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SANTA CRUZ

**“TELLING YOUR FATHER THAT HE’S WRONG”:
THE POLITICS OF SEXUAL AND REPRODUCTIVE HEALTH AND
RIGHTS IN UGANDA**

A dissertation submitted in partial satisfaction
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

SOCIOLOGY

by

Nichole M. Zlatunich

June 2012

The Dissertation of Nichole M.
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Vice Provost and Dean of Graduate Studies

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List of Abbreviations

ABC	abstinence, be faithful, condom use
ACP	AIDS Control Programme
ACTS	advise, consent, test, support
AIDS	acquired immune deficiency syndrome
ARV	antiretroviral
AU	African Union
CDC	Centers for Disease Control and Prevention
CPR	contraceptive prevalence rate
DANIDA	Danish International Development Agency
DFID	United Kingdom Department for International Development
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EQUINET	Regional Network on Equity in Health in Southern Africa
FDA	United States Food and Drug Administration
FDC	Forum for a Democratic Change
FOWODE	Forum for Women in Democracy
FP	family planning
FP/RH	family planning/ reproductive health
FPAU	Family Planning Association of Uganda (now known as Reproductive Health Uganda (RHU))
FY	fiscal year
G-77	Group of 77

GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
HCII	health center two
HDI	Human Development Index
HIPC	Heavily Indebted Poor Countries
HIV	human immunodeficiency virus
HIV/AIDS	human immunodeficiency virus/ acquired immunodeficiency syndrome
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
ICT	information and communications technology
IDI	Infectious Disease Institute
IDP	internally displaced persons
IEC	information, education and communication
IGO	intergovernmental organization
IMF	International Monetary Fund
INGO	international non-governmental organization
IPPF	International Planned Parenthood Foundation
IRB	Institutional Review Board
IUD	intra-uterine device
JMS	Joint Medical Stores
JPP	Joint Programme on Population
KY	Kabaka Yekka

LGBT	lesbian, gay, bisexual, and transgender
LMIS	logistics management information system
MDG	Millennium Development Goal
MoFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MP	Member of Parliament
MSM	men who have sex with men
MSU	Marie Stopes Uganda
NDP	National Development Plan
NEPAD	New Partnership for African Development
NGO	non-governmental organization
NMS	National Medical Stores
NRA	National Resistance Army
NRM	National Resistance Movement
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
PACE	Program for Accessible Health, Communication and Education (formerly PSI Uganda)
PAF	Poverty Action Fund
PAI	Population Action International
PEAP	Poverty Eradication Action Plan
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
Popsec	Population Secretariat

PPD ARO	Partners in Population and Development Africa Regional Office
PPDA	Public Procurement and Disposal of Public Assets
QCIL	Quality Chemicals Industries Limited
RH	reproductive health
RHU	Reproductive Health Uganda
SEAPACOH	Southern and East African Parliamentary Alliance of Committees of Health
SRHR	sexual and reproductive health and rights
STD	sexually transmitted disease
SWAp	Sector Wide Approach
TASO	The AIDS Support Organisation
TB	tuberculosis
TBA	traditional birth attendant
UK	United Kingdom
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UC	University of California
UCSC	University of California, Santa Cruz
UGX	Ugandan shilling
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
UNLA	Ugandan National Liberation Army
UPC	Uganda People's Congress
UPDF	Uganda People's Defence Force
UPE	universal primary education
UPMA	Uganda Private Midwives Association
US	United States
USAID	United States Agency for International Development
USD	United States dollar
VCT	voluntary testing and counseling
VHT	Village Health Team
WHO	World Health Organization

Abstract

**“TELLING YOUR FATHER THAT HE’S WRONG”:
THE POLITICS OF SEXUAL AND REPRODUCTIVE HEALTH AND
RIGHTS IN UGANDA**

by

Nichole M. Zlatunich

This dissertation project explores the question, “How and why have Uganda’s population and sexual and reproductive health and rights (SRHR) policies failed to realize change despite clear, implementable policies, frameworks, and significant financial resources?” This project examines the extent to which population and SRHR is present in the policy environment and explores the political, environmental, cultural, and social factors that have facilitated and hindered political support for and implementation of SRHR policies and programs.

The findings of this dissertation are drawn from qualitative analysis of primary and secondary data sources. Primary data sources include in-depth, semi-structured interviews with key respondents involved in policymaking and implementation in Uganda. Participant observation and secondary data analysis of relevant policies, reports, and related documents was also utilized.

There are four key findings from this research project. First, implementation does not automatically flow from the existence of numerous policies. Rather, implementation

of policies is dependent upon tangible political commitment through funding commensurate to need and through ensuring top-down accountability.

Secondly, five factors (a critical juncture, a clear consensus, political incentive, collective action/social cohesion, and bureaucratic structure) played the largest role in Uganda's success in reducing HIV prevalence, as well as its failure to improve population and reproductive health indicators.

Third, the wider macro-environment, policy characteristics, and policy formation are key factors preventing successful policy implementation for reproductive health commodities in Uganda. Policy implementation is clearly a political issue, and thus both academic literature and program-relevant research need to address specific political factors in implementation, rather than viewing implementation as a technical function of the state and NGOs.

And finally, the findings of this dissertation challenge the good governance consensus and indicate that the "developmental patrimonialism" approach to governance may be a better fit for developing countries to move from extreme poverty to moderate poverty than the current "best practice approach". This dissertation argues that a "good enough" approach to governance that takes into account local context may be a better path to guiding country policies and the global approach to governance.

Acknowledgements

According to Goffman (1959:253), “he and his body merely provide the peg on which something of collaborative manufacture will be hung for a time. And the means for producing and maintaining selves do not reside inside the peg” (Goffman 1959).

While Goffman was making this specific statement about the production of selves as a collaborative process, this conceptualization can be easily extended to the production of a dissertation. While a dissertation appears to be a solitary academic endeavor, it absolutely cannot be done without the guidance and support of a number of other actors.

So much of my gratitude goes to my committee. Professor Paul Lubeck was helpful throughout my brief time working with him, and his own work greatly contributed to my understanding of the relation of my work to the larger field of politics in Africa. Sarah Clark, by her mere presence on my committee, constantly reminded me that there is a larger field and group outside academia who care about not only the subject, but the content of my work. She also was the originator of the connection between me and the Partners in Population and Development Africa Regional Office, whom I have had the privilege to work with during the past six years. And Professor Ben Crow was my main advisor since the beginning of my graduate studies. By allowing me to explore what interested me most (despite having expressed deep doubts in the beginning about my study of “population”), Ben granted me a great deal of independence while making the necessary interventions to shape the content of this

dissertation. He always did this in the kindest way possible, often by guiding me to a good book or article to read rather than direct criticism. His ability to help me shape a broad project into a set of simple, powerful questions guided by a clear theoretical argument was invaluable.

This dissertation has taken shape in two places, California and Kampala. My home institution, the Department of Sociology at University of California, Santa Cruz, is a breeding place of ideas and inspiration. The cross-disciplinary environment of the UCSC campus, promoting graduate students to take broader coursework and form research clusters bridging departments was also key to my studies. The Idea of Africa Research Cluster, which bloomed for a period of years on the UCSC campus, was a critical inspiration in my early graduate school career. The theoretical insights and important work that other graduate students were doing provided not only inspiration, but also an impossibly high standard. The Development Research cluster, formed in 2010, not only inspired me through the research colleagues were doing, and the questions we were all asking, but also provided valuable input into the conceptualization of my ideas, and in particular, to the arguments made in “Chapter 5: ‘What Is Allocated Is Not What Is Delivered’: The Policy-Implementation Gap of Contraceptive Commodities”.

There are also a number of people who are likely unaware of the great influence they have had on my dissertation work. My mater’s paper and qualifying exams chair,

Professor Pamela Roby, pushed me from the beginning to not only develop but to express feminist theories in my research methods as well as my writing. Professor Roby provided wonderful inspiration and detailed feedback on the methodological appendix of this dissertation. Professor Craig Reinerman was a demanding reader of my master's paper and his contemporary sociological theory class was a springboard for thinking through my overabundance of ideas. And Ann McCardy, the Graduate Assistant in the Sociology Department, not only supported my work through helping me to navigate the academic bureaucracy of the department and the university through providing a wealth of clear and detailed information, as well as being an incredibly kind person ready to assist in a range of matters, from the trivial to the critical.

As I've neared the completion of my formal academic study, I have come to the realization that all of my research has been narrated by the question of the role of the individual and questions of agency within structures. In good part, I have to thank my first academic mentor, Professor Laura Grindstaff, of the University of California at Davis. While I, like most undergraduate students, was motivated by a particular topic, she pushed me to think of broader theoretical questions that gave meaning to my research. While she started me on this journey of professionalization, I am also grateful to all of those who helped me along the way in the Sociology Department at UC Davis, particularly Professor Lyn Lofland and Professor Ryken Grattet.

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I would be remiss if I did not thank my closest friends in Kampala: Patience Amayo, Phionah Bitariho, Yvette Ayebare, Evans Musiime, Roger Agamba, Val Okecho, Jackie Chemisto, Brenda Amony, Brian Kwawun, Bunny Mack Yiiki, and Amanda Muganwa. They all helped make Uganda my second home. They welcomed me into their group and homes, nursed me when I was sick, cheered me up when homesick, celebrated our accomplishments and milestones regularly, and kept me updated by email when I was in California. Unbeknownst to them all, their friendship provided me with a very deep understanding of everyday life and realities for my contemporaries in Uganda. Without them, my extended trips to Kampala would have been lonely and my research would have been far less.

And to all of my interviewees, who must remain nameless in this dissertation. Their willingness to share insights, knowledge and experience with me has been more than what I ever expected. They are the true backbone of my knowledge. I am also very grateful for the comments and feedback that a number of them gave on earlier drafts of sections of this dissertation; their time and effort helped to improve my thinking, and ultimately, this text.

And most of all, I could not have done this without my family. My mother, father, and brother provided abundant encouragement and the resolute belief all along that I would get to this point. And my husband, Sean, whose unwavering support through

extended physical absences while in Uganda, and mental absences while being unable to do anything other than live, breathe, write, think, and stress about the progress of my dissertation. He is the model of patience, support, and love.

I gratefully acknowledge permission granted to reprint two political cartoons by Mr. Ras, originally published in the New Vision newspapers on 15 October 2008 and 27 September 2010 (Ras 2008; Ras 2010b). I also wish to acknowledge the sources for two additional images, the US White House (2003) and Brewer (2007) who allow use under creative commons licensing.

Finally, I also wish to acknowledge the generous funding provided to me by the University of California Santa Cruz through a number of different varieties of support: Fee Fellowship, Dean's Fellowship, Regents Dissertation Fellowship, as well as specific project funding through the Sociology Department and the Jessica Roy Memorial Scholarship Fund.

Preface

From the beginning of my academic research journey, I have been motivated by questions of the relative roles of agency and structure. I have questioned assumptions of the powerlessness of teenage girls in the face of dominant media structures and representations (Zlatunich 2009). I have examined the role of activists against larger organizational and institutional norms and frames (Zlatunich 2008b). And now I look at the role of agency and politics against the current emphasis in development literature on the dominant role of the state and institutions.

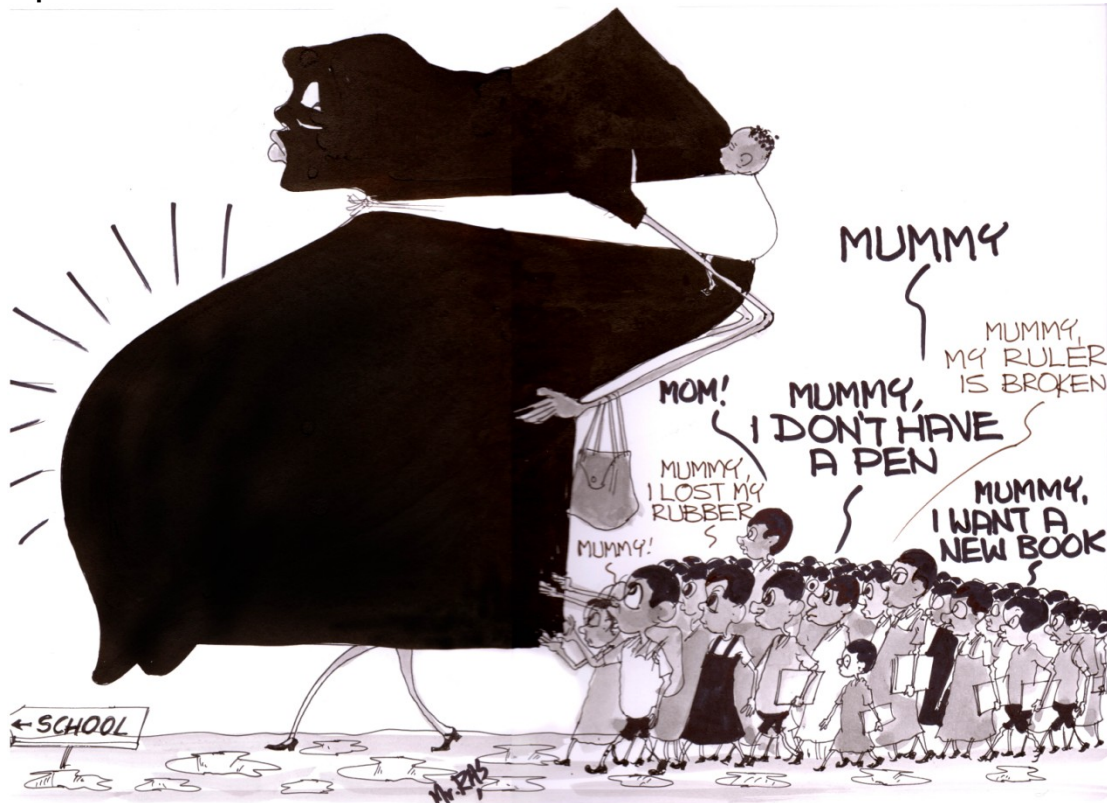
As much as we pretend that we know, so much is still unknown and unknowable, thus, I follow Goffman's beautiful metaphor in the introduction to *Asylums*, "I think that at present, if sociological concepts are to be treated with affection, each must be traced back to where it best applies, followed from there wherever it seems to lead, and pressed to disclose the rest of its family. Better, perhaps, different coats to clothe the children well than a single, splendid tent in which they all shiver" (Goffman 1961:xiii-xiv).

Like Goffman, I am disinterested in constructing a single, unifying theory. Thus, I have followed several paths with different chapters utilizing different theories. My ultimate goal is to use the theoretical arguments that works best and make sense for each topic, even as the result leaves each chapter somewhat independent of the others. But utilizing disseperate theories and arguments allows me to approach the politics of

sexual and reproductive health and rights (SRHR) in Uganda from different vantage points, drawing on sources in sociology, politics, development studies, and public health, among others. In the end, I also hope to contribute to larger theoretical understandings.

Chapter 1: Introduction: “You Simply Do Not Care About Women”: An Introduction to Uganda’s Political Economy and Reproductive Health

Figure 1: Political Cartoon Captioned: “Uganda’s high fertility rate, if not checked, could affect primary education and health in the next 30 years.” *New Vision*, 27 September 2010



Source: (Ras 2010b)

At the July 2010 African Union Summit’s theme on maternal health promoted a special public discussion on the theme. The panelists included presidents (President Museveni of Uganda, President Armando Emilio Guebuza of Mozambique), United Nations and African Union representatives (Thoraya Obaid the Executive Director of UNFPA at the time, and Bience Gawanas, the Commissioner for Social Affairs at the

African Union), and an celebrity-activist (Yvonne Chaka Chaka, the South African singer and human rights activist and UNICEF and Malaria Goodwill Ambassador) and was moderated by an international journalist (Zeinab Badawi).

After introductory remarks by the panelists, Ms. Badawi prompted them to begin discussing each other's views on the subject and plans for improving maternal health in their countries and regionally. In the midst of this discussion Yvonne Chaka Chaka turned to Museveni and said, "You simply do not care about women."

My ears perked at this statement. "Did I hear correctly?" I thought to myself.

As Yvonne Chaka Chaka, the South African singer, human rights activist and UNICEF and Malaria Goodwill Ambassador, continued, she was, in this very public and very normally-diplomatic forum telling Ugandan President Museveni that she believed he did not prioritize the needs of women, particularly their reproductive health.

Museveni then proceeded to tell the other panelists that "even you activists or human rights or this and that, start with production. Production not consumption! . . . But if you talk about social expenditure without talking about production, then you are just wasting your time and everybody's time" (Zlatunich 2010a).

With the usual protocols, the rest of the African Union summit, was not as confrontational as this special session. It was an exception to the normal activities, likely due to its involvement of an outspoken activist as a panelist with presidents. Yet, a number of individuals and groups particularly interested in this topic walked away disappointed by Museveni's dismissal of the topic as a priority for the development of Uganda, and more broadly, for Africa.

"It was an outright disappointment. I was ashamed for what he said," a government official in the Ministry of Health later told me (Interviewee #37).

While the summit had the special theme of Maternal Health in Africa, the main focus of the heads of state was on the "hard" issue of terrorism (due to the July 11, 2010 bombings in Kampala, Uganda during the World Cup), rather than the comparatively "soft" issue of maternal and child health. The leader of a well-respected non-governmental organization (NGO) working on health issues in the country later told me, "The terrorists have again won. And not just their own battles, but ours as well" in regards to the redirection of focus away from the summit theme of maternal health (Interviewee #34).

At the most basic level, Uganda’s continued “failure” to address its serious population and sexual and reproductive health and rights (SRHR)¹ issues seems evidently clear from the response of the president. Even a casual observer could conclude that the solution to Uganda’s problem is leadership—that President Museveni (and the rest of the government, by default) has yet to be convinced of the importance of supporting family planning programs. If he were to come along on the issue, like he did when providing leadership on HIV, then Uganda would have a population “success” much like the country’s success regarding the significant decline in HIV prevalence in the country.

Yet, early on in my dissertation research, even before I settled on a specific topic, the complexity of Uganda’s political situation and advocacy for population and reproductive health issues was clear. In 2007 I spoke with the leader of an NGO, who explained to me the situation faced by population and reproductive health advocates working within the Ugandan government. In particular he noted the difficult advocacy position of the Population Secretariat, who itself is part of the government, yet trying to change the pronatalist position of President Museveni who has been in power since 1986: “It’s like telling your father that he’s wrong.” This phrase struck in my head for the next five years—and became more telling the more time I spent in Uganda, as I grew to understand the deeply patriarchal nature of private and public life, and how intensely people and institutions are attuned to hierarchy.

In this dissertation, I show that the story of population and reproductive health in Uganda is not as clear or simple as it appears on the surface. There has been a significant amount of research on fertility decision-making at the household level. Unfortunately, not as much research has been done on the political and policy front. While this dissertation will do little to help readers understand individual fertility decision-making (as it is well-covered elsewhere), I will provide a description of the context, policy environment, and global conditions under which people make (and are unable to make) decisions about their fertility.

This is a story of the politics of the state, and of the politics of reproduction in an African country. It is a story of how and why population and reproductive health policies have failed in apparently good conditions of significant donor involvement, a strong NGO sector, a history of “success” combating HIV, relative stability in much of the country, and exceptional and strong economic growth.

This dissertation is focused on the question, “How and why have Uganda’s population and sexual and reproductive health and rights (SRHR) policies failed to realize change despite clear, implementable policies, frameworks, and significant financial resources?” In the following chapters, I examine the extent to which SRHR is present in the policy environment (as separate policies and as integrated into larger development policies and frameworks). I also explore the political, environmental,

cultural, and social factors that have facilitated and/ or hindered political support for and implementation of SRHR policies and programs.

This introductory chapter proceeds as follows: First, it summarizes the academic literature on the state, development, and politics. Then, it briefly discusses a subset of literature on policy analysis which often ignores larger political-economic factors. The research methodology is then presented before the chapter concludes with an overview of the research results in the following chapters.

The African State and Development

The academic literature is full of pessimistic conclusions about the state in Africa. Van de Walle argues that Africa is under “permanent crisis” of both the economy and state (van de Walle 2001). Chabal and Daloz state that the African state is ruled by informal actors and institutions (Chabal and Daloz 1999). A large number agree that the African state is neo-patrimonial or governed by personal rule (Bratton and van de Walle 1997; Jackson and Rosberg 1982; Jackson and Rosberg 1984; Léonard and Straus 2003; Lindberg 2003). Médard accuses states in Africa of confusing the public and private (Médard 1991). Others authors, both academic and program-oriented, conclude that African states are corrupt, predatory, kleptocratic, engage in criminal activities, fraud, and theft of resources for personal and network gain, do not promote development or deliver basic public services, and often continue despite popular

opposition (Acemoglu, Robinson, and Verdier 2004; Balogun 1997; Bates 2005; Bayart 2009; Bayart, Ellis, and Hibou 1999; Frimpong-Ansah 1992; Mbembe 2001; United Nations Conference on Trade and Development 2007; van de Walle 2001).

Weaknesses in African states are often attributed to causal or historical factors including colonialism and late and incomplete formation of the state (Moore 2001). Due to colonial hegemonic outcomes, the maps of African countries encompass multiple subgroups (and accompanying allegiances) based on tribe, ethnicity, language, and clan. These groupings created perceptible differences upon which allegiances were built; these differences and allegiances were exploited by leaders during colonialism as well as post-Independence. States create political parties and armies to draw allegiances from other groups and create ties to the state (Migdal 2001). This transfer of allegiance “entails conveying to people the routines, symbols, and ways of behaving represented by the state leadership are essential to their well-being” (Migdal 2001:71), thus making the process of governing easier. Yet, when there are many groups to accommodate, the process of transfer of allegiance is difficult and turns into a “politics of survival” (Migdal 2001), that draws the attention and energy of even well-intentioned leaders away from implementing policies towards struggles to merely stay in power (Young 1994). The “politics of survival” lead to behaviors and practices that are against “good governance” including patronage to placate potential restless sectors, interest groups, and opposition leaders (Migdal 2001). Corruption is tolerated as a form of political control, with threat of

disclosure and legal action if the individuals stopped supporting those currently in power (Migdal 2001).

In *Citizen and Subject*, Mamdani argues that state-centrists see the form of state power of the African “patrimonial autocratic state” similar to “its ancestors in seventeenth-century Europe or early postcolonial Latin America, often underlined as a political feature of the transition to capitalism” (Mamdani 1996:11). Yet, due to colonialism (as well as a range of historical, environmental and social factors), the conditions of states in Africa cannot be compared to that of Europe or Latin America during other periods.² Most states in Africa are new, economically poor, and have borders drawn without regard to ethnic and linguistic groups (Clapham 1996). The experience of colonialism in Africa was varied based on the colonial power (the main colonizers being the United Kingdom, France, Belgium, and Portugal), the method of colonization, and the time period (Bayart 2009; Lange, Mahoney, and vom Hau 2006; Mamdani 1996). The United Kingdom and France generally left their colonies with limited bureaucratic structures and trained officials in place. Belgium and Portugal, however, left their former colonies with little to no functioning bureaucracy (Clapham 1996; Lange, Mahoney, and vom Hau 2006).³

According to Mamdani, Africa’s colonial legacy is significant, as the colonial era produced states that were bifurcated, marked by racial separation in urban areas combined with a reification of tribe and “native” in the rural areas (Mamdani 1996).

The state operated with two forms of power: direct (civil society, protecting rights) and indirect (customary rule, enforcing tradition). This bifurcated colonial state created artificial exclusive jurisdiction for “village chiefs,” changing the historical multiple and non-exclusive model of jurisdiction over people, land, and property to a colonially-appointed chief. This created two statuses under colonialism: citizen (nonnative) and subject (native, governed by a supposedly customary tribe) (Mamdani 1996).

While this dissertation builds on these arguments and conclusions, it does not support the conceptualization of the African state in complete crisis, and the idea that African states are entirely corrupt institutions. Instead, I argue that the story is much more complex and that the recognition of the particular histories and trajectories of African states is critical to understanding why and how states appear to operate in predatory ways. Thus, this dissertation focuses on the particular behaviors of the Ugandan state in relation to its conception of reproductive health policy and the implementation of such policy. With this in mind, I next give a brief overview of what states are and what states do, a slightly longer discussion on the role and function of state capacity, a discussion of bureaucracy and its role in state formalization and state capacity, and an overview of literature on policy formation and implementation.

The State, State Formation, and Formalization

“The classical liberal definition of the nation-state is of a political authority with territorial integrity, sovereignty, and legitimacy, with the role of providing a legal system and guaranteeing the currency (sometimes known as upholding the rule of law and money, respectively), which together can be seen as setting the terms of market and social interactions. It also taxes citizens in order to provide welfare services and provides a sense of identity and “nationhood” to secure social order, while arbitrating or repressing dispute” (Bracking 2005:1014). The broad conception of the liberal state by Bracking includes Weber’s often-cited definition: “a state is a human community that (successfully) claims *the monopoly of the legitimate use of physical force* within a given territory” (Weber 1946).⁴ It also incorporates the concept of “infrastructural power” of the state—the “capacity of the state to actually penetrate civil society, and to implement logistically political decisions throughout the realm” (Mann 1986:113).⁵ This understanding of the role of the state can be somewhat expanded by incorporating the view that the state provides good and services over which it holds a monopoly in exchange for taxes (Bates and Lien 1985; North 1981; Timmons 2005). Currently, the mainstream paradigm argues that states should provide a range of social services—but that states need to be effective and efficient. This could entail changes to states and their programs including decentralization, privatization, and monitoring to avoid corruption, clientelism, and ineffectiveness (Grindle 2010).

One aspect of states that is critical to my latter arguments is the conception of the modern state as rational, coherent, and ordered. The dominant view is that states are powerful and make and implement decisions based on higher rationality (Lund 2008). When a number of official state institutions exercise governance, increased institutionalization and bureaucratic rationalization is seen as a key feature of state formation (Weber 1978). Throughout this process, state institutions are never definitively formed but rather are continually undergoing change in levels of public authority (Steinmetz 1999). Moore defines processes of increasing institutionalization or regularization as “processes which produce rules and organizations and customs and symbols and rituals and categories and seek to make them durable” (Moore 1978:50). State institutions often appear to operate and remain stable with little open conflict. However, these institutions are actively being reproduced by individuals and organizations, although this process may not appear conspicuous on the surface (Lund 2008). Institutions then come to depend on these “social relationships for their continued reproduction.” A reduction in the number of state institutions may also be related to increasing regularization and state formation (Médard 1991). While formalization is often pushed by official government institutions, however, this formalization process, as well as laws and policies, are often negated or reversed due to corruption, as well as by political networks and alliances within the same government institutions (Médard 1991).

Alternatively, Moore's conception of the processes of situational adjustment states that there are simultaneous countervailing forces of informalization, whereby individuals exert agency within processes to create or exploit indeterminacies leading to "unpredictability, inconsistency, paradox and ambiguity, and ultimately institutional incongruence" (Lund 2006:699). This aligns with poststructuralist views of the state (Abrams 1977; Das and Poole 2004; Ferguson 1994; Ferguson 2006; Steinmetz 1999) that see public authority as exercised by transient and competitive parallel structures and alternative locations of authority (Lund 2006; Lund 2008).

Despite the continual fluxations in governance and its relation to non-state actors, the state is an important actor in governance in Africa. Migdal writes, "Like any other group or organization, the state is constructed and reconstructed, invented and reinvented, through its interaction as a whole and of its parts with others. It is not a fixed entity; its organization, goals, means, partners, and operative rules change as it allies with and opposes others inside and outside its territory. The state continually morphs" (Migdal 2001:23).

While it is argued that government institutions such as ministries will move towards formalization over time, there is no clear dichotomy of formal/government and informal/non-governmental (Moore 1978). "The distinction [between state and society] must be taken not as the boundary between two discrete entities, but as a line drawn internally within the network of institutional mechanisms through which a

social and political order is maintained” (Mitchell 1991:78). Thus, institutions and forms of public authority are continually evolving (and devolving), and the distinction between state and society is continually moving. Non-state actors (including but not limited to global civil society, NGOs, financial institutions, multinational corporations, merchant elite, and non-state militia groups) are playing larger roles in governance, often, but not always in collaboration with governments (Hall and Biersteker 2002; Lipschutz 1999; Roitman 2005; Rosenau 1997). Others agree, pointing to the increasing prominence of a “diversity of public and private actors who are increasingly able to mobilize at both domestic and international levels for the attainment of political goals, whether in support of or in opposition to governments” (Hocking and Smith 1997:13).

However, most of these discussions of the African state have not created analytically useful conceptions of the state and its functions in Africa, particularly as the literature sees states on a universal-type trajectory, and as separate organizations from society, rather than as fluid conceptions that change over time (Frödin 2012; Hagmann and Hoehne 2009; Lund 2006). “The analytical division among state, society and economy is difficult to maintain in the messy world of real politics and economics” (Frödin 2012:272). Frödin also argues that the state is not a “coherent administrative and coercive apparatus,” but rather, states exist and operate in context-specific and relational ways (Frödin 2012:284).

Thus, both the object-oriented conception of the state and the idea of public policy as independent and un-politicized are problematic. Rather, all elements of the state and its associated institutions are political. The political is disseminated throughout, and operates in rarely questioned ways. According to Foucault, with depoliticization resulting from political technology, a problem or issue is removed from political discourse and recast through legal or scientific language as neutral and objective (Foucault 2007; Foucault, Burchell, and Gordon 1991). Building on Foucault's conceptualization of political technology, Shore and Wright argue that the "masking of the political under the cloak of neutrality is a key feature of modern power" (Shore and Wright 1997:8-9). What is seen as administration, bureaucracy, and implementation is not normally viewed as political, when in fact it is. As policy becomes depoliticized, and distance between those who make and implement policy and those who are affected by policies and those in power are relieved of responsibility for actual policy outcomes.

The State and Public Policy

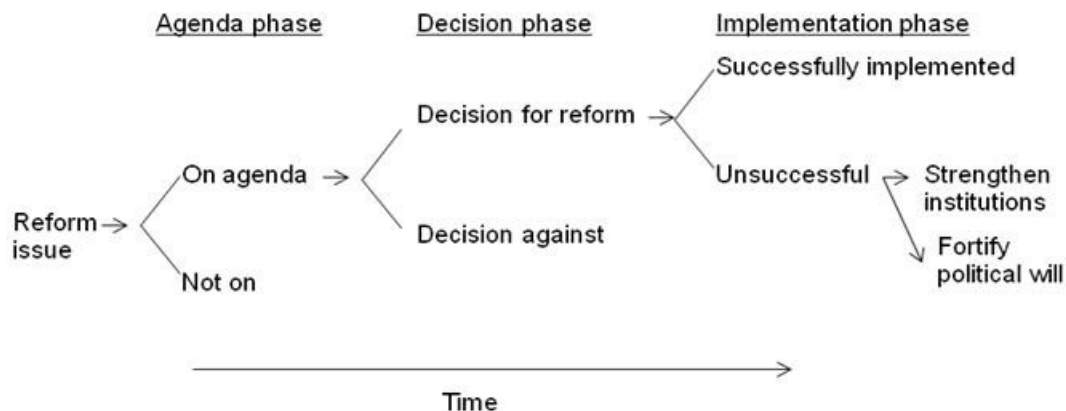
This dissertation focuses on public policy—policy that is adopted and implemented by a government. According to Dye, public policy is "anything a government chooses to do or not to do" (Dye 1972/2002:2). Dye's definition points to action, as well as inaction, as central to policymaking. It also allows for a wide continuum of what can

be considered policy, from implicit rules and principles guiding decisions to written legislation (de Leeuw 2007).⁶

A number of frameworks describing policy development and implementation have been proposed, both within and outside political science. In the most basic linear model of the policy process, decisions are made in sequential phases, beginning with the identification of an issue, a process of decision-making, then implementation of the policy. This linear model has been complicated by conceptualizing the policy process as one in which policy is made in disjointed, incrementalist ways (Lindblom 1968).

Figure 2 illustrates the linear model of policy reform as described by Thomas and Grindle (Thomas and Grindle 1990) (1990:1165). The linear model of policymaking conceptualizes policy formation as a separate, discrete activity from implementation. There is a false conception of “the notion of a divided, dichotomous and linear sequence from policy to implementation” (Clay and Schaffer 1984:147). “In general, the divorce between decision and implementation can be ascribed to decision makers’ sense that politics surrounds decisionmaking activities while implementation is an administrative activity” (Thomas and Grindle 1990:1170). Thus, in this linear policy model, if policies do not achieve their stated results, the failure is found on the implementation-side, such as poor management, resource shortages, or a lack of political will, rather than on the policy itself (Juma and Clark 1995).

Figure 2: The Linear Model of Policy Reform



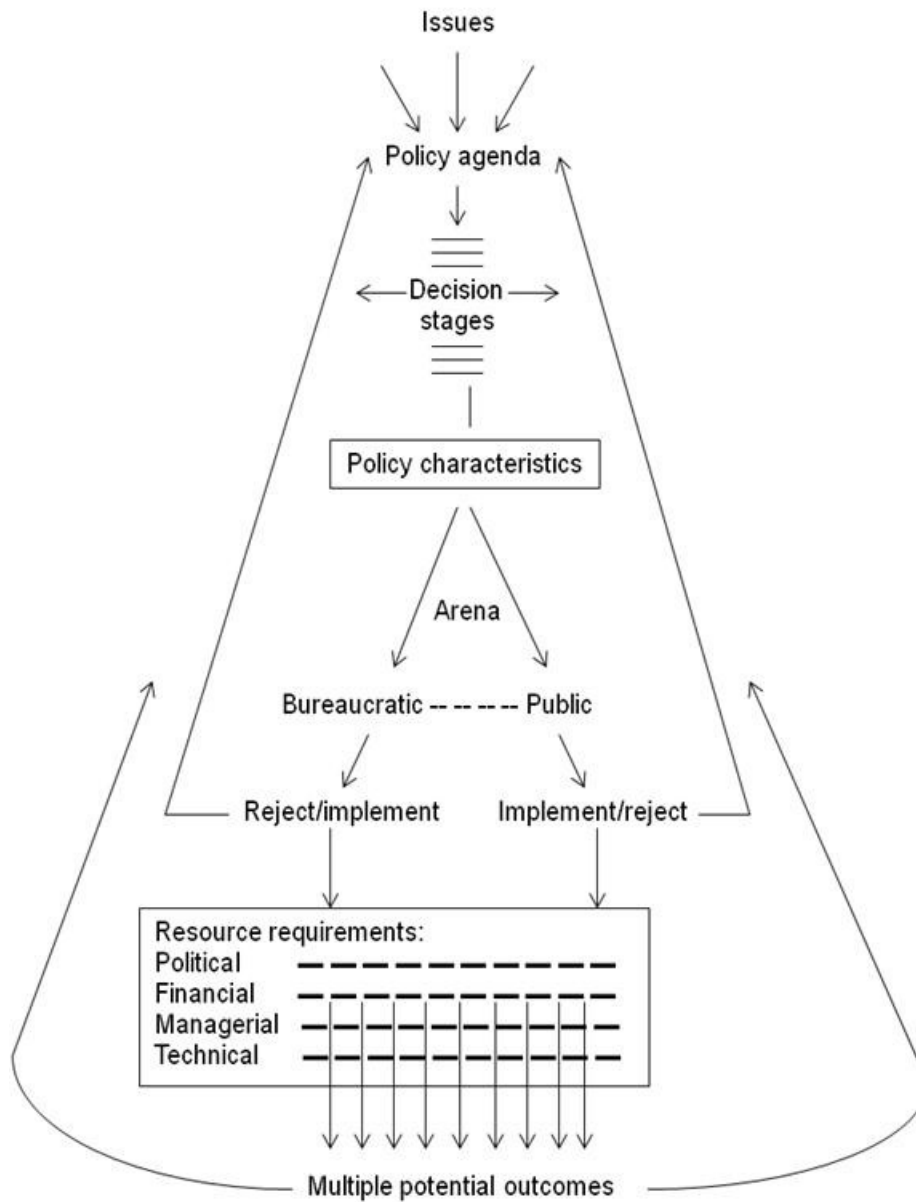
Source: (Thomas and Grindle 1990:1165)

Most analyses of public health policy rely on an “implicit linear model of policy-making” assuming “the existence of a continuum from research to policy change” and that policy decisions follow from data and scientific evidence (Bernier and Clavier 2011:110). This linear model of policymaking ignores or glosses over the processes of policymaking and the implementation of policies. Yet, other social sciences literature clearly shows that the policymaking process is “rarely characterized by rational decisions made on the basis of best information” (Young and Quinn 2002:218).

Grindle and Thomas argue against the over-simplified linear model of policymaking; instead, they develop an interactive model in which multiple actors can influence the policy process at many points (Grindle and Thomas 1991; Thomas and Grindle 1990). Policy implementation is a non-linear process that must be actively managed

through consensus building, conflict resolution, resource mobilization and adaptation (Grindle and Thomas 1991; Thomas and Grindle 1990). Figure 3 illustrates their interactive model.

Figure 3: The Interactive Model of Policy Implementation



Source: (Thomas and Grindle 1990:1167)

Hocking and Smith add to this interactive model by pointing to the specific involvement of non-state actors, including NGOs, in the policy process; “the demands of contemporary policy-making often require the maintenance of linkages and the striking of bargains between governments and non-governmental actors” (Hocking and Smith 1997:11).⁷ My findings described in later chapters in this dissertation would also add to the interactive model by showing how politics, operates through both inside and outside influence throughout all levels of the model.

Others have found that policy implementers have a significant agency in the policy process. “Implementation always makes or changes policy to some degree” (Lindblom 1968). With policymaking in developing countries (where decision-making is often centralized in the executive branch), significant political participation and accommodation occurs in policy implementation, rather than policy formulation (Grindle 1980). “Policy implementers interact with policy-makers by adapting new policies, co-opting the embodied project designs or simply ignoring new policies, hence underscoring the fact that implementers are crucial actors whose actions determine the success or failure of policy initiatives” (Juma and Clark 1995:126).

The ability of a state to implement and/or oversee the implementation of its policy goals is a central marker of state capacity. According to Midgal, state capabilities are “the ability of state leaders to use their agencies of the state to get people in the

society to do what they want them to do.” (Migdal 1988:xiii) “Capabilities include capacities to *penetrate* society, *regulate* social relationships, *extract* resources, and *appropriate* or use resources in determined ways” (Migdal 1988:4).

Frödin states that “state capacity is a matter of interplay of public, private and civic actors operating within a common institutional order, according to which they are allowed to act in different ways according to a set of constitutive and regulative rules” (Frödin 2012:275). Thus, state capacity is not only about the functioning of the administration and bureaucracy of the state; rather, state capacity is dependent upon not only the actions of state actors, but also the collective actions of public and private actors (Frödin 2012).

As discussed in the above section, the conventional view of policy processes as rational and linear has been dismantled by a number of scholars. Thus, no state policy can be implemented without considering the particular context in which it is implemented, and a large number of actors and institutions with significant agency are involved throughout an interactive policy process.

Looking Beyond the State and Institutions: The Role of Politics

At its heart, this dissertation explores a broader structure-agency debate (Giddens 1979; Hays 1994). This debate stretches back to Marx who argued “Man makes his

own history, but he does not make it out of the whole cloth; he does not make it out of conditions chosen by himself, but out of such as he finds close at hand. The tradition of all past generations weighs like an alp upon the brain of the living.” (Marx 1907:5). The structural side of the debate emphasizes that institutional and structural factors shape behavior while the agency argument places greater stress on the ability of individuals or agents to be autonomous.

While mainstream sociology has moved beyond this debate in more complex ways, current development literature, particularly development economics, is still overly focused on structure and institutions. The literature on developmental states has sought (and found) institutional and structural explanations for developmental success and failure. However, the role of “agential factors” that created the successful institutional forms and state configurations have been ignored (Leftwich 2010:94). While recognizing the importance of structure and not discounting its role, Leftwich argues that the often-hidden role of agency and politics need to be paid greater attention. Both institutions (structure) and politics (agency) work in tandem throughout all forms of social relationships.

Leftwich terms the type of human agency in development “the politics of development” and argues that more attention needs to be paid to agency and in particular, “the interactions of leaders and elites who dominate political, economic, military, communal, trade union, regional and ethnic interests, organizations and

sectors in most polities” (Leftwich 2010:95). This conception does not focus solely on the individual leaders, but rather the forms and functions of the patterns of leadership, which operate in both formal and informal structures of authority and power. It also aligns with a conception of the state as “an aggregate effect of a myriad of institutionalized practices” in which the state is “viewed in relational terms, as structures of interaction, which may take the form of a mutually supportive division of labour among actors varyingly defined as public, private and civic” (Frödin 2012:272-273).

Thus, politics operates both formally and informally and is not the sole domain of explicitly political or state institutions. Formal institutional structures for politics such as political parties, governments, and legislatures are not the only sites for individuals and groups to manage politics and political issues (Lund 2008). Politics regularly occur in practices outside formal and/or state institutions (Moore 1978; Moore 1986; Olivier De Sardan 2005; Scott 1990). “The definition of institutions has often been limited to formal organizational structures. However, informal organizations often shape the direction and pace of policy reform” (Juma and Clark 1995:129).

Leftwich defines politics as “all the activities of conflict, cooperation and negotiation involved in the use, production and distribution of resources, whether material or ideal, whether at local, national or international levels, or whether in the private or public domains” (Leftwich 2000:5, citing Leftwich 1983). This definition includes the

visible formal decision-making of official public policy, but also the political process that happens at all levels—from the smaller levels of the family, to organizations (both for-profit and NGO), groups, and within and across international levels. Power, and its distribution and control, is a central issue in understanding how politics operates.

Research Methodology

This research is based on a qualitative analysis of primary and secondary data sources. Primary data sources include 85 in-depth, semi-structured interviews with 121 key respondents involved in SRHR policymaking and implementation, including politicians at national and local levels, government bureaucrats in various central ministries including the Ministry of Finance, Planning and Economic Development (MoFPED) and the Ministry of Health (MoH) and district headquarters, employees of non-governmental organizations, researchers, academics, and those working at related private businesses such as hospitals, clinics, and pharmacies. All respondents were interviewed in Uganda; while a few of the respondents worked at the regional or international level, all had current projects or had spent significant time working at the national level in Uganda. I also observed various regional and national meetings and events between 2007 and 2011 via participant observation with Uganda's Population Secretariat. Secondary data sources that I analyzed include national policies, annual reports, budgets, and expenditure reports from various government

ministries, white papers by government and non-governmental bodies, and news articles. Data were written up in the form of transcribed interviews, field notes, and as information pulled from the secondary sources, and then coded and analyzed using ATLAS.ti version 6, a qualitative data management package to identify patterns. Please refer to “Appendix A: Methodologies” for detail on the research methodologies for this project.

Roadmap to the Chapters

“Chapter 2: A Short Political, Social, and Economic Background on Uganda” gives a sociopolitical primer on Uganda. The chapter begins with an overview of Uganda’s history of colonialism, postcolonial authoritarianism, civil conflict and more recent political and economic restructuring. Factors such as Uganda’s economic growth, the role of donors in the country, and indicators of well-being, poverty, and development are also discussed.

“Chapter 3: ‘The Cairo Consensus of Confusion’: Global Influence and Local Frames in the Struggles over Uganda’s Population Policy and Influences on Its Implementation” addresses the question of how to reconcile Uganda’s apparently good policies for reproductive health with persistent high fertility in the country. This chapter finds that donor conceptualizations and international trends in the understanding of population and sexual and reproductive health and rights have

shaped policies in Uganda, and that all parts of policymaking are political—from formation to implementation. A detailed analysis of donor and government budgets for health and for reproductive health and HIV show that implementation does not automatically flow from the existence of policies. Rather, the true policy priorities of the Ugandan government are reflected in the national budget which continually under-funds the health sector, particularly reproductive health. Despite numerous policies to the contrary, the national leadership of Uganda has a continuing desire for high fertility levels and comparatively low prioritization for improving women’s health. In Uganda, implementation of policies is dependent upon tangible political commitment through funding commensurate to need and through ensuring top-down accountability to policy.

“Chapter 4: ‘No One Ever Died of Overpopulation’: Comparing Uganda’s ‘Success’ on Combating HIV with Its ‘Failure’ on Population” begins by breaking apart the myths of Uganda’s HIV success story and unpacking the true causes of HIV prevalence decline in the country. This chapter also explores current HIV policy and practice in the country which is increasingly biomedicalized. Human rights and gay rights are almost ignored in HIV programming in favor of a biomedical approach to the epidemic, which acts contrary to the goal of reducing prevalence. The chapter concludes with a comparison of the five factors that played the largest role in Uganda’s success in reducing HIV prevalence and its failure to improve population and reproductive health indicators: a critical juncture, a clear consensus, political

incentive, collective action/social cohesion, and bureaucratic structure. These five factors help explain the role the political economy played in Uganda's HIV success.

“Chapter 5: ‘What Is Allocated Is Not What Is Delivered’: The Policy-Implementation Gap of Contraceptive Commodities” offers a political economy of reproductive health commodities in Uganda focusing on the actors and their motivations and incentives/disincentives in the processes of policy formulation, funding, and implementation. I challenge the larger assumption in the health policy literature that most policies are technical issues, rather than political issues. International policies and policy guidance are based on a model that sees commodity systems as determined by health needs and service delivery usage and implementation as a local technical function to be performed by the state in coordination with donors, NGOs, and community organizations. Instead, I find that the wider macro-environment, policy characteristics, and policy formation are key factors preventing successful policy implementation for reproductive health commodities in Uganda. This chapter explains how policy implementation is also a political issue, and thus both academic literature and program-relevant research need to address specific political factors in implementation, particularly in terms of funding and political commitment.

Finally, “Chapter 6: Conclusion: ‘Everyone Takes Our Policies and Just Implements, Why Can't We?’: The Contribution of a Political Analysis of Policy” summarizes the

entire dissertation, tying the independent chapters together by examining their implications for the larger literature on states and politics in Africa. I discuss the concept of “developmental patrimonialism” and how such an approach to governance requirements may be a better fit for developing countries seeking to move from extreme poverty to moderate poverty than the current “best practice approach”. I distinguish my approach as different from the good governance consensus, and align my work with a “good enough” approach to governance that takes into account local context. This chapter concludes with a brief critique of literature that ignores the role of politics in development and governance.

Chapter 2: A Short Political, Social, and Economic Background on Uganda

In this section, I give a socio-political background on Uganda. An overview of Uganda's history of colonialism, postcolonial authoritarianism, civil conflict and more recent political and economic restructuring is essential, as this review helps avoid the simplistic view that Uganda's history and political economy is similar, if not identical, to many other African countries.

Most popular global understandings of Uganda are shaped by some knowledge of the turbulence and violence of Idi Amin's rule from 1971 to 1979, and more recently, the terror and disturbance of Joseph Kony and the Lord's Resistance Army (LRA) in Northern Uganda from 1986 to the mid-2000s. Despite these popular conceptions, Uganda is often considered a success story in Africa—due to economic growth, political stability, and its status as the first and one of the only African countries to see a decline in HIV prevalence. However, ongoing conflict in the north until recently, stagnant undeveloped conditions in the eastern region, and slow progress on meeting the Millennium Development Goals, particularly for health, make Uganda less of a success than a complicated story.

Figure 4: Map of Uganda



Source: (Zlatunich 2012b)

Uganda is a landlocked country in East Africa with a large quadrant of its size in the southeast taken by Lake Victoria. Uganda is bordered by Kenya to the east, Tanzania and Rwanda to the south, the Democratic Republic of the Congo to the west, and South Sudan to the north.

Dozens of ethnic groups constitute Uganda's population. The 1995 constitution lists 56 indigenous communities, as of 1926 (Government of Uganda 1995). Currently, the Baganda, of the central area, are the largest ethnic group in the country, constituting 17% of the population. Southwestern ethnic groups include the

Banyankole and Bahima (10%), the Bakiga (7%), the Banyarwanda (6%), the Bunyoro (3%), and the Batoro (3%). Northern ethnic groups are the Langi (6%) and the Acholi (5%). The Lugbara (4%) are in the northwest. The main ethnic group in the northeast is the Karamojong (2%). Eastern ethnic groups include the Basoga (8%) and the Bagisu (5%) (US Department of State Bureau of African Affairs 2012).

Uganda is a predominantly a Christian country with growing evangelical Christian population. Uganda has been dominantly Christian almost since the arrival of missionaries in the nineteenth century. The most recent census of 2002 found that 85.1% of all Ugandans are Christian (with 41.9% of the total population being Catholic, 35.9% Anglican, 4.6% Pentecostal, and 1% other Christian; 12.1% Islamic, 1% traditional religions, and 0.7% are other non-Christian such as Hindu) (Uganda Bureau of Statistics 2002). A study in 2010 found that in Uganda roughly one-third of those raised Muslim now describe themselves as Christian, but the reverse conversion from Christian to Muslim is far less common (Pew Forum on Religion & Public Life 2010). This is different from the general pattern in Africa where a relatively small percentage of Muslims have become Christians, and a relatively small percentage of Christians have become Muslims. The Ugandan census of 2012 will likely find a much larger percentage of Pentecostal Christians in the country, as well as more Christians in general, as “Uganda is in the throes of a born-again Christian revival” (Epstein 2005). This is in large part due to the influx of American evangelical missionaries over the past 15 years. Missionaries have targeted Uganda due to its

history of Christianity and its geographic position bordering Sudan, Kenya, and Tanzania, all with more-significant Muslim populations (Epstein 2005). Ugandans also practice their religion regularly, almost 80% of Ugandans attend a place a worship weekly (Gallup 2010; Legatum Institute 2011).

British Colonialism and the Formation of Uganda

In 1877, British missionaries arrived in Uganda at the request of the Kabake (king) of Buganda, who sent a letter to Queen Victoria asking for her to send missionaries to teach his people “Western knowledge” and Christianity (Mutibwa 1992). At the time, Buganda was under threat from Egyptian military incursions and the Bunyoro, the kingdom to the north of Buganda (Mutibwa 1992). The initial declaration of Uganda as a British protectorate occurred in 1894 (Mutibwa 1992). The geographic territory that the British grouped together and renamed as Uganda was a heterogeneous mix of kingdoms and communities (Mutibwa 1992). Uganda never became a major British settler colony like Kenya or South Africa, and instead was seen as primarily a peasant economy for producing raw commodities such as cotton, rubber and coffee for export (Mamdani 1976, 1999:40-64; Mamdani 1996). Colonialism exacerbated regional inequalities between the more-developed south and the less-developed north. It also promoted ethnic, class, and religious tensions (Mamdani 1976, 1999; Mutibwa 1992).

When Uganda was colonized, the British worked through the kingdom of Buganda (the kingdom of the Baganda tribe) (Mutibwa 1992). They gave the kingdom the status of a protectorate, and employed its police and administration to govern the other areas of Uganda. The Baganda therefore occupied both a privileged and resented position within the British protectorate, as Buganda constituted a sub-state with interests conflicting with those of the larger state (Kasozi, Musisi, and Sejjengo 1994). Traditional Baganda leadership mediated British rule, or as described by Mamdani, instituting “decentralized despotism” in the country (Mamdani 1996).

Civil society organizations that existed before independence were of a number of types: mass-based, elite-led, cultural/ethnic-based, welfare and charitable, and the media (Thue, Makubuya, and Nakirunda 2002). Mass-based organizations formed as cooperatives to resist the colonial state’s monopoly on agricultural trade and as trade unions to protest poor working conditions and low wages. Trade associations and cooperatives increasingly engaged in political activism against the colonial state (Mamdani 1976, 1999). The colonial state was against such organizing by civil society and declared general unions illegal in 1952. “State action was directed not just against the organizational unity but also the organizational autonomy of the union movement” (Mamdani 1976, 1999:191). The first actors to engage in social service delivery were missions, which established hospitals and schools; they were followed by other charitable organizations such as the Uganda Red Cross (De Coninck 2004). National and local health and charity service-delivery organizations were supported

by international NGOs starting with Save the Children in 1956 and Oxfam a few years later (De Coninck 2004). The welfare and charitable organizations founded during colonialism, often under the umbrella of churches, are the precursors to modern NGOs (Thue, Makubuya, and Nakirunda 2002).

Post-Colonial Independence and Growth

Uganda gained independence from the United Kingdom in 1962, but there was (and remains) significantly unequal development among the regions. Uganda “ was marked by northern poverty and southern prosperity” (Bates 2008:66). Colonial infrastructure in the central region, as well as to a lesser extent in the west and east, was generally good although the north was underserved (Carlson 2004). At independence, there were a relatively good system of district hospitals and health centers, although the colonial health care system placed a heavy emphasis on hospitals over lower-level health clinics (Carlson 2004). In 1965 there were approximately 600 doctors in the country (Iliffe 1998:124). Yet, the number of doctors was not growing in relation to the increasing population. In 1960, Makerere University medical school, the only medical school in East Africa at the time, admitted 31 first-year Ugandan students and planned to increase its intake to 60 over five years (Iliffe 1998). At independence, Uganda’s medical system was considered a model for poor countries, although it had a strong concentration on curative medicine

rather than prevention and a system of decentralized health centers (Iliffe 1998:130-131).

Politics upon independence were based on religious and regional constituencies (Mutibwa 1992). Milton Obote became prime minister at Uganda's independence on 9 October 1962. Obote's civilian regime from 23 April 1962 to 25 January 1971 formed the precedent for the country's turbulent politics of the 1970s and 1980s (Mutibwa 1992:22). Milton Obote built his "political base in the poorer regions, propounded socialist principles, and imposed control regimes in an effort to redistribute the wealth of the prosperous regions to the semi-arid zones" (Bates 2008:66). In February 1966, Obote suspended the constitution, assumed all government powers, and removed the ceremonial president and vice president (Mutibwa 1992). In September 1967, a new constitution proclaimed Uganda a republic, gave the president even greater powers, and abolished the traditional kingdoms (Mutibwa 1992).

After independence, cooperative societies and trade unions were increasingly controlled by the government under the direct supervision of the Department of Labor and mission schools were integrated into the public education system (De Coninck 2004). In addition, political parties and traditional kingdoms were eventually banned. During this time, civil society organizations that remained were generally focused on charity and health care (De Coninck 2004). From independence in 1962 until 1971,

gross domestic product (GDP) grew an average of 5.2% per year (Uganda Ministry of Finance Planning and Economic Development 2010).

Political Turbulence and Violence

In the twenty years following independence, there were five successful coups d'états. In January 1971, the military led by Idi Amin Dada overthrew Obote's government in the first coup d'état. Amin declared himself president, dissolved the parliament, and amended the constitution to give himself absolute power (Mutibwa 1992).

Amin's rule between 1971 and 1979 was characterized by wide-spread repression and violence, as well as the expulsion of Asians in 1972 (Mutibwa 1992). It has been estimated that between 50,000 and 300,000 people were killed for political reasons during Amin's regime (Kasozi, Musisi, and Sejjengo 1994). The Acholi and Langi ethnic groups from the north were particular targets of Amin, as they were the political base for Obote and made up a large part of the army, due to military recruitment practices during and after colonialism (Mutibwa 1992).

Political violence under Amin also led to the departure of most of Uganda's international development partners and donors. "During the political turmoil of the Idi Amin regime in the 1970s, when most bilateral development assistance was withdrawn from Uganda, Pathfinder was the only US-based reproductive health

organization that continued activities in the country” (Pathfinder International 2012). The departure of most international donors and NGOs combined with low government financing of public services led to a collapse of the public health system, which was once one of the best in sub-Saharan Africa due to infrastructure and training institutions set up during colonialism (Carlson 2004). Upon assuming power, Amin also banned women’s organizations (apart from religious ones) and passed a decree in 1978 establishing the National Council of Women to oversee all registered women’s organizations, forcing some organizations into dormancy or into operating underground (Kyomuhendo and McIntosh 2006; Tripp 2000). During Amin’s rule between 1971 and 1979, gross domestic product (GDP) declined by 25% due to political instability and economic mismanagement (Uganda Ministry of Finance Planning and Economic Development 2010).

In April 1979, a coalition of several groups backed by the Tanzanian army, under the aegis of the Uganda National Liberation Front, captured Kampala, and Amin fled. The Uganda National Liberation Front formed an interim government with Yusuf Lule as president and a quasi-parliamentary organ known as the National Consultative Commission (NCC). In June 1979, the NCC replaced Lule with Godfrey Binaisa after a dispute over the extent of presidential powers. Binaisa was then removed in May 1980 and a military commission (chaired by Paulo Muwanga) ruled the country until December 1980.

In December 1980, Milton Obote was re-elected President and Muwanga elected vice president when the military government (supporting the Uganda People's Congress (UPC)) organized an election that was widely regarded as fraudulent (Okuonzi and Macrae 1995). However, the international donor community, including the IMF and World Bank, resumed aid to Uganda following Obote's election. The IMF and World Bank started stabilization and structural adjustment periods in the country between 1981-1985. International NGOs also started large-scale relief operations at this time, including an intervention in Karamoja in the early 1980s due to famine in the region (De Coninck 2004). Obote allowed some women's organizations to resume operations, but also tried to turn the National Council of Women into a party organization (Kyomuhendo and McIntosh 2006). Uganda's GDP grew 5.5% per year between 1981 and 1983 (Uganda Ministry of Finance Planning and Economic Development 2010).

The growth rates in 1984 and 1986 were negative (Uganda Ministry of Finance Planning and Economic Development 2010), in part because of a significant amount of donor resources devoted by Obote's government to combat the growing insurgency, including that of the National Resistance Army (NRA) led by Yoweri Museveni (Okuonzi and Macrae 1995). Under Obote, the army and security forces attacked a large portion of the country in an effort to defeat the NRA insurgency, particularly in the Luwero Triangle area north of Kampala. In the second Obote

period, the estimates of those killed for political reasons range between 300,000 and one million (Kasozi, Musisi, and Sejjengo 1994).

During the civil war period of 1981 to 1986, international NGOs provided emergency medical care to internally displaced and refugee populations, as well as to the general population in the most affected areas such as the Luwero Triangle (Carlson 2004).

Public sector services fell apart even more during this time and the value of pay declined in the 1980s, leading doctors and nurses to collect fees for supposedly free services (Bates 2008). The military in the mid-1980s preyed on the public and contributed to the country's decline and disorder, "Any soldier who needed money in an area of conflict would just pick an isolated, strategic part of the road, put logs or chains across it, and wait for unfortunate travellers. These twentieth-century highwaymen would rob everyone of anything they fancied: cash, watches, cassette radios, clothes, and the like. Women were often raped at roadblocks."(Kasozi, Musisi, and Sejjengo 1994:152).

In July 1985, an army brigade seized Kampala and proclaimed a new military government headed by Gen. Tito Okello, and Obote fled. In the fall of 1985 Okello's government attempted negotiations with Museveni and the NRA, pledging to improve governance and human rights, while at the same time murdering civilians and attempting to destroy support for the NRA. However, the NRA continued fighting after agreeing to a cease-fire in late 1985. The NRA defeated the military coup of

Okello in January 1986 when the National Resistance Army (NRA), led by Yoweri Museveni captured Kampala, forcing Okello to flee. By the time the NRA “stormed Kampala in 1986, close to half a million people had been killed, the infrastructure destroyed, social services neglected, the economy ruined, the need to preserve the environment forgotten, social discipline abandoned, and the quality of life undermined” (Kasozi, Musisi, and Sejjengo 1994:145).

Post-Conflict Rehabilitation, Stabilization, and the Politics of State-Making

The Ugandan government under Museveni has been heavily supported by donors. The Marxist rhetoric that propelled Museveni and the National Resistance Movement (NRM) in 1986 was quickly shed and the government almost immediately signed a policy framework paper with the International Monetary Fund (IMF) and the World Bank in 1987. This assistance allowed the government to start delivering basic social services and reduce the scarcity of basic goods. Uganda was the first country to be eligible for the Heavily Indebted Poor Countries (HIPC) initiative in 1998 and 2000 and had virtually all of its foreign debts forgiven by the IMF, World Bank, and major donors (Naiman and Watkins 1999).

After the NRA took power in 1986, the forces organized a government with Museveni as president. The first official act of the new government was to suspend party politics by stating that ethnic conflict was exacerbated by political parties

(Goetz 2008; Mutibwa 1992). The new government was more inclusive than prior governments, and spanned former political parties as well as regional and religious factions (Mutibwa 1992).

The government formed by the National Resistance Movement (NRM) prioritized stabilization of both the economy and the political situation. Even the harshest critics of President Museveni and his party admit that he dramatically improved the country's safety and stability. In 2001, Time Magazine wrote, "No one denies that for most of Uganda's 23 million people life has improved under Museveni" (Michaels 2001).

Since 1986, Uganda has remained politically stable. However, armed conflicts in the northern part of the country, particularly with the Lord's Resistance Army (LRA) led by Josph Kony persisted until 2006 (Clark 2010; Makara, Rakner, and Svåsand 2009; Van Acker 2004). The Ugandan government moved 1.8 million civilians in the north from Gulu, Pader, and Kitgum into internally displaced persons (IDP) camps, and many people in the area moved to major cities and trading centers for greater safety (Joireman, Sawyer, and Wilhoit 2012). However, the IDP camps were not safe, and people living in them were subject to disease, malnutrition, and attacks from the LRA (Joireman, Sawyer, and Wilhoit 2012).

Donors started to increasing funds to aid Uganda's recovery in 1986, particularly for health care. Donors created numerous vertical programs (e.g. UNICEF for immunization and child survival programs, USAID for family planning, Danish aid for essential drugs and the World Bank for physical rehabilitation) (Carlson 2004). UNICEF in particular played a major role as the alternative Ministry of Health, as the UNICEF director drove a large amount of national health policy (Carlson 2004). There was no national health policy until 1993 (Carlson 2004). Because of ongoing rebel activity and instability in the north and north east, donors first focused their support in the more stable central and southern areas of Uganda, but government and non-governmental programs slowly expanded into the north as the government brought stability to more areas of the country. As the World Bank and other donors forced fiscal restraint upon the government, civil society organizations, particularly NGOs, were seen to be closer to the people and less corrupt (De Coninck 2004; Sullivan 2007).

The new NRM government began to regulate NGOs in 1989 when it enacted the 1989 NGO Registration Act and regulation statutory instrument, which required all NGOs to register with the government and put their activities under the supervision of the Ministry of Internal Affairs (Government of Uganda 1989; Government of Uganda 1990). The definition of NGOs under Article 1 of the 1989 NGO Registration Act is narrow and limits the activities for NGOs to "religious, educational, literary, scientific, social or charitable services" and does not include activities such as

governance, policy, or human rights (Government of Uganda 1989:Section1(d)). The act was amended in 2006 to give the government tighter control over NGOs and holds directors and officers liable to personal conviction (Government of Uganda 2006).

In 1993 the government developed the first three-year national health plan and the Local Government Statute, which began the process of decentralization, including decentralization of health services. Uganda's decentralization was not only about devolving power to increase local input and participation and bringing services closer to the people (although this is the rhetoric parroted by the highest to lowest government officials); the Ugandan state agreed to decentralization in part to make accommodations as well as strengthen patronage networks between the national level and local power and traditional authorities (Green 2008; Mwenda 2007; Mwenda and Tangri 2005).

Uganda began the process of military demobilization in 1992, reducing the number of armed forces from about 100,000 to around 65,000 by 1995 (less than target reduction of 50,000 soldiers) (Byamukama 2000). A new constitution was approved in 1995; elections for president, parliament, and local offices held in 1996 and 1997 were relatively free from conflict although money and incumbency had very strong influences on the outcomes and the continued political dominance of the ruling NRM government (Muhumuza 1997; Mwenda and Tangri 2005).

In the mid-1990s, Museveni sought a larger regional role, with the stated aim of contributing to regional political stability. In 1997, the Uganda People's Defence Force (UPDF) invaded the Democratic Republic of Congo (DRC) to remove President Joseph Mobutu, who was said to be harboring the perpetrators of the 1994 Rwandan genocide. President Laurent Kabila ordered the Ugandan and Rwandan armies to leave the DRC in 1998, yet both governments instead increased their presence in the DRC in 1998 and 1999. Uganda regarded their military involvement in this period in the DRC as part of an operation termed "Safe Haven", and later attempted to justify these military actions as self-defence (International Court of Justice 2005). Over time, the UPDF became involved in local conflicts, which led to destabilization of the eastern DRC, and thousands of deaths and rapes. As a result, in 2005 the DRC brought Uganda before the International Court of Justice in The Hague, accusing Uganda of committing human rights violations and massacring Congolese civilians during its time there (BBC News 2006). The International Court of Justice found that Uganda violated international human rights and humanitarian law, including acts of killing, torture and the inhumane treatment of civilians, training child soldiers, and inciting ethnic conflict, as well as looting Congolese natural resources (International Court of Justice 2005). It was not proven at the International Court of Justice that there was an official Ugandan governmental policy directed at the exploitation of DRC's natural resources, however Ugandan military officials and soldiers, "including the most high-ranking officers, were involved in the looting, plundering and exploitation of the DRC's natural resources and that the military

authorities did not take any measures to put an end to these acts” (International Court of Justice 2005:251). Thus, the court found that Uganda was internationally responsible for these unlawful acts (International Court of Justice 2005:252).

Academic and media sources assert that the true motives for Uganda’s involvement in DRC were to support and enrich leaders of the state and the military, and to support patrimonial networks (Dietrich 2000; Taylor 1998; The Economist 1999). Dietrich has argued that the Uganda People’s Defence Force (UPDF) actions in the DRC were essentially a corporate-military business venture used to support domestic clientelism in Uganda, to secure patronage payments to uphold the patrimonial state: “military commercialism brings external resources under the control of the deploying country’s patrimonial network, allowing for redistribution to protect the domestic regime. In this way, the military is used in part as a formidable tool to maintain a patrimonial pyramid. . . [In the use of the Ugandan People’s Defense Force (UPDF) by President Museveni,] soldiers secure profits to the patrimonial state, hence replicating corporate employees and comprising an ‘industrial base’ for the underdeveloped state” (Dietrich 2000).

The debacle in the DRC stained the reputation of President Museveni as the head of the “new breed” of African leaders, as heralded by US President Bill Clinton in 1998 (BBC News 2006). Increasing media reports of corruption in the country at high political levels and within the presidential family also cast the president in

increasingly bad light. In addition, increasing government corruption was noted in international publications and press such as Transparency International Corruption Perceptions Index, the United Nations Commissions on the Congo, and Amnesty International starting in the late 1990s and early 2000s.

A voter referendum on Uganda's political system was held in March 2000. Seventy percent of voters endorsed retention of the Movement system over a system of limited political parties or multi-party politics. However, the referendum vote was criticized for restrictions on anti-Movement campaigning and low voter turnout (US Department of State Bureau of African Affairs 2012). In addition, the 2001 Presidential elections were marred by significant state-sponsored violence (BBC News 2006; Uganda Supreme Court 2001), as well as increasing political patronage to keep the president and the NRM in power (Tumushabe 2006). However, President Museveni was acquitted by the Uganda Supreme Court of wrongdoing as it determined that election malpractices by state agents were not done "with his knowledge and consent or approval" (Uganda Supreme Court 2001).

In July 2005, the NRM government conducted a referendum to decide on the issue of a return to multiparty politics, which passed with over 90% of the vote (Makara, Rakner, and Svåsand 2009). In September 2005, Uganda's parliament amended the constitution to remove term limits for the president (Makara, Rakner, and Svåsand 2009). Many termed this process to remove term limits a sham due to the significant

bribery and corruption documented in news reports and allegations by previous insiders (Gyezaho 2004). Preceding the parliamentary vote to lift presidential term limits, 223 out of 333 members of parliament were paid five million shillings (about \$2,500 USD) each. President Museveni defended the payments, stating that the funds were for transport and to hold public meetings on the amendment to lift presidential term limits; he also argued that the amount itself was not enough to be a bribe, “How can anybody, especially an MP, be bribed with sh5m?” (Kaheru 2004). President Museveni was declared the winner of the 2006 election, with 59% of the vote and the main opposition leader, Kizza Besigye, received 37% of the vote. The 2006 Museveni campaign was termed “win by any means” and the elections were marked by disenfranchisement of voters and noncompliance with the law due to vote-stuffing and vote-counting, bribery, and violence (BBC 2011; Gatsiounis 2011a; Uganda Supreme Court 2006). However, the Uganda Supreme Court again ruled in favor of President Museveni and the Electoral Commission, stating that the conduct of the election did not substantially affect the end results (Uganda Supreme Court 2006).

In the February 2011 elections Museveni won 68% of the vote (his fourth presidential win by vote), extending his mandate to 30 years (Gatsiounis 2011a). Kizza Besigye received 26% of the votes, a lower percentage than in the 2006 election (US Department of State Bureau of African Affairs 2012). Museveni’s campaign in 2011, estimated to have cost \$350 million, was understood by critics and opposition parties as a “win at all costs” (with financing coming from all corners of government

budgets, as well as the supplementary budget passed in January 2011). Museveni's swearing-in ceremony in 2011 has been estimated to have cost around \$1.5 million USD (Gatsiounis 2011a; Gatsiounis 2011b).

Uganda, like many African states, cannot be classified as either a democracy or autocracy. Diamond argues "more regimes than ever before are adopting the *form* of electoral democracy, with regular, competitive, multiparty elections . . . but fail to meet the substantive test" (Diamond 2002:22). Bratton and Chang call states like these liberalized autocracies; they "derive their ethos from previous military and one-party arrangements, now adapted for survival in more open political environments. Leaders in these systems pay lip service to basic freedoms; for instance, by allowing elections with token opposition. But they govern in heavy-handed fashion, typically placing strict limits on the independent press, civic organizations, and political parties to the point of sometimes imprisoning their strongest opponents or barring them from contesting elections" (Bratton and Chang 2006:1065). Tripp (2010) classifies Uganda as a hybrid state and a semiauthoritarian regime, full of ambiguity and contradictions such as improved stability, economic growth and human rights with limited political freedoms, the expansion of executive power, military dominance, and consistent challenges to the independence of the judiciary and legislature.

Donors and Economic Growth

The Ugandan government under Museveni has been heavily supported by donors.

The Marxist rhetoric that propelled Museveni and the National Resistance Movement (NRM) in 1986 was quickly shed and the government almost immediately signed a policy framework paper with the International Monetary Fund (IMF) and the World Bank in 1987. This assistance allowed the government to start delivering basic social services and reduce the scarcity of basic goods. Uganda was the first country to be eligible for the Heavily Indebted Poor Countries (HIPC) initiative in 1998 and 2000 and had virtually all of its foreign debts forgiven by the IMF, World Bank, and major donors (Naiman and Watkins 1999).

Between 1987 and 1996, GDP grew at an average of 6.5% per year, which combined with population growth meant 3.4% growth in per capita terms (Uganda Ministry of Finance Planning and Economic Development 2010). In 1987 inflation stood at 200% (Uganda Ministry of Finance Planning and Economic Development 2010). In 1992, President Museveni declared, “There will be no inflation. Inflation is indiscipline” (Manson 2011). By 1996, inflation was reduced to 7.1% (Uganda Ministry of Finance Planning and Economic Development 2010). However, inflation has again begun to rise in recent years.

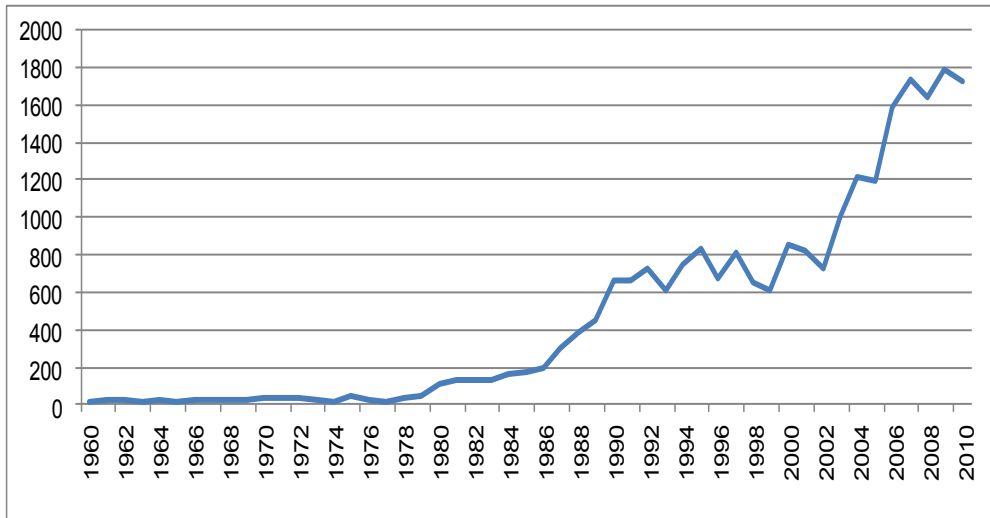
Between 1997/98 and 2000/01, during the time of the first Poverty Eradication Action Plan (PEAP), the average GDP growth rate was 7.2% per year (Uganda Ministry of

Finance Planning and Economic Development 2010). GDP growth slowed to 6.8% per year from 2000/1 to 2003/04, but again increased to 8% between 2004/05 and 2007/08 (Uganda Ministry of Finance Planning and Economic Development 2010). GDP growth again declined to 6.2% in 2008/09, but then rose again in the last years of the decade (Uganda Ministry of Finance Planning and Economic Development 2010).

However, high population growth rates during the 1990s and the first decade of the new century meant that real GDP growth per capita did not grow as fast. GDP per capita averaged 3.4% growth in the 1990s and approximately 4% growth between 2000 and 2010 (Uganda Ministry of Finance Planning and Economic Development 2010).

However, the country's dramatic economic growth was supported in good part by significant donor resources. Half of the \$6.7 million USD in official development assistance between 2003 and 2007 came from only three donors: the World Bank, the United States, and the United Kingdom (Uganda National Planning Authority 2010:67).

Figure 5: Total Bilateral Aid (ODA) to Uganda, in Current Prices, USD Millions



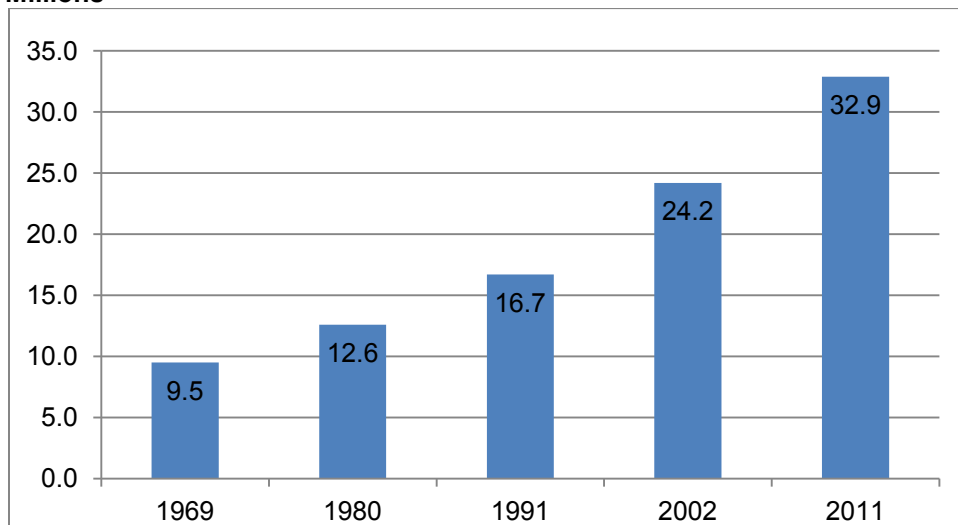
Source: (Organisation for Economic Co-operation and Development (OECD) 2011)

Population, Health, and Human Development

The population of Uganda is estimated by the government to have reached 32.9 million by mid-2011 and 34.1 million in 2012 due to rapid population growth since independence (Uganda Bureau of Statistics (UBOS) 2011c; Uganda Bureau of Statistics (UBOS) 2011d).⁸ Official censuses have given Uganda's population as 9.5 million in 1969, 12.6 million in 1980, 16.7 million in 1991, and 24.2 million in 2002 (Uganda Bureau of Statistics (UBOS) 2011d). Between 1991 and 2002, the population growth rate was 3.2 percent (Uganda Bureau of Statistics (UBOS) 2011d). More recent projections put the population growth rate at 3.5 percent in 2011 (Uganda Bureau of Statistics (UBOS) 2011c). Population growth is high due to high fertility, with an average of about six children per woman (the total fertility rate was

measured as 6.2 in the 2011 Demographic and Health Survey (Uganda Bureau of Statistics and Measure DHS 2012).

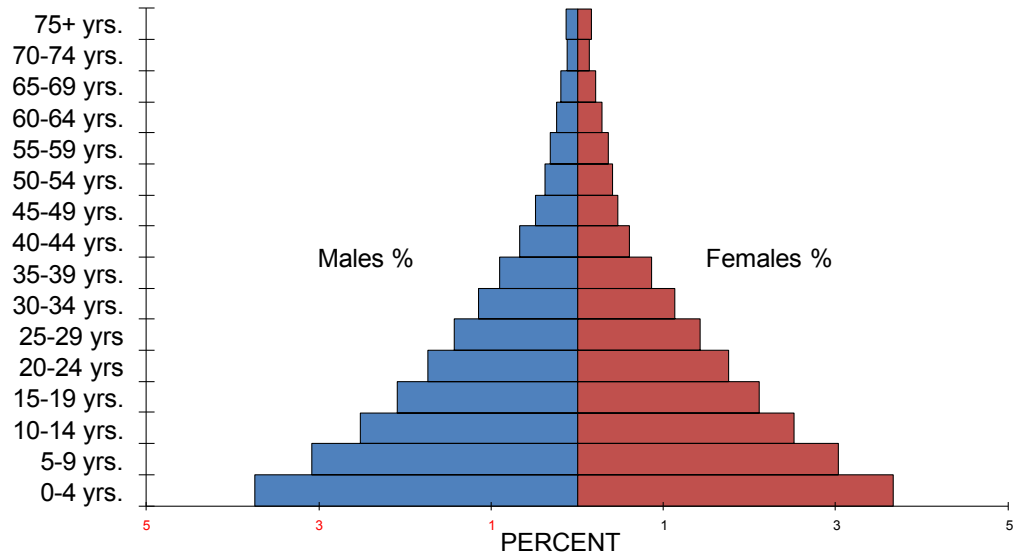
Figure 6: Census Population: 1969, 1980, 1991, 2002, and Mid-2011 Projection, in Millions



Source: (Uganda Bureau of Statistics (UBOS) 2011d)

Figure 7 gives the population pyramid of Uganda. Because the population is so young, with a large percentage yet to reach their childbearing years, there is significant population momentum. This means that the population growth will continue even if the country reaches replacement-fertility levels (a little over two children per women), because there will be a high concentration of people in their childbearing years. Thus, Uganda's population will continue to grow at a high rate even if there are significant increases in contraceptive use and lower fertility rates.

Figure 7: Age-Sex Distribution in Uganda, 2010



Source: (United Nations Department of Economic and Social Affairs Population Division 2011)

Although economic growth averaged 6.5% in the 1990s and over 7% in the last decade, high population growth has taken up much of the economic gains, meaning that real GDP per capita averaged 3.4% growth per year in the 1990s and approximately 4% over the last decade (Uganda Ministry of Finance Planning and Economic Development 2010). This still puts Uganda near the top of the fastest growing economies over the past decade.

Life expectancy has improved in recent years, with the life expectancy estimated at 52 years in 2007, rising from census calculations of 46.5 in 1969, 48.1 in 1991 and 50.4 in 2002 (Uganda Bureau of Statistics (UBOS) 2011a). Maternal mortality fell

from 600 (in 1990) to 310 deaths per 100,000 live births in 2010 (World Health Organization, UNICEF, UNFPA, and The World Bank 2012). There are 4,700 maternal deaths every year in Uganda, and the lifetime risk of maternal death is one in 49 (World Health Organization, UNICEF, UNFPA, and The World Bank 2012). In 2011, only 59.3% of births were attended by skilled health personnel (Uganda Bureau of Statistics and Measure DHS 2012).

Under-five mortality remains high, although has decreased dramatically in recent years, between 2006 and 2010, the under-five mortality rate was 90 deaths per 1,000 live births (Uganda Bureau of Statistics and Measure DHS 2012). This is an improvement from 2000- 2005, when the rate was 125 deaths per 1,000 live births, and from 1995 to 1999, when the rate was 143 deaths per 1,000 live births (Uganda Bureau of Statistics and Measure DHS 2012). However, only 51.6% of all one-year old children have all of the basic vaccinations (Uganda Bureau of Statistics and Measure DHS 2012).

The Human Development Index (HDI), a composite index of life expectancy, education, and per capita national income, gave Uganda a score of 0.294 in 1985, rising to 0.312 in 1995, 0.401 in 2005 and to 0.446 in 2011, putting Uganda 161 in ranking out of the 187 countries ranked (United Nations Development Programme (UNDP) 2011). Uganda's GDP growth since the mid-1990s and improvements in

education through the Universal Primary Education program were main sources for the gains in health, education, and the reduction of poverty since 1995.

Despite significant economic growth and donor investment in development, Uganda's poverty statistics have not improved at the same rate as economic growth. The government reports that poverty has fallen dramatically since 1992, with poverty rates decreasing from 56% in 1992 to 38.8% in 2002 to 24.5% in 2009/2010 (7.5 million people) (Uganda Bureau of Statistics (UBOS) 2011a). Although the proportion of people living in poverty has significantly declined in Uganda over time, the reduction in the absolute number of poor persons was not significant (less than a million people between 2005/2006 and 2009/2010). Poverty is regionalized; in large portions of the north and east of the country, over 60% of the population is under the poverty line (see Figure 8 for a map detailing locations of high poverty) (Uganda Bureau of Statistics (UBOS) 2009). National income inequality has increased in recent years (moving from a national Gini coefficient of 0.365 in 1992/1993 to 0.426 in 2009/2010) (Uganda Bureau of Statistics (UBOS) 2011a). The mean consumption of Kampala, the richest area, is 2.5 times greater than the northern region, which is the poorest area (Uganda Ministry of Finance Planning and Economic Development 2010).

costs. These protests throughout 2011 following the election led to a strong police response, resulting in at least ten deaths (including a two-year-old child who was shot in the head and chest by security forces), and opposition leader Dr. Kizza Besigye, hit by a rubber bullet, charged and jailed for unlawful assembly and later put under “preventative” house arrest (Gatsiounis 2011a).⁹ President Museveni seems generally unconcerned with rising inflation and the rising cost of living; in early 2011 he dismissed rising food prices by stating that the higher prices are good for farmers and in regards to rising fuel prices, he said, “What I call on the public to do is to use fuel sparingly. Don’t drive to bars” (Gatsiounis 2011a).

However, the recent financial crisis has not negatively affected the economy as significantly as a number of more developed countries. Direct investment in Uganda has generally increased in absolute terms, from \$778.4 million USD in 2007/2008, a slight dip to \$772.4 million USD in 2008/2009, then again rising to \$810.9 million USD in 2009/2010 and \$883.8 million USD in 2010/2011 (Uganda Bureau of Statistics (UBOS) 2011a).¹⁰ Donors have also generally continued to meet their pledges, preventing significant effects on the overall government budget (Uganda Ministry of Finance Planning and Economic Development 2010).

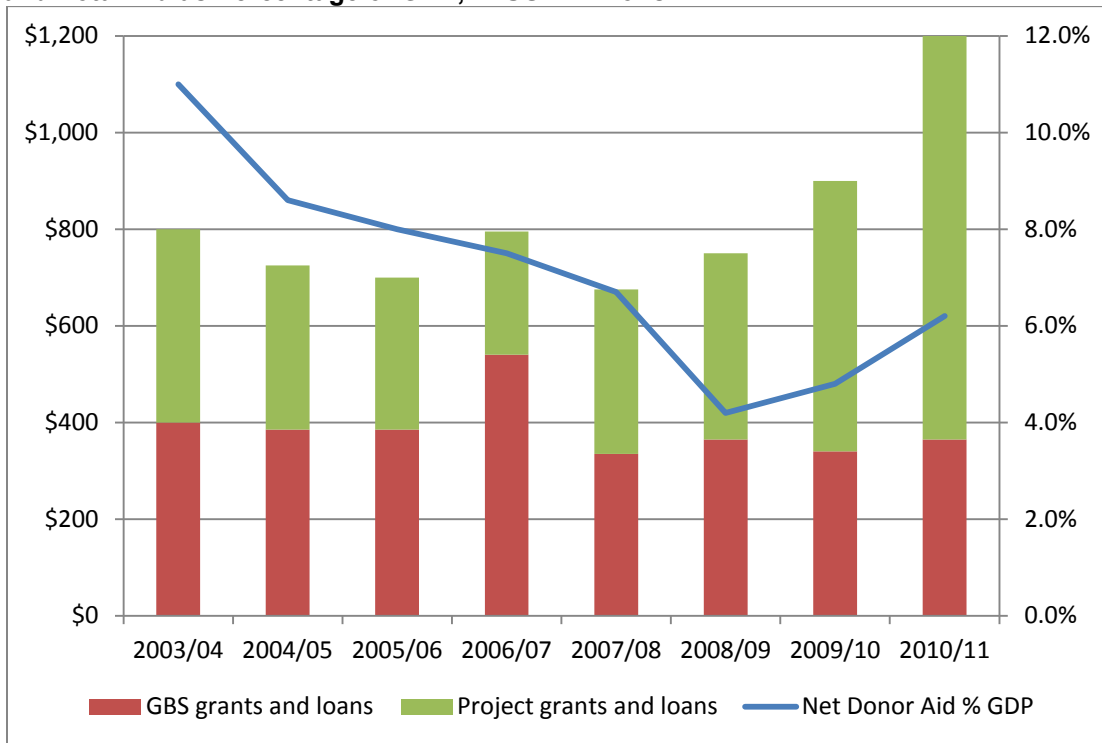
Although there are currently 29 multilateral and bilateral donors to Uganda, the largest four—the World Bank, the United States, the European Union, and the African Development Bank—provide 60% of total aid to the country (DFID 2011a).

Budget support by donors, both general and earmarked to sectors, increased from 3.4% of GDP in 1997/98 to 10.1% in 2001/02. These figures mean that donors contributed 20% of the public budget in 1997/98 and 40% in 2001/02. During this time, project support remained constant as a proportion of GDP but fell from 33% in 1997/98 to 25% of public expenditure in 2001/2 (Williamson and Canagarajah 2003:464). The dramatic change in this time period was due to the creation of the Poverty Action Fund (PAF) by the Ugandan government in 1998 to ensure that donor budget support and debt relief under the Heavily Indebted Poor Countries (HIPC) went to priority areas of the government identified in the Poverty Eradication Action Plan (PEAP) of the time. The PAF allowed donors to shift from project to budget and Sector Wide Approach (SWAp) support (Koenig and Atim 2010).

The move away from program-based funding and towards general budget support and sector-wide approaches was enshrined in the Paris Declaration on Aid Effectiveness and the follow-up Accra Agenda for Action (OECD 2005, 2008). Nevertheless, there has been ensuing doubt of the effectiveness of general budget support (e.g. due to perceptions of poor governance and corruption). This questioning of the effectiveness of general budget support has led donors including the World Bank, DFID, the Netherlands, and Ireland in recent years (most notably in 2009/2010 and 2010/2011) to reverse the earlier tendency and thus, funding is again directed more towards projects rather than direct support, as the money and its outcomes can be more easily tracked (Manson 2011).¹¹ The Netherlands cited continuing corruption, threats to

fiscal credibility, and a diminishing efforts for poverty reduction as the reasons for cutting direct support entirely in 2012 (Manson 2011).

Figure 9: Foreign Assistance to Uganda, General Budget Support and Project Support, and Total Aid as Percentage of GDP, in USD Millions



Source: (Richardson 2011; Uganda National Planning Authority 2010:58)¹²

The Ministry of Finance, Planning and Economic Development (MoFPED) has a ceiling on the overall government budget, as well as budget ceilings for all sectors (health, education, etc.), preventing ministry spending above a certain level, under the justification of preventing Dutch Disease and maintaining macro-economic control (Odaga and Lochoro 2006). In addition, the MoFPED does not treat donor funding to health sector as additional to that sector by the specific amount (Odaga and Lochoro

2006). This means that donors who want to ensure that their funds go only to health have moved back to project funding and away from general budget support. Figure 9 above shows the recent evolution in the modality of aid funding in Uganda, with about 2.4 trillion Ugandan shillings (about \$1.2 billion USD) to Uganda in 2010/2011.

Chapter 3: “The Cairo Consensus of Confusion”: Global Influence and Local Frames in the Struggles over Uganda’s Population Policy and Influences on Its Implementation

Figure 10: Political Cartoon Captioned: “The Population Secretariat has asked the Government to plan for the rapidly increasing population.” *New Vision*, 15 October 2008



Source: (Ras 2008)

Introduction

The Uganda Population Secretariat, as a semi-autonomous government institution under the Ministry of Finance, Planning and Economic Development, carries out advocacy activities at national and lower levels to disseminate governmental policy on population, to educate district leaders on integrating population activities into their

workplans and budgets, and to disseminate general information on the influence of population factors on development (such as land degradation, education, and health care). At one of these meetings in a western district of the country, a member of the Population Secretariat staff was speaking to a group of district leaders and managers. After making a presentation on population and development, the Population Secretariat staff present led a group discussion on the way forward for the district's incorporation of population dynamics into its programs. After a discussion of the national development vision, land use, environment, water and education, one member of Population Secretariat staff introduced the conflict between these issues and population growth promoted by political leaders, "You have to use your brain and change your behavior. You see Museveni on TV, what he says . . . [but] how will he come feed your family? He is telling you to produce. Is he going to feed you? . . . You are supposed to eat at UPE?"

The group then discussed how they need to make a commitment to increase the availability of family planning at the health facility level and through the village health teams at the community level. They discussed the assumption that it was the central government's responsibility to provide supplies, rather, a participant voiced the opinion that the district needed to be asking for supplies and also work to increase male involvement in family planning: "We have had a lot of contradiction, especially from the top. We need one package [saying] that it [having too many children] is bad, unless you can afford."

Before the close of the meeting, one participant said, “In my place, when you talk about family planning, we have a saying, [that] the male electorate will be against you and you will lose the votes. If you keep advocating for monogamy, they will not vote for you. They produce what they can manage. If they can manage 5 women, let them manage. Let the president give them liberty.”

This chapter addresses the question of how to reconcile Uganda’s apparently good policies for reproductive health with continuing high fertility in the country. In this chapter, I argue that true priorities of the Ugandan government are reflected in the national budget, and the continuing under-funding of the health sector, particularly reproductive health. Despite numerous policies to the contrary, the national leadership of Uganda has a continuing desire for high fertility levels and comparatively low prioritization for improving women’s health.

This chapter begins with a brief background on population and reproductive health in Uganda. I then trace the history of the global discourse on population, family planning, reproductive health, maternal health and the MDGs in order to give a background to the roles and motivations of international donors in Uganda’s reproductive health policies and programs. This is followed with a discussion of the

particular role that donors have played in Uganda through their support of health, population, and HIV policies and programs. The United States Agency for International Development (USAID) and the United Kingdom Department for International Development (DFID) have been the largest bilateral funders in recent years and the United Nations Population Fund (UNFPA) has consistently been the largest multi-lateral donor for population-related activities in Uganda. I then discuss the national environment and evolution of Uganda’s reproductive health and population policies and develop the concept of “imagined integration” to describe the disjuncture between bureaucracy as imaged in policy versus how bureaucracy operates in reality in Uganda. The next section covers the continuing politicization of “population” and accompanying public questioning of the existence of Uganda’s “population problem” by national and local leaders. The chapter concludes with arguments on the importance of the national budget in determining tangible political commitment and in ensuring top-down accountability to policy.

Background: Population, Fertility, and Reproductive Health in Uganda

Uganda, unlike its East African neighbors, has not experienced a significant fertility decline. In the last 1960s, fertility rates across the East African community ranged from 6.6. to 7.1. Today, Uganda has the highest official fertility rate in the region at 6.2 (2011), while Kenya is at 4.6 (2008/2009), Tanzania at 5.4 (2010), and Rwanda at 5.5 (2007/2008) (Measure DHS 2012; Uganda Bureau of Statistics and Measure DHS

2012). Uganda has not experienced a similar marked decline in fertility, despite having a similar population policy and family planning program as Tanzania (Vavrus and Larsen 2003). Kenya has experienced the most significant decline of the region, with total fertility falling by about 40 percent between 1980 and 2000 due to the Kenyan government's active promotion of family planning through health services (Blacker, Opiyo, Jasseh, Sloggett, and Ssekamatte-Ssebuliba 2005). More recently, Kenya's fertility decline, like Tanzania's decline, has stalled for a number of reasons (Ezeh, Mberu, and Emina 2009).

The family planning effort score is an index based on a survey of expert observers measuring the input into the national family planning program rather than outcomes such as contraceptive use and fertility decline. The total family planning effort score for Uganda was 50.4 out of a potential perfect 100 in 2009 (Ross and Smith 2010). Uganda's total effort score is slightly higher than its neighbors Kenya at 48.7 and Tanzania at 47. Uganda's scores for specific areas in 2009 are as follows: 63.4 for Policies; 47.8 for Services; 47.9 for Evaluation and 41.5 for Access in the latest 2009 survey round, pointing that its policies are stronger than its services for family planning (Ross and Smith 2010). Kenya's scores for specific areas in 2009 are as follows: 55.8 for Policies; 41.0 for Services; 75.8 for Evaluation and 43.5 for Access (Ross and Smith 2010). Tanzania's scores for specific areas in 2009 are as follows: 50.5 for Policies; 44.3 for Services; 49.1 for Evaluation and 47.2 for Access (Ross and Smith 2010). Both Kenya and Tanzania score lower than Uganda for policies, but

higher in evaluation and access, lending credence to the argument that Uganda is stronger in policy formulation than implementation of those policies.

There is significant variation in fertility levels between districts in Uganda, and between rural and urban areas, as shown in Figure 11. Although fertility is much lower in urban areas, particularly in the capital city of Kampala, the overwhelming rural nature of the population (85.2% live in rural areas) keeps fertility averages high overall (Uganda Bureau of Statistics (UBOS) 2011a).¹³

would want to space or limit the number of children they have, but are not using any method of contraception (Uganda Bureau of Statistics and Macro International Inc. 2007). Low rates of family planning use contribute to high maternal and child mortality in the country. Births that come too early, too late, or too close pose health risks for both mother and child; contraception allows women to prevent high-risk early, late, and closely-spaced births (Singh, Darroch, Ashford, and Vlassoff 2009; Stover and Ross 2010).

The adolescent birth rate is high, with 159 births per 1,000 women age 15-19 (Uganda Bureau of Statistics (UBOS) 2011a). While adolescent fertility has declined since earlier studies in 1995, 2000/01, and 2005/06 in Uganda, adolescent fertility is still higher than in most other sub-Saharan African countries. While young women in Uganda have high levels of knowledge and relatively high levels of contraceptive use, they have higher fertility at lower ages than their counterparts in Tanzania (Vavrus and Larsen 2003).

Other researchers have found that Uganda has a lower level of contraceptive use than expected when compared to other African countries with similar rates of educational attainment (Lloyd, Kaufman, and Hewett 2000a). Uganda has relatively high levels of knowledge of at least one contraceptive method, with 96% of women in 2006 knowing any modern contraceptive method, but the DHS studies do not assess the particulars of this knowledge at a more qualitative level, such as asking how the

specific knowledge or lack of knowledge shapes individual decision-making (Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007).

Nuwagaba argues that “ignorance” about modern contraceptives, including misconceptions about contraceptives leading to sterility, could be a cause of the low levels of contraceptive use in the country (Nuwagaba 1997). Other research confirms this assumption, finding that women’s misperceptions and misinformation about contraceptives leads to low levels of contraceptive use (Kibuuka, Guwatudde, et al. 2009).

In addition, gender inequality contributes to women’s inability to decide on the number of children to have or to use contraception. In 2006, forty-seven percent of Ugandan men indicated that family size is primarily their decision (Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007).

The country’s status as a Christian country with growing evangelical Christian population also plays a large role in beliefs about contraception and patterns of family planning use.¹⁴ Religious leaders of all denominations, particularly Roman Catholics, have regularly spoken against the use of artificial methods of family planning. Catholic-run health facilities do not provide artificial methods of family planning such as contraceptive pills, injectables, and condoms (Nakiboneka and Maniple 2008). Natural methods of family planning such as Moon Beads, based on the

standard days method of determining fertile and non-fertile days, were brought into Uganda in 2006 by a social marketing organization, have been promoted by First Lady Janet Museveni (a born-again Christian) and by religious leaders in public discussions (Mugisa 2008; Nabusoba 2006).

Global Population Discourse, Policy, and Programs

The context of the global discourse on population, family planning, and reproductive health is essential to understanding the role and evolving motivations of international donors in Uganda's reproductive health policies and programs. International family planning programs have been shaped by three distinct rationales: demographic, health and human rights (Seltzer 2002). At the inception of international family planning programs in late 1960s (and through the 1970s), the demographic rationale of population pessimists/ population controllers ruled. A shift to a health rationale and a focus on reducing high maternal and infant mortality occurred in the 1980s. And in the 1990s (marked by the ICPD in 1994) until today, a reproductive rights and reproductive health¹⁵ rationale is dominant (Seltzer 2002). Reproductive health/family planning was not originally included in the Millennium Development Goals, but was eventually included as a target under Millennium Development Goal 5 (Improve maternal health) as Target 5.b: Achieve universal access to reproductive health (United Nations 2012; United Nations General Assembly 2000). More recently, there has been a greater emphasis on maternal health, as advocates have

recognized the greater appeal to policymakers of health rather than rights (Crossette 2005).¹⁶ In this section I describe the history and key elements of these three rationales. This discourse, while international, is played out across a number of locations and situations—at the United Nations, between donors (governments and private donors) and recipient country governments and implementing agencies (e.g. international as well as national non-governmental organizations).

The United States' population movement advanced the demographic argument that rapid population growth was an impediment to socio-economic development in the global South (Sending 2009a). American philanthropists were among the first to promote population as an arena of social change, rather than solely an academic field of theory and study. In the 1950s and 1960s, the Ford and Rockefeller Foundations were the first to make significant investments in education and research into population dynamics and population planning (Hodgson 1991; Sending 2009b). Through their funding, they created graduate training programs in demography and public health¹⁷ and established international research networks¹⁸ linking the developed and developing world that all were “singularly addressed to the task of reducing global population growth through family planning programs” (Sending and Neumann 2006:658). This academic base laid the foundation for the establishment of international population policies that emerged in the 1960s and were driven by “advocacy groups, experts, and philanthropists, where public advocacy and elite contacts in different countries were key” (Sending 2009b:3).

The pessimism of population control theorist Frank Notestein and his colleagues in the 1940s and 1950s supplied the framework for John D. Rockefeller III and his wealthy contemporaries to fund programs for population planning (Hodgson 1991; Sending 2009b).¹⁹ In 1950, the Rockefeller Foundation described the problem of fertility reduction in developing countries as one of “motives and means” and said that the West can best contribute to fertility reduction by developing contraceptives that address the technological means (Balfour, Evans, Notestein, and Tauber 1950:118).²⁰ John D. Rockefeller III established the Population Council in 1953 and by 1962, the first intra-uterine device (IUD), called the Lippes Loop was marketed (Population Council 2011a).²¹ The role of private funds in the global population control movement was critical to its beginning. In 1965, the most significant funding from the Ford Foundation (\$10.8 million USD), the Population Council (\$2.3 million USD) the Rockefeller Foundation (\$3.2 million USD), the United States Agency for International Development (USAID) (\$2.3 million USD) and the International Planned Parenthood Foundation (IPPF) (\$935,000 USD) (Harkavy, Saunders, and Southam 1968). But by 1968, the USAID funds significantly increased, to \$34.8 million USD, surpassing private funding for population assistance (Population Action International 2011).

During this time, it was assumed by American population planners (such as the Rockefeller Foundation, the Ford Foundation, the Population Council, and USAID)

that all women wanted to control or make decisions about their fertility, irrespective of socio-economic situation or culture. The Population Council wrote, “It is often argued that in the traditional societies people are not really ready for or interested in family planning. The experience of the Council is that people are amazingly ready and that the difficulty lies in the failure of governmental personnel to realize that fact” (Warwick 1982:34). With this position, the Population Council and its allies pushed for the adoption of population policies and programs in developing countries. “A central task for American demographers became convincing Third World leaders that population control was both needed and possible” (Hodgson 1988:551). In 1955, Frank Notestein and Leona Baumgartner, working for the Population Council, assisted the government of India to develop their population policy.²² In 1959, the Population Council and the Ford Foundation provided similar assistance to Pakistan, and later to Kenya,²³ the Philippines, South Korea, Taiwan, Thailand, Tunisia, and Turkey, under a new division called the Technical Assistance Division (Caldwell and Caldwell 1986). In addition, research centers at American universities funded by the Population Council and the Ford and Rockefeller Foundations provided assistance to developing countries to establish family planning programs.²⁴ Reasons for countries’ adoption of population policies include: as a response to economic conditions, due to pressure or intervention by outside organizations or donors such as the World Bank, to show commitment to donors, and/or as an outcome of the diffusion of global norms—often through norm-setting institutions such as the United Nations (Barrett

1995; Barrett and Frank 1999; Barrett and Tsui 1999; Hartman 1995; Lacey 1990; Sullivan 2007).

Despite significant research and funding, and policy initiatives in the field, population planning was considered controversial, such that no group of the United Nations existed to provide assistance or funding in the area until 1967. In 1967, a contribution from the United States of several million dollars prompted the United Nations to create the United Nations Fund for Population Activities (now called the United Nations Population Fund (UNFPA)) to “assist countries in achieving their population goals” (Finkle and McIntosh 2002:12). UNFPA became operational in 1969 (Sending 2009b; UNFPA 2012).

The health rationale for family planning is based on concerns about the consequences of high fertility to women and children. High rates of maternal mortality,²⁵ coupled with high infant and child mortality, are associated with high numbers of pregnancies and closely spaced pregnancies, unsafe abortion, as well as lack of proper prenatal and antenatal care (particularly trained attendants at delivery) (Khan, Wojdyla, Say, Gülmezoglu, and Look 2006). Women’s health advocates working at national and international levels took issue with the emphasis on contraceptive technologies being pushed in developing countries, which they thought occurred at the expense of consideration for the context of women’s lives and that the infrastructure of health and family planning programs could alter the safety and efficacy of the contraceptive

methods (Seltzer 2002:74). Advocates were concerned with a number of examples of contraceptive technologies; two cases proved the merit for their overall concern. Quinacrine pellets were introduced in a number of developing and middle-income countries (including China, India, Indonesia, the Philippines, Vietnam, Bangladesh, Chile, Costa Rica, Croatia, Egypt, and Pakistan) as a nonsurgical sterilization method without following internationally accepted standards for testing drugs for safety and efficacy—the WHO and US Food and Drug Administration (FDA) joined women’s health advocates in calling for its removal from public use until completing testing in animals and clinic trials (Berer 1994). Decades later, this method of sterilization was still being used on poor women in developing countries without having completed drug testing to international standard (Berer 1994; Berer 1995). The Dalkon Shield, an IUD implanted in approximately 3.6 million women worldwide in the early 1970s, utilized a multifilament string, allowing bacteria to travel into the uterus of users, leading to sepsis, injury, miscarriage, sterility, and death. These injuries and deaths resulted in a large class action lawsuit of over \$2 billion USD (Vairo 1997). The rationale shift to a focus on health happened, but it was still health as a means to control fertility and population growth, rather than as a outcome in and of itself (Furedi 1997; Kabeer 1994).

Population and family planning became tied to human rights in the World Leaders’ Declaration (signed by 30 heads of government), issued by the United Nations on Human Rights Day in 1967. The declaration stated, “the population problem must be

recognized as a principal element in long-range national planning if national governments are to achieve their economic goals and fulfil the aspirations of their people . . . the opportunity [of parents] to decide the number and spacing of their children is a basic human right” (Berelson 1969:7-8).

Global debates on population at conferences sponsored by the United Nations mirrored the debates and controversies within the field. The first World Population Conference was held in August 1974 in Bucharest, Romania. The United Nations Secretariat and proponents of population planning (most prominently the United States at the time) intended to build a global consensus on the population problem and to agree on a solution to promote family planning to limit fertility. However, the reaction of a large number of developing countries at the Bucharest conference was unexpected by the population planners. A large group of developing countries, led by Algeria, argued that development rather than population was the problem, and said that the solution to underdevelopment is a new international order. In the final Plan of Action for Bucharest, two issues were articulated by developing countries: “that development, not population control, was their overriding objective, and that they would not cede national sovereignty to a coordinated global plan designed by the rich industrialized countries of the West” (Finkle and McIntosh 2002:14). The perspective that “development is the best contraceptive,” was articulated by the Indian delegate to the conference, Dr. Karan Singh (Singh 1990). Although during this conference, population was de-emphasized as a strategy for development, family planning

remained on the agenda, as health and human rights were used to justify family planning programs (Berelson 1975).

The 1984 World Population Conference in Mexico City reached a near-consensus and declared that family planning services should be made “universally available” “as a matter of urgency” (Finkle and Crane 1985; Finkle and McIntosh 2002). Despite the promotion of family planning programs, population planning perspectives were further weakened in the early 1980s with the ascendancy of liberal free-market theories which regarded state intervention in markets as unnecessary. This perspective became a policy in the US administration under President Reagan, which limited funding for population programming, through the Mexico City policy enunciated in 1984. This perspective maintained that “population growth is, of itself, neither good nor bad. It becomes an asset or a problem in conjunction with other factors, such as economic policy, social constraints, and the ability to put additional men and women to useful work” (Associated Press 1984).²⁶ The United States position reflected the interests of political conservatives, the right-to-life movement, and some religious groups (Donaldson 1990). At this time, US policymakers were also influenced by Julian Simon’s *The Ultimate Resource* (1981/1996), which made the argument that population growth is beneficial in the long run because a larger population leads to a greater number of technological innovations (Timmer, Sirageldin, Kantner, and Preston 1982).

The UN International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994 changed global perspectives and approaches on population. It was heralded as a dramatic breakthrough in the global consensus on population, responsible for re-framing the field away from the dominant narrative of the “population problem.” ICPD’s consensus framework aimed directly at a goal of comprehensive sexual and reproductive health and rights (SRHR) based on a human-rights framework; this framework both encompassed and superseded the prior emphasis on family planning programming for goals of fertility reduction in the developing world. Principle 5 in the Program of Action (PoA) signed by 179 countries states that “Population-related goals and policies are integral parts of cultural, economic and social development, the principal aim of which is to improve the quality of life of all people” (UNFPA 1995). The ICPD PoA endorsed a broader conception of reproductive health over a narrower conception of family planning. Reproductive health is inclusive of family planning, maternal health, prevention of STIs including HIV, adolescent reproductive health, and sexual health. The vision of reproductive health of the ICPD is that “every sex act should be free of coercion and infection, every pregnancy should be intended, every birth should be healthy” (Tsui, Wasserheit, and Haaga 1997:1). The ICPD marked the public shift in focus from macro-level concerns about population growth (and population targets) to more micro-level health and rights issues, and a mandate to address broader concerns of sexual and reproductive health and rights of all people, particularly women. In some cases, the ICPD led to specific policy change in some countries, such as the removal

of targets for acceptors of different family planning methods in India and the clarification of abortion policy and expansion of abortion services in Brazil (Ashford and Makinson 1999).

Gender issues became central at ICPD, as there was extensive discussion and outcomes on women's welfare, equity and empowerment (Caldwell 1996). "We are witnessing a radical change in the role and status of women throughout the world" (Finkle and McIntosh 1996:111). At Cairo, feminist NGOs had a "direct and powerful impact in the realm of policy" (Presser 1997:295). The Women's Caucus was the largest NGO caucus at ICPD, with about four to five hundred participants daily (United Nations Population Information Network 1994). The Women's Caucus was the originator of the most progressive and feminist language in the ICPD Program of Action including all of the definitions on reproductive health and the reference to "sexual" in the context of "reproductive health" (Earth Negotiations Bulletin 1994).

The alliance of feminists and population planners was uneasy. Both agree on the need for contraceptive technologies in the developing world, but many feminists struggle with the dominant agenda (the one held by most donors and country governments) that conflates women's need for contraception with slower population growth. "Most feminists have struggled to give women's need for reproductive technology a political status as one element of their broader rights to exercise control over their bodies and their lives" (Kabeer 1994:193). Feminist demographers have articulated that family

planning is a rights issue and that high rates of population growth can impede development (Dixon-Mueller 1993; Mason 1996). This dual commitment is also now (post-ICPD) clearly articulated in the programs of international development agencies and organizations such as UNFPA and the Population Council (Population Council 2011b; UNFPA 2011b).

Following ICPD, UNFPA expanded its mandate beyond a strict interpretation of population and reproductive health programming and funding. This has led partners and advocates to critique it for straying beyond its original focus on population and reproductive health; a recent review of its programming recommended that UNFPA limit its priorities to its “unique mandate” (Nugent, Bloom, and Musinguzi 2011). UNFPA’s reports regularly emphasize the need to “reinvigorate family planning programs” in order to achieve ICPD goals, yet program resources are not dedicated specifically to family planning, but rather lumped into the larger category of general reproductive health and not accounted for separately. UNFPA’s expenditure data (UNFPA’s expenditures in Uganda are discussed in detail later in this chapter) support the argument made by family planning advocates that family planning has been deemphasized since ICPD, with HIV gaining not only funding but also priority, resulting in less traction for family planning services.

The shift in the 1990s in population policy, from a focus on demographics, population planning, and family planning to sexual and reproductive health and

rights, also marked a shift in the group and in the types of experts and practitioners involved in the issues. The tremendous shift from a pure demographic focus within the population establishment to one of women's health and rights was also accompanied by a broadening to include women's groups and public health professionals. However, demographers with a Malthusian bent still have a critical voice in the academic and policy debates around population (Short and Potts 2009).

The reaction to ICPD from mainstream demographers was not entirely positive. Westoff claimed that a focus on women's rights and women's health services (including specific reproductive health issues such as the movement to end female genital cutting/mutilation) may be a legitimate concern, but doing so means that they [feminists] "ignore or minimize population growth and its perceived consequences" (Westoff 1995:179). Cleland also calls the link between women's empowerment and fertility decline "dubious" and states that "the dominance of this [the improvement of (women's) political, social, economic and health status] theme at Cairo has some unfortunate consequences and is all the more regrettable because the 1995 Beijing Conference on women offered a more appropriate forum for detailed considerations of gender issues" (Cleland 1996:107).

However, as "improving women's health is less threatening to the status quo than enhancing women's power within and outside the family" (Presser 1997:309), rights arguments are often invisible and health arguments continue to be the predominant

frame in many developing countries. The focus on health dominates in African settings, particularly among conservative governments. Health, particularly when framed as maternal health, is seen as a much less controversial subject of policy and programming, while rights, particularly sexual rights, are often argued to be “against traditional African social and cultural norms” (Interviewee #81).

International efforts to address maternal health began in the mid-1960s, when Western donor countries and international agencies began funding national Ministries of Health to implement maternal and child health programs (Campbell 2001). By the 1970s, however, maternal health was largely absent from programs in developing countries, which were largely focused on child health and family planning and little attention paid to maternal deaths occurring outside of the health care system (Rosenfield and Maine 1985). An article by Rosenfield and Maine (1985) in the *Lancet* was influential in increasing global interest in maternal mortality, and the first international conference specifically on maternal mortality in 1987 in Nairobi led to the launch of the Safe Motherhood Initiative (Campbell 2001).

The Safe Motherhood Initiative, however, did not generate the large-scale effort necessary to achieve its goal to “reduce maternal mortality by 50% by the year 2000” (Starrs 2006). Maternal health did not “attract the level of political attention its founders hoped it would receive” (Shiffman and Smith 2007). Sixteen percent of total international donor funding went to maternal and child health in 1990 (Zeitlin,

Govindaraj, and Chen 1994). However, the majority of that funding targeted child health, as only one-fifth of one percent of total donor funding was directed to safe motherhood programs (Zeitlin, Govindaraj, and Chen 1994). Large-scale programs addressing maternal health were not funded by donors until the mid-1990s, and by the late part of the decade, private funding from the Gates Foundation began to be targeted to the issue (Campbell 2001).

Maternal health became enshrined in global consensus through the MDGs as it was one of the main eight goals (Goal 5: Improve maternal health) (United Nations 2012). Reproductive health was not originally specifically included (but was eventually included in 2005) as a sub-goal under Millennium Development Goal 5b (United Nations Statistics Division 2011). Explicit mention of sexual and reproductive rights were missing from the MDGs, in part due to strong opposition from the United States, the Holy See (Vatican) and nations within the G-77 (Crossette 2005; Hulme 2009). Thus, maternal health became enshrined in global discourse and poverty supernorms, while rights arguments became largely absent from the larger global poverty-reduction discourse (Crossette 2005; Fukuda-Parr and Hulme 2011). National programs newly aligned to meeting the MDGs generally failed to protect and promote women's human rights (including their reproductive rights), despite the presence of international and regional treaties protecting reproductive rights such as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Gerntholtz, Gibbs, and Willan 2011).

Significant efforts by NGOs and INGOs to raise the profile of maternal health gained even greater global traction since 2005 with the launch of the Partnership for Maternal, Newborn and Child Health and a series of global conferences held by the advocacy organization Women Deliver since 2007 (Women Deliver 2012). In addition, a number of African countries have focused particular attention on maternal health since the Maputo Plan of Action was ratified by African Heads of State through the African Union in 2006 (African Union 2006). As of 2010, 38 African countries (including Uganda) have adopted country-specific roadmaps to reduce maternal mortality and four more countries were in the process of developing them (African Union 2010). However, few countries have implemented tracking mechanisms to measure funding and resources allocated to reproductive and maternal health (African Union 2010).

Demographic arguments have regained some power among advocates. At the 2011 International Conference on Family Planning held in Dakar, Senegal, the focus of a high-level policy dialog between African Ministers of Health and Ministers of Finance addressed the demographic dividend. Researchers have conclusively determined that substantial economic benefits can come to a country during the time period of change between high and lower fertility rates (Bloom, Canning, and Sevilla 2001). This “demographic dividend” is based on benefits from falling birth rates. A greater share of the population consists of working-age adults who have to support a

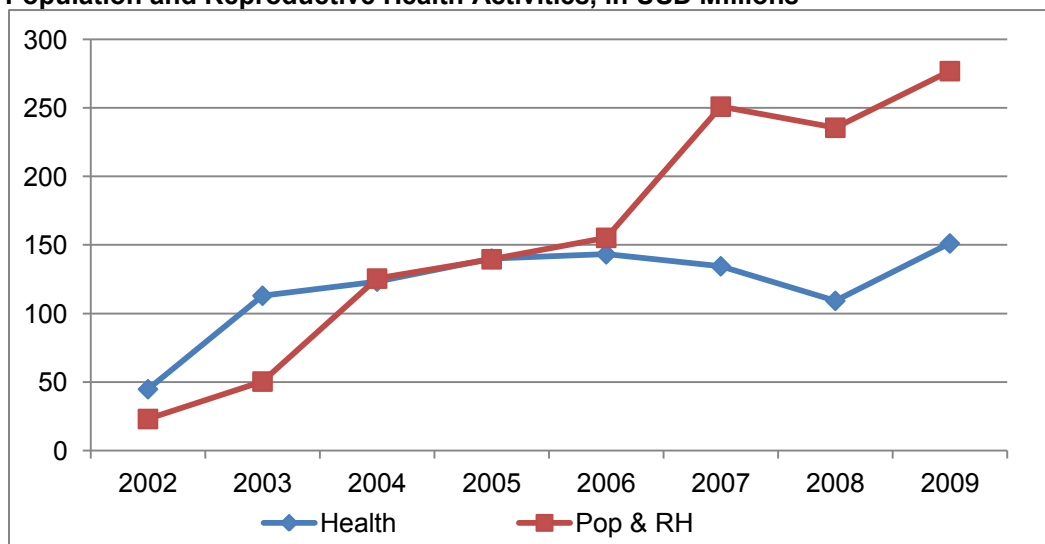
smaller proportion of dependent children—this ratio can boost productivity and allow greater savings and investment. However, the demographic dividend is not only dependent upon birth rates, it also requires social and economic policies, including openness to trade, flexible labor markets, and investments in human capital including education and public health (Greene and Merrick 2005; Ross 2004). The demographic dividend was experienced in East Asia; as much as one-third of growth between 1965 and 1990 in the “economic miracle” countries of East Asia was due to demographic dividends (Bloom, Canning, and Malaney 2000; Bloom and Williamson 1998). Recent research has argued that the demographic principles that fuelled East Asia’s growth are available to Africa, and thus, sub-Saharan African countries with good institutions and policies could be able to reap a demographic dividend (Bloom, Canning, Fink, and Finlay 2007).

International Donor Influence in Uganda: From “Reducing Fertility” to “Investing in People”

International discourse and its evolution have played a key role in how the international community and donors have viewed Uganda’s policies and programs for population and sexual and reproductive health and rights. Even more so, these global discourses and conceptualizations for the reasons and rationalizations for national policies and programs in developing countries have shaped the ways that policies and programs are framed and understood by technocrats and politicians within Uganda.

While the total donor funding (including bi-lateral funding and multi-lateral such as through the European Union and United Nations) for health was \$44.8 million USD in 2002 and increased to \$151.2 million USD by 2009, donor funding to health was surpassed by donor funding to population and reproductive health which increased dramatically between 2002 and 2009 in Uganda, from \$23.1 million in 2002 to \$276.9 million USD in 2009. However, most of that increase for population and reproductive health has been for the control of sexually transmitted diseases (STDs), which in Uganda, is almost exclusively funding for HIV. Figure 12 illustrates the growth in funding between 2002 and 2009.

Figure 12: Comparison of Total Donor Funding for Health vs. Donor Funding for Population and Reproductive Health Activities, in USD Millions

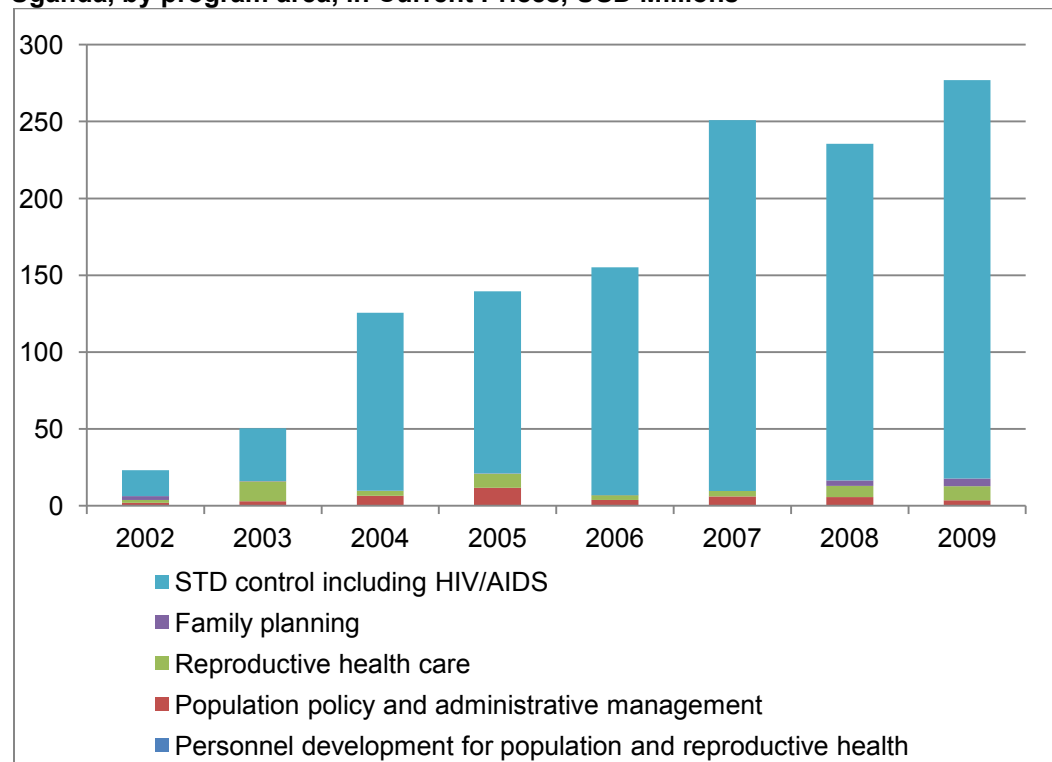


Source: (Organisation for Economic Co-operation and Development (OECD) 2011)

There is a sizeable amount of funding for HIV in Uganda, in comparison to other reproductive health areas. In 2009, sexually transmitted disease (STD) control (which

is almost overwhelmingly for HIV programs) made up 94% of the aid budget for all population and reproductive health sectors (\$259 million USD of the total funding for population/reproductive health of \$277 million). The second-closest sector was reproductive health care at 3% (\$9 million USD), followed by the family planning sector at 2% (\$5 million USD) (Organisation for Economic Co-operation and Development (OECD) 2011). HIV funding in Uganda is so dominant mainly due to the contribution from the US government’s PEPFAR program, which began implementation in 2004 in Uganda, and is discussed in further detail in the next chapter.

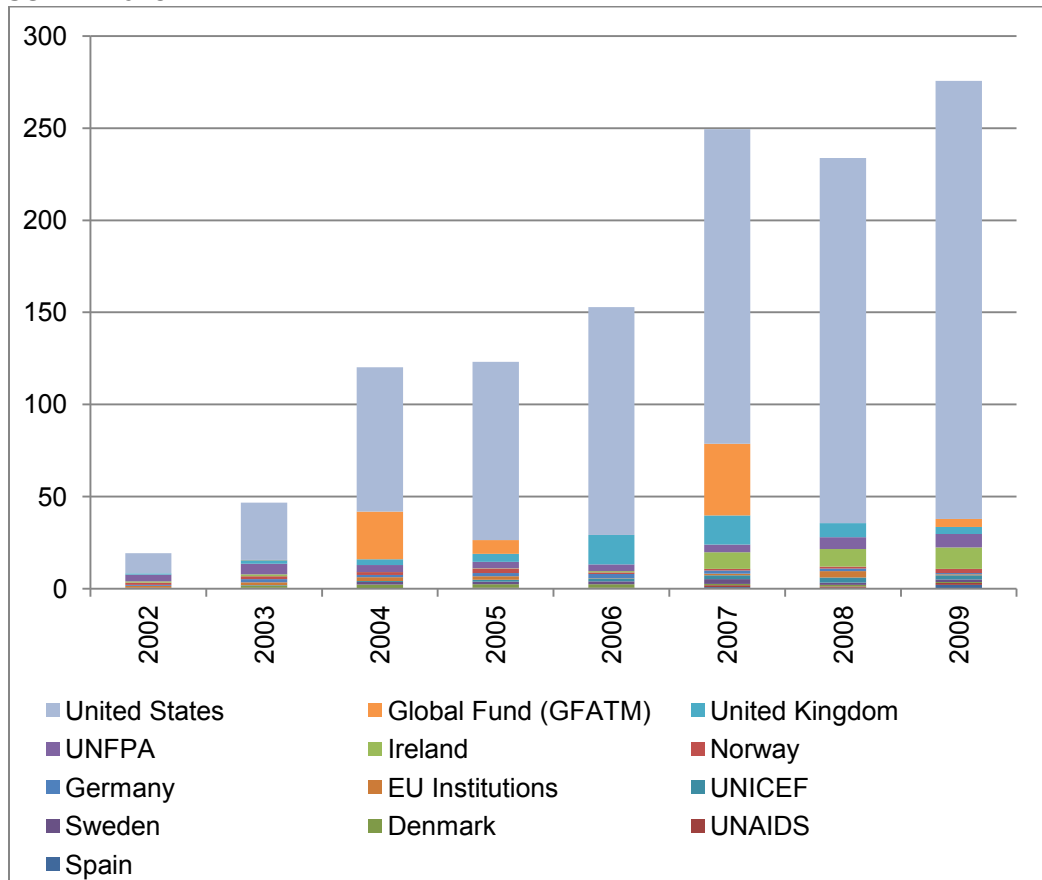
Figure 13: Population Policy/Program & Reproductive Health, Total Donor Funding for Uganda, by program area, in Current Prices, USD Millions



Source: (Organisation for Economic Co-operation and Development (OECD) 2011)²⁷

A number of bilateral and multilateral donors fund population activities in Uganda, but the discourse of donors is consistent. The largest bilateral donor for population and reproductive health in Uganda is the United States. Figure 14 shows the dominance of US funding in Uganda for population and reproductive health (including HIV) between 2002 and 2009.

Figure 14: Top Donors for Population and Reproductive Health Activities, 2002-2009, in USD Millions



Source: (Organisation for Economic Co-operation and Development (OECD) 2011)

The total United States Agency for International Development (USAID) funding to Uganda in fiscal year (FY) 2008 was \$431.2 million USD and \$417 million in FY 2009 (USAID 2011b). In 2010, the USAID total enduring enacted funding was \$456.8 million (USAID 2011a).²⁸ The total request for funding to Uganda was for \$480.3 million in 2011 (USAID 2011b) and \$527.7 million for 2012 (USAID 2011a). USAID spent \$66 million (the actual enacted total) in 2010 on the Global Health and Child Survival budget line in Uganda, but the USAID investments in general health are dwarfed by the PEPFAR investments in HIV. The USAID investments in health activities in Uganda between 2008 and 2012 detailed in Figure 15 illustrates this disparity.

Figure 15: USAID Funding to Uganda for Global Health, FY 2008-2012, in USD Millions

	FY 2008	FY 2009	FY 2010 Estimate	FY 2011 Request	FY 2012 Proposed
3.1 Health	306.1	318.4	378.1	397.1	
3.1.1 HIV/AIDS	255.0	257.6	294.1	294.1	322.9
3.1.2 Tuberculosis	2.2	2.2	4.0	4.0	6.0
3.1.3 Malaria	21.8	21.6	35.0	32.5	32.5
3.1.6 Maternal and Child Health	14.5	17.1	6.0	16.0	22.0
3.1.7 Family Planning and Reproductive Health	10.6	15.0	18.0	23.0	26.0
3.1.9 Nutrition	-	-	14.5	25.5	13.0

Source: FY 2008-2011: (USAID 2011b); FY 2012: (USAID 2011a)

USAID’s rhetoric about health in Uganda has shifted since 2001; in 2001, “the objective of USAID activities in the health sector is to reduce fertility, reduce maternal and child mortality, and slow the transmission of HIV/AIDS” (USAID 2001-2011). Ten years later, health is framed as “investing in people” and USAID

Uganda states that it “USAID trains community outreach workers in treatment of tuberculosis and malaria, supports immunizations against childhood diseases, provides insecticide-treated bednets to prevent malaria, and improves the quality of and access to family planning services. Uganda is a focus country for the President's Emergency Plan for AIDS Relief, under which USAID collaborates with government, religious, and community-based institutions to deliver comprehensive prevention, care, and treatment of HIV/AIDS” (USAID 2011a).

The United Kingdom Department for International Development (DFID) has more recently become a significant donor for population policies/programs and reproductive health in Uganda, with two large projects in Uganda (DFID 2011d). This is a significant change from its previous strategy of providing general budgetary support, but is in line with recent shifts in the funding environment away from general support to the government budget and towards project support (Richardson 2011). DFID Uganda's operation plan for 2011-2015 states that it will “focus on those areas where we have comparative strengths” . . . [and] “reduce the share of budget support in its programme” but does not give specific reasoning for this reduction (DFID 2011a:3). According respondents in Uganda, the overall impression of DFID's reasoning for the shift to program support was that DFID, particularly leadership in the United Kingdom, was not seeing enough results through general budgetary support funding. There were also particular concerns with continued high levels of corruption within the Ugandan government and low political ownership for

the health sector (such as for improving the quality of health services) (Interviewees #63, 66, 97).

Between 2011 and 2015, DFID’s budget for reproductive, maternal and newborn health is \$92 million USD (£57.1 million) and HIV/AIDS has been budgeted at \$75.7 million USD (£47 million) (DFID 2011a).²⁹ As part of the UN Joint Programme for Implementation of the National Population Policy, described by DFID (but not by either UNFPA or Popsec) as “National, community, cultural and issue-based leadership are managing the acceleration of a downward trend in population growth,” DFID has pledged \$48.9 million USD (£30.4 million) starting in late 2010 to the end of 2014. \$15.9 million USD (£9.8 million) has been spent as of December 2011.³⁰

Figure 16: DFID Support to UN Joint Programme for Implementation of the National Population Policy, 2011-2014, in USD Millions³¹

Population policy and administrative management	\$19.7 (£12.2 million)
Family planning	\$14.5 (£9.0 million)
Personnel development for population and reproductive health	\$9.8 (£6.1 million)
Secondary education	\$4.8 (£3.0 million)

Source: (DFID 2011c)

The DFID project Accelerating the Rise in Contraceptive Prevalence in Uganda has the purpose “to expand the provision of family planning services through the private sector.” The total project budget is \$56.6 million (£35.1 million), from late 2011 through the third month of 2015. \$6.5 million (£4.0 million) has been spent as of December 2011 (DFID 2011b).

Figure 17: DFID Support to Accelerating the Rise in Contraceptive Prevalence in Uganda, 2011-2015, in USD Millions

Family planning	\$34.0 (£21.1 million)
Reproductive health care	\$22.6 (£14.0 million)

Source: (DFID 2011b)

The United Nations Population Fund (UNFPA) is also a significant donor in Uganda for population activities, with approximately \$12 million USD going to Uganda in 2009 and 2010, making Uganda the seventh top recipient of UNFPA funding globally. UNFPA in Uganda has a strong partnership with the Ugandan government, and works closely with the Population Secretariat (UNFPA Uganda 2010a). UNFPA played a large advocacy and funding role in setting up the Population Secretariat, as well as supporting the development of the first Population Policy in Uganda in 1995 and the revised policy in 2008.

Currently DFID and UNFPA (along with partner United Nations agencies including the World Health Organization, Joint United Nations Programme on HIV/AIDS, UN Women, United Nations Children’s Fund, World Food Programme, International Organization for Migration, United Nations Human Settlements Program, United Nations High Commissioner for Refugees, and the International Labor Organization) support the work of the Population Secretariat through a four-year program from 2011-2014 called the Joint Programme on Population: “Investing in People” (UNFPA Uganda 2011). The program is national, in addition to specific focus in 15 districts (Abim, Amudat, Arua, Bundibugyo, Gulu, Kaabong, Kanungu, Katakwi, Kitgum,

Kotido, Moroto, Mubende, Nakapiripirit, Oyam, and Yumbe). In addition to the focus work with the Population Secretariat, the program also includes other government bodies such as the Ministry of Finance, Planning and Economic Development, Ministry of Local Government, Ministry of Lands, Housing and Urban Development, Ministry of Education and Sports, Ministry of Health, Ministry of Gender, Labour and Social Development, National Planning Authority, and Uganda Bureau of Statistics. Civil society, including NGOs, the media, and academic institutions are also involved.

Working with Uganda’s youthful population (where nearly 70% are under 24 years of age), the Joint Programme on Population (JPP) aims to accelerate the onset of the demographic transition in Uganda and set the conditions for the demographic bonus³² through five ways:

- “1. Women and couples have options to space their children and have the number of children they desire;
2. Efforts to improve maternal, newborn and child health and survival, are accelerated;
3. Girls' access to education is increased;
4. Opportunities for skills development and participating in planning [and] decision making are availed to young people and vulnerable groups; and
5. Policy makers and community leaders support inclusion of population issues in development plans at all levels” (UNFPA Uganda 2011).

Figure 18: UNFPA Project Expenditures in Uganda, 2006-2010, in USD Millions

2006	\$5.7
2007	\$5.8
2008	\$7.9
2009	\$12.1
2010	\$12.0

Source: (United Nations Population Fund (UNFPA) 2010)

Through significant funding of population and reproductive health activities in the country (at a level significantly higher than that of the Ugandan government itself) the United States Agency for International Development (USAID) and the United Kingdom Department for International Development (DFID), as the largest bilateral funders in recent years, and the United Nations Population Fund (UNFPA), as the largest consistent multi-lateral donor for population-related activities in Uganda, have played an influential role in setting the agenda and priorities for both the Ugandan government and non-governmental organizations working in the country.

Donors to Uganda working in reproductive health have followed global norms in discourses—evolving from population-based arguments to health and rights arguments (particularly focusing on maternal health) and most recently towards also incorporating the conceptualization of the demographic dividend and related economic arguments for supporting reproductive health. With new frameworks about aid such as the Paris Declaration on Aid Effectiveness (OECD 2005, 2008), donors to Uganda have moved to a country-ownership model, although the project versus sector or general budgetary support has been shifting due to donor concerns over a lack of Ugandan government prioritization to reproductive health.

Local Policies and Influences

Uganda's family planning programs first started in 1957³³ when the Family Planning Association of Uganda (FPAU) was started by a group of volunteers (Leahy and Akitobi 2009; Reproductive Health Uganda, UKAID, and Advance Family Planning 2011). FPAU became a member of the International Planned Parenthood Federation (IPPF) in 1966, increasing its access to international funding (Reproductive Health Uganda 2012). In the late 1960s, FPAU was allowed to promote family planning in government clinics, although the government itself was not offering the service. Idi Amin banned family planning in 1971, arguing that it went against African culture (Potts and Hayden 2010; Reproductive Health Uganda 2012). However, in 1975, the Ministry of Health changed its policy and accepted child spacing as part of primary health care, allowing government health centers to again work with FPAU to offer family planning for child and maternal health (Reproductive Health Uganda 2012).

While family planning services were integrated into the government health services in 1984 (Uganda Ministry of Health 2009a),³⁴ the Ugandan government did not begin to actively promote family planning until 1995 (Blacker et al. 2005). In addition, Uganda was comparatively late in Africa to adopt an official population policy (Sullivan 2007).³⁵ As discussed earlier in this chapter, in Africa, population policies were adopted for both external and internal reasons; external reasons include direct pressure from international organizations such as USAID and the World Bank (Hartman 1995; Liagin 1996) as well as normative pressure stemming from the 1994

International Conference on Population and Development (ICPD) (Barrett and Frank 1999). Population policies also signify commitment to donors, and thus are useful in securing donor funding for population activities (Barrett and Tsui 1999). Sullivan argues that the earliest countries in Africa to adopt population policies (those who adopted policies prior to 1994) were difficult to govern, so the adoption of population policies was used to “ ‘manage’ their populations and . . . consolidate their regimes” while the countries who adopted policies after 1994 did so due to diffusion via geography and/or regional economic communities (Sullivan 2007:5).

Thus Uganda’s relatively late adoption of a population policy was not due to an historical anomaly, but rather a confluence of factors. It was in part because the general understanding of population issues in the country has been to equate population and family planning, rather than to see family planning as a component of a comprehensive population policy (Kirumira 1998).

Population issues were recognized, but not seen as a significant component of development, in the first government of Obote (Miller 1971). Uganda’s Second Five-Year [Development] Plan (1966-1971) stated:

In Uganda, population pressure as such is not the critical problem it is in many developing countries. However, the high growth rate does mean that a large proportion of the population is in the school-age group, which makes the education burden much greater than in most wealthier countries, which experience lower population growth. . . Growth in output and employment of nearly 3 per cent per annum is necessary in order to maintain per capita standards and hence for increasing per capita income an even higher rate of

growth has to be achieved. (Uganda Ministry of Planning and Economic Development 1967:6)

At this time, the government recognized population only as a factor in terms of the sheer number of students to educate but not a significant issue for development as long as economic growth kept up with population growth. Family planning was also politically sensitive due to ethnic tensions during this time (Miller 1971). Ethnic tensions were high due to tribal-based recruitment of the military during and after colonialism, and less obviously, in the bureaucracy. After Obote (who was from the Langi ethnic group) declared himself president and banned all kingdoms, he used the military (dominated by tribes from the north due to historical British precedent and training) against all real and imaged threats, including that of his former Baganda allies (Mutibwa 1992).³⁶

Population became a factor of interest for the government starting in the early 1970s. The Third Five-Year [Development] Plan (1971/2-1975/6) included a chapter on the country's demography. "Government's main interest at this stage is to make people fully aware of the potential benefit of child spacing to their own family welfare, and to make available to those families who actually demand it, the means for regulating their sizes. In all this, every care will be taken to ensure that the programme is not conducted with detriment to the culture and morals of our society" (Uganda Ministry of Planning and Economic Development 1972:76). While signed by Amin in 1971, this development plan was a legacy of the previous regime of Obote (De Coninck 2004). The development plan also listed a goal of fertility rate decline to 3 per cent by

1979, something that has still yet to happen. While the government then saw the non-governmental organization Family Planning Association of Uganda (FPAU), now known as Reproductive Health Uganda (RHU), as the main implementer of this governmental policy at the time, the government intended that the Ministry of Health would take over responsibility for the national family planning program.³⁷

In 1980, a series of general health and population proposals without programming specifications was put before Parliament. They included: “support of family planning for demographic reasons; integration of family planning with health services; population growth targets; extension of family planning services; and family planning information, education and communication (IEC) activities in government and private facilities as well as at community level” (Kirumira 1998:190-191). The proposals did not pass despite the lack of specifics and the dependence on the Family Planning Association of Uganda (FPAU) and other NGOs to lead in the provision of services (Kirumira 1998).³⁸ And as discussed in the earlier section on Uganda’s history, this was also a turbulent time politically, which distracted the government’s focus away from social issues and towards addressing bubbling political dissent and defense of political power.

Uganda began the process of formulating its first population policy in 1988 when it established the Population Secretariat as a semi-autonomous government institution under the Ministry of Finance, Planning and Economic Development, to coordinate

the formulation and implementation of a population policy and “to ensure the incorporation of population variables in Uganda's development planning at all levels” (Uganda Population Secretariat 2008). At the same time, the first Demographic and Health Survey for the country was being conducted in 1988/1989 (Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007).

The original intention was that the government population entity in Uganda would be an entity led by a Permanent Secretary-level position. However, the first paperwork signed by President Museveni in 1988 detailed a population entity to be at the level of a Secretariat under the Ministry of Finance. The Minister of Finance then went back to the president with another set of paperwork that established the department as an independent body with the head at the level of Permanent Secretary, however when signing the paper, the president dated the paperwork to take effect the following year, and not immediately. The choice was made to begin at the level of a Population Secretariat beginning immediately in 1988, rather than to wait a year for the other paperwork to take effect and risk the chance that President Museveni could change his mind on the matter (Interviewee #18). Since that time, the Population Secretariat has been campaigning to be made a Population Council, which is expected in 2012 under the new Cabinet appointed by President Museveni in 2011.

The turbulent post-colonial years (of war, dictatorships, and military rule) were one factor in the lack of a population policy—as one retired advisor to President

Museveni told me, “No one of any intelligence would prioritize social issues . . . including population concerns . . . when there is no economy to speak of, the people have been hiding and not working with all the fighting, and a stable government only came after years of armed conflict” (Interviewee #24).

In March 1993, new policy guidelines for Maternal and Child Health and Family Planning were released by the Ministry of Health. This policy document detailed the integration of family planning into primary health care and established access to family planning as a human right (Kirumira 1998). Despite this apparent concession to the international human rights movement, family planning has yet to be fully integrated or dealt with as a rights issue at the service level.

The insertion of human rights language in government policy without significant intervention or accompanying change at the program level was, and continues to be, intentional. A mid-level manager in the Ministry of Health explained how policy is written up after the key issues (and what they feel can pass politically) are decided on, sometimes with and sometimes without public consultations,

[When] writing a policy document . . . you put in a little of this and that to make sure everyone is happy. The human rights people, they get their [piece], ‘health care is a human right.’ Now [you] make sure that you can’t leave off the people concerned with money and budgets, ‘immunization coverage saves so many times over its cost blah blah’ . . . But then, go to any clinic, [and] ask about human rights and cost-savings, or even the policy [itself], and the nurse looks at you like you’re crazy. . . It [human rights] only exists in policy in Uganda. (Interviewee #35)

A lower-level government employee told me of how her department makes sure to review policies from other countries, as well as NGO reports and pull ideas, if not language, “When working on the report, I looked at the internet and all this stuff on human rights from the UN, from NGOs, and so I used it in the report. Everyone said it was good.”

The politicization of population issues in Uganda led governments since independence to see population as a matter of “political arithmetic” rather than as a component of development (Kirumira 1998:185). As discussed in the earlier section on Uganda’s historical, economic, and political background, Uganda’s elections had historically been divided by religion and ethnicity, with political parties dominating different religious groupings and ethnically-dominated regions. Funded and advocated for by UNFPA, Uganda’s first population policy in 1995 was marked by evasiveness on the part of the government; prior governmental inattention to the issue was attributed to Uganda’s history of ethnic and religious divisions and conflict (Kirumira 1998). Discussion of population issues in Uganda at the time were “unduly politicized” (Kirumira 1998:185). The National Population Policy of 1995 for Uganda had the goal “to influence the future demographic trends and patterns in desirable directions in order to improve the quality of life and standard of living of the people” (Population Secretariat 1995). Uganda’s first population policy addressed many sectors, cut across multiple government ministries and programs, and incorporated human rights, health, and development as key issues (Population

Secretariat 1995). Yet the specifics of accountability to the strategies to achieve the desired goals and outcomes is unstated, other than designating the Population Secretariat as responsible for the coordination of the implementation of the population policy and relevant ministries as having related roles for policy implementation.

Uganda's population policies, like the policies in numerous other countries have been shaped not only by national and local players, but also by global discourse, and in particular, by frameworks promoted by donors (Richey 2002; Richey 2008). This meant that the framing of the policies was shaped in large part by external, global interpretations of the "population problem." International understandings of the impending population problem had significant sway, leading in-country experts and managers to creating policies and programs that they believed would be more likely to be funded by donors (Kirumira 1998); (Interviewees #15, 38, 39, 65, 70, 84, 85, 86, 104).

The existence of the 1995 national population policy made Uganda a new player in the international arena of population politics and discourse. Uganda's population policy was instated in 1995, the year following the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt. However, the Ugandan policy was conceptually a pre-ICPD policy with human rights and health issues included in the policy, but as additions rather than forming the theoretical base for the

policy. The 1995 policy also did not address the role of gender and power in fertility decision-making. Thus, the 1995 population policy had more in common with policies and programs envisioned prior to the conference than those stemming from the ideological shift during and subsequent to the conference. The idea to re-examine and update Uganda's population policy with ICPD in mind was proposed almost immediately following the launch of the 1995 Population Policy, yet it was not until 2008 (eight years after the end date of 2000 specified in the 1995 plan's targets) that the Population Secretariat was able to launch a revised population policy emphasizing broader reproductive health issues over demographic concerns (Uganda Ministry of Finance Planning and Economic Development 2008).

Uganda's 2008 population policy, "National Population Policy for Social Transformation and Sustainable Development" has the goal "to improve the quality of life of the people of Uganda through policies and programmes that address population trends and patterns." Its 11 objectives are:

1. To integrate population factors and variables at various levels of development planning.
2. To monitor population trends and patterns and relate them to socio-economic development.
3. To promote the improvement of the health status of the population.
4. To enhance competitive skills building and human capital development.
5. To advocate for improved nutrition and food security, increased household incomes, protection of the environment and sustainable use of natural resources.
6. To promote positive health seeking behaviour.
7. To reduce the unmet need for family planning.
8. To promote effective social welfare programmes for special interest groups.
9. To advocate for planned urbanization and human settlements.

10. To mobilize resources for the effective implementation of the National Population Policy and programmes; and
11. To develop a monitoring and evaluation system for the implementation of the National Population Policy. (Uganda Ministry of Finance 2008:19-22)

The 2008 population policy makes explicit recognition “that health, in particular Reproductive Health, is a basic human right” (Uganda Ministry of Finance 2008:6). While sexual rights are not acknowledged explicitly as rights in the principles section of the document, “sexual rights” as in “sexual and reproductive health and rights” is mentioned twice in the 2008 population policy (Uganda Ministry of Finance 2008:5, 20).³⁹ Uganda’s laws explicitly make abortion and homosexuality crimes, and controversy over abortion rights delayed Uganda’s ratification of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, commonly known as the Maputo Protocol.⁴⁰

Changes from the 1995 policy include the harmonization with more-recent international and regional agreements such as the Programme of Action of the International Conference on Population and Development (ICPD) (UNFPA 1995), Millennium Development Goals (MDGs), and the New Partnership for African Development (NEPAD). And at the national planning level, the 2008 policy was harmonized with the then-current Poverty Eradication Action Plan (PEAP) and updated understanding of the population situation as detailed in the 2002 National Census and 2006 Demographic and Health Survey (Uganda Bureau of Statistics (UBOS) 2002; Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007). Despite the updating of the policy, the definition of the population problem did

not shift much between the 1995 and 2008 policies. Demographic concerns of high population growth and poor reproductive health with high maternal and child mortality are used as justifications for both the 1995 and 2008 policies.⁴¹ In both policies, the main “solution” of family planning remains the same.

In addition, the implementation plan for the population policy, the National Population Policy Action Plan, 2011-2015, outlines the roles to be taken by thirty coordinated stakeholders and partners (Uganda Ministry of Finance 2010b). Yet, the matrix listing activities and indicators for each sub goal and outcome does not give any specific targets for the indicators. For example, Indicator (1.4.3) “Number of decision makers reached with information on population issues” gives no target for the goal number for decision makers to be reached between 2011-2015 (Uganda Ministry of Finance 2010b:34). The lack of targets is strategic for a bureaucratic organization, as it removes any measure of accountability. Without targets, it is impossible to determine at any time if there is successful or unsuccessful performance on implementation. In the simplest terms, it is a race with no finish line. A lack of targets in the action plan guarantees the avoidance of failure.

Uganda’s Policymaking Process: The Imaginings of Policy vs. Mandates, Practices, and Boundaries

The development of, implementation of, and compliance to national policies is the responsibility of the national government and its ministries. For example, the

Ministry of Health is responsible for policies and guidance for the health sector. Identification of the need for policy can come from the ministry level, from needs identified by service providers, or from pressure by parliamentarians, civil society groups and NGOs, or donors. Usually, a draft policy is written by either a consultant or a committee formed of members of the ministry, as well as outside members from other relevant ministries and NGOs. The draft policy is then presented to a larger group of stakeholders through meetings in order to develop consensus. In order to ensure that the policy meets international standards, stakeholders such as the World Health Organization, UNFPA, UNAIDS, and international NGOs are involved at this point, if not sooner, and donors such as USAID, DFID, and DANIDA are usually consulted, as well. The draft policy is then sent to the minister for approval. After approval (which often necessitates revisions and edits), the draft is presented to cabinet. The draft policy becomes official national policy after approval by cabinet. The ministry then usually prints an official version for dissemination and often holds an event to announce the policy. Sometimes the policy launch is an event aimed at reaching the media and other government and NGO stakeholders at a large hotel in Kampala (such as the National Population Policy for Social Transformation and Sustainable Development launched in 2008) and other times the launch takes place as a public event occurring at the parade grounds in an outside district (such as with the launch of the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda 2007-2015 in 2008 in Mpigi). Policies are also

subject to revision over time to incorporate new issues and new international standards and guidelines.

In addition to the population policy, there are a large number of active government policies addressing population and sexual and reproductive health and rights.

Figure 19 below lists these policies, the date of implementation or time period the policy or plan covers, and the ministry or department that authored the policy.

Figure 19: Active Government Policies Addressing Population and/or Sexual and Reproductive Health and Rights

- National Development Plan, 2010/11-2014/15, National Planning Authority
- National Population Policy for Sustainable Development, 2008, Population Secretariat
- National Population Policy Action Plan, 2011-2015, Population Secretariat
- National Health Policy II: 2009/10-2014/15, Ministry of Health
- Health Sector Strategic Plan III: 2010/11-2014/15, Ministry of Health
- National Policy Guidelines and Service Standards for Reproductive Health Services, 2001, Ministry of Health
- National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, 2006, Ministry of Health
- Strategy to Improve Reproductive Health in Uganda 2005-2010, Ministry of Health
- A Communication Strategy to Accelerate Implementation of Reproductive Health in Uganda, 2005, Ministry of Health
- Sexual and Reproductive Health Care Minimum Package, Ministry of Health
- Guidelines for Gender Mainstreaming in Reproductive Health, 2007, Ministry of Gender, Labour and Social Development⁴²
- Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda, 2007 – 2015, Ministry of Health
- National Family Planning Advocacy Strategy 2005-2010, Ministry of Health
- The Reproductive Health Commodity Security Strategic Plan 2009/10- 2013/14, Ministry of Health
- Uganda Clinical Guidelines, 2010, Ministry of Health
- Policy Guidelines for Prevention of Mother-to-Child Transmission of HIV, 2006, Ministry of Health
- The National Adolescent Health Policy for Uganda, 2004, Ministry of Health
- Adolescent Reproductive Health Strategy, 2000, Ministry of Health
- Uganda National Drug Policy, 2002, Ministry of Health
- Guidelines for Traditional Birth Attendants and Village Health Teams, Ministry of Health
- Uganda National HIV and AIDS Policy, 2011, Uganda AIDS Commission
- National HIV and AIDS Strategic Plan 2007/8- 2011/12, Uganda AIDS Commission

- Uganda National Policy Guidelines for HIV Counselling and Testing, 2005, Ministry of Health
- The Policy for Reduction of the Mother-to-Child HIV Transmission in Uganda, 2003, Ministry of Health
- Uganda National Antiretroviral Treatment and Care Guidelines for Adults and Children, 2003, Ministry of Health
- National Guidelines for Implementation of Antiretroviral Therapy, 2003, Ministry of Health
- Antiretroviral Treatment Policy for Uganda, 2003, Ministry of Health
- National Policy on HIV/AIDS and the World of Work, 2007, Ministry of Gender, Labour and Social Development
- Ministry of Education and Sports 5 year HIV/AIDS Prevention Strategic Plan 2011-2015, Ministry of Education and Sports
- National Youth Policy, 2001, Ministry of Gender, Labour and Social Development
- Universal Primary Education and Universal Secondary Education Policies
- Penal Code law against early marriage
- Penal Code law against female genital mutilation, 2009
- Penal Code law establishing the minimum age of sexual consent (Defilement Act)
- The Uganda Decentralisation Policy, 1993/94
- Local Government Act, 1997, Ministry of Local Government

When viewed and analyzed as stand-alone documents, all of these policies are quite good according to national and international experts, as they are often modeled on international standards such as medical guidelines issued by the World Health Organization (WHO) as well as many human and gender rights norms ratified at the level of the United Nations and developed in consultation with donors and experts. However, when considered as a whole, the sheer number of policies and the overlapping and conflicting mandates of governmental and non-governmental bodies create confusion and conflict. Uganda's significantly higher family planning effort score for policy (63.4) than for access (41.5), services (47.8), and evaluation (47.9) suggests "that it is considerably easier to declare favorable policies than to implement them" (Ross and Smith 2010:27).

Ugandan policies crafted by different ministries are viewed (by those in the ministries and even by NGO involved) as “non-political” in line with traditional public administration doctrine. Traditional public administration doctrine sees politics and administration as conceptually discrete, separate activities, creating a “politics-administration dichotomy” with the administration being a neutral, non-political expert body (Kaufman 1956:1060). This view of the state aligns with the conceptual “rational actor model” that argues that states are viewed as rational and unified actors and that the behavior of states is the outcome of rational decision-making processes (Allison 1971). In this model, there are three basic steps: the options for a given situation are explained; the consequences of each option are projected into the future; the choice that maximizes the values of decision makers is made. Any problems/errors are then attributed to poor projection of outcomes and/or inappropriate values (Allison 1971). The implicit assumption in this model is that bureaucratic administration is objective in the formation and implementation of policy intent. Policymaking at the ministry level (such as through guidelines, operational regulations, and standards) is considered objective, as it was informed by expertise and best practice, and is not thought to be influenced by politics.

Yet, bureaucratic interests are critical in policy formulation in Uganda. This argument aligns with the “bureaucratic politics model” in which a large number of bureaucratic actors have a significant role in determining outcomes; “players make governmental

decisions not by a single rational choice, but by pulling and hauling” (Allison and Halperin 1972:43).

In policy, public health services are envisioned as integrated. And at the service-delivery level, services are somewhat integrated. However, bureaucratically, there is no integration. For example, HIV falls under both the jurisdiction of the Uganda AIDS Commission (under the Office of the President) and the Ministry of Health STD/AIDS Control Programme (under the Communicable Diseases unit). The Ministry of Health is tasked with HIV service delivery and some policy; policies on HIV generate from both the Ministry of Health and Uganda AIDS Commission, depending on if the specific policy topic is seen as more “medical” and relevant to health service-delivery or more relevant to social issues and socially-driven change. National reports and publications related to HIV are often jointly published. The Ministry of Health’s Reproductive Health Division (under the Community Health department) is tasked with family planning and maternal health services and policy, although the Population Secretariat at the Ministry of Finance, Planning and Economic Development also is engaged with promoting these issues, both nationally and at the district level.

The overlapping of policy and mandates had led to confusion in responsibility and roles, even within the same ministry. For example, the Reproductive Health Division in the Ministry of Health manages public antenatal clinics for delivery, pre-natal, and

post-natal care, including services for the prevention of mother-to-child transmission (PMTCT) of HIV. However, PMTCT is financed and managed by the Ministry of Health STD/AIDS Control Programme. While the policy on PMTCT in the Ministry of Health is clear, with a revised policy from the STD/AIDS Control Programme issued in May 2010 that articulates a clear role for the importance of family planning and gives a specific target “to increase access and utilization of family planning (FP) services to 80% of all women living with HIV and their partners identified through the PMTCT programme,” (Uganda Ministry of Health 2010d:13), it is silent on what division within the Ministry of Health is ultimately responsible for the financing and management of family planning in PMTCT. “PMTCT managers strongly believe that increasing access to FP services within PMTCT settings is the responsibility of the Reproductive Health Division, which is responsible for this service in the overall healthcare system” (Asiimwe, Kibombo, Matsiko, and Hardee 2005:13). This confusion in the Ministry of Health has contributed to slower-than-desired progress in reducing mother-to-child transmission of HIV (Interviewees #30, 41, 56, 62).

One mid-level government manager explained how the collaborative, cross-ministry process in policymaking results in bureaucratic stagnation and inertia,

We all [across different ministries] work together on it [the policy], we have meetings. I’ve sat on too many policy draft committees to count . . . It [the policy] gets approved, off to the printer, [and] launched. And now [it is] time to implement. We all run [laughs]. Because there’s no money for this implementation. So maybe we go back and make an action plan and maybe even a budget. There’s no money. And then maybe the ones who are actually supposed to implement were not involved in [the decisions about] the policy. And the fact that so many people were involved means shared responsibility.

We know what needs to be done, but even if you specify that this is Health, this is Finance, Education and Sports. . . And it could be not clear who and what department within the ministry is supposed to do what with no money. . . [If] it comes up, just report that no funding was released, so no one is responsible. So it [the policy] sits until the date expires and a new committee is formed to make the next policy. That's how to make policy. (Interviewee #101)

In addition, donors are almost always involved in the policy-formulation process, participating in and financially supporting the creation of new policies. However, often due donor's limited staff capacity in the country, involvement in the policy implementation process is left to the "policy owners" in the ministries, without continued involvement, follow-up, or monitoring, unless the policy implementation (with allocated funding) is specifically written into donor projects and sector-funding.

Policies often do not seamlessly match organizational mandates; the bureaucratic structure of the organizations do not promote integration between ministries or even between divisions and departments in the same ministry. If policies are not accompanied by changes in mandates to particular ministries, divisions or departments, it is too easy for inertia to prevent change and the implementation of the policy. The different divisions and ministries have created "boundaries," both formal and informal of what they consider to be the domain of their work. In my research, I found that government bureaucrats referred to their "mandate," as both a personal job function ("That is not my mandate") and as a larger organizational mandate ("That is not my department's mandate") and understood clear boundaries between what they and their organization did and what was not their role to do, to both create boundaries

and as a method to stake territory and defend against encroaching and potentially ever-expanding work. For example, one officer in the STD/AIDS Control Programme at the Ministry of Health told me, “We’re not mandated to do family planning. That’s what the Reproductive Health Division does. We work with them, we have training for counseling on condoms and dual protection. . . But providing pills. . . is their [Reproductive Health Division’s] job” (Interviewee #42). This statement echoes the quote from a Senior Official in the Ministry in a 2005 study, ““If talking about family planning, we are talking, but if it is implementing, we are not implementing. We only added counseling and testing to the existing antenatal services. We take no responsibility for FP [family planning]. I am not mandated to do that”” (Asiimwe, Kibombo, Matsiko, and Hardee 2005:13).

The lack of integration across and within ministries aligns with how donors interact with and fund ministries in Uganda. Generally, donors support project-based activities—while some projects and programs are cross-cutting across ministries and departments, most are run and managed by individual divisions within the ministries, which have independent relationships with different donors aligning with their perceived “mandates.”

As seen in the discussion above, the processes of policy formation and the policies themselves can be just as political as those made by “politicians.” Ugandan policies create a world of “imagined integration” where the different government ministries,

departments, civil society, and the private sector are thought to work together seamlessly. And they do for a brief period in the policy development process, right up until the end of the development and approval of the policy. Then, institutional “standard bureaucratic operating procedures” and institutional and individual bureaucratic mandates come into play and prevent actual integration during implementation from taking place. All of the different ministries come together to develop the policy, and as soon as it is time for implementation, the “imagined integration” falls apart in favor of a world with mandates.

Uganda’s ‘Population Problem’ and Political Denial

Despite the existence of a national policy since 1995 and the preponderance of linked policies and strategy documents, there was, and remains significant debate within Uganda if a “population problem” even exists. President Museveni refuses to acknowledge that population is a problem in Africa and instead argues that under-population is a problem in Africa rather than overpopulation. In 2008 when asked “How do you reconcile your policy of encouraging population growth with the scarcity of resources in the country?” President Museveni responded,

You can fit India into Africa eleven times. And yet, even today, when the population has somewhat increased, still the population of the whole of Africa is smaller than the population of India. . . Therefore the problem of Africa is not population, please, it’s not population. It is underdevelopment and to some extent, even that underdevelopment is caused by under-population. Under-population itself [is] a factor of underdevelopment. For instance, the phenomenon of exporting raw materials instead of exporting finished products. That is the biggest problem, not population. By for instance, Uganda

exporting unprocessed coffee, for which we get one dollar per kilogram. This coffee is taken to UK where it is processed by a company called Nestle into finished coffee and for their effort they get about 20 dollars per kilogram. . . Now by sorting that one out, the economy of Uganda can go up by a factor of ten. (International Reporting Project 2008)

Museveni has articulated blame for Uganda's slow economic growth on low absolute population numbers, although in recent years he has begun to support family planning for women's and family health (Zlatunich 2010c); (Interviewees #7, 8, 18, 26, 47, 48, 57, 70, 105). In 2010, Museveni expressed his position on family planning and his opposition to "population control,"

I am not against family planning but I have not been able to support population control. The population of Uganda is now 32 million and its growing fast and we are encouraging family planning in the form of spacing children but we have never said that women should not have many children. This one we have not said because I myself, I have not really been convinced that population is the main problem of Africa. But spacing, yes. I totally agree to spacing the children. (Zlatunich 2010c)

Museveni has repeatedly denied concern for the country's rapid population growth; in a discussion with an UNAIDS official in 2009, Museveni said that the issue of population growth would automatically solve itself with the defeat of corruption, and the improvement of education and infrastructure in the country. Museveni stated, "I am not worried. It [population growth] will sort itself out. Once people have gone to school, they will not have many children. The educated don't have time to look after 12 children. They have time to work, party and go to bars" (Mukasa 2009).

Some of President Museveni's closest advisors and ministers disagree with the president's beliefs on population. The central bank governor, Emmanuel Tumusiime-

Mutebile, has publically stated his opposing beliefs, “The extremely high population . . . growth is one of the major things I oppose him about” (Manson 2011). One of Museveni’s advisors will only admit in confidence that “He may be wrong on this one. But he has yet to be convinced.” (Interviewee #8). Another (retired) advisor reveals that the president understands the concerns of donors, as well as those in ministries who regularly advocate for more comprehensive addressing of population issues in the country, but that he cannot tactically address the issue openly and promote a smaller family size, much less family planning for anything other than maternal health,

[He] cannot tell people to use family planning and have less children. It is enough to go along with donor programs and for the Popsec to print posters and talk about it amongst themselves and with NGOs. But if the president went around telling people to have less children, first there would be talk of how he wants there to be less of the other tribes. And there are also his long-term prospects, everyone, any politician wants voters. You can’t tell people not to create more voters. (Interviewee #24)

The common perception of Ugandan politicians to encourage large family size among their constituency in order to increase the number of voters for the future often resonates as a far-fetched idea to the outsider used to term limits for most political offices. But considering that President Museveni came to power in 1986, and his having spent the last 15 of those years as elected president (winning elections in 1996, 2001, 2006, 2011), it may not be ridiculous for Ugandan politicians to imagine that children born today may later become their voters. But even more powerful than this long-term perspective argument against a pro-family planning stance (in addition to risking offending conservative religious and traditional leaders who are against

modern contraceptives) is that district budget allocations come in the form of unconditional block, conditional, and equalization grants which are allocated to the growing number of districts⁴³ based on a calculation of district geographical size, population size, poverty and health needs calculated by infant mortality (Egger and Ollier 2007; Government of Uganda Local Government Finance Commission 2003).

Leaders of ethnic groups also are concerned with the size of their tribal group in relation to the larger population of the country, and thus often take public pronatalist positions. Top positions in parastatals are dominated by tribes from western Uganda due to ethnically-based recruitment as the NRM appointed jobs to its political and ethnic clients, particularly from southwest (Habati 2010; Okuku 2002). A news report in 2008 stated that 71% of cabinet members were Bahima (the same tribe as President Museveni), and that they control approximately 75% of the budget (Makara, Rakner, and Svåsand 2009; Mwenda 2008). While appointed political and bureaucratic positions are not allocated based on sectarianism or according to formulas based on tribal populations according to President Museveni, the conception that greater power for one's ethnicity and/or tribe will result from greater population numbers continues to appear, in conversation and the media (Habati 2010). There has also been statements and discussion about some tribes worrying that their population is remaining stagnant in numbers or percentages, while other groups are growing at faster rates, and thus, the need to keep up proportionally (Interviewees # 9, 10, 11, 18, 22, 47, 56, 106, 110).

Others I spoke with acknowledged how the president's power, both regionally and internationally, is drawn in good part from Uganda's large and growing population size. The country's geographical size of 241,038 sq. km. (93,072 sq. mi.) makes it about the size of the US state of Oregon (with about ten times the population density of Oregon) (US Department of State Bureau of African Affairs 2011). Though it only has the 6th largest population in Africa, and 36th largest in the world, the government of Uganda wields disproportionately large power regionally. In particular, President Museveni has served as the head of the Organization of African Unity from July 1990 to June 1991, as well as a two-year term on the UN Security Commission starting in January 2009 (Asiimwe 2008). In 2010, Museveni stated, "I have no apologies for high population growth . . . We live in a nice part of the world. You need some numbers to defend your piece of the territory. We need some optimal population" (Lutaaya 2010). Museveni's statement points to his prioritization of national security over individual rights to determine fertility and family size; in Museveni's Uganda, population matters extend beyond the fertility desires of women and their families.

Museveni has also argued that declines in the population growth rate would occur when more women attained higher education levels and "secure office jobs," but that the processes of the slowing of the population growth rate should not be forced. This has been supported in statements by his cabinet members. In September 2010, Hon. Eriya Kategaya, the deputy prime minister for Uganda at the time, said, "once they

[girls] go to school, we will not have the problem” of high fertility (Zlatunich 2010b). It is true that women with higher levels of education generally wait longer to begin having children and also have smaller families. This is because women with more education usually have their first sexual experience later, marry later, want smaller families, and are more likely to use contraception than women with less education (Population Reference Bureau staff 2004). However, gaining a small amount of education (less than seven years) does not necessarily reduce fertility—women with some formal education do receive higher incomes and better nutrition but often bear as many children as their peers without any formal education. However, women with at least seven years of formal education have fewer children; seven years of education may be a threshold for fertility decline (Jejeebhoy 1995).⁴⁴

Uganda’s ministers have also proposed a number of theories as to why Uganda’s population rate is high. In one speech alone, in September 2010, Hon. Eriya Kategaya, the Deputy Prime Minister for Uganda at the time, proposed more than five reasons for high population growth rates: to replace people dying from AIDS, idleness in IDP camps in Northern Uganda during the war, under-development, lack of electrification providing no entertainment opportunities other than sex, and the inability to use condoms in the dark due to a lack of electrification (Zlatunich 2010b).⁴⁵

With HIV/AIDS, the young are dying very fast, those that survive want to replace those that are dying very fast. . . in the north [of Uganda], there is accelerated production when our people were in these camps, they had nothing much to do, so they resorted to producing as many kids as possible.

So chairperson, we should discuss the correlation of family planning, reproductive health services and development. Otherwise, [we are] running up and down. MDGs were not the first declaration. . . In the rural areas, this is where people are in the darkness from 7 in the evening until 5 in the morning. People are in bed, what do they do in this time? If there was light, they could go to dance, they could read and they could go back tired. So in the rural area, they are in bed and they have sex during this time. The other day, I asked the good lady from the World Bank, you should help us give lights rather than condoms. How can you wear [a] condom in the darkness? She said there were few condoms in the country. I said yes, [but] the rural areas are in darkness, how can they use condoms? Have you ever tried to wear condoms in the darkness? You can't. (Zlatunich 2010b)

GDP growth in the 1990s averaged 6.5% per year (World Bank 2012). During the 2000s, growth increased, and GDP grew 6.8% per year between 2000/01 and 2003/04, and increased to 8% from 2004/05 to 2007/08, declined in 2008/2009 to 6.2%, and rose slightly to 6.4% in 2009/2010 (Uganda Ministry of Finance Planning and Economic Development 2010:64). However, because of population growth rates, real GDP per capita averaged 3.4% in the 1990s and approximately 4% in the 2000s (Uganda Ministry of Finance Planning and Economic Development 2010). As an informant from the National Planning Authority put it, “This [population] growth means that the everyday people [do] not benefit from economic growth rates” (Interviewee #44).

In addition, there is some evidence that the government has not been releasing accurate population figures. This may perhaps be in part to create the appearance of greater economic growth in the country. Comparisons between the official statistics put out by DHS and village-level censuses conducted by NGOs as part of their programs (such as to have accurate counts for distribution of bednets to prevent

malaria) and by independent HIV researchers show that village populations are up to 20-30% larger than the official counts reported by the Uganda Bureau of Statistics (UBOS) (Interviewees #6, 112, 120). This was confirmed by the opinions of district leaders that the government figures undercounted populations in many villages (Interviewees # 87, 110).

Government Priorities: “The Truth is in the Budget”

In July 2010 at the 15th session of the Assembly of the African Union Heads of State and Government held in Kampala, Ugandan President Yoweri Museveni said, “if you talk about social expenditure without talking about production, then you are just wasting your time and everybody’s time.” Elaborating on his point, he continued, “we cannot deal with maternal and child health in isolation without dealing with key development factors like job creation, training a critical human resource base and developing infrastructure like roads, railways and generation of sufficient electricity to support industrialization” (Zlatunich 2010c). Museveni emphasized the importance of creating economic growth before addressing social services such as maternal and child health. Yet, the stated, immediate concerns of the president—of economic growth, poverty, unemployment, national security and defense—are in good part due to past and current rapid population growth. Ironically, the Ministry of Health has articulated its concern that the budget cannot keep pace with high population growth rates, stating in a report that “high population growth puts pressure on existing

resources since some activities are for universal coverage e.g. immunization” and thus, rapid population growth is a key factor contributing to the failure to meet financing targets (Uganda Ministry of Health 2010a:15).

The Ugandan government acknowledges that health, and maternal health, in particular, are problems of concern for the country. A large number of government reports, policies and plans, including the Ministry of Health’s Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda 2007-2015 argue that Uganda will not meet the MDGs, and in particular the health MDGs, especially MDG 5 to improve maternal health, without significant investment and improvement in health services across the country (Uganda Ministry of Health 2008). Even parliamentarians such as Hon. Sylvia Namabidde Ssenabulya have acknowledged that implementation of the maternal and neonatal roadmap, which was supposed to take place from 2007-2015, did not begin until early 2011 (Muwonge, Sizomu, Songa, Herbert, Samuel, and Brucker 2011:5). Uganda is behind on most MDGs, but maternal health indicators in the country are particularly poor and have the slowest progress.⁴⁶

Budget analysis in Figure 20 below shows that health, while a significant expenditure for the Ugandan government, is not its highest priority. The budget is one of the most significant policy instruments for a government, as it reflects the government’s true priorities. The total funding for health in Uganda was 737.68 billion Ugandan

shillings (\$368.84 million USD) for 2009/2010, with 435.87 billion UGX (\$217.93 million USD) from the Government of Uganda and 301.81 billion UGX (\$150.9 million USD) from donors and GHI.⁴⁷

Figure 20: National Budget by Sectors, 2009/10 and 2010/11, in USD Millions⁴⁸

	2009/2010 Approved Budget				2010/2011 Budget Projections			
	GoU	Donor	TOTAL	% of total budget	GoU	Donor	TOTAL	% of total budget
Works and Transport	427.8	179.6	607.4	18%	342.8	116.9	459.8	14%
Education	465.0	74.8	539.8	16%	498.2	86.5	584.7	18%
Health	217.9	150.9	368.8	11%	220.6	97.6	318.2	10%
Public Sector Management	236.4	116.1	352.5	11%	288.5	82.2	370.7	12%
Energy and Mineral Development	175.2	174.3	349.5	10%	71.0	170.2	241.2	8%
Security	243.8	0.0	243.8	7%	244.1	0.0	244.1	8%
Accountability	171.2	60.2	231.5	7%	179.8	37.5	217.3	7%
Justice, Law and Order	172.2	7.7	179.9	5%	200.4	0.5	200.8	6%
Agriculture	102.8	52.6	155.4	5%	118.4	54.0	172.4	5%
Public Administration	108.5	0.0	108.5	3%	152.1	0.0	152.1	5%
Water and Environment	60.7	25.5	86.1	3%	67.4	42.3	109.6	3%
Legislature	60.2	0.7	60.9	2%	60.2	0.0	60.2	2%
Tourism, Trade and Industry	20.2	3.7	23.9	1%	20.8	0.0	20.8	1%
Social Development	13.1	3.1	16.2	0%	15.1	2.1	17.2	1%
Lands, Housing and Urban Development	10.2	0.0	10.2	0%	11.7	0.0	11.7	0%
Information and Communications Technology	4.8	0.0	4.8	0%	5.5	0.0	5.6	0%
TOTAL	2490.0	849.2	3339.2	100%	2496.4	689.8	3186.2	100%

Source: (Uganda Ministry of Finance 2011)

When government contributions for each sector are considered alone (excluding donor contributions), Education and Works and Transport still remain high priorities, however, Security and Public Sector Management are elevated as priorities over the Health sector. The lower prioritization of health, as the fifth highest funded sector by the government is shown in Figure 21. Donors currently contribute on average 40% of the health budget, a huge increase from the late 1990s before the creation of the Poverty Action Fund (PAF) by the Ugandan government in 1998 to ensure that donor budget support and debt relief under the Heavily Indebted Poor Countries (HIPC) went to priority areas of the government identified in the Poverty Eradication Action Plan (PEAP) of the time.⁴⁹ The PAF allowed donors to shift from project to budget and Sector Wide Approach (SWAp) support (Koenig and Atim 2010).⁵⁰

Figure 21: Percent Contributions to Sectors by the Government of Uganda, 2009/10 and 2010/11

	2009/2010 Approved Budget	2010/2011 Budget Projections
	% GoU only	% of GoU only
Education	18.7%	20.0%
Works and Transport	17.2%	13.7%
Security	9.8%	9.8%
Public Sector Management	9.5%	11.6%
Health	8.8%	8.8%
Energy and Mineral Development	7.0%	2.8%
Justice, Law and Order	6.9%	8.0%
Accountability	6.9%	7.2%
Public Administration	4.4%	6.1%
Agriculture	4.1%	4.7%
Water and Environment	2.4%	2.7%
Legislature	2.4%	2.4%
Tourism, Trade and Industry	0.8%	0.8%
Social Development	0.5%	0.6%
Lands, Housing and Urban Development	0.4%	0.5%
Information and Communications Technology	0.2%	0.2%

Source: (Uganda Ministry of Finance 2011)

The total public funding equates to a per-capita expenditure of about \$11.10 USD, which is below the level needed for basic health services, but above the average for most of the 2000s. Public per capita expenditure averaged \$8.90 USD between 1999/2000 and 2009/10 (Uganda Ministry of Health 2010b:xxiii). In the least developed countries, essential health interventions (excluding emergency care, hospitals, and family planning), cost a minimum of \$34 USD per person per year by 2007 and \$38 USD per person in 2015 (Sachs 2001). The cost of delivering the minimum health care package is estimated as \$41.20 USD per person in 2008/09, rising to \$47.90 USD in 2011/12 (Uganda Ministry of Health 2010b:133). It has been calculated that the real costs of financing a health system are at least \$60 USD per

capita per year while meeting the MDGs and goals to combat HIV costs up to \$150 USD per capita (EQUINET 2007).⁵¹

The figures above show that that in the 2009/2010 Government of Uganda budget, 11% of the total government budget of 6678.3 billion shillings (\$3.4 billion USD) was allocated to the health sector. The rate of health spending has not dramatically changed since 2005/2006, when the total budget for health was \$498.24 million, and per-capita expenditures on health were \$14.80, and 8.9% of the total government budget going to the health sector. Domestic health spending falls short of both Uganda's own HSSP II target of 13.2% and the Africa-wide Abuja target of 15% of national expenditure to the health sector (African Union 2001; Uganda Ministry of Health 2010a:14). Other countries in the region spend a larger percentage of their domestic budgets on health. Kenya has the lowest percentage spending on health at 7%, Tanzania spends 14%, and Rwanda allocates 20% of the domestic budget to health (World Health Organization 2012).

The National Development Plan 2010/11- 2014/15 outlines the government's approach to reduce dependency on donor aid and increasingly fund its budget from domestic revenues in the long term, but does not give specific targets for sectors (Uganda National Planning Authority 2010). However in 2004 the government said that it intended to increase its share for the funding of health to between 80% and

90% of the entire expenditure for the health sector, with donors only supporting about 15% of the health budget by 2015 (Brownbridge 2004).

It is well-known that while the budget, in name, is presented by the Ministry of Finance, Planning, and Economic Development (MoFPED) to Parliament, in reality, it is an instrument that reflects the priorities of the president. He directs the MoFPED in its preparations and allocations to sectors are set and approved by his cabinet.^{52, 53}

The military and infrastructure (roads) are prioritized, and other sectors are underfunded (this may be best exemplified by the existence of the large-mandated yet poorly-funded Ministry of Gender, Labor, and Social Development).

Conclusion

Shiffman and Smith develop a framework to determine how health initiatives receive priority from international and national political leaders. Their framework utilizes four categories: “the strength of the actors involved in the initiative [actor power], the power of the ideas they use to portray the issue, the nature of the political contexts in which they operate, and characteristics of the issue itself” (Shiffman and Smith 2007:1370).

Donor conceptualizations and international trends in the understanding of population and sexual and reproductive health and rights have shaped policies in Uganda. In the

context of Uganda's population policy described above, there were a number of powerful actors involved in pushing the issue of policy adoption, including international donors. Global consensus post-ICPD meant that Uganda's adoption of a population policy was aligned within the larger normative discourse on reproductive health. And the development of a large and growing number of policies in Uganda in part is the result of changes in reproductive health and development priorities, including HIV.

The slow progress or lack thereof on implementing policies is in good part due to the political climate of the country. The characteristics of the issue of population itself made it contentious, in part due to Uganda's history and political sensitivity to issues of ethnicity, and the pronatalist stance of the country's highest political leadership. In particular, the president and his cabinet have publically denied that population is an issue of concern in the country, creating a climate of confusion and conflict between official policies and leadership opinion. Many policies were created in part due to donor pressure and specific requirements for frameworks for health and population programming. However, the abundance of policies along with a lack of top-down accountability on outcomes has created a climate in which the solution to ongoing stagnation is the creation of more policies, more cabinet positions, and more districts rather than a deeper examination into the failure of previous policies or emphasis on implementation.

It is clear that policy implementation does not automatically flow from the existence of policies and commitments; in Uganda, it is dependent upon the interests of key stakeholders in government to fund programs and ensure top-down accountability. The once low-levels of funding for reproductive health commodities and the recent tripling of government budget discussed in “Chapter 5: ‘What Is Allocated Is Not What Is Delivered’: The Policy-Implementation Gap of Contraceptive Commodities” show how commitment via funding for policy and top-down accountability pressures can occur. The policy/budget disconnect described in this chapter reveals the real disconnect between the official policies in Uganda and the beliefs (and actual stance) of Uganda’s top political leadership. Political priority is not only determined through enacting policies; leaders also need to express their concern publically and provision financial resources equivalent to the issue’s needs (Shiffman and Smith 2007).

The conflict between the president’s position (and the official position of those in his cabinet) on population and the position of advocates for population issues in government ministries, donors, and NGOs has led to two results: (1) half-hearted implementation efforts by government matched with consistently low funding and (2) the proliferation of government policies in attempt to remedy the politics of the situation. These efforts are often justified with arguments that if policies are good, then institutions and politics would follow. The argument that politics follows policy has gained ascendancy recently, particular in line with the growing emphasis in development on randomized control trials which address technical, policy-level issues

(Banerjee and Duflo 2011; Duflo 2011). However, as explained in this chapter, politics do not clearly follow policy.

Chapter 4: “No One Ever Died of Overpopulation”: Comparing Uganda’s “Success” on Combating HIV with Its “Failure” on Population

Figure 22: Poster in Uganda, “She’s Keeping Herself for Marriage . . . What About You?”



Source: (Brewer 2007)

Uganda was once considered the country worst affected by HIV. It has since come to be seen as a “success story” in combating as HIV. Prevalence rates are regularly (yet mistakenly) reported as having fallen from 30% to less than 6% in a decade.⁵⁴ The academic and programmatic literature attributes Uganda’s success to “strong and decisive national leadership” (Campbell 2003:158), open and public discussion of the pandemic, and “perhaps the most vigorous IEC [Information, Education and Communication] and program support services for HIV/AIDS prevention and control

in sub-Saharan Africa” (Kirumira 2001). However, the popular attribution for Uganda’s success as leadership and open educational programs is not the full story.

Uganda’s HIV prevalence rates did decline (just not as dramatically as often reported), particularly starting around 1992. Uganda became the casebook example of how to control HIV and the international HIV “industry” focused on two somewhat misperceived elements of Uganda’s HIV strategy: 1) the supposed use of ABC (abstinence, be faithful and condom use) as the national prevention strategy and 2) the role of political leadership in speaking about the epidemic (Tumushabe 2006). This story of Uganda’s “success” in addressing HIV has become so politically important to both the Ugandan government and to the international HIV community that careful and critical analysis has been rare (de Waal 2003).

In this chapter, I begin by giving the historical background of the HIV epidemic in Uganda. I then discuss early government response to the epidemic and the political factors that shaped how the government, and in particular how President Museveni, addressed HIV information and education. I next discuss how Uganda became a global HIV success story and unpack the causes of HIV prevalence decline in the country. This is followed by a discussion of current HIV policy and practice in the country. I argue that human rights and gay rights are almost ignored in HIV programming in favor of a biomedical approach to the epidemic, which acts contrary to the goal of reducing prevalence. I conclude the chapter by arguing that five factors

played the largest role in Uganda's "success" on HIV and its failure on population and reproductive health: a critical juncture, a clear consensus, political incentive, collective action/social cohesion, and bureaucratic structure.

Background

AIDS was first documented in southwest Uganda, in the district of Rakai in 1982 (Barnett and Whiteside 1999; Barnett and Whiteside 2006). It is believed that the HIV virus had established itself among high-risk groups in Rakai and in Kampala by the late 1970s (Barnett and Whiteside 2006). The early epidemic had higher rates of infection in rural than in urban areas, and seemed to radiate from a few centers including Rakai district, Kampala, and the main trade routes from the East African coast, particularly long-distance truck routes from the Kenyan coast to Rwanda and Burundi (Barnett and Whiteside 1999:211; Obbo 1993). Appendix B: HIV Prevalence Maps is a series of visualizations of HIV prevalence at sentinel sites throughout Uganda between 1989 and 2009, using data from the Ugandan Ministry of Health (2010c) and shows the main long-distance truck route from the coastal city of Mombasa, Kenya through Uganda and into Kigali, Rwanda. The main pattern of infection in Uganda was heterosexual (Obbo 1993), although some critics argue that unsterilized and household-level use of injectable drugs played a larger role in the epidemic's spread in Uganda than usually reported (Allen 2005).

As discussed in the earlier historical section of this dissertation, Uganda in the 1970s and for the first half of the 1980s was marked by war and a lack of security. These conditions created a social climate where HIV could spread rapidly. The government was engaged in war and its energy and funding were focused in that area, leaving little room for the provision of social services. Health care was poor, if even available; this meant that sexually transmitted infections, which were prevalent, were untreated or incompletely treated (Barnett and Whiteside 1999). Illicit trade and smuggling were common across and around Lake Victoria (Obbo 1993). Women's status is traditionally and culturally lower than men's; access to family resources favored men, and legal rights such as land ownership were not available to women at this time (Kyomuhendo and McIntosh 2006). In these social and economic circumstances, women's access to resources was dependent upon men, and sexual relationships with men (whether through marriage, as a side girlfriend, or prostitution) were often the only source for women to access goods, services, and money to support themselves and their children. This led to concurrent as well as rapid and "disassortative" sexual mixing, meaning that sexual relations were outside of peer groups and geographical areas. During the period of increasing HIV prevalence, there was an "increase in the number of links (sexual contacts) between persons or groups of people (such as within villages, around nightclubs or bars, or at funerals or other ritual events), and especially an increase in the links between highly infected persons or clusters that were highly linked to other persons or clusters, such

as soldiers, transportation workers, ‘sugar daddies/mamas,’ and others” (Thornton 2008:45).

A number of researchers have proposed that the spread of HIV in Uganda was exacerbated by conflict (Collier, Elliott, Hegre, Hoeffler, Reynal-Querol, and Sambanis 2003; de Waal 2002; Hooper 1999). “A big part of the blame for Africa’s AIDS epidemic must fall on wars, soldiers and cultures of militarization” (de Waal 2002:4). The Tanzanian army had been encamped on the western shores of Lake Victoria, in the same area of the district of Rakai that retrospectively had been determined to be the location of the epidemic’s source in Uganda (de Waal 2002:2). “Epidemiological research on the spread of HIV/AIDS points out that the initial spread of HIV is closely associated with the war in Uganda in 1979. . . The spread of AIDS from the south to the north of Uganda exhibited the same route as the one Idi Amin’s soldiers followed after the war in 1979” (Collier et al. 2003:47).

Evidence does support that the armed conflict in Uganda in 1978-1979 likely seeded HIV throughout the country, as the epidemic was in the early stages at this point and post-conflict demobilization allowed HIV-infected troops to return home throughout the country. One study found a positive correlation between clinically reported AIDS cases in 1990 ethnic patterns of recruitment in the Ugandan National Liberation Army (UNLA) after the overthrow of Idi Amin approximately 10 years earlier in 1979

(Smallman-Raynor and Cliff 1991). This argument concludes that what would typically be a localized outbreak is spread further due to the conditions of war.

Others question this assumption, as competing research has found that conflict does not necessarily create conditions for increased HIV transmission, and that HIV prevalence among soldiers is not always drastically higher than the rest of the population (Allen 2005; Becker, Theodosios, and Kulkarni 2008). A comparative study of seven conflict countries including Uganda found that there is insufficient evidence to suggest that conflict consistently increases the epidemic spread of HIV (Spiegel, Bennedsen, Claass, Bruns, Patterson, Yiweza, and Schilperoord 2007). Other than the 1978-1979 conflict and resulting HIV spread discussed earlier, HIV prevalence in urban areas in Uganda appeared to decline after periods of conflict while rural prevalence remained stable (Spiegel et al. 2007). For example, in the midst of conflict in Northern Uganda, the antenatal surveillance at Lacor Hospital near Gulu experienced a decline in prevalence from 27.1% in the mid 1990s, to 11.9% in 2002 (Allen 2005:17).

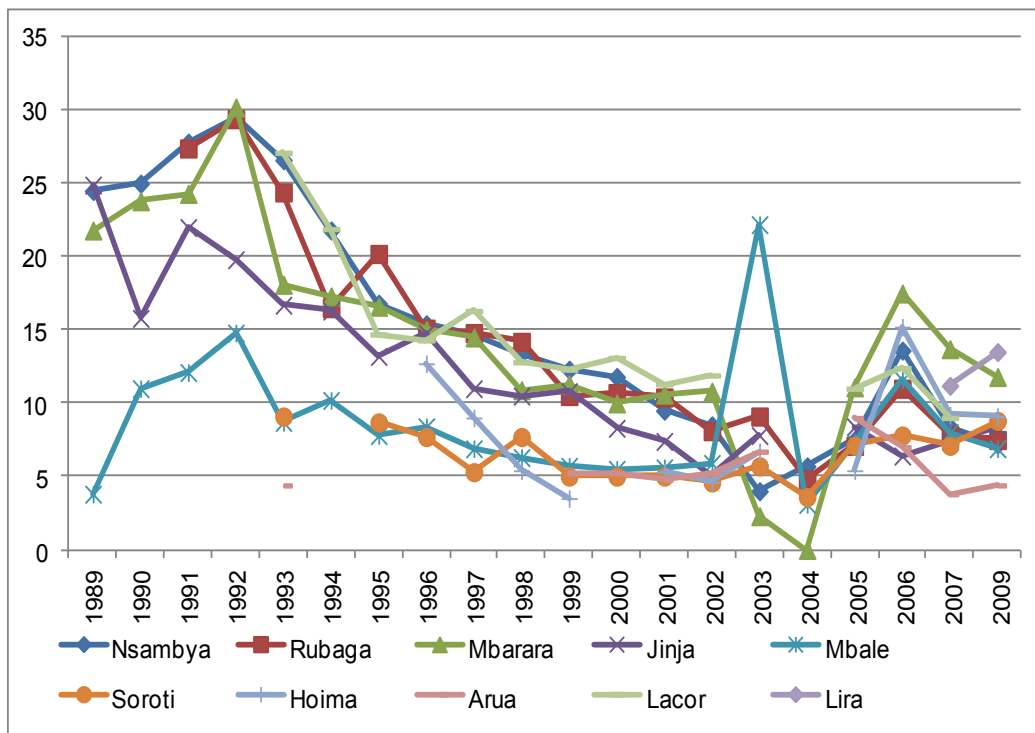
By the late 1980s, Uganda was in the midst of a generalized epidemic; a 1988 survey (that excluded some northern areas for security reasons) found that more than one million Ugandans were likely to have HIV (Uganda AIDS Commission 2011c). HIV prevalence rose in Uganda very rapidly in the 1980s and early 1990s until 1992, when a rapid prevalence decline started. When HIV was first measured at antenatal clinics

in 1985, prevalence was already above 10%, indicating that “it is likely that HIV had been endemic at a low level in Uganda for at least a decade, and possibly for generations, before it was first tentatively measured in 1982” (Thornton 2008).

The government of Uganda reports that HIV prevalence peaked at an average rate of 18% in the first phase of rise between 1989 and 1992; between 1992 and 2002, the trend changed into one of “rapid decline,” and the third phase starting in 2002 is one of stabilization of prevalence at a rate between 6.1 and 6.5 observed between 2002 and 2005 (Uganda AIDS Commission 2011c). Independent analysis confirms similar trends (Kirungi, Musinguzi, Madraa, Mulumba, Callejja, Ghys, and Bessinger 2006), although a number of scholars argue that prevalence data in Uganda has often been misstated and misinterpreted (Allen 2005; Kirumira 2001; Parkhurst 2001). Allen argues that the official government rate of 18% found in the 1992 seroprevalence study was not representative nationally, as few areas outside of the south were covered (Allen 2005). Allen argues further that median antenatal surveillance data in 1993 gave a national rate of just under 12%, which then declined to about 5% in 2000, and then subsequently rose to about 6% (Allen 2005). A national seroprevalence study in 2004/2005 (based on testing a random sample of the population) found HIV prevalence to be 6.4% overall (Uganda Ministry of Health and ORC Macro 2006). According to a 2011 national survey, prevalence has risen slightly since 2004/2005, with 6.7 percent of Ugandans age 15-49 testing HIV positive (Uganda Ministry of Health and ICF International 2012). HIV prevalence remains

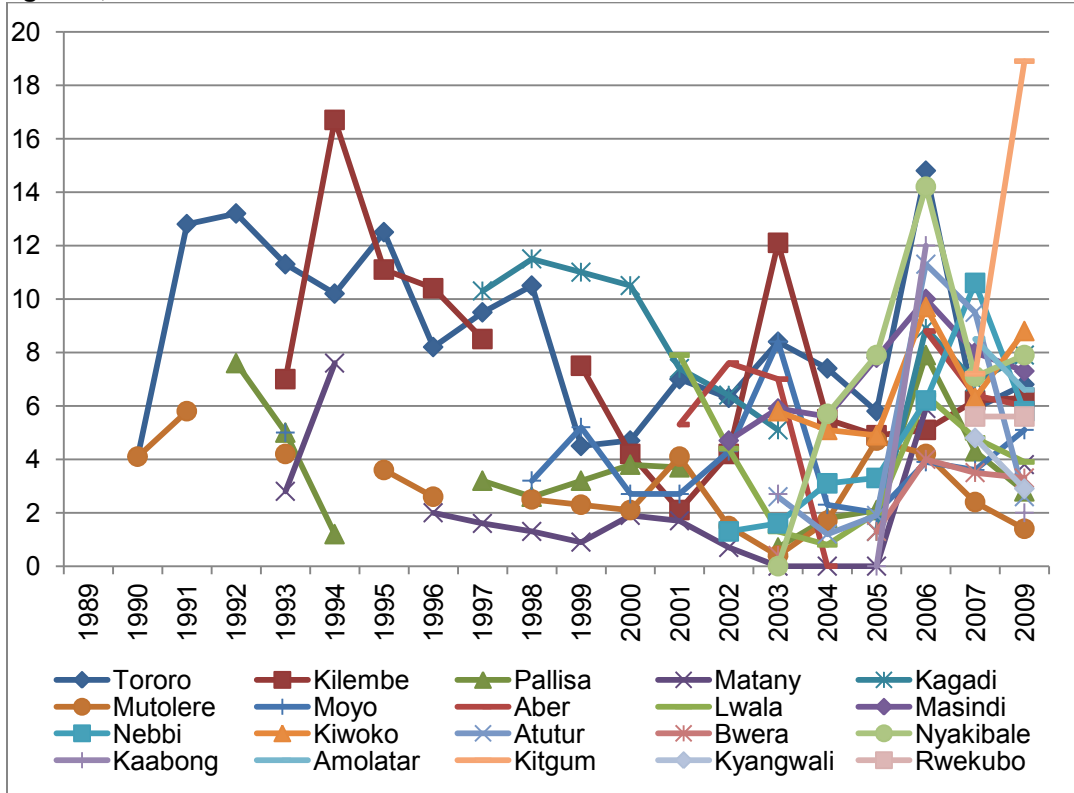
higher in women (7.6%) than men (5.6%) (Uganda Ministry of Health and ICF International 2012). Figure 23 shows annual trends in antenatal prevalence at urban sites in Uganda between 1989 and 2009. Figure 24 gives annual trends at non-urban sentinel sites, and Figure 25 compares the differences between urban and rural sites. For example, at the urban sentinel site in Mbarara prevalence peaked at 30.2% in 1992 (the highest rate ever recorded anywhere in Uganda), declining to 10% in 2000 and rising to 17.5% in 2006, before a gradual decline to 13.7% in 2007 and 11.8% in 2009 (Uganda Ministry of Health 2010c).

Figure 23: Annual Trends in Antenatal HIV Prevalence at Urban Sentinel Sites in Uganda, 1989-2009⁵⁵



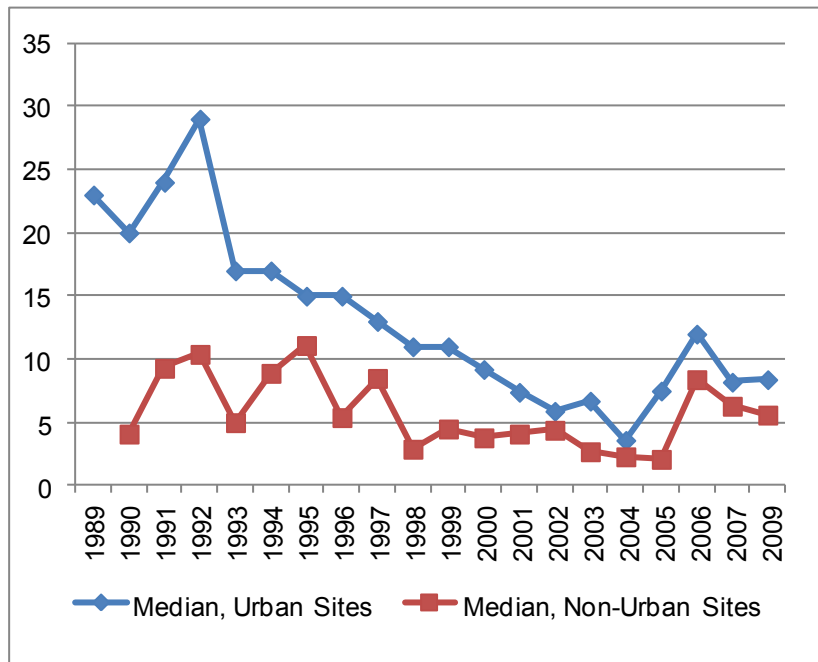
Source: (Uganda Ministry of Health 2010c)

Figure 24: Annual Trends in Antenatal HIV Prevalence at Non-Urban Sentinel Sites in Uganda, 1989-2009



Source: (Uganda Ministry of Health 2010c)

Figure 25: Annual Trends in Antenatal HIV Prevalence at Urban vs. Non-Urban Sentinel Sites in Uganda, 1989-2009



Source: (Uganda Ministry of Health 2010c)

Despite the government claiming that there has been general stability in HIV prevalence since 2001, the government does acknowledge that risky sexual behaviors, particularly among men, have been on the increase since 2001 (Uganda AIDS Commission 2011c). In particular, the percentage of men with multiple sexual partners increased from 25% to 29%, men reporting extra-marital sex increased from 14% to 29% and condom use at last casual sex decreased from 61% to 53% among men between 2001 and 2005 (Uganda AIDS Commission 2011c). The government attributes this “disengagement from preventative behavior” in part to the “normalization of HIV&AIDS by some sections of the community” (Uganda AIDS Commission 2011c:4-5). Others attributed the rise in prevalence and the coming

increases predicted by researchers to the changes in messages from both the government and NGOs. The once-prevalent pro-condom slogans on billboards, radio, and television in the 1990s faded and almost disappeared during the 2000s, a time coinciding with the George Bush administration from January 2001 to January 2009, which a number of interviewees in NGOs directly attributed to the US restrictions on financial support for condom promotion.⁵⁶

Early Government Response

As Yoweri Museveni's National Resistance Army took power in January 1986, the government quickly recognized and started taking action on HIV in the country. In May 1986 the new Minister of Health, Dr. Ruhakama Rugunda, announced that AIDS was one of the country's major health problems and that the government was taking action by launching a program of "mass public education." He said, "There is no national pride whatsoever in hiding the prevalence of AIDS . . . If anything, in my view, you objectively destroy the standing and pride of your country if you hide such a problem" (Harden 1986).

In October 1986 the government set up the national AIDS Control Programme (ACP), which in addition to conducting research into the extent of spread, transmission, and improving the safety of the national blood bank, started a mass education campaign with the participation of the president (Tumushabe 2006).

Education through radio programs, billboards, and government speeches used the slogans “Love Carefully” and “Zero Grazing” meaning to “avoid indiscriminate and free-ranging sexual relations” (Epstein 2007:162; Low-Ber and Stoneburner 2004; New Vision 1986). The government and NGOs trained educators to lead workshops in all areas of the country. At this time, there was also a vigorous public debate about condoms (Epstein 2007). At this early time, President Museveni also mandated that every Minister and high-ranking government official in his government speak about HIV at every public appearance (Interviewees #2, 18, 24, 38, 47).

Museveni cultivated relationships with a range of churches; it was his socially conservative approach, combined with the experiences of churches with their leadership and parish being affected, that eventually won over churches in Uganda to the campaign against HIV (Putzel 2004). In its earliest approach, the government “did not push for condoms very strongly, instead pursuing a ‘quiet promotion of condoms,’ and inviting religious leaders to take part in discussions of condoms as a state policy” (Parkhurst 2001:78).

President Museveni points to the discovery in 1986 that 18 of 60 Ugandan soldiers sent to Cuba were HIV positive as a turning point in realizing the extent of the epidemic’s impact in the country (Parkhurst 2005). In addition, the outbreak hit hard in the home areas of Museveni’s family and senior army officers and commanders, as the tradition of sharing wives between Banyankole brothers and remarriage of

widows to the deceased husband's brothers, contributed to the spread of the virus (Tumushabe 2006); (Interviewees #8, 18).

Museveni's government acted when it perceived a significant threat to its power. President Museveni realized early that his political survival was dependent upon addressing HIV. The political incentive structure in the late 1980s was that the president had little to lose and everything to gain (Putzel 2004). This is similar to how others have analyzed where, when, and how governments decide to address potential "crises." Government famine-prevention strategies show how the political impulse of governments is primary as government reaction to famine occurred only when the cost of inaction was too high (de Waal 1997). The president's openness to addressing HIV was in part because he could not risk losing his primary power base of the military, as "by 1986 [he] lacked a political base to govern Uganda" (Tumushabe 2006:8).⁵⁷ According to a prior high-ranking governmental advisor, Museveni responded to HIV seriously when he found that there were high rates among army officers (Interviewee #24). In sum, Uganda's early response to HIV was to encourage and lead public education and discussion about HIV.

An AIDS Control Strategy of Uganda began to be developed by July 1991 (Barnett and Whiteside 1999). And in 1992, the Uganda AIDS Commission (UAC) was established under the Office of the President (Uganda AIDS Commission 2011a). The Uganda AIDS Commission (UAC) is charged with coordinating the country's

response to HIV; it currently pursues a multi-sectoral strategy working with donors and NGOs to coordinate national information and education campaigns, voluntary testing and counseling (VCT), school health programs, home-based care for those living with AIDS, research and broader education and treatment for sexually-transmitted infections. The location of the UAC in the Office of the President is not coincidental—it was about power—“all the institutions of government needed to be transformed and made subservient to it [the presidency]” (de Waal 2006:100).

According to a retired government official who worked on early HIV campaigns, the UAC’s “priority is to promote the work of the president. Any work on AIDS is secondary to that” (Interviewee #50).

The UAC produced a series of strategic frameworks and plans to guide its work outside of an overarching longer-term policy (which was not approved until 2011). In 1992, the UAC produced the 1992 Multisectoral Approach to the Control of HIV/AIDS (MACA) which outlined national priorities and the mechanisms for implementation. In 1994, the UAC produced the National Operational Plan (NOP) for STI/HIV/AIDS Activities 1994-1998. This was followed by a National Strategic Framework (NSF) for HIV/AIDS Activities 1998-2000 which was revised in 1999/2000 into the NSF 2000/1-2005/6, published in March 2000. This framework was then succeeded by the National Strategic Plan for HIV/AIDS Activities 2007/8-2011/12 (Uganda AIDS Commission 2011b).

Despite apparent government fast-tracking of response to HIV, in 1993 President Museveni said, “I am worried about other things. AIDS is not really such a big crisis. Voluntarily you go and look for it. What will happen is that many people will die and then others will begin to fear . . . The population of Uganda is now 17 million. Even if you assume that 2 million will die, you will still remain with 15 million which is higher than the population of 1956” (Githongo 1993:36).

How Uganda Became an HIV Success Story

Uganda’s status in international light in the late 1990s and early 2000s was rapidly falling due to increasing international awareness of corruption as well as Uganda’s involvement in the destabilization of eastern Democratic Republic of Congo. In 2005 the DRC brought Uganda before the International Court of Justice in The Hague, accusing Uganda of committing human rights violations and massacring Congolese civilians (BBC News 2006). It was against this background that President Museveni started promoting Uganda as an HIV success story, and this particular leadership as key to the stall in HIV prevalence. In 2000, at the African Development Forum, Museveni reported a dramatic decline in prevalence,

As a result of our awareness campaign, close to 100 percent [of] Uganda[ns] know what HIV/AIDS is and how it is spread; the risks involved; and how it can be prevented. . . Uganda's estimated prevalence rate reduced from around 30 percent in the early 1990s to around 8 percent in the late 1990s; the age of first sex among girls increased from 14 to 16 years; and from 14 to 17 among boys between 1995 and 1998; sex with non-regular partners has also considerably reduced; and condom use increased from 57.6 per cent in 1995 to 76 percent in 1998. Next year, we shall require 80 million condoms. Most

important of all, the stigma attached to people living with HIV/AIDS has virtually evaporated. (Museveni 2000)

Of particular note is his description of the specifics of HIV decline, although he does not spell out the ABC, he gives statistics presenting increases in abstinence (with age at first sex increasing), be faithful (reductions in sex with “non-regular partners”), and condom use.

The term ABC emerged as the rallying point to explain Uganda’s success globally, however, the A, B, and C were not actually promoted equally, if at all in Uganda during the time of Uganda’s apparent decline in prevalence. A large number of AIDS activists and leaders of NGOs that I interviewed said that they had not heard of the “ABC” acronym until around 2000.⁵⁸ They noted that the strategy of faithfulness, delaying sexual onset, and condom use was used in programs, but that the term “ABC” appeared first in USAID reports and materials and then came into use by the government and NGOs. The first messages coming from the government on the disease were “love carefully” and “zero grazing” (Interviewees #4, 33, 50, 56, 61, 70). These messages from around 1987 to 1992 were encouraging reduction in the number of partners, as well as faithfulness (Epstein 2007). Although not explicit, the campaign acknowledged the existence of formal and informal polygamy (concurrent sexual relationships) and that monogamy was not always practicable.⁵⁹

By 2002, the statistics in prevalence decline being reported by President Museveni were even more impressive, “This recognition will encourage the people of Uganda

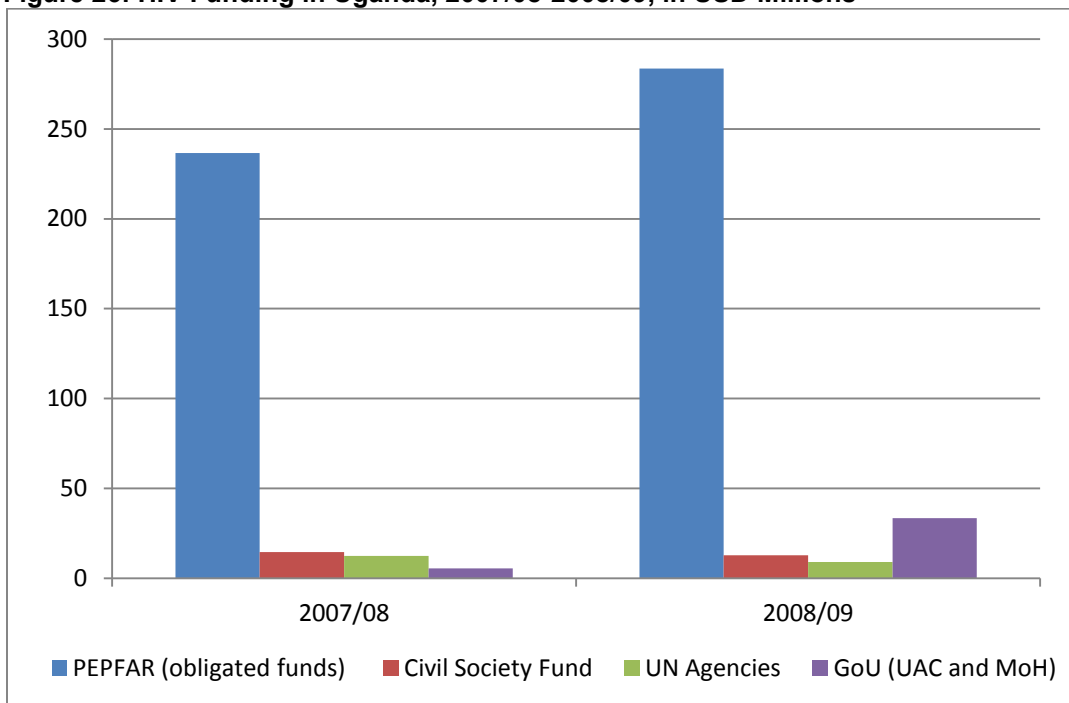
that they are doing well and that they should do more in the fight against AIDS.

Uganda's rate of HIV/AIDS has dropped from 30% in 1986 to 6.1% presently” (New Vision 2002). Museveni also began to attribute Uganda’s success on HIV with his own efforts, “The decline these people are talking about was because I went around preaching in every county. That is why there was a dramatic fall” (Olupot and Maseruka 2004).

In promoting ABC and the Ugandan success, the government responded to pressure to justify the immense donor resources being spent. Funding for HIV in Uganda has grown at a rapid pace. In 2004, Uganda was selected as one of the first countries to receive funding from the United States President's Emergency Plan for AIDS Relief (PEPFAR), under which USAID collaborates with government, religious, and community-based institutions “to deliver comprehensive prevention, care, and treatment of HIV/AIDS” (USAID 2011a). PEPFAR is the largest donor to HIV funding in Uganda, with budgeted contributions of \$90.8 million USD in fiscal year 2004, \$148.4 million in 2005, \$169.9 million in 2006, \$236.6 million in 2007, \$283.6 million in 2008, \$287.1 million in 2009, and \$286.3 million in 2010 (PEPFAR 2012a; PEPFAR 2012b; PEPFAR 2012c; PEPFAR 2012d; PEPFAR 2012e; PEPFAR 2012f).⁶⁰ This totals to approximately \$1.5 billion USD between 2004 and 2010. United States funding alone constitutes more than two-thirds of the entire country’s HIV response, including donor and government resources.

Spending by the government of Uganda on HIV through the Uganda AIDS Commission was approximately \$1.5 million USD per year in 2007/08 and 2008/09. Yet government funding for HIV through the Ministry of Health grew dramatically from about \$4 million USD in 2007/08 to \$32 million USD in 2008/09.

Figure 26: HIV Funding in Uganda, 2007/08-2008/09, in USD Millions

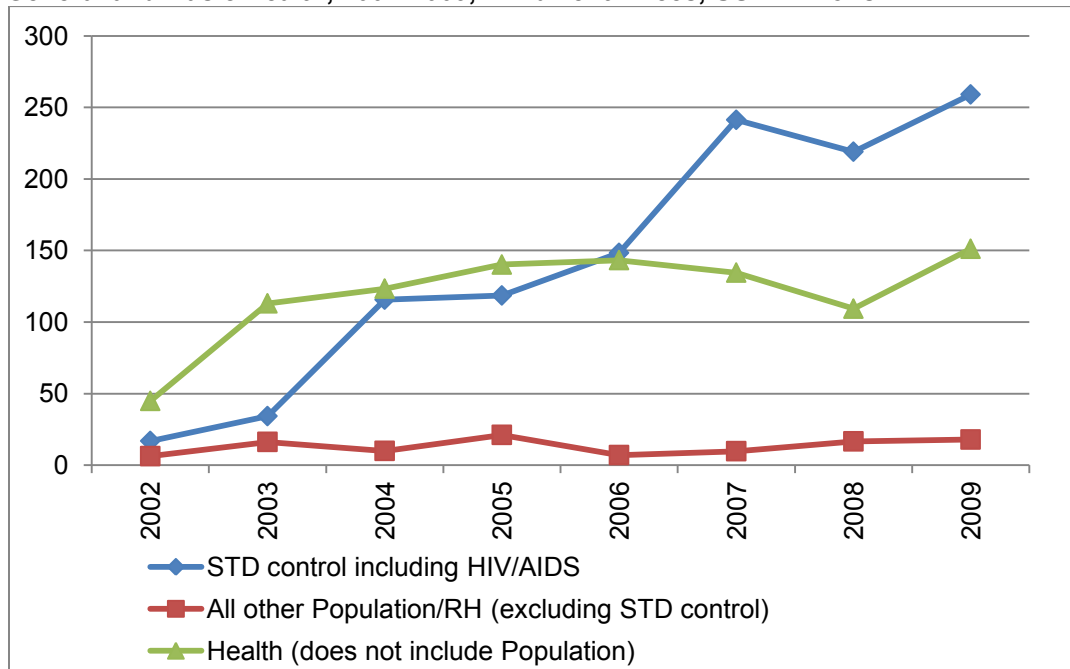


Source: PEPFAR data: (PEPFAR 2012b; PEPFAR 2012c)
 UN Agencies, Civil Society Fund, and GoU data: (Government of Uganda 2010:98)⁶¹

HIV funding from donors overwhelms the other components in the population and reproductive health sector by constituting 94% of the of the aid budget for the sector (\$259 million USD out of the total disbursements for population/reproductive health of \$277 million USD). This also means that HIV receives significantly more donor

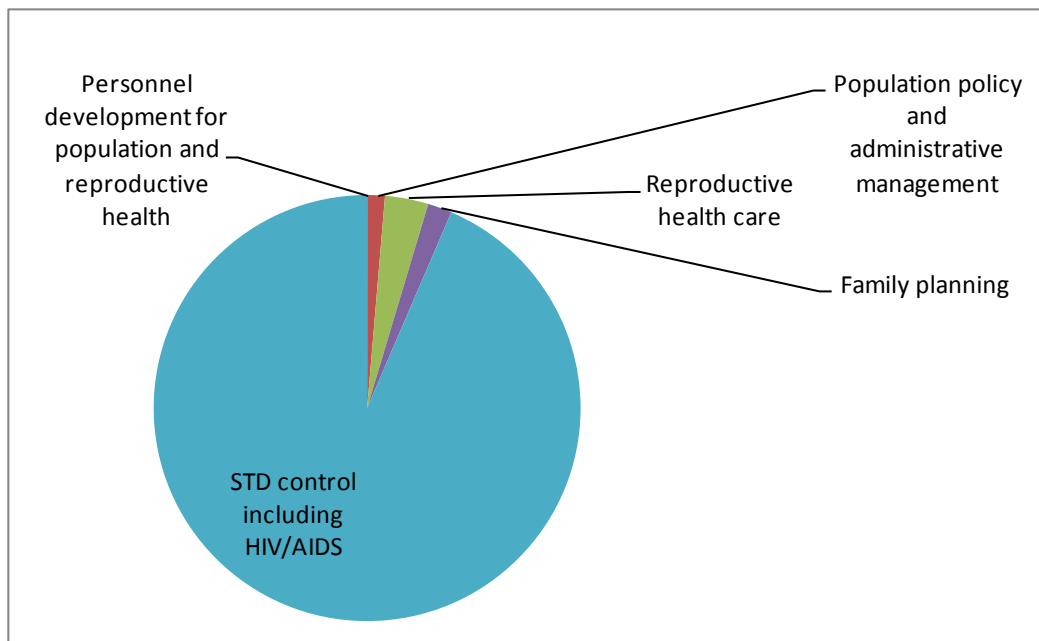
funding than for general and basic health care services which received \$151 million USD from donors in 2009 (OECD 2011).⁶²

Figure 27: Total Donor Funding for Uganda, for HIV, All Other Population/RH, and General and Basic Health, 2002-2009, in Current Prices, USD Millions



Source: (OECD 2011)⁶³

Figure 28: Population Policy/Program and Reproductive Health, Total Donor Funding for Uganda, 2009, by program area



Source: (OECD 2011)

In line with increasing funding through PEPFAR under the US Bush administration and Republican pressure, President Museveni started speaking out against condoms around the time of the appearance of PEPFAR funding in Uganda in 2004. This was another shift for President Museveni, one from his clear “ABC” stance in 2000, when he had bragged about increasing condom use in the country and the large number of condoms (80 million) that were to be required by Uganda in 2001.

Dr. Sam Okware, a former Director at the Ministry of Health and at the Uganda AIDS Control Programme, who in the international media has been credited as the designer of “early, frightening, anti-AIDS campaigns” (Timberg 2007) and as the developer of

the “ABC method” (Kaiser Health News 2006) said PEPFAR has distorted the message of the ABC method. According to Okware, PEPFAR “really shifted the emphasis to A and B just because of the amounts of money being put into these programs” (Kaiser Health News 2006).⁶⁴

Figure 29: United States President George W. Bush Meets with Ugandan President Yoweri Museveni on Friday, 11 July 2003 in Entebbe, Uganda



Source: (U.S. White House 2003)

Influenced by his wife and the US Bush administration (who were funding abstinence-only HIV programs), President Museveni’s messages started to shift starting around 2004. In May 2004 President Museveni said, “I am going to review this issue. I will open war on condom sellers. Instead of saving life they are

promoting promiscuity among young people. When I proposed the use and distribution of condoms, I wanted them to remain in town for the prostitutes to save their lives” (Ssejoba 2004). This statement was clearly different from his early awareness campaigns where he promoted condom use to youth in schools; at one time, he instructed girls in elite secondary schools “that if they had to eat sweets, they should do so with the wrapper on” (de Waal 2006:99). President Museveni’s new stance was that condoms were inappropriate for Africa, and that avoiding sex was the reason why Uganda had a decline in infections.

At the July 2004 International AIDS Conference President Museveni said that condoms promoted promiscuity and again said they were inappropriate for Ugandans; he said condoms “are not the ultimate solution to this problem.” He argued that the best way to fight HIV was with “relationships based on love and trust, instead of institutionalized mistrust, which is what the condom is all about” (Museveni 2004). He continued, attributing the decline in prevalence to behavior change, rather than to condom use, “In Uganda we managed to bring the HIV sero-prevalence from 18.6% to 6.1% using just a social vaccine, a reduction close to 70%” (Museveni 2004). Similarly, in November 2004, President Museveni said that HIV is spread through “indisciplined sex” and that sexually transmitted diseases can spread despite the use of condoms (Olupot and Maseruka 2004). Museveni’s new position did not entirely exclude condoms, but it was in alignment with PEPFAR’s new approach in which

abstinence played a much larger role, and condoms were only for a narrow, high-risk segment of the population, such as prostitutes.

In addition to pressure from the US administration, First Lady Janet Museveni's born-again Christianity also played a large role in the Executive's evolving stance against condoms. Janet Museveni has explicitly associated the HIV decline in Uganda with abstinence and the Christian faith, saying that the Ugandan strategy against HIV has been "guided by the principles of the word of God" (South African Christian Leadership Assembly (SACLA) 2003). In 2002, during the congressional debates, Janet Museveni presented a letter to Republican lawmakers in Washington D.C. stating that abstinence, rather than condoms, was the key to Uganda's success over HIV (Epstein 2005). Her involvement contributed to the final bill's \$1 billion abstinence earmark (Epstein 2005). The Republican-dominated Congress of 2002 authorized more than \$200 million for Uganda for abstinence education.

First Lady Janet Museveni has also spoken more strongly against condoms than her husband. In August 2004, she said that condoms should not be distributed to young people, as it is "pushing them to go into sex" (Namutebi 2004). "Giving young people condoms is tantamount to giving them a licence to be promiscuous; it leads to certain death," Janet Museveni said to an audience at a meeting in Washington D.C. in 2004 (Gill 2004). The First Lady's Office also received USAID and other donor funding to promote abstinence and faithfulness (a no-condom message), in part through the use

of the tagline promoted across billboards, leaflets, stickers and promotional t-shirts: “Abstinence & Faithfulness 100% Guaranteed!” Billboards by the Office of the First Lady pictured a truck driver being pursued by two women next to the sign for “Safari Hotel.” The billboard is captioned “Thank GOD I said NO to AIDS. Driving home to my wife. ABSTINENCE & FAITHFULNESS 100% GUARANTEED. ABSTINENCE WHY NOT?” Another billboard pictured two crested cranes (Uganda’s national bird) and read, “The Crested Crane sticks faithfully to one partner until death! COINCIDENCE? ABSTINENCE & FAITHFULNESS 100% GUARANTEED. ABSTINENCE WHY NOT?” (Ross 2005). A third large billboard featured the picture of a smiling young woman, saying “She's saving herself for marriage—how about you?” (Boseley 2005). The Uganda Youth Forum, founded by Janet Museveni, also received significant PEPFAR funding to promote abstinence, including at least \$215,000 in 2007 (PEPFAR 2007:20, 32) and \$250,000 in 2009 (PEPFAR 2009:28), in addition to funding from US religious groups like Focus on the Family (Anastasion 2007).

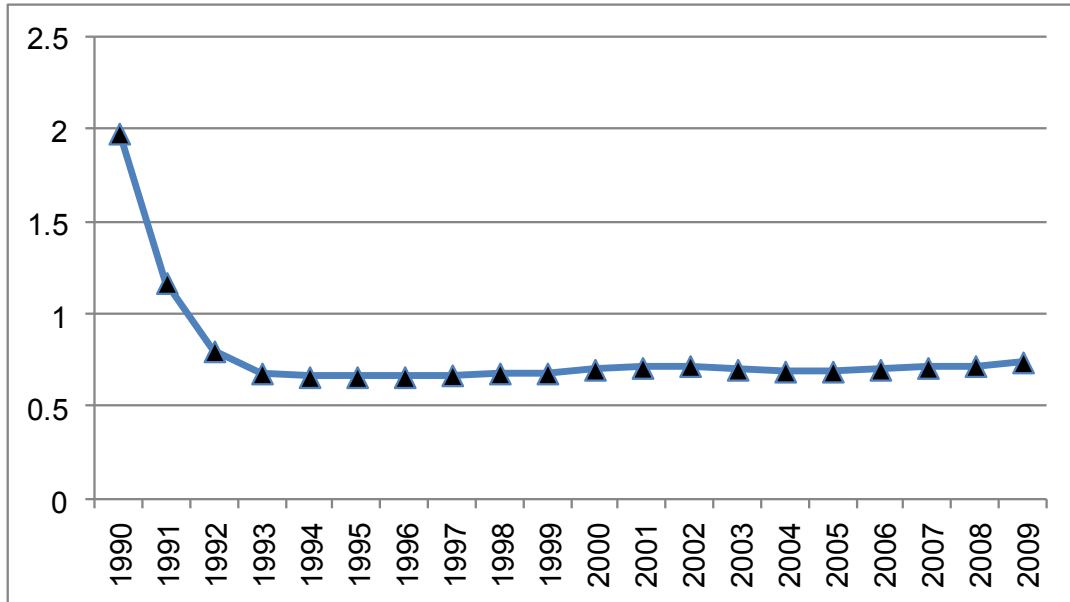
Janet Museveni and President Museveni have a close relationship to Martin Ssempe, the fundamentalist Christian pastor of Makerere Community Church, who had earlier ties to US evangelical pastor Rick Warren (Alsop 2009).⁶⁵ Pastor Ssempe acted as a representative of Janet Museveni at the 2004 meeting of the HIV Partnership Forum (Long 2007; Uganda AIDS Commission 2004). And in April 2005, he also acted as a Special Representative to the First Lady of Uganda's Task Force on AIDS and

testified before the United States Congress (House of Representatives Committee on International Relations 2005). In addition to his outspokenness against condoms (including a demonstration in September 2004 in which he set fire to a box of condoms at the Makerere University campus and prayed over the burning boxes, saying, “I burn these condoms in the name of Jesus”), Ssempe also played a leading role in the movement against homosexuality in Uganda. Most recently he has been an advocate for the “Anti-Homosexuality Bill” which includes the death penalty for “aggravated homosexuality” (Evertz 2010; Jacobson 2009) which I discuss in more detail later in this chapter. In 2007 Pastor Ssempe’s church also received funding of \$90,000 from PEPFAR as a sub-partner to provide abstinence and faithfulness education through the Campus Alliance to Wipe Out AIDS (PEPFAR 2007:20, 32).

In 2006, the then-Director of the Population Secretariat, Dr. Jotham Musinguzi, admitted that the moral crusade of the First Lady and her United States backers was not supportive of comprehensive HIV education efforts, “There are some prominent people in government, and some outside, who with the help of conservative agents in the US are stigmatising Aids, saying that only sinners use a condom . . . That is the message we are struggling with” (Duff 2006). According to a number of government officials and activists interviewed, the moral campaigning of Janet Museveni combined with the overall reduction of pro-condom messages has increased stigmatization of condoms, but has not increased abstinence or faithfulness within relationships, which they believe has contributed to the current stagnation in the

incidence rate and the growing numbers of those newly infected (Interviewees 18, 26, 57, 70, 95, 120).

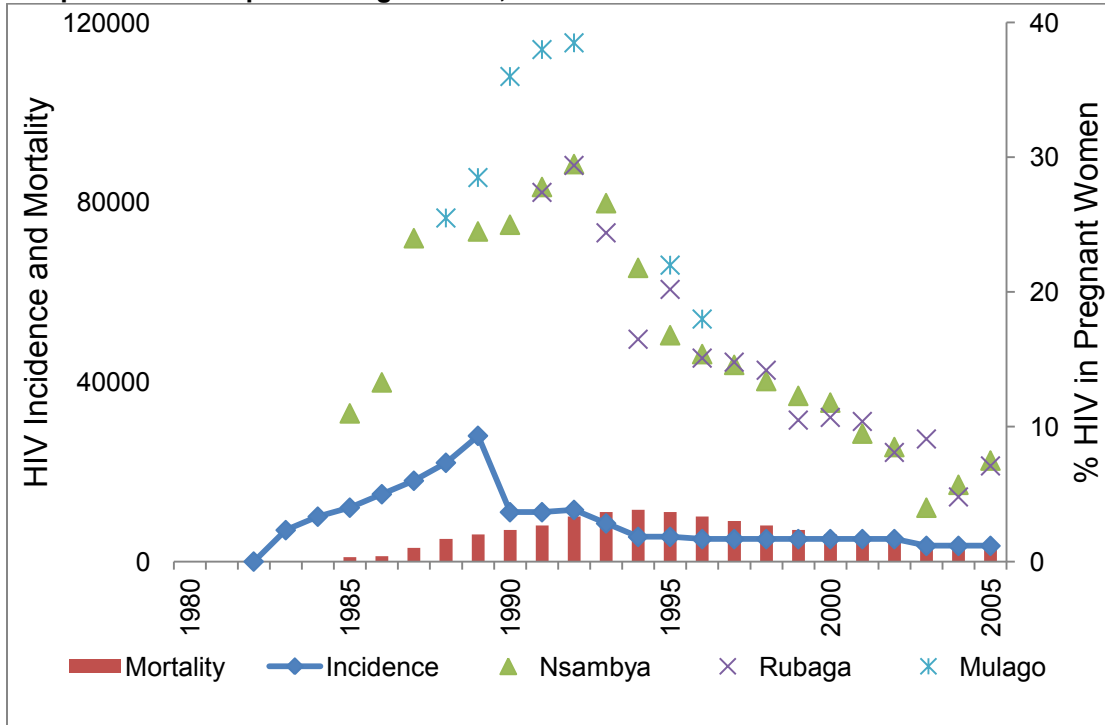
Figure 30: Estimated HIV Incidence Rate, 15-49 Years Old, Percentage (mid-point), 1990-2009



Source: (United Nations Statistics Division 2011)

The HIV incidence rate (the rate of new infections in the population) has held steady at about 0.7% (meaning that around 7 in 1,000 Ugandans age 15-49 years old become newly infected every year) since the early 2000s (United Nations Statistics Division 2011). The incidence rate has dropped from its peak in the 1980s; in 1990 the incidence rate was estimated at 1.98% (almost 2 in 100 people becoming newly infected each year), where it quickly fell to an average of 0.67% between 1993 and 2000 (United Nations Statistics Division 2011).

Figure 31: Stoneburner and Low-Beer Model of HIV Incidence and Prevalence in Kampala for the Population Aged 15-59, 1981-2005



Source: (Stoneburner and Low-Beer 2004:717); Additional and updated HIV prevalence: (Uganda Ministry of Health 2010c)

The graph in Figure 31 estimates HIV incidence and mortality in the population aged 15 to 59 in Kampala between 1981 to 2005. The graph and model were developed by Stoneburner and Low-Beer (2004) and show empirical HIV data from antenatal clinic sentinel surveillance sites of Nsambya (green triangles), Rubaga (purple crosses), and Mulago (blue stars) with modeled levels of incidence and mortality in Kampala. In Stoneburner and Low-Beer’s modeled scenario, incidence rates are reduced by 80% over a two-year period among 15 to 24-year-olds starting in 1992-1993 (Stoneburner and Low-Beer 2004).

What Was the Cause of HIV Prevalence Decline?

The Ugandan government was lauded internationally for its success, through constant reference and by hosting international meetings on HIV. The world was so desperate for an African success that the truth and specifics of the decline were secondary to the positive message.

In a Lancet article, Parkhurst argued that although there was evidence of Uganda's success in reducing HIV, that there have been misuses and misinterpretations of the data available (Parkhurst 2002). Parkhurst adds that sentinel surveillance data is difficult to understand and that the overall picture is more complex, with some dramatic declines, yet no decreases in prevalence in other areas (Parkhurst 2001). In addition, data drawn from a small number of urban antenatal clinics is not indicative of the country's status, as 87 percent of the population lives in rural areas (IRIN 2002; Parkhurst 2001).

Parkhurst later stated that “the standards of proof for policy recommendations seem to have been lowered to provide the international community with the African success story it wanted, or even needs” and said that the pressure to produce “results” may be due to donor fatigue, reductions in overall donor funding to Africa, and as an effort to boost the morale of health workers (IRIN 2002). Government leaders did not take

kindly to this criticism; the Minister of State for Health Mike Mukula, and Minister of State for General Duties in the Prime Minister's Office Mondo Kagonyera, reported to parliament that the president's data "were the result of scientific research" (IRIN 2002). The Minister of State for Health, Mike Mukula, continued, "They don't believe that any country in Africa can do anything positive" (IRIN 2002).

Yet prominent figures in the country such as Major Rubaramira Ruranga, one of the earliest military commanders to publically declare himself as HIV positive in 1993 and currently an HIV activist and leader, also questioned the figures produced by the government that claim success, "We should stop producing doctored information for fear of evaluation and for want of more money" (de Waal 2006:96). The argument that government data was not fully based on scientific evidence was supported by a number of people. In 2010, a researcher who previously worked as a consultant on a number of Ministry of Health and related projects told me,

The president and others were giving figures before they were even available to the research team. I know this because I was in the midst of trying to access those data and I talked to the [research] team and he [the lead researcher] was saying that the data had yet to be inputted. Almost the next day, there was an announcement of a dramatic decline by the government. I went back to the lead [researcher], asked where the figures were and if I could access them, he admitted they had yet to even input the data. . . [chuckles and pauses, almost a smirk with one lip rising] that's how official research works. The result[s] come out before the data is even tabulated. (Interviewee #75)

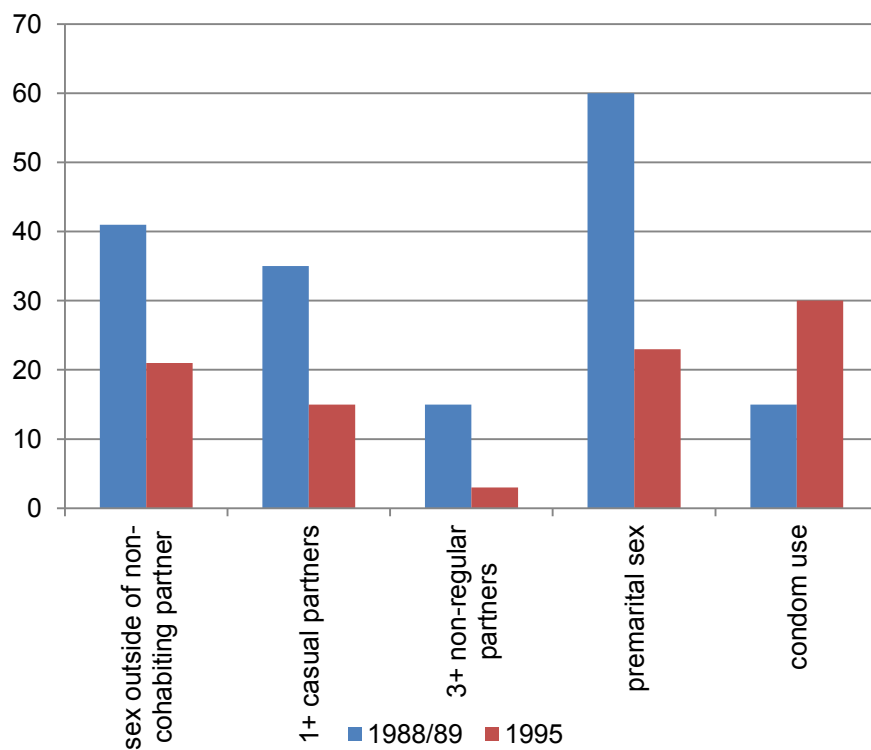
Others at NGOs spoke of their suspicions of how the government would have figures even before data was supposed to be collected, confirming the story of the researcher interviewed (Interviewees #47, 82).

Apart from the political arguments made by Museveni and the First Lady that ABC, or more recently, A and B were the causes for the decline, what other arguments have been put forward as the cause of the prevalence decline? Examining the available data, researchers have concluded that new HIV infections (incidence) began to decrease in 1988, and around 1992 prevalence (the proportion of people living with HIV) levels peaked (Low-Beer and Stoneburner 2004). Thornton argues that it is very likely that during the period of decreasing prevalence, “overall connectivity [in the sexual network] decreased, but especially the links between highly infected persons or groups in the network and the general population decreased” (Thornton 2008:45). By 1994, national surveillance showed the first measured decline (Low-Beer and Stoneburner 2004). This is consistent with the earlier figure in this chapter, in which data from the Uganda Ministry of Health shows that HIV prevalence declined between 1993 and 1996 and began to level off in 1997. HIV work in its earliest years was largely domestically designed, driven and funded; “when HIV incidence in Uganda began to fall, just a few million dollars had been spent” (de Waal 2006:99).

The WHO's Global Program on AIDS (GPA) surveys from 1988/89 and 1995, while not nationally representative, has some of the earliest data on HIV-related behavior in men (Bessinger, Akwara, and Halperin 2003). Data from a number of indicators reveals that there was a dramatic shift in behavior, particularly in partner reduction which most likely played a large role in the epidemic's decline in Uganda. The

proportion of men reporting three or more non-regular partners in the previous year fell from 15 to 3% between the 1989 and 1995. There were similarly large declines in the proportion of people reporting having casual sex in the previous year, from 35% to 15% among men and from 16% to 6% among women (Bessinger, Akwara, and Halperin 2003). Figure 32 below compares a number of indicators of sexual behavior in men from the WHO's Global Program on AIDS (GPA) surveys from 1988/89 and 1995.

Figure 32: Changes in sexual behavior among men in Uganda, 1988/89-1995



Source: (Bessinger, Akwara, and Halperin 2003)

Tumushabe argues that the decline in prevalence in Uganda between 1993 and 1996 was actually a result of behavior change in the mid- to late 1980s because of the time

necessary for behavior change to be visible and the time delay between infection and detection of the virus (Tumushabe 2006:12). A decline in prevalence beginning in 1992 would correspond with a fall in incidence from the beginning of 1985, as prevalence rates will reflect declines in incidence only after a time lag of approximately seven years or more (Garnett 1998; Parkhurst 2002; Stoneburner, Low-Ber, Tembo, Mortens, and Asiimwe-Okiror 1996). 1985 was a time of civil war in Uganda, when there were no prevention policies or governmental attention to HIV. Behavior change in the southwest of the country likely started to happen as soon as people began to make the link to the disease of “slim” and sexual behavior; this likely occurred before the national HIV/AIDS program was set up in 1987/88 (Parkhurst 2002).

High AIDS-related mortality likely played a large factor in the decline between the early 1990s and early 2000s. One study found that the decline in HIV prevalence between 1990-1992 in Rakai, Uganda, was due to higher levels of HIV-related mortality (among those infected on average 9-10 years earlier) relative to the rates of new infections occurring (Wawer, Serwadda, Gray, Sewankambo, Li, Nalugoda, Lutalo, and Konde-Lule 1997). Another study found that most of the prevalence declines between 1994/5 and 2002/3 were due to high levels of AIDS-related mortality (Wawer, Gray, Serwadda, Namukwaya, Makumbi, Sewankambo, Li, Lutalo, Nalugoda, and Quinn 2005). Others suggest that “widespread behavioral

change occurs in response to large increases in mortality, at which point the HIV epidemic may be nearing its peak” (Barnett and Whiteside 1999:205).

According to Putzel, the centralized character of the Ugandan government (despite decentralization in name) allowed for clear messages to disseminate quickly from the national level to villages, and also for creating political space for NGOs (Putzel 2004). While the government takes credit and pats itself on the back for its leadership in turning around the HIV epidemic, other scholars point to the tremendous role of others as well as other factors in Uganda’s success. In particular, people living with HIV started a NGO called The AIDS Support Organization (TASO) in 1987, which has played a huge role in education and de-stigmatizing HIV, as well as in providing care. Musician Philly Lutaaya came out as HIV-positive in 1989 and made significant efforts to educate people about HIV through his popular music. Other NGOs and community support groups worked with little funding and assistance from the government or outside groups (Tumushabe 2006). More recently, NGOs, recognizing that HIV prevalence is on the increase in the country, particularly among married people, have begun popular campaigns emphasizing how sexual networks are a key transmitter of HIV and encouraging the open discussion of the role of “side dishes,” a slang term for ongoing, extra-marital or extra-union relationships, in fueling the HIV epidemic (Interviewees # 23, 70, 100, 112, 116). Figure 33 below shows a billboard for one such campaign in 2010.

Figure 33: Billboard in Kololo, Kampala, March 2010, Good Life Campaign by the Uganda Health Marketing Group



Source: (Zlatunich 2010d)

In addition, the behavioral change central to Uganda's prevalence decline was not as purely voluntary as the Ugandan government promotes. From the beginning, human rights were not a component of HIV strategies in Uganda. The reconstruction of local government and Resistance Councils was linked to the national fight against HIV in Uganda (de Waal 2003:21). The Resistance Councils, a system adopted after the NRA took power in 1986, were a way for administration and power to move from the central level to the local level. Resistance Councils enacted social discipline adapted

to AIDS control measures; these measures included preventing the movement of young women between villages and closing discos and bars, and in some areas, “threats and violence against women whose behavior was considered socially unacceptable” (de Waal 2006:101).⁶⁶ Uganda’s early HIV control strategies were clearly coercive, although this was, of course, never promoted by Museveni or other leaders when taking credit for Uganda’s prevalence declines.

Assuming that Uganda’s “best practices” of open communication were the cause of its success, would these best practices work outside of the country? There is little evidence to support this—Botswana implemented an HIV education program with the same components and comparable (or higher) commitment and at the same time as Uganda (de Waal 2006). But Botswana has not experienced HIV success—adult prevalence was estimated at 4.7% in 1990, rising to 12.6% in 1993; 21.8% in 1996, peaking at 26.5 in 2000-2001, slowing lowering to 25.4% in 2004, and reaching 23.9% in 2007 (UNAIDS 2008).

Ugandan HIV Policy and Practice: Current Complacency, Human Rights, and Gay Rights

“Uganda is the only country receiving large amounts from the Global Fund that has rising prevalence rates. We’ve become complacent” (Interviewee #30). Although efforts have been underway in Uganda to have a national HIV policy, an official policy was not finally approved until 2011 (Uganda AIDS Commission 2011d). In

1993, the Uganda AIDS Commission (UAC) drafted the guidelines for the policy, which were reviewed and re-drafted in 1999 and sent to the President's Office for further steps (which were not forthcoming from the Ministry level). In 2002 the UAC hired consultants to write another national policy which was again submitted to the President's Office in 2004 (Tumushabe 2006). The UAC finally received approval for the "Uganda National HIV and AIDS Policy" in 2011 (Uganda AIDS Commission 2011d). A number of individuals in both NGOs and in government whom I interviewed said that the reason that the overarching policy (rather than the time-bound strategic frameworks and strategic plans that each spanned between two and five years) took so long to be finalized and approved by the Office of the President was that the president wanted to maintain discretionary authority over everything the UAC did and without a written strategy, he would be able to do so.

Many interviewees spoke of how the government's efforts are focused on the bio-medical aspect of HIV—curbing the spread and providing treatment and care. With the focus on the physical, little effort and funding has gone to addressing the rights aspects of HIV. A staff member at an NGO told me,

There is a lot of discrimination against HIV positive people in hospitals and clinics. In Mulago [the national referral hospital in Kampala], pregnant positive mothers are not assisted during delivery. It's not just reports like we see in the media, I've seen it happen. And at one time, I was visiting a cousin delivering there [in the private ward] and I went through the public [area], and I saw this poor woman hunched over in pain on the floor, without even a mattress. She was on the floor, she had started labor and everyone was moving away from her, I asked her what the problem was, if she didn't have some money to give them to help her [health care is supposed to be free but often requires a bribe and/or provision of one's own supplies such as gloves,

as well as any medicine the facility does not have in stock] . . . she didn't have any help or money. I took pity . . . bought gloves and what and had to physically get a nurse to actually assist her. . . The nurses were not wanting to help her since she had HIV. It was only because of me that they even gave her drugs for [to prevent] transmission. (Interviewee #103)

Despite wide knowledge of discrimination against HIV-positive people in medical services and in employment, the government has done little to prevent rights from being violated, and in some cases, has even promoted discrimination with its own practices, such as in not promoting HIV-positive members of the army. Museveni stated in 2001, "There is no reason why people living with HIV/AIDS should be offered opportunity in the army. Because training officers who later die not from bullets in combat but from AIDS is so frustrating. It is like fetching water in a basket with holes" (The Monitor 2000).

In March 2001, the then-vice president, a medical doctor, said to parliament, "People with HIV/AIDS should be told in the face since AIDS is like malaria" (Tumushabe 2006:18). This implies that the government supported open disclosure of individuals' HIV status, a practice that has been condemned by human rights organizations. The rhetoric making Uganda a success story clearly obscures the significant weaknesses and needs still present for HIV policy and programs.

A large number of activist and NGO leaders criticize the government's and others' apparent lack of energy in addressing rising prevalence and risky behaviors. In 2002, President Museveni, when accepting an award for his personal leadership and

commitment against HIV, stated, “AIDS spreads . . . through unprotected sex. We don't have homosexuals in Uganda, so this is mainly heterosexual transmission” (New Vision 2002).

Museveni’s statement clearly illustrates the social exclusion of homosexuals in Uganda. Despite the obvious false statement of the Ugandan president, gay-rights activists have campaigned to “Let Us Live in Peace” (McClelland 2012; The Economist 2011; Wilson 2011). The Ugandan penal code makes “carnal knowledge of any person against the order of nature” a criminal offense, punishable by up to life imprisonment (Government of Uganda 1950; McClelland 2012). In 2005, the constitution was amended to prohibit same-sex marriage (Mujuzi 2009).

Homosexuality in Uganda is both invisible and illegal—creating a catch-22—if they truly did not exist as President Museveni and a number of his ministers insist, why the need to outlaw and make homosexuality increasingly criminal?

In 2004, the then-Minister of Information, Nsaba Buturo wrote to both UNAIDS and the Uganda Aids Commission “to protest the inclusion of support for lesbian, gay, bisexual and transgender groups because they are illegal under Uganda's laws” (Angelo 2004). In 2006, James Kigozi, spokesperson for the Uganda AIDS Commission (UAC) stated, “There's no mention of gays and lesbians in the national strategic framework, because the practice of homosexuality is illegal . . . These two groups [gays and lesbians] are marginal; their numbers are negligible” (PlusNews

2006). In 2006, the then-Minister of State for Health, Jim Muhwezi, said that, “They [homosexuals] don't deserve a special message. They shouldn't exist, and we hope they are not there. If they do exist they are covered under the three-pronged approach of ABC and should be content with that” (PlusNews 2006). In this statement, Muhwezi insisted that Uganda’s broad approach to prevention via ABC was adequate for all groups, including homosexuals (“if they do exist”).

There is international scientific and political consensus that HIV policies and programs need to address all groups, but to have particular strategies to reach vulnerable populations such as men who have sex with men (MSM). According to UNAIDS, specific policies for men who have sex for men (MSM) need to be included in national policies, programming, and funding (UNAIDS 2009). The US’s PEPFAR also identified MSM as a prioritized group in HIV prevention activities, and its guidelines state that “PEPFAR country teams should support the establishment of laws, regulations and policies that support HIV prevention efforts for MSM” (PEPFAR 2011:14). Men who have sex with men are a particularly vulnerable group, as evidenced in the discussion above. One 2008 study of gay and bisexual men in Kampala found that only 80% of the study participants always use lubricants for anal sex, and that 36% of had unprotected anal sex in the prior six months (Kajubi, Kanya, Raymond, Chen, Rutherford, Mandel, and McFarland 2008). A Centers for Disease Control (CDC) study of the status of MSM in Kampala found an HIV prevalence rate of 14 percent (UG Pulse 2011). Another study found that 40% of

MSM in a Uganda study also had sex with women (National AIDS Control Council of Kenya and Population Council 2008), meaning that the increased MSM vulnerability to acquire HIV also extends to populations outside MSM. However, as HIV prevention messages in Uganda are focused on the risk of heterosexual sex, gay and bisexual men in Kampala have a low perception of their own risk for HIV (Kajubi et al. 2008).

As of 2008, “no informational materials on HIV/AIDS even mention gay and bisexual men in Uganda, let alone address their specific sexual health needs” (Kajubi et al. 2008). Of the \$285 million to Uganda from PEPFAR in 2009, only one program with funding of \$5,000 USD targeted “men who have sex with men” (Alsop 2009). In addition, the Ugandan government has also actively prevented the dissemination of HIV information addressed to MSM by imposing fines on local radio stations who discussed the issue of HIV risk among MSM (National AIDS Control Council of Kenya and Population Council 2008).

The small number groups and individuals working for gay rights attack the government for leaving out the sexual health needs of homosexuals in the country. I was told by one activist, “A lot [of gay men] have resorted to cooking oil and avocados [for lubrication]. It’s not safe, and they know it. We’ve educated [them] on not mixing oil and condoms. But they either can’t afford or access lube.” (Interviewee

80). Others I spoke to acknowledged the government's non-response to gay populations in the HIV epidemic.

The Ministry of Health has even publically blamed the international community for promoting sexual rights, apparently at the expense of general prevention strategies preferred by the government. In 2011 the AIDS control manager in the Ministry of Health, Dr. Zainab Akol, said the rights of minorities were derailing the fight against HIV, "By the time we are through with one group's rights, we have 130,000 new infections . . . It is as if the global agenda is to use HIV to propagate sexual minority groups. Let them use the proper channels to deal with such issues" (Mugisa 2011). In late 2011, it was reported in the Ugandan media that the failure to secure the full requested amount from the Global Fund is due to a lack of addressing gay rights, "The Global Fund has denied Uganda \$270m needed to put over 100,000 more people on lifesaving ARVs because the country's policies are deemed harsh on sexual minorities" (Mugisa 2011).

In part, the Ministry of Health's response to Global Fund cuts has to do with the controversy and Uganda's international public relations nightmare of the Anti-Homosexuality Bill, sponsored by Ugandan Member of Parliament David Bahati.⁶⁷ The Anti-Homosexuality Bill proposes that any homosexual acts would be punished by life in prison (up from the current maximum of 14 years), and the death penalty would be the punishment for a new offence termed "aggravated homosexuality"

(which would include “serial offenders,” HIV-positive “offenders,” or those engaging in homosexual activity with a minor or disabled person). In addition, anyone could receive seven years in prison for helping, counseling, or encouraging a person to engage in a homosexual act (BBC 2010).

In January 2010, President Museveni said that the cabinet will talk to Bahati “to reach a position that will leave both the local and international community satisfied” (Independent 2010). A cable released by Wikileaks dated January 28, 2010, described a meeting between United States Ambassador Jerry P. Lanier and Ugandan President Yoweri Museveni; in the meeting, Museveni said that “someone in Uganda” referring to himself is handling the matter (El País 2011b). Another cable released on Wikileaks dated February 11, 2010 reported that Museveni asked the Americans to be less critical publically and said “I’ll handle it” in regards to the anti-homosexuality bill (El País 2011a). The president’s remarks identified that the bill is not just a domestic matter, but rather one with international ramifications, including potential aid reductions by donors (which is significant, considering that a large portion of Uganda’s budget and about 6% of Uganda’s GDP is foreign aid) (Richardson 2011). Donors and international advocates continue to speak out against the bill. International repercussions through reduced aid levels has yet to happen, but in October 2011 United Kingdom prime minister David Cameron proposed aid sanctions against countries with anti-gay bills (Wilson 2011).

HIV “Success” and the Relationship to Population/Reproductive Health “Failure”

As discussed in this chapter, the most commonly told story on Uganda’s HIV “success”—that political leadership was the key factor in turning around the epidemic—is a myth. Yet the Uganda’s “success” has continued to live and perpetuate itself, not just in Uganda, but among international agencies, donors, and other countries still suffering under even-larger HIV epidemics than Uganda’s. Uganda’s story has been used to illustrate arguments that political commitment is necessary for the success of any issue, and not just HIV.

HIV clearly has a disproportionate share of leadership attention and budget. HIV programs, including all donor resources, constitute a huge portion of spending for health in the country; approximately \$325 million USD was allocated for general health services (excluding HIV) and \$293 million USD for HIV services and programs from government of Uganda and all donors in 2008/2009.⁶⁸ Others have reached similar calculations; in 2007, HIV spending constituted 50.2% of the health budget in Uganda from public and international sources (Amico, Aran, and Avila 2010).⁶⁹

Unlike HIV, issues of reproductive health and population lack both consensus and a significant government budget in the country. In this concluding section for this

chapter, I draw from the above analysis of Uganda's HIV history and mythology to better understand the current status (and lack of "success") on population and reproductive health in Uganda. In this analysis, I identify five factors that played the largest role in success on HIV and failure on population and reproductive health: a critical juncture, a clear consensus, political incentive, collective action/social cohesion, and bureaucratic structure (competing vs. centralized/aligned).

Critical Juncture

HIV was an internal as well as international critical threat in Uganda (as well as everywhere where there is a generalized epidemic); HIV had clear potential cross-cutting effects across the social, economic, and political status of the country. In Uganda, HIV presented as a "critical juncture" (Collier and Collier 2002). In comparison, population and reproductive health have never been considered a problem necessitating immediate action; this is very different from the critical juncture of HIV. As one interviewee stated, "It's hard to make your point really hit hard. No one has ever died of overpopulation. . . . You can make arguments all day that the Bududa landslides were caused by overpopulation, but [the arguments are] so indirect. This [overpopulation] is not AIDS" (Interviewee #51). Landslides in March 2010 killed at least 80 people around the Mt. Elgon area in Bududa district; similar slides in the area have killed over 500 people since 1993 (Mafabi 2011b; Makuma 2011; Vision Reporters 2010). The Population Secretariat also has made the link of landslides as being caused by farming in previously forested areas due to population

pressures, and conveyed that message to district leaders, as well as cultural and traditional leaders, particularly in the eastern part of the country.

Clear Consensus

As argued in this chapter, the clear popular recognition of the problem of HIV was the true, underlying cause of Uganda's decline in prevalence. Large-scale population behavioral change started to happen as soon as people began to make the link to the disease of "slims" and sexual behavior; this likely occurred before the national HIV/AIDS program was set up in 1987/88 (Parkhurst 2002). A decrease in overall connectivity in Uganda's sexual network (particularly in the links between highly infected persons and groups and the general network) produced the decrease in incidence starting around 1985 (Parkhurst 2002; Thornton 2008). Yet this reduction in HIV incidence was not reflected in HIV prevalence declines until 1992 (Garnett 1998; Parkhurst 2002; Stoneburner et al. 1996). The dramatic decrease in incidence (and later, in prevalence) was because individuals severed sexual network links with high-risk individuals through reductions in the number of partners or condom usage (Thornton 2008). It was popularly recognized that HIV or "slims" was being transmitted through contact with high-risk individuals and groups.

This behavioral change in the sexual network started in the 1980s was supported and fueled by both cultural and political leaders. Almost upon assuming power in 1986, Ugandan leadership recognized that the problem of HIV could only be addressed by

“overcoming single or multiple collective action problems” (Leftwich 2010:108). Uganda’s leaders were clear that they needed to cultivate the consensus on HIV already working in the country. Unlike HIV, there has yet to be a clear consensus on population issues among the general population or among political, traditional, cultural, and religious leaders. Evidence arguing for population and reproductive health is often complicated and technical, and thus easy for the population (and leaders) to not understand, to ignore, or to argue with.

Social conservatism was surmounted with HIV; it did not work against the policies and messages that were used early in the epidemic—an ambiguous argument for partner reduction (“zero grazing”) was culturally acceptable, and the government was able to eventually win over religious leaders, particularly though the de-emphasis on the role of condoms. However, social conservatism works against almost all of the policies and messages for family planning. Advocates have yet to fully win over groups in opposition to family planning for anything other than “child spacing.”

In part because of this, the Ugandan state has been much more evasive on its stance on population, as opposed to its stance on HIV. As discussed in “Chapter 3: ‘The Cairo Consensus of Confusion’: Global Influence and Local Frames in the Struggles over Uganda’s Population Policy and Influences on Its Implementation”, different state actors in Uganda present conflicting messages on population and reproductive

health. President Museveni has taken an optimistic view of population in the country, perhaps for theoretical reasons, but also for political reasons.

Political Incentive

The political incentive structure in Uganda at the time created the right conditions to force the government to act on HIV (Putzel 2004). These conditions—including the legacy of the war, the support of donors, and a strong coalition behind the president—meant that HIV was beyond “partisan politics” (Putzel 2004). Currently, there is a stronger political incentive for financial support to HIV than to general population or reproductive health programs. In particular, providing life-saving drugs is an easy political move. The Ugandan government has pushed to increase not only donor project funding for treatment, but also for government funding and support to increase access to treatment drugs. In 2001, the then-State Minister for Health, Mike Mukula said, “This is a matter of national priority and urgency to have the drugs locally manufactured.” He also said that the government will give companies tax holidays, in order to promote local manufacturing (New Vision 2001).

There are a good deal of politics involved in the actual splitting of government funding for drugs and health commodities in Uganda. According to an official in the Ministry of Health, a company called Quality Chemicals Industries Ltd, which has a factory in Luzira, Kampala, producing antiretroviral drugs since 2009,⁷⁰ wanted approximately 60 billion Uganda shillings in 2010 (Interviewee #79). This figure

amounts to almost 1/10 of the government budget for health in 2010 and 1/3 of the budget for health commodities and supplies (the entire health sector has been given a budget of around 743 billion shillings in 2009/2010 and 638 billion in 2010/2011 and the budget for health commodities is approximately 205 billion for 2010/2011) (Mugerwa 2010a; Uganda Ministry of Finance 2010a). The shareholders and management of Quality Chemicals have significant clout with the government, according to a number of government officials and others that I interviewed (Interviewees #8, 17, 61). Emmanuel Katongole, the Managing Director of Quality Chemicals Industries Ltd., was named in the tabloid *Red Pepper* newspaper as a top National Resistance Movement (NRM) tycoon financially supporting Museveni's reelection campaign (Red Pepper 2009). The president, in turn, has not only promoted the local manufacturing of this company, but he has also directed that a significant portion of the government budget for drugs go to locally-produced antiretrovirals. The Ugandan government was an early investor in Quality Chemicals and held a 20% stake in the company until January 2011, when it sold off its shares "at cost," worth 10 billion Ugandan shillings (approximately \$5 million USD) (New Vision 2011). This investment and political link has meant that the government has a financial and political interest in seeing Quality Chemicals succeed. In May 2011, President Museveni "reprimanded" government officials in health and finance ministries and told them to buy locally manufactured medicine rather than importing drugs. He specifically told both ministries to buy from Quality Chemicals rather than to procure ARVs from abroad, using a metaphor of war within his own government, "We built

an ultramodern ARV factory, but it is always facing a lot of challenges from the health and finance ministries. They prefer importing drugs to buying the ones produced here. I am always at war with them. I always keep shouting. Even now there's a war going on" (Kagolo 2011). In part, the political relationship between Quality Chemicals and the government has resulted in lower budgetary shares for other drugs and commodities, including for family planning and reproductive health.⁷¹ As discussed in "Chapter 5: 'What Is Allocated Is Not What Is Delivered': The Policy-Implementation Gap of Contraceptive Commodities", the government funding for family planning commodities has been an insignificant portion of the overall health budget, and thus, donors have been the main financiers of reproductive health commodities in the country.⁷²

Population and reproductive health does not have the same clear short-term political imperative as HIV (the political imperative, if it does exist with population and SRHR, is much longer-term and more abstract). And as discussed in "Chapter 3: 'The Cairo Consensus of Confusion': Global Influence and Local Frames in the Struggles over Uganda's Population Policy and Influences on Its Implementation", political gain can result from larger populations and large youth cohorts. And unlike HIV, the political motivations to address population and reproductive health are not as large, and there is no clear critical juncture or political incentive to act. Despite activists' attempts to re-define maternal mortality as a public bus crash killing 16 women every day, the news media in the country has not defined maternal mortality as a crisis that

must be addressed by the government. In addition, deaths due to maternal mortality, although common, are significantly lower than the rates caused by HIV during the peak of the epidemic, and maternal mortality is attributable to a range of reasons, including personal and family responsibility (due to delay in seeking care at a health facility, lack of prenatal visits), and actions at the health center itself (for example, when blame for a woman's death is put on an overburdened health worker who failed to attend to a woman during delivery promptly).⁷³ Family-level outcomes due to high fertility such as maternal mortality and morbidity, higher poverty, poor health, and lower educational attainment for children are often not experienced and thought of as results of higher fertility, but as the result of poverty and low economic development. Country-level outcomes due to high fertility such as increased financial burdens on social service provisioning in education, health, water, roads, and other sectors are often not considered at the budgetary level, as the investment in education and services for reproductive health and family planning are opaque and have delayed benefits (where the cost-savings are seen in the future, rather than the current budgetary cycle).

Collective Action/Social Cohesion

The problem of HIV was seen as something that had to be pursued in coalition. The building of the consensus was clearly political, as discussed above. The solution devised to address HIV was not (at least originally when the HIV prevalence decline began and was later continued) based on a global "consensus" of experts from

Washington or Geneva. The solutions devised were not made in a perfect Weberian bureaucratic state of “Denmark” (Pritchett and Woolcock 2004). Rather, solutions and HIV planning was open to external ideas, as long as they were appropriate to local situations; this was not “institutional mono-cropping” (Evans 2004).

In addition, the action to be taken against HIV happened at the individual, family, and community level, not just the political level. Scholars have identified the particular timing of Uganda’s HIV crisis, coming after decades of war and disorder, was also a time of the rebuilding of social cohesion. Barnett and Whiteside identified “the expansion and strengthening of civil society” as a factor in the success of Uganda’s HIV programs and that “community action to confront the epidemic may have been a significant catalyst in the strengthening of civil society” (Barnett and Whiteside 1999:228). During this time, Ugandans openly shared information on HIV with their friends, families, and neighbors. Survey data from the mid-1990s show that Uganda ranks highest among all African countries in the percentage of people who cite friends, relatives, or community meetings as sources of AIDS information (99.2%) (Measure DHS 2012). Uganda’s rate is double that of many other African countries at the time (Measure DHS 2012).

President Museveni also attributed success against HIV in Uganda to collective action and involvement, “In the African villages, once a lion comes to attack the village, you make a very loud alarm, so that the whole village comes and attacks the lion, and that

is what we did with AIDS” (New Vision 2002). In 2008, Dr. Kihumuro Apuuli, Director General of the Uganda AIDS Commission said “Uganda's achievements in fighting the epidemic cannot be attributed to a single stakeholder or even a cluster of stakeholders, but the collective efforts of all” (PEPFAR 2008).

According to Epstein, the HIV rate fell due to the collective efficacy of Ugandan communities, “what mattered most was something for which public health experts had no name or program. It was something like ‘collective efficacy’—the ability of people to join together and help one another. Felton Earls, the sociologist who coined the term, was trying to explain varying crime rates in American cities, but the phenomenon is present everywhere there is a spirit of collective action and mutual aid, a spirit that is impossible to measure or quantify, but that is rooted in a sense of compassion and common humanity” (Epstein 2007:160) citing (Sampson, Raudenbush, and Earls 1997).

Bureaucratic Structure (Competing vs. Centralized/Aligned)

The clear government bureaucratic structure for HIV under the Uganda AIDS Commission has shifted in recent years with the influx of funding from PEPFAR, which has dramatically increased resources to the Ministry of Health. While the Uganda AIDS Commission is still “the leader” on the country’s HIV response, the Ministry of Health is tasked with duties related to the medical response to the epidemic, which have grown in prominence along with funding, to the extent that the

country's response to the epidemic has become "medicalized". A number of interviewees connect the increasing medicalization of the HIV response, including increasing access to antiretroviral drugs at the expense of social programs targeting prevention, with increasing prevalence rates (Interviewees # 45, 62, 73, 95, 120). The Uganda AIDS Commission (UAC) is seen as the leader of the current cultural, social, and community response. While the UAC began work after the most significant declines in incidence were likely to have already started, the UAC played a significant role in continuing the momentum for HIV prevention in the country by authorizing and supporting the work of community-based organizations and by enabling a supportive environment for them to work, allowing the decline due to behavioral change to continue.

However, as discussed in "Chapter 3: 'The Cairo Consensus of Confusion': Global Influence and Local Frames in the Struggles over Uganda's Population Policy and Influences on Its Implementation", there are even stronger competing bureaucracies for sexual and reproductive health and rights and population policies and programming. Reproductive health and population are not coordinated or organized in a similarly centralized manner to HIV. Reproductive health (excluding HIV) has been separated and partitioned out across government units—the Ministry of Health has a Reproductive Health Unit under the Community Health Department, as well as a separate AIDS Control Program. The Population Secretariat (Popsec) operates under control of the Ministry of Finance, Planning and Economic Development, and

although it has been attempting to become a Population Council with a separate Board for governance almost since its inception, it has yet to achieve this. Although the Ministry of Health and Population Secretariat have separate mandates, they sometimes do work together, yet their programming is rarely fully or well-coordinated and their programs operate vertically. They often operate as competing bureaucracies at different levels—while Popsec is charged with advocacy for population and development issues and the Ministry of Health with advocacy for and implementation of reproductive health issues and programming, Popsec has conducted training of District Health Officers in reproductive health areas, sometimes involving the national-level Ministry of Health and Ministry of Local Government and sometimes without their involvement or participation.

Competing institutions and bureaucracies for reproductive health and population have created confusion in part due to overlapping mandates. With divided programming and methodology, but shared goals and outcomes for improving reproductive health and lowering fertility, no single institution is ultimately responsible for outcomes. This has meant that it is easy to push the blame for failure to another ministry or department, yet still be able to take credit for the successes that do occur.

Conclusion

In this chapter, I argue that Uganda's HIV story of success through political leadership is a myth that was created and cultivated for political reasons. Currently, Uganda is relatively complacent on HIV; this is different when compared to the active collective stance during the height of the epidemic. HIV has become a business, not only for NGOs, but also for the government, which illustrated its malleability to donor policies and beliefs, particularly with the United States government's PEPFAR emphasis on abstinence and faithfulness over condoms between 2004 and 2008. Uganda's current government policies and programs have ignored human rights in favor of a biomedical approach to HIV, which has led to the active role the government has taken to make gay and homosexual Ugandans invisible in HIV policy and programs, not only reflecting poorly on the country in international advocates and donors, but also creating a gap for a vulnerable population.

Five factors that played the largest role in the HIV political economy are not present for population and reproductive health: a critical juncture, a clear consensus, political incentive, collective action/social cohesion, and bureaucratic structure (competing vs. centralized/aligned). These political factors explain some of the failure in realizing improved reproductive health indicators and declines in fertility. These five factors help explain the role the political economy played in Uganda's HIV success and the

failure to make significant improvement on population and general reproductive health.

Chapter 5: “What Is Allocated Is Not What Is Delivered”: The Policy-Implementation Gap of Contraceptive Commodities

Figure 34: The Full Stock of Drugs at a Health Center in Southwest Uganda, October 2010



Source: (Zlatunich 2010e)

Introduction

In March 2010, the general unavailability of a number of family planning commodities (stock-outs) began to get serious media attention in Uganda. Newspaper reports stated that some government health facilities had not been supplied with contraceptives for close to a year (New Vision 2010a). The major daily newspapers

covered the issue through prominent articles and editorials; health advocates were pleased that this issue was finally being taken seriously, if only in the media (Kiwawulo 2010; New Vision 2010a; Seruwagi 2011). An editorial cartoon even appeared in the government-owned newspaper, portraying the future of the country in December 2010, with pregnant women lined up to enter hospital labor wards and emerging carrying newborn babies (Ras 2010a). The media began covering the stockout issue in part due to continued advocacy activities of a number of NGOs as well as international non-governmental organizations and networks such as Population Action International and the Reproductive Health Supplies Coalition who had been working with local NGOs as well as the Uganda Ministry of Health and Population Secretariat to address commodity supply issues in the country (EARHN 2007; Leahy and Akitobi 2009). This advocacy push, combined with the general direction from newspaper editors for reporters to also cover the topics making headlines in the other major national newspapers, led to a significant, but short-lived, media blitz on this issue (Interviewees #27, 99, 100, 102).

Yet while health facilities were experiencing shortages, there were drugs available at the national level. According to stock reports in March 2010, there were over eight months of full supply for the entire country of the contraceptives Depo-Provera (injectable), about 10 months of implants, 11 months of combined oral pills, and 16 months of oral progestin pills available at the central level for public health facilities to order free of charge (Securing Ugandans' Right to Essential Medicines 2010).

Newspapers were filled with stories reporting the stock-out of contraceptives, as well as other critical drugs. For example, between May 2009 and March 2010, Lira Hospital only had contraceptive pills, and no long-term methods such as injectables or implants, which are preferred by women in the community (Kiwawulo 2010). Other health facilities in Mityana and Kampala were also regularly out of contraceptives, leading to unintended pregnancies (Mwesigye 2010). One major newspaper reported that between 32-50% of essential medicines to treat common diseases like malaria, pneumonia, diarrhea, HIV, tuberculosis (TB), diabetes and hypertension were not available at government facilities between 2005 and 2009 (Okiror 2009). Only 40% of items on the essential drugs list were being stocked at health facilities in appropriate quantities in 2008 (Kaheru 2009).

In this chapter, I explain the problem of reproductive health commodity shortages identified so clearly in the media reports. International policies and policy guidance (in the form of donor analysis, conditionalities on donor aid, etc.) are based on the understanding that commodity systems are determined by health needs and service delivery/implementation is a technical function to be performed by the state (a “service delivery state”) in coordination with donors, NGOs, and community organizations. In addition, most analysis of contraceptive commodities in a country or sub-national unit examines the logistics processes and is technically-oriented, offering technical or management solutions to identified problems.

The political determinants of health are rarely fully considered in health policy analysis. Public health policy research is generally concerned with policy impacts and outcomes and rarely focuses on the policymaking process (Bernier and Clavier 2011). Theoretical insights from political science are rarely used to study health policy (Breton and De Leeuw 2011). Instead, the academic and program-directed/ “white paper” literature analyzing policies, funding, and programs for health regards these policies and programs as technical and administrative functions of the state (or NGOs), rather than as political. “Politics” –“the political activity or processes of making collective decisions”—are not seen as the conditions under which policies are made, but rather, politics is considered as interference to good governance, or as inefficient or unethical (Bernier and Clavier 2011:111). However, as clearly defined by Lasswell, politics is “who gets what, when, and how” (Lasswell 1936). Yet with the theoretical premise in the literature ignoring politics as a determining factor in health policy formation and implementation, there is no clear narrative of causality and proposed solutions to problems. Analysis of public health policy is often focused on micro-level policies as specific cases and largely ignores the macro-level trends that influence the specific micro-level cases they are studying (Bernier and Clavier 2011:110).

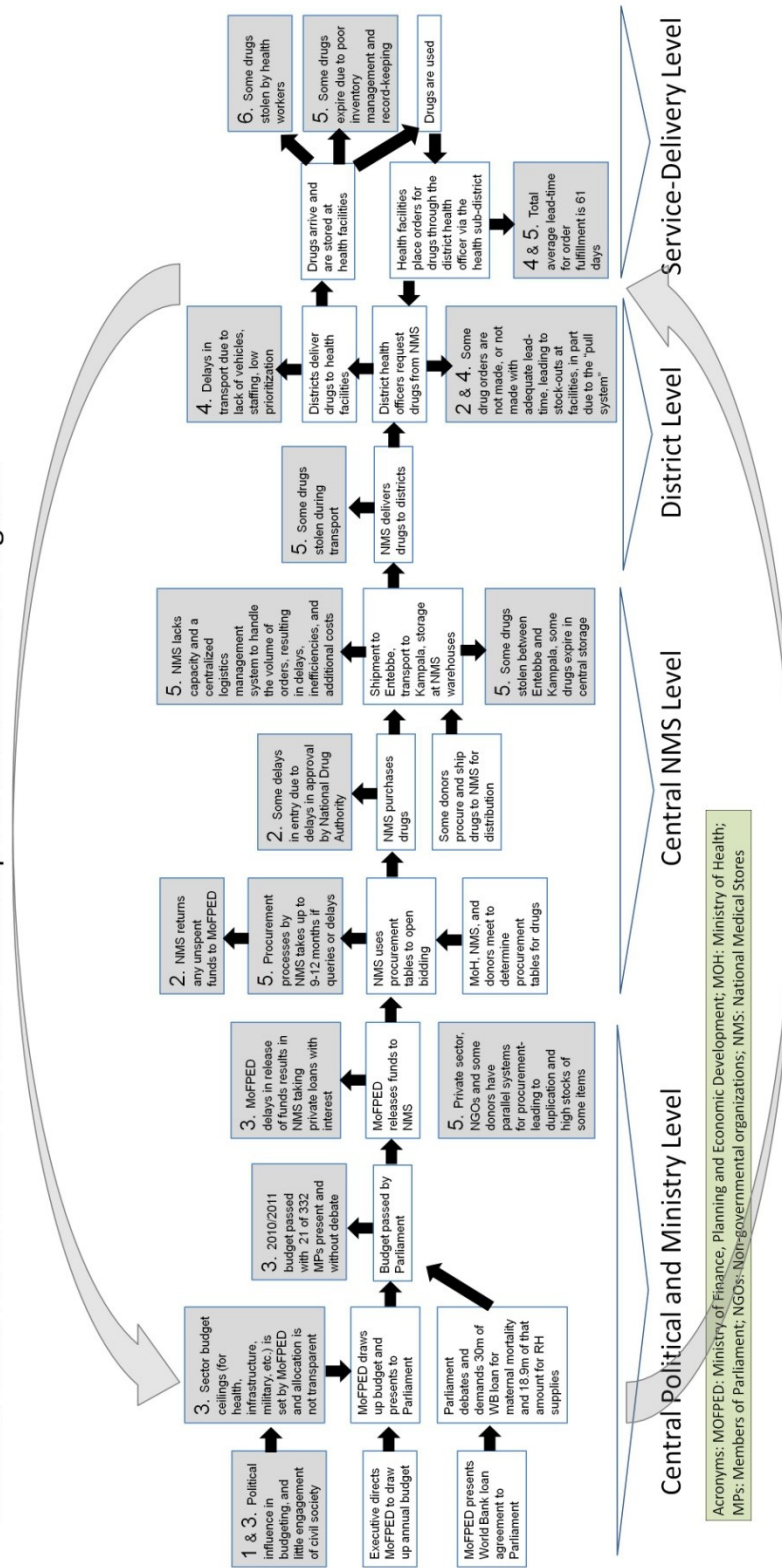
Instead of following the typical model of health policy analysis which is often linear, following specific institutions, and focusing on technical and operational issues in

implementation, I pay attention to politics, discourse, and context. In this chapter, I offer a political economy of reproductive health commodities in Uganda focusing on the actors and their motivations and incentives/disincentives in the processes of policy formulation, funding, and implementation. I focus on the national political level, rather than the technical or service level, where the processes of implementation, although just as important to ultimate outcomes, have already received some attention by researchers and by technically-focused program interventions (Bategeka, Kiiza, Mugisha, Muwanika, Ssewanyana, and Wokadala 2009; Carlson 2004; Jahre, Dumoulin, Greenhalgh, Hudspeth, Limlim, and Spindler 2010; Kuehn 2010; Leahy and Akitobi 2009; Mbabazi 2009; Mbonye 2009; Reproductive Health Uganda 2009; Reproductive Health Uganda and International Planned Parenthood Federation 2009; Uganda Ministry of Health 2009a; Uganda Ministry of Health 2009c; Uganda Ministry of Health 2010a). Like Ferguson (1994), I challenge the larger assumption that most policies are technical issues, rather than political issues. I specifically argue against the assumption that commodity supply is solely a technical issue, and instead argue that policy implementation, even for commodity systems, is also a political issue. Therefore, in this chapter, I describe the history of and policies on family planning commodities in Uganda, with a particular focus on the recent years of 2008-2011. I detail the positions and influence of actors involved in the policy changes, funding changes, design and implementation of the changes in order to give a political economy of policies, funding, and implementation of the reproductive health commodity system in Uganda.

Figure 35: Overview of the Processes and Gaps for Reproductive Health Commodity Procurement for Public Health Facilities in Uganda

The numbering of one to seven in the boxes in this figure corresponds to the seven factors with influence over policy implementation (Hill and Hupe 2009), which are discussed in depth in the next pages. The seven factors are: 1) wider macro-environmental factors, 2) the policy's characteristics, 3) policy formation, 4) layers in the policy transfer process, 5) the overall characteristics of the implementing agencies, 6) the behavior of front-line staff, and 7) the impact of responses from those affected by policy.

National-Level Procurement for Public Contraceptive Commodities in Uganda



Policy Implementation Factors for Reproductive Health Commodity Supply and Access in Uganda

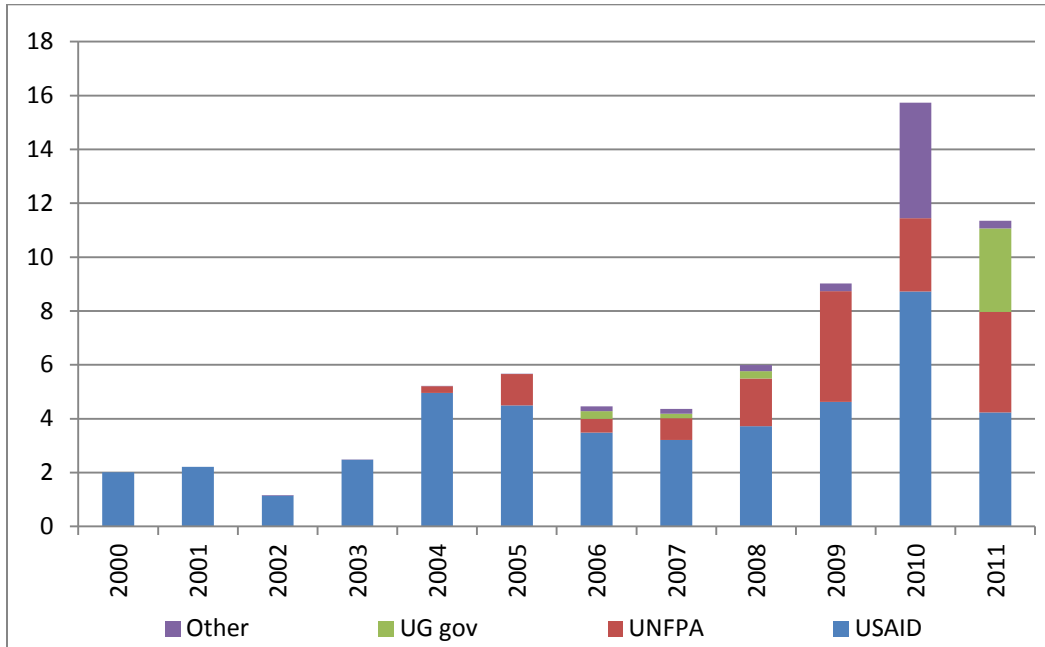
Hill and Hupe suggest that seven factors or independent variables have influence over policy implementation (Hill and Hupe 2009). These are: wider macro-environmental factors, the policy's characteristics, policy formation, layers in the policy transfer process, the overall characteristics of the implementing agencies, the behavior of front-line staff, and the impact of responses from those affected by policy (Hill and Hupe 2009). In Figure 35 above, these factors are numbered as they apply throughout the policy and procurement process for reproductive health commodities in Uganda. These factors are applied to this situation in order to better analyze the policy-implementation failure of reproductive health commodities in Uganda. While it is difficult to draw clear boundaries between the seven categories as they all work in tandem, an examination of each separately helps to determine which have greater weight in this particular case.

1. Wider Macro-environmental Factors

Larger macro-environmental factors include all of the factors and influences at play in the larger policy environment, some of which governments can have little or no influence over (Hill and Hupe 2009). In Uganda, these macro-environmental factors include the general funding environment for reproductive health commodities. USAID and UNFPA are the most significant actors in the procurement of contraceptives for the public sector, although other donors such as DFID have stepped in to meet commodity gaps in recent years (Reproductive Health Supplies

Coalition 2012b). The Ugandan government has a budget line item for reproductive health supplies (Mbonye 2009; Reproductive Health Supplies Coalition 2012a; USAID Deliver Project Task Order 4 2011). However, expenditures against the government budget line are not necessarily reported on in official MoH or MoFPED documents in the larger health or commodities budget and thus, budgets and expenditures must be gathered from individuals in the different ministries who oftentimes resort to estimates (USAID Deliver Project Task Order 4 2009).⁷⁴ The total national requirement for reproductive health commodities have been estimated with ranges from a little under \$10 million USD to \$18.8 million USD in recent years, with the higher ranges including the cost to meet the high unmet need in the country (Uganda Ministry of Health 2009a; Uganda Ministry of Health 2011b:17; UNFPA Uganda 2010b).⁷⁵

Figure 36: Contraceptive Commodity Procurement in Uganda 2000-2011, in USD Millions⁷⁶



Source: (Reproductive Health Supplies Coalition 2012a; Reproductive Health Supplies Coalition 2012b; USAID Deliver Project Task Order 4 2009; USAID Deliver Project Task Order 4 2010; USAID Deliver Project Task Order 4 2011) (Interviewee #79)^{77,78}

The Ugandan government figures included in Figure 36 above are budget expenditures, rather than the allocated amounts. The latter are significantly higher for most years after 2005/2006 (see Figure 37). The government regularly failed to spend the full allocation for reproductive health commodities.⁷⁹

According to an official in the Ministry of Health interviewed in 2009, the Ministry of Finance, Planning and Economic Development (MoFPED) believes that additional funding from the government should just be only a small amount in addition to the amount contributed by donors, “They [MoFPED] only want to allocate a little bit above donor’s contribution for family planning [commodities]. We did advocacy with

them and they said that we have enough to ‘survive on.’ So they just send us some of the budget we are to have” (Interviewee #36). Before 2009/2010 the low expenditure against budget was also attributed in part due to the quarterly fund release to the Ministry of Health which did not allow for advance procurement arrangements and to long lead time (up to one year) for National Medical Stores (NMS) (USAID Deliver Project Task Order 4 2009).⁸⁰

In addition, prior to the change in funding in 2009/10, bureaucratic procedures in the Ministry of Health contributed to poor communication and management. Under Uganda Program 9 funding of reproductive health commodities, multiple divisions within the Ministry of Health were involved in the reproductive health supply procurement (even before orders are placed with NMS): the Pharmacy Division, Reproductive Health (RH) Division, the Permanent Secretary, and Accounts and Finance. An Annual Health Sector Performance Report produced by the Ministry of Health identified a number of major challenges for sexual and reproductive health and rights. Two of the major challenges identified were related to government funding: “i) Funding constraints were in form of delayed release of funds coupled with unpredicted budget cuts. ii) Logistic challenges faced were those on delays in procurement of contraceptives using government funds” (Uganda Ministry of Health 2010a:53). Central shortages were also caused by international delays; “central level stock outs were caused by delays in donor shipments. High unexpected demand and

limited global supply especially for long term methods caused the stock outs”
 (USAID Deliver Project Task Order 4 2010).

Figure 37: Utilization of National Budget Line for Reproductive Health Commodities, 2005/06- 2010/11, in USD⁸¹

Year	Allocated	Spent	% spent ⁸²
2005/06	\$780,000	\$288,000	36.9%
2006/07	\$742,000	\$172,000	23.2%
2007/08	\$729,000	Approximately \$280,000	6.4%
2008/09	\$750,000	\$0	0%
2009/10	\$652,000	\$0	0%
2010/11	\$1,900,000 (new allocation, plus amounts rolled over from 2008/2009, 2009/2010) ⁸³ ; \$3,100,000 including World Bank ⁸⁴	\$1,900,000; \$3,100,000 including World Bank	100%

Sources: (Muwonge et al. 2011:27; Reproductive Health Supplies Coalition 2012a; USAID Deliver Project Task Order 4 2009; USAID Deliver Project Task Order 4 2010; USAID Deliver Project Task Order 4 2011); (Interviewee #79)⁸⁵

Between 2005/2006 and 2009/2010, the Ugandan government allocated approximately 1.4 billion Ugandan shillings (UGX) per year for reproductive health commodities (this is around \$650,000 to \$750,000 USD, depending on fluctuation of the exchange rate). This budget allocation was not expended fully in 2005/2006-2007/2008, and was not spent at all in the 2008/2009 and 2009/2010 financial years, but the budget funds were carried forward into the 2010/2011 fiscal year (USAID Deliver Project Task Order 4 2011). In 2010, President Museveni directed that \$3 million USD be made available for contraceptive procurement (USAID Deliver Project Task Order 4 2011).

Under-expenditure on reproductive health commodities is not only due to specific, technical bureaucratic issues in the Ministry of Health and National Medical Stores in accessing and releasing budgets. Political support for budget implementation also plays a significant role in this process. Political priority has been defined as the presence of (1) sustained concern expressed (publically and privately) by political leaders, (2) enacted policies addressing the issue by organizations and political systems led by these political leaders, and (3) the provision of resources matching the severity of the issue (Shiffman and Smith 2007). One of the few (and effective) forms of top-down political pressure is ensuring accountability to budgets.

Yet, as seen in the discussion above, political support for family planning is inconsistent—policies are in place as shown by the long list earlier in “Chapter 3: ‘The Cairo Consensus of Confusion’: Global Influence and Local Frames in the Struggles over Uganda’s Population Policy and Influences on Its Implementation”, yet until very recently, funding from the government was not present to support implementation of these policies. In part, because of the strong involvement of donors, the government of Uganda has not been forced to increase its commitment through budget allocations in line with the country’s needs.

The Ministry of Health identifies “weak political commitment” for reproductive health as the cause of low allocated funding to the sector, and stated that competing

government priorities, particularly for infrastructure, receive greater political attention and funding (Uganda Ministry of Health 2010a). The Ministry of Health has also identified commitment for reproductive health commodity security as inadequate (Uganda Ministry of Health 2009c:22). While the Ugandan government itself identifies its own “weak political commitment” as the reason for a lack of funding, the low level of political interest in improving reproductive health and reducing population growth has more deep and complex reasons than are briefly mentioned by the government as the causes. Rather, top political leadership in Uganda believes that it has compelling interests (such as security, regional power, and market growth) to act in opposition to programs that would truly lower the country’s fertility, as discussed in “Chapter 3: ‘The Cairo Consensus of Confusion’: Global Influence and Local Frames in the Struggles over Uganda’s Population Policy and Influences on Its Implementation”. Uganda’s political leadership therefore justifies its actions and budgeting based on the higher prioritization of other social services such as education and infrastructure, rather than discussing its underlying motivations for ignoring reproductive health and population. As argued by President Museveni at the July 2010 African Union summit,

But the problem is [there are] 5 issues to deal with: [including] roads, health, education, electricity, water . . . but you don't have enough money. If you fund each 30 percent, how do you describe, what alternative do you have? Many African countries do not have the resources. (Zlatunich 2010c)

If it were the case that Uganda’s leadership was deeply concerned with reproductive health and population, the lack of funding and actual expenditure against budget would be immediately rectified. This shift in political will having almost-immediate

effects has happened previously in two related cases in Uganda: the change to direct funding for National Medical Stores (NMS) and the creation of the Medicines and Health Service Delivery Monitoring Unit to prevent theft of government drugs.

The change to direct funding of National Medical Stores (NMS), which happened with Vote 116 in 2009, more than quadrupled the available funding for commodities. The National Medical Stores⁸⁶ originally received its funding channeled through the Ministry of Health. The total annual budget for the NMS has hovered around 50 billion Ugandan shillings (approximately \$25 million USD). This funding is channeled to the Ministry of Health from the Ministry of Finance and is sent in pieces over fiscal year. Yet, NMS received 13 billion Ugandan shillings (approximately \$6.5 million USD) in the 2007/8 financial year, a small portion of its intended budget (Kaheru 2009).

The difference in the budget and actual release to NMS was in part due to theft of funds within the Ministry of Finance and Ministry of Health (Interviewees #8, 12, 21, 72). The Ministry of Health also would re-allocate funds to other sectors and the spending was not transparent (Interviewees #8, 34, 72). “Dr. Moses Muwonge, the national reproductive health commodity security coordinator at Uganda’s Ministry of Health, says what is allocated is not what is delivered. Some of the fund is diverted to other sectors like primary healthcare” (Mwesigye 2010).

In addition, NMS would supply drugs on credit and then send invoices to the Ministry of Health and other health facilities asking to be paid. Delays by the Ministry of Health to release funds sometimes forced NMS to resort to commercial banks for loans with interest, making the drugs in the public sector fewer and more expensive. Although a good deal of funding was allocated to NMS in the annual budget, they were not receiving the funds and thus not able to do everything they were mandated to do (including supplying drugs to local governments).

In 2009, President Museveni directed the Ministry of Finance to create a vote for the NMS within the national budget in Parliament (Vote 116). In Uganda, government bodies and programs are funded through votes in the budget passed by parliament annually. Thus, until Vote 116 was included in the budget, NMS could not receive specific direct funding to procure commodities without the funds being channeled through the Ministry of Health or through local government budgets. Despite the involvement of a number of national and regional advocacy organizations and projects addressed towards improving funding and commodity security more broadly (Loewenson and Apunyo 2011), Members of Parliament immediately took credit in international fora for pushing for the NMS commodities vote (PPD ARO, EQUINET, APHRC, and SEAPACOH 2009). One parliamentarian later told me, “It was the pressure from parliament that forced the government to finally get committed [to fixing the funding for NMS]. Resource allocation is a struggle. The health budget does not give much to drugs. . . drugs must be a priority (Interviewee #5).⁸⁷

The ratio of drug supply through NMS was also increased due to efforts of Members of Parliament in the Social Services Committee.⁸⁸ Previously, NMS supplied 30% of drugs in public health centers, and 70% of drugs were procured through direct funds received by district health officials. Now, 70% of drugs are to be procured through NMS and 30% of drugs through direct funding (Kaheru 2009). In 2009, after Vote 116 that gave funds directly from the Ministry of Finance, Planning and Economic Development (MoFPED) to National Medical Stores (NMS) rather than via the Ministry of Health, NMS directly received 63.2 billion shillings (approximately \$31.6 million USD) in 2009/10 (Jahre et al. 2010; Kaheru 2009), a huge increase over the 13 billion Ugandan shillings (approximately \$6.5 million USD) NMS received in the 2007/8 financial year (Kaheru 2009).⁸⁹ Funding NMS directly created greater accountability and transparency in commodity funding, as the release of funds against the budget would have to be reported on by the Ministry of Finance directly, and with the Ministry of Health removed as an intermediary, the Ministry of Health could no longer appropriate funding for drugs and commodities to other programs, and hide this internal re-allocation within its larger budget and programs.

The second example of how the improvement of wider macro-environmental political factors was the creation of a special unit of State House (the Medicines and Health Services Delivery Monitoring Unit) by President Museveni in September 2009 to investigate, arrest, and prosecute drug theft in the health sector (Mukisa and Bagala

2010b). This police unit has reduced low-level theft of drugs (Interviewees #21, 69, 72), however drugs are still stolen during transport, and from public clinics and pharmacies, and sold in private clinics, even when clearly marked “Government of Uganda, not for sale” (Seruwagi 2011). As of 11 March 2010, 83 cases of suspected misappropriation of drug funds have been recorded by the Medicines and Health Service Delivery Monitoring Unit, close to 100 people have been arrested and charged with suspected drug theft (including a number of mid-level administrators in government offices), and drugs worth Shs6 billion from private drug shops have been recovered (Mukisa and Bagala 2010b).⁹⁰ According to Godber Tumushabe, a leader of a Ugandan NGO that tracks public expenditures in the health sector, the creation of this special unit was a bandage solution,

Whenever there is a problem—instead of resorting to the existing institutions to address that problem, we create a new institution. . . In the process we've created multiple institutions that actually continue to blur the lines of responsibility and accountability. . . You are almost putting a vote of no-confidence in your own institution, which is not helpful at all. (Croome 2011)

The most significant issues regarding commodities—the lack of funding and actual expenditure against budget—can clearly be improved if the political priority (through leaders expressing sustained concern, enacting policies, and resource provisioning) is present to allocate more funding, to enforce budget expenditure, and to remove any bureaucratic or administrative rules that hampered the procurement and distribution processes (Shiffman and Smith 2007). This has been proven previously in Uganda in the two cases detailed above (the change towards direct funding of NMS more than quadrupled the available funding and the reduction in theft of drugs).

2. The Policy's Characteristics

The Ministry of Health identifies a “weak policy environment to regulate, guide, prioritize and finance reproductive health commodities procurement, management and the role of the different providers within public and private sector” as a contextual factor for reproductive health commodity security (Uganda Ministry of Health 2009a:2). However, when discussing the current policy environment for reproductive health commodities with bureaucrats in the Ministry of Health, as well as others well-versed in the commodity security situation in the country, both the bureaucrats and NGO managers admitted that the policies for reproductive health commodities are not necessarily weak (in fact, they are thought to be strong in terms of international standards/best practices), but rather, just ill-matched to the capacities of the implementing agencies—particularly to the current capacity of lower-level health centers, as well as NMS's current capacity (Interviewees # 6, 26, 29, 36, 39, 54, 70, 104).

The current policy governing the distribution of contraceptive commodities is ill-matched to capacities of the implementing agencies. The drug distribution system in Uganda from 1986 to 2000/2001 was a push system, in which the central level would use a formula to determine the kinds and amounts of drugs needed at the health facility level, and then send the drugs out. The current pull system started in 2000/2001; in this pull system, health facilities are to request contraceptive

commodities that they need, and specify the types and amounts they will need sent to them (Reproductive Health Supplies Coalition 2012a).⁹¹ In the pull system, health facilities place orders for drugs based on their current stock and past consumption data, but this system can easily fall apart without proper training of staff at each health facility in determining the amount of each drug to order and how far in advance orders must be placed to ensure no stock-outs. This policy of a “pull system” is designed for a health care system that is well funded and fully functional. It does not take into account the current capacities of NMS, districts, and health facilities to requisition and receive commodities in time to prevent stock-outs. Even when districts have specific line item budgets for health commodities, the budget can sit unused.

Dr. Chris Baryomunsi, a member of the Ugandan Parliament who chaired the Social Services Committee in the eighth parliament, told the following story at a regional parliamentary meeting on health, “[I have] checked National Medical Stores [to ensure that] each constituency has [a] line item. [I found that] 90% [of the budget allocation] was lying there” (Zlatunich 2008a). In part due to a lack of capacity at the local district level to anticipate their needs and order medicines on time (pull), NMS is transitioning to a modified push system for distribution of drugs to lower-level health facilities, who receive a standardized kit of commodities including contraceptives (Lirri 2010; Reproductive Health Supplies Coalition 2012a; Uganda Ministry of Health 2011a).

Another component of the policy that creates additional difficulties for the procurement of contraceptive supplies by NMS is that unspent funds each fiscal year are re-claimed by the Ministry of Finance, Planning and Economic Development (MoFPED), despite the presence of policies that often delay the procurement process to 9-12 months, and into the following fiscal year. Unspent funds must be returned to the MoFPED at the end of the year due to regulations on the procurement of drugs governed by the Public Procurement and Disposal of Assets Act, yet, as discussed below, procurement takes 4 months without interruptions, and can last 9-12 months if there are queries or delays, preventing expenditure by the close of the fiscal year. While the allocated funding for RH commodities has been consistent and increasing in recent years, the expenditure of that funding has been inconsistent, as discussed earlier in this chapter. This issue could easily be explained as a technical one, in which NMS is held responsible for not beginning the procurement process with enough time to prevent the re-claiming of unspent funds; yet, there is no overwhelming argument for why unspent funds at NMS that have been allocated to an ongoing procurement process could not be held by NMS for up to 12 months after the close of the fiscal year. In 2007, the Parliamentary Sessional Committee on Finance, Planning and Economic Development noted in their report on the budget for 2007/08 that the return of unspent balances is “partly explained by the persistent late releases of funds to these Institutions by the MFPED” and recommended that “unspent balances for previous years must be included as part of the resource envelop

for the current budgeting period” as “the Minister of Finance, Planning and Economic Development does not reflect the unspent balances as part of the resource envelop for appropriation. Thus, the utilization and accountability of these resources is not transparent and clear” (Parliament of Uganda 2007). In early 2011, the then-Minister of State for Finance Fred Jachan Omach said, “We are revising PPDA (Public Procurement and Disposal of Public Assets) Authority law to enhance procurement and allow departments to spend all money given them” (Croome 2011). However as of March 2012 the last revisions to these laws were made in 2003 for the national level and 2006 for the district level (Uganda Public Procurement and Disposal of Public Assets Authority 2012).

3. Policy Formation

The Government of Uganda has developed a large number of policies and frameworks to address the country’s poor reproductive health indicators. Dr. Wilfred Ochan, the Assistant Representative at UNFPA Uganda, articulated the concern that most reproductive health advocates and even government bureaucrats share about Uganda having solid policies, but poor implementation, “We know very well that in this country we have beautiful policies. The issue is, how do we translate these policies into action in to benefit the population and the future generation?” He noted that government support is necessary to “translate the many beautiful policies and strategies into concrete political commitment, leadership commitment and financial allocation to help us implement the policies” (The Monitor 2011).

As discussed in the earlier chapters, these policies are numerous, redundant, with overlapping mandates and a lack of collaboration across sectors and ministries. Five policies of particular note to this chapter include: the Reproductive Health Commodity Security Strategic Plan (2009/10- 2013/14), the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015), the National Population Policy for Social Transformation and Sustainable Development (2008), the National Development Plan (NDP) (2010/11-2014/15), and the Health Sector Strategic Plan III (2010/11-2014/15).

The Reproductive Health Commodity Security Strategic Plan (2009/10- 2013/14) has the following objectives: “1) To increase the contraceptive prevalence rate from 23% to 50% and reduce the unmet need for contraceptives from 40% to 5% by 2015; 2) Increase the proportion of health facilities with NO stock outs of selected RH commodities to 80% by 2015; and 3) To increase public sector/government budget allocation and expenditure on reproductive health commodities, including contraceptives to 80% by 2015” (Uganda Ministry of Health 2009a:vi). The total cost estimated for RH commodities for the five years is \$237.1 million USD, with \$76 million USD for contraceptives and \$161.1 million USD for other reproductive health supplies (Uganda Ministry of Health 2009a).⁹²

The Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015) has the goal of accelerating the reduction of maternal and neonatal morbidity and mortality in Uganda to help the country achieve the health-related MDGs (Uganda Ministry of Health 2008:viii). One of the key activities for the strategy is to “support logistics management for the right family planning commodities and supplies in the right times and right places” (Uganda Ministry of Health 2008:20). Its targets include increasing the contraceptive prevalence rate (CPR) (all methods) to 35 percent by 2010 and 50 percent by 2015; and to decrease unmet need for family planning to 20 percent by 2010 and five percent by 2015 (Uganda Ministry of Health 2008:33). Implementation of the roadmap was estimated to cost \$80.8 million USD between 2007-2010 (Uganda Ministry of Health 2008:39). This figure does not include the cost for reproductive health commodities, which are estimated at an additional \$31 million USD per year (Muwonge et al. 2011:12).

The National Population Policy for Social Transformation and Sustainable Development (2008) includes the strategies of both advocating and promoting “reproductive health commodity security” (Uganda Ministry of Finance 2008:19, 21). In addition, the implementation plan for the population policy, the National Population Policy Action Plan, 2011-2015, while it aims to outline the roles to be taken by thirty coordinated stakeholders and partners, like the population policy itself,

does not give specific targets for the objectives and strategies, such as targets for contraceptive prevalence and stock-out rates (Uganda Ministry of Finance 2010b).

The National Development Plan (NDP) (2010/11-2014/15) links family planning and reproductive health to poverty in the discussion of the effects of the high fertility rate on individual families' economic situation. The National Development Plan has the objective to “reduce the unmet need for family planning” through the strategy “promote adherence to a manageable family size among couples” which includes the intervention to “promote efficient commodity security logistics” (Uganda National Planning Authority 2010:203).

The Health Sector Strategic Plan III (2010/11-2014/15) includes the following indicators with targets: The proportion of health facilities with no stock-outs of essential RH medicines and health supplies increased from 35% to 70% and contraceptive prevalence rate increased from 24% to 35% (Ministry of Health Uganda 2010b:87).

The description of five policies above and the longer list of policies in “Chapter 3: ‘The Cairo Consensus of Confusion’: Global Influence and Local Frames in the Struggles over Uganda’s Population Policy and Influences on Its Implementation”, give credence to the argument that there are too many separate policies with overlapping mandates, work, and goals that cut across multiple government

ministries. The development of policy in Uganda has become a professional specialty in its own right, with practitioners dedicated to policy formulation and strategic plans who are almost entirely uninvolved in any form of implementation of the policies and strategies they help they develop. Rather than collaborate across sectors and ministries, government bureaucracies prefer to have separate policy frameworks, without full integration and alignment with other ministries and sectors. This is not due to outright malice, but because departments only want to agree to what they are in charge of, rather than have their work dictated by the policy developed by an outside organization or different sector. The goal of survival is at the heart of any organization.

Policy exists not only in the written frameworks developed by the government but is also made through budgeting and financing. In Uganda, financing is strongly controlled by the Ministry of Finance, Planning and Economic Development (MoFPED) under the directive of the Executive, although Parliament has to approve the annual budget (Interviewees #2, 18, 39, 88, 89). Initial sector budget ceilings for different sectors (ministries) are set by the MoFPED. Outside political influence during the budgeting process can also influence the specific allocations to different sectors, as well as budgets within sectors (such as the example of funding ARVs over reproductive health commodities, discussed in “Chapter 4: ‘No One Ever Died of Overpopulation’: Comparing Uganda’s ‘Success’ on Combating HIV with Its ‘Failure’ on Population” regarding the political factors in budgeting in relation to

government leadership and Quality Chemical Industries Ltd.). According to a number of parliamentarians I spoke with, the processes through which the MoFPED sets budget allocations for each sector does not involve them and the reasons for increases or decreases to different sectors is not clear when they receive the budget for review and approval (Interviewees #2, 88, 89).

For example, annual and supplementary budgets can be passed without transparency and full oversight of Parliament. The 2010/2011 fiscal year budget of 8 trillion UGX (about \$4 billion USD) was passed in one day with 21 of 332 Members of Parliament present and no debate (even figures that were rejected in committee reports were passed). Some opposition MPs, “led by the Public Accounts Committee, walked out of the proceedings complaining that it would be professional dishonesty for them to stay and help the ruling party legitimize a flawed process” (Mugerwa 2010b). Yet by early January 2011, the 8 trillion UGX (about \$4 billion USD) budget (for July 2010-June 2011) had been already been over-spent (Karugaba and Bekunda 2011). A special supplement of 600 billion UGX (about \$300 million USD) was passed in early January 2011, along with a supplementary budget which included 20 million UGX (about \$10,000 USD) for each Member of Parliament to “monitor government programs” (opposition politicians termed this budget supplement a “bribe”) (Karugaba 2011; Karugaba and Bekunda 2011; Mugerwa and Nalugo 2011; Mugerwa, Nalugo, Ladu, and Imaka 2011). According to MP Dr. Chris Baryomunsi, the eighth Parliament, which passed the 2010/2011 budget and budget supplement,

had “ceded its powers to the executive. In fact, there was no difference between the executive and Parliament. Parliament completely lost its independence. It was like a sub-committee of the executive” (Lumu 2011).⁹³

However, there have been times when intervention by politicians at key moments of the budgeting cycle has resulted in greater and specifically-targeted funding for reproductive health. In the government budget for 2008/2009, Parliament, following the recommendation of the Social Service Committee of Parliament, refused to approve the Ministry of Health budget until the Ministry could give the specific budgetary allocation for reproductive health. The eighth Parliament also refused to approve World Bank loans until there were specific allocations for maternal health; the result was that the World Bank loan was finally approved in 2010 was for \$130 million USD for health system strengthening had a specific allocation of \$30 million (of the total \$130 million) for maternal health (including for family planning and reproductive health commodities) (Muwonge et al. 2011; PPD ARO and SEAPACOH 2011); (Interviewees #5, 88, 89, 99, 114).

NGOs and CSOs have strong interests in the commodity situation, but local NGOs have little actual influence in policy formation and government commodity management. The Ministry of Health identifies “little engagement of civil society organizations and the private sector in reproductive health commodity security management and in policy advocacy” as a contextual factors for reproductive health

commodity security (Uganda Ministry of Health 2009a:2). Yet the Ministry of Health does not harmonize and do joint procurement with CSOs, smaller donors (other than UNFPA and USAID), and the private sector (Uganda Ministry of Health 2009a). The Ministry of Health leads the Reproductive Health Commodity Security Committee, which meets a few times a year to review Contraceptive Procurement Tables and coordinate financing and logistics, yet it does not fully include the private sector, although it does include social marketing entities, important NGOs such as Reproductive Health Uganda (the national member of the International Planned Parenthood Federation), as well as donors (DFID, USAID, UNFPA) and government bodies such as Population Secretariat, National Medical Stores, as members (Leahy and Akitobi 2009; Uganda Ministry of Health 2009a).

A representative at a major donor agency told me that NGOs in Uganda have been “suffocated” because of politics; “NGOs must be depoliticized, [they] do not want to be labeled as ‘opposition’” (Interviewees #63). In addition, a number of NGOs purposely stayed away from involvement in policy and funding with the government, as they saw it as both corrupt and corrupting. There is constricted political space for NGOs, many feel that they cannot criticize the government, even on issues which are not explicitly political such democratization and governance (Thue, Makubuya, and Nakirunda 2002). One leader of an NGO that provides health services in addition to other community health promotion activities told me,

We stay away from politicians. And the ministry when possible. If you work with them, they want money. And they already have money. . . And there are others to

do this work, and they try, but they then become corrupt because you can't do the work without working in the system. There's no other option. So I've kept us out of that, even though there are some partners that want to push us that direction and have money to engage. . . They [government officials] do not directly ask for money to do their job, but they demand payment every time they go to a meeting, even if they just sit there and read the papers. And for the Ministry of Health, it's their job to do this work! Then they ask for sponsorship to a seminar in the UK or Europe. So if you don't help them . . . they've abandon you . . . and they do nothing. . . [It's] *prid pro quo*. (Interviewee #32)

A number of others at NGOs agreed that involvement with the government, both the political side as well as technocrats in ministries, was purposely avoided, along with advocacy. Two organizations I spoke with had tried to do advocacy work, but stopped when the project ended, as they felt that the corruption unintentionally produced by the project outweighed any benefit the project may have had. A bureaucrat in the Ministry of Health told me that “donors give allowances to the people who do extra work” (Interviewee # 36). Government bureaucrats (and politicians) regularly receive and expect “top-up allowances,” or additional pay from project funds, as well as per diem for attendance at meetings, even meetings at hotels within walking distance of their offices.

4. Layers in the Policy Transfer Process Due to Decentralization

Decentralization has also contributed to policy implementation difficulties for the health system. Decentralization in Uganda was one of the most radical and comprehensive decentralization programs in Africa (Onyach-Olaa 2003).

Improvements in the delivery of social services have been attributed to central government conditional grants rather than to decentralized decision making (Francis

and James 2003). The rapid pace of the creation of new districts has also led to lower levels of expertise and experience in new districts.⁹⁴

Decentralization requires local government councils to set priorities, however local governments are most interested in allocating resources to infrastructure (Uganda Ministry of Health 2009c:22). When districts have the opportunity to spend unconditional block grants, spending on health is much lower, as much as one-quarter of the previous amount spent when budgeting was centrally-controlled (Jeppsson 2001). There is poor prioritization and commitment to reproductive health at decentralized levels, even by district health officers. District health officers are unable to advocate for more resource allocation to reproductive health (Uganda Ministry of Health 2009c). According to a District Health Officer, “people talk about family planning, but when time comes for budgeting, they keep quiet” (Uganda Ministry of Health 2009c:23). This has resulted in low funding levels for reproductive health at the district level.

District-level budgets for health, much less reproductive health, are almost impossible to track. Since 1993/1994, districts have not been required to forward their budgets to the central level (Jeppsson 2001). Approved national MoFPED health budget estimates for districts in 2009/2010 can range from 12 to 18% of the total district budget, which works out to 3,800 to 8,400 Ugandan shillings (approximately \$1.90 to \$4.20 USD) per person available at the district level for health care (Muwonge et al.

2011:38-39).⁹⁵ However, budgets available at the district level do not match and give very different figures for health spending, averaging 10%, with a range from 8.6% to 14%, which are significantly lower than the figures available from the MoFPED approved budget estimates (Muwonge et al. 2011:39). Donor contributions at the district level towards district health budgets are also very low, averaging around 5%, but ranging from 1.15% donor contribution in the district health budget for Kamuli district to up to 25% in Wakiso district 2009/2010 (Muwonge et al. 2011:39). The actual expenditures on reproductive health are almost impossible to determine as services are integrated and record-keeping is poor and un-standardized across districts (Muwonge et al. 2011).

5. The Overall Characteristics of the Implementing Agencies

5a) National Medical Stores (NMS)

There is no centralized or coordinated Logistics Management Information System (LMIS), leading to poor data collection, processing, analysis, use, dissemination, and storage and retrieval at central, district, and facility levels. This has led to significant information asymmetry between the reproductive health commodities available at National Medical Stores and what districts, facilities and end users can order as stocks (Uganda Ministry of Health 2009a). The poor inventory management systems extends to a lack of guidelines for storage, destruction, withdrawal and re-distribution of commodities between and across levels and providers (Jahre et al. 2010).

Supply-chain logistics at NMS are overly bureaucratic, with high levels of complexity in distribution levels and poor flow of information (Jahre et al. 2010:10). The high levels of complexity and bureaucracy and lack of efficiency in procurement and distribution lead to delays. As of late 2009/early 2010, a conservative estimate for the total average lead-time for an order to be fulfilled at health centers is 61.2 days, and can regularly extend to four months (Jahre et al. 2010:10). This means that it usually takes about two months between the time that a health center orders drugs and the drugs are received. The process between ordering and receiving is as follows: the order made at the health facility, transported and processed by the health sub-district, then transported and processed by the District Health officer, then the order is transported and received at National Medical Stores, and inputted, registered, loaded and transported back to the District Medical Store, to be received, stored, and transported to the health center where it is eventually stored for usage (Jahre et al. 2010). And as noted earlier, procurement can take from 9-12 months if there are queries or delays, preventing expenditure by the close of the fiscal year, and necessitating return of unspent funds to the MoFPED due to regulations on the procurement of drugs governed by the Public Procurement and Disposal of Assets Act.

NMS lacks capacity and staffing to handle the volume of orders. A lack of storage space at NMS required the rental of private storage space on the open market, poor forecasting, and non-efficient funding and ordering processes (taking up to six

months to complete tendering processes) all compound the issue of poor logistics management. A new warehouse management system was installed at NMS in 2009; however, complete use of the system has not been fully implemented and staff error in using the system has led to issues such as incorrect stock accounts giving higher numbers than actual amounts in inventory, leading to delays in procurement (Interviewee #79).

Additional recent attempts to fix problems in NMS included recruiting new staff and procuring a larger fleet of vehicles, and starting a second, night shift to move drugs out of the stores in early 2010 (Kaheru 2009). NMS also consolidated warehousing and improved planning cycles, but despite this “we [NMS] have not been able to supply even 50-60% of our mandate” (Jahre et al. 2010:7). As of September 2009, 80% of essential drugs are available in appropriate quantities at NMS (Kaheru 2009). However, the general inefficiencies in NMS had yet to fully improve as of 2011; 98% of health units have experienced incessant stock-outs of drugs to be delivered from NMS (Seruwagi 2011). NMS has reviewed and made changes to its distribution system to improve drug availability—yet drugs still linger at the central and district level, undistributed to health facilities. In addition, even when commodities are distributed, leakages including commissions and pilferage occur at higher and lower levels, including during transport and delivery (Mukisa and Bagala 2010a; Seruwagi 2011).

Private and NGO facilities were unable to order reproductive health commodities from NMS until late 2010. They had been supplied by NMS in earlier years, but stopped receiving drugs, in part because NMS had shortages in supplying public facilities. In 2010, the Ministry of Health (MOH) instructed National Medical Stores to re-activate the MOH account for issuing contraceptives to non-public sector entities.⁹⁶ However, while NGOs have been able to place orders with NMS, they have often been unable to receive the full amount of their order, and in some cases, less than a third of the requested amount (Interviewees #48, 79).

Continued poor performance of the logistical system in Uganda is not only a technical problem. Poor logistical performance could also be, in good part, improved with political interest and commitment. If political leaders were invested in the use of funds and the availability of services, strategic financial investments could be made to implement a centralized and coordinated Logistics Management Information System (LMIS) and to monitor the implementation of such a streamlined system.

5b) Health facilities

The failure of the Ugandan health care system can be clearly seen at the health facility level. After Museveni and the NRM took over in 1986, structural adjustment and competing government priorities did not allow the health system to recover from the years of neglect during Amin's rule, as well as the following years of coups, turmoil, and war.⁹⁷ In recent years to aid the recovery of the health system, the government

has emphasized the construction of health posts to provide health services in rural areas, reducing the previous emphasis on higher-level hospitals located in cities. However, the construction of health posts and clinics is much easier than the continued staffing, financing, and supplying these clinics, resulting in physical clinics that are under-staffed and under-resourced, often without critical drugs and other supplies. The innovation of the “maama kit”—basic delivery supplies of a clean plastic sheet, surgical gloves, a sterile razor to cut the umbilical cord, cord ligature, cotton wool, sanitary pads, tetracycline, and soap—often provided to expectant mothers in advance of delivery points to the lack of basic supplies in government clinics and the inability of poor families to buy them from private vendors (Uganda Ministry of Health and World Health Organization).

In the fiscal year 2009/2010, Uganda’s target for stock-out levels was 30% (meaning that 70% of health facilities would have all five drugs all the time). The Ministry of Health supported the stories reported in the newspapers, giving data for how rampant drug stock-outs were throughout the country. The Ministry of Health tracks drug availability through measuring the availability of six tracer drugs at all health facilities throughout the country. These six tracer drugs are cotrimoxazole, ORS (oral rehydration salts), measles vaccine, medroxyprogesterone injection (also known under the brand name Depo-Provera), sulphadoxine-pyrimethamine, and artemether-lumefantrine (also known as the trademarked Coartem). However, in determining drug availability, artemether-lumefantrine (Coartem) is often excluded from

calculations in government reports, as supplies of the drug are dependent on funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and thus the other five drugs are used. Stock-out levels at health facilities for “5 tracer medicines and supplies” since 2004/2005 is as follows: FY 2004/05: 65% of health facilities experienced stock-outs of the five drugs and supplies; 2005/06: 73%; 2006/07: 65%; 2007/08: 72%; 2008/09: 74%; 2009/10: 59%; (Uganda Ministry of Health 2010a:5-6; Uganda Ministry of Health 2011a). If Coartem is included in the calculations of availability of tracer drugs, then 79% of health facilities experienced stock-outs in 2009/10 (meaning that only 21% of health facilities did not experience stock-outs in 2009/10) (Uganda Ministry of Health 2010a:6). In 2010/11 57% had stock-outs (meaning that 43% of facilities had the six basic drugs at all times) (Uganda Ministry of Health 2011a). In addition, 30% of health units had stock-outs of Medroxyprogesterone injectables ("Depo-provera") in the 2009/2010 fiscal year (Ministry of Health Uganda 2010a:174). The Ministry of Health has identified the major barriers to drug supply in the country as “i) inadequate financing of medicines and health supplies, and ii) poor medicine management at health unit level” (Uganda Ministry of Health 2010a:7). A USAID project also identified the causes of lower-level stock-outs as due to weak management of supplies at the facility level due to poor planning and ordering (USAID Deliver Project Task Order 4 2010).

Figure 38: Percentage of Public Health Facilities Without Consistent Supply of Basic Drugs⁹⁸



Sources: 2004/05- 2008/09: (Uganda Ministry of Health 2010a:5-6), 2009/10- 2010/11: (Uganda Ministry of Health 2011a)

Due to drug stock-outs, public health facilities have low drug dispensing rates (the percentage of drugs dispensed that are prescribed) of about 30%, while private not-for-profit facilities have drug dispensing rates of around 90-98% (Kasyaba 2010). Government health centers have low levels of utilization; a primary reason that people cite for their non-use of government facilities is a lack of a consistent drug supply (Jahre et al. 2010). The 2006 Demographic and Health Survey (DHS) found that a large percentage of contraceptive users procure their contraceptives from private, rather than public sources, despite the cost (user fees for health services at public facilities were abolished in 2000) (Deininger and Mpuga 2005; Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007).

The poor health system is a contributing factor to the high rates of maternal mortality in Uganda, which was estimated at 310 deaths per 100,000 live births in 2010 (World Health Organization, UNICEF, UNFPA, and The World Bank 2012). Maternal mortality has been declining at an average annual rate of 3.2% since 1990 when there were an estimated 600 deaths per 100,000 live births and 2000 when there were an estimated 530 deaths per 100,000 live births (World Health Organization, UNICEF, UNFPA, and The World Bank 2012). Maternal mortality is remains high in part because only 59.3% of births were attended by skilled health personnel in 2011 (Uganda Bureau of Statistics and Measure DHS 2012). A retrospective study of maternal deaths found a number of health center-level factors, including inadequate supply of antibiotics, intravenous drug fluids, and blood for transfusion were significant risk factors for maternal mortality in Uganda (Mbonye 2001).⁹⁹ Although delivery, like all health care at public health facilities, is supposed to be free in Uganda since 2000 (Deininger and Mpuga 2005), health workers regularly demand fees for services and for basic supplies and drugs that patients and their families are instructed to purchase before care can be given. In 2011, a well-publicized story of a young teacher, Cecilia Nambozo, died during labor at a government health clinic, with the full knowledge of staff, because of her family's inability to raise funds of 300,000 Ugandan shillings (approximately \$150 USD) to pay for health workers to assist her (Candia 2011; Mafabi 2011a; Mafabi 2011c). Health worker absenteeism (and shortage), poorly equipped health centers, stock-outs of essential drugs, and demands for "payments" for supposedly free services all discourage people to seek

“free” health care from government facilities. Private health facilities (often staffed by government doctors and nurses and sometimes stocked with supplies stolen from government clinics) have sprung up to provide services that the government would and could not provide at a cost to the user (Mukisa and Bagala 2010a).¹⁰⁰

“Most [health] facilities are in a state of disrepair, do not have the required facilities for them to function effectively (e.g. staff housing, water and energy, theatres, equipment, stores etc) and required ICT and related infrastructure. These tend to compromise the efficiency, quality and access of these services” (Uganda Ministry of Health 2011a:134). Health facilities, even if stocked with drugs from NMS, often do not have proper storage facilities for the commodities (Seruwagi 2011). There is also a general lack of supplies, particularly for infection control (e.g. the equipment necessary to sterilize equipment) (Uganda Ministry of Health 2010a; Uganda Ministry of Health 2011a).

6. The Behavior of Front-line Staff at Health Facilities

Health workers in Uganda operate under difficult conditions. Ugandan health care workers in both the public and non-profit sector are generally dissatisfied with their jobs, particularly their compensation and working conditions, and judge their workloads to be unmanageable (Hagopian, Zuyderduin, Kyobutungi, and Yumkella 2009). Only half of health care workers have the supplies (gloves, needles, bandages) to do their jobs well and safely, and less than half have the equipment (ultrasound x-

ray, blood pressure cuffs) to their job well (Hagopian, Zuyderduin, Kyobutungi, and Yumkella 2009).

A new medical officer (doctor) in the public health sector earns less than \$400 USD a month and nurses and midwives earn only about \$175 USD per month from their government salaries (Bategeka et al. 2009). Health workers are usually trained at government expense, but some immigrate to other countries such as Kenya or Rwanda, where they will earn higher salaries (Bategeka et al. 2009). More than half of all physicians and approximately one in four Ugandan health workers would leave their jobs soon if they could (Hagopian, Zuyderduin, Kyobutungi, and Yumkella 2009).

In addition to a lack of supplies and equipment to support counseling (e.g. written family planning guidelines, individual client cards), the communication gap between service providers and clients hinders counseling and decision-making on contraceptive method choice (Reproductive Health Uganda 2009). Providers are not sufficiently equipped and lack the necessary time, supplies, and skills to adequately counsel clients on contraceptive methods (Reproductive Health Uganda 2009). Health care workers are also frustrated by stock-outs and inability to provide clients with contraceptive methods they want (Reproductive Health Uganda 2009). They also underestimate the attachment clients have to particular methods and thus

underestimate the impact of the shortage of a single commodity (Reproductive Health Uganda 2009).

Service providers are also often unaware of government policies, guidelines, and tools to help them deliver care, even when they are available. For example, in a 2005 study, family planning service providers were unaware of the existence of written guidelines or protocols to help them deliver HIV services; however, their facilities had copies of protocols by the Ministry of Health, client cards to assess behavior and risk, and copies of a guide on VCT developed by a NGO (Asiimwe, Kibombo, Matsiko, and Hardee 2005).

There is also poor documentation and record-keeping for commodities, and some health workers have distributed expired drugs to patients (Seruwagi 2011). High rates of health worker absenteeism in Uganda also contribute to poor service delivery. Nationally, health workers may be absent from their posts up to 35% of the time (IntraHealth 2011). Another study in 2010 found that absenteeism rates in Karamoja (a north-eastern Ugandan sub-region currently encompassing seven districts, historically pastoralist in nature, and currently with high levels of conflict and low service provision) was 22.5%, and as high as 45% among health center two (HCII) facilities in Abim district (Uganda Ministry of Health 2011a:159-160). HCII are the lowest-level government health facility, intended to serve a parish of a few thousand people with basic health care.

7. The Impact of Responses from Those Affected by Policy

Because of the significant and regular stock-outs due to the factors listed above, women are aware that contraceptive stocks are unpredictable, so they think it is better not to use any modern method rather than risk having to stop due to unavailability (Reproductive Health Uganda 2009). These contraceptive shortages are disruptive to women's lives (Reproductive Health Uganda 2009). Clients see the providers' "not caring" as leading to stock-outs. For example, one client explained:

These people [clinic staff] do not really know the trouble one goes through to reach here and the reason why one chooses to have an injection instead of pills. If they really cared they would order for those injections well in advance. But because they don't care they will just tell you 'they are finished try something else.' Client, Mityana (Reproductive Health Uganda 2009)

Women in Uganda do want to use modern contraceptive methods, but are prevented from doing so due to the high levels of unavailability in the country. While those affected by the policy are clearly in a vertical relationship with policymakers, as well as government employees implementing the policy, family planning clients have only a narrow range of options, one of which is to not use any modern methods of family planning at all, rather than risk having to start and stop methods or switch methods due to unavailability.

Conclusion

Many analyses of contraceptive commodities in a country or district analyze logistics processes and are technically-oriented, offering solutions to identified problems

located in the commodity procurement body (National Medical Stores) or within the Ministry of Health or at the distribution or health-facility level (Bategeka et al. 2009; Carlson 2004; Jahre et al. 2010; Kuehn 2010; Leahy and Akitobi 2009; Mbabazi 2009; Mbonye 2009; Reproductive Health Uganda 2009; Reproductive Health Uganda and International Planned Parenthood Federation 2009; Uganda Ministry of Health 2009a; Uganda Ministry of Health 2009c; Uganda Ministry of Health 2010a). This line of research focuses on the factors listed as 4, 5, 6, and 7 (layers in the policy transfer process, the overall characteristics of the implementing agencies, the behavior of front-line staff, and the impact of responses from those affected by policy).

Factors listed above as 1, 2, and 3 (the wider macro-environment, policy characteristics, and policy formation) have not been fully analyzed and considered in research on contraceptive commodities in developing countries until now. This research argues that the influence of wider macro-environmental factors, particularly political influence, underlies most of the other six factors that prevent successful policy implementation in Uganda. All policies are the result of political processes, and the implementation of policy is highly dependent on the navigation of political factors that occur at all levels of the policy formulation and implementation process, as described above. While the seven categories described above all work in tandem (Hill and Hupe 2009), the separate examination of each gives evidence that political

influence throughout the process (particularly through top-down pressure) has tremendous weight in implementation in this particular case.

International policies and policy guidance (such as donor analysis and conditionalities on donor aid) are based on a policy model that sees commodity systems as determined by health needs and service delivery usage and implementation as a local technical function to be performed by the state (a “service delivery state”) in coordination with donors, NGOs, and community organizations. Instead, I argue that policy implementation is also a political issue, and thus both academic literature and program-relevant research need to address specific political factors in implementation, particularly in terms of funding and political commitment. This research makes a contribution to the field of health policy analysis. It begins the consideration of a wider range of factors that need to be made in analysis of health policy implementation in low-income countries (Gilson and Raphaely 2008).

Chapter 6: Conclusion: “Everyone Takes Our Policies and Just Implements, Why Can’t We?”: The Contribution of a Political Analysis of Policy

When Uganda's President Yoweri Museveni visited Rwanda in July, travelling journalists [from Uganda] were so impressed with . . . [Rwanda's] progress that one of them suggested that concepts like democratic freedoms may, after all, not matter much to impoverished populations. What use, he asked, is freedom to patients stranded at a hospital that has no medicines, or to farmers who can't sell their produce? (Kavuma 2011)

Throughout my work and research in Uganda, I continually hear references by Ugandans to the developmental success of Rwanda. Ugandans refer to the cleanliness and orderliness of Kigali's streets in comparison to the dirt and chaos of Kampala. They talk of the “seriousness” of the government of Rwandan President Paul Kagame and compare it to Uganda's corruption, outright theft and disorder. Ugandans remark how “free” they are in Uganda, yet wistfully discuss how there are drugs available in Rwanda's hospitals and how schoolchildren there even have laptops, while Ugandan mothers die unattended during delivery and Ugandan schoolchildren study under trees due to a lack of classrooms.

In this concluding chapter, I first discuss the concept of “developmental patrimonialism.” I then distinguish my approach and arguments as different from the good governance consensus, and align my work with a “good enough” approach to governance. I conclude the chapter with a brief critique of literature that ignores the

role of politics in development and governance before I call for both academics and practitioners to pay greater attention to context and the role of politics in policy.

A prominent NGO leader in Uganda expressed her frustration about the failure of the Ugandan government to implement its policies,

Uganda has so many good policies and systems on paper. Our system of health [care] referral would be great if it was just implemented. There are so many good policies from our Ministry of Health. Our bureaucracy is technically good at designing the policies, but an absolute failure at implementation . . . but then you look at Rwanda, and they have just taken our policies, they copy . . . customize them a bit, but don't waste time, and they just implement and they work. . . Everyone takes our policies and just implements, why can't we? (Interviewee #83)

Booth and Golooba-Mutebi (2011) argue that Rwanda may fit a new conception they and others term “developmental patrimonialism.” Developmental patrimonialism is a subtype of neopatrimonial regime with centralized management of economic ‘rents’ in support of a long-term vision (Booth 2011a). Under the general neopatrimonialist regime, governing is “based on personal loyalties and the provision of material incentives and rewards” with a “set of informal institutions which are regularized, accepted and practiced” and “the ruler’s personal powers are . . . enhanced by his maintaining of modern administrative and military apparatuses” (Guliyev 2011:577-579). But under a developmental patrimonialist regime, leaders also work to enlarge the national economy, make real progress against corruption, and improve public-sector performance (Booth and Golooba-Mutebi 2011; Kelsall 2011; Kelsall, Booth, Cammack, and Golooba-Mutebi 2010).

Developmental patrimonialism works within current institutional arrangements and political structure, and supports what works “well enough for development”; “less-than-perfect standards of transparency and accountability are often considered acceptable [by citizens] so long as there is peace, development is visible and the distribution of benefits among the various segments of society is perceived as broadly fair” (Booth 2011b:3). Governance in East Asia (South Korea, Indonesia, and Malaysia) during periods of significant economic growth, as well as during the initial growth of European political systems, had significant neo-patrimonial elements (Kelsall 2011; Kelsall, Booth, Cammack, and Golooba-Mutebi 2010).¹⁰¹

“Less-than-perfect standards” of governance are not the desired end, but learning from these examples could provide possible models for improving health services, as well as for suggesting paths to leadership to more a development-oriented vision. As stated by Booth, “ ‘developmental patrimonialism’ is not an alternative development model that should be promoted by donors or anyone else” (Booth 2011a:10).

Rwanda has experienced significant socioeconomic development yet has not followed the “good governance” path advocated by donors and development experts (Booth and Golooba-Mutebi 2011). Rwanda’s specific success in slowing population growth has been attributed to broad political will (Solo 2008; Wadhams 2010). However, closer research examining of the details of Rwanda’s case found that Rwanda’s policy for health has been successfully implemented at the local level due to a host of factors

including ongoing top-down pressure accompanying decentralization and governance reforms, creating upward accountability mechanisms, performance-based financing that is prompting service providers to ensure all standards are met and orienting health facilities towards innovations to improve the implementation of health policies (Chambers and Golooba-Mutebi 2012).¹⁰² Chambers summarizes one of the major findings from the study on health policy reform in Rwanda, as “policy drive from the top down is a critical condition for progress at the grass roots” (Chambers 2012). Rwanda’s reforms in the health sector are clearly predicated on a specific type of political will, one that is much closer to a form of developmental patrimonialism than of the type of good governance approach advocated by donors.

The broad consensus of the good governance agenda promoted by the World Bank, other donors, and international agencies includes “transparent and predictable decision making and implementation; oversight mechanisms that guard against arbitrariness and ensure accountability in how resources are used; public officials committed to the achievement of social goals, including the efficient provision of public services; a political process that is broadly viewed as legitimate; and the protection of property rights” (Levy 2010:1). This conception of good governance has led to the belief that significant institutional reform (state capacity building) is a necessary prerequisite for growth to take off, however specific case studies have shown that, “the onset of economic growth does not require deep and extensive institutional reform. . . .Moderate changes in country-specific circumstances (policies

and institutional arrangements, often interacting with the external environment) . . . can produce discontinuous changes in economic performance. . . .Once growth is set into motion, it becomes easier to maintain a virtuous cycle, with high growth and institutional transformation feeding on each other” (Rodrik 2007:190-191). Currently, the mainstream paradigm argues that states should provide a range of social services—but that states need to be effective and efficient—this could entail changes to states and their programs including decentralization, privatization, and monitoring to avoid corruption, clientelism, and ineffectiveness (Grindle 2010).

As part of the good governance approach, there has been a growing emphasis on (vertical) social accountability initiatives for governance to amplify citizen voice to increase the transparency of decision-making, improve the effectiveness of public service delivery, and strengthen policy design (Malena, Forster, and Singh 2004; McNeil and Mumvuma 2006; World Bank 2004).¹⁰³ These initiatives have been supported by a range of donors such as the World Bank, DFID, the Ford Foundation and the William and Flora Hewlett Foundation (McGee and Gaventa 2010). However, it has been found through a number of studies that improving client “voice” alone does not necessarily improve accountability as intended, unless it is also tied to some form of top-down pressure (Leonard 2000; McGee and Gaventa 2010; Menocal and Sharma 2008).

The “best practice” approach to good governance (bringing the democratic governance and institutional best practices of developed countries to the developing world) has not been shown to work in developing countries (Booth 2011b). A good deal of research on developing countries has found that the requirements to move from extreme poverty to moderate poverty is different than the governance requirements for currently developed countries (Centre for the Future State 2010; Chang 2002; Evans 2004; Greif 2006; Levy 2010; Meisel and Ould Aoudia 2007; Rodrik 2007). Rodrik has argued that while we are still uncertain about what institutions and policies induce sustained growth in developing countries; “appropriate growth policies are almost always context specific” (Rodrik 2007:4). Rodrik (2007) also shows how China’s development experience does not follow the good governance model.¹⁰⁴

Despite growing criticism of the good governance approach by leading thinkers, development programs and policy advice is still based on a universalistic, institutional model of governance (Kelsall, Booth, Cammack, and Golooba-Mutebi 2010). Thus, blame for a lack of developmental success (such as economic growth, poverty reduction, improved health care provisioning) is cast upon the poor transposition of one or more institutional “best practices.” Therefore, implementation failure is seen as a programmatic failure, rather than policy or political failure. As argued in earlier chapters, this is what most health policy literature in developing countries focuses

on—an examination of programs in search of problems, rather than for underlying political causes or poor policy design in the given socio-cultural environment.

In this dissertation, I have argued that more explanatory power should be given to the hidden political processes and the role of agency, rather than limiting focus to institutions and policies. In Uganda “getting the policies right” is clearly not enough to get to the desired outcomes. The politics also have to be right. And I do not mean “right” in a perfect or idealized sense of equality, democracy, and perfectly functioning economic institutions. “Right” in my understanding actually means a lasting political settlement or coalition (including but not limited to political elites) that not only consents to policy change, but supports implementation and sustainability of the policy change (Leftwich 2010:106).

Neither politics nor policy has to be “perfect” or held to a comprehensive list of “best practice” standards in order to work. In fact, perfect policies based on international standards and norms may not be the best place to prioritize funding and program effort. Grindle’s (2007; 2011) concept of “good enough governance” may be useful to help think through what “good enough policies” could be—ones that were not developed in “Denmark,”¹⁰⁵ but rather contextualized to the social, political, and economic climate of the country. Grindle focuses on the role of politics and argues that instead of attempting to implement all policy and institutional changes at once,

there may be a smaller number of “good enough” governance reforms that can kick off the development process (Grindle 2007; Grindle 2010; Grindle 2011).

This is why “good enough” initiatives in Uganda such as the Maama Kit (providing pregnant women with basic supplies for a clean and safe delivery) have been successful—this policy recognized that although it is best to have women deliver in health centers attended by professional nurses or midwives, the distance, cost, lack of supplies and health workers, and preference to be delivered by a local traditional birth attendant (TBA) all impeded the goal of having all women delivering in health facilities (Uganda Ministry of Health and World Health Organization). While some groups have continued to make policy recommendations to the government to outlaw all TBAs in the country (Reproductive Health Uganda, UKAID, and Advance Family Planning 2011:30), it is inconsistent with the Ministry of Health’s prior program to work with and train TBAs in safe delivery practices and to equip them with Maama Kits, as well as with the conditions of the health system in Uganda. Good enough policies that are contextualized to local conditions need to be supported by advocates, rather than combated.

Rather than focusing on changing the current political and institutional dynamics within countries like Uganda, academics and practitioners need to focus on effective use of those dynamics. We need to be innovative and build on the dynamics already present when looking to improve “social accountability” such as through sectoral

reform processes in which there is “collective action by or on behalf of poor people to demand accountability from policymakers and service providers” (Centre for the Future State 2010:41).

One does not have to look far for examples of the success of social accountability projects—a Ugandan initiative to publish data in newspapers on funding for each school reduced local administrative educational fraud significantly (Reinikka and Svensson 2011). This social accountability initiative was successful because it was a program of the central Ministry of Education—by informing citizens to the specific funding for each school, the government showed that education was a priority, and that it would not tolerate the capture of funds by local administrators and politicians. Without this kind of top-down pressure, the reduction of corruption would have likely been less. In fact, 47% of the schools who did not receive the full amount of their funding in 2001 complained or protested to formal or informal authority that could either transmit the complaints onwards or act on them (Reinikka and Svensson 2011:959). Ignoring the specific politics that led to the success of this initiative could lead to potentially unsuccessful social accountability initiatives without the critical element of incorporation of top-down pressure (such as from a central ministry or other authority).

Advocates of randomized control trials in development have argued that policies can be advanced and dealt with separately from politics and criticize what they term the

institutionalist view of the prioritization of politics in development (Banerjee and Duflo 2011; Duflo 2011). Yet, as in this case of Uganda, population and sexual and reproductive health and rights policies have not solved the problem of politics. Leftwich argues for the primacy of politics in development (Leftwich 1983; Leftwich 2000; Leftwich 2009; Leftwich 2010). Politics do matter when considering the largest, as well as the smallest policies. In this dissertation, I argue for an awareness of the existence of politics, even in the construction and implementation of policies that are seemingly “technical” and the domain of bureaucrats.

So ultimately, the solutions proposed in this dissertation do not align with the normative arguments of development discourse on good governance—which are based on large data and even-larger normative stories of development and governance trajectories. Instead, what this dissertation supports is the argument of a number of scholars and practitioners who are calling for consideration of the specificity of individual country histories, situations, and stories and for the use of case studies for development theory rather than the norm of generating theory through cross-country regression analysis (Booth 2011c; George and Bennett 2004).

I want to challenge the development community to be more creative, more experimental, and more willing to find solutions, even if they may leave a slightly bitter taste in our mouths due to their low likelihood for short-term improvement in what we consider to be good governance, democracy, and human rights. The research

on developmental patrimonialism and the good enough governance position give evidence that incremental, rather than wholesale, reforms seem to be the most effective in helping countries leave extreme poverty. We have already failed to do it according to the “best practice” models and modernization theories of our field. It is time to consider more deeply what is working, or in the case of Uganda, what is not working, and learn from successes, as well as failures. Rodrik states, “straightforward borrowing (or rejection) of policies without a full understanding of the context that enabled them to be successful (or led them to be failures) is a recipe for disaster. Once one understands that context, there will always be variations on the original policy (or different policies altogether) that will do a better job of producing the intended effects.” (Rodrik 2007:4-5). It is time to pay even greater attention to context, and to the politics of that context.

Appendix A: Methodologies

Talking about methodologies in qualitative fieldwork is “in effect, to air the dirty laundry of the ethnographic enterprise,” writes Laura Grindstaff in the epilogue “Airing Another Kind of Dirty Laundry: Confessions of a Feminist Fieldworker” to her book *The Money Shot: Trash, Class, and the Making of TV Talk Shows* (2002:276). Despite the increasing number of articles, appendices, and thick description of methods of the ethnographic processes (Duneier 1999; Venkatesh 2008), and the accompanying personal revelations, the process of writing my own “confessional tale” of the methods and theories, as well as the successes and failures of my own fieldwork, has not been an easy one. Yet, as a feminist researcher, I recognize the importance of making my participation and stake in the construction of this research visible (Sprague 2005:194), as feminist epistemology realizes that research is a process and, thus, the contexts of both the process and results are important (Hesse-Biber, Leavy, and Yaiser 2004:22).

The construction and performance of my own identity while conducting this research played a large part in *how* and *why* I was granted access to people and institutional settings. I began working in Kampala, Uganda in July 2007—first as a short-term consultant working with an inter-governmental organization (IGO) called Partners in Population and Development (PPD). The organization had opened an office for Africa in February of that year, and was in the process of finalizing their strategic plan for the office, as well as setting up basic financial and administrative procedures. I was recommended by a former boss to assist her in finalizing the strategic plan and

to set up basic monitoring systems for the office's finances and work, more generally. After this short contract ended in September 2007, I was picked up by the organization's main donor, to continue providing all-around program support on a part-time basis, from both my home in California and from the office in Kampala, when I was able to travel there with my graduate school schedule.¹⁰⁶

While in this position with Partners in Population and Development Africa Regional Office (PPD ARO), I began spending time with and working with staff at Uganda's Population Secretariat, who provided office space and administrative support to PPD under an agreement between PPD and Uganda's government. I also began observing and understanding the particular social and economic contexts of the country—the high birth rate of almost seven children per woman, the relatively high rate of HIV, the rampant poverty not only in rural areas but also the capital and large cities, the presence of donors, and the bureaucracy, systems and politics that seemed to be ineffective, or at best, slow, to respond to the urgent needs across the country in so many areas.

Around 2008, I began seriously considering my dissertation topic—and despite my work and knowledge of other places and issues—Uganda and the politics of its population problem continued to haunt my thoughts. How could all of these well-intentioned and hard-working people, with well-designed policies and plans, and despite significant external and internal resources, continue to falter?

No matter where I turned, and whom I talked to, a continuing topic of conversation was the failure of the Ugandan government to implement its own policies. I decided that this topic, with a bit of re-shaping and focusing, would provide more than enough fodder for my dissertation, if not, a lifetime of work. I ended up focusing my research with the question, “How and why have Uganda’s population and sexual and reproductive health and rights (SRHR) policies failed to realize change despite clear, implementable policies, frameworks, and significant financial resources?” I examined the extent to which SRHR is present in the policy environment (as separate policies and as integrated into larger development policies and frameworks) and what political, environmental, cultural, and social factors have facilitated and/ or hindered political support for and implementation of SRHR policies and programs?

“Studying up,” or studying the powerful, “amounts to transposing many questions common in both scholarly and popular discourse”—“it shifts the way we see ‘the problem’ from those who are the victims of power to those who wield it disproportionately” (Sprague 2005:186, citing Nader 1969:289). Rather than studying rural women with little to no access to health care and ten children and asking “Why do poor women have so many children?,” I chose to study elite politicians and bureaucrats and ask, “How can the government claim to provide free health services for all of its citizens, yet not provide them the full access and ability to act on these stated rights?”

It was clear to me that my research questions would have to be answered using an exploratory, qualitative methodology that sought to understand not only what happened, but also the causality inherent to policymaking and implementation. My questions could not be answered through other methodologies of inquiry such as structured or randomized surveys as the information gathered would not flush out the political processes and people selected at random for a survey would most likely not have access to the information I sought.

Drawing from Reinharz's argument that "feminism is a perspective, not a method," (Reinharz 1992:241), I combined a number of qualitative, sociological methods for this project.

My methods included:

- In-depth, semi-structured interviews with key individuals involved in sexual and reproductive health and rights (SRHR) policymaking and implementation;
- Participant observation with Uganda's Population Secretariat; and
- Content analysis of reports and documents from government, donor and non-governmental sources involved in SRHR and population policy in Uganda.¹⁰⁷

Feminist theory recognizes that there is no single reality, but rather, researchers need to understand how different people's accounts of reality are arrived at, as well as the purposes that different accounts serve. Triangulating methods in a research project

does not solve the issue of discrepancies among accounts, as different accounts from triangulated methods cannot be easily added together to produce a singular truth or reality. Yet, through triangulation, I am able to gather accounts from various people, perspectives, and locations to reach a fuller and deeper perspective on the issue. By collecting data from multiple types of sources, method triangulation not only increases the credibility of findings, but also can reveal weaknesses of some sources who may otherwise be seen as reliable, in part due to the censorship inherent to government accounts of policymaking or some interviewees' elite status (Davies 2001). I compared data from interviews with data from written documents and observations to verify information and to determine the strongest factors with influence in policy formation and implementation. This triangulation is critical to ensure the credibility, reliability and validity of the findings of this research (Denzin 1970).

To ensure that I would be able to clearly explore the causal processes of complex political and administrative decision-making, I also utilized a number of insights and research methods drawn from the process tracing method of political science to explore causal relationships within individual cases (George and Bennett 2004). "In process tracing, the researcher examines histories, archival documents, interview transcripts, and other sources to see whether the causal process a theory hypothesizes or implies in a case is in fact evident in the

sequence and values of the intervening variables in that case” (George and Bennett 2004:6).

I received approval from the Uganda Population Secretariat and related bodies in Uganda to conduct this research in 2009 and began working with them directly in 2010. The UC Santa Cruz Institutional Review Board (IRB) approved my request for exemption from the Human Subjects Protocol in 2010.

Interviews with Key Individuals

To select interviewees, I combined positional criteria with a reputational chain-referral (snowball) methodology. I began by identifying an initial set of relevant respondents, who are involved in policymaking and implementation through review of publically-available national reports and other public sources, including websites, that listed positions in different government ministries and bodies (Rivera, Kozyreva, and Sarovskii 2002). I then asked this initial set of interviewees whom they considered to be most centrally involved in sexual and reproductive health and rights (SRHR) and population policies and implementation in the country. This meant that I was not only looking for respondents according to their position, but also according to the extent that they are considered influential to the issue (thus, I was also sampling for reputational criteria in the snowball sample). I continued this process until I was

generally referred back to people I had already included in my sample and I was receiving no significant new information during the interviews (data saturation).

Farquharson (2005) argues that the reputational snowball method can identify influential actors who may be ignored in positional sampling, as elites can often suggest influential people whom researchers may not initially have presumed relevant to the study. I found this true in my sampling, as I included a number of people in interviews whom I would not have intentionally included in my sample—such as an advisor and a secretary to the Ugandan president, as well as influential people in ministries that would seemingly be uninvolved in SRHR issues. The reputational snowball method also allows the researcher to assess the *level* of influence of key elites; for example, when someone receives multiple nominations from others, it suggests they may be particularly influential and at the core of a policy network, and thus a critical interviewee (Farquharson 2005).

For this research, I carried out a total of over 85 interviews with a total of 121 people.¹⁰⁸ Interviewees included heads of government divisions and departments, officials in a number of government ministries and agencies, parliamentarians, local politicians, political advisors and assistants, intergovernmental organization officials, officials at bilateral and multilateral donor agencies, “technical experts” from academic and research institutions, women’s rights and health activists, and officials at international and national NGOs, CSOs, and religious organizations. The

interviewees ranged in their work positions and level of organizational power and seniority—I targeted higher-level and senior decisionmakers such as the Director or Head of Unit in each organization, but in most of the most relevant organizations, I also made sure to interview people at mid-level. This is consistent with the theory that lower-level officials may often be better elite interview sources given their day-to-day involvement with political processes (George and Bennett 2004:103).

I was able to interview 121 of the 131 individuals I identified as key informants for the study. Over half of the 131 key informants I identified were referred to me by other informants. Five of the individuals in the key informant list of 131 people referred me to others in their office, stating that the other individual would be better to interview for my research and declined to be interviewed themselves. An additional two people identified said that they were unavailable for an interview in person or by phone or email. I was also unable to reach three of the individuals on my key informant list through phone or email in order to request an interview. Overall, I was very happy with the success rate, as I was able to interview a very diverse group of people, and was unable to interview only a very small percentage.

The interviewees were also diverse in age, race, gender, and class, although almost all could be considered “elite” and upper-middle-class or above. Most of the interviewees were in the 40s and 50s, although a percentage were in their 20s, 30s, and 60s or above.¹⁰⁹ The government bureaucrats and politicians were all Ugandan

(from a range of different tribes across the country—the most common tribal affiliations of political and government interviewees were Baganda and Banyankole, Basoga, and Bakiga, generally mirroring the country’s larger tribal makeup). Most of the donor agencies and international NGOs employ a mix of international and national staff. My overall makeup of interviewees was 82% Ugandan, and 18% from other countries, with the majority of the non-Ugandans from the United Kingdom, the United States, Germany, as well as a small number of other European countries, Australia, Kenya, and South Africa. A slight majority (60%) of the interviewees were men.

I purposively targeted elite high-level politicians and bureaucrats for interviews, as I wanted to understand the decisions and actions behind policy and implementation decisions. These interviews are critical as primary sources such as documents rarely make clear the political and administrative processes, actions and motivations behind the actions and decisions. Yet, I also came to recognize that interviewing elites has its own difficulties and limitations. Access to elites is not easy, as “people and institutions with power can use that power to shield themselves from view” (Sprague 2005:129). I also found that politicians were not often the best subjects to talk impartially on issues and their motivations for supporting a particular issue. In addition to often having their own agenda for a conversation, politicians also seem to have a set of standard “talking points” for any interview, whether from a news reporter or me. This is consistent with prior research, which found that politicians

may slant their accounts, as well as minimize or inflate their own role in an event or process depending on whether there is political capital to be gained or lost from association with the issues in question (Kramer, Allyn, Blight, and Welch 1990). Policymakers also may slant their account of a process to portray a “careful, multidimensioned process of policymaking” (George and Bennett 2004:102) and civil servants may be prone to under-representing their role in political decision-making (Seldon and Pappworth 1983). Therefore, according to George and Bennett, researchers should consider four elements when considering particular documents or interviews: “who is speaking; who are they speaking to; for what purpose are they speaking; and under what circumstances?” (George and Bennett 2004:99).

The interviews were semi-structured and open-ended (Hammer and Wildavsky 1989). Although the interviews included some common questions, I did not use a standard set of survey questions, as each interviewee has different experiences and knowledge and I wanted to allow unforeseen topics to emerge in each interview. Instead, I asked exploratory open-ended questions to elicit narrative and more detail on each interviewee’s knowledge. I also had a list of topics and particular subjects that I wanted to cover, ensuring flexibility built-in to the project to enable me to ask probing follow-up questions to ensure that I was able to get as much relevant information as possible. Following Acker, Barry, and Esseveld’s instruction that “as [feminist] researchers, we must not impose our definitions of reality on those researched” (Acker, Barry, and Esseveld 1983:425), I continually sought to allow

interviewees to explain their own understanding and theory of the situation and use their own voice, rather than trying to insert my own understanding and interpretation into the conversation.

Most of the interviews lasted between one and two hours, although some were only around 30 minutes and others extended over three hours. Other interviewees were interviewed multiple times. To protect the confidentiality of interviewees, the interviews were not taped and transcribed, but I took detailed shorthand notes during each interview, which were expanded immediately following the interview (sometimes immediately in a written format, but most often as a recorded field memo to myself) and included a detailed record of my observations of the interview itself, as well as elaboration on specific issues, and my thoughts on my evolving understanding of different topics and themes.

Participant Observation

The main institutional base for this study's participant observation is the Uganda Population Secretariat, a semi-autonomous government institution under the Ministry of Finance, Planning and Economic Development (as of October 2010, the Population Secretariat began the process of becoming a National Population Council, granting it additional autonomy, however this process was extended as it had to begin afresh with the new cabinet after the 2011 elections). I spent significant time working with

and observing the work and practices of Uganda's Population Secretariat in 2010 as well as at other occasions between 2007 and 2012. I worked with Population Secretariat and observed their work during activities and events such as annual celebrations of World Population Day, the launch of the State of Uganda's Population Reports, advocacy meetings with parliamentarians, joint quarterly activity reviews conducted with UNFPA, and regular staff meetings. I also travelled with officers from the Population Secretariat to rural districts in the north, east, and west to observe the work of the Population Secretariat in the field and to hear from key stakeholders and local political leaders.

The kind of access I was able to have at Popsec and with a wide variety of people, politicians to bureaucrats, would not have been possible without the ongoing support and assistance of Dr. Jotham Musinguzi, the Regional Director at the Partners in Population and Development Africa Regional Office (PPD ARO), who also was the former Director of Uganda's Population Secretariat. Without the benefit of his deep ties, connections and knowledge of the ins and outs of the subject matter of SRHR, and more importantly, politics, I would not have been able to write such a nuanced and insider-informed account of my topic.

My position working as a consultant to PPD ARO also allowed me access to a number of people, events, and a range of information. I have not excluded data and information gathered from events that I attended while working for PPD ARO (such

as the AU Summit, meetings of EQUINET, and meeting for regional parliamentary groups such as SEAPACOH). To do so would be to lose a wealth of information that gave me critical insight into my topic. I however, was leery of revealing other kinds of information I was privilege to because of my position, and therefore I created my own rule on the matter—to include data collected at meetings and events to which the press were invited and to exclude information obtained in private meetings and reports that I was only privy to due to my work. A good deal of the second category of excluded data was, however, brought up in confidential interviews, and it became data and included in my research through those means.

While ‘in the field,’ I made both written and mental notes. At a number of official events hosted by Population Secretariat, I was asked to rapporteur the meeting, and therefore, was able to take notes overtly during the meeting to both meet the needs of the organization’s record-keeping of the main proceedings and statements made during the event, as well as my own research needs. Otherwise, when taking notes would have been outside of my assumed scope of work activities with Population Secretariat, and to minimize reactivity (the influence of the researcher on social events), I took short notes covertly and wrote up detailed observations when I arrived back home (Emerson, Fretz, and Shaw 1995; Lofland and Lofland 1995).

Content Analysis of Documents

In the process of this research, I carefully read, coded, and analyzed hundreds of documents. These documents came from sources including the media, national government and international surveys; reports produced by government bodies; government policy and guideline documents; national development plans; annual and supplementary budgets; reports from bilateral, multilateral and private donors; reports from NGOs and CSOs; and research reports and publications.

It is always quite astounding to try to measure, much less understand, the amount of materials produced by any one government department. While the number of publically-available reports and documents is, of course, much more limited than the amount of internal documents, the quantity of documents to analyze and understand can be overwhelming, particularly if the topic at hand cuts across different government organs. In my case, this is absolutely the situation, and I collected and analyzed reports from the following government bodies: Ministry of Finance, Planning and Economic Development (MoFPED), Population Secretariat, Uganda Bureau of Statistics (UBoS),¹¹⁰ Ministry of Health, National Medical Stores (NMS, which is an autonomous government corporation), in addition to documents from other ministries, sectors, and NGOs.

I gathered these documents from many sources, including government libraries, offices of donors and NGOs, electronic and printed documents from research libraries

in the United States, and websites. I also regularly asked interviewees (particularly in government offices) for assistance in procuring particularly difficult-to-find reports.¹¹¹ The difficulty of compiling a complete register of the relevant reports and documents is compounded by the fact that many reports are produced in public form by the government as only printed documents. This increases not only the amount of work to track down the most important reports from the appropriate government office (that is, if a printed report is available to take, rather than to borrow) but also the weight of the international researcher's luggage. In many cases, if I could not track down a personal copy to keep, I found myself borrowing a printed copy of a report from someone's office (or from the library at Statistics House at the Ministry of Finance) and scanning it page by page into an electronic form. I found that I had to do this rather often because the electronic copy of the report held by the government bureaucrats would have been edited heavily during the process of working with the printing company, such that the content would dramatically change or that an electronic copy could not be found on their computers due to a change in staff or a computer virus. But this was not always the case, and many of the government ministries in Uganda do have final copies of their major reports available in electronic form on their websites.

It is important to note that despite the quantity of written reports from many sources, these materials often do not include much information on the processes of policy formation or implementation for a number of reasons. Reports will often present the

official version of events, thus concealing the informal processes preceding official decision making (George and Bennett 2004:103), as well as potentially leaving out information that could be considered harmful to the organization in question (particularly when issues of corruption and/or future financing of the organization are at play). It is also likely that written reports present decisions in a way that implies consensus and agreement, when disagreement may actually be extensive and that during the process, other decisions may have been considered extensively and not documented (Davies 2001). Also, key documents may not be public due to government secrecy rules (George and Bennett 2004:99) or in some cases, due to unwritten policies and practices that discourage the sharing of information with outside audiences.

A Feminist in the Field

Feminist scholars have been mindful of fieldwork's ethical and moral dilemmas, including the inability to truly escape inequality and exploitation inherent to ethnography (Abu-Lughod 1990; Stacey 1988; Wolf 1996; Wolf 1992). Race, class, and gender are salient in most social interactions, including research interactions (Ridgeway 1987). This means that inequalities due to our social constructions of race, class, and gender must be acknowledged and taken into account in the research process. The dynamism of race, class, and gender, as well as other historical, cultural and social factors shaped my experience in the field and my access to data. My status

as a young white woman, as an American, as a student, and as middle-class in the United States, but comparatively well-off in Uganda, certainly played a key role in the access and information I was able to gather.

Overall in this research, I was dealing with a group of people who were more powerful than I—they controlled not only when and where they were available to me and what they wanted to reveal to me in conversation, but many could also have made a simple phone call to a colleague or friend in the relevant ministry which could have ended my permission to conduct research, if they had so desired. I had never “studied up” before in research—in a previous research project with adolescent girls, I was “studying down” (Zlatunich 2009), and in research with reproductive rights activities, I was “studying across” (Zlatunich 2008b). I did have previous work experience with people of greater power (wealthy donors, national politicians, and Ministers), so the positionality of being “below” those I was working with (or for) was not new to me.

This power differential from studying up played out in ways beneficial to my research. I found that once I was granted access (and interviews), I was told things and allowed to see things that these powerful people (most often men) would probably not have allowed someone whom they considered an equal or more powerful to them to know. I was privy to conversations that if the participants had thought again, I would not have been privy to.¹¹² I think that my gender and relative youth made most of the interviewees consider me non-threatening—few asked

specific questions about my research and what I would do with the information I gathered.

Like others, also I found that “the sexism in the local culture can be enacted against the visiting researcher” (Sprague 2005:122). As a woman, I was looked down on by many of the Ugandan men working in government offices—I sat on countless benches, couches, and chairs in the lobby, or next to their Secretaries desks, trying to stay out of the way, waiting for my audience, who were often late by 10, 30 minutes or even an hour. Fortunately, the interviews usually went better than the waiting. I found that women in similar positions in the government generally would not keep me waiting for more than 10 or 15 minutes.

It is hard for me to reflect on how race shaped the process and outcomes of my research—my status as a white foreigner probably did give me access that a young Ugandan may not have had. My status as a foreign doctoral student also gave me some prestige and became a topic of discussion with a number of Ugandans who studied in the United States or the United Kingdom and happily reminisced about their time as a student. Race, of course, did shape my time more generally in Uganda—I was “marked” as foreign, as an “other,” on the street and in everyday encounters and conversations. But my difference and marking was rarely unpleasant—Uganda was a British protectorate, and never a colony like Kenya or South Africa—so there does not seem to be the kind of anti-white sentiment as

elsewhere. My understanding of the effects of my whiteness were also not clear due to my status as a foreigner or a guest, as hospitality and showing respect to guests is culturally important among most tribal groups in Uganda.

Locating Motives and Meanings in My Research

I work from the perspective of standpoint feminism (Smith 1996)—in particular, one aim of my research project is to bridge the historical difference between academics and activists by creating usable information for *both* academic researchers and for activists. First, I am interested in contributing to the academic literature in various sectors, including that of development and the state (Bayart 2009; Clapham 1996; Foucault 2007; Migdal 2001), health policy in developing countries (Gilson and Raphaely 2008; Hill and Hupe 2009), and sexual and reproductive health and rights (SRHR) in developing countries (Blacker et al. 2005; Briggs 2003; Bulatao and Ross 2000; Dmytraczenko, Rao, and Ashford 2003; Population and Development Program 2007; Richey 2008; Solo 2008).

Secondly, and no less importantly, I recognize my obligation to “create knowledge that empowers the disadvantaged” (Sprague 2005:79). I am guided by a sense of “practical enquiry”—a drive to inform practice and speak to policymakers and activists concerned with improving sexual and reproductive health and rights (Hammersley 2000). I take seriously Sprague’s challenge to “ask passionately,

analyze critically, and answer empoweringly” (Sprague 2005:199). I was led to the questions I asked in this research because of the seemingly incongruous policy and situation on the ground in Uganda—women are having more children than they desire and they are dying due to births too early, too closely spaced, and due to complications from unsafe (and illegal) abortions. My outrage at the situation led me to work in this field, and to do so strategically in positions where, although I was not providing direct services to women, I am working with organizations advocating and working with governments to improve reproductive health policies and programs, and therefore, hopefully benefitting an even larger number of women by improving institutional situations. Through my work, I slowly came to realize, at least in Uganda, that the problems were not as much with the policies (which are generally good—with the exception of a few policies including those barring the provision of abortion services), but with the implementation of the policies. After spending time at clinics and talking to service providers and their clients, and talking to people at all levels and organizations, I came to realize that the implementation failure was generally not at the level of the clinic—or at least to the extent that the failure could be greatly controlled at the clinic level by the nurses, doctors, and medical aides. A nurse will not have enough time to adequately counsel patients if her clinic is short-staffed due to a lack of funding. A pharmacy aide may not have drugs when the time between placing an order and delivery of the drugs averages over 60 days. Both of these examples may appear to be solved by administrative changes—increases in funding at clinics and improving drug logistic systems and training for staff. This was

my initial conception at the time of beginning the study—and this was the conclusion reached by most other researchers and donors, who would then target programs to improve the financing for health care and/or the capacities of the bureaucracy and health workers to implement policies.

But my research through this project led me to another conclusion. In summary, from spending more and more time in Uganda over the past four years, reading newspapers, talking to bureaucrats and politicians, and collecting data of every form I could conceive of, I came to the realization of the relevance and importance of politics to not only policymaking, but policy implementation. To address the full causes of failure in implementation, I found that politics and the influence of political actors cannot be ignored. Therefore, I found myself “studying up,” as well as outside of my country, culture, and often gender.

My contribution through this research project addresses the importance of understanding wider political and economic influences in policy change and implementation in SRHR, and illustrates how such influences operate at the national level. This research is important, as it not only makes a significant contribution to various academic literatures, but it also has operational importance in terms of policy implementation and funding for sexual and reproductive health and rights in Uganda. Hopefully, this small contribution will lead to improved implementation and use of

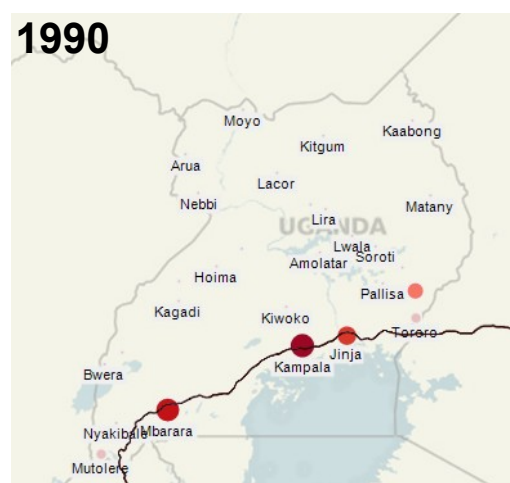
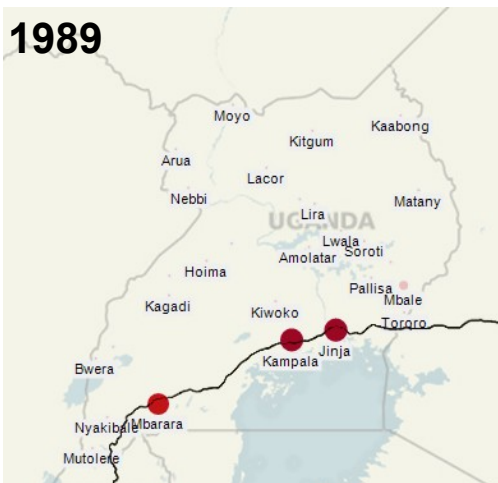
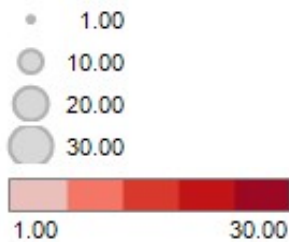
funds for sexual and reproductive health and rights (SRHR), and ultimately, to improved health and rights for women, and for their families.

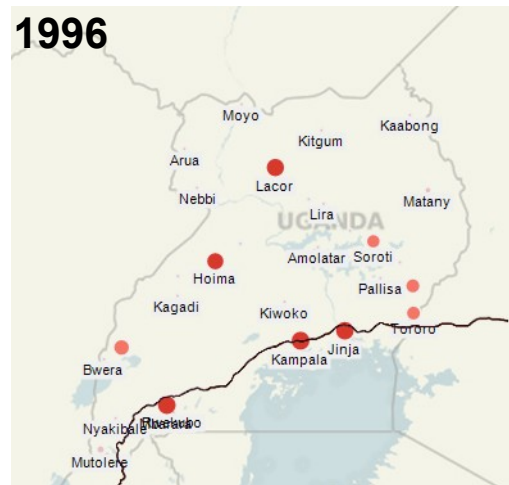
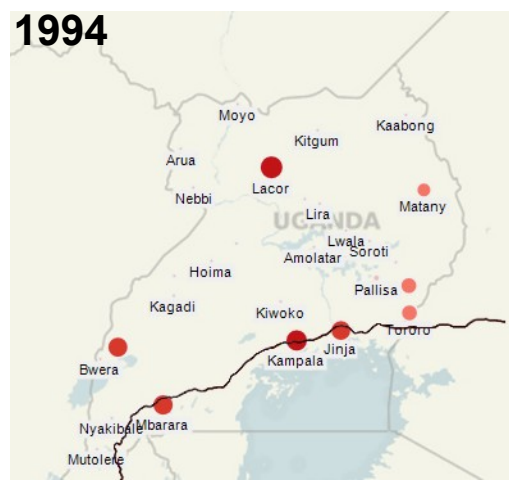
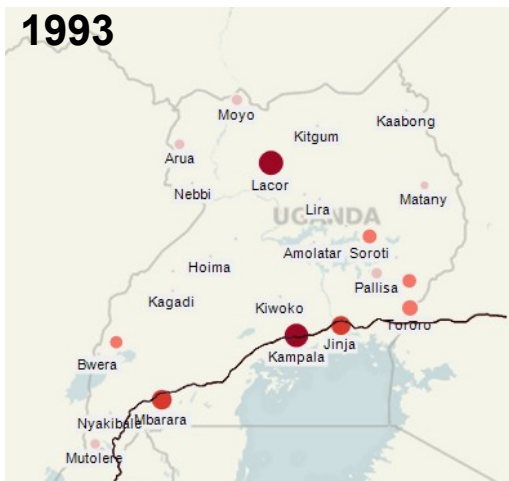
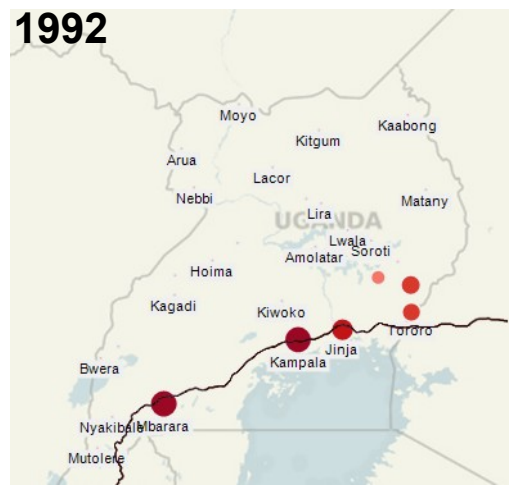
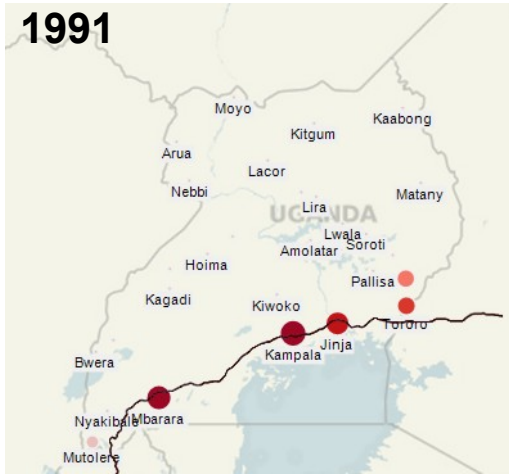
Appendix B: HIV Prevalence Maps

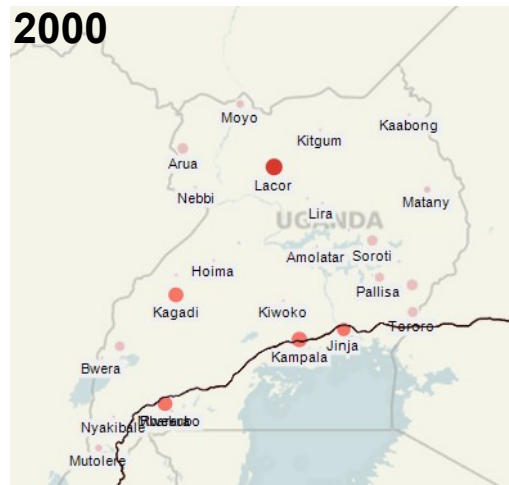
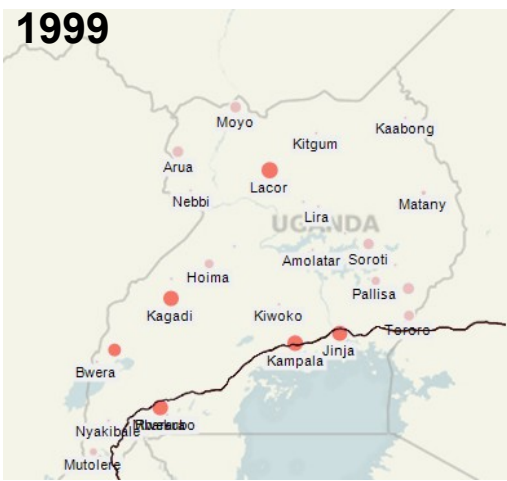
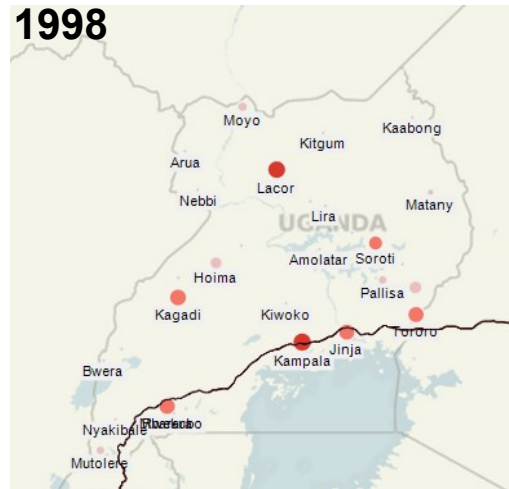
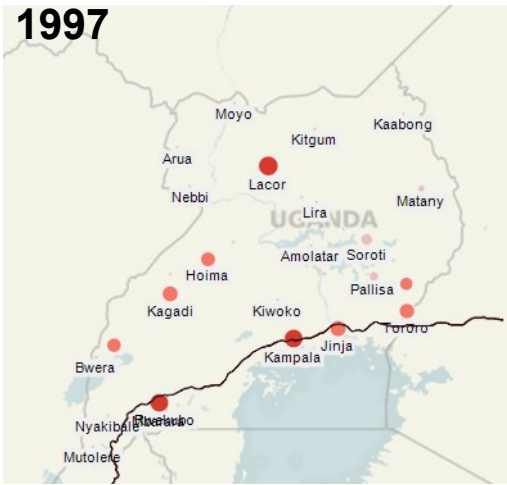
This appendix is a series of maps showing HIV prevalence at sentinel sites throughout Uganda between 1989 and 2009, using data from the Ugandan Ministry of Health (2010c). The maps also show the main long-distance truck route from the coastal city of Mombasa, Kenya through Uganda and into Kigali, Rwanda. Data for 2008 is unavailable from the Uganda Ministry of Health.

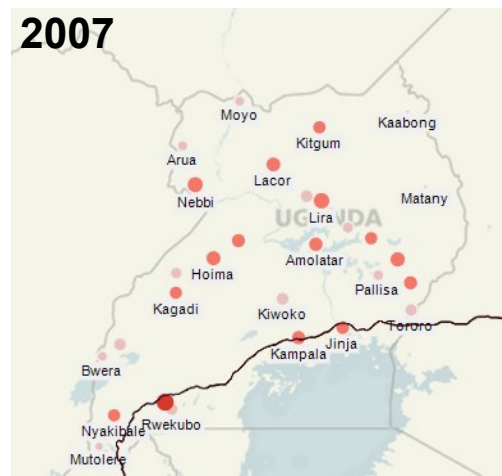
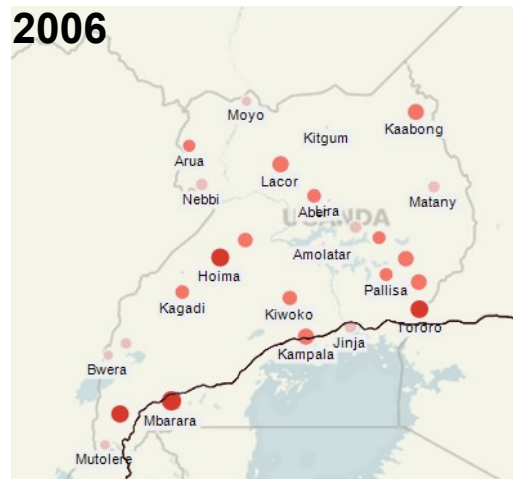
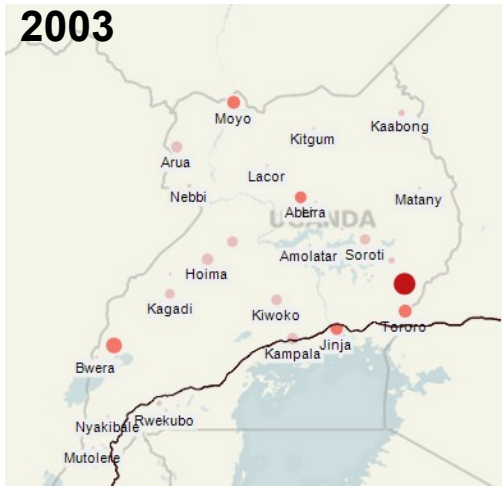
Maps Detailing Antenatal HIV Prevalence at Sentinel Sites in Uganda, 1989-2009 Source: (Uganda Ministry of Health 2010c), (Zlatunich 2012a)

Key for all maps









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Endnotes

¹ For the sake of not driving my reader crazy with acronyms, as is the norm in most development program reports and even research studies, I will on occasion spell out sexual and reproductive health and rights (SRHR), but I will more often use reproductive health in order to reduce the use of “and” and tire my reader’s patience. I certainly do not mean to remove sexual rights from my argument, and in places, I will explicitly talk about sexual rights.

² Although according to Tilly (1992), the early stages of state formation in Europe were closer to organized crime than a project of social good, which many theorists use to generalize the process of state formation between Europe and Africa.

³ Herbst argues that there is actually greater continuity between the politics of precolonial and postcolonial Africa and that the impact of colonialism can be exaggerated in some accounts (Herbst 2000).

⁴ Liberal theorizing on the role of the state can be traced back to Adam Smith, ““Little else is required to carry a state to the highest degree of opulence from the lowest barbarism but peace, easy taxes and a tolerable administration of justice”” (Hall 1994).

⁵ Infrastructural powers are differentiated from despotic powers, which Mann (1986) defines as “the range of actions which the elite is empowered to undertake without routine, institutionalized negotiations with civil society groups” such as the ability to use force.

⁶ “There are two extremes on a conceptual continuum: at the one end, there are those who believe a policy to be a rule or principle that guides decision-making. In many cases, such rules or principles might remain implicit. At the other extreme, policy has been defined as the explicit (and thus documented) formal decision by an executive agency to solve a certain problem through the deployment of specific resources, and the establishment of specific sets of goals and objectives to be met within a specific time frame. Legislation (with associated sanctions and incentives) could be regarded as ultimate policy statements.” (de Leeuw 2007)

⁷ However, as pointed out by Breton and De Leeuw (2011), the most authoritative policy frameworks have been based on Western-style systems of democratic governance and thus, may not be relevant to understanding policy change elsewhere, including under authoritarian governance.

⁸ A number of interviewees reported that the government has not been releasing accurate population figures, possibly for political reasons. Project surveys by NGOs

have shown that village populations in some areas may be up to 20-30% higher than reported by the government. This was reinforced in a number of interviews, including with a district leader who said that the official statistics undercount the population in a large percentage of villages in his district, and with an HIV researcher who had to do a re-count of the population in a survey area due to the huge discrepancy in data from UBOS, finding that the population in a number of villages was between 25-30% higher than the official government figures, and almost 35% higher in one village (Interviewees # 6, 87, 112, 120).

⁹ Fellow opposition leader Norbert Mao was also imprisoned by the government in early 2011 in relation to his involvement in the opposition protests.

¹⁰ Foreign direct investment has declined, but only minimally, from 5.3% of GDP in 2007/2008 to 4.6% in 2008/2009 (Uganda Ministry of Finance Planning and Economic Development 2010).

¹¹ General budget support to Uganda has been provided by Norway, Ireland, United Kingdom, the European Commission and the World Bank; sector budget support has been provided by Denmark, Belgium, Sweden, France and Italy (Koenig and Atim 2010).

¹² Ugandan shillings converted to USD at rate of 2,000 UGX to 1 USD. DFID calculates these figures differently, giving total external assistance was around \$1.6 billion and GDP as \$16 billion in 2009/10 (DFID 2011a).

¹³ Some parts of Uganda, as in many African countries, have relatively high rates of infertility. High infertility in Africa is in good part due to high rates of untreated sexually transmitted infections (STIs) (Cates 2003). Studies in Uganda have shown that districts with relatively lower fertility levels have higher levels of chronic gonorrhoea in both males and females (Arya, Nsanzumuhire, and Taber 1973; Arya, Taber, and Nsanze 1980; Griffith 1963). But natural rates of sterility may be relatively high in some regions of Uganda, as over 20% percent of women between 45-49 years of age in the South-West were recorded as having no children since the earliest demographic information was collected in the country (Frank 1983). Ironically, while infertility contributes to lower fertility rates for a country as a whole, high rates of infertility contribute to fertility uncertainty, which in turn can lead to higher rates of fertility, “infertility will represent a major obstacle to Africa's fertility transition, because uncertainty in childbearing inhibits response to intrinsic and extrinsic pressures to reduce fertility goals” (Frank 1983:143).

¹⁴ Research in Malawi found that religion plays a different role than usually thought; the attitudes of congregational leaders toward family planning and sexual morality (which do not neatly fall along broad denominational lines) is more relevant than the larger denomination in predicting the contraceptive use of women. While Catholic

leaders were less likely to endorse family planning (60% versus the overall 80% approval in the larger sample), Catholic women were more likely to have used family planning, which the researchers attribute to this group's higher level of education (Yeatman and Trinitapoli 2008).

¹⁵ The ICPD definition of reproductive health and rights, that 179 countries signed up to in 1994, is: "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." (Programme of Action, Paragraph 7.2) "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents." (Programme of Action, Paragraph 7.3) (UNFPA 1995) A more expansive definition of reproductive rights by UNFPA is: reproductive rights include "includes the rights to: "Reproductive health as a component of overall health, throughout the life cycle, for both men and women; Reproductive decision-making, including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children and the right to have access to the information and means needed to exercise voluntary choice; Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy" (UNFPA 2011).

¹⁶ Advocates have also recognized the benefits of promoting reproductive health as essential to reaching a number of the MDGs, including improving gender equality and women's empowerment (MDG 3), reducing child mortality (MDG 4), improving maternal health (MDG 5), and reducing the spread of HIV (MDG 6).

¹⁷ The Population Council established or funding specialized research programs in family planning and related fields at the University of Chicago, Columbia University, University of Michigan, University of Pennsylvania, Boston University, Princeton University, Cornell University, the University of Minnesota, and Dartmouth College (Critchlow 1999:240).

¹⁸ The Population Council was also involved in establishing and funding the UN's regional demographic research and training centers in Bombay (1957), Santiago (1958), and Cairo (1963) (Critchlow 1999:240).

¹⁹ Frank Notestein and Kingsley Davis reinvigorated Malthusian theory in the 1940s and 1950s (Hodgson 1983). Both Notestein and Davis believed that the world could not support the population growth rates that followed WWII and that development is hampered by high population growth.

²⁰ The Foundation's perspective illustrates a tension in the field of population— motives vs. means. Investment in socio-economic development, education and public information would aim to change the motivation to regulate fertility (“demand-side approach”), while developing and providing new and better contraceptives (“supply-side approach”) would address the technological means for fertility reduction. Feminists such as Gita Sen and Adrienne Germain would later attack this perspective, arguing that approaches to development should value women's well-being and health holistically, rather than treating women's bodies as the cause of underdevelopment, necessitating technical and medical involvement of the developed world (Germain 1993; Sen, Germain, and Chen 1994; Sen and Grown 1988).

²¹ This device was later replaced with newer models including the infamous Dalkon Shield (which used a multifilament string, allowing bacteria to travel into the uterus of users, leading to sepsis, injury, miscarriage, sterility, and death) and the newest and currently marketed model of IUD to the developing world, the Copper T 380A (Vairo 1997).

²² “A population policy as narrowly defined is a formal statement by a government of perceived national demographic problems, solutions, and desired goals and objectives, together with a systematic organizational plan of implementation . . . the role of a population policy is to modify the demographic behavior of a given population in a desired direction” (Dixon-Mueller 1993:15).

²³ In 1967, Kenya was the first African country to develop a population policy. Ghana was the second in 1969. However, no other African countries had policies until Nigeria became the third country in 1988, which was then followed by a large number of other African countries (Sullivan 2007).

²⁴ Population research centers at the universities of Michigan, Harvard, Johns Hopkins, North Carolina, Chicago and Pittsburgh provided technical assistance, course, and seconded staff to help establish population policies and programs in the developing world (Population Council 1965) cited by (Sending 2009).

²⁵ Maternal mortality is the death of a woman during pregnancy or the postpartum period due to pregnancy-related causes. In 2005, there were 535,900 maternal deaths (Hill, Thomas, AbouZahr, Walker, Say, Inoue, Suzuki, and (on behalf of the Maternal Mortality Working Group) 2007).

²⁶ This statement was associated with a policy to deny federal funding to NGOs who promoted or performed abortion as a means of family planning outside of the United States. This policy was overturned by Clinton in 1993, reinstated by the Bush Administration in 2001, and again rescinded by Obama in 2009.

²⁷ The Gates Foundation began reporting data in the OECD 2011 report with data for 2009. In 2009, the Gates Foundation was the third largest international donor of aid to health (Disbursing a total of \$1.8 billion USD) following the top donors of United States and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Smith 2011).

²⁸ The enduring actual amount was \$458.1 million USD in 2010 (USAID 2011).

²⁹ The USD figures are as converted from British pound sterling to USD at a rate of 1.6 British pound sterling to the US dollar.

³⁰ The USD figures are as converted from British pound sterling to USD at a rate of 1.6 British pound sterling to the US dollar.

³¹ The USD figures are as converted from British pound sterling to USD at a rate of 1.6 British pound sterling to the US dollar.

³² The demographic bonus is more commonly known as the “demographic dividend;” the demographic dividend is discussed earlier in this chapter in the section on the global population discourse.

³³ The Ministry of Health says that family planning in Uganda began in the 1960s by NGOs (Uganda Ministry of Health 2009).

³⁴ Others report that the Ministry of Health included family planning in the primary health care package in 1986 (Leahy and Akitobi 2009).

³⁵ “Policy” is often understood as formal government laws and statutes. However, it also includes written guidelines, operational regulations, and standards, as well as unwritten norms which are informal, yet have just as much, if not more, impact on the success or failure of policy implementation as formal policy documents.

³⁶ Later, Idi Amin targeted and murdered people who were seen to have supported Milton Obote, particularly the northern Acholi and Langi (Obote was Langi) and also dismantled the Kingdom of Buganda into separate districts.

³⁷ This has happened to some extent; the Ministry of Health has been providing family planning at national, district and local levels for some time, although supplies of specific commodities are often unavailable or out of stock (see the more detailed discussion of Uganda’s commodity chain and its political and logistical problems in “Chapter 5: ‘What Is Allocated Is Not What Is Delivered’: The Policy-Implementation Gap of Contraceptive Commodities”). NGOs, including Reproductive Health Uganda, are often the only regular suppliers in some areas and account for a larger percentage of the distribution for family planning in the country.

³⁸ Contraceptive use in Uganda was first provided by non-governmental organizations. In 1984, the Association for Voluntary Surgical Contraception (AVSC) International spearheaded the provision of long-term and permanent family planning methods in Uganda in government health facilities and the Uganda Protestant Medical Bureau (UPMB) in partnership with the Government of Uganda (Kasedde 2000:9) Yet visibility of the government in promoting long-term contraceptive methods has been limited (Kasedde 2000:9). Vasectomy began in Uganda in 1984 at three hospitals: Mulago (Kampala), Mbarara, and Jinja Hospitals. In the first years after its introduction, only three to six vasectomies were performed each year. By early 2000, over 600 men had undergone vasectomies and it was available at seven sites in the country. Tubal ligation was introduced in Uganda in 1986; by early 2000, at least 25,000 women had undergone the procedure which was available at 31 locations in the country. Norplant was introduced through a trial in the country at three hospitals in the county and as of 2000, it was available at 22 sites and 5,000 women had received the device (Kasedde 2000).

³⁹ That reproductive health should be considered a human right may be subject to disagreement by President Museveni, who publically dismissed human rights advocates at the 2010 African Union Summit arguing for improved maternal health in Africa, “even you activists or human rights or this and that . . .” (Zlatunich 2010).

⁴⁰ The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa was adopted by the African Union on 11 July 2003 at its second summit in Maputo, Mozambique. Uganda signed the protocol, however Uganda’s parliament did not ratify the protocol until July 2010 in good part due to opposition from the Joint Christian Council in Uganda and the Catholic Bishops’ Conference of Uganda, as Article 14 addresses the right to abortion “in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus” (Catholic Bishops’ Conference of Uganda 2006; International Federation for Human Rights 2010; Scheier 2008).

⁴¹ More recent work and presentations by the Population Secretariat have begun using more complex demographic arguments to justify increasing investments in family planning in order to reduce the population growth rate.

⁴² Despite the existence of the marginalized Ministry of Gender, Labour and Social Development, feminist ideas are left off of the agenda in policies and programs. While groups such as Forum for Women in Democracy (FOWODE) attempt to advance a platform inclusive of women’s empowerment and broader rights, including abortion rights, they are generally ignored and excluded from high-level policy discussions within and outside of government. “We always end up talking only to ourselves,” as one feminist activist stated (Interviewee #78). Indeed, at the launch of FOWODE’s comprehensive platform agenda for the 2011 elections, the only

representative from the Ministry of Health in attendance was the Secretary to the Permanent Secretary, herself a woman (Zlatunich 2010).

⁴³ The number of Ugandan districts keeps increasing at such a rapid pace, that the most current source is newspapers, rather than any official government documents. Even government ministers are reported not to know the current number of districts (New Vision 2010). As of December 2011, a number of news articles and UBOS (Uganda Bureau of Statistics (UBOS) 2011b) report that there are 112 districts in Uganda, and the Ministry of Local Government reports the existence of 111 districts and one city (Uganda Ministry of Local Government 2011). With the rapid creation of new districts, Uganda now leads in the number of sub-national administrative units in Africa and fourth-highest in the world (Gatsiounis 2011).

⁴⁴ As of 2001, in Mali, women with no education have about seven children on average, while women with at least a secondary education have approximately four children. Yet, as factors in addition to education come into play, the effects of education are not uniform across countries (For example, in Mali, more-educated women have about four children while in Cambodia, women with the same level of education have about three children on average) (ORC Macro 2011). In many developing countries, fertility declines are more rapid when primary school enrollment is nearly universal—as social norms change and the cost of children rises as parents have to pay school fees and lose the income and housework produced by the labor of their children (Lloyd, Kaufman, and Hewett 2000). Women’s education is also correlated with better child health—educated women are more likely to obtain health care during pregnancy, to immunize their children, and to seek medical care when a child is sick (Gwatkin, Rutstein, Johnson, Suliman, Wagstaff, and Amouzou 2007).

⁴⁵ The myth that a lack of electricity leads to higher fertility rates has been disproven. Research has shown that fertility does not peak 9 months after a blackout (Udry 1970). More recent research in the African context has shown a negative association between electrification and fertility in rural areas (with lower fertility attributed to the information about contraception gained from mass media such as radios available to households with electricity), but a positive effect in urban households (households with electricity in urban areas were more likely to have higher fertility, which the researchers attribute to electricity’s ability to create more leisure time) (Peters and Vance 2010).

⁴⁶ **Millennium Development Goals, Uganda Country Progress**

Goal/Indicator	Progress			Target 2015
	2002	2005/06	2009/10	
Goal 1: Eradicate extreme poverty and hunger				

1 Poverty head count	38.8	31.1	24.5	28
2 Poverty gap ratio	11.9	8.8	6.8	
3 Prevalence of underweight children under-five years of age	22.8	15.9		12.5
4 Employment-to-population ratio	77.5	70.3	75.4	
Goal 2: Achieve universal primary education				
5 Net enrolment ratio in primary education	85.8	81.8	83.2	100
6 Literacy rate of 15-24 year-olds, women and men	81	76.3		
Goal 3: Promote gender equality and empower women				
7 Ratios of girls to boys in primary education	0.95	0.95	0.94 (2011)	1
8 Ratios of girls to boys in secondary education	0.8	0.81	0.95 (2011)	1
9 Share of women in wage employment in the non-agricultural sector		37	43.7	50
Goal 4: Reduce child mortality				
10 Under-five mortality rate	156	137	90 (2011)	56
11 Infant mortality rate	87	76	54 (2011)	31
12 Proportion of 1 year-old children immunised against measles	56.8	68.1	75.8 (2011)	90
Goal 5: Improve maternal health				
13 Maternal mortality ratio	505	435		131
14 Proportion of births attended by skilled health personnel	39	41.1	59.3 (2011)	90
15 Contraceptive prevalence rate	22.8	23.7	30.0 (2011)	
16 Adolescent birth rate	190	159	134 (2011)	
Goal 6: Combat HIV/AIDS, malaria and other diseases				
17 Antenatal care coverage- at least one visit	92.4	93.5	94.9 (2011)	
Antenatal care coverage- at least four visits	41.9	47.2		
18 Unmet need for family planning	34.6	40.6		
19 Condom use at last high-risk sex- male		54.5		
Condom use at last high-risk sex- female		38.3		
20 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS- male		38.2	37.8 (2011)	
Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS- female		31.9	36.8 (2011)	
Goal 7: Ensure environmental sustainability				
21 Proportion of land area covered by forest	21.3	18.3		

22 Proportion of population accessing an improved drinking water source (total)	62.6	67.6	73.8	
Proportion of population accessing an improved drinking water source (total)- urban	86.9	86.8	92.3	100
Proportion of population accessing an improved drinking water source (total)- rural	57.6	63.6	69.5	70
Goal 8: Develop a global partnership for development				
23 Debt relief committed under the HIPC initiative, USD millions	69.7			
24 Debt service as a percentage of exports of goods and services	20.4	15.8		

Source: (Uganda Bureau of Statistics (UBOS) 2011a:xiii); 2011 updates (Measure DHS 2012; (Uganda Ministry of Health and ICF International 2012)

⁴⁷ Official development aid (ODA) to Africa for health currently averages \$13 USD per person in recipient countries, but with high variations between countries—12 countries received less than \$5 USD per person while another country received \$115 USD per person in ODA (WHO 2011).

⁴⁸ Converted from UGX to USD at a rate of 2,000 UGX to 1 USD.

⁴⁹ The PEAP framework of 1997 has since been replaced by National Development Plan (NDP 2010/11-2014/15).

⁵⁰ Budget support by donors increased from \$20 million USD in 1998/99 to over \$130 million USD in 2001/02 (Williamson and Canagarajah 2003:463).

⁵¹ The median level of real per capital government spending from domestic resources on health in Africa is now \$12.20 USD, with a range of the lowest spending per capita at \$0.47 USD and the greatest at \$316 USD. The governments of 33 African countries currently spend less than \$33 USD per capita on health (WHO 2011).

⁵² In addition, Museveni will regularly declare “I have directed” funding for a certain program or initiative, such as “Prosperity for All” and has a history of creating new ministries and related ministerial cabinet positions (as of 2011, there are 71 cabinet ministers in Uganda) (Kiggundu 2011).

⁵³ **Uganda’s Budgeting Processes**

The Budget Act 2001 sets out the budget process in Uganda (Government of Uganda 2001). Under the authority of the President, the budget is prepared by the Ministry of Finance, Planning, and Economic Development (MoFPED) who sets a total ceiling for the public sector and the “appropriate level of resources to be allocated to individual programmes within that sector” (Government of Uganda 2003:Part 2:3.1.a). In addition, Chapter 9 (Articles 155-158) of the 1995 Ugandan constitution provide the legal framework for the preparation and approval of the national budget

and Articles 190-197 describe local government financing. The basis for the local government budget process is described in the Local Government Act, cap 243, and is further enshrined in the 2007 Local Government Financial and Accounting Regulations. The fiscal policy framework and regulation of public financial management are covered in the Public Finance and Accountability Act of 2003 (Government of Uganda 2003; Parliamentary Centre 2010:9). The Standing Orders of the Ugandan Parliament (Order no. 102; 108) also regulate the national budget approval process (Parliamentary Centre 2010:9).

The overall ceiling on public expenditures is a measure instated by the Ugandan government in an attempt to combat Dutch disease and the economic destabilization that is thought to occur when there are large public expenditures financed through donor aid (Brownbridge 2004; Odaga and Lochoro 2006). The sectoral ceilings set by the MoFPED are each given a percentage share of the overall government budget. These ceilings are approved by cabinet (in line with national priorities and also subject to non-discretionary expenditure) (Odaga and Lochoro 2006). Then, the MoFPED shares the macroeconomic outlook, government priorities and budget ceilings in the “Budget Call Circular” which give the ceilings approved by Cabinet (Parliamentary Centre 2010).

Each sector (as well as local governments) then prepares medium-term budgets consistent with their sector expenditure ceilings, called Budget Framework Papers (BFPs), for the MoFPED to review and compile before forwarding to cabinet for approval. Finalizations of earlier estimates are harmonized between the MoFPED, sectors, and local governments are then made (Uganda Ministry of Finance 2011). Then the MoFPED organizes a public expenditure review meeting with development partners, CSOs and NGOs where the draft budget framework paper and mid-term economic framework allocated estimates are presented and discussed before the MoFPED submits the finalized budget to cabinet (Parliamentary Centre 2010). After final approval by Cabinet, the macro-outlook, budget framework paper, and revised ceilings are sent to Parliament along with a request for the annual appropriation bill to be passed. Each year the Minister of Finance presents the budget speech and each ministry also submits a policy statement to Parliament with detailed information on planned expenditures and outputs (Parliamentary Centre 2010). After parliamentary scrutiny and debate, both in committees and committee reports to the plenary session of parliament, Parliament approves the budget between July and September. The President has the authority to release funds into the first four months of the fiscal year according the 1995 Constitution Article 154(4) (Parliamentary Centre 2010).

While stakeholder such as donors, CSOs and NGOs can be involved and influence the budgeting at the sector level through budget framework paper workshops, sector working groups, public expenditure review, consultative group and sector reviews (Odaga and Lochoro 2006), only the President, cabinet, and the MoFPED (but not

Parliament) has a role in setting the overall budget ceiling and ceilings for each sector. Donor funding for sectors is not treated as additional by the MoFPED, thus the amount of each sector's expenditure ceiling is not equally increased by donor aid to the sector as the government does not want its budget distorted (Brownbridge 2004; Odaga and Lochoro 2006; Uganda National Planning Authority 2010). There was significant conflict when the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) wanted their funds to be additional to the health sector budget. The MoFPED refused with the argument that "inflows of donor funds above its Medium Term Expenditure Framework ceilings would upset macro-economic stability" (Poore 2004:53). An exception was eventually made for GFATM funding to be additional to the health sector budget ceiling, but only after the intervention of President Museveni (Poore 2004).

The Ugandan government has also declared that its budget process is to be "free of international meddling from external donors" (Odaga and Lochoro 2006:16). Yet changes to sectoral ceilings can occur, including by Parliament, but the total budget ceiling is constrained by the amount set by the MoFPED (Odaga and Lochoro 2006). In the 2002/03 fiscal year the defense budget was increased and other discretionary sector budgets (excluding health, poverty reduction and "some critical central government ministries") were reduced by cabinet by 23% after the sector ceilings were approved (Uganda Ministry of Finance Planning and Economic Development 2003:16).

MPs passed the 2010/2011 budget for 8 trillion UGX (about \$4 billion USD) without debate (Mugerwa 2010). Of the 332 Members of Parliament serving in Parliament at the time of the budget (Inter-Parliamentary Union 2011), only 21 MPs were present for the 2010/2011 budget debate (campaigning for the upcoming 2011 elections was underway), and the budget was passed in one day without debate (even figures that were rejected in the committee reports were passed) (Mugerwa 2010). Some opposition MPs, "led by the Public Accounts Committee, walked out of the proceedings complaining that it would be professional dishonesty for them to stay and help the ruling party legitimize a flawed process" (Mugerwa 2010). Committee reports were not read and discussed in Parliament, instead the Speaker of Parliament, Edward Kiwanuka Ssekandi instructed the MPs present, "Read only figures, we supply and we proceed to the next report. Please summarize because we don't have time to waste. This budget must be approved today" (Mugerwa 2010).

The total government budget for 2010/2011 (fiscal year running July 1- June 30) was 8 trillion UGX (about \$4 billion USD), yet by early January, 8.6 trillion UGX had already been spent (Karugaba and Bekunda 2011). A special supplement of 600 billion UGX (about \$300 million USD) to the budget was passed in early January 2011, in time for the 2011 elections in February. 79 billion UGX (about \$38.5 million USD) of the 600 billion UGX was for State House (Karugaba and Bekunda 2011).

After the supplementary budget was passed, Museveni spent a controversial \$740 million USD on fighter jets (Gatsiounis 2011). This special supplement was immediately followed by a supplementary budget of 20 million UGX (about \$10,000 USD) for all MPs to “monitor government programs.” Opposition MPs rejected the additional payment, terming it a bribe for passing the supplementary budget for the State House (Karugaba 2011; Mugerwa and Nalugo 2011; Mugerwa, Nalugo, Ladu, and Imaka 2011).

⁵⁴ The HIV statistics reported here are measures of prevalence (% of general population who are infected), rather than incidence (the number of new infections). Prevalence can vary dramatically with the death rate for people with HIV (prevalence will increase as more people live longer with HIV due to anti-retroviral therapy), migration, as well as methodological changes in measurement (de Waal 2006).

⁵⁵ Data for 2008 is unavailable from the Uganda Ministry of Health in the cited reference.

⁵⁶ There have been some international media reports in late 2011 that condoms cannot be advertised on television stations in Uganda until after 9pm (York 2011). But these reports are not accurate; while condoms are not as prevalent on billboards, radio and print media as they were in the 1990s, they are not banned or restricted to certain times of the day. For example, as of February 2012, Condom O has advertisements on the NTV television channel during the day through sponsorship of the program line up and also advertisements running at 11am on Sanyu FM radio, in addition to regular mentions by the station DJs throughout the day (Interviewee# 118).

⁵⁷ In 2002, then-Chief of Staff General James Kazini said that AIDS was still a significant problem in the Ugandan army, as half of the deaths in service are reported to be AIDS-related (de Waal 2002:3).

⁵⁸ A few prominent leaders did say that it was the Ugandan government which invented the ABC strategy “in the late 1980s,” most notably, Rev. Sam L. Ruteikara, the co-chair of Uganda's National AIDS-Prevention Committee, who in an op-ed in the Washington Post in 2008, attacked foreign advisors for removing fidelity and abstinence from the National Strategic Plan for PEPFAR and international AIDS experts who “had the financial power to force their casual-sex agendas upon us” (Ruteikara 2008).

⁵⁹ The “zero grazing” term, while it was politically useful in that it acknowledged polygamy and avoided direct mention of sexual behavior, was not a clear message. A number of people I spoke with, including a number of reproductive health experts and advocates, admitted that not everyone had a clear idea of what the slogan exactly meant, and what the take-away message truly was meant to be. One mid-level government officer offered this definition to me using cows to stand in for men and

women: zero grazing “is when you have a bull, and you don’t let it wander around. So it’s tied up. But a girl cow could wander by at any time. But the bull is not out, looking for anything. But if something happens, it happens. That’s the message promoted. Not to go out looking for it since you’re tied up, but if it comes to you, so be it” (Interviewee #14).

⁶⁰ The discrepancy between donor budget allocations such as from PEPFAR stated here and the data presented in the figures above from the OECD is because the figures use actual disbursement figures rather than budgeted allocations for each year.

⁶¹ These figures do not include private donors, private-sector spending, or household expenditures in Uganda, due to a lack of available data.

⁶² The grouping of general and basic health in the OECD funding includes funding for health policy and administration, medical education/training, medical research, medical services, basic health care and infrastructure, basic nutrition, infectious disease control (excluding HIV), health education, malaria control, TB control, among others (OECD 2011).

⁶³ Data for the portion of the donor allocation of health to HIV was not separately tracked until 2002. But as indicated by the trends in this figure, spending on population, and HIV was significantly less in the 1990s in Uganda. The large jump in funding starting in 2004 is due to the start of PEPFAR in Uganda, with approximately \$90.8 million USD in fiscal year 2004.

⁶⁴ More recently, he has said that the current HIV strategy and programming in Uganda is “too big now, too heavy. . . It has adapted too much to international guidelines instead of sticking to our own methods, which were very controversial at first but which worked” (Timberg 2007).

⁶⁵ Warren cut his ties to Ssempe in October 2009 as controversy over the Anti-Homosexuality Bill grew (Alsop 2009).

⁶⁶ In 2001, President Museveni argued that abstinence until marriage was a traditional African value, punishable by death for both girls and boys, but this value broke down due to colonialism which led to permissiveness and the eventual spread of HIV (Epstein 2007).

⁶⁷ Before his election to political office, David Bahati served as the Head of Finance and Administration at Uganda’s Population Secretariat from 1998 to 2005. David Bahati is also reported to be a member of “The Family,” an elite fundamentalist group in the United States, and organizes their Ugandan National Prayer Breakfast, and has received millions of dollars from The Family. Museveni has also been reported as having deep ties to The Family, as well (Gross 2009). Pastor Ssempe, as discussed

earlier regarding his condemnation of condoms, is a close associate of Bahati; in 2010, Ssempe and other pastors “consecrated” Bahati to “rid Uganda of homosexuals” (Ackerman 2010). Pastor Martin Ssempe has a long history of anti-homosexuality activism; he organized a rally in Kampala in 2007 to protest “homosexual agents and activists” who were “infiltrating Uganda” (Alsop 2009).

⁶⁸ These figures include funding from donors to NGOs and CSOs, and not only the funds from donors channeled to or through the Ministry of Health. The total allocation to the health sector in 2008/09 from the Government of Uganda was about \$188 million USD (Uganda Ministry of Health 2010:134). Of that amount, about \$32 million USD was allocated to the Ministry of Health for HIV (and additional \$1.5 million USD was allocated by the government to the Uganda AIDS Commission) (Government of Uganda 2010:98). In addition, around \$259-\$264 million USD was contributed by donors for HIV in 2008/2009 (Government of Uganda 2010:98; OECD 2011; PEPFAR 2012a; PEPFAR 2012b). About \$169 million USD was contributed by donors in 2009 to cater for population, reproductive health (excluding HIV), and all general and basic health services (OECD 2011).

⁶⁹ In 2007, HIV health spending was \$265.9 million USD of the total health spending of \$529.2 million USD for Uganda’s population of 31.5 million people. This meant that spending on HIV per capita was \$8.43 USD and total health expenditure per capita was \$16.77 USD, and 50.2% of the health expenditure went to HIV (additional spending on HIV that is non-health related such as for human rights and support for orphans and vulnerable children is not included in these figures) (Amico, Aran, and Avila 2010).

⁷⁰ It started manufacturing drugs in February 2009 and received qualification from the WHO in March 2010 to market and distribute drugs nationally and internationally (Pharmaceutical Technology.com 2012).

⁷¹ The cost of ARVs in Uganda is also likely to grow, as the prevalence of drug-resistant HIV strains in Uganda has risen from 8.6% to 12% between 2008 and 2012. The high rate of drug-resistant strains has been attributed to a number of causes, including poor treatment adherence to ARVs, shortage of health professionals, limited training, deficient adherence counselling, inconsistent drug supply and weak enforcement of quality standards” (IRIN 2012). This list of factors aligns with the arguments I make in “Chapter 5: ‘What Is Allocated Is Not What Is Delivered’: The Policy-Implementation Gap of Contraceptive Commodities”.

⁷² In 2011, there was an independent government investigation into the apparent price-rigging between National Medical Stores (NMS) and Quality Chemicals Industries Limited (QCIL) resulting in the government being overcharged for antiretroviral drugs (Kiggundu and Mutaizibwa 2011).

⁷³ Complications from HIV are also a relatively large cause for maternal mortality in Africa (Khan, Wojdyla, Say, Gülmezoglu, and Look 2006). 25% of maternal deaths in Uganda are AIDS-related (World Health Organization, UNICEF, UNFPA, and The World Bank 2012).

⁷⁴ This has resulted in conflicting figures released by different people. The figures in this chapter are September 2009 figures by Dr. Jennifer Wanyana, the Assistant Commissioner, Health Services (RH Division) and Dr. Moses Muwonge, the Reproductive Health Commodity Security Coordinator, MoH/UNFPA (Muwonge, Sizomu, Songa, Herbert, Samuel, and Brucker 2011). However, there are also figures from June 2009, in which Anthony K Mbonye, the then-Assistant Commissioner, Health Services (RH Division) reported government allocations as: 2005: \$339,232; 2006: \$202,724; 2007: \$55,456; 2008: \$200,000; 2009: \$750,000. The only agreeing figure is the budget for 2009, whom both report as \$750,000 USD (Mbonye 2009).

⁷⁵ In 2010, UNFPA Uganda estimated that the total cost for national requirements for commodities is \$10.2 million USD. UNFPA's calculations do not include unmet need, but are based on "factors such as history and trends of utilization, population adjustments, system absorption capacity" (UNFPA Uganda 2010). A Ministry of Health report from December 2009, "Reproductive Health Commodity Security Strategic Plan: 2010/11-2014/15," gives a figure of \$18.8 million USD for contraceptives for fiscal year 2010/2011. This figure includes the cost to meet unmet need in the country (Uganda Ministry of Health 2009b:17). Official Ugandan government contraceptive procurement tables, which are calculated in consultation of the Ministry of Finance with USAID, UNFPA and other stakeholders, have estimated the costed national contraceptive requirements for year 2011 and 2012 as \$9.98 million USD and \$12.08 million USD (for both the public and private sectors) (Uganda Ministry of Health 2011). The requirements in the public sector are estimated at \$4.77 million USD in 2011 and \$5.97 million in 2012; NGO and social marketing entities are estimated to need \$5.21 million USD in 2011 and \$6.11 million in 2012 (Uganda Ministry of Health 2011).

⁷⁶ Government figures for 2005/2006 are listed as 2006 in this chart, 2006/2007 as 2007, 2007/2008 as 2008, etc.

⁷⁷ The significant increase in the 2010 "Other" allocation was due to DFID's contribution of \$3,631,996 that year.

⁷⁸ Specific citations for the figures in the table are as follows:
USAID, UNFPA, Other donor data (Reproductive Health Supplies Coalition 2012b)
Ugandan government expenditures from: 2006: 2005/06, 2007: 2006/07
(Reproductive Health Supplies Coalition 2012a); 2008: 2007/08 (USAID Deliver Project Task Order 4 2009); 2009 Spent: (USAID Deliver Project Task Order 4

2010); 2010: 2009/2010 Spent: (USAID Deliver Project Task Order 4 2011); 2011: 2010/2011 Spent: Estimate from Interviewee #79

⁷⁹ The Ministry of Health reports that the expenditure of the entire reproductive health budget is also significantly less than budgeted; “the RH expenditure as a proportion of the allocated budget was 62.1% in FY 2005/2006; 74.1% during FY 2006/07; and it declined to 40.4% in FY 2007/2008” (Uganda Ministry of Health 2009c:25).

⁸⁰ Joint Medical Stores (JMS) is an NGO that is licensed by the government to import and distribute drugs and health supplies, but as it does not distribute family planning commodities (other than “natural” methods such as Cycle Beads) because one of the founding partners is the Uganda Catholic Medical Bureau. This means that JMS is not an alternative to NMS as a source for most reproductive health commodities for the public, private, or NGO sector.

⁸¹ The USD figures are as converted from UGX at USD at a rate of 2,000 shillings to the dollar.

⁸² The Ministry of Health gives very different figures, listing the reproductive health expenditure as % of budget in FY 2005/2006= 62.1%; in FY 2006/2007= 74.1%; and in FY 2007/2008= 40.4% (Uganda Ministry of Health 2009b).

⁸³ A direct allocation of UGX 2.4 billion was made to NMS in 2010/2011 for reproductive health commodities. In addition, there was an additional UGX 434 million from a letter of credit for the financial year 2008/09 and UGX 1.4 billion rolled over from financial year 2009/10. The sum of these three is approximately UGX 4.234 billion (\$1.9 million USD) available for NMS to procure reproductive health commodities in 2010/11. This amount does not include the additional amount in the World Bank UGHSSP project, with funding for contraceptive commodities of \$3.33 million USD to be released starting in 2011 and another \$3.33 million USD starting in 2013. An additional \$8.24 million is dedicated to the procurement of additional reproductive health supplies starting in 2011 (including inter-uterine devices, implants, mini laparotomy kits, implant insertion and removal kits and manual vacuum aspiration kits), and another \$7.8 million to be released starting in 2013, for a total of about \$11.6 million in 2011 and \$11.1 in 2013.

⁸⁴ Procurement for UHSSP began in May 2011, and is expected to cover from February 2011- January 2013; this is why entire amount of \$11.6 million was not spent in fiscal year 2010/2011.

⁸⁵ Specific citations for the figures in the table are as follows:
Allocated amounts: 2005/06, 2006/07, 2007/08 (Muwonge et al. 2011:27)
Allocated: 2005/06, 2006/07, 2007/08 Spent: 2005/06, 2006/07, 2007/08
(Reproductive Health Supplies Coalition 2012a), for 2007/2008, gives spent as
\$47,000
2007/08 (July 07-June 08) allocated and spent: (USAID Deliver Project Task Order 4
2009)
2009 allocated: Estimate from Interviewee #79
2009 (1/09-12/09) Spent: (USAID Deliver Project Task Order 4 2010)
2009/10 (07/09-06/10) Allocated (Budget Document FY 09/10 gives UGX 1.5 billion
(approximately USD 652,000) allocated per year to commodities, estimated \$326,000
is for contraceptives), Spent: (USAID Deliver Project Task Order 4 2011)
2010/11 allocated and spent: Estimate from Interviewee #79
In addition, the Ministry of Health reports different figures from NMS for
reproductive health commodity procurement between 2005 and 2007: 2005:
\$339,232.23 USD, 2006: \$202,724.51, and 2007: \$55,456.34 (Uganda Ministry of
Health 2009c:24). I do not use these figures, as they are not listed as corresponding to
a fiscal year and conflict with figures that were validated by more than one source.

⁸⁶ National Medical Stores (NMS) was established in 1993. It performs competitive tendering. Of all of its products, about 93-95% are imported generic products from India (70-80%), China, Kenya, South Africa, Egypt, and Brazil (Jahre, Dumoulin, Greenhalgh, Hudspeth, Limlim, and Spindler 2010:6).

⁸⁷ This comment also brings to light how some members of parliament in Uganda consider themselves as “outside” of government, rather than a part of government. When later asked about this issue in a second interview he said “We’re part of the government, but our role is to push the government, the leadership to do what is right. That is why the people elect us” (Interviewee #5).

⁸⁸ In the eighth Parliament (2006-2011) Uganda Parliament’s Social Services Committee was chaired by Rosemary Seninde and Dr. Chris Baryomunsi, who have worked closely with NGO and IGO advocates on issues of commodity security and funding for reproductive health and primary health care, more generally. The current chair of the committee in the ninth parliament is Lyomoki Samuel (The Parliament of Uganda 2012a).

⁸⁹ The Ministry of Health reports different figures for the 2009/2010 fiscal year than NMS, reporting that the MoFPED released 75.7 billion UGX (this included 47.3 billion UGX for ACTS & ARVS, and 28.4 billion UGX to Vote 116) to NMS ((Ministry of Health Uganda 2010:174). An additional 1.5 billion UGX for reproductive health supplies was also given by donors to NMS to do procurement for RH supplies (Ministry of Health Uganda 2010). The Ministry of Finance reports that

Vote 166 to NMS approved 75.7 billion UGX for 2009/10, and the projected budget for NMS is 205.8 billion UGX in 2010/11 (Uganda Ministry of Finance 2011:245).

⁹⁰ Mid-level administrators who were arrested include Dr. Richard Ndyomugenyi, the program manager, Dr. Myers Lagemwa, deputy manager, and Mr. Martin Shibeki, the program administrator of the Malaria Control Programme at the Ministry of Health for negligence and theft of drugs worth 2 billion UGX (about \$1 million USD) (Mukisa and Bagala 2010).

⁹¹ Until 2009/2010, the pull system worked based on credit lines to NMS. Under the credit line system, there was an account at NMS under which program 9 funds from the Ministry of Health would be channeled once orders were placed by facilities and fulfilled. The credit line system existed between 2000/2001 and 2009/2010 until Vote 116 pooled the funds from credit line system and primary health care non-wage funds originally allocated directly to health centers.

⁹² This plan has unclear financing requirements for commodities, with high annual estimates for the cost of broad line items such as “Context (policies),” “Coordination” and “Commitment.” The line item for “Context (policies)” has an estimated funding need of \$500,000 per year for the first four years of 2010/2011 to 2013/2014 and \$150,000 for 2014/2015, totaling \$2,150,000 over five years. “Coordination” also has a high estimated financing need of \$800,000 for 2010/2011, \$700,000 in 2011/2012, and \$500,000 in 2012/2013 to 2014/2015, totaling \$3,000,000. “Commitment” is similarly costed, with \$500,000 estimated as the need per year for 2010/2011 and 2011/2012, \$400,000 per year for 2012/2013 and 2012/2014, and \$200,000 for 2014/2015, totaling \$2,000,000. However, “demand and utilization” is priced much lower at \$20,000 for the first two years, \$50,000 in year three, and no cost in the final two years of 2013/2014 and 2014/2015 (Uganda Ministry of Health 2009a).

⁹³ The eighth parliament served from 2006-2011. The current parliament is the ninth parliament, serving from 2011-2016 (The Parliament of Uganda 2012b).

⁹⁴ See earlier footnote 43.

⁹⁵ Funding for health at the district level comes from three sources: revenues generated by local governments (taxes), primary health care conditional grants from the central level, and project funding from donors (Muwonge et al. 2011). Districts can receive some funding directly from donors, but it usually constitutes an insignificant portion of their budgets for health; one study found that donor contributions to the health budget in districts ranged from 1.15% in Kamuli to 25% in Wakiso in 2009/10 (Muwonge et al. 2011).

⁹⁶ Reproductive Health Uganda (RHU), Marie Stopes Uganda (MSU), Uganda Private Midwives Association (UPMA), Infectious Disease Institute (IDI), The AIDS

Support Organisation (TASO), Program for Accessible Health, Communication and Education (PACE, formerly PSI Uganda), and Mildmay Uganda were then allowed to access reproductive health commodities directly from NMS if they first secure permission for an order from the Reproductive Health Division at the Ministry of Health.

⁹⁷ The Ugandan health care system of the 1960s was commended as one of the best health care systems in Africa at the time, with “an excellent national referral and teaching hospital, and a hierarchy of government health units and district hospitals, as well as many mission-run facilities.” (Whyte and Birungi 2000:129). Until Amin’s coupe of 1971, health care and medicine were free; this changed between 1971 and 1986. “From 1976 and 1988 numbers of patients in government health units fell by half” (Whyte and Birungi 2000:129-130).

⁹⁸ The 2009/10 and 2010/11 data measure supply of six basic drugs, and the 2004/05-2008/09 data measure supply of five basic tracer drugs.

⁹⁹ 25% of maternal deaths in Uganda are AIDS-related (World Health Organization, UNICEF, UNFPA, and The World Bank 2012).

¹⁰⁰ In late 2009/early 2010, government-ordered drugs from NMS were embossed “Government of Uganda, Not for Sale.” However, drugs that are donated by USAID, UNFPA, and other donors are not marked “not for sale.” Despite this, drugs are still stolen at lower levels and sold in private clinics, even when clearly marked “Government of Uganda, not for sale” (Seruwagi 2011).

¹⁰¹ Case studies have concluded that governance during East Asia’s rapid and poverty-reducing economic growth was mainly through informal relationships (rather than formal rules) and that investors led institutional reform that was often experimental and incremental (Moore and Schmitz 2008). This is the opposite of the current development paradigm which argues that formalized good governance leads to economic growth.

¹⁰² In addition, following Rwandan President Kagame’s reelection in August 2011, all public sector employees were required to take a public oath to uphold the values of the state and not to use their authority in pursuit of personal gain.

¹⁰³ Horizontal accountability is when state institutions such as the judiciary or parliament can check abuses by other public agencies, officials or other branches of government while vertical accountability is when the media, citizens, and other forms of civil society seek to ensure the good performance of public agencies and officials.

¹⁰⁴ This line of research developed from earlier research on developmental states, which documented the processes and policies that led to industrialization and

economic growth in East Asia as far different from the current conceptions of the right policies for development (Amsden 1989; Evans, Rueschemeyer, and Skocpol 1985; Jenkins 1991; Johnson 1982; Kohli 2004; Wade 1990; Waldner 1999).

¹⁰⁵ (Pritchett and Woolcock 2004)

¹⁰⁶ In 2007, I spent approximately three months total in Uganda, from July-August and a separate trip in December; in 2008, I was in the country for most of July through early December; in 2009, I was in Uganda from July through December; in 2010 I was in Uganda from February-March, and again from July through November. In 2011, I was in Kampala in September and October.

¹⁰⁷ To illustrate the tremendous number and sectors of institutions involved in SRHR and population policy in Uganda, 30 separate categories of stakeholders were identified in the National Population Policy Action Plan. These are the Office of the President; Office of the Prime Minister; Parliament of Uganda; National Planning Authority; Ministry of Finance, Planning and Economic Development; National Population Council; Uganda Bureau of Statistics; Ministry of Local Government; District Local Governments; Ministry of Health; Ministry of Agriculture, Animal Industry and Fisheries; Ministry of Education and Sports; Ministry of Water and Environment; Ministry of Energy; Ministry of Lands, Housing and Urban Development; Ministry of Gender, Labour and Social Development; Ministry of Works and Transport; Ministry of Information, Communication and Technology; Ministry of Public Service; Ministry of Internal Affairs; Ministry of Justice and Constitutional Affairs; Institutions of Research and Higher Learning; Uganda AIDS Commission; Office of the First Lady; Cultural Institutions; Faith-Based Institutions; Media Houses, Practitioners and Artistes; Development Partners; Civil Society Organizations (Non-Government Organizations, Community Based Organizations); and Private Sector Companies.

¹⁰⁸ I had originally intended to conduct individual interviews with all participants, but a number of the interviewees suggested that it would be more useful to have group interviews with other staff in their organization, rather than separate, individual interviews.

¹⁰⁹ I did not solicit interviewees' age or social class status. I used other determining factors to make estimates of social class, such as education and occupation. Nationality and tribal affiliation of most participants were determined in consultation with local informants, if they did not come out in natural conversation during the interview. I also determined gender by appearance, dress, and by formal title used in meeting reports; I did not ask if participants identified as women or men or female or male, as it would seem out of context to ask such an obvious question to most Ugandans.

¹¹⁰ Both Popsec and UBoS are under the Ministry of Finance, but during the time of my research, they operated as semi-autonomous and autonomous bodies, respectively.

¹¹¹ As far as collecting relevant printed government reports and documents, I am forever indebted to Ms. Barbara Kyomugisha, Acting Documentalist, in the Information and Communication Department at Population Secretariat. During the course of my stays, and even while I was back in California, she would regularly keep copies of reports and advocacy materials that she thought I would be interested in. I am also grateful to Diana Nambatya Nsubuga, Program Officer at PPD ARO, who in addition to helping me make connections with a number of people I later interviewed, worked tirelessly on a number of occasions to track down policy documents and reports on my behalf.

¹¹² For example, at a wedding reception, a previous interviewee with a powerful position in a ministry introduced me to a number of his colleagues and friends (who were all also men), and after clear introductions to all that I was a researcher, they then proceeded to discuss the particular motivations of President Museveni to stop some drug theft but allow other corruption in ministries to go on to allow his important supporters “to eat”. During this discussion, another of the men hinted that the source of his farm improvements in the village were part of his “meal” from the government coffers, in part due to his friendship with and allegiance to President Museveni.