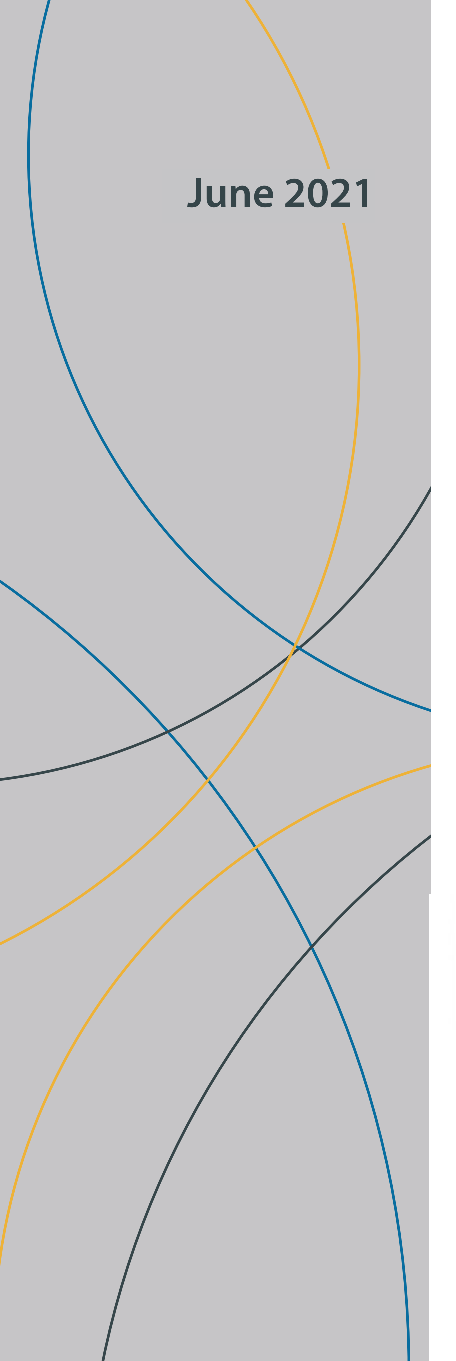

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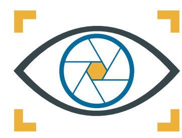
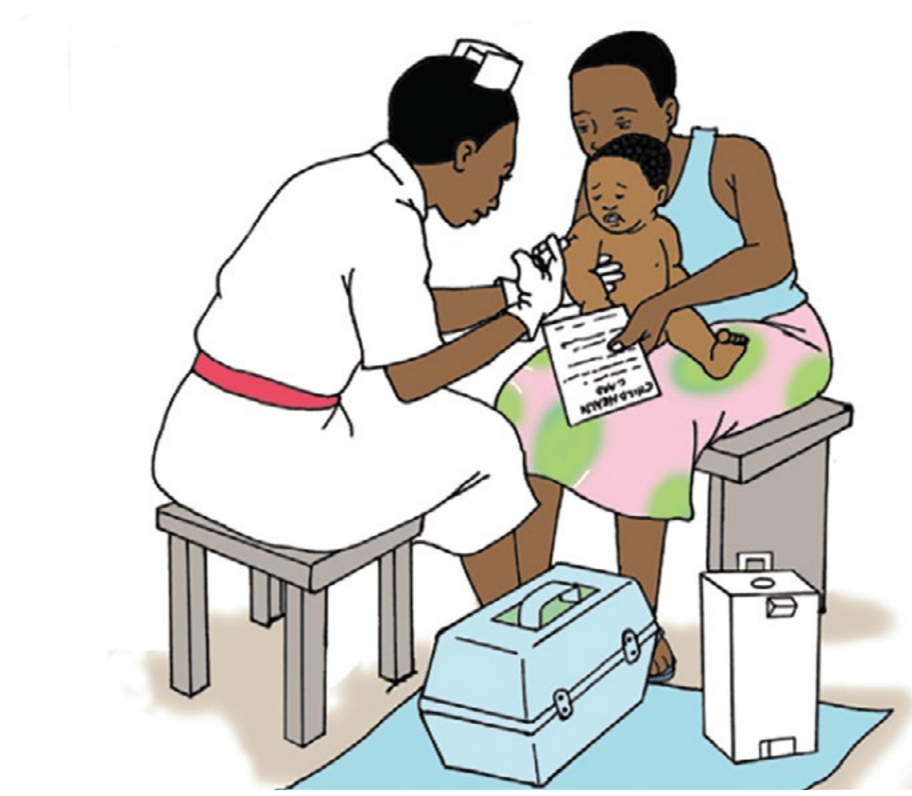


Bottom-Up Accountability in Uganda: Learning from People-centered, Multi-level Health Advocacy Campaigns

Angela Bailey
Vincent Mujune



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Accountability Research Center

KEY INSIGHTS

This brief analyzes how the Accountability Can Transform Health (ACT Health) program activated bottom-up citizen action to secure government responses and more accountable health services in Uganda. This brief focuses on ACT Health's "people-centered advocacy" approach which supported almost 400 community advocates representing 98 health facilities to organize, identify joint advocacy priorities, directly monitor health services, and collaborate on health advocacy campaigns in 18 districts.

1. **Even in contexts dominated by complex political and administrative hierarchies, it is possible to create spaces for citizen–state engagement across multiple levels.** Using a people-centered advocacy approach, the Accountability Can Transform Health (ACT Health) program supported almost 400 community advocates to monitor public health services and design advocacy campaigns in 18 districts. Advocates engaged government officials from health workers to district leaders to national line ministries, presenting evidence and voicing demands for change. Through training and cycles of engagement, many community advocates went from being fearful of government authorities to actively questioning gaps in health service delivery.

2. **Citizen-led engagement engendered a range of responses: government officials in 8 (of 18) intervention districts met or exceeded their commitments to action.** While government responses were uneven, they included: increased government monitoring of health centers, increased proactive transparency, countering backlash against advocates, application of sanctions, bolstered budget allocations, and government recognition of advocates.

3. **Building a bottom-up campaign to engage national-level officials requires time and technical support.** The national campaign engagements differed from conventional civil-society organization (CSO) led advocacy efforts because they were grounded in extensive prior mentorship and organizing work in districts including community-level dialogues, followed by citizen-led advocacy campaigns targeting sub-county and district officials. Building from district campaigns, the ACT Health consortium helped community advocates reach national audiences.

4. **Analysis of the ACT Health program surfaced ways in which citizen-led advocacy stimulated government responses to improve health service delivery.** First, community advocates worked to activate subnational governmental checks and balances and improve government oversight at the points of public service delivery. People-centered advocacy campaigns triggered productive synergy between bottom-up (citizen-led) and top-down (state-led) accountability efforts.

5. **As exciting as the cycles of citizen action and government responses evident in the people-centered advocacy are, induced interventions like ACT Health have limits and risks.** Independent monitoring by citizens alone risks placing excessive burdens on those closest to problems, but with the least resources and authority to directly solve them. Nonetheless, strategic support from funders and CSOs can create an enabling environment for horizontal organizing and collective voice, slowly shifting power dynamics between citizens and government. Long-term, iterative and people-centered approaches targeting multiple levels of governance can create conditions for deepening democratic change.

About ACT Health (2014 – 2018)

The Accountability Can Transform Health (ACT Health) program (2014-18) aimed to improved health outcomes for Ugandan citizens through strengthening accountability in public health services. It was implemented by a consortium of civil society organizations who worked with citizens in 18 districts of Uganda. The civil society consortium included: Coalition for Health Promotion and Social Development (HEPS Uganda), GOAL, an international humanitarian organization, Kabarole Research and Resource Centre (KRC), and Multi-community Based Development Initiative (MUCOBADI).

Phase 1 of ACT Health (2014-2016) included a series of five semi-annual CSO-facilitated dialogues between community members and health workers in 282 government health facilities; the use of citizen report cards to share information about health facilities with community-level stakeholders; and community action plans, reviewed in follow-up meetings every six months. Phase 1 was evaluated through randomized control trial (RCT) research, which tested the impact of the citizen report cards (information) and community-level dialogues.[1]

In Phase 2 (2016-2018), the ACT Health consortium developed and applied its people-centered advocacy approach. Building on the relationships and foundations in Phase 1, ACT Health supported 396 community advocates to monitor government health facilities and collect and analyze their own data. Across 18 districts, advocates from 98 health center catchments organized, designed, and implemented health advocacy campaigns. In 14 districts, these campaigns focused on the commonplace but complex issue of health worker absenteeism. In 8 out of 18 districts, government officials' responses improved accountability and health services. Advocates also engaged national stakeholders such as the Inspectorate of Government (IGG) and parliamentarians.

While based on a longer Working Paper, Bottom-up Accountability in Uganda: Learning from People-centered, Multi-level Health Advocacy Campaigns (February 2021), this Brief focuses only on Phase 2 of the program, highlighting the people-centered advocacy approach, activities, and outcomes.

Health Governance in Uganda

The ACT Health program responded to contextual challenges of health governance in Uganda. In theory, the country's legal and policy provisions enable citizen participation in planning and monitoring government services. In practice these spaces are often inaccessible. Centralized political power, proliferation of subnational government entities (districts), complex health governance, and narrowing civic space limit civil society and citizens' engagement with government powerholders.

Centralized control: Despite a decentralized governance system with five subnational local council levels–village (LCI); parish (LCII); sub-county (LCIII); county (LCIV); and district (LCV)–decision-making in Uganda is quite centralized. A "bottom-up" planning process should enable priorities to be set sub-nationally, but resource allocation decisions are often centralized, leaving local governments with limited discretion to plan and implement service delivery. The growing number of district governments further diffuses power, reinforcing central control.[2]

Administrative challenges: Public health centers in Uganda offer basic preventative and curative services at sub-county and parish levels, with outreach services delivered through Village Health Teams. Understaffing is a persistent challenge, compounded by an uneven distribution of health workers. Health Unit Management Committees, intended to bridge communities and health facilities, have limited functionality to serve the oversight functions mandated to them. Further, from the village to the district level, parallel governance structures with overlapping mandates give rise to administrative ambiguity, creating space for the abuse of authority or accountability gaps.

Invisible power: Even when mandated for official government processes, community participation is often passive. Affected people tend to be consulted about pre-determined agendas, but rarely supported to advocate directly. CSO-led accountability work is prolific in Uganda, yet organizations and funders often underestimate the difficulties in shifting the 'invisible power' that shapes the boundaries of participation.[3]

What is People-centered Advocacy?

In Uganda, advocacy is often driven by formal CSOs that gather information and convey it to decision-makers, speaking for communities. In contrast, the ACT Health program took a people-centered approach defined as:

> *"People-centered advocacy is a systematic process owned and led by those affected by an issue, using evidence to influence people with power at different levels to make sustainable change in practices, policies, laws, programs, services, social norms and values for the betterment of those affected by the issue."* [4]

ACT Health supported people-centered advocacy by creating space for community advocates to own and lead advocacy campaigns, gather and analyze evidence to support their 'asks', and reach powerful people with their arguments. Following the principle of people-centeredness, CSOs took a back seat as these campaigns unfolded, finding ways to support community advocates rather than communicating on their behalf. This required 'unlearning' by CSO staff, who confronted their own preconceptions about community capacities and their own invisible power dynamics. Shifting advocacy agenda-setting power from CSOs to citizens pushed CSO staff into uncharted territory. In many cases, the CSO facilitators and community advocates were developing skills together through training, action, and reflection. Mentorship and support were also needed to ensure constant engagement to putting the principles into practice.

Figure 1. Community Advocates During a Campaign Review Meeting (Phase 2)

During a people-centered advocacy review meeting in Omoro District, a community advocate reports on the progress made in their health center as a result of the advocacy work on absenteeism. Credit: Jackson Bagabirwa, GOAL Uganda

The Evolving Principles of the ACT Health Approach

In addition to people-centered advocacy, the ACT Health approach also included five other, interconnected principles that evolved through practice as the program was implemented from 2014 – 2018.

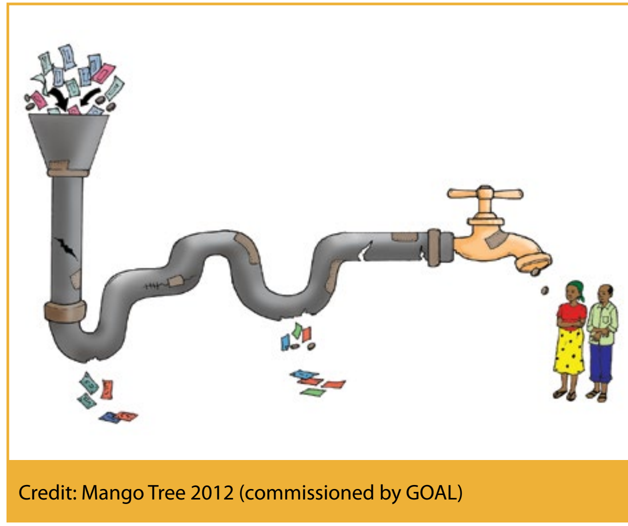
Spaces for state-society interface: The strategy focused on use of 'spaces', understood broadly as "opportunities, moments and channels where citizens can act to affect policies, discourses, decisions and relationships that affect their lives and interests."[5] Phase 1 focused on these spaces at the community level; as Phase 2 began, the approach expanded to include strategies for accessing higher-levels, particularly 'invited' spaces like government budget planning meetings, and 'claimed' spaces, in which citizens created opportunities to engage public officials and allies.

Organizing across communities to encourage collective voice: Supporting citizens to work together and exert influence was necessary because of entrenched power dynamics. Citizens from multiple health centers were organized at two levels: **intra-district** (bringing community advocates from multiple health facility catchments within a district together for joint district campaigns), and **inter-district** (bringing representatives of community advocates from multiple districts together for national campaigns).

Multi-level action: The original ACT Health program strategy acknowledged that service delivery challenges at the 'end of the pipe' (Figure 2)—the point of services delivery—often emanate from challenges and bottlenecks higher up. The ACT Health strategy assumed that coordinated engagement by citizens with government officials beyond the point of service provision would be necessary to trigger state responsiveness. During Phase 1, the research design required that activities focus primarily on community-level stakeholders, but the people-centered advocacy of Phase 2 deliberately took a multi-level approach.

Citizen-led problem analysis: After relatively light-touch facilitation and action planning during dialogues in Phase 1, during Phase 2 CSO staff facilitated iterative cycles of multi-day workshops, providing space to diagnose root causes of problems, collect and analyze data, devise solutions and develop advocacy strategies and target mandated powerholders.

Figure 2. The 'leaky tap' illustrates problems along public service provision pipeline



Credit: Mango Tree 2012 (commissioned by GOAL)

Community monitoring: In Phase 1, external research teams gathered data via household and health center surveys, analyzed that data, and prepared citizen report cards to provide information to community-level dialogues. In contrast, the people-centered advocacy in Phase 2 supported community advocates to directly monitor facilities, then collect and analyze their own data—demonstrating a very robust community monitoring in practice.

Putting People-centered Advocacy into Practice

During the final Phase 1 community-level dialogues in 98 health facilities, participants developed selection criteria and identified almost 400 community advocates. All advocates signed a pledge to provide continuous feedback to their community. Throughout the trainings and campaigns, advocates tested their new skills in practice.

CSO support to advocates included practical, interactive training, lasting three to five months.[6] The training moved from problem identification, to collecting and making sense of data, through identifying campaign targets and planning to how to persuade them, to developing and monitoring advocacy action plans.

Figure 3. Omoro District Community Advocates

Omoro District advocates photographed after completion of all training sessions of People Centered Advocacy (PCA) in April 2018. The 24 advocates represent six catchment areas. Credit: Robert John Offiti HEPS-Uganda

By the end of the series of trainings, each district had an advocacy strategy. Advocates immediately started implementing these strategies. Campaigns varied by district, but all included: 1) delivery of developed messages and 'asks' to targets and allies, 2) community feedback sessions, 3) regular campaign review meetings with CSO staff to monitor and strategize, 4) participatory data analysis to review activities and responses from duty-bearers, and develop next steps.

Health worker absenteeism: a priority community advocacy issue

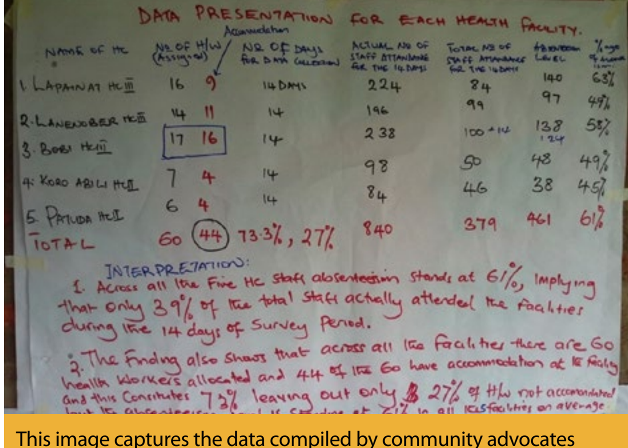
Advocates in 14 of the 18 districts identified "absenteeism, late coming and early departure of health facility staff" as their main concern, and focus of their advocacy. Health worker absenteeism in Uganda is a complex issue to 'solve' because it comes from systemic challenges beyond the ability of community members to address. It is often driven by dissatisfaction or insufficient support from the broader health system. In real terms, absenteeism is an everyday abuse of power felt most directly by citizens who cannot access government health services. Advocates in most districts specifically sought to trigger more robust oversight, monitoring and corrective actions for health workers found systematically absent from duty.

Coordinated community monitoring and data analysis

The process of collecting data, organizing information, and analyzing evidence was intimidating for many advocates, especially given power hierarchies. Advocates worked through their fears as they planned and coordinated monitoring of multiple facilities in each district. Advocates focusing on absenteeism monitored health worker attendance for a minimum of 14 days. Day after day, advocates went to facilities and collected detailed information including staff names, titles, and times of arrival and departure.

These monitoring efforts put health center workers 'on notice' of intentions to take concerns to higher-level officials. Many health workers asked advocates "*Who do you think you are? Do you want to become our supervisors? We don't even know you!*". During the workshops, community advocates had used role plays to prepare for such resistance and challenges.

Figure 4. **Collective analysis by community advocates of monitoring data from five health facilities**



This image captures the data compiled by community advocates who systematically coordinated their monitoring of health worker attendance in five public health facilities in Omoro District. After data collection, community advocates convened with their primary data and CSO staff helped them to compile all their data for analysis. The detailed monitoring data anchored petitions and asks to government officials. Credit: Robert Ofiti, HEPS-Uganda

In workshops and review meetings, advocates combined monitoring data from multiple facilities (Figure 4); calculated summaries, averages and percentages of staff arrival and departure times; and documented stories about the effects of staff absences on patients. Advocates' monitoring of health facilities provided more realistic data than sporadic government supervision visits and staff record books, which are prone to abuse.

Advocates' monitoring data also enabled their petitions to go beyond general statements such as 'health workers do not come to work'. The details presented by advocates made it clear to government officials that the advocacy petitions were backed by robust monitoring. Citizen monitoring data with names of staff found absent, arriving late, and/or leaving early for each of the monitored health centers created a path to action for higher-level duty bearers. While absenteeism data from surveys may provide officials with rates of absenteeism, such data is not specific about which staff are errant, making administrative action difficult.

Community-led political economy analysis to identify advocacy allies and target audiences

For campaigns up to the district level, advocates mapped authorities and influencers in their district. This community-led political economy analysis built on advocates' knowledge of institutional and individual power structures, which fed into campaign plans. CSO staff supported access to, interpretation of, and advice on integrating government policies and standards in advocacy petitions to duty-bearers. Community advocates crafted messages and petitions directed to higher-level officials based on duty-bearers' levels of authority and influence. As campaigns progressed, the advocates learned more about the dynamics of power, influence and relationships between officials, using that new knowledge to adapt future engagements with power-holders and duty-bearers.

Mobilizing collective action for multi-level engagement with local government actors

Community advocates viewed themselves as the leaders and drivers of the campaigns for change, but also solicited opinions and inputs from their communities, built consensus on strategies, shared progress, and re-strategized. This advanced collective voice, mobilizing others to join campaigns, and promoted the feedback loops and accountability of advocates to their communities.

In Phase 2, the ACT Health program provided **no** material incentives to community advocates to execute their campaigns (money, supplies, transport, identification cards, t-shirts, etc.). This is uncommon in Uganda, particularly in donor-funded projects. In all 18 districts, advocates mobilized resources and in-kind support from community members and allies to implement district campaigns. Campaigns took off without CSO funding.

Campaign engagements often started with appeals and petitioners to village elected leaders (LCI), before cascading upwards to deliver demands to elected officials and administrative appointees at sub-county and district levels. Advocates also engaged in government-invited spaces (such as budget planning meetings) where citizens can, in theory, directly access leaders. In several districts, community advocates called in to radio talk shows to ask questions or get feedback from duty-bearers whom they had petitioned. Innovative advocates also used community spaces and social events, such as weddings or funerals, to pass on campaign messages or put leaders on the spot.

Noteworthy Special Campaigns: While working on district-wide campaigns, advocates from approximately half of the 98 health facilities used their skills to advocate on additional issues. Community members from one HCIII engaged Kabarole District officials about the lack of safe water in Harugonjo sub-county, contributing to the building of 10 new wells. Bukedea advocates collected data in 3 primary schools, finding average class sizes nearly twice the recommended teacher–pupil ratio, then developed and delivered advocacy messages to sub-county officials and the District Education Officer.

Escalating advocacy to the national level

Building from district campaigns, the ACT Health people-centered advocacy approach helped community advocates reach multiple audiences at the national level. In the national-level engagements, CSOs provided support to community advocates navigating the corridors of power. CSOs also reviewed health sector laws and policies, highlighted policy gaps that exacerbate absenteeism on the ground, and the multiple accountability failures that contribute to it. Unlike many CSO-led advocacy efforts, the national-level engagements were grounded in extensive prior work in districts.

The national-level advocacy focused on a coordinated escalation of the absenteeism campaign by community advocates from multiple districts. Advocates boldly prioritized absenteeism in their national campaigning. Advocates representing each district brought evidence to be compiled for a national level campaign. The orchestrated national-level engagement culminated in April 2018, when ACT Health organized a symposium for community advocates from 14 districts to engage a range of national stakeholders on increased community monitoring of primary health care.

What Changed, Why and How?

Each advocacy campaign was monitored and all activities and responses and outcomes were documented. This data informed a 'Heat Map' that summarized actions of community advocates and reactions of government officials in each of the 18 districts. The original Heat Map rated government reactions as **red** (officials largely unresponsive), **yellow** (officials made commitments but implementation was limited), or **green** (officials implemented commitments). After a review of the data a fourth category was added: **purple** (officials implemented actions beyond campaign commitments). During the analytical reviews, a cautious and conservative rating of the responsiveness of

officials across all districts (Figure 5) showed that in 8 of 18 districts officials either fulfilled or surpassed the commitments they made to community advocates.[7]

Figure 5. Subnational Government Responsiveness to Community Advocates' Campaigns (as of June 30, 2019)

Number of Districts

10
8
6
4
2
0

2 RED — Government Officials Largely Unresponsive

8 YELLOW — Government Officials Made Commitments but Implementation was Limited

5 GREEN — Government Officials Implemented Commitments

3 PURPLE — Government Officials Implemented Actions Beyond Campaign Commitments

Source: Bailey and Mujune 2021

Many advocates reported that their ongoing monitoring did not show significant improvements in attendance of health workers to the advocates' satisfaction, even when advocates reported that officials were responsive. This is unsurprising, given the complex nature of absenteeism. However, many more nuanced outcomes emerged from the cycles of interaction between community advocates and progressively higher levels of government actors.

Government responses and their implications

Increased government monitoring: Advocates' bottom-up monitoring and advocacy triggered increased monitoring by district officials. In 13 of 14 districts focusing on absenteeism, district-level officials went to verify evidence presented by community advocates. As one official noted: *"The biggest problem is 'organized absenteeism' where health workers make their own informal timetable. Community advocates helped us discover this practice. We have taken a serious intervention."* [8] Here, independent citizen monitoring highlighted and filled gaps in standard government monitoring tools to track health worker attendance.

More downward accountability and proactive transparency: Responses included proactive transparency by government officials to and beyond advocating communities. The Resident District Commissioner of Manafwa District (Heat Map rating: green) went on the radio to share the outcomes of his monitoring visit to the health facilities, while in Mubende (Heat Map rating: yellow) the District Health Officer called public assemblies in all five facilities to share his findings, publicly appreciating the advocates' role in triggering the monitoring investigation. These examples of reporting back to those who requested action illustrate closing of feedback loops, and a degree of answerability and downward accountability. Such micro-shifts in power dynamics are significant in the Uganda context.

Countering backlash: In some cases, government officials responded to backlash against community advocates by frontline workers or local level officials, in ways that altered the power dynamics of accountability. In one district (Heat Map rating: yellow), health workers banned advocates from accessing services, and advocates reported this to

higher officials. The Resident District Commissioner—a political appointee—intervened and put the health workers 'on notice' that no one would be refused treatment for exercising their rights as citizens. Here, community advocates leveraged new relationships with higher-level officials to protect themselves against retaliation by service providers—shifting the power balance between community members and health workers.

Application of sanctions: In 8 districts, officials issued verbal or written warnings or instructions to health workers implicated by advocates. In Omoro District (Heat Map rating: green), officials planned to withdraw salaries for health facility staff confirmed absent from duty for more than 15 days. Two districts reinstated or reinvigorated Rewards and Sanctions Committees. However, the disciplinary mandate for government employees at the subnational level lies with the District Service Commission, which was not active in any district. This under-resourcing of mandated structures highlights the complexity of achieving accountability in Uganda's local governance structures.

Bolstered budget allocations: Several advocacy campaigns used invited spaces to influence budgetary allocations for particular health services. In one district (Heat Map rating: green), sub-county officials allocated funds for electricity and lighting in 6 of 7 health centers included in advocates' petitions. Although advocates' work was unlikely the only trigger, examples in ACT Health show the power of informed citizen advocates and their campaigns.

Official government recognition of advocates: Recognition of advocates by government officials—such as the provision of letters introducing them as community volunteers in 6 districts—introduced advantages and challenges. Such formal recognition is highly valued in Uganda, and advocates presented letters to access health facilities for monitoring. However, this recognition may also imply the transfer of monitoring responsibilities from mandated government officials to community advocates, further minimizing the state's performance of its mandated duties.[9] Others have more optimistically suggested this is a form of co-production, whereby citizens and the state share responsibility for monitoring in resource-scarce settings.[10] These dilemmas illustrate both the power and the complexity of independent citizen-led monitoring and accountability efforts.

National policy-makers also responded to community advocates: Beyond the orchestrated campaign engagements around the national symposium in April 2018, some advocates also directly engaged national-level authorities. Advocates from Mubende District (Heat Map rating: yellow) had petitioned about absenteeism at the district level, but no official had done more than promise action. In response, advocates directly petitioned the central regional office of the Inspectorate of Government (IGG), a national oversight body. The IGG conducted its own investigation into health worker absenteeism, leading district officials to take action. Community advocates from 16 districts later met the IGG in Kampala. This escalation of activities in response to inertia highlights the persistence and confidence of advocates to reach more senior government actors and trigger top-down action. Citizens' ability to directly trigger the horizontal oversight mechanisms of the Inspectorate of Government is an important tactical approach to claiming accountability.

Figure 6. Community Advocates Meeting the Inspectorate of Government in Kampala

In April 2018, community advocates representing 16 districts met the Inspectorate of Government in Kampala to ask for investigations into the performance of all relevant councils, commissions, and district management teams in relation to health worker absenteeism and, where necessary, to charge those who have neglected their duty as accessories to attempted murder or murder. The IGG heard their concerns and provided a copy of the Human Rights Report it had produced. Credit: Prima Kazoora, HEPS-Uganda

Outcomes for participating community advocates

During Phase 2, most community advocates worked collectively to advance district advocacy campaigns, and the joint agenda-setting, monitoring, and campaigns were accomplishments in their own right. Even in this donor-funded intervention, these accomplishments showed signs of deepening democratic citizenship among community advocates.

Many community advocates developed or enhanced their reputations as leaders, mobilizing community members to contribute to campaigns, attend advocacy actions, and report problems. The success of community advocates' local resource mobilization is significant in the Ugandan context, in which induced participation in projectized approaches renders more organic coalition-building and organizing very challenging. Advocates in almost half of the 98 health facility catchments used their skills and knowledge to take on additional advocacy agendas. The special campaigns initiated by advocates demonstrated use of knowledge and skills to expand their advocacy work.

"When I was selected, at first I was worried if I would be able to represent the community. When we first went to the health center, we asked for documents like the supervision book even though we did not know what the documents should even look like. When we went to the technical people they would dodge around, and the district officials asked us what our qualifications were. If I have a problem does it matter if I have a qualification? If I don't have training, does it matter, because I'm suffering?"

~ Patricia, Community Advocate

In 2018, 47 community advocates (over 10 percent of the total) were elected as village Local Councilors (LCIs). While people interested in becoming community advocates may have sought office anyway, the people-centered advocacy process fostered an understanding of government policy and practice that enhanced their public service capabilities. This may not improve health outcomes in the short term, but political learning, capabilities, and the exercise of citizenship are important for more transformational change.

For many of the 396 community advocates, working on their campaigns was transformative. On reaching district officials, one advocate said: "*We have engaged the Chief Administrative Officer, Resident District Commissioner, District Service Commission and because of these achievements, I'm so confident I could even speak to the President about ACT Health people-centered advocacy – I'm very comfortable.*"[11] This advocate found the engagements empowering, regardless of any further outcome.

Conclusions: What have we learned from people-centered advocacy?

Much of the literature on accountability emphasizes the need to shift power, which takes significant work in practice and is difficult to research. The nature and intensity of the inputs and processes for citizens to seek accountability, such as the interpersonal, relational, and trust-based nature of facilitation and support for citizen-led advocacy on health services are under-discussed in the research. The health accountability literature has limited examples of

analysis of iterative cycles of multi-level citizen action and response explored here, under the ACT Health people centered advocacy.[12]

The ACT Health program shows that through mindful implementation, **it is possible to create spaces for citizen–state engagement across multiple levels, even in contexts dominated by complex political and administrative hierarchies.** Citizen-led engagement engendered a range of responses, with government officials in eight districts meeting or exceeding their commitments to action.

However, the program also shows that **building a bottom-up campaign to engage national-level officials requires time and technical support.** The national campaign engagements differed from conventional CSO-led advocacy efforts because they were grounded in extensive prior work in districts. Building from district campaigns, the ACT Health consortium helped community advocates reach multiple national audiences.

ACT Health also showed that **it is possible to open the doors of national government officials to citizens.** But while the process of intra-district organizing and executing subnational campaigns was viable without material incentives, reaching the national level was more challenging; national-level advocacy may require more resources than citizen groups can raise.

Community advocates can activate subnational governmental checks and balances. District level campaigns had to navigate three parallel governance structures: the Chief Administrative Officer (a centrally appointed bureaucrat), the Local Council V Chairperson (elected), and the Resident District Commissioner (executive branch appointee). To activate checks and balances at the subnational level, community advocates engaged leaders in all positions—often approaching one leader with requests to influence or pressure another leader to act.

People-centered advocacy campaigns can also trigger synergy between bottom-up and top-down accountability efforts. Advocates focused on informing and advocating for 'top-down' official oversight by government for more accountability to citizens. Some higher-level officials were initially skeptical or resistant, but many came to appreciate the earnest independence and detailed monitoring work of advocates. In 13 of 14 districts, officials took many actions to verify reports of health worker absenteeism, showing that advocates effectively triggered top-down oversight.

As exciting as the cycles of citizen action and government responses evident from the people-centered advocacy approach are, **project interventions like ACT Health have limits and risks.** Independent monitoring by citizens alone risks placing excessive burdens on those closest to problems, but with the least resources and authority to solve them.

This research on the ACT Health program shows that iterative, people-centered approaches targeting multiple levels of governance can create conditions for deepening democracy and positive change.

Notes

For full citations, please see references section of the February 2021 Working Paper here: https://accountabilityresearch.org/publication/bottom-up-accountability-in-uganda-learning-from-people-centered-multi-level-health-advocacy-campaigns/

1 The ACT Health randomized control trial (RCT) was designed as a replication of the earlier published research based on the Björkman, Martina, and Jakob Svensson, 2009. "Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda." *The Quarterly Journal of Economics* 124(2):735-69. For discussion of Power to the People and ACT Health RCT findings, see section V (ACT Health RCT: Study of a Community-level Intervention) in the February 2021 Working Paper.

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7 For a more complete discussion of the data and analysis, see Section IV (Data Sources) in the February 2021 Working Paper.

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12 See: Hernandez, Alison, Ana Lorena Ruano, Anna-Karin Hurtig, Isabel Goicolea, Miguel San Sebastián, and Walter Flores. 2019. "Pathways to Accountability in Rural Guatemala: A Qualitative Comparative Analysis of Citizen-led Initiatives for the Right to Health of Indigenous Populations." *World Development* 113:392-401.

About Accountability Research Center (ARC)

The Accountability Research Center (ARC) is based in the School of International Service at American University. ARC bridges research and frontline perspectives to learn from ideas, institutions, and actors advancing strategies to improve transparency, participation and accountability. Support for ARC comes from the William and Flora Hewlett Foundation, the John D. and Catherine T. MacArthur Foundation, Open Society Foundations, and the David and Lucile Packard Foundation. For more, see www.accountabilityresearch.org.

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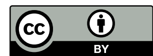

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About the Authors

Angela Bailey has worked at the Accountability Research Center (ARC) at American University in Washington, DC since 2016. Previously, she worked with GOAL in Uganda as director of the Accountability Can Transform Health (ACT Health) program. Angela holds a Master's in International Affairs from Columbia University's School of International and Public Affairs.

Vincent Mujune led GOAL's people-centered health advocacy work in Uganda from March 2015 to December 2020. Vincent is a member of Uganda's Civil Society Budget Advocacy Group and has trained civil society actors on people-centered advocacy in Sri Lanka, Malawi, and Sierra Leone.

As co-authors, we acknowledge our roles as architects and stewards of the ACT Health program because we understand that our closeness to the work brings strengths and weaknesses to this analysis. As self-critical practitioners committed to learning and advancing participatory governance, our direct experiences with the ACT Health program collaborators, participants, and government officials enable us to highlight many dimensions of this multi-level, people-centered approach and offer valuable insights into the "black box of implementation."

American University
School of International Service
4400 Massachusetts Ave NW
Washington, DC 20016
www.accountabilityresearch.org