as to counteract influence of the President and MFPED on national policy	Politically motivated allocation of medical equipment and infrastructure disadvantaged Northern Uganda that often voted for the opposition.
Prioritising Northern Uganda's Needs	Formal	Poor participation of line ministries and local governments in the implementation of the PRDP	Resource allocation criteria in the health sector failed to factor in the special circumstances of the post conflict setting. The prime focus of all PRDP funders was infrastructural development rather than recurrent health expenditure, e.g. wage bill.
	Informal	National governance stakeholders were sympathetic to the plight of the returning population of Northern Uganda. Corruption in the OPM deterred its effectiveness in addressing Northern Uganda's reconstruction needs. The needs for attribution lead some donors to provide funding parallel to the PRDP.	Corruption and a non-committal attitude of OPM officials and the district local government counterparts affected outcome of the PRDP on maternal health care.
Policy implementation challenges	Formal	Proper implementation of policy deterred by government adherence to MTEF and donors abiding by their own funding interests.	Lack of technical capacity and skills in MoH to translate adopted policy into interventions that could address Northern Uganda's maternal health needs.
	Informal	Government technical experts were motivated to adopt new policies due to generous allowances that they were paid for the process. Interference of the district level planning processes by politicians at national level.	Corruption limited the funding available for health policy implementation.
Women and maternal health governance	Formal	Women parliamentarians formed caucuses. They were supported by CSOs and technocrats from the MOH in their advocacy work	Collective action was not exploited in advocating for the special health needs of Northern Uganda.
	Informal	Women politicians were motivated by their own experiences to promote maternal health care	Women parliamentarians did not use their motivation to address special maternal health needs of the resettling population.
Human resource challenges	Formal	Health worker recruitment ban and the adoption of the single spine salary structure were ultimately affecting the quality of health care	Lack of political and technical leadership in Northern Uganda to harness PRDP funds for the development of infrastructure that would attract health workers to the region.
	Informal	Quality of care affected by health workers attracted to settings that provided dual employment opportunities	Market forces not adequately addressed and made the region less attractive. See also section 6.2.2

6 SUB NATIONAL FINDINGS

6.1 Approach to this chapter

This chapter presents findings that capture perceptions; attitudes; and actions of: i) politicians and technocrats in the district local governments and civil society organisations through in depth interviews; and, ii) community opinion leaders, women leaders and village health team members through focus group discussions in relation to maternal health care governance and its influence on maternal health care utilisation in Northern and East Central Uganda during the immediate post conflict period.

As mentioned in the Methods chapter, section 4.6 (pg. 149), and as was applied in the previous Chapter Five, the analysis of the results here is based on the Political economy Analytical Framework by Harris (2013) supported by the Framework Analytical Method developed by Ritchie and Spencer (1994).

The voices of key informants and focus group discussants are synthesised together into common themes using the Framework Analytical method and then further categorized using the PEA as depicted in Figure 4.3 (pg. 151) using political, economic and social processes into institutional and agency related themes.

The **Structural diagnosis** (*2a, in the Figure 4.3, pg. 151*) represents: i) **context** – the policies, their influencers, and trends. This information has been gained from the policy analysis conducted in the previous Chapter five section 5.2.2 & 5.2.4; ii) **institutions** – the formal rules and procedures, and the informal traditions and norms at decentralised level in Northern and East Central Uganda determined through key informant interviews and focus group discussions.

The **Agency diagnosis** (*2b, in the figure 4.3, pg. 151*) refers to power relationships, incentives, constraints, collective action, information sharing and other dynamics that are a consequence of the interplay of the formal and informal institutions described. As in the previous chapter the agency issues are described and discussed within the narratives of each theme.

6.2 Institutional factors

In this section I report the perceptions, attitudes and actions of individuals representing organisations located at sub-national level in Northern Uganda and East Central Uganda. These organisations played a role in maternal health care governance during the immediate post-conflict period. The time frame considered being the years 2006 to 2011.

The policy stakeholders that were interviewed were categorized into four groups according to the type of organisation. The four groups are:

- i) Administrators – politicians and technocrats within the district local governments;
- ii) Health Providers – the midwives;
- iii) Civil Society - representatives of community based organisations, NGOs and donor partners active at district level.
- iv) Community - representatives of the community collective voices, for example opinion leaders, women community leaders and village health team members.

For the stakeholder groups (i) to (iii), seven key informant interviews were conducted in Northern Uganda and ten in East Central Uganda. The key informants were women and men that had worked in either of the two regions during the period after the end of conflict in Northern Uganda and their work was directly or indirectly related to maternal health care governance. In Northern Uganda, the interview respondents were 46% female; in East Central Uganda, they were 51% female. Overall more male administrators and more female civil society respondents were interviewed. The health providers, that is, the midwives were all female.

In addition, in each sub region three focus group discussions were conducted. As represented by group (iv), a total of 31 community members participated in the FGDs in Northern Uganda and 29 community members participated in East Central Uganda respectively. The opinion leaders in both regions were made up of retired civil servants, traditional leaders, religious leaders and grass-root level political

leaders (see discussion on “opinion leaders” in section 4.5.4 pg. 146). The opinion leader category was open to both gender, but only one female participated in this category.

Table 6.1: Actor Mapping and Citation Codes

Category	Male North	Female North	Male ECU	Female ECU	Notes
District Administration Actors	DAA.NU.M.1 DAA.NU.M.2	DAA.NU.F.1	DAA.ECU.M.1 DAA.ECU.M.2 DAA.ECU.M.3 DAA.ECU.M.4		Represent the district politicians and technocrats that include the district health team members
Health Provider		HP.NU.F.1		HP.ECU.F.1	Midwives at the health facilities
CSO Representatives	CSO.NU.M.1	CSO.NU.F.1 CSO.NU.F.2	CSO.ECU.M.1	CSO.ECU.F.1 CSO.ECU.F.2 CSO.ECU.F.3 CSO.ECU.F.4	National NGOs, District based NGOs and CBOs
Community Representatives	Opinion Leader, NU: 1 up to 11 VHT Member, NU.M.1, 2,3,4, 5,6 and 7	Woman Leader, NU: 1 up to 10 VHT Member, NU.F 8,9, 10 and 11	Opinion Leader, ECU 1 to 10 VHT VHT Member, ECU.M.1, 2,3, and 4	Woman Leader, ECU 1 to 9 VHT Member, ECU.F.5, 6,7 8, 9 and 10	Focus group discussants who were Opinion leaders (mostly male), women leaders and VHT members
NU = Northern Uganda; ECU = East Central Uganda; VHT = Village Health Team; CSO = Civil Society Organisation; NGO = Non- governmental organisation.					

6.2.1 The civil society role in maternal health care

A number of civil society organisations were operational in Northern and East Central Uganda. Discussions with stakeholders in the district local governments suggested that the community level activities in Northern Uganda appeared more vibrant presumably due to the availability of donor funding.

Formal institutional related responses

According to discussions with CSO respondents in Northern Uganda, there were overt funding gaps for the CSOs to support maternal health care service delivery as compared to funding that was available for demand side activities. It was common to see maternal health being addressed through crosscutting HIV and gender-related projects. Where maternal health care services were supported by CSOs the

support was selective in coverage and area of focus. The services were poorly coordinated, with many of the CSO remaining primarily answerable to their respective donors.

The influence of donor interests on CSO choices was reflected by some organisations that had been addressing maternal health care in East Central Uganda either relocating or closing down as the donors refocused their attention to Northern Uganda. In East Central Uganda, it was felt that the exit of the CSOs had greatly influenced the state of maternal health utilisation in the region,

*“They [the NGOs] have decreased because some were removed to go and address issues in the north ... like UNFPA and UNICEF. But for the period they were here they were doing good work in advocacy, in supporting us to sensitize the people, training and also giving material support in terms of improving transport, communication to address maternal issues and also handling adolescents... but they were taken to the north”***(Administrator, DAA.ECU.M.2).**

Many of the accounts provided by the respondents were suggestive of the health service delivery focus by the CSOs in East Central Uganda and Northern Uganda being significantly different. In East Central Uganda, most of the CSOs appeared to have focused on the “supply side” providing additional resources that complimented district health service delivery. The CSOs played a minimal role in addressing community factors that influenced the uptake of maternal health care,

*“Most of the NGOs in the region are service based. What do I mean? Most of us what we do is provide HIV care services, provide STI screening and treatment and probably share the data with the district and you have your numbers. But we are talking about a voice in the community recognizing a need and you get back to the relevant authorities”***(Civil Society Representative, CSO.ECU.F.2).**

On the contrary, in the North respondents recognised that there were more advocacy-based civil society organisations and a relatively limited number of organisations addressing “supply-side” maternal health care service delivery,

“Again when you look at the different ways that the people thought that they would try to influence maternal health care, it was mainly through advocacy

processes because many NGOs built the capacities of the people in the region to really demand for their rights, demand for service delivery, accountability from the duty bearers who were mainly from the technical wing and then political wing”(Civil Society Representative, CSO.NU.F.1).

In the North one of the important outputs of donor investment, therefore, was the mobilisation of communities, both women and men, to participate in formal governance processes that had a bearing on the quality of maternal health care they desired,

“Among some of the responsibilities that many NGO participated in was to encourage people to attend the planning process. Because that is the only way they could influence the delivery of services to them irrespective of what service department; health, education, social services. Many organizations including NGO forum participated in encouraging communities to attend the planning process because that’s where their voices could be heard and that is where the government planned for the different lower levels: parish, sub county, and district”. (Civil Society Representative, CSO.NU.F.1)

Informal institutional related responses

In East Central Uganda, respondents stated that CSOs commenced advocacy-related support for maternal health care much later as compared to Northern Uganda; it was still a poorly emphasised area of health care,

Anyway, the only unfortunate bit is that work around our advocacy was stressed from 2009. Much as I have a long background in civil society work my engagements before were not so much into this kind of advocacy... You see in terms of community mobilization and then taking maternal health as a community concern. I can say it is regrettable and quite unfortunate that our people have the idea ... especially the CSO leaders. They have a feel of what the ideal is and know what it takes but the will to do it is what fails (Civil Society Representative, CSO.ECU.M.1).

The inference made from the above statement was that despite having the technical capacity to enhance health promotion for maternal health in East Central Uganda,

the CSOs felt significantly constrained. The *“but the will to do it is what fails”* statement above reflected an attitude of resignation or self-preservation in the face of political pressure against advocacy work by the CSOs. One other respondent intimated that NGOs were playing it safe by supporting more technical, “supply-side” areas of maternal health service delivery.

It was commonplace for various stakeholders in society to at one time or another accuse advocacy-focused CSOs in Northern Uganda and East Central Uganda of being either patronised by politicians or politically biased. In Northern Uganda, CSOs were accused of working against the district politicians when they launched and widely disseminated a scoring system that assessed the district local government performance,

“I mean look at this newspaper of yesterday... in grading performance of district local governments countrywide... our district local government and our district chairman was the poorest performer by ranking! And so you get that kind of thing happening and it is rubbished as just politics instead of accepting the truth ... the politicians will normally want to say you are doing all this because of your affiliation to a particular party or organization.”(Civil Society Representative, CSO.NU.M.1)

Similarly in East Central Uganda, the CSOs had to be mindful of the implications of engaging politicians as champions for their community related activities,

“If you are dealing with a politician, the people are thinking that you are now campaigning for them. You are looking for votes. Then you are like, “look here people! I do not need your vote! I do not even need to work here really but I have brought this person whom you voted into office for you to tell exactly what you think they should be doing for you! At the same time, the politicians also have their own selfish interests and sometimes have a way of grabbing it from your hands and taking credit for it.” (Civil Society Representative, CSO.ECU.F.2)

The power relationship between CSOs, the district local governments, and the community appeared to determine the nature of response that the community received in response to their demands for better accountability.

In Northern Uganda, CSO respondents suggested that they had significant clout, being able to mobilise community gatherings that even drew in key district leaders, including Members of Parliament in some cases. An example was given of one such meeting where decisive action was taken to name, shame and interdict a health worker involved in the abuse of office,

“The reaction on the errant in charge of the Health Centre was so swift! The district health officer had to come back to request that at least he [the health worker] is given time to come and harvest his food crops before he is summarily fired. So the population had to be alerted so that if they saw him in the area, it was not because he was coming to work again - it was to harvest to his crops. ... So as a consequence the assistant DHO, actually stated that she was going to give additional feed back on radio about the steps that they have taken. Immediately after that, they had a meeting for all the in-charges in Apac district who were warned against some of these bad behaviours and corruption tendencies and so forth.” (Civil Society Representative, CSO.NU.M.1)

CSOs in East Central Uganda were similarly able to work with their communities to expose corrupt dealings amongst health workers by mobilising their communities. However, the CSO respondents in this region expressed disappointment at the lack of fairness in the responses of the district local governments. Errant health workers were rarely punished for their wrongdoing. In one case, a health worker that was caught stealing government drugs was simply relocated to another unit,

“She attested and apologized to the community over the issues and she also confessed that she was selling off Co-artem [an anti-malarial drug] to different drug suppliers. She was penalized by being transferred which on our part was just not enough because no one deserved such a kind of health worker who was

ethically not right ... but that's how it went.” (Civil Society Representative, CSO.ECU.M.1).

6.2.2 “Supply side” issues and the utilisation of maternal health care

In Northern Uganda the respondents tended to blame the state of maternal health care on deficiencies in supply side processes. In contrast, in Eastern Uganda the perception was that the challenges highlighted were predominantly demand side related. Though the differing CSO strategies in each region may not be the sole cause for these gaps, it is notable that in both regions they were this opposite to the strategies opted for by CSOs on the ground as noted in Section 6.2.1.

Formal institutional related responses

Contrary to the opinions of some national-level respondents suggesting deterioration in the quality of maternal health in post conflict Northern Uganda, the focus group discussions with the community tended to reveal a more positive perception of maternal health care services. The community members felt that with the resumption of peace, the government had afforded them better access and quality of maternal health care. Many of the female focus group respondents reported having used traditional birth attendants for their own birthing needs while still in the camps and this was because they had no alternative at the time. During the period of encampment, it was difficult to access skilled birth attendance: trained midwives were scarce, roads were impassable and insecure, and the population was too poor to pay for private delivery services. This finding is corroborated by the DHS information that I presented in the Uganda Chapter section 3.3.4. For instance, the DHS surveys shows that while in 2006 70% of Northern Uganda’s population delivered assisted by traditional birth attendants, in 2011 this had reduced to 30% with 70% of the population delivering either in public or private health facilities. The community’s opinion also tallies well with findings from an interview with a district health team member of one district that had its entire population displaced during the war,

One of the things we have managed to do is maternal auditing; for the last one or so years I don't remember any maternal death but in the camps it was very common, even neonatal deaths... majority of the women were delivered by TBAs in the camps in our case. But the situation is steadily improving because I remember at one point we were at about 25% delivery in the hands of qualified staff then we raised it to about 38% and at the moment we are at about 44% so that indicates a gradual increase. Our people are now making informed choices and know which better facility to go to.”(Administrator, DAA.NU.M.2)

As mentioned by interviewees in the previous section 6.2.1, despite the preponderance of donor support in Northern Uganda, relatively fewer projects focused directly on maternal health care service delivery. A few examples that were cited by district health team respondents in Gulu and Kitgum districts included: UNFPA that provided mama kits²³; UNICEF; Doctors with Africa (CUAAM); and, the Association of Volunteers in International Service (AVSI) supported the training and remuneration of midwives in selected government and private-not-for-profit health facilities in selected districts. It was stated by one of these respondents that this short-lived and very selective project support often resulted in sharp fluctuations in attendance and utilisation of maternal health care services; the community were drawn to health facilities that were providing more comprehensive, quality services. The sudden shifts in utilisation of the various health facilities are stated to have made planning difficult. The functionality of the health sub district concept was disrupted as patients by-passed more proximal facilities so as to access services in facilities that were better endowed,

“Comparing workload, like the facility where I am. I am a midwife we have a lot of deliveries in this facility but now that the NGO has closed down the project, people have started going back to their different facilities in other sub counties

²³ Women that report to health facilities for normal delivery are often instructed to buy and provide basic items for delivery that many cannot afford, often causing them to seek the help of more affordable traditional birth attendants. The Ugandan ministry of health with support from UNFPA and WHO designed the mama kit, a standard pack containing plastic sheeting for the pregnant woman to lie on during labor and delivery, surgical gloves; soap, cotton wool, a blade plus other important sundry items. Every woman coming to deliver at a health facility should be provided the mama kit to ensure a clean, safe and affordable delivery.

to deliver there since we are not giving these mama kits ...”(Health Provider, HP.NU.F.1)

Like it did for the rest of the country, MOH disseminated a number of new health policy guidelines that had a bearing on maternal health care services in the region. However, the adoption of these new policies was impossible due to the same ministry failing to appropriately plan for necessary medicines, supplies and technical support required for implementation,

“Sometimes they really bring the policy out for us here on the ground and it will be very difficult to implement, like the issue of the Option B+ policy; all these babies delivered by HIV+ mothers should be given nevirapine syrup. They are not supplying us the syrup and so what are we supposed to give! Now what are we going to tell these mothers if their babies turn HIV positive? It has now taken like three months without the nevirapine syrup!” (Health Provider, HP.NU.F.1)

Respondents from most of the districts in Northern Uganda were consistent in identifying human resource challenges as a critical issue that was majorly the responsibility of central government. However, a discussant from Lamwo, one of the more remote newly created districts, reported that they had managed to attract, recruit and deploy midwives into most of the lower level health facilities including their Health Centre level IIs'. Where health workers at lower level health facilities were not retained, the Lamwo respondent narrowed down the main reason to a lack of accommodation. The Peace Recovery and Development Plan (PRDP) had been engaged by the district administrative authorities to address these gaps.

Discussions with the key stakeholders at national and sub-national level portrayed Lamwo district's local government as one that had shown effective leadership by being able to garner PRDP and independent donor support to address its human resource needs. This had produced significant improvements in maternal health care service delivery in the district.

The respondent from Lamwo District observed that attaining district status did not give the district any comparative financial advantage as compared to other districts in Northern Uganda, however it had enhanced the decision space for the area's local leaders and their communities,

The difference wouldn't be obvious to me if we [Lamwo district] were still under Kitgum district; it's just like the same resources cut into two! ... However in terms of planning, in Lamwo we now tend to do things differently from Kitgum district. Our priorities tend to be a little different given the reviews that we always take; we always see in terms of the basic indicators so maybe that is the only difference but in terms of resources they are more or less the same ... the resource allocation is limited (Administrator, DAA.NU.M.2).

As described above, Lamwo's district leaders had a greater opportunity to plan for their district. This contrasted greatly with the governance arrangements that existed at the time when the district was a county within Kitgum district. The district leaders proudly described their elaborate health sector planning and implementation processes; the elaborate consideration for the populations maternal health needs was paying off,

"at the District Health team, we would sit and review all the visible indicators including the indicators on maternal health , deliveries in the health facilities, ANC attendance, some of these basic indicators. We review and see how we are performing, analyse it as well as the contributing factors. By doing that we managed to plan and ensure that: we addressed the need for a cadre of health worker; we addressed the need for midwives so that at least we expanded our services up to the level of Health centre II; we addressed the need for these equipments to ensure these health centres provide maternal health services; we addressed the need for types of transport means to ensure that we provide appropriate referrals for these mothers; and we also planned for providing housing so we that when we recruited staff at least they are accommodated."
(Administrator, DAA.NU.M.2).

I conducted a review of Lamwo District's ranking in the district league tables generated by the Ministry of Health from the regularly collected Health Management Information System reports. The league tables for the first quarter of 2011 ranked Lamwo district as the 24th out of 112 districts in an aggregate ranking for achievements made across a wide range of health related parameters²⁴. A specific league table parameter for health facility deliveries ranked Lamwo District sixth in the country. In that league table, Lamwo district had more deliveries in its health facilities than any of the older districts of Northern Uganda.

In the annual MoH district league table for a later period, 2013, Lamwo district's aggregate ranking had precipitously declined to 86, however it was notable that the district's ranking in health facility deliveries had slightly increased from the 2011 figure of 6.0 to 6.8 which was above the average national ranking of 5.8. I considered this consistency in ranking for Lamwo significant and suggestive of skilled assisted deliveries taking place in proportionally more health facilities in Lamwo District as compared to other districts in the post-conflict and non-conflict settings. My findings were further corroborated by discussions with the technical staff at MOH who stated that Lamwo District's outstanding performance was well recognised. The district also had two other peculiarities: the political head of Lamwo District was a former health worker himself; and, the Member of Parliament for the district was the only Cabinet Minister from Northern Uganda at the time. These two factors may have been pivotal in prioritising the planning and implementation of maternal health care²⁵.

A view held by the women's focus group in East Central Uganda was that there were some improvements that had taken place with respect to access and utilisation of maternal services over the post conflict years (that coincided with the post-election

²⁴ The league tables are generated to reflect the performance of the district health system in addressing common disease conditions in specific thematic areas like Malaria, Antenatal, Maternity, HIV/AIDS counseling and testing Maternal and perinatal conditions. It also focuses on the district statuses for Essential drugs, vaccines and contraceptives (Komakech, 2005).

²⁵ This conclusion is entertained with caution; the district chairman of another of the Northern Uganda's newer districts was a former health worker, however that district consistently performed dismally according to MOH reports.

years) 2006 till 2011²⁶. However, among the community's opinion leaders, concerns were raised about a perceived decline in the quality of care being provided.

Incidents were cited that showed that doctors were less available in the health facilities and the recruited nurses were lacking in the required skills. East Central Uganda district local government technical staff that I interviewed insisted that despite limited donor support to the region public health care facilities were better staffed and health workers were more available. This contrasted with the state of affairs at the remote lower level health sub-district health facilities within East Central Uganda. Some respondents reported that clinicians and other medical personnel were frequently absent from station. The contrast was reflective of inadequacies in technical support supervision that were also linked to a lack of PHC funding, gaps in planning and implementation of the health sub-district policy. The district health teams themselves expressed the latter factor,

“The money we get here is just too small for support supervision it doesn't help us much. May be now our request is that the government to add more money in health to enable us do that and so that these more experienced midwives within the DHT can help to train the other ones.”(Administrator, DAA.ECU.M.3)

Another district health team member in East Central Uganda reported a significant improvement in the provision of medicines and other supplies by government through the National Medical Stores. The recentralisation of the procurement and distribution²⁷ of these medicines and supplies that was decreed in 2009 was appreciated to have been key in making essential drugs more available at health facilities across East Central Uganda.

Nevertheless, that positive outlook contrasted with the opinions of a number of community respondents; they gave accounts of widespread pilferage of drugs in the health facilities, and incidents of much needed medicines not being dispensed but

²⁶ The period 2006 to 2011 was the intervening period between two presidential elections and coincided with the immediate post conflict period in Northern Uganda.

²⁷ In November 2009, the National Medical Stores, a government parastatal organization that procures, stores and distributes drugs and medical supplies for the public health sector, was given the sole rights to handle the supply chain mechanism for all the public health facilities in the country. Prior to this each district was planning, budgeting and procuring its own medical drugs and supplies

instead expiring in the health facility stores. A respondent working with one coalition that brought together NGOs in the region that were engaged in human rights advocacy reported an initiative that they had spearheaded that was intended at highlighting the dire state of affairs in major health facilities across East Central Uganda,

“On getting there we found that the entire 250-bed hospital did not have enough BP machines; they only had three! But remember the hospital has different departments and different wards. Three cannot even serve half of the outpatient department. Some medical personnel had to have their own private BP machines. Imagine how important taking some one’s BP, weight, and temperature are to getting to a patients diagnosis! Look at such a thing!” (Civil Society Representative, CSO.ECU.M.1)

The lack of appropriate infrastructure in many of the health units was a key bottleneck for maternal health care service provision in East Central Uganda. This was another issue raised by in the interviews with district health team and CSO representatives. The district health team representatives for the region believed that both the government and its donors had failed to recognize and prioritize the infrastructural needs of this non-conflict region. Much of the health infrastructure was built in the 1960s during the early post-independence period. The buildings were dilapidated and could not accommodate the needs of the greatly increased population. An important case in point was the roof of a maternity ward in Kiyunga Health Centre IV the main referral health facility in the new district of Luuka District had been destroyed in a fire about four years prior. The remaining structure had lain fallow for this period with midwives providing antenatal and delivery services in rooms sequestered from their own dwelling quarters,

Unfortunately here the women are inconvenienced ever since the maternity ward was burnt; the alternative room we use for childbirth is very small and cannot accommodate those in labour pains and those giving birth. So some mothers in labour are told to keep waiting from outside or somewhere else such that they come in when they are just about. Unfortunately the timing is

*sometimes wrong because those mothers end up giving birth from outside, and that means under the trees or on the veranda ... Some women fear to come to the hospital and yet this is our main hospital for Luuka district and we can't stand the shame of giving birth in the open"***(Woman Leader, ECU.7)**

Some respondents from both Northern and East Central Uganda decried the less than adequate provision of family planning and adolescent health services. In both regions there were frequent stock outs of family planning products reported. This was despite a number of NGOs working either independently or through the health facilities to complement the efforts of government. A number of conclusions emanating from the women leader's focus group discussions in both regions notably alluded to the lack of family planning counselling support and an absence of follow-up services for women suffering adverse effects to the family planning options. As a consequence, in East Central Uganda, many women were exposed to unwanted pregnancies because their fears in using available family planning methods were not addressed.

In Northern Uganda, the impact of the family planning support was similarly evident in the discussions held with some of the women leaders. One focus group member graphically described the challenges associated with family planning use,

*But there is a woman who got injected to stop pregnancy however she is always bleeding like someone that has just given birth. Then there is another one that had the tablet inserted in her arm, she became thin like someone suffering from AIDS and then when you come to the health facility here to remove it, you are asked to pay 10,000 [approximately £2.00²⁸]"***(Woman leader, NU.1).**

Similarly women leaders in East Central Uganda in reflecting on similar challenges described the negative impact that family planning use was having on their day-to-day activities and consequently their livelihoods,

²⁸ This is a significant out of pocket payment for a community whose households largely depend on less than US \$1 (£70p) per day.

“Another challenge is that there are some side effects of family planning especially heavy bleeding; you can find a woman bleeding for two months and above as an effect of family planning. Some cannot do heavy work. They say that they cannot manage to dig when they are bleeding. Many get headache and joint pains. And whoever bleeds is later found with cancer. So people think that family planning causes cancer and they fear to use it.”(Woman leader, ECU.2)

Discussions with respondents from the district health management team in Northern Uganda, considered the lack of health workers as the major cause for the poor reproductive health services in the region. On the other hand, according to CSO representatives in East Central Uganda where health worker recruitment rates were high, their availability and commitment to duty had affected the quality of service provision.

The management of reproductive and maternal health needs of the youth was another area of concern that district health teams were yet to address. In Northern Uganda, the combination of health worker attitudes and the upholding of some traditional norms appeared to be deterring adolescent girls from accessing maternal health care services,

“Even of recent I heard feedback from the youth at the health centre. They say that when you are in the line, when more elderly women come, they tell them [the adolescent girls] to sit aside and wait so that the big people are served first, even when you are sick and also need support! Also the way they handle your issues, they don’t handle you with respect as for an adult. Even if you are in the open there, somebody will just start asking you very embarrassing questions, you even fear to share in detail!”(Civil Society Representative, CSO.NU.F.2)

This account underscored the unmet maternal health care needs of Northern Uganda’s youth. This was a critical gap in maternal health care considering that even

after the end of war, Northern Uganda's adolescents were still exposed to early sexual activity, pregnancy and all their consequences,

"Our challenge now is young mothers, girls who leave their babies to go to look for men; these children start giving birth even before their bodies are ready. The babies also suffer; they are left without proper care. Here children are giving birth to children, and they are many!" (Woman leader, NU.3)

Two respondents from East Central Uganda representing different CSOs gave discrepant views about the status of adolescent reproductive health. One CSO reported her organisation being a member of the Sexual and Reproductive Health alliance that comprised of CSOs including, Reproductive Health Uganda, Straight Talk Foundation, SchoolNet Uganda and Restless Development. They had been targeting teenage girls in the schools, clinics, health facilities and communities of East Central Uganda with reproductive health services. Her impression was that the alliance was contributing to a tangible change in the number of teenage pregnancies in that setting,

"Maybe what I will say is that there is some change compared to before (...) We review our monthly reports. We sit and look at the data; before we used to get so many young people who used to come in pregnant, now you see the number going down. It's reducing, and the other thing is that these young people who come in to pick emergency contraceptives pills. You find that maybe things are changing."(Civil Society Representative, CSO.ECU.F.4).

However, another CSO that had been providing rehabilitative care for East Central Ugandan women that had suffered obstetric fistulae had a different opinion with respect to the coverage of reproductive health services for the younger age group,

"not that I have the exact data, but when you look at it critically, an obstetric fistula is due to a failure of a women getting the services she needs and the fact that not all our fistula patients are 40 and above - we have 17yrs olds that we find with fistula, and you know that the girl got that fistula in the recent time,

means that the system is not supporting them (...) our health centres are not there yet.” (Civil Society Representative, CSO.ECU.F.3)

Informal institutional related responses

Some respondents from the different actor categories, representing both regions, talked about the role of local politics in maternal health service delivery. In East Central Uganda a respondent drew attention to incidents where district development funds originally earmarked for health care projects were diverted to the development of infrastructure that could then be used for rent-seeking. An example was cited of funds that were designated for equipping a health centre maternity wing being redirected to building classroom blocks in the one politician’s constituency. An account was also given of district politicians pushing to have health centre II’s built in all the parishes of their constituencies at the expense of functionalising the already existing health centre IVs.

“Then you find on-going struggles between the politicians and the technical people. You tell him that there will be no human resources and supplies for yet another health centre II... there is therefore not only confusion between government and donors but also between us here in the local government.”

(Administrator, DAA.ECU.M.2)

It was scenarios such as these that made the district technocrats in East Central Uganda that I engaged with more appreciative of central government’s decision to recentralise some local government functions.

In the North, the politicians were considered more supportive of programmes that improved maternal health care. My opinion was that the PRDP process was already funding the erection of health centre II, making such structure less valuable as a rent-seeking tool and this relieving the district technical team of undue pressure. CSO respondents stated that the effectiveness of the local politicians was always in check; they had to address glaring challenges that the returning communities faced and understood. When they promoted interventions that addressed these needs that is when they gained politically,

With these politicians, it has not been so hard. It is all about explaining what you want to do and what you want to achieve at the end of the day. Sometimes I think people miss out. That is why they get conflict with the politicians. But as long as you know what you want to achieve and you explain to them, what their role is going to be and how it is going to benefit them or their communities, they will cooperate with you. So we didn't have big challenges with these politicians". (Civil Society Representative, CSO.NU.F.1)

The role of traditional birth attendants in the two regions was also deliberated upon. In Northern Uganda, where the vulnerability was widespread, the return process was described as inadequately managed, families returning home were faced with a lack of health care services but furthermore, were not provided information about where to access maternal health care services. This strongly motivated the returnees to turn to the traditional birth attendants that were easily accessible,

"At the initial stage it was a complex situation that engulfed the people who were returning to their home sites. As you know the return process was in phases. There was returning to the supply camps and then to their real places of origin, or their real land. So in all those stages there were complexities in health service delivery... the return sites still had a lot of challenges. One, the infrastructure was broken down; many of the health centres were broken down. Two, there was ignorance of the community about how to access the different health services especially maternal health. Moreover, in the camps it was mostly the traditional birth attendants who were responsive to the needs of the pregnant mothers". (Civil Society Representative, CSO.NU.F.1)

Similarly, one key informant from East Central Uganda suggested that the region had a sizable population of poor, more vulnerable and marginalized communities. They were not able to access maternal health care services easily. Traditional birth attendants were the only option in these settings. According to one discussant in the women's group, in these poor communities, men dictated the birth choices of their spouses. Birth in these settings was considered a normal process that did not merit

any ado. This attitude was particularly associated with the more remote lakeshore and island fishing communities where limited health promotion efforts by government and civil society had been undertaken,

“I cannot say maternal deaths have reduced because every other time you walk into the community, there is just that feeling that nothing is being done and of course when it comes to rights, the women do not know exactly what their right is. For some of them giving birth in a health facility is like a dream come true... like a special favour. Those indicators really? I don't think there is much that is really going on!”(Civil Society Representative, CSO.ECU.F.2)

Discourses about birth preferences in Northern Uganda led to the poor attitude of health workers in the region being discussed. Women leaders in the focus group discussions gave accounts of grossly unethical, inhuman acts by the health workers in Northern Uganda,

“There are cases where during delivery, as the baby's head pops out, they push it back saying it's not yet time for delivery. It reached a point when one woman hit the midwife's hand as she was trying to push the baby's head back and the baby popped out. The midwife in anger then pulled hard when doing the final stitches.” (Woman leader, NU.7)

Such accounts though difficult to credit were important because they were reflective of a deep unaddressed rift in the relationship between health workers and the communities that they served. The health workers interviewed suggested that this may have, in part, been orchestrated by: the heavy workload; the lack of supplies and equipment; a lack of technical support; and the lack of training opportunities that motivated health workers to provide better care. They were particularly bitter that their district local governments were barring them from returning to school to pursue higher education.

“You see, there was a time I was with my former in-charge only two of us; that was an ART [antiretroviral therapy] clinic day, I had to finish up the antenatal clinic and then go to run OPD. For him he sat in ART clinic; Patients got their

treatment though with a lot of tiredness (...) also this issue of salary not being there for like two months, it demotivates (...) if I want to go to school why should you stop me? When I have mental capability !? Because if I did not have that capability, I would not even request, I would just continue with my work! So when I want to go to school just give me the chance and I go to school. Then the infrastructure here is so poor; if you see in our setup like this one the doors are broken. The district local government should make our working environment more conducive for our work; just like is the case NGO health facilities. They are well equipped and have adequate supplies. If they can do this we will feel we are doing the work that we were trained to do from school..."(Health Provider, HP.NU.F.1).

A technical leader from Northern Uganda expressed concern about NGO-led capacity building activities being poorly coordinated by local governments; this was contributing to indiscipline among the limited human resource in many of the districts,

So I am sorry to mention it: [assume that] I am a midwife, I am called by AVSI(Association of Volunteers in International Service)for training, and then also NUHITES (Northern Uganda Health Integration to Enhance Services) wants to train me. So it will no longer be training of knowledge but for making of money. I will go and register there then I have some few hours with them then I rush the other side ... Even if it's not like that sometimes you find that our health workers because training has some money attached to it, of course this per diem issue and so forth, they will not care to leave somebody at the health facility. There has been a situation where you find the Health facility is closed and then when you call the in-charge, they say, 'we are for training' not knowing that their core responsibility is to give service delivery to the community!"(Administrator, DAA.NU.F.1).

East Central Uganda provided a stark contrast to the above; only two respondents in opinion leader's focus group discussion talked about poor health worker attitudes. In another focus group discussion health workers at a health centre were

appreciated for being considerate. A story was told of health workers being faced with an obstetric emergency that they could not manage. The mother in labour needed urgent referral but could not meet the cost of hiring a vehicle. The health workers put together their own meagre finances and hired a vehicle to transport the district hospital.

I never gained any negative reports about health worker performance in East Central Uganda. One got the impression that either i) the health workers in East Central Uganda were better motivated and therefore showing a better attitude to their patients; or ii) the communities in this region were either not willing to talk ill of the health workers but at the same time assumed that they had to fend for themselves, did not expect much from government and were unaware of their rights to better health care.

6.2.3 The role of women at sub national level in maternal health care

A number of respondents suggested that women in political leadership at sub national level had played a limited role in influencing the utilisation of maternal health care. This finding was strikingly similar for both Northern and East Central Uganda. With regard to the role played by women in their communities, the informal institutions in post-conflict Northern Uganda appeared more permissive of women working collectively to address bottlenecks in maternal health care.

Formal institutional related responses

The government and the donor community alike were recognised for having provided women in Northern Uganda with a platform to address their needs. From this context, a majority of respondents felt that advocacy by women groups in the region, and their engagements with the district local governments was responsible for a change in attitude amongst the district political and technical heads as far as maternal health care was concerned. Despite the constraints in funding maternal health service delivery, the will to effect improvement among the district political and technical staff was commendable,

At district level is where we see the change of attitude towards maternal health but not at national level. Because at district level after the dissemination is where you find the change. We disseminated at different levels. We [the civil society] did it at community level, sub county level, then the district level where we call the health partners, District Health Officers, the Chief Administrative Officers and the Local Council V all present there because these are the policy makers at the district level. (Civil Society Representative, CSO.NU.F.1)

In contrast, respondents from civil society and from a focus group discussion in Eastern Uganda felt that advocacy work that promoted maternal health care became more visible and made a greater impact during the election period,

"If I can say - you see most of our behaviours are political, so women empowerment groups are there but they are political and they are formed during [the] campaign season... For sure, now they are idle but their season is about to start!" (VHT Member. ECU.1)

In both regions, women were increasingly being elected by their communities into political office, and as representatives in to village health teams, but less often to health unit management committees. Again, in both regions, civil society had engaged women in various formal roles. For example, respondents highlighted the role women played as the preferred contacts for household livelihood or microfinance projects. Women were volunteering to serve their communities as budget monitors. Here they acted as community level ombudswomen, their work had proved important in holding service providers to account. The respondents stated that it was women's voices in Northern Uganda that led to PRDP funds being used for maternal health related infrastructural development,

"So in that process, I do not only think, but I know they [the community voice] had influence on service delivery especially on saying that we need a maternal health centre here, we need a maternal ward, something around in this health centre, responses to that really took place a lot." (Civil Society Representative, CSO.NU.F.1)

Informal institutional related responses

The role of women in monitoring services due to them in East Central Uganda was marred by the persistence of some tradition norms and a lack of education, according to some of the respondents. One female respondent stated thus,

“I think it gets back into probably the gender roles and may be the education levels of women because not many women have gotten into those levels and of course getting to platform of voicing out your needs and all that. We have seen it even at our community meetings. If you have women and men in the same meeting, you may not get what you really want to get across. For some reason women fall behind and the men take over the whole discussion ...” (Civil Society Representative, CSO.ECU.F.2)

Similarly, a key informant that held a senior technical position in one of the districts of East Central Uganda considered female district local councillors across the region as cowed and contributing little to the cause of maternal health care. The informant suggested that reasons for this attitude was that the female politicians were less educated than their male counterparts and were bound by tradition to act acquiescent to their male counterparts,

“The major problem as I have told you is the education level. Someone will come and stay in the council for five years but she has never raised her hand to say anything because one if they are illiterate then they usually fear to talk because they are not confident of what they are going to say so they just come in and sit and get their allowance and go.” (Administrator, DAA.ECU.M.1)

Respondents of a focus group discussion with women leaders suggested that party politics was another issue causing the poor performance of some of their women leaders,

“We would expect that when we are discussing about health matters we the leaders should put aside our political parties and consider all ideas regardless of political party. We should all work together as women leaders, but that is not the case.” (Woman Leader, ECU.4)

In Northern Uganda, it was a commonly held view among the women focus group discussants that female politicians in that constituency had not lived up to the community's expectations. They had not played any role in addressing the community's maternal health needs. They were considered unapproachable and were holding their personal interests above those of the community. It was noteworthy that members of the women's focus group discussants credited the male policymakers for being more responsive,

"Those people are now different. At least the male MP has worked hard to ensure that there are some changes in the hospital, Just meeting the woman MP is very hard; Even at the District, you don't know where to begin from and where to end but at least we are seeing some change from our male MP"

(Woman Leader, NU.1)

In East Central Uganda, there was no instance in the discussions that reflected women taking centre stage in voicing the community concerns. However the focus groups for women leaders in that region considered it significant that women were gaining the courage to go against tradition and were taking charge of their own reproductive health needs by either making unilateral decisions to access family planning services or by prompting the domestic discussion,

"For a woman to get confidence to tell the husband about spacing is a big issue. But you find that a man has three wives and other children that are not going to school and most of the responsibility is left to the wife. So if you realize that all is on your shoulders, you are forced to decide that enough is enough and you are caused to sit at a round table with your husband to inform him that you need to space the children. Now because you are looking after all the children's needs and the man realises that if you conceive you won't be able to climb up into the lorry to go to the auction or market to do any business, he will accept that you do the business to cater for those children before having another. That is where we get the confidence and the men buy into the idea...women have decided to take charge! (Women Leader.ECU.2.)"

Opinion leaders in Northern and East Central Uganda hinted about other traditional practices that promoted poor utilisation of maternal health care services that the government had as yet failed to address. In Northern Uganda, the notoriously exorbitant bride price practice was cited as an important deterrent to maternal health care access. Once a girl was married off following the payment of a hefty bride price she was expected to measure up to her material value; bearing the rigors of childbirth with minimal financial stress to the spouse's family. This often implied being assisted at birth by a traditional birth attendant. Dowry paying is deeply ingrained in culture; some opinion leaders in the Northern Ugandan focus group discussion talked of having married off their own daughters under the same arrangements despite their qualms about it. They felt individually bound to act within the bounds of tradition, but suggested that collective action could eventually cause a change in the practice.

In East Central Uganda, there were frequent expressions of traditional norms that were strongly promoted by culture and were negatively influencing women's utilisation of maternal health care services,

"Here they have a saying of "omwami kyakoba"²⁹". Even in this era where there are so many avenues of accessing information, that still holds the highest priority in most communities, for example we do family planning outreaches but a woman's accessing the service is determined by their men ... many times when you ask she will say "I was coming but he said don't come" so I didn't come that time. It's the same with other maternal issues like pregnancy and deciding whether you want to do an institutional delivery or traditional birth ... So the cultural aspect matters a lot." (Civil Society Representative, CSO.ECU.F.3)

In Northern Uganda, an account was given of an incident that appeared to showcase the leadership role that older women held in their communities. During a mass protest in the district of Amuru, elderly women were widely reported by the

²⁹ Omwami Kyakoba loosely translates as "what the man says...", referring to the traditional norm that holds the man's decision as supreme in any domestic issue.

Ugandan press to have stripped naked in a desperate bid to protect their ancestral land from government's law enforcers. The enforcers who were flanked by the Minister of Internal Security and other security officials were intent on redrawing a border between two districts. The community feared that this would eventually lead to their eviction from the land. The action of these women was key to government abandoning the exercise. Again, the incident occurred outside my study timeframe and was not directly related to maternal health care but stood out as an illustration of how women in Northern Uganda were increasingly playing a leading role in protecting their communities' rights.

The participation of men came into focus as gender roles and governance at household level were discussed. The focus group discussion with Village Health Team members in East Central Uganda underscored the influence of poverty and the fear of being tested for HIV as reasons for poor male involvement in maternal health care utilisation. While some village health team focus group participants in Northern Uganda offered similar accounts for poor male involvement, alcohol abuse that was reported as rife in the region was distracting many men from domestic responsibilities. In many of the communities in the North, community leaders were enforcing a local by-law that made it a requirement for men to support their wives through the childbearing process.

6.2.4 Community participation in health service delivery

The health unit management committees and village health teams were entities commonly discussed by respondents when reference was made to the communities engaging formally in the provision of health care. The respondents from both regions shared remarkably similar perceptions with regard to governance and this thematic area: the HUMCs and VHTs as formal structures had the potential of improving maternal health care utilisation; were functional where there was donor funding; they had suffered neglect by government despite policies governing their existence; and, local politicians were exploiting these structures for political patronage.

Formal institutional related responses

The Health Unit Management Committees (HUMCs) and Village Health Teams (VHTs) appeared more functional in Northern Uganda given the preponderance of donor funded programmes that had funded their activities. The training and equipping that the VHT gained tended to be activity-based; the support that the VHT provided their community was selective. Examples of the selectiveness of the VHT support in Northern Uganda was the training provided for a PMTCT campaign; only HIV positive members of the VHT were chosen for that training. Other intervention specific trainings were those supporting the distribution and promotion of the use of Long Lasting Insecticidal Nets.

A number of organisations had, of late, supported the VHTs of East Central Uganda in a similar manner. The effectiveness of the VHT in supporting maternal health care was challenged by the poverty in the communities. When they made referrals for pregnant women that needed urgent medical attention it was often not effected,

“So this is what I was saying, at times there are issues of money, and when you check the pregnant women in the morning from the time you referred them, you discover that they have not been attended to. When you come in the evening you still find them there... not referred and still in the same state.”(VHT Member, ECU.M4)

MOH had not undertaken any follow up trainings, facilitation or technical support supervision ever since they were inaugurated. The VHT members in both regions felt that this lack of support had limited their usefulness,

“That’s why we are saying we are half-baked. There are family planning problems and also some other neglected and complicated diseases in some families like epilepsy, deafness and so on, we needed to approach these people and tell them where they can get help for such cases. If the training for medical workers is five years, let ours be at least three months such that can we understand some of these things.”(VHT Member, ECU.M.1)

In reference to health unit management committees, a CSO respondent from Northern Uganda suggested that during the immediate post conflict period, the donors had ensured that when health facilities were being revamped the health unit management committees were also reactivated. The opinion leaders in the Northern Ugandan focus groups reported that a number of committees in their jurisdiction were able to meet, plan and monitor the activities of health facilities at health sub district level. Similarly in East Central Uganda a number of HUMCs were revamped by donor agencies. Akin to the effects of the MOH's lack of support for the VHTs, often the HUMC activities waned whenever donor funded projects ended. Another challenge with depending on donor project funding was that the training and technical support had targeted a limited number of health facilities. According to two respondents, the poor technical support to the HUMCs was causing them to be sources of discord in the health facility,

"If you see, these committees are being instituted but majority of them are not even being trained. They do not know their roles, what to do, they do not know how to bridge the gap between the health sector and then the communities. They are [supposed to be] like arbitrators in conflict. Instead when you critically look at them, they are the ones that generate conflict, just because they do not know their roles and responsibilities. Some of them are not ethically right in the way they do their things."(CSO.NU.F.1)

It was also stated by respondents from both Northern and East Central Uganda that the lack of formal induction for the HUMCs made them dependant on health care workers for guidance, making them lose their independence and often being drawn into the corrupt practices of errant health workers.

Informal institutional related responses

In Eastern Uganda, according to discussions with the opinion leader focus group, the communities had grown to mistrust the health unit management committees. Corruption was considered the main reason for individuals seeking that office. The account of a CSO respondent shed light on these concerns when he described what

ensued when they facilitated a forum that brought the communities and the health unit management committees together,

The first time it was like members of the community tasked their health unit management committee to meet them on a day that they agreed and furnish them with information pertaining to the business at the health facility ... the committee found itself in a trap! That's when we realised that the other members of the committee had been rendered useless and idle. It was only the chairperson of the committee who was teaming up with the in-charge to come to the bank to withdraw money and spend it in a way they wished.

(CSO.ECU.M.1).

It appears that the HUMC had also become a target for cronyism; senior politicians, in both regions, were rewarding their political supporters with positions on the HUMC. It was notable that this was one area where political patronage was cited as existing within Northern Uganda's health system. A majority of focus group discussants in Northern Uganda asserted that HUMC members, especially managing the larger health facilities were often political appointees and people that did not know the local challenges; they were not part of the community, and were mostly men. They did not expect such persons to represent their interests,

"it would be good for those leaders at the top to provide feedback when issues are raised, for example how the hospital management committee is selected; many committee members don't know us and the community members doesn't know them. These committees should meet with the community and teach them how we can give our feedback so that everyone is aware of their roles and the community knows what action to take when being faced with problems in the health facility. They should also be available".(Opinion Leader, NU.M.2)

In East Central Uganda, respondents amongst the CSO community blamed the communities for not being bothered about engaging the HUMCs. This had allowed the health unit management committees to slink into dormancy,

"Actually the community nominated and elected these people but it also came out that they had outlived their tenure. But because, of course, the community

*was in 'slumber-land', they were not bothered about what was going on. It was none of their business; no one was making it a point to get others to come and attend to this issue and see that the business is run the way it is supposed to."***(CSO.ECU.M.1)**

For the two regions, I sought to determine peoples' incentives for volunteering on the village health teams in the face of the numerous challenges highlighted. While explicit reasons were not forthcoming, the discussions seemed to point to intrinsic motivation,

*"like in my catchment area it was one year when we lost about four mothers and this greatly hurt me and I got concerned. So when they started electing VHTs, I said I must go in so that I try to help. It is such situations that moved me to join and become a VHT."***(VHT Member, ECU.M.4)**

Additionally, some individuals may have perceived the VHT as a convenient springboard for getting into political office; during the VHT focus group discussion in Eastern Uganda the respondents genially heckled one of their colleagues suggesting that he was harbouring future political ambitions.

Relatedly, the VHT in Northern Uganda made mention of the respect they commanded from the different echelons of their communities,

*"Even the local political leaders here, there are lots of changes, they are working hand in hand with health staff and VHTs. If the health assistants call a certain meeting they come in time and attend, with the VHT also. There is a lot of cooperation and they respect people. They know the role of the VHT that is why they respect the VHTs."***(VHT Member, NU.F.8).**

The formal participation of the communities of both regions in maternal health care had not made significant gains. Even in Northern Uganda where more resources had been availed for these activities, the support was not holistic and did not address sustainability. Other elements of the health system, for example adequate staffing of the health facilities, efficient ambulance services and appropriate PHC funding that would have enhanced their functionality were not in place.

6.2.5 Decentralisation

Respondents from each region provided a number of contrasting opinions about the decentralisation of governance and its effect on maternal health care. In Northern Uganda, decentralisation was considered vital for the rehabilitation process. In East Central Uganda, many of the technocrats in the district administration were appreciative of the recentralisation of some vital administrative functions.

Formal institutional related responses

In Northern Uganda, in-depth interviews with members of two district health teams revealed that while decentralisation may have contributed to Northern Uganda's isolation during the years of conflict, it had proved vital for the post conflict reconstruction effort. For example, decentralisation had made it possible for the district local governments to gain from a more direct relationship with a number of donor and implementing agencies,

“WHO and UNICEF were some of the key and consistent partners. These partners insisted on strengthening of the district leadership. And the pattern was, where the district leadership took charge of coordination, the utilization of resources, the creation of outputs was well done as compared to some cases where the district health team involvement in coordination was weak and where NGOs assumed the chair of the coordination committees. By supporting district structures they left the district with skills that have been built upon to improve health care to date.”(Administrator, DAA.NU.M.1)

By inference, districts that had a working relationship with donor agencies gained skills in effective leadership that turned into greater opportunity for maternal health care. The newly created district of Lamwo (that I previously discussed) stands out as a good example, so does the older district of Gulu.

Lamwo District had only one Health Centre level IV and eight Health Centre's level III. However, the district local government was able to harness support from the PRDP and other donor agencies to upgrade a number of Health Centre IIs so they could provide essential obstetric care. Lamwo's Health Centre II upgrading strategy

happened at a time when the government had placed a ban on the development of health centre IIs across the country. Decentralisation had made it possible for Lamwo district to have its own special policy provisions, working with the donor community under the PRDP to address its own peculiar needs.

In Northern Uganda, there was evidence of some districts, for example, Gulu and Lamwo whose health systems had benefited from the decentralisation process. It had made possible the participation of a wide range of local stakeholders, including civil society and the communities that they represented, in planning, prioritisation and monitoring of district activities. More appropriate considerations for maternal health being reflected in the decentralised annual budget was an important output of this collaboration,

“what we have done is not us directly influencing budget funding but it is empowering the communities to participate in the planning process so that what they want for themselves comes up. Because whatever the community plans is what comes up in the budget conference. If they have not initiated anything around maternal health, then there is nothing that will come around maternal health.” (Civil Society Representative, CSO.NU.F.1)

In East Central Uganda the role of the various stakeholders in the district planning process was similarly highlighted. In this case, the opinion of respondents was mixed, some civil servants from the district local governments were not happy with the impact of decentralisation on health care so far. They were appreciative that the recruitment and remuneration of senior civil servants and health workers that was previously managed by the district local government was to be recentralised to central government.

In East Central Uganda, one got a vivid impression of discord among the numerous stakeholders, each jostling to have their conflicting interests prioritised in the district planning processes. With limited donor funding for the region, the newly created districts were facing challenges in addressing their health care needs. An

appeal made by one district administrator during one of the interviews captured the sense of desperation,

“Just my humble request: since Luuka is a new district if there are some NGOs that they can send to Luuka please! Luuka is a very needy district! We actually need those NGOs, we just request the government to assist us ... send us more NGOs.”(Administrator, DAA.ECU.M.3)

At the same time, respondents from the old districts in East Central Uganda also decried the challenges that the creation of new districts was causing to their own capacity to provide health care services. When a new district was born, the mother district’s resources were simply apportioned between the two with the new districts in many instances taking the lion’s share,

“I would prefer that when you sub-divide you leave me with the money that I been having, because it is already not enough! And then you have resources to create for the new baby. Eh! Now it is like when you deliver another child, you just cut the dress of this child into two! ...What they do when they sub-divide. They divide the resources that have been coming and they take much of it to the new baby, because the new baby should be attended to. That’s where we suffer. Already, what is coming has not been enough and people are not accessing health care and you are stifling them even more and more. (Administrator, DAA.ECU.M.2)

In the post-conflict region, the presence of donors had helped to cushion the additional burden decentralisation caused. Two respondents from district health teams and a CSO representative explained that whenever new districts were created the implementing agencies reconfigured their interventions so that they could accommodate the needs of the new districts as the Lamwo district example showed.

Informal institutional related responses

In both regions, the civil society respondents articulated the role of political patronage and rent seeking in the district decision-making processes. It was suggested that in Northern Uganda’s case and to a lesser extent in East Central

Uganda, the significant investments made by civil society and the work that they had done to enhance community participation had offset the negative effects of politics at the decentralised level.

In Eastern Uganda, where CSO efforts were still in their infancy, the attitude of the community was considered to have perpetuated the negative role of politics in health care planning and prioritisation,

“Like now that we are approaching the elections that’s when they realize that they need the community because they go there to ask for votes and you would expect the community to ask them to account for what they have done. Then what is surprising, basing maybe on of their level of education, the community will just say, ‘you go and “eat” because the other one has eaten enough’... they will not say, ‘you go and bring us services!’ ”(Administrator, DAA.ECU.M.1)

The impression of the communities was that the politicians were seeking political office primarily for personal gain. The voter’s needs were rarely addressed. For the communities in East Central Uganda’s it therefore made good sense to demand for immediate tangible benefits from the politicians. One respondent described this as a “*mere ya leero*”³⁰ mentality. However, the community’s behaviour of demanding for money every time the politicians consulted with them had led the politicians to rarely engage with the electorate in between the main campaign seasons. It was reported that this had influenced the quality of representation negatively; in between election seasons the politicians rarely consulted the electorate,

“So where there could have been opportunity for a consultative meetings, the biggest concern of the person aspiring [for a political position] is, ‘after we have had a discussion won’t that render me a disservice? The community are going to ask me for some sitting allowance, or may be to “sign somewhere”, or may be for a meal! And if I don’t give them that won’t that immediately spell political disaster?’ So to avoid all that, they say, “we know this community and the issues

³⁰ *mere ya leero* can be loosely translated as “food for today”

therein so there is no need for a consultative meeting" (Civil Society Representative, CSO.ECU.M.1)

Respondents particularly from East Central Uganda described the waning interest that the community and other stakeholders had in the consultative budgeting process. In some quarters it was felt that the budget process was all a façade; the way funds were allocated to the districts was inflexible. The funds were largely earmarked for predetermined activities that were often far removed from the population's specific needs,

"if we had our own resources locally we probably would be topping up but now you find funds most especially PHC which comes from the centre is limited and of course Government would have agreed with the local Government on how to spend it on the priorities so we tend to depend more on their priorities rather than ours because it's their money. Much as its participatory, we prepare the work plans and either they approve them or make adjustments." (Administrator, DAA.ECU.M.1)

The frustration expressed by the district health teams in both regions appeared to be exacerbated by continued lack of proper knowledge of how the central government apportioned its funds. This was mainly expressed in East Central Uganda where there was less donor funding,

They try also to explain to us but at some stage it becomes complicated. They first use equity then they use population. The formula is looking at population numbers. Actually it is not very fair. At first it looks at population then diseases, it is a general thing for everything, but we have different challenges. It should be looking at specific challenges in a place rather than numbers, the need really! But we accept..." (Administrator, DAA.ECU.M.2)

6.3 Summary

This chapter brought together perceptions, attitudes and opinions of various health system governance stakeholders at sub national level with regard to the relationship between governance and maternal health care utilisation in post-

conflict Northern Uganda and non-conflict East Central Uganda. The political economy analysis framework was applied in the identification of five themes that captured key formal and informal institutional dynamics at sub national level that were influencing the maternal health. Table 6.2 below summarises perceptions and attitudes of civil society, women and communities in Northern and East Central Uganda, that represent similar or contrasting formal and informal institutional dynamics which were contributing to the status of maternal health care and its utilisation. In addition, the “supply-side issues” and decentralisation themes, also captured in table 6.2 represent perceptions and attitudes related to formal and informal institutions influencing the actions of district local governance and health system stakeholders with regard to maternal health care in the contrasting settings of post conflict Northern and non-conflict East Central Uganda.

Table 6.2 Summary Table for Sub National Research Findings in the two contexts informed by PEA

Theme	Sub-themes	Northern Uganda	East Central Uganda
Civil Society	Formal	NGO activities predominantly advocacy & rights based. Maternal health indirectly addressed through cross-cutting themes, e.g. gender & HIV	NGO's activities predominantly service oriented, supporting clinical maternal health and family planning activities.
	Informal	Political drive for peace, reconciliation and stability provided favourable environment for demand side activities	Political environment encouraged avoidance of demand side activities which were anti-government
Supply Side Issues	Formal	Significant improvement in access and utilisation of facility based maternal health services after end of war	Access and utilisation better than in NU, but perception of change not remarkable
		Human resource for Policy advocating for affirmative action not adhered to. Limited health worker recruitment and retention.	More health workers recruited but policy not addressing dual employment.
	Informal	Adverse health worker attitudes were commonplace	Health worker attitudes better than in NU (and discussion evaded), however non-availability recognised
		District politicians & district technical staff supportive of development of EmOC infrastructure	District politicians prioritise building of structures that offer more political gain compared to EmOC infrastructure.
		Reduction in the use of traditional birth attendants during post conflict period	Traditional birth attendants use among vulnerable remote communities, particularly fisher-folk still widespread
Women	Formal	Formal women groups actively engaging government and enjoying a level of responsiveness	Formal women groups weak and not effectively responded to
	Informal	Low education status and cultural norms influencing the effectiveness of local women politicians	Similar to NU; low education status and cultural norms influencing effectiveness of local women politicians
Community participation	Formal	Limited government financial and technical support to HUMC and VHT. Functional due to donor support	VHT functional but gained less capacity building. Also dependant on donor support. HUMC's largely dormant.
		VHT elected members of the community, HUMC members often foreign to community, politically appointed.	VHT elected members of the community, HUMC members often foreign to the community, politically appointed.
	Informal	Reasons for seeking VHT position: i) concern about community state of health, ii) admiration & respect gained	Reasons for seeking VHT position: i) concern about health of the community, ii) potential political gain
Decentralisation	Formal	Decentralisation was vital for governance, development but may not have been supportive of maternal health.	Recentralisation of key governance processes favoured by district technical leadership considered to have promoted better prioritisation of maternal health
		Available donor support for governance and development of newly created districts.	Special donor support for newly created districts not available. Serious lack of funding for maternal health care
	Informal	Local politicians gained politically by addressing the real needs of the post conflict population. Donor funding limited rent-seeking opportunities	Vote buying common and negatively influenced health sector development. Politicians were constructing health centre II's as a rent-seeking ploy.

7 DISCUSSION

Introduction

The discussion is structured in line with a conceptual framework that identifies each critical node along the maternal health care governance continuum (see Figure 7.1). The nodes are grouped into three governance relational levels: Central government to health ministry, district local government and community levels (**C₁**, **C₂** and **C₃** respectively); Ministry of Health to district local government (**H**); and decentralised local government to community level (**D**). For each level, key themes that were developed in line with the PEA framework in chapters five and six are reviewed and discussed. The review consists of an **overview**, then a synopsis of the **context**, **institutions** and **incentives** that were functional at each of these levels of governance. The incentives section, discusses stakeholder attributes and actions that are associated with contextual, and institutional findings. The discussion section for each level is enriched by parallels drawn from empirical evidence in other post conflict settings elsewhere around the world. Because this section is an analysis of findings in previous sections, throughout the chapter, I include references to data presented in the findings chapters five and six.

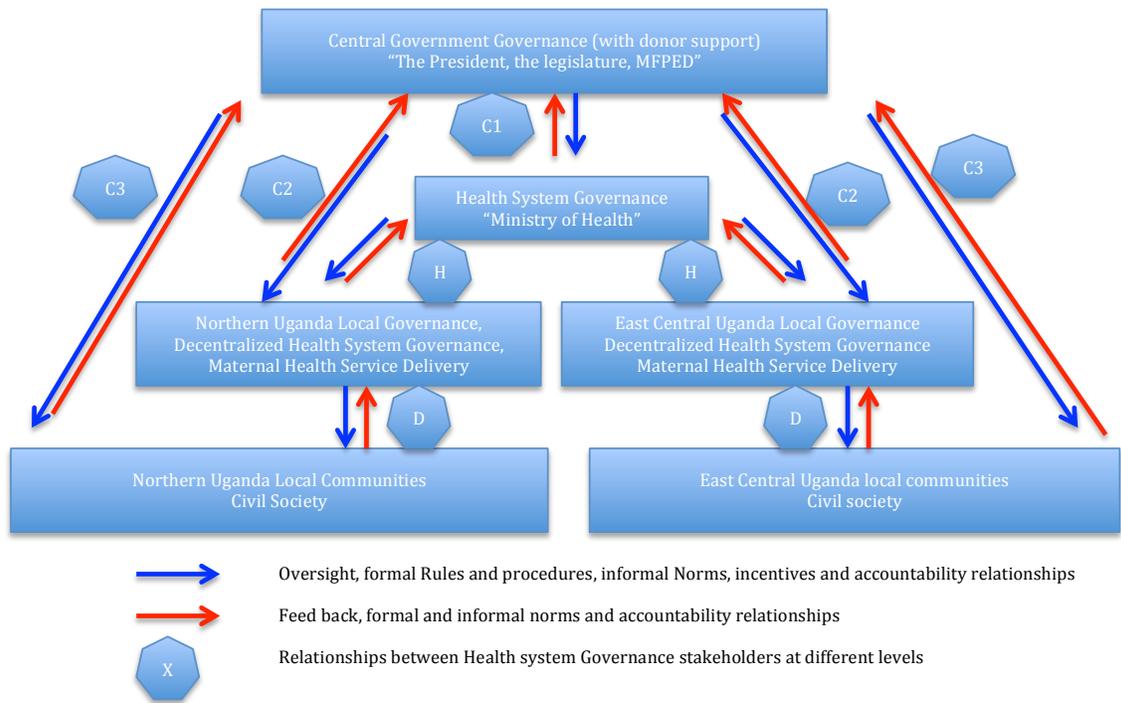


Figure 7.1. The study conceptual framework

After the review of findings and level specific summary discussions that are sections 7.1 to 7.5, an overall summary in section 7.6 consolidates the key messages of the study. This is followed by a reflection on the research methods in section 7.6 and an overview of the study’s limitations in section 7.7. The chapter ends with a conclusion in section 7.8, a statement on the study’s contribution to knowledge in section 7.9, and additional recommendations in 7.10.

7.1 Central government governance relationships

The policy elite considered here are: the executive; the development partners; the legislators; and ministry of finance technocrats. The policy elite has a governance relationship with stakeholders – technocrats – in the central Ministry of Health (C₁ in the Figure 7.1); stakeholders within the district local government (C₂); and, stakeholders at community level (C₃). The central ministry technocrats include policy makers, managers and implementers at that level. The district local governments include local councillors from district to community level, and health providers working at all levels of care. The community level stakeholders include communities and civil society organisations working within the respective districts.

7.1.1 Overview

Central government to health ministry relationship

During the immediate post conflict period, the President of Uganda and the country's donor partners influenced the funding decisions made by MFPED to the health sector. There was a poor understanding amongst other political elite about the criteria used by MFPED to allocate the government's limited resources (*Sec. 5.3.1*). For the health sector, a resource allocation formula was used but the formula was often abandoned for a more patronage-based approach to resource distribution. Priority went to the defence, road and energy sectors. The MFPED's funding priorities conflicted with those promoted by the legislators (*Sec. 5.3.1*).

During that period, the legislators worked for better funding for maternal health care. Women legislators were at the fore of successful collective action that brought together civil society and technocrats in the health sector to agitate for maternal health care across the country. Maternal health care, gender, and human rights issues tended to galvanise legislators across the political divide into action (*Sec. 5.3.4*). However, this bipartisan response was not able to address the unique maternal health needs of Northern Uganda (*Sec 5.3.2*).

Central government to decentralized districts relationship

The policy elite funded maternal health care service delivery at district level through the Ministry of Local Government (MOLG). MFPED had intentions to use allocation formulae to distribute resources to multiple sectors in the districts. However, macroeconomic considerations limiting any increments that should have occurred in public spending and political considerations made the allocation of resources a powerful rent-seeking tool (*Sec. 5.3.1*). It is notable that the post-conflict period coincided with the resumption of multiparty politics in Uganda.

The resource allocation formula did not factor in the health related needs of the post conflict population. However; the Office of the Prime Minister and donor agencies made funds available through the PRDP. There was inadequate guidance given to the district local governments on how to channel PRDP funding into the health

sector (*Sec 5.3.2.*). The lack of participation of the Ministry of Health technocrats in the PRDP process was glaringly apparent. The donors often provided financial and technical support directly to the district health sectors much against the precepts of the SWAp (*Sec 5.3.2.*).

Because donor funding was available for Northern Uganda, the limited public funds were diverted to other areas of need that were not necessarily within Northern Uganda. In Northern and East Central Uganda alike, there was incoherence between approved district budgets presented to MFPED and the subsequent disbursements made to the districts. In East Central Uganda, this action by Central Government was causing a waning in participation in the budget planning process. In Northern Uganda, the donors supported the funding gaps enabling the PRDP implementation to be more functional.

Central government to community relationship

The President championed the establishment of the PRDP and emphasised a peace building and economic growth agenda. However, this did not prioritise health care (*Sec 5.3.2.*). Often medical equipment was allocated to the districts during presidential engagements with the community (*Sec. 5.3.1.*). Legislators mainly interacted with their constituents during election season, a view equally expressed in Northern and East Central Uganda (*Sec. 6.2.5.*). The performance of Members of Parliament was judged by their alms giving and by what voters understood as tangibles development. Maternal health care was affected by these expectations; meagre district and national resources were diverted to developing Health Centres II's that lacked the capacity to provide delivery and antenatal care services (*Sec.5.3.1.*).

There was a lack of action by all the stakeholders of Central Government in addressing the unequal distribution of midwives across the country. Health worker packages did not consider the difficult post-conflict environment. Peaceful regions like East Central Uganda provided greater opportunity for dual employment and attracted health workers into the setting (*Sec.5.3.5.*).

7.1.2 Context

The 1996 Uganda Constitution provides for the President as the Head of State to oversee the functions of MFPED. The President, the legislators and the MFPED technocrats are bound by the Constitution to equitably address the basic needs of *all* Ugandans. Aligned to the NRM's political manifesto was the country's pro-poor development agenda called the Poverty Eradication Action Plan (PEAP).

Decentralisation of the health sector is part of the Government's overall decentralisation as stipulated in the Uganda Constitution and enacted in the 1997 Decentralisation Policy. For Northern Uganda, the PRDP is founded on similar precepts as the PEAP with \$100m earmarked for programmes in Northern Uganda for three years from 2007. Donors were expected to raise an additional \$200m for the PRDP.

7.1.3 Formal institutions

Like other social sectors, health care got a low priority in the NRM manifesto. The manifesto focuses principally on ensuring political stability, economic modernisation and industrialisation. This stipulated greater spending on defence, internal security, roads and energy. The PEAP specified a strict code of spending guided by the Medium Term Expenditure Framework.

According to Article 79 of the Ugandan constitution, the role of legislators is to represent their constituents in the law making functions of the Ugandan Parliament, in protecting justice and good governance. The 2001 Budget Act provides for legislators to scrutinise and vet the draft budget.

The Parliament Act stipulates for the creation of interest groups, like example NAWMP, that perform the function of advocacy, information sharing and lobbying within parliament (*Sec. 5.3.4*). Maternal health care policies like the Roadmap (2007 – 2013) and later “the Promise Renewed (2013)”, give guidance for the equipping of lower level health facilities with human resources and equipment that would enhance their capacities to handle emergency obstetric care. These policy documents fail to specify Northern Uganda's peculiar maternal health needs.

The health ministry is obliged by the Constitution to provide *upward* accountability for funds disbursed by Government. Quarterly appearances at Parliaments Public Accounts Committee take place. The health ministry with MFPED regularly publish financial and programme reports that are disseminated widely to all stakeholders. The Annual Joint Review Mission brings together all health sector stakeholders to appraise its performance and plan for subsequent seasons.

The decentralisation act of 1997 actualises constitutional provisions for the devolution of political, administrative and fiscal decentralisation. This has been partially achieved because MFPED still plans and tightly regulates district spending; disbursed through the MOLG to respective districts on the basis of the allocation formula. The formula uses a *deprivation index* for determining equalisation grants for more vulnerable districts across the country. The formula does not factor for displacement or social disruptions (*Sec.5.2.4*).

There are a number of centrally procured medical equipment that are to be equitably distributed by MFPED to the various health facilities serving the communities through the guidance of MOH and in accordance with the National Health Policy.

7.1.4 Informal Institutions -

Presidentialism - The President's powers brought finality to the MFPED policy actions even when they were contrary to parliament's approved health sector budgets (*Sec. 5.3.1*). Again the President's relationship through the technocrats in MFPED ensured that the funding of actions to safeguard peace, security and economic development were prioritised (*Sec. 5.3.1*).

The impact of presidentialism on the developmental agenda was reinforced by development agencies buying into the PRDP agenda (*Sec.5.3.2*). During the post-conflict period, the President used his authority to ensure that the PRDP programme was well funded despite the implementation challenges (*Sec 5.3.2*).

Unlike Northern Uganda in East Central Uganda, the immediate impact of the Executive's influence was not obvious. Local politicians in the region were the

power brokers; as it were, presidentialism was decentralised – as I discuss further under section 7.3.4.

Political Patronage – this played out in the interactions of the Executive with the rest of the political elite as well as with more peripheral stakeholders in rural Northern and East Central Uganda. The President rewarded the legislators within his camp just as much as he did his supporters in the rural communities. The legislators were under pressure to compromise their independence and follow pro-development model that did not favour the health sector (*Sec. 5.3.1*).

Gender Roles - It was notable that both the women and men recognised maternal health issues as primarily a concern for female legislators. The male legislators would participate in maternal health related causes whenever emotive issues were raised. The female legislators were seen as the natural champions for maternal health. In effect, this attitude was a conveyance of traditional norms into parliament (*Sec 5.3.4*).

Corruption - Respondents described how members of influential legislative committees received illegal payments for guaranteeing loans for public projects (*Sec.5.3.1*). It is certainly possible that this behaviour was influencing the status of maternal health in North and East Central Uganda. The pilferage of PRDP funds, shoddy construction work that were reportedly engineered both at central and district local government level limited the effectiveness of the programme (*Sec. 5.3.2*)

Collective Action - The action legislators took in favour of maternal health reflected the importance of collective action. The collective action enabled four functions to take place: i) it promoted the legislators from the lowly position in their power relationship with the executive (*Sec. 5.3.1*); ii) it provided the numerical strength required for the passing of pro-maternal health bills. This was seen in the bipartisan vote that blocked the use of externally sourced loans until provisions were made for maternal health (*Sec. 5.3.1*); iii) it protected the legislators from punitive political discipline (*Sec. 5.3.1.*); iv) the collective action was perceived as a representation of

national opinion and made it politically expedient for the executive and MFPED to respond to health care concerns raised (*Sec. 5.3.1*)

7.1.5 Incentives –

The maternal health care agenda was in competition with the peace building, stabilisation and economic development model that was prioritised by the policy elite. Existing formal and informal institutions favoured the latter model during the post conflict period in both Northern Uganda and East Central Uganda.

Weak maternal health care policy

The Ugandan maternal health policies failed to detail strategies that maternal health policy advocates could use to agitate for more appropriate services targeting the unique needs of Northern and East Central Uganda (*Sec. 5.2.3*). The lack of understanding of maternal health care policies by legislators and other lobbyists limited the effectiveness of such policies (5.3.3).

Strong grounded pro-development national policies

The pro-development policies like the PEAP and other complementary policies had gone through a process of feedback and amendment by government over several years however they continued to carry their limited focus on maternal health care. The pro-development model adopted was well articulated and appreciated by a wider group of stakeholders. The adoption of the sector wide approach and emphasis on the Uganda National Minimum Healthcare package were part of this model but failed to translate into investments that could have strengthened maternal health care (*Sec 5.3.1*). In other words there was a strong ideological incentive for the President, Ministry of Finance and donor agencies like the World Bank to pursue this model yet its stringent control of spending and focus on infrastructural development was not supportive of the immediate requirements for maternal healthcare strengthening.

The PRDP approach was testament to the fact that donor communities had bought into the PEAP pro-development model. There was greater focus on infrastructural development and less on “software” during the post war reconstruction effort.

PRDP funds did not go towards hiring health care workers, community health workers or referral and ambulance services. The PRDP approach enabled donors to have their funds spent on more noticeable projects (*Sec. 5.3.2*).

Information asymmetry and the policy elite power relationships

The strong connection between MFPED technocrats and the Executive gave the former the clout to pursue their preferred pro-development model irrespective of parliamentary decisions (*Sec. 5.3.1*). The President-finance technocrat interest group held privileged information about the management of the national budget. This strengthened their privileged position further (*Sec. 5.3.1*).

Collaboration between the legislators and civil society produced well-packaged information about the real needs in the community that were emotive enough to garner collective action amongst the legislators. The President rewarded those that supported his political agenda. However, on occasion, collective action made it possible for the legislators to support more spending in the health sector support that was often parallel to the President's preferred approach to development (*Sec. 5.3.3*).

Relationship with the development agencies

Development partners that were stakeholders for maternal health governance fell into two categories. The first were mainly international Financing institutions like the World Bank and IMF that had a long-standing working relationship with MFPED and the President and had for long been key to the country's economic policy development. They were also instrumental in the development of the PRDP. This donor group was motivated to promote the government's peace and development approach both with regard to Northern Uganda and to the country at large (*Sec. 5.3.2*).

Another group were the health developmental partners that included WHO and UNFPA; they supported advocacy and policy reform. This group of donors were associated with legislators in the policy elite group and as health oriented were mandated to promote maternal health related issues as this study shows (*Sec. 5.3.3*).

Patronage politics

Patronage had a strong bearing on political activity both at policy and operational level. Akin to his approach at the central government level, the President had extended his approach of rewarding political support to the decentralised level. Pledges by the President to provide one service or another, whether they were honoured or not, played a role in incentivizing the electorate into voting for the ruling party (*Sec. 5.3.2*).

Political corruption being the norm meant that Members of Parliament were expected to pay their voters for attending constituency consultative meetings. Legislators were therefore strongly motivated to stay away from their constituencies till the next election season (*Sec. 6.2.5*). This exchange of political support for handouts appeared more prevalent in East Central Uganda, than in Northern Uganda.

Gender Roles

Women politicians in Uganda's parliament considered it as a moral incentive to identify with women in the communities given their own experiences as mothers, midwives, or wives (*Sec 5.3.4*). They were able to empathise with the challenges that women in the communities faced in childbirth. The interest group NAWMP-Uganda Chapter was created on this premise; it went on to successfully garner collective action from a number of stakeholders. However, in a bid to maintain national representativeness and avoid the sectarian tendencies associated with Uganda's violent past, the women legislators failed to respond to the maternal health needs of special groups across the country, and in particular, the special reproductive health needs of women in the post-conflict setting of Northern Uganda (*Sec 5.3.4*).

Attribution

Particular development partners needed to retain a level of recognition for their funding and technical support efforts and therefore opted to provide their funding to Northern Uganda outside PRDP's pool or basket funding mechanism. It was stated that this was necessary for their corporate image and for accountability to the

home country taxpayer. The overall impact on maternal health care development was therefore hard to manage and monitor (*Sec. 5.3.2*). This however, does not disregard the fact that some donors had poor confidence in national processes and accountability for funds.

Political Legacy

The President had a strong imperative to focus on building peace and stability in Northern Uganda. It was in line with the long held values of the NRM government and its desire to steer Uganda away from a warring past (*Sec, 5.2.3*).

The legislators, on the other hand, were motivated to set precedent and outshine their predecessors in parliament. This was incentive enough to override the fear of going against the party's political stance (*Sec 5.3.1*). Similarly, by championing maternal health causes, NAWMP had raised profiles of Uganda's women parliamentarians amongst their peers across Africa as well with the more politically aware Ugandan electorate (*Sec. 5.3.4*).

7.1.6 Discussion of Central Government Governance Relationships

From the summary above, and with regard to the health sector emerges a picture of a more dominant peace and economic model to development; and, a less dominant socio economic model. The policy elite promoted the more dominant approach, with presidentialism as its driving force. In spite of this, women legislators played an important role in getting some maternal health care concerns through into policy. Post conflict Northern Uganda, however, did not benefit from this effort.

Presidentialism

As I indicate in this study the International Finance Institutions; the President of Uganda; and, technocrats in MFPED (that included the Central Bank officials) were the dominant policy stakeholders. They had a preference for a policy approach that focused on political and macroeconomic stability, and infrastructural development. The legislators, also part of this elite group, were less influential but were able to occasionally promote interventions supportive of maternal health care that

nonetheless lacked in specificity in regard to the health related peculiarities of the different sub regions.

Moncrieffe, Nsabagasani, and Kayabwe (2003) also recognise the same power relationship amongst Uganda's political elite with President Yoweri Museveni playing a dominant role in Uganda's politics by "setting the policy priorities and establishing the policy direction"(p.29).

Uganda has had a long history of executive dominance that, as Kasfir and Twebaze (2005) state that can be traced back to the first decade after independence³¹. The Movement "No-party" system deliberately instituted measures within the 1995 Constitution, that included providing parliament with specific decision-making and accountability-seeking provisions so as to kurb the powers that the 1967- Constitution gave the president. But akin to Kasfir and Twebaze's(2005) conclusion my study shows that these powers have long since been eroded by neo-patrimonial tendencies. It is now politically expedient to work within the bounds of a policy framework that is agreeable to the President.

In many countries, executive dominance has been seen as a force for good under special circumstances (Chaisty, Cheeseman, and Power, 2012). In Kenya and Brazil for instance, the presidents reigned over a broad coalition government by using their executive powers to expand the cabinet, and increasing funding for the ruling party's patron-client networks and in the process won over support from political dissenters. In Uganda, with far reaching consequences on maternal health, President Museveni is notably known to have used such authority to: constitutionally guarantee women one third of the seats in parliament; appoint a woman as Speaker to Parliament; and, appoint women to senior cabinet positions (Bauer, 2012).

Uganda's society is highly fragmented, divided along ethnic and religious lines. Though this did not come out distinctly in the results, it remains anecdotally

³¹ In 1967 Prime Minister Milton Obote singlehandedly drafted a new constitution, ordering the national assembly to become a constituent assembly and had it debated and adopted within three months thereafter declaring himself President without elections. Similarly, the rule by Idi Amin (1971 – 79) and again Milton Obote (1980 – 85) were characterized by policy-making by decree (Moncrieffe, 2004). *Also see chapter three for more details on this history.*

recognised as an important factor perpetuating the unfair distribution of the country's resources. Morrissey and Verschoor (2006) concur that under the "No Party" Movement system, President Museveni used his powerful influence over the legislature and finance ministry, coupled with his backing from the donors to push for pro-poor reforms that ring-fenced the country's meagre resources for the poor nationally including Northern Uganda during the post conflict period.

My research findings indicate that the return to multiparty politics may have been one of the factors that appeared to distract the President from the pro-poor reform that he had earlier on been credited for. He was drawn into investing in patronage-networks to ensure his political party's survival. The advent of multiparty politics may have watered down the good effects of presidentialism. However because the pro poor approach did not favour maternal health for Northern Uganda, the adoption of multipartyism portended better prospects for health care quality and access; and more particularly for Northern Uganda.

While Buse and Booth (2008) also hold this same view other researchers posit that political corruption, excessive presidentialism, and neo-patrimonialism were already evident long before the multiparty dispensation was re-instituted into Ugandan politics (Hickey, 2003). Nevertheless as my study suggests, if any change took place during the "no-party" political period to improve access to maternal health care services it did not extend to Northern Uganda, which was in the thick of conflict at the time.

The role of donor and MFPED

My study portrays the influence of the donor in the state's decision-making. Their influence on Uganda's policy development and implementation was palpable long before the war in Northern Uganda came to an end. Harrison (2001) attributes this nature of donor involvement to a *post-conditionality* donor aid strategy that Uganda and a few other African states in the 1990s benefited from. By gaining such a favoured status with the aid donors the more distinctly impersonal donor-recipient conditional approach to aid funding was abandoned for one based on mutual trust and shared goals. The new approach that Harrison (2001) describes as a "*more of*

carrot and less of stick" (pg.659) approach entailed greater use of financial incentives often accompanied by the embedding of donor personnel in the recipient state institutions of governance and finance.

Analogous to my findings, researchers note that closer collaboration between the government and the donors was advantageous to Northern Uganda. The donors had greater leverage in ensuring that Northern Uganda's plight was attended to by government; hence the declaration of the region as a disaster area and subsequently the cessation of hostilities.

My study also shows that the "*principal-agent*" relationship between MFPED and the legislators and the wider public was flawed. MFPED as agent held vital information about the country's health care financing modalities that was not adequately shared with other stakeholders either due to its technicality or due to deliberate sanctioning of information (*see Sec. 5.3.2*). As also noted by Hickey (2005) the lack of knowledge limited the capacity of parliament to agitate for better health care spending.

Furthermore, this study finds that MFPED played a major role in the Chief Executive's initial reluctance to support special programming for Northern Uganda during its period of transition (*Sec. 5.3.1*). This is corroborated by a Ministry of Finance working paper that cautions against having special programmes for Northern Uganda lest the region is isolated from mainstream national political and economic processes by such action (MFPED and OPM, 2003).

Contrary to my findings that suggest that MFPED was withdrawing or withholding funds already allotted to the health sector, earlier research points to the Poverty Alleviation Fund (PAF) as having been functional during the study period, channelling funds saved from the Heavily Indebted Poor Countries (HIPC) Initiative into the health and education sector. However, Lentz (2014) still suggests that at decentralized level, PAF secured funds were not assisting the poor. The absorption capacity at districts level was weak: they lacked the technical capacity to

appropriately use the funds. Given Northern Uganda's more severe human resource constraints this limitation was of greater consequence.

The role of female legislators on health policy

A number of Ugandan studies validate my findings of women legislators having played an important role in national governance, in this case linked to maternal health care.

Wang (2013) gives a detailed account of the Uganda Women's Parliamentary Association (UWOPA) having had a fledgling existence until the 2006 resumption of multiparty politics when UWOPA spearheaded the passing of a number of women-friendly legislations.

The conclusions of a systematic review of research on women's involvement in contemporary politics around the world by Bauer (2012) mirrors the findings of my study. The review recognises that two factors enhanced African women's accomplishments in parliament: the women's parliamentary caucuses cut across party lines; and, the women parliamentarians invigorated their advocacy work and information sharing activities through technical support that they gained from partnerships forged with women activists and gender-support civil society organisations. Wang (2013) in addition notes that women legislators formed coalitions with their male counterparts and alliances with technocrats in the line ministries in a bid to pass pro-women legislations. This study recognised that such efforts by UWOPA and NAWMP led to additional funding for maternal health care.

The women legislators to some degree addressed equity in the distribution of resources by insisting on the supply of resources for maternal health to lower level health facilities. However, the legislators failed to emphasise the special health related needs of the population of Northern Uganda who were facing the double tragedy of being impoverished and carrying the greatest disease burden as well as emerging from a long standing conflict. My study's account about the female legislator that highlighted the plight of children with Nodding Syndrome shows the capacity that Women Parliamentarians had to advocate for the special health

challenges facing the region. A UNDP (2015a) report uses Uganda's parliament Hansards of 2010, 2011 and 2012 to show that the women parliamentarians from Northern Uganda raised a number of gender related concerns on the floor of parliament, such as sexual and gender based violence and property ownership rights. It was however noteworthy that maternal health care was not one of the issues discussed.

No specific health reform for post conflict Northern Uganda

The entire nation Uganda was itself 20 years post-conflict by the time the regional war in Northern Uganda was ending. My study indicates that the government's response to the maternal health care needs of Northern Uganda had a lot to do with policy reforms opted for earlier on as the entire nation (including East Central Uganda) recovered from the war in 1986 that ushered the NRM government into power. As evidenced from DHS data (that I reviewed in Chapter three) and focus group discussions that I conducted in both Northern and Eastern, it is notable that though Uganda did not attain its MDG goals there was an improvement in access and utilisation of maternal health service across the country.

My study's policy analysis and interview findings share concurrence with Carlson's (2004) conclusion that the Ugandan government minimised the Northern Ugandan crisis to a "*'micro-difficult environment' within a more stable 'macro non-difficult context'*" (pg.105). This appeared to have shaped the government unaltered approach of handling the region's health care needs. Indeed, Uganda's donor partners accepted this attitude and did not apply pressure on government to address Northern Uganda's special health sector needs before or after the end of conflict (ACCS, 2013).

Carlson (2004) suggests that the lack of action by government was due to an absence of willingness to address the needs in the North. My research did not discover any evidence of this lack of willingness, probably reflecting a change in attitude amongst the different stakeholders following the end of conflict. My study indicates that the lack of response was more a result of a critical information gap between the Office of the Prime Minister and the sector ministries. In addition, the

line ministries lacked the technical capacity to contribute specific responses by government to the peculiar health care needs of the region (*Sec. 5.3.2*) (*Sec. 5.3.2*).

7.2 Central health sector level to decentralised governance stakeholders relationship

This level, denoted as “H” in the study conceptual framework, considers the governance linkage between, governance stakeholders working within MOH at central level, other sector ministries that play a role in health care, and the decentralised health care system. The other line ministries with a stake in health are the Ministry of Local Government, the Ministry of Public Service, the Ministry of Gender, and the Ministry of Education and Sports. The interviews for this group were predominantly conducted with stakeholders within the Health Ministry.

7.2.1 Overview

During the post-conflict period, with the devolution of health care provision to the decentralised health system, MOH concentrated on providing policy-making, policy guidance, monitoring, and support supervision. Inadequate funding from the MFPED hampered MOH playing its supervisory role in the implementation of policy (*Sec.5.3.3*). MOH played an indirect role in addressing the human resources for health challenges in the post conflict setting. It had to negotiate with MFPED and the Ministry of Public Service in order to get more health workers recruited (*Sec. 5.3.5*). MFPED was seen to consult MOH to some extent with regard to resource allocation (*5.3.3*)

MFPED and donor agencies selectively funded the health ministry’s activities, severely restricting its governance role at district level (*Sec 5.3.1*). The situation was made worse by frequent delays in disbursement and the arbitrary withdrawal of funds from the health sector accounts on occasion (*Sec 5.3.1*). The support supervision teams from different departments of the health ministry often exhibited incoherence in the policy guidelines that they followed (*Sec. 5.3.2*).

Towards the end of the war, more policy documents began to capture the unique challenges of the region (*Source: Policy Analysis section 5.2.3 and 5.2.4*). However

policies generated by MOH did not lead to an appropriate response to the maternal health care needs of Northern or East Central Uganda. The technocrats had limited capacity to appropriately translate the health policy to suit the different contexts across the country (*Sec. 5.3.3*). The country's maternal health policies were often adoptions of templates prepared by global agencies (*Sec. 5.3.3*).

The Ministry of Health is faulted for having failed to provide adequate technical guidance as the PRDP programme for Northern Uganda's health sector was being rolled out (*Sec. 5.3.2*).

7.2.2 Context

The Poverty Eradication Action Plan is the overarching policy within which all health care policies are aligned. The stringent macroeconomic policies act as a counterbalance to the health sector's policy aspirations providing affordable, equitable and acceptable care to all in the land. The Poverty Action Fund ring-fences some funds for the functioning of the decentralised health care system. The National Health Policy describes how the different social sector ministries including the health sector work together to improve the health status of all Ugandans. The National Health Policy (1999 – 2009) which was developed after Uganda's development partners deferred with the recommendations of the 1987 Health Policy Review Commission and provided guidance for the adoption of Primary Health Care in line with the Alma Ata Declaration of Health for All (HFA). The PHC adoption also prompted the restructuring to the health ministry with many key functions decentralised or shifted to other line ministries. Medical training was transferred to Ministry of Education, health care financing to the Ministries of Finance and Local government and, human resource management to the Ministry of Public Service.

7.2.3 Formal institutions

The Health sector strategic plan II gives guidance on how MOH amongst other stakeholders work to achieve equitable health service delivery. The maternal health policies specify how to improve the availability, access, and utilization of quality

maternal and new born care services. The Human Resources for Health Policy articulates the equitable distribution, training and remuneration of health workers. Powers to recruit and deploy health workers lies with the Ministry of Public Service and the Health Service Commission. MOH supervises their professional performance. All these documents lack detail of how equity will be achieved in the different regions of the country including the post war recovery needs of Northern Uganda (*Source: policy analysis section 5.2.3 and 5.2.4*). Many Ugandan health policies are adoptions of international developed health policies. Technocrats at the health ministry often wrote policies at the behest of different development partners and health care interest groups (*Sec. 5.3.3*). These policies are often incoherent with standing government policy, not budgeted and lack guaranteed funding. Many of the documents are never implemented (*Sec. 5.3.3*).

7.2.4 Informal institutions

MoH was seen as having given little priority to the PRDP. Junior central ministry staff handled the health ministry's participation in the PRDP planning and implementation process. They lacked the decision-making authority and were not providing effective feedback to their superiors at the health ministry (*Sec. 5.3.2*). PRDP health sector investment decisions were left for respective district health teams to make with limited guidance from the health ministry (*Sec. 5.3.2*). This had a direct bearing on the impact of the PRDP on Northern Uganda's health sector.

7.2.5 Incentives

The line ministry officials were not keen in participating in the PRDP planning process. This may have, in part, been related to the limited information that was shared by MFPED and OPM with regard to the PRDP and its mandate in reconstructing Northern Uganda's health sector (*Sec. 5.3.2*).

Ministry of Health personnel were motivated by hotel retreats and paid generous honoraria to adopt a number of international health policies even though they were not necessarily implemented. On the other hand, the international agencies

sponsoring policies were under pressure to have policies that they sponsored adopted, that were important for the poorly paid public servants (*Sec. 5.3.3*).

7.2.6 Discussion – Health central ministry level

My evaluation of the Ugandan Ministry of Health portrays it as powerless, among the key national level health system governance stakeholders. In this discussion the lack of clout explains MoH's poor performance at sub national level, but more particularly, MoH's absence in the planning and execution of PRDP projects in the health sector of Northern Uganda. At the centre of MoH's incapacity at sub national level is a long standing ideological struggles with MFPED and its allies.

An ideological struggle

The finance ministry was the health ministry's nemesis with regard to the prioritisation of health policy. Hickey (2005) who also recognised the unique power relationship between these two Ugandan sectors described them to be in a "*hegemonic struggle*" (pg.1002). Other social service ministries and civil society were recognised as allies of the health ministry in this ideological standoff. On the other hand, officials of the International Funding Institutions and members of the private sector that favoured greater investment in the economic sector were allies of MFPED and the policy elite. Fulfilling the Health Ministry's wishes implied increased borrowing and spending by Government. The MFPED approach would mean the restriction of pro poor policy reform to programmes that supported income generation and infrastructural investment as Hickey (2005) also suggests. Given MFPEDs influence with the policy elite, as Brock et al (2002) puts it, the policy space had been restricted and controlled by MFPED. In part, this had been achieved by keeping the health ministry and other social welfare promoters in the dark about decisions made on health care spending, often going against the agreed budget for the sector. Being stripped of key responsibilities further weakened the health ministry's position in the power relationship.

The genesis of the decision to strip MOH of its powers is etched in the country's political history. Macrae, Zwi and Gilson (1996) describe MOH during the first few

years of the NRM Government's rule as having been a highly bureaucratic organisation that was mainly managed by clinicians that had limited managerial skills. Their post conflict recovery strategy reflected a preference for a centrally controlled, hospital-based health care system. The new government, civil society and the donor agencies were against this approach. They were more in concurrence with Primary Health Care oriented health care reform in accordance with the 1978 Alma Ata agreements. This meant the restructuring of the health ministry and decentralizing a number of health sector functions to the districts in line with the PEAP (Jeppsson, 2003).

However as I highlight in this study, the government has been rethinking the current health ministry; some of the governance challenges faced at decentralised level have led to a recentralising of key health system functions including medicines procurement and distribution, and human resource management (*Sec. 6.3.2*).

The tendency to create "super" finance ministries is apparently a common phenomenon across the aid-dependent world according to Wilks and Lefrancois (2002). It comes out of a shared ideology between IFIs, recipient government economists and planners and the political elite that considers trade, fiscal liberalisation, and investment in infrastructural development as a prelude to poverty reduction and social development (Wilks and Lefrançois, 2002).

Just as Pavignani and Durao (1999) note, in Mozambique, another post conflict setting, it was already recognised that the central health ministry needed to have free reign over important financial and management functions if the health system was to be more responsive to the peculiar needs of different parts of the country. It was recognised that the finance ministry had too many vested interests that would interfere with health sector rehabilitation (Pavignani, 1999). The peculiar health care needs of post conflict Northern Uganda and non-conflict East Central Uganda may have benefited from such an approach.

It is also notable that Claussen et al (2008) absolves MoH for its absence from Northern Uganda during the post conflict rehabilitation process. The researchers

indicate that despite the setting up of the Inter Ministerial Technical Committee (ITMC) that offered all line ministries with a forum to participate in the planning and execution of the reconstruction programme, MFPED and the Office of the Prime Ministry consistently failed to convene these meetings. In effect the MoH was sidelined by this process. MFPED preferring to engage directly with the district health teams during its planning efforts (Claussen *et al.*, 2008).

7.3 Decentralised health system to community relationship

The decentralised health system includes the politicians and technocrats managing the district local government as well as the health providers working in the different health facilities. It also includes the CSOs supporting the delivery of health care services to the community. “D” in the conceptual framework in figure 7.1 denotes the governance relationship between this group of stakeholders and the community.

7.3.1 Overview

During the immediate post-conflict period, an allocation formula guided the disbursement of funds for the health sector to the post conflict and non-conflict regions of the country; however it was not consistently used (*Sec. 5.3.1*). For Northern Uganda, additional funds to support the resettlement process were channelled through various projects coordinated by the Office of the Prime Minister and implemented through the district local governments. Many district health teams often lacked planning and implementation skills. This had an impact on the level of support obtained by the district level health sector. There were fewer donor agencies funding projects in East Central Uganda to support the district health teams in addressing these challenges.

In the newly created district of Lamwo, the technical and political teams addressed the challenges affecting maternal health care utilisation through effective leadership and collective action by donors, politicians and district technocrats (*Sec.6.3.1*). The district technocrats in East Central Uganda welcomed the recentralisation of medical supplies procurement and health worker recruitment (*Sec. 6.3.2*). The creation of new districts, in both regions, resulted in the unequal splitting of the

mother district's fiscal resources with the newly created districts taking a larger share (*Sec. 6.3.5*).

Health workers in Northern Uganda were limited in number. In addition, they lacked capacity-building opportunities and had poor relationships with the community (*Sec. 6.3.2*). East Central Uganda was a more attractive destination for health worker's seeking employment. Many health workers in this setting were engaged in dual employment making them less accessible in the duty stations (*Sec.6.3.1*). In East Central Uganda the actions of the politicians went against the community's maternal health care needs. The politicians often opted to use meagre development funds for erecting new infrastructure while the district technocrats favoured the rehabilitation and maintenance of existing hospitals (*Sec.6.3.2*).

An adherence to gender-related customs and having a low educational attainment was negatively affecting the performance of women in the district political leadership; this was articulated more in East Central Uganda (*Sec.6.3.2*). These two factors may explain why women leaders in both regions limited their interactions with the communities they represented. In the North male politicians were more engaged in addressing maternal health issues according to the community in one locality (*Sec. 6.3.3*).

The civil society organisations in Northern Uganda approached the maternal health related needs from a human rights and gender based perspective (*Sec. 6.3.1*). In East Central Uganda, the CSOs were more technically focused and supported the supply side of health service delivery (*Sec. 6.3.1*).

In both regions, CSOs had mobilised communities to demand greater accountability from the health care duty bearers. The process elicited a more positive response from government in Northern Uganda by the provision of funding from the PRDP through projects like NUSAF that would attempt to address several of these demands voiced by the resettling communities (*Sec. 6.3.1*). For Northern Uganda, government invested in social accountability related activities as part of its peace building efforts.

7.3.2 Context:

This includes some tenets adopted at national level as described in section 7.1 above. Specific to Northern Uganda during the immediate post conflict period (2006 – 2011) the contexts include: i) The Juba Cessation of Hostilities; ii) The financial and technical transitory process from humanitarian aid to development aid; iii) The Poverty Eradication Action Plan policy; and iv) The PRDP policy for Northern Uganda.

In East Central Uganda the specific contextual considerations include: i) Long standing peace and stability in the region; ii) The National Cultural Policy that legalises the existence of the traditional institution in East Central Uganda, the Kingdom of Busoga; and iii) The recently concluded first multiparty general elections in 2006.

7.3.3 Formal Institutions

This is a summary of the formal institutional evidence derived from the policy analysis section of chapter five, Section 5.2.3 and 5.2.4.

A decade after Uganda emerged from the 1987 war, the Local Government Act of 1997 was enacted to steer the operationalization of the decentralised system of governance, stipulating the establishment, composition and election of local council members and elaborating on budgetary procedures at district level.

The PRDP was a comprehensive development framework for post conflict Northern Uganda acting as an instrument of the PEAP. It gave guidance for the mobilising and allocating of additional funds to Northern Uganda so that the North-South socio-economic development gaps could be bridged. It articulated the inclusion of women, the disabled and the elderly in groups for special consideration.

The Human Resource for Health Policy was important because it emphasized that affirmative action would be taken in relation to training and recruiting health workers for disadvantaged areas and vulnerable groups. However this aspiration has not yet been achieved. The reproductive health, family planning, and adolescent

health policies also gave guidance for the decentralised mode of health service delivery.

The maternal health policies specify how to improve the availability, access, and utilization of quality maternal and new born care services, particularly at health sub district level.

The district local governments, civil society and local community in the districts all participate in the annual government budget planning exercise. Civil society organisations are also provided for in the Constitution, regulated by the Non governmental organisations act; they are an organised mouthpiece for communities across the country to government.

For the health sector, district local governments provide feedback on policy through annual performance reports, through the budget planning process and through the national joint medical review mission as previously stated.

7.3.4 Informal Institutions

In East Central Uganda, NGOs were supporting the supply side of the health system (*Sec.6.3.1*). In Northern Uganda through advocacy and human rights support, NGOs were supporting the health system's demand side (*Sec. 6.3.1*).

The funds disbursed by MFPEd to the districts did not reflect the approved district annual budgets. The disbursements were on occasion delayed or reduced in amount. For Northern Uganda, the presence of donors and the PRDP helped to cushion the consequences of this erratic pattern of funding (*Sec, 6.3.5*). Lamwo district was able to efficiently plan and execute programmes that improved maternal health care utilisation in the district through collective action by donors, district local government politicians, technocrats and the communities. All these stakeholders worked together to improve emergency obstetric care in the district (*Sec.6.3.1*). In East Central Uganda the lack of collaboration between key district level governance stakeholders was reflected in a number of health facilities remaining in states of disrepair despite disbursements being made from the finance ministry (*Sec.6.3.2*)

Again in East Central Uganda, the district politicians and the communities they represented had a patronage-based relationship that was manifested in a number of ways. A corrupt practice - voter bribery – was reported as rife in the region. In addition, politicians acted against guidance from the technocrats and used the scarce district resources to build health centre IIs that couldn't offer maternal health care services (*Sec. 5.3.3*). Politicians were avoiding voter consultations in a bid to avoid having to pay sitting allowances for such sessions (*Sec. 5.3.2*).

Women politicians were reportedly mute during council meetings in both regions. Limited educational attainment as compared to their male counterparts, and an adherence to traditional gender roles was offered as an explanation for this. This observation was also made in Northern Uganda (*Sec. 6.3.2*).

Health workers had a preference for employment in East Central Uganda. The region was peaceful and closer to large urban centres. It offered health workers with lucrative dual employment opportunities and vital amenities for the health worker's families (*Sec. 6.3.2*).

In Northern Uganda, in-service training workshops run by NGOs working within the region drew health workers away from their daily routines. Health facilities were left devoid of personnel to attend to patients (*Sec 6.3.2*). Midwives in Northern Uganda were described as having bad attitudes to the women under their care (*Sec.6.3.2*). This was notably less emphasised in East Central Uganda.

The district local government technocrats, many of who were graduates, expressed discomfort with being supervised by politicians that often had a lowly education. This sentiment was more common in East Central Uganda (*Sec. 6.3.2*).

7.3.5 Incentives

Cultural constraints

Traditional sentiments and lowly educational attainment led women politicians in Northern and East Central Uganda to be restrained in their governance role.

Economic incentives

National and International NGOs were attracted to work where funding was more available. For the same reason and given that major focus in Northern Uganda was on establishing peace and stability and human rights, most NGOs in the region were engaged in these areas. A smaller number of NGOs in Northern Uganda supported the supply side of maternal health. In East Central Uganda more focus was on the supply side of maternal health care.

Voters elected politicians that handed out money, alcohol and other items that were considered of value. However the norm was causing politicians to limit their consultative engagements with the electorate because of such expectations.

Given their meagre salary, health workers engaged in other money generating activities to supplement their livelihoods. This drew them away from their duty stations. In Northern Uganda, the attendance of donor-funded workshops and meetings that paid honoraria was an important source of income. In East Central Uganda, holding a secondary job in the private sector was cited as a common option.

Self Preservation

As representatives of the people, district politicians were constitutionally given the responsibility of supervising the district technical team. The district technocrats were often not in agreement with the decisions taken by the district politicians who, according to them, were driven by selfish political interests and a lack of technical knowledge. Nevertheless district technocrats opted to remain acquiescent and dared not to defy their superiors. It is interesting to note that the availability of donor funding in Northern Uganda to an extent permitted the convergence of district politicians and district technocrat interests. The district technical and political leaders, and donor agencies in Lamwo district, for example, had a convergence of interests that favoured improvement of maternal health care in the district.

In East Central Uganda where such funding did not exist, the actions of the politicians grossly diverged from the objectives and aspirations of the district technical teams.

Self-preservation also explains why many district technocrats in Northern Uganda avoided using PRDP funding for projects that would promote maternal health care. Instructions on how to use the funding for health sector development were unclear. It was therefore considered prudent to avoid committing PRDP investments into this area.

7.4 Discussion - Decentralised health system to community relationship

A number of important variables affected the impact of the decentralisation of governance on the health sector in Northern and Eastern Uganda. These variables included: more overt factors like political patronage, information asymmetry as well as donor funding preferences; and less obvious factors like the role of gender in governance at sub national level.

The varied outcomes of decentralisation

My study shows that the decentralisation strategies initiated by government to bring services closer to the population in Northern and Eastern Uganda was increasingly deterred by local political patronage. The levels of patronage in each region appeared to be different and affected decentralisation differently.

In Northern Uganda, where political representatives dealt with the electorate in a less venal manner as compared to non-conflict Uganda, decentralisation appeared to have played a role in the rehabilitation effort. My study shows that the positive attitude of local politicians was ameliorated by: i) the population being more aware of their dire circumstances and needs, given the closure of the camps and the withdrawal of humanitarian organisations as opposed to the routine circumstances associated with peaceful East Central Uganda; ii) civil society organisations making the population aware of their rights and equipping them with skills to agitate for better social services; and, iii) Central Government under national and international pressure exhibiting commitment to support the resettlement process (*Sec 5.3.2*).

Given the above, decentralisation proved to be an important platform through which Northern Uganda would gain from the technical and financial support provided by the donor community. Lamwo and Gulu district are examples of new and old districts whose health system's gained from decentralisation. In Gulu District the District Disaster Management Committees co-chaired by the UN and the district local government mentoring the political and technical district leadership in programme prioritisation (*Sec.6.3.5*). In Lamwo, as earlier mentioned, a functional and united district leadership efficiently channelled donor funds towards improving maternal health care service delivery.

However, though decentralisation was necessary it was not sufficient to guarantee a sustained improvement in maternal health care services for Northern Uganda. The human resource gaps remained unaddressed. As I previously mentioned, the MOH was disenfranchised of its human resources for health management role. Fiscal decentralisation had not yet been achieved and donors were reluctant to invest in developing the region's health work force (*Sec 5.3.5*).

My study portrays a more negative picture of decentralisation and its impact on maternal health care in East Central Uganda. For this region, the convergence of local politician and voter interests favoured the diversion of PHC decentralized funds to the construction of health centre level IIs that played no role in providing delivery services (*Sec. 6.3.5*).

Oates (1999), one of the early proponents for decentralisation, argues from an econometric point of view, stating that where there are multiple jurisdictions with varied demands, decentralisation affords *Pareto-efficiency* to the provision of public goods in comparison to the more centralised approach to service delivery. As is shown in this study, while Uganda fiscal planning is partially decentralised, resource allocation is still *centrally* controlled. My findings highlight important factors that Oates (1999) suggests limit the Pareto efficiency of decentralisation and these were at play in Northern and East Central Uganda.

Firstly, there was a lack of adequate knowledge (or information asymmetry) about the real health needs of the different regions and in the case of the post-conflict setting this was manifested by an inappropriate allocation of resources for health care. The second factor was political; as my study clearly shows the politicians and other members of the political elite at national level expressed reluctance to initiate programmes that positively discriminated for particular regions despite the evidence of greater need in these jurisdictions (*Sec. 5.3.2*).

Furthermore, Akin, Hutchison and Strumpf (2005), use data from Uganda's district annual health work plans compiled by decentralised districts in fiscal years 1995/96, 1996/97 and 1997/98 to show that decentralisation in the long run does not guarantee the rational use of disbursed funds on public goods. According to these researchers, in the 1990s health planners and district local governments in the more established districts tended to spend more on health sector related non-public goods like car maintenance, construction and repair of buildings and allowances as opposed to public goods like the immunisation, health education or village health team support. Though the researchers do not state this in their narrative, it is apparent from my study that the patronage and corrupt practices at decentralised level had a role to play in those choices.

The incessant creation of new districts is another factor that may have impacted negatively on health system development. Grants remitted by government were inadequate and the newly appointed politicians and technical teams were often not experienced enough to decide how to utilise the meagre resources. As one respondent caricatured, the financing for these new districts was like *"tearing a piece of the mother's old dress to wrap the baby"* (*Sec. 6.3.5*).

In East Central Uganda, the communities of the newly created districts were eager to immediately reap dividends; the local politicians were under pressure to prioritize the building of health centre II's as I earlier mention, tended to be non-functional with regard to maternal health care.

As my study indicates this creation of units that are poorly funded and poorly administered is driving the recentralisation of a number of key functions. As stated in chapter three, Lewis (Lewis, 2014) argues similarly in her study and suggests that the recentralisation taking place is still part and parcel of a patronage agenda, however this time of the national executive. This phenomenon is not unique to Uganda but is taking place in many “*democratizing*” developing nations globally that have citizens that feel marginalised and are seeking better services, and a have a political establishment grappling with neo-patrimonial tendencies (GROSSMAN and LEWIS, 2014).

Despite all these challenges with decentralisation as previously mentioned the performance of Lamwo in Northern Uganda remained outstanding. Two additional factors may have played a role in making this Lamwo district gain from its creation. Firstly, the district’s Member of Parliament was a Cabinet Minister in government — the only Cabinet Minister from Northern Uganda; he was able to use his own patronage networks to fulfil his political ambitions. Secondly, the district has been a hotspot for a number of disease outbreaks including Hepatitis E viral Fever, Yellow Fever, and the Nodding Disease Syndrome. These new and re-emerging disease outbreaks attracted additional technical and financial support to the fledgling district (Mwaka, Kitara and Orach, 2016). Lamwo District’s performance was not representative of other districts in Northern Uganda.

Reproductive Health

From the interviews held and policy documents reviewed, this study shows that the Ugandan government and its donor partners failed to adapt the reproductive health services to the needs of the post conflict population and continued to provide services similar to those offered to the peace time population of East Central Uganda. My study shows that the limited central capacity in planning, the poor attitude of health workers and a lack of recognition of the special need of the female and male adolescent in the region contributed to the high maternal mortality rates, high teenage pregnancy rates and low contraceptive rates in Northern Uganda (*Sec. 6.2.2*).

The governments of a number of countries that suffered regional conflict alongside peace and development like the Democratic Republic of Congo and Sri Lanka likewise failed to ensure equitable provision of reproductive health care and this contributed to poor reproductive health statistics (Coghlan *et al.*, 2006; Kottegoda, Samuel and Emmanuel, 2008). Clearly, in such settings the lack of health workers and other necessary infrastructure make the provision of RH services challenging (Casey *et al.*, 2013). However, these disparities may further be explained by preferential ODA funding for reproductive health going to non-conflict affected settings as is explained by the findings of an analysis of ODA funding by Patel et al (2009). The analysis showed that for the period 2002 to 2011, the ODA funding for reproductive health disbursed to non-conflict least developed countries was 57% higher than that provided for the conflict settings.

District level gender concerns

The ineffectiveness of women district leaders at sub national level is explained in this study as being due to: i) the observance of traditional gender norms and poor education attainments; and ii) political patronage particularly in East Central Uganda.

The adherence to traditional norms is a finding supported by a UNDP (2015a) report on Northern Uganda that describes women councillors having their roles in council meetings reduced to “*seconding, signing and supporting*”(pg.54) proceedings in the District Councils.

In East Central Uganda, while the picture of acquiescence to traditional norms was similar, the additional challenge faced by women given the levels of political patronage is supported by Muriaas and Wang (2012) who suggest that the limited interactions with the electorate and the cautiousness in debate may have been a symptom of financial dependence: many of these women district politicians had to ally with the ruling party or their wealthier male counterparts who could shoulder their electioneering costs.

The immediate post-conflict period coincided with the aftermath of Uganda's first multiparty general election. As I have shown in this study the implications of adoption of multiparty politics on the governance roles of women at national and sub-national level were nuanced. At national level a comparatively larger window of opportunity for women in governance for political participation appears to have been created. A number of researchers attest to this (Bauer, 2012; Muriaas and Wang, 2012; V. Wang, 2013). At sub national level despite the adoption of multipartyism nationally, the Movement no-party dispensation seemed to have remained in place. Political space remained constrained within the districts for both female and male councillors. Green (2013) suggests the Movement government through its district level mobilizers tended to manage political debate; deliberate actions were taken to maintain control over opposition political activity within the grass root structures. Given the above, Muriaas (2009) believes that district-level politicians simply had no incentives to ally with an opposition that was too weak and disorganised to counteract NRM's strong presence.

Therefore, women leaders at sub-national level did not replicate the crucial role played by national women leaders in agitating for the prioritisation of maternal health care. This state of affairs also showed that the gender-mainstreaming policy of government had not influenced the circumstance for women in governance in the decentralised governance structures. As Oloka-Onyango, 1998 quoted in Ahikire (2004) puts it, a reliance on top-down state reforms to promote governance roles for women at district level was too weak to undermine male dominance that was pegged to age-old tradition.

As this study indicates, both nationally and in both sub regions there was a nuanced assumption in society that responding to maternal health concerns was primarily the responsibility of the female gender. The study however also indicates that there were various instances where men were spearheading efforts to improve maternal health care for their communities. This was particularly so at the decentralised level. In both sub regions male village health team members explained that their main volition for volunteering was to address the poor state of maternal health in their

setting. Indeed, the male VHTs took charge, by virtue of greater physical strength and resources, in ensuring that pregnant women were navigated into appropriate care. In Northern Uganda, in particular, male politicians were recognised as more assertive in addressing the poor quality of maternal health care services in health facilities. I discuss male involvement at community level in section 7.4.6.

7.5 Community relationships with central government and district government

The community governance stakeholders are the population at grass root; civil society at this level is represented by community-based organisations. The nodes C3 and D denote the governance relationships between central government and district local government respectively with the communities in Northern and East Central Uganda.

7.5.1 Overview

During the immediate post conflict period, Northern Uganda had an active civil society composed of both international and national NGOs and CBOs. Most of these CSOs focused on advocacy and rights based interventions targeting the returning communities either directly or through community based organisations (CBOs). Many CBOs had their programming linked to the PRDP after its inception in 2007(*Sec. 6.3.1*). In East Central Uganda fewer CBOs were on the ground, most engaged in health service delivery. A number of CBOs closed after their funders shifted from East Central Uganda to Northern Uganda when the post conflict recovery effort commenced (*CSO.ECU.M.1, interview, Sec.6.3.1*).

CBOs in both Northern and East Central Uganda had used human rights based approaches to engage predominantly with women in the community so they could demand for better services and better accountability from their technical and political duty bearers. This activity appeared to have gained more ground in Northern Uganda: the communities in Northern Uganda were able to elicit more positive responses from their local governments (*Sec. 6.3.1*). In East Central Uganda similar activities were more prevalent towards the election season.

Communities in both regions perceived an improvement in the availability of maternal health care services during the immediate post-conflict period though there were concerns about the quality of care (*Sec. 6.3.2*). Communities in Northern Uganda unanimously decried poor health worker attitudes (*Sec 6.3.2*). In East Central Uganda the communities were guarded in discussing health worker performance. The communities in both regions lacked appropriate family planning services. Women in both regions expressed concern about the persistence of teenage pregnancies (*Sec.6.3.2 & Sec. 6.3.3*).

7.5.2 Context

Similar to other stakeholder levels discussed above, there are major international, and regional human rights charters to which Uganda is a signatory that set the policy context for health system governance at community level. They include: the International Covenant on Civil and Political Rights – ICPPR (1995); the Convention Against All forms of Discrimination Against Women – CEDAW – (1985); and the African Charter on Human and People’s Rights (1986). In line with these agreements the 1995 Uganda Constitution stipulates protection, promotion and enforcement of civil liberties by the state while the PEAP offers guidance on the pro-poor focus of national development.

7.5.3 Formal institutions

The fifth pillar of the PEAP is of particular relevance to community stakeholders: it deals with human development, and preventive care under the crosscutting themes of health promotion, prevention and community health initiatives.

The PRDP addresses the needs of resettling communities across Northern Uganda. It does this by promoting interventions that address peace, stability and accelerated development. The PRDP has a goal to stimulate socio-economic transformation in Northern Uganda so that it can catch up with the rest of the country (UNDP, 2015a, p. 4). Government in accordance with the NGO Registration Act formally registers civil society organisations in Northern Uganda. The CSOs are purposed at partnering with Government and its donor partners in support of stability and economic

development in both post-conflict and non-conflict Uganda. The participation of the communities at grass root in district local government planning is stipulated in section 36 of the Local Government (Amendment) Act (1997).

The Gender Policy 1996 updated in 2007 provides for gender mainstreaming in all areas of social and economic development, ensuring that women gain equal opportunity in all areas. The Health Sector Strategic Plan II recognises the need to make reproductive health a priority area, focusing amongst others on offering equitable services to women all over Uganda. Uganda's Adolescent Health Policy addresses the provision of family planning services and youth friendly services for both regions. HSSP II also saw the establishment of Health Unit Management Committees and Village Health teams. These are formal organisations through which communities participate in health system governance.

7.5.4 Informal institutions

Traditional norms in both Northern and East Central Uganda dictate a subordinate social position for women in society. It inadvertently influences the level of participation of women in civic activities. In East Central Uganda the gender roles were reported as an important determinant for a woman to access skilled assistance during childbirth. Societal disruptions that occurred in Northern Uganda as a consequence of war may have provided a window of opportunity for the emergence of a leadership role for women (*Sec 5.3.2*).

Male involvement in accessing maternal health care was negatively influenced by these gender norms. However, in Northern Uganda men were getting involved in the health care needs of their partners (*Sec. 6.3.4*). This was being enforced by the local district administration of some communities.

The primary deliverable that the community in East Central Uganda demanded from their politicians was cash hand-outs', and other "private goods" in exchange for political support (*Section 6.2.5*). Local politicians in the post-conflict setting were less associated with the diversion of government resources for the other rent-

seeking related projects like classroom blocks and lower level health centre during the study period (*Sec 6.2.2*).

The high degree of politicking in East Central Uganda was interfering with the work of CSOs. The district politicians and communities in the districts of East Central Uganda quickly perceived any form of advocacy work as politically motivated (*Sec 6.2.1*). In both regions, women were the predominant volunteers amongst the budget monitors, and the village health teams. Some men that participated in this activity in East Central Uganda saw it a conduit for getting into local elective politics (*Sec 6.2.4*). The health unit management team members were often of the male gender (*Sec 6.2.4*).

7.5.5 Incentives

Altruism

The members of the different communities in both regions often found it hard to give reasons why they were volunteering in various governance roles in their communities. The roles were often strenuous and drew the volunteers away from their livelihoods and families. Other than more abstract morality related reasons that were given as explanations for volunteering, a number of individuals stated the compulsion to contribute to efforts that could reduce the rampant maternal deaths that were taking place in their communities (*Sec 6.2.4*).

Political gain

Politics constituted an important reason for many actions that took place at community level. A few of the community volunteers saw volunteerism as a platform for recognition from the electorate. It was notable that women oriented community based organisations in East Central Uganda were more active towards the election season (*Section 6.2.4*).

Economic gain

The health unit management committees were considered as lucrative; members of management committees earned sitting allowances and societal recognition. In both

Northern and East Central Uganda, positions on such committees were offered as rewards to political supporters (*Sec 6.2.4.*).

Collective action and leadership

Through collective action women were able to overcome their disadvantaged position in the community and hold their local governments more accountable. This phenomenon was more in operation in the post-conflict setting than in the non-conflict setting. Women in these communities were educated on their rights and taught advocacy skills by a number of rights based organisations. Circumstances in that context had already thrust many of these women into leadership roles; many were widows and single mothers and had become breadwinners and decision makers in their respective communities.

Information asymmetry

A lack of appropriate information about the maternal health services available in the local health facilities was fuelling the poor relationship between the community and health workers. This was particularly noted in Northern Uganda. Similarly lack of proper information on family planning and its side effects amongst others was affecting the uptake of Family Planning products in both regions. In East Central Uganda the communities being less willing to discuss the performance of their health providers was in itself an expression of a lack of awareness of their rights.

Poor quality of care

Health worker attitudes were a key factor limiting the utilisation of health care services. Their attitude was influencing the use of reproductive health care services and was driving the adolescents away from reproductive health care. It was also influencing the delivery choices of women in both Northern and East Central Uganda and was deterring the involvement of men. The non-availability of ambulance services was also delaying the referral process and access to health care.

Cost of accessing care

The communities of Northern Uganda and East Central Uganda were desperately poor and the potential costs of accessing maternal health care in the government

health facilities were driving many away. The improved utilisation of maternal health care services following the free provision of mama kits to the different communities attests to this (*Sec 6.2.2.*).

7.5.6 Discussion - Community relationships

This study established that communities played a significant role in maternal health care governance in Northern and East Central Uganda. Governance at this level and the variance of its consequences on maternal health care utilisation in the two regions was associated with the levels of community cohesiveness and the role of politicians, women and civil society. These associations are discussed below.

Community participation social capital and cohesion

Village health teams, community budget monitors and health unit management committees are the more formal forms of community participation that were discussed by the interviewees in this study. Both post-conflict and non-conflict regions of the country were suffering from a lack of support to these governance structures by government. The lack of support had in turn led to the health unit management committees in Northern and East Central Uganda suffering local elite capture. The representation of women in the health management unit committees was limited. In Northern Uganda, the perks of being a committee member included sitting allowances made available by donor agencies as well as the prestige that the position carried. In East Central, probably more than in the North, given the absence of donor funding, the other attraction that came with the position was the opportunity for graft.

Political interference of health management committees is a universal challenge as documented in a systematic review by McCoy, Hall and Ridge (2012). A Kenyan study by Sohani(2005) recognises that it is particularly HUMCs serving the most vulnerable communities that are taken over by patronage networks; the most vulnerable have the least capacity to question the action of their leaders. This reflects my findings in both settings. Another study by Kaseje, Sempebwa and Spencer (1987) also identifies the exclusion of women and the poor from health unit

management committees and this is recognised to have had a profound effect on their impact on improving maternal health care.

The role of civil society and government in protecting the HUMC cannot be overstated. A study by Iwami and Petchey (2002) in Peru associates effective community-led health management committees with strong support by non-governmental organisations in the South American setting. In Northern Uganda, HUMCs that had gained more frequent support from the donor agencies had probably enhanced the quality of health service delivery in those health facilities. While funding was a key driver here, the close supervision and capacity building offered to the HUMCs by the donor agencies were key for the HUMC successes registered.

Village health teams in both regions appeared less attractive for the male folk and enjoyed a greater participation of women. They were positions that were considered less lucrative and had suffered less from elite capture. That women were willing to work in a less lucrative VHT role drew my attention to a meta analysis of experimental research on gender economic preferences by Croson and Gneezy(2009). The collections of field and lab-based research showed that women were more risk averse and altruistic, making them less likely to adopt corrupt undertakings. Boehm (2012) additionally recognised that women were more sensitive to social cues and in their societal interactions tended to draw upon their maternal instincts – probably a reason why they were attracted to taking up the VHT role. It was a more caring role as opposed to the HUMC position that was more managerial and assumedly recognised by that society as better suited for men. Just as was the case with the district councils, women in the community were subdued by societal expectations to limit their leadership ambitions.

Community budget monitors were another group of community volunteers that had proved more effective in Northern Uganda where rights-based NGOs were more active. It was clear from my findings that vulnerable communities were able to effectively participate in holding government accountable if their rights to do so were upheld and promoted: i) by government; ii) by organised civil society; iii) and

by the propagation of social “*connectedness*” within the communities themselves (McCoy, Hall and Ridge, 2012; Kenny *et al.*, 2013). I contend that an absence of these conditions was more expressed in East Central Uganda. Social capital that could have been harnessed to improve maternal health care was lacking in that setting. Below I briefly examine the decline of social cohesiveness and social capital and later I will consider the self-censorship of advocacy and rights focused NGOs in the East Central region relative to those in the North.

Loss of social capital

A recent study by Hollard and Sene (2016) on social capital and health in sub Saharan Africa using self-reported trust as a proxy measure for social capital shows a causal association between the level of engagement of community and the quality of basic health care in the catchment area.

In East Central Uganda the lack of social cohesion and the resultant limited availability of social capital was exemplified by the failure of the communities to galvanise each other into responding: i) against corrupt and incompetent health workers; and, ii) against local politicians that diverted resources away from the rehabilitation of their maternity units. Putnum (1995) postulates that the loss of cohesion within these peaceful communities may be part of a “*generational phenomenon*” that is gripping rural communities across the globe. For such settings, a decline in agricultural cooperative movements, unemployment and an enhancement of urban influences are postulated to play a role (World Bank, 2011; Kenny *et al.*, 2013). In peaceful East Central Uganda the privatisation of agricultural produce marketing and the decline in cooperative movements as well as ever-increasing urban influences is evident.

A decline in social cohesiveness in Northern Uganda was revealed by the failure of the peace agreement, the land disputes that followed the return process, the high levels of alcoholism and sexual and gender based violence. Social research has for long associated war and displacement with such decline in social cohesion (World Bank, 2011).

However this study seems to suggest that compared to what was happening in East Central Uganda, there was some level of resilience amongst the communities in Northern Uganda³². This ensured that a level of social cohesion in the communities was retained. It is possible that advocacy work by NGOs in the communities contributed to this. A DFID sponsored evaluation of the impact of the PRDP points to social cohesion being one of the programmes gains (International Alert, 2013). Nevertheless this community spirit was yet to cause a palpable impact on maternal health care.

The politician – community relationship

A key concern that was raised by the study respondents in East Central Uganda was the vote-buying taking place between local politicians and voters. However, I noted that the politicians were still under pressure to demonstrate that they had delivered some level of development to their respective constituencies. The erecting of Health Centres II's or classroom blocks were popular choices. These health units were often unable to provide maternal health care services due to a lack of equipment and health workers (see *Section 5.3.3.*).

Much of my discourse in this chapter with respect to the politician-community relationship appears to align itself with the Traditional Public Choice theory promoted by scholars like Gwartney and Wagner (1988), suggesting that in democracies (and even in dictatorships) the “*will of the majority*” is correct but often goes unheeded because politicians have “*agency problems*” created by their desire for political and economic gain.

However, I find the community and the politicians culpable for the poor health system governance and its consequences on maternal health care. As was mainly manifested in East Central Uganda, the electorate through the ballot had the capacity to influence local politicians to heed to their choices. Their voting actions were driven by imperfect knowledge. These imperfections were in turn informed by traditional norms – gender norms - that disregarded the critical health needs of

³² Here an important assumption is being adopted in making these deductions: there was no ethnically based difference that could have contributed to the differences in social cohesion recognized.

pregnant women as was exhibited in this study. Misinformation about the health centre II's functionality and the ubiquitous nature and permissiveness of corruption in society - the allure of "easy money" in the face of widespread poverty - were contributors to the community's choices.

An alternative argument promoted by Caplan and Stringham (2005) about Public Choice supports the preceding argument. Based on the work of Ludvig von Mises, it presupposes that the course of a nation's policies, democracy and dictatorship alike, are influenced by economic ideas propagated by public opinion that is often flawed or misinformed (Mises, 1998 cited in Caplan and Stringham, 2005).

A field based study conducted in Indonesia by Shin (2015) to explain the persistence of patronage in poor settings also speaks to my preceding arguments. He found that when both patronage and policy options were offered to poor less educated voters, they tended to demand patronage exemplified by money or jobs over national programmes like free education and universal health care coverage. Further more Teorell (2007) whose work I discuss in Chapter 2 section 2.4.2 uses a similar argument: she proposes a "demand side" explanation for the paradox of corruption, recounting an interesting scenario in Victorian Britain where voters reportedly put out adverts in the papers seeking a third political candidate in the hope of "*creating a contest that would raise the gifts and treatments distributed by the candidates to the voters*"(pg.7).

Through this latter argument, the drawing away of meagre public funding from the revamping of maternal health services due to the flawed nature of public opinion in East Central Uganda is perceivable. Similarly, the role of the PRDP and civil society in moderating the flawed nature of public opinion in relation to maternal health care in Northern Uganda is also perceivable, though the presence of extra funding from the PRDP and other donors buffered any irrational choices that were made. Additionally, NGOs worked to enhance the community's awareness about their real needs, which included maternal health care.

Gender roles

Though the cultures of North and East Central Uganda have different foundations, they both adhere to enduring patriarchal norms. As this study suggests, during the immediate post conflict period, there were signs of an enkindling of community level empowerment amongst women but more so in Northern Uganda. This had the potential of influencing both the demand and supply sides of maternal health care. I recognised this empowerment being manifested through two distinct paths: the non-traditional and traditional.

In the non-traditional path, the enhanced exposure to a more contemporary lifestyle through education, commerce and the media was influencing a change in attitude amongst the women and men in both regions. This study shows that in East Central region women are partners in ensuring a household income and on this premise gained greater say in their childbearing choices. My findings resonate with research by Sorensen (1996) conducted among rural households in East Central Uganda. She determined that following the privatisation of crop marketing; there has been a loss in distinction between the male-controlled cash crop farming and female-managed subsistence farming. With this came greater autonomy and bargaining space for women that cut across all aspects of their lives including their reproductive health choices as shown in this study. This privatisation came as part of the economic reforms that the NRM government ushered into place. This same narrative applies to parts of Northern Uganda that were less affected by the war.

This study did not find strong evidence of transitions in tradition that were a premise for women empowerment and enhanced maternal health governance during the post conflict period. However, the incident where elderly rural women used unorthodox means to successfully save their ancestral land was a harbinger of the powerlessness of a male-dominated traditional institution that was giving way for women in the traditional setting to get into headship. An important double take on this issue is that these elderly women by tradition could not hold legal claim over customary land. That these elderly women were willing to humiliate themselves

over land that they could not own showed the sense of duty they felt for their kin. I argue that this was a measure of social cohesiveness.

Civil Society in post-conflict and non-post conflict environments

There was a difference in approach that the CBOs and NGOs in each sub region used to address the needs of the community. The study shows that it was greatly determined by the power relationships that these organisations had first with government at national and sub national level, and secondly with the donors.

In regard to Northern Uganda, and as observed by Dolan (2006) during the conflict international NGOs working in the area actively abstained from addressing human rights issues; their funders the Western donor states and multilateral agencies were supportive of the military approach adopted by government. However, my study shows that during the post conflict period, as the Government elaborated a human rights focus as part of PRDP's first strategic objective it paved way for the numerous international and national NGOs that moved into the region to address rights-based issues as part of the recovery effort.

There were comparatively fewer NGOs providing support to the supply-side of maternal health care, and many were aligned to supporting HIV programming³³. Maternal health care was often an adjunct to their interventions: most supporting the HIV/PMTCT component of maternal and child health (Patel *et al.*, 2009; Casey *et al.*, 2013).

East Central Uganda's provides a comprehensive picture of the government-CSO relationship in Uganda outside the realms of Northern Uganda's civil crisis. The lack of engagement in advocacy and human rights issues portrayed self-censorship taking place. In this regard, I argue that supporting the supply-side and the avoidance of politically contentious issues was a more viable option for both local and international NGOs working in the region. Dicklitch (2002) states that in

³³ The NGOs include UNICEF, World Vision, Marie Stopes, Reproductive Health Uganda, The AIDS Support Organisation, the JSI/Northern Uganda Malaria AIDS and TB programme, Baylor College of Medicine HIV Programme and the AVSI Foundation. All of these except AVSI were covering HIV, TB, Malaria and OVC programmes.

Uganda political repression and harassment of the more vocal NGOs has for long sent a message to the rest to stay within the bounds of what is politically acceptable. She further notes that most NGOs have resigned to taking on the role of “gap filling”, covering up deficits in the privatisation and social service delivery by government and international NGOs(Dicklitch, 2002, p. 215). My findings speak to this.

The smaller CBOs in East Central Uganda were not spared of this self-censorship. The disappointing response of government to the efforts of the community budget monitors in this predominantly ruling party leaning region spoke to this. In contrast, the CBOs in the North appeared to have political clout, exposing graft and on occasion summoning the area Member of Parliament to attend community meetings. Many of these districts in the North were strongholds of the political opposition that often accused these CBOs of being agents of the state.

CSOs in Sri Lanka have experienced strikingly similar challenges. Orjeula (2005) details the long standing uneasy relationship that the Sri Lankan government has had with both local and national NGOs. As they engage in reconstruction and peace building, NGOs have been accused of being partisan and siding with the rebel groups in the North and East of Sri Lanka. They have regularly been subjected to acts of intimidation by national and district level government functionaries. A number of rights-based NGOs have closed down as a result.

7.6 Summary

The governance factors that influenced maternal health care service utilisation outcomes during the immediate post-conflict period in Northern Uganda and East Central Uganda can be conceptualised as being generated by stakeholders situated at four levels: central government; central health ministry; district local government; and, community level. These factors were of relevance to both regions during the post conflict period. The period coincided, with the aftermath of the first multiparty general elections.

At Central Government level the President, the technocrats in the health ministry and International Finance Institutions had forged an alliance that had dictated an

overarching policy agenda that consistently featured in all national and sector specific policies. The agenda focused on maintaining security, infrastructure development and rapid economic growth; however the model continued to give health care low prioritisation. Northern Uganda's PRDP that was championed by the country's President also embodied this development model; the health sectors secondary prioritisation was a feature. Pressure on government to improve funding for maternal health was often channelled through women parliamentarians. Their legislative actions led to occasional boosts in funding for maternal health needs nation-wide. However, they did not draw attention to the special maternal health needs of Northern Uganda's resettling population.

The central health ministry was side lined in the Government's pursuance of its development agenda. MOH was divested of important responsibilities, limiting the governance role that it could have had in advancing maternal health care nationally. MFPED's stringent control over health care spending made planning and implementation of health sector programmes difficult. However, if the ministry were given additional authority there is no certainty that this would have benefited the post-conflict region. The ministry was perceived to lack the technical capacity to equitably address the unique challenges to maternal health in Northern or East Central Uganda.

At decentralised levels, health service delivery was greatly influenced by local political patronage and power struggles between the local politicians and district technocrats. The presence of donor and PRDP supported programmes had watered-down these influences upon Northern Uganda. Unlike Central Government where women had spearheaded campaigns for better maternal health care, the district women politicians were not playing effective roles. Gender mainstreaming had not permeated the decentralised local governments.

Reproductive health care services were inadequately provided in both regions mainly due to: a lack of human resources in Northern Uganda; and, absenteeism of health workers in East Central Uganda. The effective harnessing of donor and the

PRDP programme funding in some districts in Northern Uganda had helped to ameliorate their human resource challenges.

There was effective community volunteerism in Northern Uganda that was more supportive of maternal health care as compared to East Central Uganda. Again in Northern Uganda, there was evidence of stronger women activism but it was still weakly harnessed for maternal health. Civil society had played an important role in supporting this collective action. This was less the case in East Central Uganda where civil society found it politically expedient to stick to supporting the health system supply side. District politicians and the community were engaged in a patronage relationship that did not augur well for maternal health care. This had a more overt impact on East Central Uganda where community activism as well as CSO, donor and PRDP support was not available to play a mitigating role. Unlike East Central Uganda, the end of conflict presented health system governance stakeholders at each level an opportunity to address Northern Uganda's special needs.

Political patronage, an adherence to an economic development model that gave health care secondary prioritisation and the persistence of retrogressive gender roles were some of the factors that deterred the governance stakeholders from harnessing these opportunities for maternal health in Northern and East Central Uganda.

7.7 A reflection on the research methods

This study's main focus was health system governance and its relationship with the state of maternal health care during the immediate post-conflict period in Northern Uganda in comparison with East Central Uganda. As already mentioned in the Methods chapter, having worked in Uganda's health system my positionality had significant influence on my approach to answering the research question (Section 4.8). My positionality also gave me a head start in being able to identify suitable data sources. The probing and iterative processes thereafter were also grounded in my prior understanding of the environment.

I found the Political Economy Analytical approach appropriate; it provided a way of studying governance, one of the six building blocks of Uganda's health care system. Through this approach I was able to focus on the political policies, economic processes and social institutions that were probably critical determinants of maternal health care reform in post conflict Northern Uganda but yet the least considered.

By incorporating East Central Uganda as a comparator, the regional nature of the Northern Ugandan conflict and the overriding national level contextual issues at play were incorporated into the study. The approach first and foremost questioned the assumption that non-conflict Uganda was doing better than the conflict parts of the country. It then made possible a deeper understanding of *how* and *why* the inequities existed between the two settings. It also afforded the study an opportunity to determine broader governance issues that were generalizable and comparable with studies conducted elsewhere. Using framework analysis to ensure rigorous qualitative analysis was a vital component of this PEA approach and augmented the induction process, the generation of new themes. The special role women in leadership played in enhancing maternal health care was one of those themes identified through this process.

I argue that for this study's question the opted approach held important advantages as compared to other methods that have been applied in the analysis of governance. Good governance framework methods, for example, those used by Siddiqi et al (2009) and Cleary, Molyneux, and Gilson (2013) emphasised the *a priori* application of Good governance elements to accessing the performance of governance stakeholders. Cleary, Molyneux, and Gilson (2013) focused on accountability and transparency and through this were able to study the accountability mechanisms at work at PHC level. However, my contention was that while this would have been a suitable approach to understanding the governance relationships between each of the key levels within the contrasting contexts, my evaluation went further into exploring other governance-related drivers as well, their "*hows and whys*" and their peculiarities in each of the two contexts.

The Kingdon Three Streams model(1985) was another attractive option that could have been applied to this study. The convergence of the politics, policies and processes “streams” and the “window of opportunity” are concepts easily recognised in the dynamics that I explore. However, I contend that the model is limited because it only addresses the *how* component of the research question. The PEA goes further to consider power relationships and incentives that led to particular decisions and actions by the governance stakeholders, that is, the *why* component. Furthermore, Kingdon’s model would not have addressed the policy implementation issues at the decentralised level.

One other strength in my study was the triangulation of policy analysis with the PEA. The policy analysis enriched the PEA’s assessment of contextual factors and made it possible to correlate the policy development trajectory with parallel political, economic and social trends that were taking place at the same time.

Finally, the structured approach that the PEA provided for evaluating maternal health care governance in post conflict Northern Uganda made possible the identification of critical but yet often abstract governance issues that were amenable for reform if Uganda was to build a more equitable health system.

7.8 Limitations and constraints

7.8.1 Methodological limitations

Health systems

The study is premised on the WHO health systems framework that recognises governance as one of the six systems elements. Given that all the system components contribute towards its performance and outcome, analysing the relationship between governance and the utilisation of maternal health care was wrought with interpretation challenges. Many of the interpretations being attributed to governance may have therefore been confounded by significant contributions from the other health system components.

Retrospective data

One major concern here was the deterioration of data due to recall bias. However as I discuss in the methods section, there was a higher likelihood of gaining reliable data where the topic was associated with health service usage and health related events (Dex, 1995). To enhance the data collection process, as discussed in the methods chapter: I collected the recall data by use of open-ended questions that encouraged narrative style responses on governance and health care; I identified the end of the war and the 2006 general elections as points for recall; and, the retrospective questioning occurred more in the in-depth interviews that sought detailed information about health system governance and maternal health care during the immediate post conflict period. The focus group discussions addressed more attitudinal issues and entertained responses to questions about governance and maternal health care that were even in the present.

The Comparative method and subnational analysis

During the evaluation and later during analysis, on occasion I got the impression that cultural differences between the communities of Northern and East Central Uganda were influencing their perceptions, attitudes and actions. However, I did not engage in ethnographic studies in this analysis. Sorensen (2008) suggests that, accounting for the actions of a culture by using the logic of this culture ³⁴ in a comparative analysis may compromise the quality of the conclusions.

However, I applied methodological considerations advocated for by Marcus (1995), Yanow (2014), Jacob (2015) and others to account for any of the cultural differences between Northern and East Central Uganda.

Firstly, I noted that the study population in Northern and East Central Uganda had important commonalities; this was the basis of their selection. Both populations were rural and predominantly agriculturalists. Furthermore, the two regions are governed by the same national government and served by the same national health

³⁴ or in other words “*ethnographic view from the inside*” (Sørensen, 2008, p. 315)

system. These areas of similarity acted as anchors or grounding for the study or, as described by Sorensen (2008), were a *tertium comparationis*.

Limitations of depth

Still related to the issues raised in the section above was the recognition that in answering the research question of this study, I had to delve into the governance influences at national level and at sub national level in Northern Uganda and East Central Uganda and the perspectives of multiple actors from different echelons of society. This posed as a constraint on the depth of information that could be obtained from the different sources given the limitations in time and financial resources. Additional key informant interviews and focus group discussions could have been conducted as part of iteration, but this was not possible. However, triangulation with data obtained from the policy document review as well as important input from my unique positionality bolstered the effort to maintain credibility of results obtained and eventually interpretations and conclusions made.

7.8.2 Data collection limitations

Location of interviews and FGDs

The focus group data was collected from within health facility grounds in most cases. It was only in Nwoya district where I met with the different focus groups outside the health facility grounds. It was in Nwoya district where the strongest remarks were made regarding poor health worker attitudes. It is possible that the paucity of data obtained addressing health worker attitudes in East Central Uganda was a consequence of the interviews being conducted within the hospital grounds. Some of the in-depth interviews did briefly discuss health worker attitudes.

Skype Interviews

My last three interviews were conducted via Skype voice calls. These were with interviewees that I was programmed to meet, but failed to do so due to conflicts in schedule. These interviews were all conducted when I was back in the United Kingdom. One of the interviewees was in Khartoum, Sudan and two in Kampala, Uganda. The lack of face-to-face interaction may have affected the quality of the

interview. However I considered them to be some of the more informative interviews conducted. This was understandable given that, as part of the iteration process, they were at the very end of the chain of interviews. The discussions were more focussed and more intended for corroborating data already collected. All the interviews were voice (not video) calls. Sullivan (2012) discusses the effectiveness of Skype interviews as a data collection method but cautions on the ethical issues. I was able to verify that though Skype occasionally collects data on Skype calls they are encrypted and protected from would-be hackers.

Historical policy documents

There were limitations in accessing policy documents of relevance. Some of the documents from the 1980s and 1990s were difficult to access. I relied on secondary documents that evaluated or reviewed these policies to understand their contents and their focus.

7.8.3 Limitations to the interviews

Information related to the actions of the political elite, the resource allocation methods of government, corruption, and the donor-recipient relationship were areas that would have gained from additional input. However, many of these issues were sensitive and a complete assurance of confidentiality could not be offered given the public nature of this document. The degree of discussion and probing during the interviews had to be deliberately measured.

I also had to give consideration to my own positionality in this issue. It was possible that many potential interviewees consented to doing the interview because they knew that I was the husband to a senior manager in the health sector. I was at pains to avoid putting such persons in the awkward position of discussing issues that were deemed critical of her office.

The donor agencies proved to have immense influence over policy decisions making at national and sub national level, often driven by their respective home country policies. However my study focused more on governance and policy decisions that

were generated by stakeholders at country level; so information on donor involvement is limited.

Constraints

The government employees that I interacted with have been sworn to secrecy by oath. This may have had an impact on the quality of information gleaned from this group of interviewees.

I have a limited understanding of the Bantu dialect used in East Central Uganda this may have impacted on detecting nuances in the responses obtained. However, I worked with an experienced health educator whose concurrent observations, accompanying comments and interpretations I took note of.

The districts that I visited in both regions may not have been representative of the rest. A case in point was the choice of the new district of Lamwo that I found to be an outlier, in as far as challenges that newly created districts were facing. However given my earlier preference for the contextual constructivism tradition as described by Freeman(2006) there was relevance in having purposively selected this district for investigation.

7.9 Conclusion

In relation to this study's research question, there were both positive and negative political, economic and social governance factors that influenced health system performance in the post-conflict and non-conflict populations of Uganda.

Political factors - The positive factors associated with health system recovery were the adoption of political pluralism, decentralisation of government and the creation of equalisation programmes for the post-conflict region. In my investigation, the PRDP was found useful for maternal health on two counts: directly by infrastructural investments particularly health worker accommodation; and, indirectly by the ability to neutralise the effect of political corruption that was rife elsewhere in Uganda.

Decentralisation had positive aspects; it provided a platform for health system recovery efforts to take place. The negative aspect of decentralisation was its proneness to local political patronage and local elite-capture. Where this occurred, particularly in East Central Uganda it diminished the gains of devolution. In Northern Uganda, these negative features were countered by the presence of donor funding and the PRDP as previously mentioned. This study identified secondary advantages of donor funding, it curbed on rent-seeking opportunities and enhanced the capacity of the communities to demand for better service delivery.

The creation of new districts had a predominantly negative impact on health system recovery. In my study this applied to both the post-conflict and non-conflict parts of the country. However the success registered in Lamwo district went to show that effective leadership, collective stakeholder action and donor funding could overcome financial and administrative challenges faced by these nascent districts.

Civil Society had a strong demand-side impact on health care in Northern Uganda; they had been given leeway by the State to pursue a rights-based approach to their work. This contrasted sharply with East Central Uganda where the weakness in demand-side action by civil society contributed to an equally non-satisfactory maternal health care outcome.

Socio-political Factors - From my study findings, I conclude that women leaders in parliament play an important role in promoting maternal health care. However the study also illustrates that the quota system stipulating greater representation of women in parliament also created power relationships that compromised the capacity of women leaders to address horizontal equity, in this case, between post-conflict and non-conflict regions.

Similarly, it is evident that the post-conflict setting provided a window of opportunity for rural women to participate in the improvement of health care. For Northern Uganda, unfortunately government and civil society did not harness this resource effectively for maternal health care.

It is again evident that the Ugandan society assumes that it is the role of women to address maternal health concerns. It is notable, however, that male politicians nationally and in Northern Uganda, in particular are participating in addressing maternal health.

Economic factors –The adoption of the pro-poor Poverty Reduction Strategy was useful for post war recovery, given its equity focus. However, in Uganda’s case the associated macroeconomic policies, particularly the application of budgetary ceilings in line with the MTEF worked against health system strengthening. The centralised, stringent control of health financing left the Ministry of Health incapacitated; maternal health policies could not be adapted to local context or implemented. This is exemplified by the 30% attainment of the *Roadmap for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality in Uganda policy* which MoH officials attribute to lack of reliable funding.

Political patronage and corruption are factors of growing importance in Uganda; my study suggests that they are more ubiquitous in the peaceful parts of the country than in the post conflict setting. In line with definitions by Teorell (2007) (see discussion in Chapter two, section 2.4) it is best perceived as an institution, affecting the participation of communities in improving their health care.

7.10 Contribution to knowledge

My contribution to the body of knowledge can be considered from a number of perspectives.

Firstly, the research question provides an opportunity to delve into the complex nature of policy and governance and their influence on a country’s maternal health status; in Uganda’s case, contributing to its inability to achieve MDG 5. Furthermore, Shaw and Mbabazi (2004) describe Uganda like many other fragile states as tending to show contradictory characteristics: exhibiting democratic developmental qualities in part, and features of a *failed* state in another. The role of politics and health system governance and particularly the lack of leadership in such unstable

and uneven environments in deterring universal health coverage are reflected in this study.

Secondly the Political Economy Analytical method may not necessarily be unique but its application in the comparative analysis of governance in contrasting sub national health systems, in this case with regard to exposure to conflict, is novel. The analytical methods, for instance show findings that are reflective of power relationships at different levels of governance each contributing to the provision of health care in complex national contexts. From this study I envisage important points or nodes that are amenable to change that policy makers and health planners should address if Uganda is to successfully attain to the new SDGs.

A number of assumptions and their implications on maternal health have been challenged by the findings of this study including: the finding of greater social cohesiveness in post conflict Northern Uganda as compared to East Central Uganda; and, the different roles NGOs have played in the two contexts of study. The important role women play in the provision of social services has also been affirmed by this study. The importance of leadership, as is exhibited by the district team in Lamwo District that used collective action to circumvent key governance challenges and improve maternal health care. These issues provide new knowledge but also raise questions for additional study.

In my contribution to knowledge, I am keenly aware that many of the findings are context specific; the generalizability to other contexts may be limited. However my review of relevant literature finds that countries that have similarly sustained conflict alongside development have made policy choices that have led to consequences that resonate with my findings. In this sense, I am validating the work of other researchers.

7.11 Recommendations

This study has highlighted political, economic and social factors that influenced health system governance and in turn affected the capacity, the versatility and resilience of the health system in affording equitable health care in both post

conflict and non-conflict Uganda after the Cessation of Hostilities agreement was signed between the Ugandan Government and the Lord's Resistance Army in 2006. From these factors, I have generated some recommendations for health system governance stakeholders at the different levels of governance to consider as the country strives to become a modern prosperous society by 2040 and as it works to achieve the SDGs by 2030. The findings also have wider implications on other health systems further a field - in nations that have suffered confined conflict.

National Level

Uganda's second National Development Plan 2015/16 – 2019/20 (NDPII) is recognised as Uganda's roadmap for addressing the SDGs. The document identifies the stagnation in the improvement of key national health indicators including those for maternal health and prioritises the health sector as one of its "development fundamentals" (Government of Uganda, 2015, p. 2).

To actualize the aspirations of the NDPII, the importance of national governance on the health sector should be recognised and made more conducive for positive health system performance outcomes. Institutions like the Uganda Law Review Commission (ULRC), academic think tanks and advocacy groups might be instrumental in identifying and advising the government on laws, policies and informal institutions that are stifling the development of the health sector and affecting its capacity to support the recovery of Northern Uganda. The Uganda Law Review Commission (ULRC) was set up through an Article of the Uganda's 1995 Constitution. It holds the mandate of studying and keeping under constant review the Acts, Laws and policies of Uganda with the purpose of making recommendations for their systematic improvement, development, modernization and reform. In this regard, the ULRC should pay closer attention to the constitutional bottlenecks that this thesis discusses that are affecting the health sector and are deterring the provision of equitable health care to all Ugandans given its diverse contexts.

Some evaluations that might be part of a health sector focused constitutional review may include: an evaluation of policies and laws that are disempowering women

leaders in the district councils; reviewing Uganda's electoral laws and the identification of areas that may be propagating the venal politician – voter relationship; and a reflection on the incessant creation of new districts and the impact this has on the health system in both post conflict and peaceful settings.

A review of the role women and men members of parliament play in addressing the nation's maternal health concerns might be important in harnessing their comparative advantages and in altering the manner that parliamentary business is conducted in this regard.

There is also a need to review the power imbalances among the political elite; the role of the Ministry of Finance and the legislature in determining health policy funding and implementation requires revisiting. In the same vein, the ULRC and other related institutions should be key in evaluating the implementation of the Budget Act of 2001 and determining why the legislature continues to play a limited role in seeing national budgets through to implementation.

Northern Uganda's health sector was apparently unable to gain maximally from PRDP projects. According to this study this was a reflection of poor collaboration between the Office of the Prime Minister and the Ministry of Health. There is need to set mechanisms that ensure that similar equalisation or rehabilitation programmes clearly stipulate the roles of each line ministry in the planning and implementation of such programmes.

Uganda in 2007 launched its Vision 2040 policy document whose vision statement is to operationalize the transformation of the nation from a peasant to a modern prosperous one within 30 years. In support of this aspiration, there is need to reflect on the government's prioritisation of health sector development, from this study's findings there is a need to break away from the secondary prioritisation of the health sector that has characterised the last 30 years of NRM rule.

The work of donor and implementing agencies has had a spin-off effect, buffering health sector development in the post conflict-setting from the ill effects of political patronage and bureaucratic corruption. The limited number of development

partners in the non-conflict setting and unchecked political corruption that has been rife in these peaceful parts of Uganda appears to be associated and stand out in sharp contrast to the situation in Northern Uganda. Both government and development partners should be cognisant of this important monitoring role that the partners play. Development agencies should both consider avenues of harnessing this protective role further as support the implementation of government health policy in disrupted environments.

Health Ministry Level

This study highlighted a lack of coherence between the more politically orientated overarching health sector policies, (for example, the Health Sector Strategic Plans and National Health Plans) and the technical strategic plans and guidelines. While the health sector strategic plans reflected national aspirations for equitable health care in both post-conflict and non-conflict settings of Uganda, the technical policy documents did not reflect strategies to achieve this. As efforts are made to attain universal health coverage the health sector's political heads and technical managers need to harmonise health policy writing, adoption and implementation. There is also need to review the role that the health ministry plays in Primary Health Care. From this study it is evident that the partial control that the health ministry has over important health system components, for example, human resources for health, training of health worker and finance needs to be revisited. This has clearly impacted on the implementation of policy at PHC level in the decentralised model of national governance.

Decentralised Governance level

This study has shown the crucial role that civil society plays in the development of the Ugandan health system. The independence of civil society that was better respected in the post conflict setting allowed NGOs to be more effective in strengthening health system governance and improving demand. It could be assumed that if peace in Northern Uganda persists, then the NGOs in the setting will begin to self-censor their activities as they experience growing intimidation and

obstruction, as is the case in East Central Uganda. There is an urgent need for the NGO umbrella organisations (for example, the National and district level NGO forums) to step-up the call on government to adhere to its obligations under both national and international law that uphold and promote the rights of all citizens to have the freedom of expression, association and assembly. It is notable that a report on the status of NGOs in Uganda by Human Rights Watch makes similar, albeit less sector specific recommendations (Human Rights Watch, 2012).

This study highlights important contrasts in the leadership role that women in the community played in the post conflict as compared to the non-conflict setting. There is need to conduct ethnographic evaluations to determine these differences were influenced by culture or by conflict.

Corruption is indeed an institution that is influencing and at the same time is fuelled by both formal and informal institutions in Uganda. Studies that can inform governance stakeholders on the strategies at national, district and at community level that could curb corruption will be important contributors to the enhancement of health system performance and health care utilisation.

Wider Global Recommendations

Other nations, other than Uganda, that have suffered conflict, and particularly confined conflict, are also signed up to achieving the Sustainable Development Goals by 2030. This study points to governance gaps within countries facing the dual context of peace and war which, if addressed would enhance the versatility and resilience of these fledgling health systems to equitably address the differing health care needs across the nation. My study's findings are of primary relevance to decision makers in International Financing Institutions, Development Agencies and academicians involved in global health and development research, as well as governance stakeholders primarily in countries that have been affected by confined conflict as well as fragile states in general.

International Financing Institutions (IFI's) and Development Agencies need to recognise and harness the critical influence that they have on leadership in central

government and within the different levels of governance in the health system in these nations. This study shows that other than providing critical financial and technical support these institutions play a another role of providing a protective influence over recovering health systems shielding them from the ills of political patronage and corruption within national and sub national institutions. This protective role also works to guarantee the health systems with space for better policy making and implementation amongst others. This study indicates that IFI's influence governance and hence post conflict health system recovery predominantly from the privileged power relationship they hold as part of the policy elite at central government level. The Development Agencies have an impact on health system governance the relationships with the leadership at the Ministry of Health and at sub national level where they engage district administrative teams and civil society organisations. Collaboration between different agencies with a view to harnessing this power relationship focused at improving health system governance will promote health system recovery.

The role of health ministries in fragile states in adapting policy documents to the different national contexts is an area that requires further research. Inquiry is required in determining how international health agencies influence health policy and how are these policies are being adapted to different national contexts with respect to war and peace.

Many conflict-affected nations, like Angola, Mozambique, Sri Lanka and others, are beneficiaries of the post-conditionality approach to donor funding. I alluded to this previously in section 7.1.6. In line with the tenets of the Paris Declaration on Aid Effectiveness, national governance stakeholders have a greater say in the use of donor aid. This study indicates that contextual political, economic and social factors that fomented the confined conflict in the first place still play a role in the policy paths opted for as regards health system recovery. Research has to be conducted evaluating the post conflict recovery actions across such nations, determining whether there was a pattern in the governance paths taken with regard to health system recovery and how this influenced equity. The relevance of the Paris

Declaration on Aid Effectiveness should also be evaluated to ascertain whether it remains ideal for the nations with the dual contexts of post conflict and non-conflict.

This study indicates the need for a more in-depth inquiry into the leadership role played by women in health system recovery in the fragile environments and further more where polarisation in society is manifested by confined conflict. My study indicates that while international edicts have provided for the empowerment of women globally national governments in the fragile states might not have ensured the permeation of gender mainstreaming throughout the national and sub national governance structures. This lack of effective women leadership might be a missed opportunity for health system recovery in the conflict affected states and also a missed opportunity for addressing health care equity where there has been confined conflict. More evaluations have to be conducted to ascertain whether this is the situation pertains to similar settings across the globe.

The reversed roles of civil society in supporting the health system in the dual national context of post-conflict and non-conflict requires further evaluation in countries that have similar contexts to Uganda's. Similar findings will imply the need for a greater call to international action for the protection for civil society from the political machinations of the state not only in the recovery settings of a nation but also in those settings that have been at peace.

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9 Appendices

Appendix I - Uganda Research Approval

Appendix II - Sample of Letter of Introduction

Appendix III - Maternity Wards in East Central and Northern Uganda

Appendix IV - Topic Guide National Level In-Depth Interviews

Appendix V – Topic Guide Sub national Level In-depth Interviews

Appendix VI – Topic Guide Focus Group Discussion

Appendix VII - Screen Shot of StataSE of Do-file for Analysis of Secondary DHS data

Appendix VIII - Screen Shot from Nvivo 10 – Thematic Analysis - I

Appendix IX - Screen Shot from Nvivo 10 – Thematic Analysis - II

Appendix I - Uganda Research Approval



Uganda National Council for Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

15/05/2014

Our Ref: HS 1600

Dr. Andrew Alyao Ocero
School of Women and Gender Studies
Makerere University
Kampala

Re: Research Approval: Equity in Maternal Health Care Services in Post-Conflict Northern and Non Conflict East-Central Uganda: A Comparative Mixed Methods Multi-Case Study

I am pleased to inform you that on **05/05/2014**, the Uganda National Council for Science and Technology (UNCST) approved the above referenced research project. The Approval of the research project is for the period of **05/05/2014** to **05/05/2015**.

Your research registration number with the UNCST is **HS 1600**. Please, cite this number in all your future correspondences with UNCST in respect of the above research project.

As Principal Investigator of the research project, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the research protocol or the consent form (where applicable) must be submitted to the designated local Institutional Review Committee (IRC) or Lead Agency for re-review and approval prior to the activation of the changes. UNCST must be notified of the approved changes within five working days.
3. For clinical trials, all serious adverse events must be reported promptly to the designated local IRC for review with copies to the National Drug Authority.
4. Unanticipated problems involving risks to research subjects/participants or other must be reported promptly to the UNCST. New information that becomes available which could change the risk/benefit ratio must be submitted promptly for UNCST review.
5. Only approved study procedures are to be implemented. The UNCST may conduct impromptu audits of all study records.
6. A progress report must be submitted electronically to UNCST within four weeks after every 12 months. Failure to do so may result in termination of the research project.

Below is a list of documents approved with this application:

	Document Title	Language	Version	Version Date
1	Research proposal	English	N/A	April 2014
2	Study tools	English	N/A	N/A
3	Informed Consent	English	N/A	N/A

Yours sincerely,

Leah Nawegulo Omongo
for: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

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P. O. Box 6884
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TEL: (256) 414 705500
FAX: (256) 414-234579
EMAIL: info@uncst.go.ug
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Appendix II - Sample of Letter of Introduction

TELEPHONE: General office
340874/231563/9
PSC's office: 340872
TELEFAX: 231584
TELEX: 61372 HEALTH UGA.



MINISTRY OF HEALTH
P.O. Box 7272
KAMPALA,
UGANDA

In ANY CORRESPONDENCE ON
THIS SUBJECT PLEASE QUOTE NO. ADM. 103/202/01

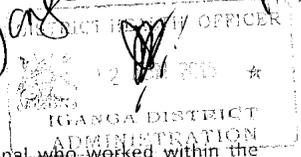
5th June, 2014.

The District Health Officer,
Iganga District Local Government
Dr David Mwangizi

I Received & approved to attend Iganga Hospital & Namagale Health

Dear Sir/Madam,

Re: Introduction for PhD Student Researcher



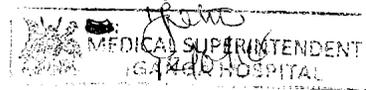
This is to introduce **Dr Andrew Alyao Ocero**, a health professional who worked within the Ugandan health system for about 17 years but is now a PhD student in Health Economics and Health Policy Research at the Liverpool School of Tropical Medicine in the United Kingdom.

Dr Ocero has approached this office for support to conduct his PhD study titled, "*Equity in Maternal Health Care Services in Post-conflict Northern and Non-conflict East-Central Uganda: A Comparative Mixed Methods Multi-Case Study*" His research protocol has been reviewed by the Institutional Review Board in Liverpool and approved by the Uganda National Council of Science and Technology.

Dr Ocero's study aims to "*evaluate the performance of the health system and the health policies that afforded maternal health care to the post-conflict population of Northern Uganda during the immediate post-conflict period, 2006 till 2011,*" making comparison with the health system performance in East Central Uganda, a setting that did not suffer from the LRA conflict and was therefore not considered post-conflict during the time period covered by the study.

Initially, he will conduct costing evaluations at selected lower level health facilities that provide maternal health care. This will involve assessments of historical inventory and audit records for the years 2006 and 2011, and where required physical inventory exercises as well as key informant interviews with in-charges and heads of departments of selected health facilities. At a later phase interviews with key maternal policy stakeholders in the districts of Gulu, Lamwo, Apac, Kole, Luuka and Iganga will be undertaken.

II Received & approved.



Appendix III - Maternity Wards in East Central and Northern Uganda



Figure 9.1: Damaged HC IV - East Central Uganda



Figure 9.2: New HC III - Northern Uganda

Appendix IV - Topic Guide National Level In-Depth Interviews

1. What was the maternal health policy landscape like during the post conflict period in Northern Uganda?
 - A. What were the key policies driving maternal health care in Northern Uganda, in the country.
 - B. Who were the more influential actors at the time in Northern Uganda?
 - C. What were the drivers of policy change if any and what determined successful implementation?
 - D. Were there specific national efforts to address the maternal health care needs in Northern Uganda?
2. What was your organization's role in policy formulation around the post conflict period? Who were the other actors that you interacted with?
3. What was your organizations role in policy implementation around the post conflict period? Who where the other actors that you interacted with and from what level of society?
4. What was your organizations governance role in in maternal health service delivery at national level and in Northern Uganda specifically?
5.
 - A. What their any preferential support for the post-conflict population and if not, why not?
6. How successful was the effort to improve maternal health care over the post conflict period? Is maternal health in Northern Uganda better off today than it was at the end of the war? How does the state of maternal health in Northern Uganda compare with the rest of the country?
7. From a gender perspective what role did men and women play in policy formulation and policy implementation during the post conflict period?
8. What were the missed opportunities in the formulation and implementation of maternal health policy during the post conflict period?
9. Given a similar occurrence of conflict and cessation of hostilities as occurred in Northern Uganda, would you have a different approach to addressing maternal health needs in Uganda and in Northern Uganda in particular ?

Appendix V - Topic Guide Sub-national Level In-Depth Interviews

1. What was your organisations role in maternal health care governance?
2. What was your role in that organisation?
3. What were the key challenges faced in providing maternal health care services during the period 2006 to 2011 (immediate post-conflict period - Northern Uganda or immediately after the 2006 General elections – East Central Uganda).
4. Was there any change in the approach to providing maternal health care services during this time frame? What were the key drivers for these changes?
5. Are you aware of any national policies, general health policies or specific health policies that influenced maternal health care service delivery? Did they?
6. Who are the other stakeholders at district level that you related with in supporting maternal health care during the timeframe 2006 to 2011?
 - a. Describe the supportive relationships and the impact on maternal health care
 - b. Describe the challenging relationships and the impact on maternal health care
 - c. What was the role of the community in improving maternal health care
7. What do you think could be done to improve the collaboration of the different stakeholders to improve maternal health care services in the district?
8. How was the budgeting process conducted at district level? Which stakeholders participated and how did they influence the outcome of the budget planning process? Was maternal health care catered for in the planning process?
9. How were health sector grants managed by the district local government? How were the disbursements prioritised? Who had a say in the final funding choices made?
10. How do you compare the role of the women and men at the different levels of governance? Did they have equal influence on the maternal health care governance?
11. What would you do differently to address maternal health care given what you experienced or know?

Appendix VI – Topic Guide Focus Group Discussion

1. Introduction of topic - **Note:** set a time frame to the discussion in Northern Uganda by emphasizing period after the end of conflict. For East Central Uganda emphasize the period after the first multiparty general elections
2. What are kind of maternal health care services are available in this community?
3. What roles have you played in supporting access and utilisation of maternal health care in this community?
4. Who are the other stakeholders that you interact with that help/influence women to access and utilize maternal health care services?
 - a. Politicians; b. Health workers; c. District medical staff?
5. How has the provision and utilization of maternal health care changed ever since the war ended in 2006 (or since the 2006 multiparty general elections - East Central Uganda)?
6. What are the challenges women and men face in accessing and utilizing maternal health care services?
7. What do you think would make more women use maternal health care services?
8. What do you think will make the men folk support the utilization of maternal health care services?
9. What do you recommend for government to do to ensure better maternal health care services in this community

Appendix VII - Screen Shot of StataSE of Do-file for Analysis of Secondary DHS data presented in Maternal Health Statistics Review Chapter Three, Section 3.2.4

```

Education Status  maternal.do
use "C:\Users\Andrew\Documents\Datasets\2006\IndividualRecode2006\STATA\UGIR52FL.DTA", clear
use "C:\Users\Andrew\Documents\Datasets\2006\HouseholdMemberRecode2006\STATA\UGPR52FL.DTA", clear

keep caseid v000 v001 v002 v003 v004 v005 v190 m15* v024 m13* m14* m42* m43* m44* m45* m49* m57* m65* m66* m70* v401 v467* v2

describe
describe v0*
describe d11*

codebook

tabulate v024
tabulate v024 if v024==4 | v024==6

generate region = 0 if v024==4
replace region = 1 if v024==6
label define region 0 "East Central" 1 North
label values region region

tab region

*declaring data as survey data
svyset _n [pweight=v005], vce(linearized) singleunit(missing)

keep if v024 == 4 | v024 == 6
svy linearized : tabulate v190

*****
use "C:\Users\Andrew\Documents\Datasets\2006\HouseholdMemberRecode2006\STATA\UGPR52FL.DTA", clear
svyset _n [pweight=hv005], vce(linearized) singleunit(missing)

generate region = 0 if hv024==4
replace region = 1 if hv024==6

label define region 0 "East Central" 1 North
label values region region

tab region
*****Table 1: freq distribution summary
* Age
svy: mean hv105
svy: mean hv105, over(region)
svy: mean hv105 if (hv105 > 14 & hv105 < 50) & hv104 == 2 , over(region)
test [hv105] subpop 1 = [hv105]North

```

Appendix VIII - Screen shots from Nvivo 10 – Generation of Themes

The screenshot displays the Nvivo 10 software interface. The top menu bar includes Home, Create, Data, Analyze, Query, Explore, Layout, and View. Below the menu is a toolbar with icons for Open, Get Info, Edit, Paste, Copy, Merge, Format, Paragraph, Styles, Select, Find, and Delete. The main workspace is divided into a left sidebar and a central table.

SOURCES

- Internals
 - FGD
 - East_Central
 - North
 - InDepthInterviews
 - East_Central
 - National
 - North
 - Externals
 - Memos
- NODES**
 - Nodes
 - A_PeAs
 - All together
 - Cases
 - East Central Uganda
 - National
 - Northern Uganda
 - PEA
 - Node Matrices
- CLASSIFICATIONS**
 - Source Classifications
 - Node Classifications
- COLLECTIONS**
- QUERIES**

OPEN ITEMS

- Decision-Maker & Technocrat

SOURCES TABLE

Name	Sources	Referen...	Created On	Created By	Modified On	Modified By
Local	5	31	16 Jul 2015, 18:56	AAO	20 Dec 2015, 20:15	AAO
National	3	3	16 Jul 2015, 18:56	AAO	15 Nov 2015, 18:10	AAO
International	9	30	16 Jul 2015, 18:56	AAO	20 Dec 2015, 20:15	AAO
Politician	11	49	16 Jul 2015, 18:52	AAO	20 Dec 2015, 20:15	AAO
Women	2	8	16 Jul 2015, 18:52	AAO	20 Dec 2015, 20:15	AAO
AA - AF_Accountability (3)	1	1	16 Jul 2015, 18:52	AAO	15 Nov 2015, 18:10	AAO
Community	7	15	16 Jul 2015, 18:52	AAO	20 Dec 2015, 20:15	AAO
Decision-Maker& Technocrat	4	5	20 Jul 2015, 09:57	AAO	20 Dec 2015, 20:15	AAO
Health System	2	2	16 Jul 2015, 18:52	AAO	15 Nov 2015, 18:10	AAO
Central	9	22	16 Jul 2015, 18:52	AAO	19 Dec 2015, 05:53	AAO
District	7	14	16 Jul 2015, 18:52	AAO	19 Dec 2015, 05:53	AAO
Health Worker	4	6	16 Jul 2015, 18:52	AAO	20 Dec 2015, 20:15	AAO
Organisation	10	41	16 Jul 2015, 18:52	AAO	20 Dec 2015, 20:15	AAO
Politician	6	11	16 Jul 2015, 18:52	AAO	20 Dec 2015, 20:15	AAO
Women	1	1	16 Jul 2015, 18:52	AAO	15 Nov 2015, 18:10	AAO
AA - AG_Information (3)	1	1	16 Jul 2015, 18:52	AAO	15 Nov 2015, 18:10	AAO
Decision-Maker& Technocrat						

Summary Reference

1 reference coded, 2.59% coverage

Reference 1: 2.59% coverage

So that advocacy really helped and genuinely without any selfish interests or motives all members of parliament were unanimously supporting the cause. For example when the NAWMP women MPs came with the statistics of the women that die daily - and especially now when they now drew the analogy using a Kamunye... because the statistics was saying that everyday... or something like that... I think they talked of 12 ... no 14 ... or 20 die. And so the analogy was that everyday a kamunye full of women is crashing and killing all of them daily. You know that painted a very sordid picture with made people realize that there is problem.

BREADCRUMBS: NODES > Nodes > All together > AA - AF_Accountability (3) > Decision-Maker & Technocrat

Appendix IX Screen Shot from Nvivo 10 – Thematic Analysis

The screenshot displays the Nvivo 10 software interface. At the top, there is a menu bar with options: Home, Create, Data, Analyze, Query, Explore, Layout, and View. Below the menu bar are various toolbars for editing and formatting. On the left side, there is a navigation pane with sections: SOURCES, NODES, CLASSIFICATIONS, and COLLECTIONS. The 'NODES' section is expanded to show 'Northern Uganda' and 'Provider perceptions of community'. The main area shows a table of sources and a detailed view of a node with references.

Name	Sources	Referen...	Created On	Created By	Modified On	Modified By
Power dynamics	1	1	3 Jul 2015, 14:00	AAO	6 Jul 2015, 12:50	AAO
Provider perceptions of community	1	4	6 Jul 2015, 12:26	AAO	6 Jul 2015, 20:37	AAO
Public health needs a stenwise proce...	1	1	3 Jul 2015, 17:36	AAO	3 Jul 2015, 17:37	AAO

The detailed view of the 'Provider perceptions of community' node shows a 'Summary' tab and a 'Reference' tab. The 'Reference' tab displays the following text:

and to make them understand that they have problems is quite a process. 1

Reference 2: 2.09% coverage
 Maternal health has been a challenge because of: one also because of ignorance and then two; inadequate male involvement actually before 2-3 years back when we started bringing men on board but before there was lack of men involvement apart from having their partners with them. Once their partner conceives they don't feel part and parcel of the problem

Reference 3: 2.82% coverage
 Poor male involvement me I think culture plays a big role then two what I would put as there is a way men is ignoring their roles in the society like it could be because of women empowerment so you find that sometimes in a household a woman will earn more than the man; those are for people who are abit educated but for people who are down there in the villages culture has played a role then secondly also ignorance has played a big role and of course poverty, you can't run away from poverty

Reference 4: 5.22% coverage
 The poverty here would be like much as somebody wants to be part of this system but you find that the little they have because this is a mother; let me talk of somebody who is pregnant you tell them that pregnancy needs plan; these are people who don't plan in the home so when a woman is pregnant even if you tell them to put some savings for this pregnancy because each pregnancy has its own uniqueness; you don't say this one will be complicated and this one will not be complicated anytime the complication can come in even if the woman was still very ok so you find that for them instead of putting aside little savings they don't see that as a priority because they have many things to do so they prefer channeling funds for other things then another thing that has caused low male involvement is alcoholism in our area because most of them give priority to drinking than to mother and

The bottom status bar shows the current path: NODES > Nodes > Northern Uganda > Provider perceptions of community

