

# INTEGRATION OF ADULT EDUCATION AND PUBLIC HEALTH POLICY:

## A CASE STUDY IN UGANDA

by

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### ABSTRACT

The purpose of this study was to understand the process of forming an integrated adult education and public health policy in Uganda. This qualitative case study examined how adult education strategies were integrated into Uganda's National Health Strategic Plan. The unit of analysis was the instance of policy formation involving the integration of adult education strategies within Uganda's National Health Strategic Plan. I analyzed documents that elaborated adult education and public health policy positions stated by international and national entities and conducted interviews with eleven participants involved in formation and implementation of the integrated policy. Three research questions guided this study: (1) What interests shaped the integration of adult education approaches within national public health policy, (2) How were the interests negotiated during the policy making process, and (3) What learning did policy makers need to undertake to effect the integration of these policies?

The data analysis employed the constant comparative method of data analysis grounded in perspectives from program planning theory and the advocacy coalition framework. The findings that emerged from the analysis identified multiple interests that

influence public policy formation in Uganda. First, policies for improved health and education within the international and national coalitions are conceptually linked to poverty eradication. Second, constitutional stability, increased human resources, socio-cultural cohesion and control of investments were interests involved in decisions about the policy. Third, shared beliefs that bound the coalitions centered on poverty eradication, community self-reliance, and commitments to development. Fourth, with regard to the second research question on how interests were negotiated, institutional and individual power and positionality were persuasive factors in how core beliefs became policy actions. Finally, policy oriented learning centered on methods of implementation and advocacy. Four conclusions were developed from the findings about the process of integrated adult education and public health policy in Uganda: (1) International forces play a major role in guiding public policy in Uganda, (2) Positionality impacts the extent of one's influence in policy making, (3) Policy negotiation focuses on secondary aspects of the policy rather than core beliefs that bind the policy coalitions, and (4) Learning needs of policy makers center on the means of implementation and resource mobilization. Practical implications and suggestions for further research are also presented.

**INDEX WORDS:** Policy Analysis, Adult Education Policy, Public Health Policy, Integrated Policies, Community Education, Uganda, Africa

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## DEDICATION

This dissertation is dedicated to the loving memories of  
my grandparents, Sara Jane Gamlen and Harry Gamlen,  
my mother, Alice Laura Gamlen, and  
my aunt, Cecelia Gamlen Munro.

I also dedicate this dissertation in honor of  
my dearest aunts, Josephine Gamlen Ross and Elaine Gamlen Foster.

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## CHAPTER 1

### INTRODUCTION TO RESEARCH

#### Background and Rationale

Health is an interaction of several domains, most of which lie outside the health sector (Okunzi & Birungi, 2000). The factors that make communities more susceptible to poor health are not limited to any particular individual predisposition to disease, but include a range of socioeconomic and political barriers to health (Krieger, Northridge, Gruskin, Quinn, Kriebel, Smith, et al., 2003). When interventions address only the biomedical domain without considering the socioeconomic determinants of health, the goal of healthier communities remains elusive (McMichael & Beaglehole, 2000). Integrated economic, social and health policies can mitigate the socioeconomic determinants of health that contribute to disease, illness, and death (Marmot, 2005). Given the increased pressures on communities in the era of globalization, policy for public health needs to be about more than just the disease risk factors (Gostin & Powers, 2006). Strategies for addressing improved community health should include the other socioeconomic influences on health that are outside the health domain. Chief among these socioeconomic influences on community health is the education level of women and its affect on the health of families overall and on young children in particular (Addai, 2000; Marmot, 2005; Pongou, Ezzoti, & Salomon, 2006).

The interaction of health with the social and education domains is echoed in the declaration from the Fifth International Conference on Adult Education (CONFINTEA

V) that specifically recommends to the Member States of the United Nations that they consider integrated social solutions in support of adult education and health (UNESCO, 1997a). More to the point, the proceedings from CONFINTEA V explicitly stated that “literacy and non-formal education programmes can lead to significant improvements in health and general well-being” (UNESCO, p. 3).

One avenue for enhancing the link between literacy and non-formal education with health policy is in the alignment of adult education with public health. This alignment is a natural fit since both public health and adult education are avenues for affecting social change (Daley, 2006; Institute of Medicine, 1988). To appreciate the alignment between these two fields, one can compare the substance of each field. The central core philosophy of public health centers on “community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of epidemiology” (Institute of Medicine, p. 41). The essence of adult education emerges from its definition by Merriam and Caffarella (1999) as “usually a form of social intervention that often begins with a problem to be solved” (p. 75). This definition is parallel with the essential mission of public health, and situates adult education as a social intervention, with knowledge formation as a tool for social change (Merriam & Caffarella, 1999).

Social action models of adult learning are instrumental in understanding how adult learning affects the ability of adults to organize civil society and participate in the social and health policies that affect them directly. Adult learning, for example, leads to behavior change that could affect improved participation in civil society and thereby address the social determinants of health. At individual and community levels, adult

education activities can strengthen competencies in identifying problems, finding solutions and organizing for change. For example, a World Bank (2001) evaluation of the literacy programs in rural Uganda documented how women's participation in a literacy program led to improved decision-making at the household level, better understanding of nutrition and hygiene practices in the household, and ability to follow directions more easily. Clearly, these are outcomes derived through education and adult learning that have a direct influence on the health of women and their children. These advantages afforded by education could be maximized by their integration into national health policies, especially in low resource areas.

Understanding the health profile for vulnerable areas helps to establish the value of adult education in its role to overcome social and educational barriers to health. For example, communicable diseases are the leading cause of illness and death in forty-six African countries (World Health Organization, 1999). As can be seen in Table 1.1, more than half of all deaths in children less than five years of age in Africa are due to a very few communicable diseases: neonatal causes including tetanus, acute respiratory infections, diarrhoeal diseases that result in dehydration, malaria, measles, and HIV/AIDS (United Nations, 2005). One-third of the deaths occur in the first few days of life due to preventable causes (United Nations, 2005).



Table 1.1

*Leading causes of death in children less than 5 years of age in sub-Saharan African countries (United Nations, 2005)*

Cause	Percent of all deaths in children less than 5 years of age
Perinatal and neonatal causes	38%
Acute respiratory infections	23%
Diarrhoeal diseases	20%
Malaria	10%
Measles	4%
HIV/AIDS	4%

Efficacious and cost-effective actions (such as vaccines, treatments and prevention strategies) for preventing and controlling these diseases are available and are well known. In spite of the availability of these interventions, progress towards reducing the burden of these preventable diseases has not been satisfactory (Black, Morris, & Bryce, 2003). Yet the majority of external funding for social and health development in the developing world is allocated to specific biologic responses for disease control (immunization programs, for example), resulting in limited attention and funding for implementation of equally well known community responses that impact health outcomes. Integration of adult education strategies such as maternal literacy, community organization, and social action could greatly contribute to the reduction in transmission of these devastating but preventable diseases and lead to stronger, more resilient communities.

#### Maternal Literacy and Child Health Outcomes

Literacy supports acquisition of skills for decision-making and the critical social interactions that allow women to navigate health care systems and seek care for

themselves and their children (Nigenda, Langer, Kuchaisit, Romero, Rojas, Al-Osimy, et al., 2003). When women are literate, health benefits accrue for their children (Buor, 2003). In fact, a 10% reduction in the rate of maternal illiteracy results in a corresponding 10% reduction in mortality rates for children less than five years of age (Amouzou & Hill, 2002). These benefits are afforded to women and their children regardless of class (Joshi, 1994).

The statistical association between literacy and health was well described by demographers and economists during the 1980s and 1990s (Bicego & Boerma, 1993; Caldwell & McDonald, 1982; Cleland & van Ginnekan, 1988; Hobcraft, 1993). While the extent of the influence of women's literacy on children is debated among these studies, the studies are similar in asserting that a woman who is literate is more likely to access health care for her child in time to do something about the problem. There is agreement that literacy may confer an element of empowerment that influences women's ability to provide adequate care for her children and household. For example, a literate woman can read dosage levels and comply with clinical instructions for treating her child at home (Buor, 2003). She is also more likely to bring her children for preventive care and participate in immunization campaigns, use hygienic practices and comply with disease prevention strategies. In a study by Olaogun, Adebayo, Ayandiran and Olasode (2006), the value of maternal education levels on achieving positive health outcomes for children is illustrated. The authors measured the effect of various socio-economic factors (including education) to find out how well mothers managed fever illnesses in children less than five years of age. Being able to identify a child ill with fever and to bring that child for care is a critical health behavior for the community given the overwhelming

impact that malaria (usually presenting as a high fever in a young child) has on children in African countries. The results of the study found that the likelihood that a mother would seek treatment for her child with fever would increase with her educational level.

In a demonstration of this threshold effect on health afforded by education, Sandiford, Cassel, Montenegro, and Sanchez (1995) found that maternal literacy acquired directly through adult education programs had significant impact on child survival outcomes. The authors compared women in the same socio-economic class who acquired literacy in an adult education program (as opposed to years of formal schooling) with women who did not attend the program. Sandiford et al. (1995) matched literate and illiterate women by age and neighborhood to control for socioeconomic factors. Child survival rates were significantly higher among women who attended the adult literacy classes than those who did not. The implication of this study is that provision of adult education is at least as effective (if not more) than interventions to increase health services.

In another study, Daniels, Kennedy, and Kawachi (2004) assert that “one of the strongest predictors of life expectancy among developing countries is adult literacy, particularly the disparity between male and female adult literacy, which explains much of the variation in health achievement among these countries after accounting for GDP” (p. 71). The authors report that this correspondence between income and health is most definite in the lower social gradients in a society. But the research indicates that addressing literacy and adult learning in communities at the lower ends of a country’s social gradient have definite protective influences on the health of children and adults in that community.

## The Public Health Policy Context in Uganda

Uganda is a unique example of an African country that has endeavored to include adult education strategies in their public health policy so that children benefit. Uganda is a country in the highlands of central Africa, bordered on the east by Kenya, on the west by the Democratic Republic of Congo, and to the south, Rwanda and Tanzania. In 2008, the population was approximately 31 million, with females accounting for about 51% of the population (Uganda Bureau of Statistics, 2008). Nearly half the population is under age 15. In a recent report by the Uganda Ministry of Education and Sports (2005), overall national literacy rates were reported as 76% for males and 61% for females, although when the national data is disaggregated, the gap in rural areas is much wider than this national rate. Additionally, eighty percent of the workforce is involved in agriculture with the majority of activities taking place on small farms (World Bank, 2001).

In Uganda, children are a significant proportion of the population with children less than five years of age making up 20% of the population (Ministry of Health, 2002). This group, however, is particularly vulnerable as indicated by their high rates of infant mortality (80 deaths per 1,000 live births), children less than five years of age mortality (138 deaths per 1,000 live births) and maternal mortality rates (506 deaths per 100,000 live births).

During 2005, Uganda developed its second Health Sector Strategic Plan (HSSP II) (Ministry of Health, Uganda, 2005), a 5-year plan extending from 2005/06 to 2009/10 under the aegis of the National Health Policy (Ministry of Health, Uganda, 2003). In the formation of the HSSP II, the policy context was such that policies were aligned across

sectors in order to affect the socioeconomic and health status of the rural areas. The national HSSP II (Ministry of Health, 2005) defines the social and health problems at village levels as significant for affecting the health and economic status of women. The policy states that:

Evidence on the link between gender (the socio-economic aspects of being male or female) and poverty and its relevance to health status and access to health care, calls for adoption of a gender mainstreaming strategy to address the gender issues in the [health] sector (p. 1).

HSSP II asserts two critical goals for addressing determinants of health afforded by increasing women's civic participation. One assertion calls for more equitable access to health; the other calls for improved empowerment of individuals and communities for promotion of health. There is a special focus on women because of their influence on the health of children. The strategic goal is to promote health and to strengthen community level health education through local village health teams (VHTs). Because women are the main caregivers of children, women are the principal focus of the activity (Ministry of Health, 2005). Success in reaching the goal will be monitored through a series of measurements of very specific disease reduction indicators.

Applying adult education strategies in service to achievement of health outcomes for children, HSSP II seeks to influence social determinants of health. By linking education and health, there is increased opportunity for women to gain skills for decision-making, learn new norms and behaviors, acquire new or different perspectives on managing family life, improve communication skills for participating in the public sphere, and adopt critical disease prevention knowledge. These skills are pathways to

better health outcomes for children at risk for communicable diseases in vulnerable communities. It was anticipated that the outcomes of this policy will mitigate the socioeconomic determinants of health and result in healthier families and communities.

Even though it is understood that individuals do not operate outside of their socioeconomic or historic contexts, efforts to mitigate the risks to their health need to be about more than the interaction between host and disease agent. Public health leaders recognize that the measurement of a community's health is more than its epidemiologic profile (Gordis, 2000). On the other hand, disease-specific interventions are implemented through parallel system resulting in fragmented approaches and missed opportunities for resource efficiencies (Okunzi & Birungi, 2000). Merriam, Courtenay, and Cervero (2006) point out that implicit in public policy formation are the "priorities of a society, which in turn determines distribution of resources" (p. 492). Thus, the process of policy formation is a process involving multiple actors with multiple interests in decisions about how a society will allocate scarce resources. The process of policy formation is closely allied with program planning for adult education so that program planning theory has relevance for understanding the policy formation process. Cervero and Wilson (2006) in particular offer a theory of educational program planning that is grounded in a critical perspective which allows for an examination of the role of structural power and competing interests. The researcher can look not only at whose interests are being served, but also what those interests are. Given how power relations emerge in interactions between major international agencies and national governments in the development of global health policy, critical theory provides a relevant perspective for framing research into how integrated social and health policies are formed. The

philosophical underpinning of critical theory is a desire to define a more just and equitable world. Thus critical theory is about “research that seeks to bring about change” (Merriam & Caffarella, 1999, p. 341).

Models of international health policy formation must account for the relationship between national governments and powerful international forces with recognition that nations are not always sovereign in addressing their own policy agendas (Okunzi, 2004a; Walt, 1994). This is true especially in developing countries that must rely on external sources of budget support to fund internal policies. In the same way that a researcher can examine the influence of politics, interests, values and beliefs in program planning for adult education, a researcher looking at policy formation processes may seek to understand what influences affect health policy formation in the international sphere comprised of multiple actors and forces.

In the case of African countries, external actors have a powerful influence over national priorities and capacities (Okunzi, 2004a). These are actors such as the United Nations and its agencies such as World Health Organization, UNICEF, UNESCO, the World Bank and the International Monetary Fund. Bilateral donors such as the United States, the European Union, and others also assert influence in how aid dollars are distributed (Hill, 2004). The pronouncements of large international meetings (such as the UN Millennium Project) also influence the policy-setting agenda in African countries. In the specific case of Uganda, for example, the government encourages health development partners to directly support the national budget, but the external partners prefer to fund discrete projects resulting in fragmented approaches.

Because Uganda has attempted to absorb into its policy formation process the research about the positive influence of women's education on the health of children, an analysis of the policy formation process should provide important insights into how the policy was developed and adopted. These insights could inform similar processes in other countries in the African region and help reveal the strategies for integrating adult education approaches and biologic interventions.

### Problem Statement

Health is influenced by the interactions between the social, cultural, material and environmental domains, all of which are outside the health sector. Adult education connects these domains through activities that result in learning and social change. This connection is evident in the link between adult education especially for women and disease prevention in young children. Research shows that infant mortality rates decrease among children of women who have attended adult education programs (Sandiford, Cassel, Montenegro, & Sanchez, 1995). This relationship has been shown to be at least as effective as increasing access to health care for preventing deaths in children. When women are literate, health benefits accrue for their children (Buor, 2003).

Communicable diseases are the leading cause of illness and death for children in African countries (WHO, 1999). In spite of the availability of effective, affordable, biomedical interventions for responding to these diseases, child mortality rates for sub-Saharan Africa continue to be the highest in the world. Clearly, biomedical interventions alone are not sufficient for making a difference in children's health in African communities. Since national health policy formation is a process for deciding how to prioritize and allocate scarce resources, integration of adult education into public health



policy can increase the potential for adult education to contribute to the mitigation of the social determinants of health and affect the well-being of African communities.

Understanding how policy formation takes place, what external and internal forces are brought to the table, and where opportunities exist to align adult education and public health policies can provide insights for policy makers and funding partners who are looking for successful combinations of interventions that can improve child health outcomes. Critical theory provides a framework for challenging whether national health policy making is a rational process aimed at achieving the greater good. In fact, the policy making context is one that involves multiple actors with multiple interests and positions of power and influence that impact how national health policy is formed and resources allocated. Given these multiple actors and influence on national policy formation affecting the lives and health of communities, application of adult education program planning theory that emphasizes ethical decision making grounded in a significant commitment to democratic processes is relevant to understanding policy formation.

The national health policy of the Republic of Uganda is a unique example in Africa of a country that sought to integrate adult education within its national health policy with the explicit purpose of improving women's skills for influencing family and community health. While numerous studies presenting evidence that adult education has a positive relationship on improved child health outcomes in the developing world (Bicego & Boerma, 1993; Farmer, 2003; Sandiford, Cassel, Montenegro, & Sanchez, 1995; World Bank, 2006), few studies identify how adult education is integrated with national public health policies. This is reiterated by Buor (2003) who states that the next

step in linking these results to their policy implications has not been achieved. Uganda's experience provides a unique opportunity for understanding the policy making process that can link adult education with policies to improve the life chances of children in vulnerable areas.

### Purpose Statement

The purpose of this study is to understand how the process of policy formation in Uganda resulted in integration of adult education strategies into the national health policy. To achieve this purpose, this research will focus on the following questions:

1. What interests shaped the integration of adult education approaches within national public health policies?
2. How did the policy makers negotiate their interests during national policy making?
3. What learning did policy makers need to undertake to effect the integration of these policies?

### Significance of the Study

This study is significant because it provides insights for policy makers and funding partners who are interested in identifying novel combinations of interventions that will more effectively improve child health outcomes. Presently, international and local resources for implementing public health interventions in the developing world focus principally on biologic interventions (for example, immunization campaigns, laboratory screening tests, antimicrobial treatments, and so on). Relying solely on biologic interventions is not adequate for meeting community development goals. Without considering an integrated policy framework that addresses the broader

determinants of health, there is reason to doubt that we will see success in meeting the desired goal of reducing illness and death in low resource areas, especially for children less than five years of age. By investigating the case of Uganda in its experience with integration of adult education strategies with public health policy, this study contributes to the theoretical literature that describes the complex influences on health policy formation and methodologies for examining them.

This study also contributes to the adult education literature in its demonstration of practical steps for connecting the respective determinants with adult education strategies. The linkages between adult education and child health outcomes, for example, are clearly evident in Table 1.2 on the following page describing the benefits of adult education strategies and adult learning possible for ensuring the impact of public health interventions.

Table 1.2

*Public health interventions and benefits of adult learning*

Public health intervention	Examples of how skills accrued through adult education approaches influence interventions
Create demand for and/or participate in immunization services	Leadership Communication Organizational knowledge Reduction of fatalism
Use insecticide treated bed nets	Understanding disease transmission Self-efficacy Following instructions
Access to safe water supplies	Organization Connection between information and action Problem solving Community organization
Compliance with drug treatments	Reading and listening Following complex instructions Understanding benefits of treatment
Knowledge of safer sexual practices	Reduction of fatalism Self-efficacy Negotiation Autonomy
Prompt access to care or improved seeking of care	Understanding of disease transmission Confidence in navigating complex or official system
Improved household practices that are preventive	Improved hygiene, nutrition, and participation in community action Access to information Improved participation rates for children attending school

Often, disease-specific interventions are implemented through parallel system resulting in fragmented approaches and missed opportunities for resource efficiencies (Okunzi & Birungi, 2000). Clearly the goal to improve child health outcomes in Africa requires more integrated, comprehensive strategies that maximize resources across sectors to provide relief to the communities affected by these largely preventable diseases. By making explicit the linkage between adult education and child health

outcomes, policy makers have the opportunity to more effectively and efficiently consider policies that feature adult education in its role as a remedy for mitigating the social determinants of health. This study provides that explicit direction towards understanding how an integrated policy framework can be defined. It provides evidence regarding whose interests are being negotiated and whose influence is placing – or keeping – the topic from the policy agenda. The results of the study are available for other countries to analyze their policy formation networks and seek to affect change that will result in better integration of resources in service to the health and well-being of African communities.

## CHAPTER 2

### REVIEW OF THE LITERATURE

#### Introduction

The purpose of this study is to understand how the process of policy formation in Uganda resulted in integration of adult education strategies into the national health policy. The research questions guiding this study are: (1) What interests shaped the integration of adult education approaches within national public health policies, (2) How did the policy makers negotiate their interests during national policy making, and (3) What learning did policy makers need to undertake to effect the integration of these policies?

This chapter will review the literature in four areas: (1) lifelong learning and international adult education, (2) public policy formation with an emphasis on international health policy formation, (3) critical theory, and (4) program planning and development. I conclude the chapter with a discussion of the policy context in Uganda. To develop this review, I searched the PubMed data base using the following key words: literacy, health education, adult education, health and education policy, Uganda, mothers, female literacy, maternal behavior, developing countries, and child health. The search was limited to articles since 1980. Selected articles were restricted to those that addressed maternal literacy as a component of public health policy and interventions in developing countries especially in Africa.

### *Definitions*

In this review, the term “maternal literacy” is based on the UNESCO definition of literacy (UNESCO, 2005), “the ability of [the mother] to read and write a sentence [that] she understands in the context of her own life.” “Maternal education” refers to women’s attendance in formal schooling, usually years of primary school enrollment. “Child health outcomes” is a term that relates to mortality indicators for deaths due to the major causes of childhood death in Africa: malaria, measles, acute respiratory infections, diarrhoeal diseases with dehydration, and malnutrition. “Infant mortality rate” addresses deaths due to largely preventable causes during the time period from birth to age 12 months. “Children less than 5 years of age” is usually the period from 12 months up through to 5 years of age, although the term can also be inclusive of infant mortality rates.

I will use the term “adult education” as defined by Merriam and Caffarella (1999) when they wrote that adult education is a “social intervention that often begins with a problem to be solved” (p. 75). Youngman (2000), in his writing about adult education and economic development, echoes this understanding when he describes adult education as social policy used by organizations to deliver interventions. Adult education, writes Youngman, is a “product of deliberate action by organizations to influence society” (p. 51). The learning activities associated with this view of adult education are typically delivered through non-formal education. These are education activities delivered outside the formal education system, and which may include activities such as adult literacy, health education, health promotion, community organization, and income generation (Merriam & Caffarella, 1999).

## Lifelong Learning and International Adult Education

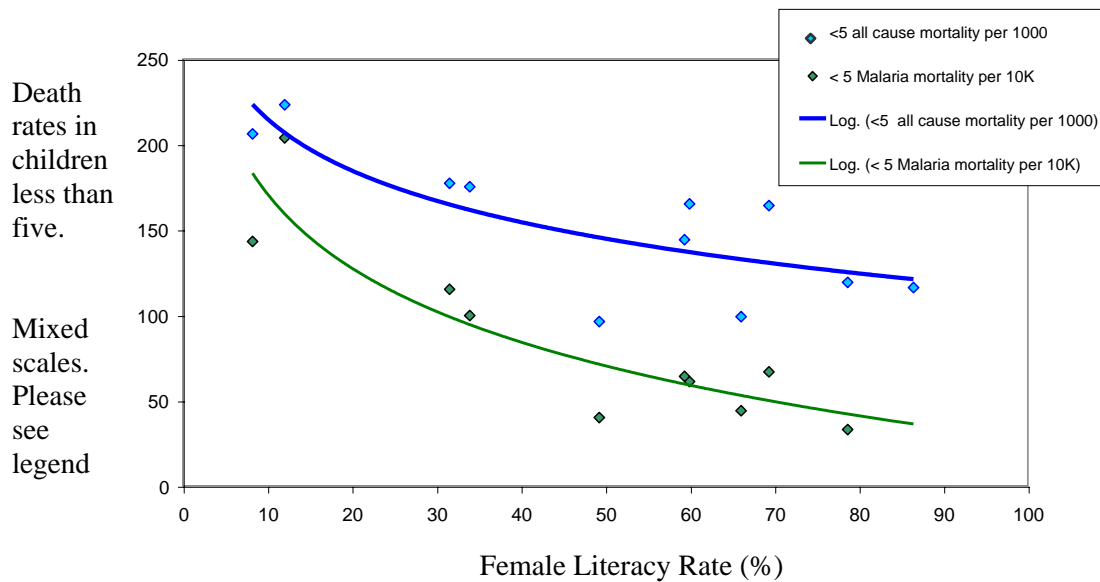
In its discussion of lifelong learning, UNESCO (1997b) emphasizes the mitigating relationship between education and health for addressing the impact of poverty and low education levels on health outcomes. Within the broad context of lifelong learning, adult education takes into account adult experiences and their daily life needs. Alignment of health promotion and adult education approaches is recommended because both domains see education as a force for social change in contributing to healthy communities (Daley, 2006). We can compare the mission of public health with the essence of adult education to see that the conceptual congruence is strong. According to the Institute of Medicine (1988), the mission of public health is “the fulfillment of society’s interest in assuring the conditions in which people can be healthy” (p. 40). These “conditions” can easily be regarded as the social determinants of health. The substance of public health centers on “community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of epidemiology” (Institute of Medicine, p. 41). The parallel mission and substance of adult education is evident in the definition of adult education by Merriam and Caffarella (1999) as “usually a form of social intervention that often begins with a problem to be solved” (p. 75). What makes adult education different from other types of education is its role in supporting adults to meet perceived needs for improved circumstances and increase access to control of the social influences on their own lives. Success of social policies eventually depends upon the individuals at the local level rather than the achievement of economically driven, top-down targets and goals (Archer, 2005). Thus, health education should be more than receiving knowledge about health; it should



include acquisition of knowledge and skills that can be applied towards action to improve one's own health and that of one's family (UNESCO, 1997b).

The positive impact of maternal literacy on child mortality has been well-described (Bicego & Boerma, 1993; Caldwell & McDonald, 1982; Cleland & van Ginnekan, 1988). When women are literate, health benefits accrue for their children (Buor, 2003). Thus it is not difficult to appreciate the Hamburg Declaration's privileging of adult education in the service of health when empirical evidence suggests that significant reductions in mortality rates for children less than five years of age could be realized through increases in maternal literacy rates (Amouzou & Hill, 2002; Buor, 2003).

To further illustrate the relationship between literacy and health outcomes, I compared the overall death rates and the specific death rates due to malaria in children less than five years of age with the reported national literacy rate for women in ten countries. The ten countries were chosen because they are project sites in my work on at CDC. The countries are Burkina Faso, Cameroon, Ethiopia, Ghana, Kenya, Mali, Mozambique, Sudan, Tanzania, Uganda and Zimbabwe. The line graph on the next page illustrates the increase in women's rates of literacy (as shown on the bottom axis) and the decrease in rates (overall mortality and specific mortality due to malaria of death in children under 5 years of age (as shown on the left axis).



*Figure 2.1:* Relationship between female literacy and child health outcomes in selected African countries

The findings of Sandiford, Cassel, Montenegro, and Sanchez (1995) continue the evidence for supporting the linkage between adult education and health. Their study showed that women's participation in adult education programs had significant impact on child survival outcomes, with the implication that provision of adult education is at least as (if not more) effective than interventions to increase the access to health services. One logical application of this kind of empirical finding is to adopt non-formal adult education strategies that integrate health, literacy and social development interventions at local levels (Buor, 2003).

The model of lifelong learning provides adult educators with a framework for understanding the opportunities afforded generally by adult learning theory and specifically by learning styles of women and the community context. UNESCO (1997a) defines lifelong education as learning that takes place in multiple environments throughout one's lifetime. This lifelong process occurs throughout life and engages

adults' internal learning strategies, consideration of alternatives, formation of lessons learned and adoption of a position of action (Marsick & Watkins, 2001). Examining lifelong learning foregrounds how knowledge, skills and attitudes are the infrastructure whereby adults make meaning and take control of their lives (UNESCO, 1997a). Adult education as articulated in the Hamburg Declaration is a part of lifelong learning (UNESCO) and is linked to adult development (Fenwick, 2000).

As a consequence of this link with adult development, adult learning theory underpins our understanding of the opportunities afforded by adult education for addressing health communities in developing countries. Insight into the opportunity for lifelong learning to impact health is embedded in theoretical stances such as Mezirow's theory of perspective transformation (1978) and Freire's social transformation model (1995). Both illustrate how adult learning results in deep changes in values, attitudes, beliefs and actions (Magro, 2001). In the case of Mezirow's theory of perspective transformation, learning is seen as a profound critical awareness of how our assumptions limit our understanding about our role in the world and how we act in it (Mezirow, 1978). An ultimate goal of this perspective is emancipatory learning that leads learners to take action in decisions on their own behalf and in the service of their own interests (Mezirow, 1978).

Freire's model (1995) is closely allied with emancipatory learning, although Freire's view is different from Mezirow's. For Freire, learning is linked to social change rather than perspective transformation. Freire's work asks a critical question on behalf of less powerful populations about who owns knowledge and who is its intended recipient (Merriam & Caffarella, 1999). In Freire's approach, acquisition of literacy is centered on

content generated by the learners themselves. The acquisition of literacy becomes the vehicle whereby learners examine their own social context and expand their awareness about the structural factors that constrict their rights to access for social services and civic engagement. Thus the content of a health education program grounded in social action has the opportunity to encompass more than just delivery of health information; it can also serve to enhance skills for civic participation and decision making towards the social determinants that affect an individual's and community's health.

In considering how adult education functions within a community setting to change child health outcomes, it is prudent to mention how adult education is engaged with women since women are the principal caregivers for children in traditional societies. Adult education provides insight into views about women's approaches to learning and their connection to their communities. This insight is pertinent given the desire to identify how adult education and public health policies can be integrated in a way that maximizes the empirical evidence linking women's literacy with child health outcomes (Sandiford, et al., 1995). For example, in a study by Belenky, Clinchy, Goldberger, and Tarule (1986), women's learning was characterized as "connected knowing" (p. 35). They found that women's definitions of their world are created through primacy of relationship networks (Hayes, 2001). Knowledge acquisition takes place through these connections and is the preferred learning styles for women in "embracing new ideas and seeking to understand different points of view" (Hayes, p. 37). A limitation in applying the findings of this study to the context of women in African communities is that the participants in the study were mainly college-educated North American women. However, the findings do have relevance in illuminating for the researcher the

importance of considering already existing non-formal networks in traditional African societies (Nafukho, Amutabi, & Otunga, 2005).

Women who take part in adult education programs in African communities are concerned with their feeling of exclusion from the business of their communities because they cannot read directions or follow instructions (World Bank, 2001). Thus the tools of adult education are pathways for social change in these situations. For example, women who participated in a non-formal literacy program in Uganda reported that as a result of the acquisition of skills through the adult education program, they no longer felt embarrassed or cheated in the market place because they could understand and participate in the transactions (World Bank, 2001). They also reported an increased perception of their role as a respected citizen which they attributed to their participation in a non-formal literacy program (World Bank, 2001). This finding underscores that adult education is about more than the dissemination of skills or knowledge to a marginal population; adult education results in shifts in women's understanding and confidence in her own abilities to make decisions and navigate her socio-political landscape (Hayes, 2001).

#### *The role of non-formal education in international adult education*

UNESCO defines adult learning as taking place in formal, informal and non-formal settings (UNESCO, 1997a). Formal education is linked with educational institutions and is often a credential-based program. It is a chronological, structured system that begins with childhood and extends into adulthood with structured organization (Infed definition retrieved from <http://www.infed.org/biblio/colonialism.htm> on September 1, 2006). Informal learning is any learning that takes place outside of

formal institutions and is most closely associated with the learning adults experience everyday life (Marsick & Watkins, 2001).

Non-formal learning is a specific educational program or activity that is delivered outside of the formal education system (Infed definition retrieved from <http://www.infed.org/biblio/colonialism.htm> on September 1, 2006). In fact, the proceedings from Fifth International Conference on Adult Education (CONFINTEA V) explicitly stated that “literacy and non-formal education programmes can lead to significant improvements in health and general well being” (UNESCO, 1997b, p.3). Non-formal education is central to discussions of adult education in developing countries because of limited resources for meeting universal schooling. Governments and organizations employ non-formal education as a mechanism for basic education, literacy classes, and work education that can reach populations unable to access formal education either because of weak infrastructure (for example, lack of passable roads) or marginalization due to ethnic, gender or class constructions (Youngman, 2000). Non-formal education targets a particular audience segment and seeks to achieve particular learning outcomes (Infed, no date). Non-formal community education programs are aligned with movements to increase and foster democratic participation in the life of the community. In this discussion, *community* is a dynamic context wherein people interact, define themselves and their others, and interpret what is possible as an individual and as a collective goal (Youngman, 2000). Thus, the role of adult education in a community setting is a critical one which can contribute to an environment that will empower learners to be critically reflective about the forces and issues at work in their lives (Merriam & Caffarella, 1999). When this type of reflective, non-formal learning is

community focused, it becomes a venue for social learning that results in improvements in the quality of people's lives (Merriam & Caffarella).

Yet many social programs are influenced by external educational and health philosophies (driven by market forces, for example) that privilege the individual over the collective (Youngman, 2005). The assumption in the external ideologies from Western states is that it is up to the individual to overcome hardships, take responsibility for her own learning and health, and pursue an income that will not make her dependent on others (Nafukho, Amutabi, & Otunga, 2006). This focus on the individual is in contrast with some traditional cultures where individual success comes with an obligation to the community.

There is sufficient historical precedence for building on the tradition of non-formal education in African village communities. The tradition of non-formal education involves the transfer of cultural and historic knowledge and beliefs that form the community's identity. This outcome is realized through story telling, passing of proverbs, songs and animated dances with masks that serve to pass down information, values, beliefs and rules about how a particular society operates (Nafukho, et al., 2006). Thus the notion of non-formal education is not foreign to African village life (Nafukho et al., 2006). Adult education can be the impetus for critical examination of the current situation and thereby help to define a more equitable, relevant way forward.

People have experiences that they bring to the learning situation, and learning how to unveil one's assumptions to find underlying truths about one's situation and then taking action to do something about it is fundamental to creation of a rights-based society (UNESCO, 1997b). What matters in the intersection between international adult

education and public health is how adult education can contribute to enhanced skills and understanding for improving individual and community life chances with the resources that people have.

### Public Policy Formation

Public policy is that category of policymaking that affects more people than if the policy emerged from a private entity (Birkland, 2005). In public policy formation, government is the central actor with the political authority to take action. The public policy formation process is the way in which problems are conceived and placed on the government's agenda for solutions (Sabatier, 1993). Merriam, Courteny and Cervero (2006) state that implicit in public policy are the "priorities of a society, which in turn determines distribution of resources" (p. 492). In fact, it is during that policy formation process that decisions are made about societal problems, their causes and the ways the parties involved in the process want to solve them (Birkland, 2005). As the policy is formed, interests and conflicts are negotiated and resources are allocated (Institute of Medicine, 1988). The decision-making surrounding policy formation is in service to the public (and thus, to real people) and, consequently, adherence to an ethical platform is essential (Gostin & Powers, 2006).

Any policy formation model based on rational problem-solving assumes that problems can be isolated out of context (Walt, 1994). But Sabatier and Jenkins-Smith (1999) characterize policy formation as a complex process with multiple actors, taking place over a very long time span, with multiple levels of government engaged in disputes over technical issues, values and beliefs. All actors are armed in the process with evidence they will present, but which may be presented selectively and serve to distort



meaning and positions (Sabatier & Jenkins-Smith, 1999). Actors in the policy formation process are likely to intentionally misrepresent a position or an opponent to achieve one's own interests. Additionally, policymakers involved in making social policy may not adequately understand implications of health disparities to access for education and social services (USAID, 2006).

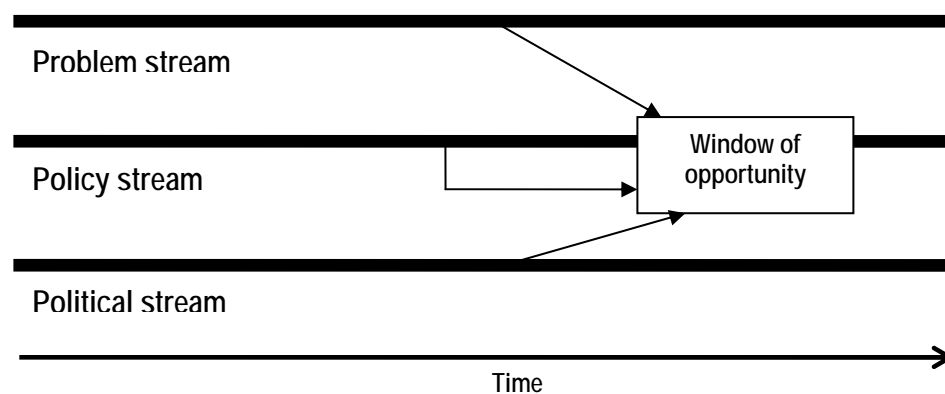
### *Policy formation models*

Early classical models of policy formation described a technical process involving a stages or systems theory approach. The stages approach was dominant during the 1970s and 1980s. It presented policy making as a series of stages consisting of a disaggregated set of complex, interwoven steps (such as agenda setting, implementation, and so forth) (Sabatier, 1993). Earlier, during the 1960s and 1970s, systems theory influenced policy models by describing an input-output dynamic between the environment and the political system (Sabatier, 1999). The underlying concept in the systems theory approach touched on how the environment influences the political system which, in turn, produces policies implemented within the environment (Sabatier). Sabatier describes a complex model by Hofferbert as illustrative of this systems theory application. The Hofferbert model can be graphically represented as a cone lying on its side to illustrate the flow and sequence of multiple incidents and factors and their effect on policy formation. The multiple incidents are spread throughout and across the base of the cone and then “funnel” into the narrow end that represents the point of conversion for the incidents and factors into a formal policy and outputs (Sabatier, 1993). The factors extend across a temporal range and include historic conditions, socioeconomic factors,

mass political behavior, governmental institutions, behavior of the elite all mitigated by politically relevant incidents (Sabatier).

Sabatier (1999) regards this and other systems-design models as limited because they only reflect the external conditions; they do not account for the role and motivations of multiple organizations and individuals involved in these processes. These models do not describe the scope of conflict inherent in the policy process, nor do they address the reality of knowing whose interests are being served during the process (Sabatier).

In more contemporary times, says Birkland (2005), attention has focused on three models of policy formation: the multiple streams model, punctuated equilibrium, and the advocacy coalition framework. The multiple streams model was developed by Kingdon (Birkland, 2005) to suggest the dynamic concurrent influences of multiple domains on the policy process. This model posits that the opportunity for policy change increases when the political, policy and the problem streams converge to create a “window” of opportunity (Birkland, p.226) as illustrated in the following graphic taken from Figure 9.5 in Birkland (p. 226).



In this model, politics includes public opinion and the political atmosphere; policy is the emergence of possible solutions, and the problem stream conveys the attributes of the issue of concern. Birkland (2005) explained Kingdon’s view of these streams as

flowing in parallel but also evolving independently within a particular policy domain. The threshold is marked by a focusing event, such as a perceptual change in the public's understanding of the problem or a change in the political philosophy. This change causes two or more of the streams to unite and create a moment (the window of opportunity) where there is a possibility for policy change. Sabatier (1993) believes that the multiple streams model is effective for describing the moment of "the decision" but the multiple streams model does not account for what happens after the window is opened. The value of the multiple streams model, however, is that it allows researchers to follow any one of the "streams" independent of the other (Walt, 1994). It is important to note that there are not linear, sequential stages or steps to policy formation; rather, there are positions, solutions, and problems that have existed for some time. Any one of the streams can be investigated in order to understand the policy agenda (Walt).

The second model in current literature is punctuated equilibrium. Birkland (2005) attributes this model to Baumgartner and Jones (1993) who wanted to account for the intersection of policy making and political instability. They borrowed from theories of natural selection in biology which suggest long periods of stability interrupted by sudden changes and corresponding shifts in organisms (Birkland). According to Birkland, in the case of policy formation, the long period of equilibrium is punctuated with sudden shifts in public understanding and attention to an issue. There may be a shift, for example, in the balance between political power and advocacy groups. What is different from Sabatier's notion of the stable series of events is that the long period of equilibrium in punctuated equilibrium is a function of a "policy monopoly" which is a closed system of important policy actors that ultimately benefits those in the closed group (Birkland,

p.228). The period of equilibrium is broken with the occurrence of some focusing event (increased media attention focused on a particular issue, for example) that destabilizes the political domain (Sabatier & Jenkins-Smith, 1999). The dynamics emerging from the focusing event begin to break down the monopoly, and the ensuing critical attention leads to conditions that result in policy change. This period of change is followed by restoration of a long period of equilibrium.

The third model is the Advocacy Coalition Framework model (ACF) proposed by Sabatier (1999). ACF expands the streams metaphor and shifts focus to the agents or coalitions involved in the policy process. Like the Kingdon model, the ACF posits policy formation as taking place over a long period of time, but locates the unit of analysis as the policy subsystem (Weible, 2006). Policy change in the ACF model requires stable systems and a stable progression of events. The policy subsystem is comprised of all the actors involved in the policy formation including officials from all levels of government, advocacy and special interest groups, the media, various community and professional organizations, and so on (Weible, 2006). At some point, interest groups organize themselves around their beliefs and values and form groups or coalitions. Their beliefs are seen in the ACF as hierarchal beginning with deep core values, policy values, and secondary beliefs that direct how implementation of the policy will take place (Sabatier & Jenkins-Smith, 1999). The deep core beliefs serve to bind the coalitions making any possibility of change to those deep core values very low. Negotiation takes place within the definition of the policy and the secondary beliefs about how the policy might be implemented. The ACF designates “policy learning” as the expression of behavior change that comes about amongst the coalitions as a result of intense competition

between coalitions about the shaping of the eventual policy (Sabatier & Jenkins-Smith, 1999). These coalitions debate the issue. The product of this debate is the problem definition and policy solutions. The positions are resolved through what Sabatier (1993) calls “policy brokers” who enter the deliberations and develop compromises (p. 122). Sabatier suggests that his model opens the “window of opportunity” in Kingdon’s model so that the mechanisms for implementation are revealed. The Advocacy Coalition Framework (ACF) has not been applied in many developing world settings resulting in very limited research making use of the ACF in this area. One study applies the ACF in China to telecommunications policy (unknown author, retrieved November 18, 2008 from <http://www.pinggu.org/bbs/b53i218981.html>). More recently, Munira and Fritzen (2007) included the ACF in a composite of frameworks to analyze and understand how developing country governments adopt vaccine program. The value of the ACF to these studies appears to focus on mapping the actors in the policy making process.

#### *Theories of change in policy formation*

Of course, policies are not effective if they are not implemented. Weiss (1998) presents a perspective based on theories of change that is useful in understanding the potential for successful implementation of a public policy. The theories of change surrounding policy formation are the assumptions and beliefs which underpin the goals or hypothesis of the intended intervention (Weiss, 1998). As such, the theories of change link the intervention’s program inputs and activities to its intended outcomes (Weiss). Because programs are complex and involve more than their stated technical objectives, understanding the underlying theories of change is important for accessing the causal links between the social policy intervention and the ensuing program objectives and

activities. As presented by Weiss (1998), the theories of change can account for the program's resources, activities, outcomes and goals. In short, extracting the theories of change clarifies not only *what* will be done but also *how* the goals will be achieved. The theories of change provide a practical justification for the program's hypotheses.

Weiss (1998) points to two major components that make up a program's theories of change: the program theory (the program and its goals) and the implementation theory (the manner of its implementation and any consequences). The program theory describes what the program will do and how people targeted by the social program will respond to the program activities. The implementation theory is the description about how the objectives are translated into activities and how the service delivery affects the policy outcomes (Weiss). Embedded within these two theories are contingency theories that explain the consequences and unintended effects of the program if the program is not carried out as it was planned. Discerning the theories of change provides the analyst with a pathway for evaluating not only whether the policy worked, but what factors were responsible for its success or failure.

#### *International health policy formation*

Models of international health policy formation must account for the relationship between national governments and powerful international forces (Okunzi, 2004b; Walt, 1994). Similar to educational planning, policy formation in the international setting is not devoid of the influence of politics, interests, strongly held values, and desires for extension of belief systems. In the international sphere, nation-states are not always sovereign in addressing their own policy agendas (Okunzi). Assuming that health policy formation focuses only on the technical aspects and takes place in a rational arena

will not let us account for how privileged groups assert power over the concerns and interest of communities that the policies aim to serve (Jeppsson, Birungi, Ostergren, & Hagstrom, 2004). In the case of African countries, problems are almost always often identified by powerful actors outside of the national priorities and capacities (Okuonzi, 2004). Strong pressure is asserted during policy formation by external donors and partners such as the World Bank, the International Monetary Fund, the World Health Organization, bilateral government partners (including the United States, the European Union, and other major Western and Asian governments), various United Nations agencies, and multinational corporations (Kickbusch & Leeuw, 1999; Walt, 1994). Global health policy is decided each year when country representatives meet in Geneva at the World Health Assembly (Gostin & Powers, 2006). Resourced countries want to promote their interests so that their views and economic interests are placed on the agenda. Positions are presented, discussed and adopted. Adoption is a virtual mandate for inclusion in a Ministry of Health's ensuing 2-, 5-, or 10-year plan. In this way, the priorities of the ministry become those of the donors with the conferring authority of a World Health Assembly proclamation (Kickbusch & Leeuw, 1999).

Another external influence on the direction of national health policies in developing countries is the pronouncements of large, international meetings that state dramatic agendas for change. Some analysts see these global pronouncements as meeting the interests of the rich countries rather than local interests (Rist, 1997; Youngman, 2000). The global adoption of these agendas confers on them the blessing of international consensus and so Ministries of Health and other Ministries charged with social action take on the goals, for example, from Dakar Education for All, the United Nations

Millennium Development Goals, polio eradication, and so on (Seya, 2005). Structural pressures on struggling national health budgets affect whether a country can even meet its routine and global health needs (Walt, 1994). For example, the International Monetary Fund (IMF) requires countries to keep inflation low and cut public funding of services (Archer, 2005). Structural relationships within the low resource country also impact policy formation.

While the state is the authoritative entity that controls resources and compliance with policies, multiple complex factors including wars, civil strife, ruling class desires for longevity, ethnic rivalries, and changes in leadership influence how authoritative control is asserted or defined (Walt, 1994). These factors significantly influence the policy environment and what policies are enacted and for whom. A risk to health may remain silent because more powerful interests want to apply resources to alternate needs. Decisions for accepting inappropriate or lower priority aid will be made for reasons that are not necessarily the highest health priority of the country because the lower priority aid package is likely to include opportunities for hiring personnel, providing vehicles and fuel, and paying of per diems (Gostin & Powers, 2006; Walt, 1994).

The domestic ideologies of a donor nation also influence how health policy is made and implemented in a low resource country (Hill, 2004). For example, the Bush administration ideology favors promotion of abstinence over availability of condoms for AIDS prevention. Countries receiving AIDS funding through the U.S. Presidential Emergency Fund for AIDS Relief (PEPFAR) are required to apply at least one-third of their funding to abstinence programs and to limit distribution of condoms to prostitutes only. As a condition of the aid, prostitutes, a high risk population, must be made aware



that they are considered a stigmatized group with low social value. Since the implementation of this policy, there has been a corresponding rise in the incidence of HIV in Uganda, a country that has previously been successful with controlling the AIDS epidemic (Marmot, 2005). Therefore, decisions about whose interests prevail have critical impact on the health and welfare of already vulnerable communities.

Finally, informal networks and advocacy groups affect health policy making at the national level (Walt, 1994). For example, the role of informal networks among educated classes in the African public health context is quite influential. The networks of physicians who staff Ministries of Health in most African countries evolve because as young students, these were each nation's top students who formed bonds in medical schools, and maintained their relationships as they rose to positions of influence in their Ministries of Health and in agencies outside their countries. These are effective networks that seek to support each other professionally and have professional ties with international technical experts and donor partners. Thus many of the top national policymakers, while sensitive and proactive advocates for their own country's needs, are likely to be more responsive to accountability demands from external forces (who have power to provide funds or not) than they might be to their own local constituents.

### Critical Theory

Critical theory is a social philosophy that seeks to engage social change to relieve oppression asserted through social structures (Brookfield, 2005; Cervero & Wilson, 2006; Crotty, 1998; deMarrais & Lapan, 2004; Forester, 1989; Sork, 2000). The critical tradition asserts that theories that claim a rational basis are not relevant given that rationality excludes from consideration the impact of emotion, culture, and tradition on

how knowledge is constructed (deMarrais & Lapan, 2004). In addressing a wide range of human social experience, the philosophical underpinning of critical theory is its desire to define a more just and equitable world. Thus, critical theory is about “research that seeks to bring about change” (Merriam & Caffarella, 1999, p. 341).

Jurgen Habermas is generally credited with the elaboration of critical theory (Brookfield, 2005; Crotty, 1998). Critical theory developed as part of social theory work undertaken by scholars at the Institute for Social Research, also known as the Frankfurt School, in the early 20<sup>th</sup> century (Crotty, 1998). According to McCarthy (1994), Habermas’s contribution to critical theory was his critique of the Marxist scholars who saw knowledge as an outgrowth of labor conflicts. Rather than seeing knowledge as produced from human labor, Habermas considered knowledge as inherent in social interactions within systems of power (Crotty, 1998; Forester, 1989; McCarthy, 1994). Habermas’s view is a critique of the structural forces and systems of power that aims to identify oppressive forces and lead to emancipation from the domination of those forces (Merriam and Caffarella, 1999). Working from this epistemological perspective, critical scholars, and especially Habermas, sought to find a theory that centered on the social interactions of people rather than the technical or instrumental actions. The work of Habermas provided for examination of the social sphere through analysis of communicative action (Forester, 1989). Examination of social constructs and systems engages questions about truth and how knowledge is constructed (McCarthy, 1994). The overriding question in critical theory has to do with identifying who benefits and whose interests are served in creating and sustaining power inequities in the social and political domain.

For Habermas, the communication act (meaning both verbal and non-verbal communication) is central to how knowledge is constructed in the social domain (Forester, 1989; McCarthy, 1994). McCarthy (1994) explains that Habermas saw that the act of communication is separated from the technical content. Every communication act, in the critical perspective, contains the possibility for truth and mutual understanding, or for its distortion (Brookfield, 2005). Thus, a basis for social research is the analysis of “consensual speech...that is oriented to achieving understanding” but which may be deployed for strategic purposes to persuade, conceal, or distort the underlying meaning (McCarthy, p. 288). The benefit of this theoretical view is that a critical stance makes possible the identification of how communicative acts are systematically distorted and serve the interests of power and hegemony over the authentic will of people to act in their own interests (Forester, 1989).

The assertion of democratic principles is important for this theory because critical theory looks at how institutions use communicative structures to legitimate and establish institutional power and limit participation of groups from decision-making, especially those groups most affected by the outcome of the decisions (Forester, 1989). The distortion of communication is a dynamic in the assertion of power. What action occurs, and what gets done, depends on what gets said, how it gets said, who says it, who hears it and how it is heard (McCarthy, 1994). For example, power is asserted when a ruling class or policy elite distorts political problems by defining them as technical problems thereby privileging the speech in favor of the group in control and excluding those who may be most affected by the ensuing decision. Political power can exclude affected groups from decision making by restricting or distorting arguments for alternate framing

of important questions. The resulting hegemonic distortions keep citizens from being informed. Forester (1989) states they may even be kept ignorant of the possibility of participation and the opportunity to make a difference in their own lives.

Critical theory informs adult education when researchers examine how institutions “reproduce the status quo, in particular the existing social class structure” (Merriam & Caffarella, 1999, p. 351). An assumption of this use of critical theory in adult research education is that social class structure can be defined broadly to consider how gender, class, ethnicity, sexuality, and race influence ethical decision making about adult education. The social action component of adult education is served by critical perspectives in that the emancipatory goal of critical theory is embedded in the transformational aspects of adult learning (Merriam & Caffarella). Critical theory can guide adult educators towards questions about access to and relevance of adult education and whose interests are served in the planning and delivery of educational programs (Cervero & Wilson, 2006). Critical theorists are concerned with how political, economic and social structures are constructed in ways that oppress segments of society and how a “false consciousness” prevents people from seeing how they are being affected by dominating economic structures (Crotty, 2003, p. 120). Critical theory provides the means for addressing what is ethically possible and desirable in public deliberation by subscribing to mutual understanding achieved through a participatory process and engagement in planning with the consent of the governed.

#### Program Planning and Development

Because policies are directed at knowledge and behavior change, they fulfill an education agenda. Accordingly, the insights from program planning theory have

relevance for understanding the policy formation process. Cervero and Wilson (2006) in particular offer a theory of educational program planning that is grounded in a critical perspective and that opens the possibility to understand the role of power in the policy formation process.

Traditional planning theories for describing how educational programs are planned have focused on rational, problem-solving approaches that only address the technical aspects of program design (Cervero & Wilson, 2006). In fact, Cervero and Wilson classify classical models such as those by Tyler (1949) and Sork (2000) as organizational models which do not adequately describe what educators recognize as what really goes on in planning. A program planning theory that relies solely on the organizational factors for lesson planning or sees planning as a technical, problem solving exercise is not a sufficient theory. This perspective will not help the researcher make transparent the political forces that are influencing the who, what, and how of program planning decisions.

Because educational planning is a socially constructed activity, critical theory offers a means for examining the role of structural power on social interactions as they pertain to educational planning processes (Cervero & Wilson, 2006). The communicative act from Habermas's model of social inquiry has both a desired and actual realization in that the investigator can address aspects of competence (or the ideal) and performance (or the actual event). Consequently, a program planning theory can adopt the critical perspective in order to examine how real people engage in the social act of planning. Cervero and Wilson (2006) expand this perspective by defining planning as "a social activity whereby people construct educational programs by negotiating

personal, organization, and social interests in contexts marked by socially-structured relations of power” (p. 12-13). Cervero and Wilson see the location of planning as taking place in socially constructed settings that give advantage to some interests and deny opportunity to others. In explaining their theory, Cervero and Wilson acknowledge that people who work on planning “selectively organize” attention to actual possibilities for action and that there are consequences to those actions (p. 261). Because this is an echo of Habermas’s context of the communicative act implicit in social interaction, it matters a great deal who takes part in the planning process.

Four elements frame this planning theory: power, interests, negotiation and responsibility (Cervero & Wilson, 2006). Power is exercised (or not) in the planning process through the social and structural relationships that real people bring to the planning context. Thus, any assumption that all actors will participate in public deliberation from a rational perspective is a flawed assumption. Interests, say Cervero and Wilson, are defined as the goals, values, motives, and beliefs that people bring to the planning activities. The interests and purposes of the people involved in planning may or may not be explicit but instead are inferred (Cervero & Wilson, 2006). This is not an insignificant observation in that programs are linked to “the interests of the people who plan them” (p. 89). The implication for decision-making is strong in that the eventual outcome is the result of this negotiation between multiple actors with multiple interests.

Negotiation is the main activity for planners as they exercise and navigate the intersection of their respective interests and power. A commitment to substantive democratic processes is the expression of responsibility and accountability for ethical decision making and representation of all voices (Cervero & Wilson, 2006). Ethical

decision-making is central to critical planning theory in the employ of policy formation because the target of the policy formation is the lives of real citizens. This is a critical aspect of the theory given the challenge to public planners to preserve legitimate democratic processes in an environment increasingly unfavorable to those processes because of dominant economic philosophies that favor corporate structures and privatization of public services (Forester, 1989).

Educational planning theory by Cervero and Wilson (2006) has ethical roots within the pedagogical theory of Paolo Freire. Freire (1995) sees adult education as a political stance framed in social justice for confronting and countering the power of repressive structures. The value of the social justice frame to planning adult education programs is the location of adult education as an essential tool in the struggle for knowledge and power (Cervero & Wilson). Cervero and Wilson are interested in the conditions of actual practice and assert that a theory which does not acknowledge the political domain cannot be assumed as plausible. Consequently, insights from this theory are deeply applicable to the politically rich, multiple actor environment of policy formation.

### *Summary*

Program planning theory, policy formation models and international health policy making are connected through the contexts of competing power and interests. Each of these areas illustrates how planning is a social process (Cervero & Wilson, 2006) resulting in social construction of knowledge that resonates with critical perspectives about the forces of oppression and domination of one group over another. Hegemonic control is a function of who is involved in the policy making and who is excluded. This

is a function of how powerful partners act to exert pressure through adoption of instruments of policy formation to persuade and define policy directions that are favorable to one's personal loyalties, professional practical realities, and prevailing national identities. Thus Cervero and Wilson's inclusion of ethical negotiation of interests within planning is a significant variable for understanding the extent of democratic participation in policy formation, especially for those policies that impact the health and social well-being of children and their parents in struggling economies.

### The Health Policy Context in Uganda

The deliberation of public policy, including health policy, includes decision making about national policies, values, and distribution of resources with the expectation that resources will be allocated fairly (Birkland, 2005; Merriam, Courtney & Cervero, 2006). To understand the current health policy context in Uganda, it is useful to trace the historic impulses on policy deliberation in Uganda since its independence. In this brief review of the evolution of health policy, I hope to underscore the reality of the health policy context with its fragmented political support, conflicting strategies, and weakened infrastructure that results when external donors have made aid contingent on conditions from the donor nations and agencies (Okunozi, 2004a, 2004b).

Before independence in 1962, the Ministry of Health in Uganda was a colonial structure that served the needs of the colonial expatriates and Ugandan officers in the colonial civil service (Jeppsson, Birungi, Ostergren & Hagstrom, 2005). Following independence, from 1962 to 1970, the policy of the new Ugandan state was one of expansion as the Ministry of Health sought to increase the network of health centers and increased the role of health inspectors who monitored community health activities.



Access to health services at this time was free. In Uganda, as in other sub-Saharan African nations, the intention was to model their health services on European models with full services and infrastructure even though resources were not sufficient to reach the goal. But there was not time for this policy to be examined and modified because Idi Amin came to power in 1971. During the regime of Idi Amin (1971-1980) and in the civil strife in subsequent years following that period, public services, including health, deteriorated and collapsed (Okuonzi, 2004a).

During this same time period, Uganda's health policy fell under the influence of the Alma Ata Declaration in 1978. The Alma Ata Declaration was the outcome of the International Conference on Primary Health Care, a conference of health ministers from developing countries organized by WHO and UNICEF to counter the impulse of emerging nations to adopt health models of industrialized countries. The Alma Ata declaration called for a strategy of primary health care (PHC) that would provide a package of basic health services under the slogan of "health for all" supported by local decision-making and involvement from other social policy sectors (Jeppsson, et al., 2004). The PHC concept, while well intentioned in seeking to implement relevant health models, did not result in locally relevant health services but instead became a construct for delivery of vertical health programs led by WHO and UNICEF. These were externally directed and delivered programs for immunizations and diarrhoeal disease control with some attention to intersectoral collaboration (Jeppsson et al., 2004).

In the mid-1980s, following a period of civil strife after the fall of Idi Amin, Uganda experienced an increase in the numbers of humanitarian and relief organizations that arrived to provide services. Okuonzi and Birungi (2000) report that the outside

organizations provided health service delivery outside of a national health policy context because there just wasn't a policy during this period given the collapse of public services during the previous years. Thus the outside organizations had more control of the money and health policies than did the Ministry of Health.

The next external pressure on Ugandan health policy occurred in the early 1990s with external demands for health sector reform based on a market orientation promoted by the World Bank (Okunzi & Birungi, 2000). These reforms demanded privatized health service delivery with a limited role for the central government. User-fees were introduced without any protection for those who could not pay. The result was destructive to the already fragile health system and resulted in no change in health outcomes (Okunzi & Birungi, 2000). After market reform was imposed, the evidence-based reform movement influenced the policy environment by attempting to return control of health services especially for the poor to governments rather than private organizations and NGOs (Jeppesen et al., 2005). The goal of the evidence-based reform movement was to enable reform to be led by governments rather than donors. Reform would be grounded in evidence and not on the conditions imposed by external donors.

With the period 2000-2010, the Ugandan Ministry of Health adopted the sector-wide approach (SWAP) as an indication that health is not a function of health service delivery alone but requires participation of other domains. In 2005, Uganda developed its second Health Sector Strategic Plan (HSSP II) (Ministry of Health, Uganda, 2005), a 5-year plan from 2005/06 to 2009/10 under the aegis of the National Health Policy (Ministry of Health, Uganda, 2003). HSSP II contains two critical policies addressing determinants of health afforded by women's education and civic participation. One

policy calls for more equitable access to health and the second policy calls for empowerment of individuals and communities for promotion of health, especially for women. The strategic goal is to promote health and education through local village health teams (VHTs). The purposes of the teams are to strengthen health awareness, increase women's participation and involvement in health delivery and support adoption of improved quality of family life for Ugandan communities. There is an overall commitment by the government to work towards gender equity. Initial targets call for at least one-third of the membership of the VHTs to be women (Ministry of Health, 2005).

The factors contributing to the unacceptably high levels of illness and death due to largely preventable causes are complex and transcend biomedical interventions. The health context in Uganda is exacerbated by women's low literacy, their low status in household and public spheres, and a high prevalence of very preventable communicable diseases that contribute to the overall mortality rates for infants, children, and women (Ministry of Health, 2005). Progress towards reducing the burden of these preventable diseases has not been satisfactory (Black, Morris, & Bryce, 2003). Thus the health context is profoundly influenced by social determinants of health such as education, civic participation and skills for hygienic practices which require a solution of mixed strategies rather than dependence on medical interventions alone.

Adult education in Uganda plays a role in how communities resist domination by external forces both from global pressures and from internal factors (Youngman, 2000). While domination is clearly asserted by external and central government forces and ethnic conflicts, communities resist in multiple ways and contest government action by

withholding participation. Education thus can reproduce the existing order or it can be the location of skills enhancement for increasing local participation in decision making.

### Chapter Summary

Measurement of a community's health is more than its epidemiologic profile (Gordis, 2000). In fact, health is an interaction of several domains, most of which lie outside the health sector (Okunzi & Birungi, 2000). These determinants of a population's health are a function of the influence of the social, cultural, material and environmental domains on a population's social outcomes (Marmot, 2005). Consequently, the inequities that make communities more susceptible to poor health are related not only to individual predispositions to disease, but also to structural, political and societal barriers of health (Krieger et al., 2003).

Situating public health within social justice unveils not only the surface causes of disease, but also the underlying social structures that are the causes of poor health (Gostin & Powers, 2006). For example, socio-economic and political structures can create and replicate the conditions that increase the social and environmental risks for poor health, especially for society's least powerful populations (Farmer, 2003; Marmot, 2005). Recent examples are seen in how powerful external forces impose structural adjustment programs or market-driven ideologies on delivery of health interventions (requiring the already poor to purchase insecticide-treated bed nets for prevention of malaria, for example, rather than distributing them at no cost to the families). These forces severely constrain national budgets in developing countries and result in the offering of poor quality health services in already struggling communities. Social forces such as women's low status in some societies restrict women from earning income or accessing services

for themselves or their children. The result is poor nutrition and replication of gender exclusion from the social and political life of a community (Seya, 2005).

Many adult education and social policy initiatives define their purpose in terms of contributions to economic development. “Development” is defined by Youngman (2005) as “as process of economic, social political and cultural change engineered in a given society by efforts of all stakeholders (both internal and external) with a view of improving conditions of life in a sustainable way” (p. 97). As a result, adult education is allied with the historic mission of public health in its relationship to social justice and issues of human capital, health, nutrition, governance and democracy (Gostin & Powers, 2006; Youngman, 2005). In the development context, provision of social services, including those for health and education, are often carried out through adult education strategies at community levels (Youngman, 2005). For this reason, the application of adult education for social change can be categorized as an implementation strategy for addressing inequities and for increasing participation in the organizing of citizens to define and solve problems affecting their own life chances (Quigley, 2000).

## CHAPTER 3

### METHODS

The purpose of this study was to understand how the process of policy formation in Uganda resulted in an integration of adult education strategies into the national health policy. The research questions guiding this study were: (1) What interests shaped the integration of adult education approaches within national public health policies, (2) How did the policy makers negotiate the external and internal interests during national policy making, and (3) What learning did policy makers need to undertake to affect the integration of these policies?

Because Uganda's National Public Health Policy addresses the relationship between maternal education and improved child health outcomes, an analysis of the policy formation in that country provided valuable insights into how adult education strategies can be more strategically located within national health policies. This chapter describes the methodology used to investigate these questions. In this chapter, I will present the design of the study, sample selection, data analysis, validity and reliability, any research bias and assumptions about this study, and a chapter summary.

#### Design of the Study

This research employed a case study approach to qualitative research. Qualitative research attempts to answer questions about phenomena as they exist in real-world social settings (Berg, 2007; Merriam, 1998). The philosophical underpinning of qualitative research is the epistemological stance of socially constructed knowledge (Berg, 2007;

Crotty, 1998; Merriam, 1998). Socially constructed knowledge asserts that “meanings are constructed by human beings as they engage with the world they are interpreting” (Crotty, 1998, p. 43). This does not intend to convey that meaning is constructed out of hand; rather, meaning is constructed within the interactions between human beings and their social practices and contexts (Crotty, 1998). In a constructionist stance, deriving understanding about social phenomenon is possible because the researcher is engaged with questions of how humans make meaning. Qualitative research opens pathways into the gray areas surrounding “facts” and into the spaces where daily human interaction occurs.

Merriam (1998) describes five characteristics of qualitative research. They include (1) the epistemological stance that knowledge is constructed, (2) the focus on the researcher as the data collection and analysis instrument, (3) the grounding of data collection within the research question and the research context, (4) the use of inductive strategies for data analysis, and (5) results of the analysis emanating from a data-rich description of the phenomenon under study. Patton (2002) summarizes the characteristics of qualitative research as flexible and fluid since the goal of qualitative research is the discovery of new insights and understandings about real-world knowledge.

A case study approach to qualitative research was chosen for this study because it allowed for extensive data collection around a single instance of an important phenomenon (Merriam, 1998; Yin, 2003). From Yin’s (2003) view, a case study research design is “a way of investigating an empirical topic by following a set of specified procedures” thereby uncovering the conditions and influences relevant to the phenomenon under study (p. 15). The case study does not disconnect the phenomenon

under study from its context; in fact, the context is central to the development of the research findings (Merriam, 1998; Stakes, 2006). In the view of Patton (2002), case studies relate to the understanding of practice and self-reflection because both participants and the researcher are implicated in exploring how one's own experiences and background affect how we see the world and how we respond to it. Qualitative research in general and case study designs in particular focus on people and events as they interact within their own context (Merriam, 1998; Yin, 2003). Consequently, the construct of *context* is essential to the definition of a case study design. In considering the fuller context of the phenomenon, a deeper understanding and possibility for unveiling of information applicable to decision-making is available from qualitative case study research.

The unit of analysis in a case study is “a single entity for study” (Merriam, 1998, p. 27). The case, or bounded system, is a single instance of the particular topic of concern (Merriam, 1998). The unit of analysis for this research was the instance of policy making in Uganda for integration of adult education strategies within the National Health Policy. A case study methodology was relevant to this study because the policy making took place over an extended period of time and within a dynamic context that involved the social confluence of information, institutional interests and shifting locations of power. Using a case study approach allowed me to examine the phenomenon from its inception when the issue was initially identified to its arrival on the policy makers' agenda. Because the case study approach includes exploration of the context of events, I was able to examine how several agencies and institutions deliberated, decided, justified, and eventually implemented the policy.



## Sample Selection

Purposeful sampling as a method of sample selection is a tool for developing information-rich cases in depth. This type of sampling results in cases that contain sufficient detail to support findings that illuminate a particular case rather than lead to generalizations (Patton, 2002). Sample selection in qualitative research is significantly different from sample selection in quantitative research. Quantitative researchers require representative random samples of numeric data for making generalizations (Merriam, 1998; Patton, 2002). Qualitative research, on the other hand, usually focuses on a single instance and does not result in generalizable findings; instead, qualitative research develops rich, in-depth data that, when analyzed and presented, should allow the reader of the study to decide if the lessons from the phenomenon apply to their own situation (Merriam, 1998; Patton, 2002). Purposeful sampling fits with qualitative research because the goal of both is to develop understanding and insights into how social contexts work and how meaning is made in those contexts.

Merriam (1998) distinguishes between sample selection used in quantitative surveys (probability sampling) versus the sample selection employed for qualitative research. In the case of qualitative research, sample selection permits collection of data to produce information rich cases. This type of sampling is called nonprobability sampling. Purposeful sampling is “the most common form” of nonprobability sampling employed in qualitative research (Merriam, p. 61). Purposeful sampling is congruent with the investigator’s objective to “discover, understand, and gain insight” into phenomena that are driving the research question (Merriam, p. 61). Thus the sample selection for purposeful sampling is based on selection of participants who have

experience in or know about the topic under study (Merriam; Patton, 2002). Purposeful sampling permits acquisition of information that can be studied deeply and that brings to the analysis multiple views and sources.

There were two levels of sample selection in my study. The first level was the definition of the case. The rationales for selecting Uganda as the case for study were the following: (1) Uganda has included adult education strategies as an overt aspect of their national health policy, (2) I have relationships with the Ministry of Health and other partner agencies that facilitated my access to key sources, (3) Uganda is a developing country with a colonial history and experience in negotiating multiple priorities and interests from both external and internal forces, and (4) Improving community interventions and reducing childhood deaths are priorities stated in official documents for Uganda.

The next level of sample selection was to define the participants. I interviewed eleven participants. The participants were health or education officers and advisors who met one or more of the following criteria: (1) they were engaged in health policy formation in Uganda either as a technical expert, decision maker, or policy officer in a ministry or international health agency or institution, (2) they took part in the specific instance of policy formation including implementation of the policy through expansion of the adult education role of village health teams, or (3) they evaluated community adult education and public health interventions in Uganda.

The principal method for selecting participants was the snowball or network method. In this method, the researcher requests referrals from each key informant so that the interviewees refer the researcher to others in the network surrounding the

phenomenon under study (Merriam, 1998). By employing this method, I was able to recruit participants who had experience in the formation, implementation or evaluation of the integrated adult education and public health policy. Using the snowball or network method, I was able to recognize the strengths and limitations of networks that linked the broader entities in the instance of policy formation. I was also able to identify participants that I would not have otherwise known to contact but who had information that resulted in data that was instrumental to a more comprehensive understanding of the phenomenon under study.

### Data Collection

The decision about data collection methods has strong implications for the validity of the study findings. In fact, Merriam and Simpson (2000) illustrate the implication as a question that asks, “How accurately do the data reflect the phenomenon?” (p. 144). Consequently, choosing multiple methods of data collection in a case study should contribute to the validity and consistency of the results. In this study, I employed multiple sources of data including numeric data, interviews, documents and observations (Merriam, 1998). For example, to begin creating the context of the national policy environment, data was collected and used to describe demographic patterns, literacy levels and disease trends. To examine the phenomenon of the process of national policymaking through the views of people involved in the process, I conducted interviews with key informants. Key documents provided data on official statements about the policy and how interests were defined by each key entity. Observations of how the policy was implemented allowed for more detailed understanding of essential aspects for ensuring implementation of the policy.

Merriam (1998) classifies interviews as structured, semi-structured, and unstructured. In a structured interview, for example, the questions are standardized as one might see in a written survey. In a standardized questionnaire, the worldview that dominates the exchange with the participant is that of the researcher because the researcher has formed the questions (Merriam, 1998). In a semi-structured interview, specific information is desired from the participants, but there is a mix of structured and informal questions so that the researcher can use flexibility in how the questions are framed. An unstructured interview involves open-ended questions that seek to elicit the views of the participant.

I used a semi-structured interview working from an interview guide (available in Appendix B). The semi-structured interviews facilitated the gathering of data from the perspectives and experiences of the participants. This type of interview was relevant to my study because I wanted to gather specific information about a policy making process, yet I also believed that the participants would have information that I could not possibly predict. Unexpected information gathered during an interview guided my choices about questions and areas of inquiry for subsequent interviews. Generally, I used the interview guide to ensure I addressed specific topics, but the questions asked during the interviews grew from the responses and experiences of each participant.

I travelled twice to Uganda between December 2007 and February 2008 where I conducted ten of the eleven interviews. The eleventh interview took place at my workplace in Atlanta in March 2008. Before arriving in Uganda, I notified those participants I already knew by email to invite their participation and to make arrangements for meeting them when I arrived in Uganda. Upon my arrival, we arranged

appointment times and locations that met the convenience of the participants. Referrals to the additional participants occurred during these initial arrangements and also during interviews. Most of the interviews in Uganda took place in offices or meeting rooms at the participants' workplaces. In two cases, we met in a hotel lounge. In one case, the interview took place by telephone because the participant was in Geneva, Switzerland. I took handwritten notes during all of the interviews and also recorded the interviews on an audio-recorder. After the interviews concluded, I wrote field notes that allowed me to reflect on the interview, capture observations about the context of the interview and explore questions or areas of interest for subsequent interviews (Esterberg, 2002; Patton, 2002).

As a second source of data, I gathered key documents pertaining to the adoption of adult education strategies integrated into the national health policy. Documents are not merely for the background of research; they are also worthwhile objectives of analysis in and of themselves (Prior, 2003). According to Silverman (2001), written text is a reflection of a process whereby authors have carefully constructed reality. Ideas expressed in the documents reflect "how the world comes to be known through discursive practices" (Prior, 2003, p. 126). Each of the twenty-two documents gathered for analysis in this study were official documents produced by international agencies or national governments. As such, the documents were particularly relevant because they reflected how each organization saw itself and provided a paper trail of where changes occurred over time (Hodder, 2000).

The documents I gathered (policy statements, reports, memos, guidelines, and financial documents) included national and international documents reflecting the

broader development, health and education domains. These included documents cited as authoritative sources in the Uganda National Health Policy and the Uganda Health Sector Strategic Plan II. They also included documents mentioned by participants during our interviews as influential to the instance of adult education and public health policy formation in Uganda. All of the documents became critical in establishing a chronology of essential influences on the instance of adult education and public health policy making in Uganda.

A third source of data was a day-long observation conducted during a field visit to a rural zone in Uganda. This was a single observation that was possible as a result of an invitation offered by one of my participants when we were arranging our interview. During the site visit, I observed and met members of the village health teams who implemented the integrated adult education and public health policy. Being able to observe the setting in which the integrated adult education and public health policy was actually implemented provided an opportunity to see people interacting in a complex environment of relationships and limited resources (Patton, 2002). The visit involved a meeting with the local officials in the rural area, attending a public ceremony where village health teams were recognized for completing training, and conversing informally with some of the village health team members. While being unobtrusive is desired in conducting field observations so that the researcher sees people interact in natural ways in the setting (Esterberg, 2002), my skin color and status as official visitor precluded being able to be inconspicuous. I was able to use this status, however, to make observations and record them. Because I was a foreigner accompanied by a counterpart

from the Ministry of Health and an administrator from the Local Council, taking notes was not seen as particularly unusual or disruptive to the village health team members.

### Data Analysis

The aim of data analysis in qualitative research is to develop plausible explanations for the phenomenon being studied (Patton, 2002). These explanations are the product of insights and discoveries experienced by the researcher during data collection, organization and analysis. Merriam (1998) states that because qualitative data analysis is primarily an intuitive process, employing a range of systematic techniques and approaches for working with the qualitative data is recommended. According to Patton (2002), the findings of qualitative research will be seen as credible if it is shown that the researcher employed “a systematic search for alternative themes, divergent patterns, and rival explanations” (p. 553). The researcher wants to make evident that the analysis was approached with “intellectual integrity” (p. 553). In order to keep track of how alternate themes, patterns and explanations were examined during the data analysis, the researcher must carefully organize the data and record how data were analyzed.

To analyze the data for this case study, I used the constant comparative method. Patton (2002) states that this method assists the researcher in understanding unique cases or examples as each data point is compared with remaining data points or incidents. Constant comparative analysis is a process of identifying the “conceptual links between and among the [identified] categories and properties” of the data (Merriam, 1998, p. 159). The researcher approaches the data by selecting an instance or data point from the interviews, documents or observations and “compares it with another incident in the same set of data or another set” (Merriam, p. 159). These comparisons lead to refined or

different categories and concepts such that the categories emerge from the data themselves.

Two main sources of data were analyzed in this study: participant interviews and document analysis. To analyze the interviews, I first reviewed all my field notes in order to become familiar with the data and consider potential themes (Esterberg, 2002). I also transcribed the audio recordings of the eleven interviews in order to assemble a collection of transcriptions. The process of transcribing involved listening several times to the interviews, a process that strengthened my familiarity with the views of the participants and began to suggest phrases and incidents that would become data points. I read and I referred to my research questions to identify some broad topics to serve as preliminary categories and wrote them on pieces of paper. After reading the transcripts, I used open coding to analyze their content. I selected as units of data phrases, sentences or incidents that seemed to reflect the broad topics or categories generated from my research questions. After coding each interview, I listed and sorted them for consistency with any prior data and emerging categories. I entered each of the coded units of data into a Microsoft Excel spreadsheet formatted such that one column recorded the code and the next column included the phrase, sentences or incidents that were identified as a unit of data. This list generated over 300 units of data linked to codes such as “negotiation,” “adult learning,” “issues,” and “policy learning.” The ability to electronically sort data on the spreadsheet provided a tool for revision of categories and reviewing of consistency of how the data was coded. Ultimately, diagrams and tables were used to finalize the grouping and sorting of the categories into smaller groups that fit with the topics in the research questions.



To conduct the document analysis, I drew from inductive coding approaches recommended by Ezzy (2002) as well as guidance for analyzing both surface and deeper meanings recommend by Esterberg (2002) and Silverman (2001). The unit of data analysis was the sentence. In my analysis, I first read the document several times to become familiar with its presentation and layout. I then conducted an intentional reading of the document and used open coding to identify the function of each sentence in the document. I then compiled a list of the codes I had applied without analyzing or grouping them further. I entered the list into a Microsoft Word file and used the sort command to obtain an alphabetized list of codes. This allowed me to clean the data in order to correct instances where I wrote “message to external partners” as well as “external partner message.” Corrections were made so that similar codes were written consistently. At the end of the coding process, I refined the list of codes by comparing and sorting them to achieve a smaller, more coherent group of categories. In one set of Ugandan government documents dealing with budget allocations, I employed a more deductive analysis by applying variables from the Advocacy Coalition Framework (ACF) (Sabatier & Jenkins-Smith, 1999). The ACF asks specific questions of the data about the core beliefs of the major entities that serve to bind coalitions as they interact during the process of policy formation. Questions addressed during this part of the document analysis sought to identify the belief systems of the coalitions that shaped the coalitions involved in forming the integrated adult education and public health policy (Weible, 2006). These included questions about the core values and beliefs of the coalitions, how they saw those beliefs expressed as policy, and how they believed the policy should be implemented (Sabatier & Jenkins-Smith, 1999). The scope of each belief and its

susceptibility to change were also assessed and organized in a table format. The analysis results were compared with the analysis of the participant interviews and observations in developing findings for this study.

### Reliability and Validity

As described by Merriam and Simpson (2002), trustworthiness of results is a concern for all research. This is no less true for consumers of educational research who work in real world situations with real people's lives. In the case of qualitative research, the research should be designed such that the consumers of the research will have confidence that the results were derived through a systematic and intellectually rigorous approach (Esterberg, 2002; Yin, 2003). Reliability and validity are tools for the researcher to use in data collection, analysis and interpretation to ensure confidence in the results. Reliability in qualitative research answers a question about the dependability and consistency of the results (Merriam & Simpson, 2000).

Internal validity examines how closely the study findings match with reality (Merriam & Simpson, 2000). Triangulation, peer-examination and presentation of researcher biases and assumptions are strategies recommended by Merriam and Simpson (2000) for ensuring the internal validity of a study. Triangulation is the use of multiple sources as well as data collection and analysis methods in developing findings to a study. The use of multiple sources, methods, and analysis increases the study's credibility and quality and ensures that the results are consistent and dependable (Merriam & Simpson, 2000). Triangulation ensures that the findings that are produced from multiple points of view and not solely from the perspective of a single researcher, source, or method (Merriam & Simpson, 2000; Patton, 2002). By using different methods for data

collection, for example, a richer interpretation is more likely than if only one source was consulted.

To strengthen the internal validity of this study, I used multiple sources and methods of data collection and analysis, engaged peer examination of my findings, and made my researcher assumptions and biases transparent. For example, multiple sources and methods of data collection involved observations, interviews and document analysis resulting in a variety of perspectives and views about the reality that surrounded the instance of policy formation. I conducted interviews with Ugandan and non-Ugandan participants from different government and non-governmental institutions and agencies. Participants represented a variety of agencies and government perspectives from international, national, and local perspectives. Data was also collected from documents related to the international and national health, education and development domains. My major professor provided comment as to whether my findings were reasonable. I also provide in this chapter my researcher assumptions and biases that affected my interpretation of the data and development of findings.

In considering the reliability of qualitative research, the researcher must ensure that the study design takes into account the development of credible and trustworthy findings (Patton, 2002). The findings must be seen as consistent with the data (Merriam, 1998). Thus the provision of a thick, data-rich description of the phenomenon is a major strategy for ensuring the credibility, trustworthiness and consistency of the study because the reader is the one who must decide whether the case study findings are sufficiently similar and, therefore, applicable to the reader's own situation. This study made use of a case study approach which involved extensive data collection around the phenomenon

under study and included multiple data collection and analysis methods. Examination of context surrounding the unit of analysis in case study research is central to case study research. By using a case study approach, I was able to take into account not only the narrow, limited technical issues under consideration in the policy, but also the socio-economic, political and cultural factors that influenced the perspectives of participants in the study. This study design allowed for a broad and inclusive view of the formation of an integrated adult education and public health policy.

Finally, because all the participants spoke English, there were no translation issues. In the single instance of the field observation, a Ugandan colleague assisted with translation of an informal conversation I took part in with rural health workers and the village health team.

#### Research Bias and Assumptions

Revealing the researcher's bias and assumptions is part of ensuring the reliability and validity of research findings (Merriam, 1998; Patton, 2002). In the case of qualitative research, the researcher is the research instrument. Thus, the researcher is ethically bound to reveal her subjectivities. One assumption that influenced my research was my insider role resulting from professional responsibilities with various African Ministries of Health, United States Government agencies, and United Nations agencies through most of my working life. I work within a bureaucracy and engage at least weekly with Ministry officers in various African Ministries of Health, the World Health Organization, and other United States Government agencies. With respect to conducting research in Uganda, as an external researcher, I was in an outsider in terms of my nationality, gender, and skin color. My positionality vis-à-vis the interviewees was seen as one of respect,

but also as one of privilege defined by my ability to influence program directions and to foster official and personal relationships between colleagues in the Ministry of Health, the World Health Organization, UNICEF, and Centers for Disease Control and Prevention (CDC) where I work.

I was born in San Francisco, California, and I am not from the Ugandan culture although I have 40 years experience of living and working in developing countries. I am comfortable working in developing country environments. Working in multi-cultural environments has been my life's work. Besides my Peace Corps service in Morocco, I have lived in India and Nepal. I also lived several years in the former Zaire, a neighboring country to Uganda, and I travel frequently to African countries. As a result, I am acclimated to functioning in multi-lingual, multi-racial international settings. I appreciate that there are gaps in my experience with parts of American culture because I lived outside of the United States for extended periods of time. While I have been extremely fortunate to have developed trusting relationships with African colleagues from several countries that allow for frank exchanges, I did not know well all the Ugandan participants that participated in this study.

Because I have spent many years in working with African counterparts, my bias is more likely aligned with the policy autonomy of the African countries. My political stance is such that I understand the pragmatic and reality-based politics required for working effectively with international partnerships to support improved health and education in low income countries. Even so, in weighing national autonomy against multi-lateral influence on national initiatives, my instincts are to side with the goals of low-resource countries to determine their own policies. Finally, I have a long history of

collaboratively developing, designing, implementing, monitoring and evaluating several international health and education programs. This experience takes into account my commitment to ethical review of data so that my biases are not in the foreground of data analysis.

### Chapter Summary

This chapter described the methods I used to conduct a qualitative case study on how the process of policy formation in Uganda resulted in integration of adult education strategies into national health policy. I described my choice of research design, sample selection, data collection, and data analysis methods. The selection of a case study approach to qualitative research was justified because the policy making context was one of a complex set of interacting social and political dynamics. Purposeful selection of interview subjects as well as the definition of the unit of analysis (or “the case”) was presented along with particular rationales and criteria. Choosing a semi-structured interview method allowed me to gather specific information I required for this research and provided open ended opportunities for participants to relate their experiences and perspectives to enrich the data set. The process of data analysis was described including the methods used for assessing the reliability and validity of the study. The subjectivities of the researcher were examined as they are important contributions to the confidence and consistency of the research findings.

## CHAPTER 4

### DESCRIPTION OF THE CASE AND STUDY PARTICIPANTS

#### Introduction

The purpose of this study is to understand how the process of policy formation in Uganda resulted in integration of adult education strategies within the national health policy. The research questions guiding this study are: (1) What interests shaped the integration of adult education approaches within national public health policy, (2) How were the interests negotiated during the policy making process, and (3) What learning did policy makers need to undertake to effect the integration of these policies?

This study employed a case study approach to qualitative research that allowed for extensive data collection around “a single entity for study” (Merriam, 1998, p. 27) as the unit of analysis. In this study, the unit of analysis is the formation of a national health policy in Uganda that integrated adult education strategies and public health objectives.

To provide the background for addressing the three research questions listed above, this chapter first reviews the historical and social context of adult education in Uganda, and then presents a chronology of influences on the development of Uganda’s National Health Policy. In a third section of this chapter, I present an overview of Uganda’s National Health Policy itself. The final section is an introduction to the study participants.

## Historical and Social Context of Adult Education in Uganda

Uganda is located in eastern Africa sharing its eastern border with Kenya. Other contiguous states include Sudan to the north, Democratic Republic of Congo to the west, Rwanda and Tanzania to the south. Lake Victoria is part of Uganda's southern border shared with Tanzania as shown on the map below (retrieved August 8, 2008 from <https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html>).



As of July 2008, the population was estimated as approximately 31 million people with one-half of the population between the ages of 0 and 14 years (retrieved August 8, 2008 from <https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html>). Uganda's main export crop is coffee, and agriculture is the principal economic activity with four-fifths of the workforce involved in farming. English is the national language which is taught in schools and used in the course of official business. The population is comprised of several ethnic groups who speak Ganda and Swahili in addition to English.



In 2004, a national assessment (Ministry of Finance, 2004) found that 66% of the adult population were literate (they could read and write) in either English or a local language. The literacy rate for male adults was estimated as 76.8% with results from five regional levels ranging from 79% to 94% (Ministry of Finance, 2004). The rate for female literacy is lower with an estimate of 63% ranging from 42% in the northern region of the country to 90% in Kampala (Ministry of Health, 2004). Major public health threats that are leading causes of death include malaria, diarrhoeal diseases (cholera, dysentery and childhood diarrhoea), HIV/AIDS, tuberculosis, and acute respiratory infections.

Adult education activities in Uganda are part of a historical continuum of adult learning objectives for sustaining social, political and cultural cohesion. Because adult education is so deeply involved in development strategies, a discussion of the historical and social context of adult education in Uganda establishes the context for development of a national health policy that incorporates adult education. Table 4.1 on the next two pages summarizes the principal trends affecting social policies in Uganda and how adult education was employed as an implementing tool for the policies of ruling parties. The chronological divisions in the table are based on work by Atim and Ngaka (2004). I have adopted their organization of the chronology of adult education to reflect the perspective of African adult education scholars on the historic context of policy development.

Table 4.1

*Historical context of evolution of adult education in Uganda: pre-1876 to present (Atim & Ngaka, 2004)*

<i>Time period</i>	<i>Adult education provider</i>	<i>Trends</i>	<i>Comment</i>
Pre-1876	Indigenous methods of lifelong learning	Cultural and political cohesion transmitted through story telling proverbs, dance, language forms (e.g., names that signify social roles), art, spirit groups, kinship rites, and clan cultural practices)	Kingdom of Buganda has roots into 14 <sup>th</sup> century
1876 to 1945	Arab traders European explorers Christian missionaries Colonial officials	<ul style="list-style-type: none"> <li>– Voluntary agencies (e.g., Islamic organizations and Ugandan Red Cross) source of adult education in topics of interest to agency</li> <li>– Manual skills and literacy training from Christian missionaries</li> <li>– Limited production of newspapers</li> <li>– Trained to accept, live in, and serve the colonial administration.</li> <li>– Agriculture as a commodity is introduced.</li> </ul>	<p>Technical and manual skills training limited to operational needs and evangelical goals of the Christian missions.</p> <p>During colonial period, no conscious effort to create formal adult education policies. No formal plan for technical skills training beyond mission needs</p>
1945 to 1962 Post World War II through Independence	Colonial government Trade unions Multi-national companies Uganda African Literature Committee	<ul style="list-style-type: none"> <li>– New social departments created in Colonial Government provide training in local government and small scale farming.</li> <li>– Ministry of Health trains Ugandan ex-soldiers as hygiene orderlies to demonstrate hygienic practices in rural areas.</li> <li>– Workforce training from oil, tobacco and manufacturing multinational corporations.</li> </ul>	<p>Increase in adult education activities but not grounded in a formal cohesive adult education policy.</p> <p>Colonial government did not implement adult education policies.</p>
1962 to 1972 Independence	New government departments, civic and education institutions	<ul style="list-style-type: none"> <li>– Establishment of national adult education training center for courses in community development (leadership, law, citizenship).</li> <li>– Center evaluated by the U.N., and 1- and 2-year certificate courses were established.</li> </ul>	Ugandan scholars view this period as high point of adult education in Uganda. New government and civic organizations established for purposeful attention to adult education.
1972 to 1980 Military Rule	None	<ul style="list-style-type: none"> <li>– Deterioration of public service education and tragic reduction in literacy in the population.</li> <li>– Fatal and brutal consequences for lecturers and audience</li> </ul>	Intellectuals and church officials early on in the regime pushed for continued adult education through public lectures and village

		<ul style="list-style-type: none"> <li>members attending public lectures and training.</li> <li>– Village community development activities ceased due to murderous campaigns of Idi Amin’s regime to wipe out opposition.</li> </ul>	<p>services during this regime. But many were killed and threats of random killings from Idi Amin’s agents eventually caused Ugandan intellectuals and church leaders to flee the country.</p>
1980-1985	<p>Idi Amin deposed and beginning of recovery period.</p> <p>Government adult education institutions</p>	<ul style="list-style-type: none"> <li>– Government and private adult education programs such as YMCA, YWCA, and churches revived with external funding.</li> <li>– Introduction of WHO and UNICEF vertical disease programs (immunization, childhood diarrhoeal disease control involving partnerships between government and external agencies.)</li> </ul>	<p>Still no comprehensive adult education policy and no effort to have coordination of activities. Funding remained a constraint. Areas of armed conflict continued with struggle for power between President Obote and forces led by Museveni who opposed Obote. Political stability remained fragile and eventual coup by Museveni (current president) ended this period.</p>
1986-2002 Development of adult education	<p>Establishment of Government of National Resistance Movement (NRM)</p> <p>Impact of Structural Adjustment Program from World Bank and IMF</p>	<ul style="list-style-type: none"> <li>– Modernizing platform of NRM was remediation of literacy and adult basic education.</li> <li>– Government White Paper on Education developed in 1992 which included non-formal education as stated policy and framed as essential for development.</li> <li>– Some progress with expansion of the Functional Adult Literacy (FAL) program.</li> <li>– Decentralization fostered change to “self-reliant” and “community based” management approaches for social programs.</li> <li>– Advocacy groups developed.</li> <li>– Village health team policy developed.</li> </ul>	<p>Despite recommendation from the Government White Paper on Education to include the Functional Adult Literacy Program (FAL) in the Ministry of Education and Sport, the FAL was left in the Ministry of Gender, Labor, and Social Development.</p> <p>FAL has low status in the current Ministry. Funding is limited affecting recruitment of teachers and staff. There was no attention to integrating FAL with other ministries.</p>
2002 to present	Globalization	<ul style="list-style-type: none"> <li>– Adult literacy target is part of the Poverty Eradication Action Plan but not funded.</li> <li>– Security situation in Northern Uganda remains fragile.</li> <li>– Well publicized misuse of funds by Ugandan official from Global Fund for Tuberculosis, Malaria and HIV/AIDS.</li> <li>– Oil is discovered.</li> </ul>	<p>FAL remains a weak program as a government policy.</p> <p>Adult education carried out by multiple agencies, institutions, and sectors. Funding comes from external sources. Policy is not coordinated with other ministries.</p>

### *Indigenous lifelong learning*

As a starting point, the chronology in Table 4.1 begins with recognition of indigenous forms of lifelong learning that served to support the social and political organization of traditional communities. Lifelong learning in traditional communities involved dissemination of knowledge at stages of one's lifespan as a means of transmitting the social and cultural ways of believing and acting and gave a role to each member of the society in participating in the transmittal of the knowledge (Nafukho, Amutabi, & Otunga, 2005). Knowledge was transmitted through story-telling, proverbs, dance, language, art and tool making, spirit groups, kinship rites, and clan cultural practices (Atim and Ngaka, 2004; Youngman, 2000). Early inhabitants of Uganda were pastoral and agricultural groups who eventually developed clan and then kingship systems of political organization. The king was selected by the heads of the clans as was a cultural or spiritual head (Nafukho et al., 2005). The Buganda kingdom, a dominant entity through the 19<sup>th</sup> century CE, rose to power during the 14<sup>th</sup> century, CE. In the late 19<sup>th</sup> century, European and Arab traders began to arrive and make contact with the Buganda kingdom.

### *Colonial period*

The years 1895 through 1945 in Uganda are a period of increased contact with Arab and European traders and the subsequent arrival of Catholic, Anglican and Islamic missionaries. This is also the period of the imposition of British colonization. Accordingly, adult education activities reflected the demand from colonial officials and Christian missions for skills that would keep the colonial structures working. Christian missions provided technical and manual skills training with the purpose of developing a

supply of skilled indigenous workers who could keep the missions operating (Atim & Ngaka, 2004). Literacy classes were provided to Christian converts as preparation for receiving the Church's sacraments (Ministry of Education, 2005). In the agricultural sector, colonization influenced the shift from traditional agriculture practices for self-sufficiency to agriculture as a commodity for sale (a cash crop) (Nafukho, Amutabi, & Otunga, 2005). Not surprisingly, no deliberate attempt was made to develop a formal adult education policy during this period. Instead, colonial adult education involved adult learning focused on accepting and living in a colonial administration.

After the end of World War II, limited development of formal adult education took place, but these efforts did not result in a comprehensive adult education national policy (Okech, 2005). Examples of organizing structures for adult education, however, were evident in some domains. For example, the colonial government in Uganda instituted a Department of Community Development that evolved from an earlier administrative social welfare unit which was placed in charge of adult education (World Bank, 2001). At the same time, within the colonial Ministry of Health, an education section was organized, and former soldiers were trained as hygiene orderlies. The hygiene orderlies were charged with traveling around the country to demonstrate "hygienic living" (Atim & Ngaka, 2004, p. 52). Another provider of adult education programs involving workplace training were the multi-national corporations who began to establish themselves in Uganda after World War II. Additionally, the post-war period experienced an increase in the availability of training materials and newspapers written in local languages. In spite of the impulse to address adult education as a single focus by

some colonial departments, a formal adult education policy was not developed by the colonial government (Jhuuko, 2007).

### *Independence and post-independence conflict*

Independence arrived in 1962, and many new government departments included in their portfolios the provision of adult education and learning opportunities as priority actions. For example, training topics included leadership, civic education, and agricultural and fishery management. As described by Atim and Ngaka (2005), this period is generally regarded as the “golden” period of adult education in Uganda. There were dedicated programs including lectures and public courses with a single focus on lifelong learning and adult education as a pathway to a developed and productive society.

The emergent age of adult education in an independent Uganda came to a sorrowful end with the start of the military rule of Idi Amin. The heartbreaking irony is that illiteracy was both a cause and result of the formation of Idi Amin’s devastating rule. In fact, Atim and Ngaka (2004) make the following observation about how illiteracy was a contributing factor to the evolution of repressive and deadly regimes:

It is lamentable that such an impressive start in the evolution of adult education in Uganda was almost ruined by a regime of illiterates. That such a regime can still do harm on such an extensive scale and for so long in the modern world should surely be a lesson to all people. It should strengthen the resolve to eliminate illiteracy and inculcate positive attitudes in all people wherever they may be and whatever their occupation. (p. 30)

In 1980, Idi Amin was deposed, and Obote returned to the presidency. A brief revival of adult education activities occurred within government institutions. Even though several new organizations supporting or offering adult education were initiated, some with external funding such as the YMCA, YWCA and faith-based organizations, there was still no formal adult education policy in the government (Atim & Ngaka, 2004).

In 1985, President Obote was overthrown by General Okello who instituted a military regime. General Museveni had led armed resistance to the Obote government, and staged a coup to oust Okello in 1986 because Okello had not made a place for Museveni in the new government. President Museveni took over the reins of government and installed the Government of the National Revolutionary Movement (NRM) which remains in power to the present day. The NRM placed the improvement of health, literacy and education as central to the government's development priorities. The political strategy of the NRM was expressed in a "Ten Point Program" (Republic of Uganda, State House, 2007) that specifically addressed the improvement of social services (including safe water sources, literacy, housing, decreasing disparities of health) that had been extensively and seriously degraded during the previous decade of civil disorder. Within the restored Ministry of Health in the new government, there was a focus on development of a formal, centralized structure of medical and nursing education facilities and a teaching hospital (Hall & Taylor, 2003; Okuonzi & Macrae, 1995). As a result, very few resources were made available for health in the rural areas. This was due to the new government's vision and priority: to build high quality teaching and curative facilities.

### *Rebuilding and globalization*

Meanwhile, in the international health and donor agencies, attention was focused on experiences from countries with socialist economic structures such as Tanzania, China and Sudan in their delivery of a comprehensive package of basic or primary health care. In these primary health care models, rural communities would have health services delivered and managed by community-based health workers. Building on these experiences, international agencies such as WHO and UNICEF developed a program of primary health care services appropriate for developing countries (Hall & Taylor, 2003).

A competing force during this same period that affected delivery of adult education and development was the Structural Adjustment Program (SAP) of the World Bank (Jeppssen et al., 2005; Okuonzi & Birungi, 2000). As a condition for financial assistance, already fragile economies were required to take on health sector reforms and transform their government health systems by increasing private sector capacities and limiting government spending for social programs. The SAP was developed by the World Bank, the International Monetary Fund and the United States and called for deep cuts in public spending in the health and education sectors (Klein, 2008; Youngman, 2000). To comply with the SAP, Uganda imposed “user fees” on the population’s access to health and education services.

The outcome of the SAPs was devastating as evidenced by the immediate decline in health and education levels in developing countries, including Uganda, and the impact on fragile systems caused by the emergence of the HIV/AIDS crisis in African countries (Okuonzi, 2004b). Thus in the 1980s, the influence of World Bank’s monetary policies on health and education services in developing countries exceeded the influence of the



World Health Organization (WHO). Health policy direction was affected by the tempering of the WHO vision for primary health care through dominant ideological and economic interests in the United States and within the World Bank. A major disincentive for WHO to continue supporting a rights-based primary health care vision was the withholding of contributions to WHO's core budget by the United States in favor of extra budgetary funding for specific, single disease programs. This was the creation of vertical, top-down disease programs that in effect ended any momentum for implementation of a more village-based comprehensive health care system appropriate and relevant to local community systems. Thus the arrival of vertical disease programs impacted the delivery of training, health education and implementation of community-wide development strategies.

Within the Ugandan government in the mid-1980s, government services were decentralized to remove authority from the national level to district levels. The hierarchy of local government structures (see Table 4.2 on page 107) was created and governing roles for each level were specified. This served to effectively put responsibility for service delivery at lower levels, and connected with the traditional role of the community as being able to take responsibility for itself. It was during this period that the village health team policy was created as a means for empowering community participation in development and delivery of a minimum health care package to local levels.

Although the NRM government made literacy a priority in its Ten Point Program, it was not until the 1990s that funds were placed in the government's budget to conduct a needs assessment. With support from UNESCO, UNICEF and the German Adult Education Association, pilot projects in several districts were started to provide literacy

classes in local languages (World Bank, 2001). These efforts, unfortunately, did not result in forming a common definition of adult education thus posing a challenge to development of a national adult education policy (Atim & Okech, 2004).

The effects of globalization on the social context of Uganda has been felt in areas of health (responses to the HIV crises), economics (the discovery of oil and an international coffee market), and the social sphere (increased use of cell phones and access to international communications through the Internet). In the health sector, ideology has driven President Bush's Emergency Plan for AIDS Relief (PEPFAR) to impose restrictions on how HIV/AIDS education can be framed and to whom condoms can be distributed (U.S. Government Accountability Office, 2006). As a result, HIV incidence has increased in Uganda, a country which was among the leaders in quickly addressing and reducing transmission of this disease. Agricultural exports (such as coffee and horticulture) from Uganda to industrialized countries have not resulted in higher wages for the workers who are employed on the farms and plantations due to the setting of prices by international markets rather than local costs (Government of Uganda, 2002). Further, local firms cannot compete with the large international firms who set up in Uganda, and as a result, local enterprises are failing. In the social sphere, cell phones are ubiquitous in maintaining social networks, and the Internet is widely available in the larger cities.

In summary, the historical and social context for adult education has extended from traditional society through a century of colonial and post-colonial disturbances in developing national capacities. Even with the recognition that adult education is vital to development, the designation of a director-level position for adult education has not been

carried out. Multiple sectors incorporate adult education into their strategies, such as the health sector, but the marginalization of adult education as a visible priority remains a challenge. At the same time, social conditions and the welfare of people at the local level remain a priority of the government thus making the need for efficient adult education approaches a priority of public policy.

### Chronology of Development of Uganda's Health Policy

Tracing the history of a policy's formation is a means for bringing organizational and conceptual coherence to the development process (Stubblefield & Keane, 1994). According to Merriam and Brockett (1997), examining the chronology of an event assists the analyst in appreciating the "plot" or "how events have occurred" in order to "understand the sequence of events through which a particular event has transpired" (p. 67). Understanding how "later events are the result of past happenings" (Merriam & Brockett, 1997, p. 67) and what influenced those happenings are additional benefits of chronological description. In this section, I will present a chronology of events leading up to the development of the village health team (VHT) component of the National Health Policy. The chronology will approach events from international and national documents reflecting major thrusts of the development, education, and health domains.

Figure 4.1 on the next page illustrates the evolution of events in developing the present day National Health Policy. The events are represented by documents and declarations from national and international organizations, agencies and ministries. The documents included in the table are those that were cited by participants in this study as authoritative or influential documents that guided priority setting and budget allocations.

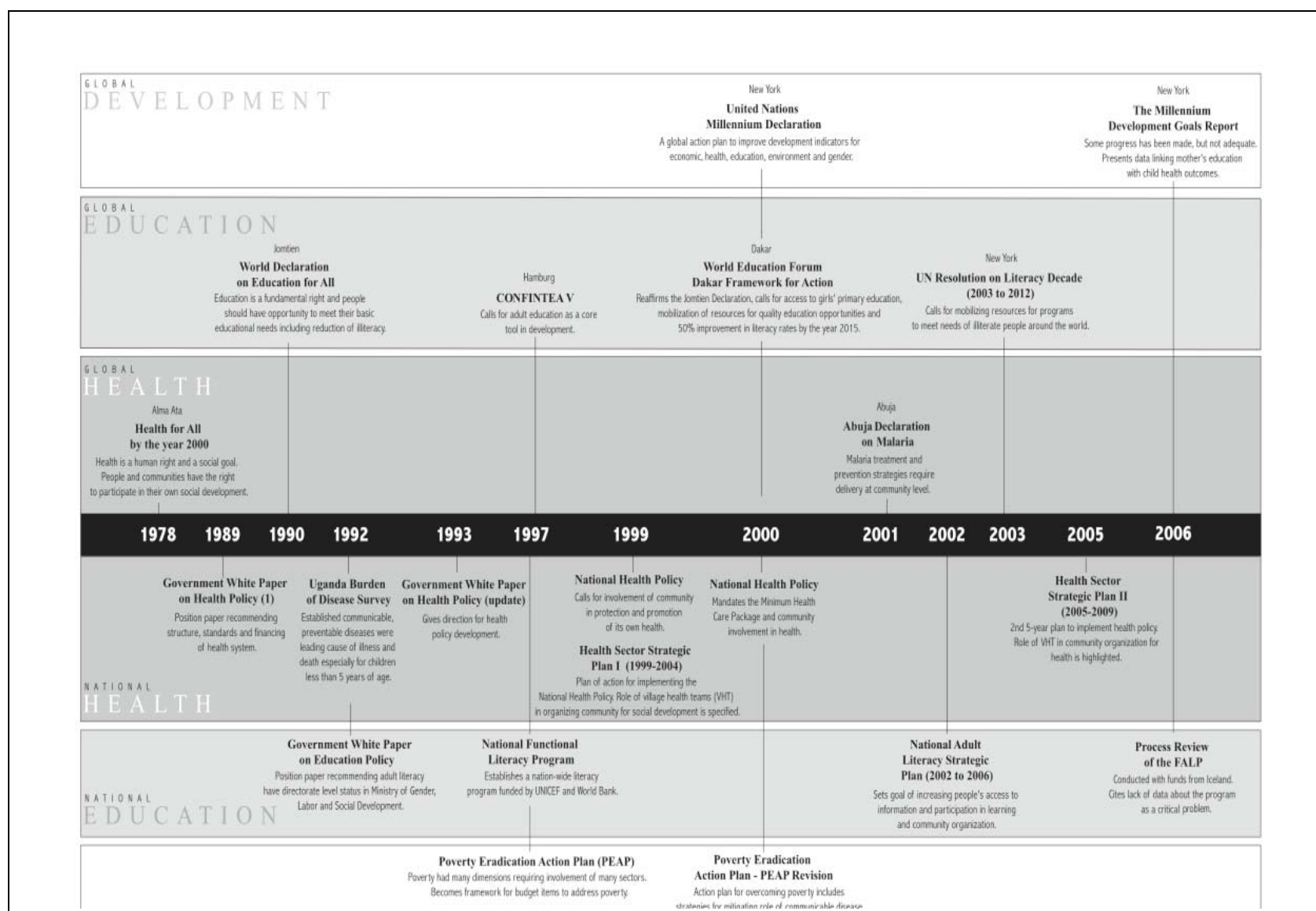


Figure 4.1: Chronology of documents influencing Uganda's integrated health and education policy

1978

The 1999 National Health Policy in Uganda establishes village health teams to implement the integrated public health and adult education policy. In so doing, it cites the WHO-UNICEF Alma Ata Declaration as an influence on the recommendations. Consequently, a relevant starting point for this chronology is an international declaration adopted in 1978 by participants attending a WHO-UNICEF conference in Alma Ata, a city in the former Soviet Republic of Kazakhstan. The purpose of the meeting was to deliberate questions around the adoption of primary health care as a vehicle for addressing health and its social determinants in developing countries (WHO, 1978). Primary health care was viewed as a pragmatic solution to a global context where the gap in disparities between rich and poor countries was growing wider, programs to address social determinants of health were decreasing and the focus on biomedical interventions and technology was increasing. The result of the conference built upon the momentum from developing countries such as Tanzania which had begun primary health care programs that included strong community components for priority setting and decision making.

The participants at the Alma Ata conference deliberated a model of primary health care that would provide comprehensive and basic social services for improving major health problems that were identified by communities themselves. The implementing agents of primary health care in the Alma Ata framework are village health workers. Targets of primary health care included community-based programs for nutrition, safe water, maternal and child health, immunization programs, and treatment and control of infectious diseases. Additionally, the primary health care vision

developed by the participants also called for organizing resources around activities of peace and social development rather than war (WHO, 1978). National governments would be expected to provide their own resources for the primary health care actions. In fact, monitoring national spending on health was one of the targets proposed by the participants. Participants proposed that countries should target 5% of their GDP to be spent on health. Additionally, the scope of the political underpinning of the Alma Ata vision of primary health care involved multiple sectors as seen in this statement from the Declaration:

In addition to health, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors. (WHO-UNICEF, 1978, p. 3)

As a result of the Declaration, countries around the world adopted Primary Health Care (PHC) as the conceptual framework for building government structures to support provision of basic services to the whole country. The slogan of the Alma Ata Declaration was “health for all by the year 2000.” Alma Ata was comprehensive in staking out the populations that would be affected, the extent of services that would be provided, and the way that community leadership would be fostered so that communities could organize on their own behalf and address their own priorities and social conditions. Alma-Ata made an explicit linkage between health and development in how it framed a structure for providing equitable health care for the whole population.

While Alma Ata could be characterized as a pragmatic solution for reaching entire populations, officials in international agencies and development offices in industrialized countries viewed the Alma Ata Declaration a threat. Almost immediately after the Alma-Ata Declaration's adoption by the conference attendees, the World Bank critiqued the declaration as too costly and instead proposed a more limited vision that would focus on a few diseases targeted principally at children less than five years of age and involve significant health care reforms including fee-for-service approaches.

As a result of the position taken by the World Bank, international agencies who had promoted the adoption of primary health care such as UNICEF and WHO, were forced by the changes in funding priorities to shift their support away from the primary health care vision to address social determinants of health and instead promote single-disease-focused initiatives favored by the World Bank (Italian Global Group, 2008). The World Bank position in effect silenced the voice of Alma Ata and instead relocated decision making away from communities and into central levels within a medical, disease-focused framework. International agencies, development experts and governments favored the disease-specific strategy given its amenability to monitoring of specific results (the number of people immunized, for example) rather than engaging in a broader strategy for supporting improved social determinants of health (Sen, 2004; Walt, 1994). This shift occurred in spite of evidence that healthy populations developed as a result of social and political commitments to equitable distribution of and access to health, education, and food security (Italian Global Group, 2008).

The circumventing of national priorities for primary health care was achieved by the institution of vertical health programs directed externally from an international source

such as WHO or UNICEF with a hierarchical delivery, funding and monitoring system that focused only on one intervention rather than a “horizontal” system that is more comprehensive in scope and integrated with other health and social interventions (Calain, 2007). The major vertical programs during this period were the WHO Expanded Programme on Immunizations (EPI) and the Childhood Diarrhoeal Disease (CDD) program. In United States foreign aid activities, these programs were packaged as “Child Survival” programs. The main point in the growth of these programs is that they were designed to overrule the Alma Ata impetus and shifted power away from communities and into the hands of the development and health experts who provided technical expertise. There were additional factors that limited the chance for Alma Ata’s success, but the shift in economic and decision-making power is of most relevance in this discussion.

### *1989*

Nearly ten years after the Alma Ata Declaration, the Museveni government was occupied with restoring and restructuring government services that had seriously degraded during the civil upheaval of the late 1970s and 1980s. Government commissions were appointed for each sector with the assignment to create directions for policies and practices. In 1987, a government health commission met to deliberate on how to restructure, reorganize and finance the health sector. The findings and recommendations of this commission were presented in the 1989 Government White Paper on Health Policy (Ministry of Health, 1989). The paper recommended organizational structures based on the NRM political structures developed during the years when Museveni’s forces were resisting the Obote government. These were



hierarchal structures that provided political control extending from peripheral to national levels. Primary health care was another recommendation of this 1989 White Paper, echoing the recommendations of the Alma Ata Declaration. As a result of the 1989 White Paper recommendations, training of health staff shifted to a primary health care approach (Ministry of Health, 1993) and explicit rationales were adopted to emphasize that improved health contributes to economic and socio-cultural well-being. Thus health was linked to attainment of economic improvements and individual fulfillment.

*1990*

In the international sphere, a World Conference on Education for All was convened in Jomtien, Thailand attended by 155 countries and representatives of more than 160 governmental and non-governmental organizations (UNESCO, 1990). The outcome of the conference was the adoption of a global strategy called Education for All (EFA). The participants rooted their declaration in the tradition of human rights by declaring that education was a right to be enjoyed by all (UNESCO, 1990). The conference convened in response to deteriorating conditions in many developing countries. The problems of the world, asserted the Jomtien Declaration, are “daunting” with increased debt, economic decline, civil strife, poor health, and increasing economic disparities (UNESCO, 1990). As a result, indicators for participation in education and acquisition of literacy skills were falling to unacceptable levels.

Citing the emerging context of a more electronically connected world and anticipating the “cooperation among nations” that globalization would bring, the participants at the Jomtien conference called for (1) reaching every child, youth and adult with education opportunities to meet their basic learning needs, (2) expanding the

education vision to maximize the benefits of increased availability of electronic means to disseminate, acquire, and use information, (3) making provision for equitable access to education for all persons, including marginalized populations, out-of-school youth, women, the disabled, and other vulnerable people, (4) measuring actual learning as an impact indicator rather than only monitoring attendance, (5) creating broader curriculum focus for basic education that addresses lifelong learning from birth to adult life stages, (6) improving the environment for learning, and (7) strengthening partnerships (UNESCO, 1990). Importantly, the Jomtien Declaration also asserted the value of integrated policy components making explicit the need for political will and political commitment in the countries to achieve the goals of the EFA strategy. This commitment from the world community would be achieved by all countries through mobilization of resources to provide the funds needed to achieve basic education for all.

A companion document to the Jomtien Declaration laid out an operational plan for implementing EFA in every country and specified necessary actions at national, regional and world levels. One of the responsibilities at the national level was to create a policy environment that brought together multiple sectors that would interact and align their specific goals and objectives within the broader development goals of the country (UNESCO, 1990). In a sense, this was a call for integrated resources and policies to address a common goal of providing lifelong learning for all citizens.

Tilak (2005) notes that the Jomtien conference is significant because of the global consensus that education is the most critical contributory factor to poverty eradication and economic growth because it improves the life chances of the poor and expands capacities for democratic governance. The declaration is also unique, according to King

(2004), in that it addressed both the industrialized and developing worlds. In fact, the Jomtien Declaration echoes the rights-based approach of Alma Ata and recognizes the critical need for an educated population in navigating an increasingly economically interdependent world.

*1992*

Certainly influenced by the Jomtien Declaration of 1990, but also in line with the Museveni government's efforts to restructure and reorganize government Ministries, a government education commission developed a 1992 White Paper on Education specifying policy directions for adult education and literacy. One of the main goals of the renewed policy direction was the stronger focus of the government of Uganda on providing adult literacy education. The 1992 White Paper on Education outlined problems to be solved through a comprehensive adult education policy that needed to include not only youths out of school and primary school leavers, but also the population as a whole by providing opportunities for continuing and lifelong education. This was a comprehensive vision. According to the 1992 White Paper on Education, all Ugandans should be able to access basic education as a means for reaching a "minimum level of learning, knowledge, skills and values" (Government of Uganda, 1992, p. 15). Various modalities for reaching these objectives were recommended including literacy programs, continuing and lifelong education, apprenticeships, and distance education. The recommendations of the 1992 White Paper gave recognition to adult and non-formal education as high priorities for the government (Government of Uganda, 1992).

With respect to restructuring, the White Paper on Education recommended that the adult education unit be raised to a director level unit in the Ministry of Education.

But the Ministry of Gender, Labor, and Social Development (MGLSD) resisted moving the program, and the MGLSD became the home of the adult education and literacy program. The MGLSD took the position that the target audience for adult education and literacy consisted of vulnerable populations (women, out of school youth, the elderly, and so on). This audience would be offered non-formal education for adults rather than pedagogy for children, a role assigned to the Ministry of Education. This is still the situation in present day Uganda sixteen years later. Unfortunately, the adult education and literacy program remains in a very low level unit of the Department of Elderly and Disability in the MGLSD and is not well-funded.

Meanwhile, in the health sector, the 1992 Uganda Burden of Disease Survey was carried out by the Ministry of Health (Ministry of Health, 1992). The results indicated that the leading causes of illness and death in the country were infectious diseases (including measles, malaria, acute respiratory infections, tuberculosis, diarrhoeal diseases and HIV) and poor nutrition especially in children less than five years of age. The survey results underscored the need for comprehensive prevention and control strategies that could reduce the incidence of these diseases. Included in the prevention strategies were education objectives and recommendations for community delivery of services.

*1993*

An updated White Paper on Health Policy was developed in 1993. The document presented an outline of desired directions, structures, standards and financing of the health system from the Ugandan Ministry of Health's perspective. Still echoing the philosophy of the Alma Ata Declaration, the White Paper on Health Policy (Ministry of Health, 1993) asserted that key issues for policy making were macro-economic in nature

(funds are needed to develop a health system), and should address socio-economic needs (improving education, literacy, and health, especially for women). Community activities should deliver services at the community level and include health promotion. The document linked improved health with the improved ability for economic participation which resonated with IMF and World Bank visions. All the same, the document is explicit in noting that the context of health is more than the biomedical interventions.

The impulse for creating an updated White Paper on Health Policy stemmed from two events. One was the acceptance of the results of the Uganda Burden of Disease Study conducted in 1992, and the other was the national government's directive to decentralize Ministry activities from national to district levels. The 1993 White Paper on Health Policy explained that decentralization was an opportunity to “empower communities to participate in their own development affairs” (Ministry of Health, 1993, p. 2) and to incorporate the primary health care model. Decentralization, reports the 1993 White Paper, is the opportunity needed to bring “services and decision making nearer to the communities” and will require “adjustment in roles and responsibilities of the providers of health services” (p. 2).

What is remarkable in the 1993 White Paper is the designation of socio-economic causes of poor health and the impact that social roles and a lack of education has on health. The renewed interest in adult literacy programs is also acknowledged in the 1993 White Paper as a key partner in health sector activities to improve social conditions. In a discussion about how to improve health status, the 1993 White Paper cites as an achievement the resurgent interest in adult literacy, and points out that “women play a key role in the promotion of health of the family, [thus] the improving of women's

education status would have multiplier impact on the health status of the country” (p. 19).

The 1993 White Paper states that “the women’s contribution to the health status in Uganda is still constrained by their low education status and low status in society and being overburdened with household chores working 12 to 18 hours a day” (p. 10).

Women, however, are also acknowledged in the document as “the most important health worker for her children” (p. 10). Designation of village health teams and the incorporation of traditional healers as agents of change are also indicated in the 1993 White Paper.

Thus the social context, determinants of health, and ways to address them were each acknowledged in health policy in this early government document. The main challenge to the health system, according to the document, is that the “health sector today...is heavily dependent on external support” (Ministry of Health, 1993, p. 19). A challenge for the health sector, claims the 1993 White Paper, is not only to mobilize external funding, but also figure out how to improve internal funding so that the country’s priorities can be achieved.

*1997*

The Fifth International Conference on Adult Education (CONFINTEA V) was held in 1997. The participants in that conference envisioned non-formal education and adult literacy programs as essential components of development programs. The deliberations of CONFINTEA V were summarized in a statement called the Hamburg Declaration which called on member states of the United Nations to consider integrated social solutions in support of literacy and health (CONFINTEA V, 1997). The development context was conceived in CONFINTEA V as overlapping social domains

and aligned social conditions with adult education strategies. Thus adult education was aligned with other interventions to improve health status and social well-being.

Meanwhile, in Uganda in 1997, the adult literacy program was renamed the National Functional Adult Literacy Program. The heightened attention to the government's own adult literacy efforts stemmed from results achieved during pilot projects implementing adult literacy programs in several Ugandan districts. These pilot programs were funded by UNICEF, UNESCO, and bilateral partners. In the early 1990s, with this external support, the government developed a curriculum and conducted programs in several districts (Okech, 2004). Needs assessments were part of the pilot programs and the results of those assessments reported that "women...ranked illiteracy as their highest ranking problem" (World Bank, 2001, p. 7). Similarly, the World Bank conducted a study to show that adult literacy "on its own explains forty-six percent of the variation in the district poverty index" (World Bank, 2001, p. 7). This was sufficient evidence for the government to review the adult literacy program and raise its visibility by renaming it as the National Functional Adult Literacy Program. Funding continued to the government for this program from World Bank and UNICEF through the year 2000.

The broader development context in Uganda received more attention during 1997 with creation of the Poverty Eradication Action Plan (PEAP). The PEAP was developed as a means for describing social and economic areas for development and laid out the national plan for poverty reduction. The PEAP became a critical instrument for all policy implementation in Uganda and is still the authoritative document under which government programs justify their budget proposals. In the PEAP, roles for each sector are defined and development actions are specified and linked to targets and indicators.

The overarching target for the PEAP is that by the end of 2017, the number of people living in poverty should decrease by 10%. The PEAP is the framework for setting government budgets and priorities for poverty reduction, and it remains so to this day. The objectives of the PEAP are to improve income for the poor, improve their quality of life, and improve capacities to govern. Primary health care is a priority area of the PEAP (Ministry of Finance, 1997a).

The PEAP originated during the time of President Museveni's 1996 election. During the election, rural constituents voiced discontent because they were not materially benefiting from the era of peace that ensued after the upheavals of the 1980s. Additionally, conditions in rural areas were still dire. In response to the restlessness of the rural population, President Museveni conducted a "poverty tour" of districts most affected by the long period of civil strife in the 1980s. He took with him on the tour policy makers and ministry representatives. He then convened – with facilitation from the World Bank – a conference of policy makers, stakeholders and donor partners to develop an action plan directed at poverty eradication. This resulted in elaboration of a policy strategy that set a target to "eradicate poverty" for 60% of Uganda's population living in poverty conditions (Ministry of Finance, 1997a). The poverty eradication strategy was written as the Poverty Eradication Action Plan (PEAP). It specified that periodically a participatory assessment process would take place to measure the extent of poverty and apply the results in the Government's action planning and budget allocation process.

As a follow up to the PEAP, the government of Uganda sponsored a nationwide assessment of the causes of poverty to better quantify and prioritize the causes of poverty



so that target-driven action plans could be made to address the causes (Ministry of Finance, 1997b). So in 1997, the government, through the Ministry of Finance and with involvement of the World Bank, developed the Poverty Reduction Strategy (PRS) and instituted the Uganda Participatory Poverty Assessment Project (UPPAP). The purpose of UPPAP was to gather evidence to help policy makers better understand the causes of poverty. This assessment process involved participation and input from citizens in rural and urban areas in all regions of the country. Funding for the UPAPP was supported by the Government of Uganda, Great Britain's aid organization (Department for International Development (DFID) and the Swedish International Development Association (SIDA). Implementation was led by Oxfam, an NGO based in Great Britain.

The question UPAPP asked was "Why do some people move out of poverty and others remain trapped" (Ministry of Finance, 1997a, p. 7). The assumption of this question is that the dynamic for poverty eradication is with the agency of "the poor" in being able to make the transition from a lack of means to an acquisition of means and locates the responsibility within an individual's inherent motivations to take action. While, of course, there are personal attributes that can facilitate one's advancement in life, the scaffolding of social structures is essential to facilitate that movement. Knowing that poor people in developing countries live on \$1.00 a day does not foreground what is required to also earn that \$1.00 a day. The effort to earn the \$1.00 a day in areas with fragile infrastructure does not allow for time to do much more than basic survival. For example, without close access to clean water sources, a woman or child from the household will spend 4 to 5 hours of her day in walking to and returning from the water

source. The amount of distance that must be covered, usually by foot, constrains the personal resources and opportunities for personal transformation out of poverty.

The results of the 1997 UPPAP provided results that showed correlation between illiteracy and poverty. In communities where illiteracy was high, poverty was also high (World Bank, 2001; Ministry of Finance, 1997a). Interestingly, the results of the UPPAP suggested that poor people defined poverty as the “lack of means to satisfy basic material and social needs... [and]...a feeling of powerlessness” (Ministry of Finance, 1997a, p. 12). The most common causes of poverty revealed in the UPPAP results were: poor health, excessive alcohol consumption by men, lack of education and skills for women, poor access to markets, idleness, lack of cooperation, limited access to capital, ignorance, and insurgencies and local security issues

Importantly, the UPPAP results showed that poor people who were surveyed stated that ill health and illiteracy were causes of poverty. The UPPAP is one of two frameworks cited as guiding policy decisions. Following the UPPAP, in 1997, the Government revised the Poverty Eradication Action Plan (PEAP). With the influence of the UPPAP and the PEAP, Ministries had the political environment to then update or elaborate national policies to better focus on the causes of poverty.

### *1999*

Uganda’s National Health Policy was drafted in 1999. It was the first written, established health policy in Uganda. One of the main goals of the National Health Policy includes “community empowerment” described as communities being able to “take responsibility for their own health and well being” (Ministry of Health, 2000). The policy document lays out mechanisms at national level with broad principles for gender

representation and engagement of civil society organizations, donors and other stakeholders at local levels to improve the “overall well being of communities” (Ministry of Health, 2000).

The 1999 National Health Policy was followed by development of two strategic 5-year plans for implementing the National Health Policy actions. The first, the Health Sector Strategic Plan I (1999/2000-2004/2005) included a section describing the role of village health teams (VHT) in organizing the community for social development. The designation of village health teams as implementers of community health interventions and empowerment was influenced by the increased attention of highly placed government officials who worked to establish the political commitment to include the policy. The advocates of this policy summarized its importance by introducing a motto for the public, which said, “Health is made at home and repaired in the health facility.” This paved the way for public and health professional acceptance of the policy. A second strategic plan was developed for the next five-year period, the HSSP II (2004/2005 to 2009/2010). In the Health Sector Strategic Plan II (HSSP II), the VHT are more directly defined as agents for improving health in rural areas.

#### *2000*

Even though the National Health Policy was formed in 1999, there were continuing influences on directions for its implementation. For example, in 2000, the Millennium Development Goals (MDGs) were adopted by member states of the United Nations. They were put forward as a framework for monitoring progress with development in health, education, environmental and technological sectors of developing countries. They represent the intended outcomes of development as seen by the authors

of the MDGS, according to Seya (2005). The MDGs call upon the global community to commit resources towards achieving a set of eight goals including 18 targets and 48 indicators by the year 2015. The perspective of the MDGs is that development cannot be the task of any one country alone; rather, it requires collaboration and concerted, dedicated resources and commitment from rich as well as poor countries (Seya, 2005).

Three of the MDGs focus on health and at least one goal includes an indicator for female literacy. Progress in sub-Saharan Africa towards the goals and their corresponding targets and indicators has not been rapid, and projections show that many African countries may not meet the education and health goals by 2015. Still, the MDGs serve to focus attention on achieving particular outcomes and reporting them to external parties. Regardless, the MDGs are cited in relevant policy documents and reports in Uganda as a way of signaling political commitment or justification for particular sectors and action plans.

As an additional impulse to develop cohesive adult and other education policies, the World Education Forum met in 2000 in Dakar, Senegal to recommit to the Education for All goals and commitments of the Jomtien Declaration in 1990. Assessments of progress towards EFA were conducted in the six United Nations regions in 1999 and early 2000. The results of those assessments helped shape the agenda and outcomes of the meeting in Dakar. Underlying this meeting was the recognition that resource mobilization by countries and donor nations remained insufficient to address the Jomtien goals. As such, the Dakar Framework for Action makes a commitment for funding from donor nations in saying that “No countries seriously committed to education for all will be thwarted in their achievement of this goal by a lack of resources” (UNESCO, 2000, p.

3). Thus the Dakar Framework describes itself as a “collective commitment to action” and specifies that “governments have an obligation to ensure that EFA goals and targets are met and sustained” (p. 8). The target addressing illiteracy is to reach 50% improvement in levels of adult literacy by 2015, “especially for women” (p. 8). The achievement of the targets should encompass political commitment, education policies and integrated approaches across sectors to achieve the outcomes.

Finally, in 2001, an additional justification for improving health and social services to community levels was professed in Abuja, Nigeria when Ministers of Health from African countries met with international agencies to consider how to accelerate reduction of malaria by improving distribution of malaria treatment. This declaration is relevant to the policy formation of the Ugandan VHT policy because a major recommendation from that meeting was to develop community access strategies for ensuring that malaria treatment (the “homepack”) reached rural areas. The Abuja Declaration specified that malaria treatment will be provided within the first 24 hours of fever and promotes home-based management of fever. This type of intervention requires a deep reaching community delivery strategy. This Abuja Declaration for malaria treatment resulted in the modification of village health team training to include delivery of this strategy.

*2002*

The National Adult Literacy Strategic Investment Plan (NALSIP) grew out of the PEAP process as a way to place a more dedicated focus on the needs of adult education and adult literacy programs. The population of illiterates in Uganda at the time of the NALSIP development was estimated at 7 million people (Okech & Zaaly’ekembi, 2007).

The NALSIP lays out objectives for achieving a 50% improvement in literacy rates by 2007. However, a companion ministry department saw the target as too ambitious and reduced the target to reflect those suggested in the Dakar framework which were considered to be much more realistic by setting the target date as 2015 rather than 2007. In the NALSIP, literacy is highlighted as a critical tool for helping communities achieve improvements in many domains of people's lives including health, agriculture, and civic participation.

*2003*

To make visible the commitment of donor countries to the worldwide Education for All targets reaffirmed in Dakar in 2000, the United Nations General Assembly passed a resolution to express "the collective will of the international community" that reduction of illiteracy is in every country's interest as a contributory factor to peace and exchanges necessary for a more economically interdependent world (United Nations, 2000). The resolution was called the United Nations Resolution on Literacy Decade (2003 to 2012)

To raise awareness of the need for resources to achieve the EFA and the MDGs the literacy decade situates itself as part of efforts in support of poverty reduction. The rationales for the resolution are similar to those listed in Jomtien and Dakar Frameworks, so the inference is that this declaration supports action to mobilize funding and remind countries of the commitments made to support those countries that are committed to education goals. Given its stated linkages with EFA and MDGs, the declaration gives impetus to mobilization of political will and commitment to provide the funding necessary to achieve the EFA and MDG targets.

*2006*

This chronology of major documents concludes with a process review of the Functional Adult Literacy Program conducted in 2006. The evaluation addressed the period covered by the NALSIP targets, 2002 to 2006. The review found that some achievements had been realized but that the FAL suffers from many challenges such as the low status in the Ministry, the lack of monitoring data and supervision, insufficient funding, and other deficiencies that significantly limit the impact of this important program (Okech & Zaaly'embikke, 2007).

### *Summary*

This section presented an overview of the historical and social context of adult education in Uganda. It described the shifts in the role of adult learning and adult education extending from the pre-colonial era to present day. The development of adult education programs after Uganda achieved independence was interrupted in periods of civil strife. Government support for adult education in general, and adult literacy in particular, is linked to poverty eradication programs supported by the World Bank and adopted by Uganda's Ministry of Finance. A chronology of key documents that illustrates the international and national influences on the development of Uganda's health policy was also presented in this section. The key documents represented views from the health, education and development domains. The chronology extends from 1978 with the adoption of the Alma Ata Declaration and concludes with establishment of global targets in the 2000s for achieving public health and education outcomes.

### **Adult Education Strategies in the National Health Policy**

This section briefly introduces the major components of Uganda's National Health Policy (1999), the specific policy element that is the adult education focus of this

investigation and the specifications for its implementation. It will also provide a general overview of the administrative organization of the Ugandan health system to illustrate the structural relationships of the health system with the central, district and village health and local government entities.

Adult education in this study adopts a view of adult education and learning incorporates a range of activities used in international development. Adult education is a means to deliver social interventions through the diffusion of skills, attitudes, values and behavior that will assist in achieving the benefits of basic health care and social well-being (Ewert & Grace, 2000; Medel-Anonuevo, 2005; Nesbit, 2007; Seya, 2005; Youngman, 2000). The recommended interventions for almost all of the infectious diseases and public health threats that afflict African communities involve individual and community changes requiring organized activities for awareness, learning, organization and action. Examples encompass adult education and learning in promotion of safe motherhood (including pre- and post-natal care) and community participation empowerment for change in the areas of gender relations and access to health services.

The National Health Policy locates the problem of poor health in terms of poverty eradication and economic development (Ministry of Health, Uganda, 2000). The policy is a transparent declaration of the government's commitment to service delivery, and, as such, highlights policy objectives directed at how the health system should be organized, what roles and responsibilities are assigned to each level, and the cadres of personnel needed to implement the health activities. The overarching vision of the National Health Policy is for improvements in health to lead to improved economic growth, increased social development and eradication of poverty. The policy states that “without good



health, individuals, families, communities, and nations cannot hope to achieve their social and economic goals” (Ministry of Health, 1999, p. 5). Adult education activities address maternal literacy and community organization capacities which contribute to achievement of improved health. As such, adult education strategies are integral to achievement of public health outcomes. Explicit policy objectives written in the Ugandan National Health Policy (Ministry of Health, 1999) that are the focus of this study include the following:

- (a) Section 5 on health education and health promotion sets a goal for improving health awareness and health seeking behaviors in general and also sets specific targets for monitoring health education and promotion targets for control of communicable diseases. These include interventions to prevent and control malaria (sleeping under an insecticide treated bednet), sexually transmitted infections including HIV (prevention, treatment, care and counseling), diarrhoeal and acute respiratory diseases (early health care seeking behaviors involving access to services), tuberculosis, and improved maternal health services for prenatal, childbirth, and postnatal care. Success with these interventions is directly related to adult education activities that underpin adoption of the health promoting behaviors.
- (b) Section 8 presents community participation and empowerment as a vehicle to ensure that “communities...take responsibility for their own health and well being, and to participate actively in the management of their local health services” (Ministry of Health, 1999).

- (c) Section 11 describes social values in health care that will ensure that “the basic principles of equity, fair play, and justice” are considered in designing and implementing policies. In achieving this objective, the policy addresses the status of women in Ugandan society and calls for promotion against “gender-related issues that lead to health problems.” Specific policy objectives monitor progress with reducing domestic violence, sexual harassment, early marriage, food taboos, female genital mutilation, and other related problems.
- (d) A section directing village health teams as the instrument of implementation for delivery of health, community and social policy objectives at the community level.

Other objectives explicitly stated in the policy which also contain adult education components more broadly aligned with change in the social sphere are those that deal with (1) immunizations for prevention of polio, measles, diphtheria, typhoid and tetanus and other vaccine-preventable diseases, (2) environmental health with a focus on improving food hygiene, safe water access and improved household sanitation (each household must build a latrine, for example), (3) improving capacity for epidemic and disaster prevention and response, (4) improving nutrition through nutrition education, and (6) improving mental health services (Ministry of Health, 1999).

Thus the National Health Policy establishes the priorities for action that include the leading causes of illness, death and disability in Ugandan communities and presents specific objectives for monitoring progress towards reaching health, community and social improvements within Ugandan villages and communities. A reorganizing of the structure of the health and political administration aligns the health system with decision-

making authority at local rather than central levels. The specification of village health teams as an implementing factor links the teams to the national health structure while also locating the teams within the communities they serve.

#### *Village health teams*

The specific policy component that is the focus of this investigation is the policy objective in the National Health Policy to establish village health teams (VHT) that can bring the minimum health care services closer to the level where health problems occur. Village health teams are the delivery mechanism for adult education strategies that enable development of the skills, attitudes and practices that would lead to improved health. Health centers in Uganda are limited in number and often distant from village households especially when measured in hours to walk to reach the health center. The VHT strategy was designated as the vehicle for achieving the community service delivery and implementing the Minimum Health Care Package.

Briefly, the VHT policy states that VHT members will be selected through consensus or voting by their own communities (or villages). In the policy, all households in a village should have a say in the selection of the VHT members. To be considered for selection, a candidate for the VHT must meet certain qualifications: he or she must be 18 years of age or older, reside in the village, be able to read and write at least in the local language, have previous experience with community involvement for health or social programs, be held in esteem by the community as a person of trust, and be willing to work as a volunteer “for the public good” (Ministry of Health, 2003).

Approximately 8 to 10 members of the team are elected by the village and supported by the local village council. One VHT member should be selected for every 30

to 40 households (Ministry of Health, 2000). The national Ministry of Health, through the Division of Health Promotion and Education, provides a 5-day training to the VHT members in topics related to the Minimum Health Care Package and strategies for teaching and mobilizing adults and communities. The VHTs are volunteers, and while they receive a certificate from the national level at the conclusion of their training program, they are not formal employees of the Ministry of Health. They are based in and accountable to their own communities.

Similar to the organization of the Ugandan local government structures, each VHT has a chair and a secretary. During the month, each village health team member visits 30 households. These visits connect households with the hierarchical health structure. During the visit, they identify any health concerns in the household, check the immunization status of children in the household to see if they are up-to-date with recommended vaccines, distribute malaria treatment (the “homepack”), conduct health education and provide antenatal counseling and referral to the Health Center II for any conditions that need care or referral (Innocent, 2007; Ministry of Health, 2004)

Village health teams also conduct village-wide screening meetings. For example, in some villages, every month, VHTs have a weighing day where all mothers of children under two years of age attend (UNACHO, 2007). Children are weighed and their weight is compared to a chart to see if the growth progress is adequate for that child’s age. The child’s progress is recorded in the village level register. When the child’s progress fails and progress is not adequate, the mother is counseled on good nutrition. If the child is severely malnourished, the child is referred to the local health center for treatment. Any child who comes to the weighing day with an illness is also referred to the parish health

center called Health Center II. If a mother with a child of the correct age does not attend the weighing day, the VHT member makes a visit to the home to follow up with the mother and child. Vital events (births and deaths) are also recorded in the village record book.

The village record book is the form used for entering information and data from the village. Each month, the VHT meets and summarizes information they have collected. They analyze the information and produce a report. The chairperson or someone delegated by the VHT travels by *boda boda* (motorized bicycle) or on foot to the sub-parish headquarters and delivers the monthly report. The supervisor or trainer reviews the report with the VHT member and then aggregates it with other information sent to the next level of the health system. The data becomes part of the national reporting system.

To complete this section, I present the structure of the local government and health systems. This structure is specified in the National Health Policy as a managerial or political objective reflecting the national government's policy of decentralization of services from national to sub-national administrative levels. Consequently, the National Health Policy outlines a restructuring of the health system that places it in alignment with the political organization of local governmental structures. In the reorganization, the national level of the Ministry of Health is responsible for formation of policies, mobilizing resources, training, coordination, and monitoring the performance of the overall health sector. The district and lower levels are charged with implementing the National Health Policy and providing all service delivery for the minimum health care package and other target areas. The expressed purpose for the reorganization of the

health system is to achieve efficiencies in providing more comprehensive services to the population. Table 4.2 on the next page illustrates the hierarchy of the government's political structure and how it aligns with the revised health structures.

Table 4.2

*Comparing structures of local government and national health systems*

Ministry of Local Government <ul style="list-style-type: none"> <li>• Headquarters</li> <li>• Defines policy</li> <li>• Defends the budget</li> </ul>	National	Ministry of Health <ul style="list-style-type: none"> <li>• Headquarters</li> <li>• Defines policy</li> </ul>
Local Council V (LC V) <ul style="list-style-type: none"> <li>• Responsible for entire district</li> <li>• Planning authority</li> </ul>	District 100,000 to 500,000 people	Health Center V (HC V) <ul style="list-style-type: none"> <li>• National and district referral, specialist and teaching hospitals</li> </ul>
Local Council IV (LC IV) <ul style="list-style-type: none"> <li>• Prioritize plans and investments</li> <li>• Approval of projects</li> </ul>	County 50,000 people	Health Center IV (HC IV) <ul style="list-style-type: none"> <li>• Supervises HC II and III</li> <li>• Inpatient care with surgical services</li> </ul>
Local Council III (LC III) <ul style="list-style-type: none"> <li>• Integrates parish plans for submission</li> <li>• Site for coordination</li> </ul>	Sub-county 10,000 people	Health Center III (HC III) <ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Environmental and outpatient care</li> </ul>
Local Council II (LC II) <ul style="list-style-type: none"> <li>• All village executives attend</li> <li>• Decides parish priorities</li> <li>• Location of parish chief</li> </ul>	Parish 5,000 people	Health Center II (HC II) <ul style="list-style-type: none"> <li>• Outpatient care, immunizations, antenatal care</li> </ul>
Local Council I (LC I) <ul style="list-style-type: none"> <li>• Includes all community members in the village or neighborhood</li> <li>• Identify problems/needs</li> </ul>	Village 1000 people	Health Center I (HC I) <ul style="list-style-type: none"> <li>• Village health team</li> <li>• Service delivery in rural areas</li> </ul>

## Study Participants

Eleven participants were interviewed between December 2007 and March 2008. Each met one or more of the study's criteria: (1) they were engaged in health policy formation as a technical expert, decision maker or policy officer in a Ministry, institution or agency capacity, (2) they took part in the specific instance of policy formation that established the adult education role of village health teams or (3) they evaluated community adult education or public health interventions.

The intention of the study was to interview a range of policymakers, technical experts and program evaluators with knowledge of the policy and its developing country context. All but two of the 11 participants were Ugandan nationals. Of the two non-Ugandans, one was American and the other was British. Because the focus of the investigation was on the National Health Policy, only one participant came from a ministry that was not involved directly with health. Four of the participants were medical doctors, one had a PhD, and the remaining six participants were nurses or educators with advanced training in a specialized field.

This section provides information about the setting for the interview and about the participant's role in the respective Ministry, institution or agency. Each has been given a pseudonym to respect the confidentiality agreement made when each consented to be interviewed. While all of the Ugandan participants had Christian names, Luganda terms were selected as pseudonyms to reinforce for the reader that a Ugandan perspective is being presented. The table on the next page lists the participants, their nationality and their professional role.



Table 4.3  
*Participants interviewed for this study*

Name	Professional Role
Ms. Alice	American director of an American funded NGO in Uganda.
Ms. Ekimuli	A Ugandan medical officer in the NGO.
Ms. Mwezi	A Ugandan program manager in the NGO.
Dr. Dan	British epidemiologist working for an American public health agency.
Mr. Ekitabo	A Ugandan educator who leads a government adult literacy program.
Ms. Enkoko	A Ugandan health education leader in the Ministry of Health.
Dr. Enyanja	A Ugandan medical director in an international public health agency.
Dr. Katonda	A Ugandan medical director of an institute affiliated with the Ministry of Health
Dr. Mulingi	A Ugandan medical director in the Ministry of Health
Ms. Nalongo	A Ugandan nurse who directs health activities in the Ministry of Health
Dr. Njuba	A Ugandan physician and former highly placed official in the government and Ministry of Health
Dr. Olwaazi	A Ugandan medical director of a regional health policy center affiliated with the Ministry of Health
Mr. Omuti	A Ugandan epidemiologist and training officer in the Ministry of Health

*Ms. Alice, Ms. Mwezi and Ms. Ekimuli*

I recruited Ms. Alice for this study after finding reports of a non-governmental organization's (NGO) village health education work during a literature search. Ms. Alice was listed as director of the American-funded NGO. I contacted her by email, and we talked on the phone before I left for a visit to Uganda. When I arrived in Kampala, I contacted her again, and we made an appointment for the interview.

Ms. Alice, the director the NGO, is an American and a former Peace Corps Volunteer. She spent the last 10 years working in US-funded HIV programs in African countries. She had been director of the Ugandan health program NGO for about 2 years when we met for our interview. The NGO develops, implements and evaluates HIV/AIDS, malaria and tuberculosis education and treatment programs in Ugandan districts. Ms. Alice's interests are health promotion and communication, and she advocates for the use of theater, dance and music in health education programs in rural villages. She had an energetic and animated personality, and she made every accommodation to ensure I was settled in comfortably for our interview.

Kampala is a city constructed on seven hills. Directions and addresses reflect locations in relation to these hills. So the NGO's office is located in Nakawa House, named after the hill of the same name. The visit took place in December 2007, during what is normally the rainy season. However, there had not been the usual rains, and so the streets and landscape were dry and dusty. The office takes up two floors of a typical African office building constructed in what I characterized as European functional architecture with simple lines and basic furniture.

The meeting with Ms. Alice turned out to be a group interview conducted with the director and her key staff at the NGO. So when Ms. Alice came to meet me at the reception desk, we walked a few doors down the hall to her office. She offered me tea, and as we sat down, an African woman came in and Ms. Alice introduced me to Ms. Mwezi, the infectious disease officer for their program. Ms. Mwezi had just returned from Ethiopia where she attended a conference on methods for delivery of malaria treatment through community access. During our interview, she referred frequently to what Uganda could learn from Ethiopia.

Ms. Alice then left the office to find Ms. Ekimuli, an African staff member who is the community development officer working with community programs for HIV prevention and response. She also serves as the liaison with the Ministry of Health. As the interview began, Ms. Alice explained that Ms. Mwezi and Ms. Ekimuli would be important to our discussion as they have had more direct contact with the Ministry of Health around issues of social programs that address adult education. Both Ms. Mwezi and Ms. Ekimuli gave examples of their recent activities including the training of more than 17,000 community based women in providing health services at the community level.

Ms. Alice, in deferring to the two Ugandan colleagues, said that she believed there were broader areas to talk about other than the village health teams that would “speak to Helen’s question.” One area of interest the Ugandan women often referred to was the traditional role of the village in Ugandan life and the values of working together to take care of one’s own kinship groups. For example, the group was keen to discuss how community dynamics in Uganda impacted the HIV/AIDS epidemic because of

traditional values and beliefs. Ms. Alice offered that “I think Uganda responded better than most countries [to the emergence of HIV] because the problem was viewed as a community problem and so it needed a community solution rather than being a health care problem to be solved by health providers.”

*Dr. Dan*

Dr. Dan is from England. He is currently an epidemiologist working with a major public health agency in Atlanta, Georgia. Dr. Dan’s first university degree was in engineering. After his university training, he worked for a private international development organization that does long term development and emergency relief work in low resource countries. Because he trained originally as an engineer, his assignments with the development organization focused on water projects. He also took part in disaster responses in African and South American countries. As a result, his experience spans countries across two continents and involves extensive work with community levels to improve access to safe water. He talked about how this work requires objectives for sustainability, and he reflected in our interview how he came to realize that:

What we were doing was asking the most deprived and least able people to take control of all their most basic services, and it seemed an extraordinary thing to do because I know I couldn’t look after my own household. Why do I expect someone with much, much less capacity to do this in their setting?

After several years in the field, Dr. Dan returned to England to enroll in a PhD program to study epidemiology. Upon graduation, he joined an applied epidemiology training program at the public health agency in Atlanta, Georgia. In early December 2007, there was a major outbreak of Ebola hemorrhagic fever in Bundibugyo district in

Uganda. This is a district along the far western border of Uganda that is very mountainous and difficult to access. Part of Dr. Dan's training program is to participate in outbreak investigations, and he was asked to join the international response team that would support the Ugandan response teams. Ebola is considered a public health event of international concern given its high case fatality rate and lack of available treatment. One of the control requirements for Ebola is the following up of suspected cases and contacts to cases, an activity that involved international and Ugandan response team members. During his experience in Bundibugyo district, Dr. Dan worked with village health teams to gather information about possible cases in rural villages. This meant that Dr. Dan had experience working closely with the village health teams, an object of my investigation. So I recruited him to be a part of this study.

*Mr. Ekitabo*

Mr. Ekitabo is the lead officer of a government program for adult literacy housed in the Ministry of Labor, Gender, and Social Development. To find out more about the integration of health topics with literacy activities, I searched the website for the Uganda Ministry of Labor, Gender, and Social Development to locate the national literacy program. Mr. Ekitabo was listed as the lead officer. I called the main number and asked to speak to him. The operator put me through to his office. I introduced myself and briefly described my study. We made an appointment to meet that afternoon.

Mr. Ekitabo's office is located within the MGLSD in the central downtown area of Kampala. The receptionist showed me the right hallway where I could find Mr. Ekitabo's office. His office was at the end of the hall. There was a small bench outside his office where I sat to wait for him. His door was open, and when he finished his

meeting, he motioned for me to come in. He sat behind a large wooden desk in a spacious and sparsely furnished room. The walls were painted green and the cabinets and filing cases were wooden and stained with a dark brown color. There were no windows in his office, but the ceiling was quite high, and a ceiling fan was turning the air. I introduced myself, and sat down. I explained my purpose in wanting to meet him, and we talked very briefly about the adult literacy program in Uganda. Mr. Ekitabo provided a brief overview of his program, and we agreed to meet again in two days for the interview for this study. As I was leaving, he handed me three government documents (two briefing papers and an evaluation report of his program). He suggested I read them first before we meet again for our interview.

For the interview, we met at the hotel where I was staying. We sat out-of-doors and ordered African tea and samosas. Mr. Ekitabo has been involved with the adult literacy program since 1992. He trained in social work and then took additional training for supporting special needs populations and hard-to-reach pastoral and nomadic communities. He provided some background to the challenges in serving hard-to-reach communities given their link with the animals that they hunt. He said:

I'm also trained in special needs education to look at the hard-to-reach communities like the pastoral communities. Today they are here in the dry season, tomorrow they move there, so how do we manage these communities, and the fishing communities, you know, the fish also migrate and the fishermen follow, and so we are involved with [programs for them].

His early work experiences and education were facilitated with support from UNESCO so that he could go to China to receive training in materials development and

participate in training opportunities in Germany. He talked about a trip to Philadelphia he took which was sponsored by an international literacy organization. During that trip, he observed a GED program where students and parents learn together at home. He was energized, he said, by the program, and said he thought such a program could work in Uganda. Mr. Ekitabo presents at many conferences, he said. Since our interview in February 2008, Mr. Ekitabo is no longer in charge of the literacy program. He has been promoted to commissioner level within his Ministry and is now occupied with topics surrounding disability and the elderly. At the time of this writing, no replacement has been named for him in the adult literacy program.

*Ms. Enkoko*

Ms. Enkoko, a senior health education officer in the Ministry of Health, met with me at the Ministry of Health office building. The offices are crowded and noisy, and so we sat in a small storage room surrounded with shelves stacked full of file folders. We could hear voices from neighboring offices while we conducted our interview. Based on the extent of experiences she reported, she is likely in her 50s. She is treated with high esteem by her office colleagues.

Ms. Enkoko started her career as a nurse midwife. She worked in the hospital where she taught nurses and midwives in addition to her duties with patients in the wards. She took her next qualification in public health nursing. She said, “I was immediately selected to do teaching, so I’ve been learning the teaching program for many years.” This period of her life was followed by another career advancement due to an opportunity to receive training in health education. At the time of her qualification in health education, the HIV epidemic had become more critical, and she was one of very

few trained nurse health educators in Uganda. The Ministry began a training program for health educators in the country, and Ms. Enkoko was selected to lead that program. She said, “So I’ve been training the educators who go to train others so I’m more of a trainer of trainers and more in the field like supervision. It puts you in a better picture.”

The program that Ms. Enkoko works in is called the Health Education Network or HEN. Ms. Enkoko described her dedication to her students and to providing them with a rigorous training experience.

For my students, I’ve always been open to them but I’m a little bit strict that if it has to be done like this or like that and it’s been proven to be the right way, let us do it that way. But if you are dodging around, you aren’t helping anybody, not even yourself. Let’s do it the right way.

Ms. Enkoko stated that she found that the students who actually followed her advice and did it “the right way” were very successful in their careers. She told me that

Many of them got their promotions and some have even done PhDs and they are actually happy because I’m like a mother to many, many people, and that’s why they gave me a name, “Mama HEN” because I am mother of the Health Education Network!

*Dr. Enyanja*

I met with Dr. Enyanja, a physician and director for programs that affect mothers and children, at 5:30 p.m. on a Friday afternoon in the Kampala offices of the country representative of an international health organization. It was near my hotel, and so I was able to arrive several minutes early. The WHO country office is newly constructed within the last five years. I went to the first floor conference room where I waited for Dr.



Enyanja. She arrived shortly after 5:30 p.m. She had just finished a long meeting with her colleagues in another department. She and her colleagues were leaving the next day for an international meeting in Europe.

Because professional staff members in her organization are paid an international civil servant salary, equivalent to European and American professional salaries, Dr. Enyanja's income was equal to that of any Western professional who might also work for the organization and considerably more than the salary paid by the Ministry of Health to professional staff that I had interviewed. As a result, Dr. Enyanja had markers of her status. Her grooming was correct and stylish. Her African dress was made from an expensive fabric (a waxed print fabric with African design) and her hair was done in a definite style. Her cell phone rang several times during our interview with questions about her trip on the next day. She was businesslike and professional, even with the late hour and another meeting to attend at the end of our interview.

It has been my experience that African professionals in the international offices in Africa are what an American might classify as "workaholics." Part of the driving force is that an international civil servant job is highly prized for the financial opportunities it opens for one's family. The level of effort is high and productivity is not taken for granted. Dr. Enyanja was no exception to my previous experiences. In spite of the demands on her time, she sat with me for a full hour and then went to another meeting after I left. During the interview, she was reflective and took her time to consider her reply and responded quite directly. As we prepared to say goodbye at the end of our hour, she said, "I am very grateful for this conversation as these questions [about how social and health policies are formed] have been a challenge for many years."

*Dr. Katonda*

Dr. Katonda is a senior level official who leads a community and occupational health organization that is affiliated with a university in Uganda. He is a physician and has a singular passion about improving the health and educational well-being for people at the village level. Dr. Katonda is a tireless advocate for this approach to health and development, and he was generous with his time and orientation to the topic of village health teams.

I had been referred to Dr. Katonda by one of his colleagues at the school of medicine. Dr. Katonda and I exchanged emails before I arrived in Uganda, and he was very hospitable and encouraging about my study. When I arrived in Kampala, I contacted him by phone. He immediately invited me to join him and his colleagues the next day during their site visit to a parish in Western Kenya located in Kyenjojo District. The purpose of the site visit was to attend a graduation ceremony for village health teams who had recently completed their training. Dr. Katonda's organization had been successful in receiving funding from a North American government to support implementation of village health teams, and now several of them were ready to graduate.

A colleague from the Ministry of Health and I traveled by road to meet Dr. Katonda and his team in Kyegegwe sub-district, about 50 miles west of Kampala. When we arrived, there was a small delegation waiting for us in the main gathering area of the small town. We sat on benches under the tree with Dr. Katonda, several local officials, Ms. Enkoko from the Ministry of Health, the local training officer, a local disease surveillance officer, a Western health officer from the North American health agency that was funding the village program, and a senior medical officer from the district hospital.

Dr. Katonda opened the informal gathering, and after ensuring that introductions had been made, provided background to his program. He told our group that he wanted to use the opportunity of our briefing to congratulate this particular parish staff. I noted that while we were in a rural area with no paved roads, Dr. Katonda wore a sport coat, tie, and slacks that reflected his senior status. He described himself as being interested in village health teams since the time of the Alma Ata Declaration, an international declaration that called for comprehensive community-based health care. When I asked why this particular district had been picked, he said:

This district showed the right leadership and commitment from the local government. The funding we had could only cover the smallest of subdistricts and this district showed commitment by using some of their funds to print reporting books for the team members. We are funding this district directly and not through the ministry but through [a European bank] and direct to this subdistrict.

After our briefing under the tree, we moved to the parish hall where the formal activities were held. Every chair in the hall was filled. The audience comprised civic, health, education and religious leaders from the community. All were dressed in formal African dresses or shirts. As part of the agenda for the formal meeting to honor the new graduates of the village health team training, Dr. Katonda addressed the community. He spoke to them in an animated way, encouraging responses from the group and exhorting the community to see a better future. Dr. Katonda spoke as if through sheer force of will, he could make the better world happen before our eyes. Addressing the crowd, he said,

“We must get tired of poverty! We must work hard to get out of poverty! VHTs are essential for getting people out of poverty! With the power of numbers, we can succeed!”

Dr. Katonda and I met again later in the week in a hotel lobby. He began the interview through establishment of the context of the village health team idea and cited the genealogy of documents that underpin the village health team concept. Dr. Katonda is an educator as well as a program director, and he approached our meeting with thorough responses and emphasis on his role as an advocate and leader in improving the well-being of people at the village level.

*Dr. Mulingi*

One of my participants had referred me to Dr. Mulingi, a senior official in the Ministry of Health. Her area of interest was improving access to health services for women during childbirth. She was attending a week-long meeting, but she said she could meet me around lunch time at the meeting’s location. So we met in the lobby of a new hotel that was built by the Chinese government in downtown Kampala. The interior and furnishings of the hotel, although clean and new, were elementary and not well insulated. The building’s walls were made of cement, and so the acoustics in the public spaces were challenging for any kind of consultation. Dr. Mulingi and I had to really pay attention to hear each other because the noise level in the hotel was high.

As a very senior official in the Ministry of Health, Dr. Mulingi’s status was reflected in her formal African dress. Dr. Mulingi, like the other Ministry participants I interviewed, conveyed frustration in knowing what was possible and necessary to carry out to improve social well being versus what was the reality of the situation with respect to administrative, resource and infrastructure limitations. Her frustration was evident in

her description of a system that exists on paper (a referral to a higher level facility for more complicated problems during childbirth) but which, for various reasons, does not exist on the ground. She conveyed her feelings when she observed:

Is Health Center III [a health facility with an operating room] open at night? It is rarely open. So if complications come for the pregnant woman, if she is giving birth, she calls on the traditional birth attendant. That is her only hope. Because by the time [the mother] would get to the health facility, it would be too late for her and the baby.

Her example served as an ongoing reminder of the pressures on professionals in low resource areas who are trained to do the right thing, but who must struggle and accept the best available options knowing that social outcomes could increase significantly if the means were available to do it.

*Ms. Nalongo*

I met with Ms. Nalongo, a Ugandan nurse who works in the Ministry of Health, in her office at the end of her work day. She is a program officer in charge of health promotion and training. She is probably in her mid- to late-30s. She is very strong in her positions and speaks with authority. Our appointment had been set for 5:30 p.m., but when I arrived at the Ministry offices, Ms. Nalongo was distracted and upset. Just that afternoon, her boss had assigned her to help coordinate a film crew from an Asian country that had arrived in Kampala to film a malaria prevention activity. She was in an exasperated state. “They’ve arrived without a plan,” she said in a tone of disbelief. Ms. Nalongo’s boss was very excited about the activity when he passed the management of the visiting film team to Ms. Nalongo. She told me some background about the project

that involved a government minister who had attended an international meeting about malaria. During the meeting, he met the film team and suggested they come to Kampala to film the Ministry's malaria insecticide spraying program. So now the film team was on the ground, and she was trying to organize what she said would be a "real story." She explained:

I want them to tell a real story, not just film the roads! They have been wandering around town taking video shots of the streets and just shooting anything! You know, I want to find a home using the [insecticide-treated bed-] net, a home not using the net, a home headed by a woman, a literate household, a non-literate household, and this can tell a story. But they are here now and they are being paid a lot of money and they arrived with no shooting plan.

I said to Ms. Nalongo that I completely understood the feeling that comes with an overloaded schedule, and I offered to come back another time. She was initially ambiguous in her response and said she wasn't sure she could stay for the interview. Then she said, "Let's talk a few minutes since you are already here." So we began the interview.

From time to time, I would offer to end our conversation so that she could go back to her work. She would reply, "No, no, it's ok," and we would continue the discussion. We ended up talking for more than the hour we'd set aside. Her responses were very lively since she had opinions about the role of the social sphere in health and was also frustrated, she said, by limitations of being a nurse working in a Ministry run by male doctors. She opined frequently that doctors were very abstract in their understanding of community problems and the work of households. After we ended the

interview, we chatted informally, and Ms. Nalongo said if she studied for her PhD, she would be very interested in examining the social sphere of health.

*Dr. Njuba*

Dr. Njuba is a former cabinet level and health official in Uganda. Our main contact was by telephone. Dr. Njuba presents on the phone as strong and passionate about improving social services at the village level. He was mentioned by many of the other participants as the inspiration and origin of the village health team policy. He saw the village health team as a continuum between the local and national levels for health. Before his elevation to the President's cabinet, he spent most of his hospital career as a cardiac surgeon working in a provincial hospital in Uganda.

At the time of our interview, he was working in a European country directing a global commission concerned with workforce issues in low resource areas. I had recruited him for this study because many of the Ugandan participants credited him as the one person responsible for placing the concept of the village health team into the National Health Policy. I emailed him from my hotel and provided background about my study and why I wanted to talk to him. His response was immediate, and he suggested we talk by phone that same day. Even though it was a Saturday, he was in his office working on preparations for a global meeting that would begin the following Monday.

When I dialed his number, he answered quickly. We conducted the consent process, and then he said brusquely, "Let's move quickly. You've already introduced yourself, so let's get started." His phone voice sounded impatient. This made me a little nervous as a result, and then I wondered if this speaking style reflected his surgeon's personality. I began by saying that I'd talk to many people already, and they each had

mentioned him in particular as instrumental in ensuring the village health team policy became part of the National Health Policy. Then I asked my first question. There was a pause on the line of approximately fifteen seconds before he replied, and during that pause, I was not sure what would happen. Then he began his reply, but now his tone was more friendly and more like the narrative tone for story-telling. His responses were direct, detailed and concise. He also took occasion to instruct and then ask me questions to check to see if I understood his points. At the conclusion of our talk, he wished me good success with my study, and I extended my thanks for the generosity of his time.

*Dr. Olwaazi*

Dr. Olwaazi is a senior level Ugandan physician who has worked for much of his career in policy and planning for the government. He was part of the team in the early 1990s that began the process of developing Uganda's national health strategies once stability began to return to Uganda. He has published on decentralization, health sector reform, district level strategies, and financing. He was in the forefront in the Ugandan efforts to undo the World Bank program to charge user fees for accessing health. Like Dr. Katonda, he used to work for the Ministry of Health but he now directs his own institute affiliated with a public health school in Uganda.

Dr. Olwaazi had an office that was in the center of town in an older colonial office building that housed many university institutes and centers. His office was on the first floor and faced the street. When I arrived, he was preparing a talk he was going to give in South Africa later in the week, and he was occupied with his computer and reference materials. We sat next to a row of windows along the street-side of his office. Because it was a warm day, several of the windows were open. As a result, the sound of



birds and passing traffic were recorded on the audio recorder along with our interview! He completed the consent form, and I gave a brief introduction to my research topic. Dr. Olwaazi very early announced his level of expertise was only at policy levels and that he has had no experience at all working at lower levels. “I work at the top, at the level of policy formation,” he said, “and I have very little to do with the district level. I’m mainly involved with international advocacy. At my level, involvement with local groups doesn’t happen very much.” So our interview began with his articulation of his position in the hierarchy and his areas of interest.

During our interview, Dr. Olwaazi punctuated his statements with easy laughter to underscore his feelings about perceived benefits or lack of relevancy in the particular events he reported. For example, he laughed heartily when he said, “We have beautifully written policies but the funding comes from donors and our internal funding is driven by market-approach forces from the Ministry of Finance! It has nothing to do with health!” His humor served to temper his frank assessments of his extensive experiences and interactions in policy development with multiple external and internal stakeholders.

*Mr. Omuti*

Mr. Omuti is an epidemiologist and training officer in the Ministry of Health. His main role is to carry out infectious disease surveillance and to also train graduate and post-graduate students in how to conduct disease surveillance, investigation and response for infectious diseases. He is part of the national outbreak investigation team and is charged with providing education to communities about prevention, disease detection, and response.

I was referred to Mr. Omuti by a colleague in my agency partly because of Mr. Omuti's history in how he came to his position in the Ministry. In the early 1990s, a two-year epidemiology training program was established in Uganda with funding from a private American foundation. The philosophy of the foundation was to charge a high tuition (comparable to what an American university would charge) to attract serious applicants. If the applicants were qualified and had medical credentials, then grants were given to support their study. Mr. Omuti was not a physician, but he wanted very much to be in this program. He was told he could not qualify for financial support as he did not have medical credentials. So he sold his car to raise his tuition and was admitted to the program. He was successful in his studies, and at the end of the two years, several expatriate faculty and the foundation organized a fund to give Mr. Omuti a retroactive scholarship that, in a sense, repaid him for the sacrifices he made to fund his training. For this reason, he has a reputation of being very devoted and dedicated to his position in the Ministry.

Mr. Omuti spends about half his time in the field working with communities and supervising students from the Ugandan epidemiology program during their investigations of public health events. In our interview, we talked about the challenges of working with very limited resources and yet having to still achieve internationally agreed upon targets. He discussed easily the dynamics of the national and international stakeholders who demand information "from the top" and yet the community levels are also "pushing the actors to do something to improve the situation." This puts the national level in the middle of strong forces, he said, because "at the end of the day, the electorate will come to judge [the national authorities] by what they can do..."

### *Participant summary*

This section presented the eleven participants who played a formative or technical role in development of the National Health Policy and the village health team objective as a means for integrating health, community and social policy objectives at the community level. They had hands-on experiences with policy formation and implementation of village approaches to health which they presented from the perspective of their professional roles. Their views as insiders illuminated the interests, negotiations and policy learning needs engaged during the process.

### Chapter Summary

Because this study used a case study approach to qualitative research, an important step for the research was to define the case. The unit of analysis for this study was the formation of a national health policy in Uganda that integrated adult education strategies and public health objectives. To define the boundaries of the case, I presented in this section an overview of the historical and social context of adult education in Uganda beginning with the pre-colonial era and inclusive of the colonial and post-colonial periods. The chapter also described a chronology of the influences on development of Uganda's National Health Policy by highlighting the multiple international and national influences coming from the health, education, and development domains. The chapter concluded with an introduction to the participants interviewed for this study.

## CHAPTER 5

### FINDINGS

#### Introduction

This chapter will present the findings of a qualitative case study that explored the process of forming an integrated public health and adult education policy in the Republic of Uganda. Adult education as a component of socio-economic development is a means for addressing the social determinants of health and for promoting actions and behaviors to prevent and control the causes of public health problems (Marmot, 2005; Youngman, 2000). The explicit adult education policy objectives within the Ugandan National Health Policy targeted by this study are the following: health education and health promotion, community participation and empowerment, and social issues related to gender and health. Because one of the instruments of policy implementation for achieving these objectives is the village health team (VHT), the policy environment around the VHTs is included in the focus of this study.

The results presented in this chapter developed from an analysis of participant interviews and specific policy documents mentioned by participants as contributing to the formation of the National Health Policy. Two theoretical perspectives guided this analysis. One perspective was the program planning theory of Cervero and Wilson (2006) that presents planning as a negotiation of people's interests and power involving technical, political and ethical domains. The other is the Advocacy Coalition Framework (ACF) of Sabatier and Jenkins-Smith (1999) which provided additional pathways for

identifying issues that could be discussed in the context of Cervero and Wilson (2007). Cervero and Wilson's (2006) program planning theory shares common factors with the Advocacy Coalition Framework (Sabatier & Jenkins-Smith, 1999). Both perspectives emphasize the interaction between hierarchical relationships during the process of decision making. Engagement with the stakeholders' interests and the policy makers' learning are also shared concerns. As analytic tools, both approaches posit a time period that encompasses the instance of policy making. Both perspectives examine processes of policy formation as well as the impact of the policy makers' learning on decisions about educational and policy outcomes.

Differences between Cervero and Wilson (2006) and the Advocacy Coalition Framework (Sabatier & Jenkins, 1999) are seen in the relative emphasis placed by each theoretical perspective on the use of quantitative data in the analysis and the definition of who participates in the planning process. The Advocacy Coalition Framework features quantitative analysis while Cervero and Wilson (2006) emphasizes the social nature of planning involving "negotiat[ion of] interests in relationships of power" (p. 12). Another difference is seen in the emphasis placed by Cervero and Wilson (2006) on democratic representation for all stakeholders while the Advocacy Coalition Framework focuses on how the learning of policy elites and the political influence asserted by coalitions leads to policy change. A final difference with relevance to this study is in how each perspective locates and describes the participants in the decision-making process. For example, in the ACF, policy formation occurs within a "policy sub-system [comprised of] ... the set of actors who are involved in dealing with a policy problem" (Sabatier & Jenkins-Smith, 1999, p. 24). The definition of the policy subsystem as being inclusive of all the actors

engaged in solving the policy problem. This definition corresponds to the metaphor of the planning table posited by Cervero and Wilson's (2007) program planning theory. In that theory, the planning table is a metaphor to illustrate where decisions are made and whose interests are represented. Accordingly, the perspective of the findings in this study frames the policy subsystem as including all the actors who are at the planning table. The advocacy coalition framework also describes all members involved in the policy formation process as comprising the policy subsystem, a term I will use to locate the groups of actors who are at the planning table.

Both perspectives focus on the role of beliefs and interests that motivate the decisions that emerge from the negotiations. In the Advocacy Coalition Framework, Sabatier and Jenkins-Smith (1999) feature the role of core and policy beliefs that define the policy coalitions and shape the interests (Sabatier & Jenkins-Smith, 1999). This is conceptually symmetrical with how Cervero and Wilson's (2006) see the role of interests and values during negotiation of the issues. One nuance of relevance is that the ACF describes policy learning as an outcome of conflict which contributes to the changes in behavior or understanding held by each of the members of the policy coalition. Conversely, Cervero and Wilson (2006) hold that interests rather than conflict are the subject of negotiation.

This study's findings are organized into three broad categories corresponding to the study's research questions which were: (1) What interests shaped the integration of adult education approaches within national public health policy, (2) How were the interests negotiated during the policy making process, and (3) What learning did policy makers need to undertake to effect the integration of these policies? Each of these broad

categories is supported by sub-themes. These categories and their sub-themes are summarized in Table 5.1 below.

Table 5.1

*Findings of the study: categories and sub-themes*

A. Interests

- a. Framing the policy problem
- b. Defining the coalitions
- c. Identifying the coalitions' interests
  - i. Preserving constitutional stability
  - ii. Preserving social cohesion
  - iii. Preserving influence on investments
- d. Core beliefs that bind the coalitions
  - i. Poverty eradication
  - ii. Community self-reliance
  - iii. International obligations to development

B. How were the interests negotiated

- a. Through emergence of a national champion
- b. Through funding relationships
  - i. Between international and national levels
  - ii. Between ministries at the national level
  - iii. Between the national and local levels
  - iv. Across local levels

C. What learning did the policy makers need to do?

- a. How to integrate resources

b. How to sustain local engagement

Interests that Shaped The Policy

The work of program planning takes place around a metaphorical planning table influenced by the social, technical and political domains (Cervero & Wilson, 2007). People who are at the table represent individual and organizational interests which are the “motivations and purposes that lead people to act in certain ways” (p. 88). Understanding and anticipating the interests provides insight into how allies and opponents will exercise their power to achieve their own objectives and negotiate interests to ensure that their beliefs will prevail (Cervero & Wilson, 2007; Sabatier & Jenkins-Smith, 1999). In describing the interests that affected the formation of the National Health Policy, I will briefly review the policy problem. Then I will define the coalitions, present their interests, and describe the core and policy beliefs that bound each coalition.

*Framing the policy problem*

The National Health Policy (Ministry of Health, Uganda, 2003) locates the problem of poor health in terms of eradication of poverty and increasing economic development. To improve the nation’s health, the government is committed to providing “a minimum health care package” (Ministry of Health, 2000). In addition, the President of Uganda made a public commitment to respond to the voices of poor communities who spoke through the results of the Uganda Participatory Poverty Assessment Project (UPPAP). People who took part in the UPPAP said that poor health and a lack of education were the causes of poverty (Ministry of Finance, 1995). The UPPAP results also revealed that access to clean water was a community problem that prevented people from participating in activities that would improve their literacy levels and economic



status. For example, the lack of access to clean water is a barrier to economic development, the respondents said. “They take long for looking for clean water,” said Mr. Ekitabo when he talked about the needs assessment. “They told us that if this problem of access to water is not addressed, how would they ever have time to come to literacy classes?” At a practical level, the national government faced a problem of how to deliver a comprehensive set of social programs that would ease the burden on people in rural areas so they could take advantage of economic opportunities.

As a result of the UPPAP process, poverty eradication was embedded in the vision and goals of the government and its ministries. Poverty eradication was defined as requiring a multi-sectoral response. Ms. Enkoko illustrated this point by noting that “[the Ministry of Health] can achieve health for all, but we need an educated, literate community to know what we are talking about.” Ms. Nalongo echoed the view that a literate population is an “enabling factor” for successful health interventions. The problem to be solved at community level was further explained by Dr. Olwaazi’s experience that “communities had no way to interact with the national level, and the villages didn’t have a way to interact with the national health system.” Another problem mentioned by participants involved organization of multiple stakeholders, donors and NGOs. For example, Dr. Nalongo said that “everybody comes with lots and lot [of programs] but how do you organize them, how do you work with them, how do you link?”

### Defining the coalitions

Three major coalitions were identified as being at the planning table to develop the National Health Policy in Uganda. These coalitions were comprised of international, national, and local entities as summarized in Table 5.2.

Table 5.2  
*Coalitions at the planning table*

International entities	National entities	Local entities
World Health Organization	Ministry of Health	Local government administrators
UNESCO	Ministry of Finance	Local health and education providers
UNICEF	Ministry of Gender, Labor and Social Development	Local clan structures
U.N. Millennium Project		
World Bank	Non-governmental organizations	
International Monetary Fund		
Governmental aid organizations from North American, European and Asian governments		

The international entities that comprise the policy sub-system include several United Nations agencies such as the World Health Organization (WHO), UNESCO, UNICEF, the World Bank, the International Monetary Fund, and the U.N. Millennium Project (the focal point for the U.N. Millennium Development Goals project). These are organizations concerned with global leadership in areas of health, education and economic development. Bilateral foreign assistance programs from North American, European and Asian governments are part of the coalition (although no one in this study

mentioned contributions of Asian governments). These are stable, established organizations that have been in existence since the post-World War II era. The U.N. Millennium Development Project and subsequent adoption of the Millennium Development Goals emerged in 2000. These international entities enjoy considerable prestige and authority in guiding all manner of development assistance to low- and middle-income countries.

In interviews with participants in Uganda and in analysis of key documents, these international organizations were mentioned as contributing to the existing health policy objectives. Funding for the international organizations comes principally from the high-income countries in the United Nations. The United States is committed to (but does not always provide) approximately one-fourth of the funding in support of the U.N. general budget (United Nations, 2007). The United States also contributes funding and expertise to WHO, UNICEF and UNESCO. Each of these organizations has a presence in Uganda either in the form of a country office with an organizational representative or ambassador, or as facilitators of public policy documents such as the World Bank's support to the UPPAP and Functional Adult Literacy Program evaluation in 1999.

The second coalition involves particular Ministries of the Government of Uganda and non-governmental organizations (NGOs). The Ministries that are represented in this study are the following: (1) Finance, Planning and Economic Development, (2) Health and (3) Gender, Labor and Social Development. Also within the national coalition are two NGOs that are active in implementing government health and education policies at village and district levels.

The Ministry of Finance, Planning and Economic Development is the lead ministry for development, implementation and monitoring of the Poverty Eradication Action Plan (PEAP) that establishes the goals and targets for all sectors of the government with input from the respective ministries. Final decisions about national program funds rest with the priorities of the Ministry of Finance, Planning and Economic Development. This ministry collaborates externally with the World Bank.

The Ministry of Health (MoH) has the responsibility for setting policies and guidelines for the Ugandan health sector. The focus is on delivery of the Minimum Health Care Package, a set of cost-effective programs for childhood immunizations, communicable disease prevention programs, HIV/AIDS activities, and health education and promotion in areas of safe water, sanitation and maternal and child health. The Ministry of Health collaborates with the World Health Organization's Country Office in Kampala and with bilateral donors and partners in North American, European and Asian governments.

A third important member of this coalition is the Ministry of Gender, Labor and Social Development (MGLSD) which houses the Functional Adult Literacy (FAL) program within the government's structure. The MGLSD's mission is to address the needs of vulnerable populations within Uganda especially the disabled, women, the elderly and children and youth out of school. The FAL has collaborated with the Ministries of Health in development of literacy curriculum that is based on content about health and sanitation topics. Up until 2000, funding came to the FAL from World Bank and UNICEF, but because of a difference with the government's request for contributions to "basket funding" rather than dedicated funding to particular projects, UNICEF stopped its

direct funding to the FAL as did the World Bank in favor of funding for programs for girls in primary school. Funding right now is challenging for the FAL.

Next are the non-governmental agencies who participated in the national coalition. They receive funding from external sources and liaise directly with Ministry programs and district level authorities. Two NGOs were represented in this study. One was funded by a North American government with a home office in a North American country, and the other was based in Uganda with funding from a second North American health agency coming directly through a major European banking system rather than the government's basket funding system. While the NGOs were involved in the deliberations around the formation of the national health policy, their more visible role is in implementing the policy objectives. Both of the NGOs involved in this study gave priority to community development programs and worked in close liaison with the Ministry of Health.

Finally, the local entities represented at the planning table through their linkages to the political administrative hierarchy and their participation in needs assessments. For example, in the UPPAP results, Mr. Ekitabo reported that "the community" rated the need for improved literacy as "number 4 in the needs assessment." The community results also point to the communities understanding that poor health and inadequate literacy levels are linked with poverty (Ministry of Finance, 1997a).

In summary, the international, national and local members of the policy subsystem who constitute the planning table are established entities that represent government and non-governmental interests. These interests will be described in the next section.

### *What are the interests?*

Understanding and anticipating the interests of the members of the subsystem provides an opportunity for insight into the motivations of the participants at the planning table (Cervero & Wilson, 2007). In this study, the analysis of the participant interviews and policy documents resulted in identification of three broad categories of interests held by the members of the policy subsystem. The interests revolved around actions that would preserve (1) constitutional stability, (2) socio-cultural cohesion, and (3) influences on investments.

#### *Preserving constitutional stability*

Preservation of constitutional stability including government structures and processes was identified in the analysis of participant interviews and documents. Specific factors contributing to the preservation of stable governing structures involved (1) organizing the health sector for economic prosperity and (2) increasing human resources.

*Organizing for economic prosperity:* Increasing economic prosperity and eradicating poverty are goals stated in the Constitution of Uganda (Government of Uganda, 1993). The specific government action plan for addressing improved economic conditions is the Poverty Eradication Assessment Plan (PEAP) developed by the Ministry of Finance, Planning, and Economic Development (MoF) and updated every three years with information from the needs assessment process through the Uganda Participatory Poverty Assessment Project (UPPAP). Each ministry links its policies to the targets within the PEAP and in response to the UPPAP. Consequently, economic prosperity is a goal for every sector represented in the government's structures.

The explicit policy objective for integrated adult education and public health policy objectives implemented through village health teams (VHTs) is an expression of the government's interest in strengthening the hierarchy that connects each level of the governing systems. At the surface level, the administrative linkages within the hierarchical structure of the Ministry of Health are parallel to the political and administrative structures as illustrated in Table 4.2 and are established in the National Health Policy document (Ministry of Health, 2000). The importance of the hierarchy to this study is to understand the practical factors surrounding implementation of the policy and the eventual creation of the village health teams. Thus it was of interest when Ms. Enkoko presented the administrative hierarchy as a political apparatus and demonstrated what people understood about how the hierarchy worked. She said:

We look at the political leaders as number one. Then we look at the administrators, like the financial administrators. So when we look at a ministry like this one the political one is like the minister, the undersecretary and so on. And then there are the technocrats and directors, commissioners and so on and then they agree up there what to do, and of course, it comes down here. The actual work is done down here.

A significant problem for the government is a lack of sufficient numbers of trained people to work in the Ministries. This is especially true in the Ministry of Health where reaching into village levels is hampered by not enough staff. Dr. Mulingi, who is a high level ministry official in charge of the national maternal health program in the Ministry of Health, alluded to this problem of inadequate staff. She described how the

VHT could fill the human resource gap so that the people in rural areas would see the commitment of the government to their well-being. She suggested:

[The VHTs] could distribute Mama Kits [kits for clean child birth] along with bed nets, and tetracycline for the newborn's eyes. Referral of difficult deliveries is a problem and we proposed that the VHT would have a cell phone owned by the team and then the community could call to the health center and a vehicle could come to attend to the woman. They could make the VHT person with the phone a salaried person.

Official documents (such as the written National Health Policy) construct an image of policy as a set of actions and directive about how government will work and defines its priorities (Bardach, 2000; Hodder, 2000; Prior, 2003; Silverman, 2001). The theme of constitutional stability was most evident from a document analysis of the National Health Policy. In a document analysis, it can be useful to look at how the written policy represented the policy reality and how words were used to represent that reality. To complete the document analysis, I conducted a sentence-by-sentence thematic analysis of the National Health Policy using open coding. After grouping and sorting the ninety-six items developed during the coding, I identified ten categories as seen below:

- Administrative organization
- Capacity building
- Decentralization
- Economic development
- Equity of access and services
- Legal standards
- Metrics
- Private sector involvement
- Service delivery
- Values



The categories clearly illustrate that the interest of the National Health Policy were not so much targeted at technical or biomedical factors but rather reflected the organizational needs of the Ministry and its link to the Government of Uganda's vision for economic prosperity. The scope of directives dealing with the structural organization of the government's organization reflected interests that met political as well as technical directives. For example, an item was grouped into "administrative organization" if it dealt with national level functions and a call for reorganization necessary for implementing the policy. "Civil society" was included as "administrative organization" because "civil society" was mentioned as an influence on community organization. "Capacity building" was the category for items that dealt with learning and/or training at either the population or health worker level. "Economic development" addressed any item regarding cost or financing. "Equity" included any item that expressed the need for gender equity in terms of access to services and actual services provided. "Legal standards" was the category for any item discussing standardized approaches, processes or practices. "Metrics" reflects the influence of globalization and the demand from international agencies for measures of competent performance. Any of the items about gathering, monitoring and evaluation of numeric data were grouped into this category. The role of the "private sector" was the focus of several items especially in the definition of traditional healers as part of the private sector. "Service delivery" encompassed health care services. "Values" was a category for grouping directives expressed as philosophic underpinnings or justifications such as "national sovereignty," "the poorest of the poor" and "ethical planning."

The complete results of the grouping of the ninety-six items into ten categories or themes are in Table 5.3 on the next page. I include it here to suggest that the interests of the policy formation process extended beyond the realm of health. The policy formation process links health service delivery with the national government's goals for economic prosperity.

Table 5.3

*Key phrases from analysis of the National Health Policy of Uganda grouped by themes*

Theme	Key words or phrases	
Administrative organization	Central level functions Civil society Collaboration Common framework	Planning Reorganization Role of central level
Capacity building	Health promotion Health-seeking behavior	Human resources Equitable deployment Human resources – pay and training Human resources – productivity
Decentralization	District health plans Functions of lower levels in decentralized system	
Economic development	Affordable care Allocation of resources Capital improvement Cost effective interventions	Cost-effective priorities Economic competition: public/private Efficient delivery Efficient systems Financing
Equity of access and services	Access to services Community inclusion in planning Disparities Equitable provision of care	Gender equity Geographic equity Underserved areas Vulnerable populations
Legal standards	Disaster and emergency preparations Joint planning	Legal framework Standards – traditional healers
Metrics	Burden of disease Causes of death Community-based health information system Dissemination of data	Generating data Monitoring impact Monitoring health worker performance
Private sector involvement	Definition of private sector Public-private partnerships Role of private sector	
Service delivery	Communicable diseases Health care delivery Health care services Hospital services	Hospital services Non-infectious causes of disease Primary health care services Village health team
Values	Accountability Cultural appropriateness Ethical planning Government role for poorest of the poor	National sovereignty Reaching all the people Research commitment

In the written policy, health is defined in economic terms as a commodity to be delivered and distributed rather than a state of being. In fact, the policy states that “Without good health, individuals, families, communities and nations cannot hope to achieve their *social and economic* goals. The overall goal of the health sector is the attainment of a good standard of health by all people in Uganda, in order to promote a *healthy and productive* life.” (Ministry of Health, 2003, p. 7). In conceiving an economic justification for improved health, the National Health Policy proposes a “Minimum Health Care Package” which is comprised of “cost effective interventions” that include appropriate technology and human resources, which are “affordable.”

In conjunction with the thematic analysis of the National Health Policy, it was also of interest to examine how words were used in the policy. This comes from an approach to documents suggestion by Prior (2003) that looking at how words are used in documents leads to insights about the construct of persuasion at work in the document. Looking at the words also helped to further explore the interest in constitutional stability and preservation of government structures through communicating how the government wanted its role in health to be seen. For example, in Section 2.0 of the National Health Policy, the document proposes strategies for improving the health situation. The strategies are written with strong verbs such as: clarify, control, formulate, increase, intensify, involve, prevent, reactivate, and update. Phrases used in this section include “concerted effort,” “essential prerequisites,” “significant input,” and “sound development policies.” These are phrases which seem to create an impression of hard work, focused attention and progress. It appears that the strong verbs and phrases of efficacy were used

to describe the Ministry's (and hence the ruling party's) commitment to meet the goal of improved health and economic prosperity.

It is worthwhile to note that women's health in the National Health Policy is presented in terms of policy directions for addressing reproductive health, domestic violence, and female genital mutilation. Women's health is also the emphasis on gender equity with access to health services and provision of relevant services. Therefore, women's health is not defined as beneficial for a woman's general well being and development potential but is, rather, mainly constructed in terms of women's domestic and reproductive roles. The discussions of women's health, however, do speak to the major health concerns that arise out of the social environment within Ugandan society that affect women's health outcomes. As such, the National Health Policy speaks to the gender equity goals in the Constitution of Uganda.

*Increasing human resources:* Provision of health services to reach local levels requires trained people who can work in the government systems to deliver services. Without service delivery being seen by the population as functional, political stability is at risk. Mr. Omuti, from the Ministry of Health, explained that the ministry "has championed the involvement of health teams" because of an expressed need of different programs "who realize there is a need to have people at [the village level]." He described the expressed need as a demand for information from the community level. Mr. Omuti continued that "the communities need to be involved from the onset so they know they are part of the problem and they are part of the solution." Establishing connection with hard-to-reach areas in this case becomes critical for the government's and ruling party's stability.

While the goal of village health teams is to assist the government in delivery of health, community and social policy objectives, one very practical role that they play is to provide the human resources necessary for service delivery. For example, Dr. Dan's experience with village health teams during the Uganda Ebola outbreak in December 2007 suggests how village health teams become essential in achieving access to remote areas during an epidemic. Because each suspected or confirmed case may have as many as 10 or 15 contacts, the follow-up and contact tracing is resource intensive. Dr. Dan said, "You are stretched too thin to do it all completely." The engagement of village health teams extended the reach of the international investigation team. Dr. Dan explained:

It was started by a Ugandan guy from [a global health agency] and he knew about these village health teams and they all came down from the mountain areas and they did some training on Ebola and contact tracing and what to do and look for and they really got that going.

The value to the government was that service delivery could be provided to remote, hard-to-reach areas. For example, the village where this particular outbreak occurred was in a high mountain area. There is a single road that winds through the area, and meeting points were established for rendezvous with the VHTs. The international team would drive the road every day and meet up with each of the village VHTs. According to Dr. Dan, the teams would "come down the mountain and meet us" and "then we'd stop and they would have a list of all the contacts." If a problem was identified, said this participant, the medical team would go to the village and visit the sick person for assessment and referral to further care. Consequently, the VHTs were

instrumental in providing a lifesaving link between normally “silent areas” (areas where information is not forthcoming) and the health establishment. Dr. Dan said they had some “really good engagement” from some of the teams from some areas, and “absolutely no engagement” from teams in other areas. In his view, “where [the VHT activity] works, there’s lots of potential, but where it doesn’t work, well, there’s nothing.”

In conclusion, the government has an interest in achieving an adequate supply of skilled human resources as a means of ensuring structural stability and provision of the services for ensuring health and education. The role of the VHT as an implementing agent of the integrated adult education and health policy fulfills as well a gap in adequate staffing and linkage to the information needs of local communities. Mr. Omuti, a Ministry of Health employee, points out the interests of the government in ensuring it is linked with communities. In his view, the use of health facilities as locations for seeking care is low in Uganda. This is mainly because of the distances (and time) required for reaching adequate facilities by foot. As Mr. Omuti explained, “This means a lot of health information remains untouched from the community. Now the village health teams penetrate deep into the community.” Participants said that the value of the teams is their ability to reach the communities because they live in the same villages as the people who are targeted by this policy. Thus the role of extending human resources is an interest of the government, a critical entity at the planning table.

#### *Preserving social cohesion*

The relationship between poor health, poor education and poverty was often linked to efforts at community levels by several participants. The health benefits that accrue to communities were evident to Ms. Enkoko who said, “If we are healthy, then we

can work, and have time to save some money, have good houses, run a good homestead.”

Another participant recognized how the social sphere impacts health, and that the community should be able to “address their own issues” as Dr. Enyanja said. She said:

We identify [social determinants] as one of the most important inputs and outputs and outcomes. You must put in those mechanisms which empower the communities, so that apart from the service delivery issues, we are empowering communities to address their own issues according to their own needs and according to where they are.

Yet the structural difficulties in achieving cross-sector and integrated domains were also highlighted. For example, Dr. Enyanja, an employee of the global health agency, reflected on her work with reproductive health issues. She explained the “challenge” for addressing reproductive health problems as one that involves “cultural things.” Because reproductive health involves cultural beliefs about gender roles, birthing practices and gender violence, community activities had to be carefully designed. In contrast, she offered an opinion that cultural issues were less difficult to incorporate in some other programs. For example, she said that “immunization programs do not [involve cultural issues] or not taking anti-malarials because you have a fever anyway, and for the behavior thing, we really cannot touch on those [cultural] vulnerabilities.” She continued with her opinion that interventions involving culture should be best handled by agents outside of the health sector. She expressed her opinion by stating:

Really health has all these other social determinants and yet [the determinants] are not happening in the health facility. They are happening elsewhere, and the best people who can address these [social



determinants of health] are outside the health facility.

Dr. Enyanja saw the solution as the national government's responsibility to provide social programs within communities. She felt that "the role of the government is to be working at the community level to achieve some of these other [social] outcomes, and that's a very positive policy." Thus there is an interest ascribed to the national government to enhance sociocultural cohesion through policy objectives for integration of adult education strategies within public health policies.

Interestingly, when I reviewed written policy documents for directives about the community structures, I found that the written National Health Policy and the Health Sector Strategic Plan II 2005/6 – 2009/2010 (Ministry of Health, 2005) -- documents that deal with integrated approaches and designation of village health teams -- are silent on the question of the traditional clan structure. Inquiry into the clan structure emerged as a result of one participant's response to a question about what would improve the implementation of the policy. Ms. Nalongo talked about the usefulness of the traditional values in the clan system of "taking care of your own community, that is, your uncle, your cousin, and extended family. You have a collective responsibility towards the economic, health and agriculture of that village."

Another indication that kingdoms and clans play a stronger role than what is written in the policies emerged during a visit to a sub-parish site in a western district where I to attend a VHT graduation ceremony. After assembling the parish and sub-parish leaders in a small community hall, the community development officer formally called the 100 or so community members to order. The first agenda item was the singing of the Toro National Song, an anthem of the Toro Kingdom sung in a local language.

The singing the Ugandan National Anthem followed. The national anthem was sung in English and Swahili. In this order of business, priority was given to the local clan's identification and its kingdom. With the clan structure operational in a well-functioning district in Uganda, I added questions about the clan structure to my participant interviews.

As described by one of the participants, “before Uganda became Uganda” the area was comprised of multiple kingdoms organized around clans and family groupings. In Uganda presently there are 52 clans divided amongst five to six kingdoms. The clans are linked by extended family alliances. The kingdom is bonded through social networks and expressed values. For example, in the kingdom that Mr. Omuti belongs to, he reported that there are five values that are geared towards survival and control of the clans and family groups. He reported that values were communicated through the language and culture of the kingdom and that they include:

1. Hard work. The underlying rationale is to instill the value of responsibility for working productively to prevent poverty, to care for children, and to support one's family.
2. Self-governance. The kingdom should operate as a federal system with three or four “states” within the kingdom. Decisions about development and administration of the kingdom should be made by the “citizens” of the kingdom itself. Kingdoms conduct businesses such as radio stations and leasing of land to raise money to run the kingdom. They also solicit donations from wealthier clan members and business people.

3. Belief in the king. The king is the symbol of unity and is viewed as descendant from a distant ancestor. There is a lineage that constructs the hierarchy and social order around a “royal family.” The king is the source of identity and point of reference for administrative and cultural identity. Safeguarding the traditions of the kingdom are one of the principal goals inherent in the expressed value to believe in the king. The role of the king in deciding actions to be taken is strong. A mandate is usually presented as “The king has directed...” according to Mr. Omuti. He continued, “If that is how it comes out, then the people will listen.”
4. Preserve your land. Keeping land in the clan and family has benefits for the extended family. Each family or clan must have a “plantation for the king.” This is land that is set aside as a cassava plantation. In practice, the cassava does not belong to the king but is rather a metaphoric function describing a social safety net. The operating principle is that in the event that hard times come, there will be food in reserve to maintain the families.
5. Religion. The final value is to believe in God. This is to ensure that people will live a good life and are aligned as a social unit to fear God and live moral lives. In this way, the people’s culture will be preserved.

Mr. Omuti explained that clans are aligned through local languages. The purpose of the clans is to avoid intermarriages because “you need to know your line of inheritance to avoid marrying close relatives.” Clans are given names as totems, usually names such as “clan of the monkey” or “clan of the bird” and in this way, when people are seeking to

marry, part of the introduction and courtship is to introduce one's self according to clan. The clans stimulate unity and provide social cohesion and organization.

*Preservation of influence on investments*

Donors from the international organizations and national governments have an interest in protecting their investments and influence on how low resource countries develop by expressing broad support for peaceful and stable economic environments. The international agencies involved in the policy subsystem targeted by this study enjoy considerable prestige and leadership in defining worldwide directions in technical, structural and financial domains. Their interests, therefore, are to preserve that prestige and leadership. The goals and targets set by external partners' impact how low-income countries will organize and execute activities for achieving the external goals and targets. Consequently, preservation of influence is an interest of the multi-national agencies operating in the integrated adult education and health policy environment including U.N. agencies such as WHO, the World Bank, UNESCO and UNICEF. National foreign assistance departments of high- and middle-income countries were also part of the policy environment. The U.N. agencies themselves are under the influence of high income governments. The national governments use their influence to shape the strategic and operational directions of the multinational agencies, and, therefore, protection of that influence is in the interests of national entities who were involved in the policy formation process. These interests for preservation of influence are suggested in the counterpart relationships between the key ministries and their counterparts in the multinational agencies that the participants and policy documents described. This counterpart relationship of interests is illustrated in Figure 5.1 on the next page.

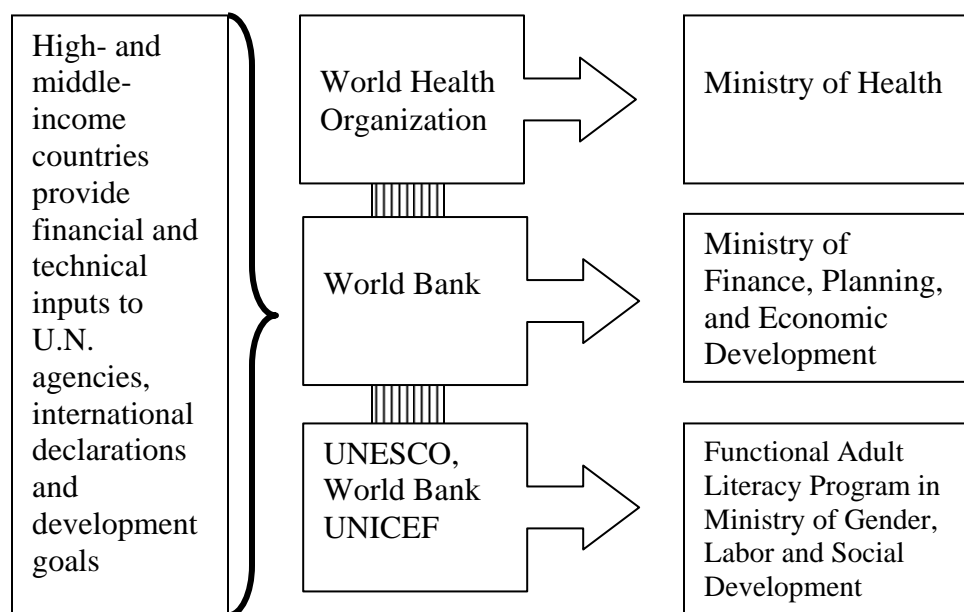


Figure 5.1  
*International coalition counterparts to Government Ministries in Uganda*

In the case of the Word Bank, it has a long history and direct relationship with the Ministry of Finance, Planning and Economic Development (MoF). The World Bank describes itself as an ally in Ugandan development (World Bank Country Report, 2006). Since the time after independence in the early 1960s, the World Bank has been involved with Uganda’s development agenda. This is reflected in written documents describing the Poverty Eradication Action Plan (PEAP) and the Uganda Participatory Poverty Assessment Project (UPPAP), two political documents that guide the strategic action plans in every sector. The World Bank is on record as supporting the PEAP’s goals and objectives which means that at one level they are endorsing their own strategy given their support and facilitation of the initial 1995 PEAP. The PEAP and the UPPAP are endorsed by the Ministry of Finance and also accepted by the World Bank in meeting the

World Bank's requirement that each country should develop a strategy paper supporting a poverty reduction approach. The World Bank's interests in working as a counterpart with the Ministry of Finance are evident in its role to develop the priorities for government spending through the PEAP. One participant called the relationship between the Ministry of Finance and the World Bank as a situation where the ministry has been "colonized" by the World Bank because the MoF now acts as a "champion of market-driven policies." Thus an added interest of the World Bank and its counterparts within the Ministry of Finance are to preserve their mutual access and ideological foundations upon which funding decisions are made.

International agencies who participated in this instance of policy formation exert influence in technical leadership for key areas such as health and education. The World Health Organization is a global agency (which also receives World Bank funding) that sets international standards, guidelines, tools and approaches for health sectors in the member countries of the United Nations. Dr. Enyanja, a director within the global health agency, describes the relationship between the World Health Organization and the Ministry of Health in more symbiotic terms. "We never work as WHO," she said, "we work as the Ministry of Health." She described the role of WHO as operating "like a broker" because they "bring people together, and where nothing exists, we try to make sure there is an organized system to deliver community health packages." By specifying the eventual target of "the community," Dr. Enyanja sees the strategic value of her agency as contributing to the organizational capacity of the country that will eventually result in service delivery. Thus the interests of a global agency like the global health organization are to extend their technical influence in the decision making and

organizational structures of the Ministries of Health. Ultimately, her agency's effectiveness is evaluated by Uganda's performance on international health indicators and thus her interests are to provide the strategic support that can contribute to the national capacity to achieve these outcomes.

Within Uganda's Functional Adult Literacy Program (FAL), UNICEF and the World Bank participated with the FAL throughout the 1990s. The funds from these two agencies allowed the FAL to grow and demonstrate the value of literacy on the well being of local communities (World Bank, 2000). The interests of UNICEF and World Bank were seen in this particular collaboration as involving improved community capacities for health and socioeconomic well-being. Progress with the FAL slowed when the Government of Uganda instituted "basket funding," a mechanism for pooling resources from all sources of assistance so that the government could coordinate the aid. UNICEF did not wish to participate in the basket funding, and they left the literacy program. This is discussed in a later section of this chapter. In brief, however, the World Bank's interests are principally economic and their interests in the FAL were on improving the socioeconomic capacities of agricultural communities.

Participants also discussed the interests of foreign assistance departments from national governments as preserving their influence on technical domains. For example, foreign assistance is provided to the Government of Uganda, but it is also a source of funding for the international and local NGOs based in Kampala. The influence enjoyed by external partners is evident from an example described by Ms. Alice, the director of the external NGO. One activity her NGO supports is to convey through song, dance and drama health education and prevention information to people waiting in line at HIV

voluntary counseling and testing sites. Ms. Alice said that she “always gets the songs translated” into English as a quality check for herself. This led her to realize that the health information being communicated was not as accurate as it needed to be. As she reported:

One of the members of the dance group had a T-shirt that said, ‘prevent AIDS by getting tested.’ Well, getting tested doesn’t prevent AIDS. You can prevent AIDS and never get tested, you know, if you follow safe sex, or you can get tested and spread AIDS all over the place. So we had some tweaking to do.

The solution her NGO adopted was one of standardizing the message, an example of how the NGO’s technical authority (which in this case is possibly life saving) was deployed. The NGO created standardized scripts for the songs, dance and drama program. Ms. Alice said that “we pass them out to the [local] NGOs we work with to help standardize the messages.” This is an example of why the NGO would want to preserve these interests to influence how policy objectives are framed and implemented.

Another interest of external national partners is to extend and protect the external country’s own economic and political interests. For example, Mr. Ekitabo described a situation where a European government established a partnership with the Functional Adult Literacy Program (FAL). The European government provided funds directly to the FAL. Mr. Ekitabo described how the government proposed their activities. He said that

They wanted to support literacy programs. They wanted to support islands because they are an island country and they wanted to support island districts [in



Lake Victoria] and that is why they went to Kalombo District and now they have expanded to Makono District.

The European government involved in this activity describes its interest further on its website. In addition to literacy, the government's foreign assistance activities in Uganda center on the fishing industry and exploration of geothermal sources of energy. Their development focus on fishing areas is to improve the quality and thus market value of Ugandan fish that are imported into the European country. The country also states its commitment to participate in efforts to assist low income countries to achieve the Millennium Development Goals (MDGs). Accordingly, the interests of this national partner are to be seen as fulfilling their commitments to assist poor countries in achieving the MDGs as well as further their national economic interests in fishing and sources of energy. Mr. Ekitabo laughed when he reported that the European national partner was also reaching out to Malawi, Mozambique and Namibia. Referring to global climate change, he laughed when he said, "Possibly they need to learn how to live in warm countries!" Regardless, the interests of external governments include preservation of their economic interests.

Dr. Katendo, the director of a Ugandan NGO, described his experience with foreign assistance from a North American government. In the specific instance where I observed their work, the North American foreign assistance funds were supporting village health teams so they could collect more up-to-date health information from hard-to-reach areas in rural Uganda. They saw the village health teams as an asset in conducting their activities; however, the expressed interest in official documents is to

contribute to the economic stability of Uganda through improvement of civil society as a vehicle for social interventions.

To conclude this section, the interests of the international participants in the planning are exhibited in their counterpart relationships with the key ministries in the government of Uganda. The interests of external governments are expressed through foreign assistance to specific activities that resonate with the external government's national economic and political interests. The national health policy is framed within the overall goal of the government of Uganda to achieve poverty eradication and economic prosperity. The policy interests of the government are to preserve its constitutional stability as well as its social and cultural heritage.

#### *Core beliefs that bind the coalitions*

In this discussion, interests are understood to emanate from and be guided by the deep core beliefs of the policy coalitions. Thus this section will seek to clarify the belief systems affecting the national and international entities involved in this policy. To identify the guiding beliefs, I analyzed two major national policy documents and four international development declarations. The results suggested that the core beliefs binding the policy coalitions involved in integration of adult education strategies with public health policy centered on (1) poverty eradication, (2) community self-reliance, and (3) international obligations to development.

*Poverty eradication:* The goal of poverty eradication was evident in the results of an analysis I conducted of the 1997 Uganda Participatory Poverty Assessment Project (UPPAP) and the first Poverty Eradication Assessment Plan (PEAP) carried out also in 1997. In the UPPAP, Uganda conducted a nation-wide assessment to obtain the views of

poor citizens in how they saw the causes of poverty and what they proposed as solutions. Following the UPPAP, the government convened the PEAP, an action plan for carrying out the findings of the UPPAP. These two processes are tightly linked to Uganda's budget allocation process and include participation from the World Bank and other funding partners. These documents are also mentioned frequently by participants as source documents that guide the government's health and education activities at local levels. I based the analysis on a policy analysis tool from the Advocacy Coalition Framework (ACF) (Sabatier and Jenkins-Smith, 1999). In the ACF, specific variables are used to identify the beliefs in order to highlight how coalitions organize around and adhere to shared beliefs. According to Sabatier and Jenkins-Smith (1999), without a stable coalition, policy change is less likely to succeed. To make the shared beliefs explicit, Sabatier and Jenkins-Smith (1999) identify components in a three-tiered belief system comprised of deep core values (how the coalition members see the world), policy core values (how the coalition believes their core values should be expressed as policy), and secondary aspects (the actual policy activities). Deep core values are fundamental philosophical or ethical stances that would primarily influence how the policy decisions are made (Cervero and Wilson, 2006; Sabatier & Jenkins-Smith, 1997). The policy core beliefs are strategic principles that state how the beliefs are translated into policy. Finally, the secondary aspects are the instrumental decisions involved in implementing policy actions (administrative, budgetary, and so forth). Further variables for analysis proposed by Sabatier and Jenkins-Smith (1999) are the characteristics, scope and examples of each of the tiers of the belief system. The results of the analysis of core beliefs are in Tables 5.4 and 5.5 on the next page.

Table 5.4  
*Policy beliefs contained in the UPPAP, 1997*

	Deep core belief	Policy core belief	Secondary aspects
Defining characteristic	Voices of the poor should inform policies for eradicating poverty.	Shift the definition of poverty away from being expressed as a level of income and move towards measuring how well solutions to problems identified by “the poor” are achieved.	Targets define success drawn from UPPAP results and they include: <ul style="list-style-type: none"> <li>– Access to social services (education, water, health)</li> <li>– Improve prospects for agriculture sector</li> <li>– Mitigate impact on poor for economic and political shocks that continue to afflict “the poor.”</li> </ul>
Scope	Cross-sectoral and inclusive of sub-national administrative districts	Holistic and inclusive of all voices Targets mostly “poor districts”	Defines indicators to monitor impact of government reforms on “the poor”
Susceptibility to change	Difficult because the process is embedded in a Ministry of Finance program and endorsed by World Bank’s program for poverty reduction.	Difficult given the high level public commitment to this process and endorsement by World Bank and other implementing partners	Difficult as the actions are a visible sign that the government is engaged in addressing the concerns of “the poor.”
Illustrative components	<ol style="list-style-type: none"> <li>1. Poverty has multiple overlapping causes thus solutions require cross-sectoral solutions</li> <li>2. Assumes perspective that personal dynamics of the poor themselves are drivers of poverty. That is, the question the participatory research seeks to answer is “why do some people move out of poverty and others remain trapped?”</li> <li>3. Provides evidence for development of the PEAP</li> </ol>	<ol style="list-style-type: none"> <li>1. Poverty reduction is a shared responsibility</li> <li>2. The methodology for assessing, analyzing and using the UPPAP results is embedded in the planning department of the Ministry of Finance and used to justify the budget allocation process – which is the responsibility of the Ministry of Finance.</li> <li>3. Disseminate results to districts for local planning.</li> </ol>	<ol style="list-style-type: none"> <li>1. Use the UPPAP results to monitor progress with PEAP indicators. (note: PEAP is the guiding process for budget priorities in the country.)</li> <li>2. Results from UPPAP are credited with an increase in progress with access to safe water sources.</li> <li>3. Poor reported education as essential for supporting poverty eradication.</li> </ol>

Table 5.5

*Policy beliefs contained in the Poverty Eradication Assessment Plan, 1997*

	Deep core belief	Policy core belief	Secondary aspects
Defining characteristic	Poverty eradication is a fundamental priority of the government and the PEAP is the government's approach to achieving its development goals.	Aims for participation from multiple stakeholders (government, private sector, donors, and (now with UPPAP) the poor  Revised every 3 years and used to inform the development of the medium-term budget.	Targets for five pillars: a. Economic growth b. Improve production, competitiveness and income c. Manage security, conflict and disasters d. Achieve good governance e. Address human development including formal and non-formal education and reduce child and maternal deaths
Scope	Cross-sector because poverty is multi-dimensional and requires comprehensive approaches.	Provides strategic direction to the government in action plans that meet objectives targeting rural and urban poor	Cross-sectoral although not integrated or coordinated. Each Ministry's target exists independent of other requests.
Susceptibility to change	Difficult. PEAP is central to government's action planning and is also endorsed by World Bank and International Monetary Fund who created the generic "poverty reduction strategy" that influences this approach.	Difficult as this is the public commitment from President Museveni as to how government will approach eradication of poverty.	Difficult, although success with implementation is facilitated or limited by available funding. Also, targets are difficult to achieve when the action plan states that "no costing" is identified.
Illustrative components	<ol style="list-style-type: none"> <li>1. World Bank identifies the PEAP as a "country owned strategy."</li> <li>2. World Bank aligns its "lending objectives" with objectives outlined in the PEAP.</li> <li>3. PEAP used by government as intersection of citizens' demands with World Bank and IMF interests.</li> </ol>	<ol style="list-style-type: none"> <li>1. Transparency and inclusive participation are promoted.</li> <li>2. Budget allocations and expenditures are printed in the newspaper each month.</li> <li>3. Create PEAP Task Force to review data. World Bank "travels to Uganda" to participate in the regular meetings of the Task Force.</li> </ol>	Each sector submits proposal or working paper to Ministry of Finance (MoF). MoF makes final decision about allocation of funding. Decision is weighted with other information from internal and external sources plus MoF's understanding of the poverty focus underpinning the requesting Ministry's proposal and data from UPPAP.

In Table 5.4, the deep core belief involves the government's priority to engage the poor in informing poverty eradication strategies. Further examination of this deep core belief continues throughout the first column. The scope of poverty eradication is cross-sectoral reflecting the belief that poverty is not the result of any one cause and would, as a consequence, require multiple solutions. The UPPAP was placed in the portfolio of the Ministry of Finance and was also endorsed by the World Bank. As such, the susceptibility to change for this core belief is not likely given the role of the World Bank in financing poverty eradication strategies. Interestingly, the main question that guided the UPPAP focused on the individual and asked, "Why do some people move out of poverty and others remain trapped?" (Ministry of Finance, 1997).

In the second column, the policy belief about how policy should be defined is explained. The UPPAP reports the shift from defining poverty as an expression of income and towards its definition as achievements with solutions in key areas delineated in the third column for reporting secondary beliefs. These key areas include improving access to social services such as education, safe water and health. The results of the UPPAP, which would be repeated periodically, would be the data source for monitoring progress with reaching budget objectives. The scope of all three-tiered beliefs is across all sectors and not susceptible to much change given the public and political commitment of President Museveni to extending economic well-being to poor regions in Uganda.

In Table 5.5, the analysis shows that with the establishment of the PEAP, poverty eradication is seen as an explicit and fundamental priority of the government. The 1997 PEAP process established the first instance of national budget planning using the UPPAP

and PEAP process. The policy belief in Table 5.5 involves the coalition's direction for policy activities that would involve participation from multiple sectors, periodic revision and updating of PEAP activities, and regular assessments to capture information from local levels. As shown in the third column, the PEAP translates the policy beliefs into sector-specific plans contained within the PEAP action plan and budget. There are related targets (referred to as "the pillars") set within the PEAP that monitor progress of government programs in the areas of (1) economic growth, (2) improved production, competitiveness, and income, (3) management of security, conflict and disasters, (4) good governance, and (5) human development including formal and nonformal education as well as health indicators for monitoring reductions in child and maternal deaths. The scope of the secondary beliefs is sector- and target audience-specific in how activities are proposed and funded. The PEAP indicators are monitored by the UPPAP results every 3 years. This means that the "voices of the poor" have input into how decisions are made.

*International commitment to community self-reliance:* A second belief that binds the coalitions in this policy formation environment had to do with the sustained commitment to community self-reliance. To identify and examine this belief, I used content analysis approaches with major international declarations related to health and to education policies in national systems. Sabatier and Jenkins-Smith (1999) posit content analysis of policy documents as a means to capture the policy beliefs of former and current actors in the policy subsystem. The content of previous positions can be compared with current positions thus allowing for insight into any change in beliefs over time (Sabatier & Jenkins-Smith, 1999). To capture the beliefs of former and current actors who operated in the international development and health policy environment, I

compared language from the 1978 Alma Ata Declaration with that used in the 2000 United Nations Millennium Declaration. These two declarations were chosen for comparison because they are explicitly cited as sources and origins of policy objectives for the National Health Policy of Uganda.

To compare the two declarations from the international development domain, I first conducted a frequency analysis to see if the most commonly used words reflected a core belief or common emphasis. When I reviewed the analysis results, the differences in verbs chosen for use was more interesting to me than the ranking of terms overall. So I returned to the documents to assess the most frequently used verbs in the two declarations. The results are listed in Table 5.6.

Table 5.6:  
*Comparison between frequency of verbs used in Alma Ata Declaration and those in the United Nations Millennium Declaration*

Most frequently used verbs in Alma Ata Declaration - 1978	Most frequently used verbs in Millennium Declaration 2000
Cooperate	Combat
Evolve	Fight
Exercise	Give support
Formulate	Grant
Launch	Pledge
Promote	Promote
Reaffirm	Resolve
Reflect	Strengthen
Sustain	Strive
	Urge

The authors of the Alma Ata Declaration used verbs that conveyed a spirit of collaborative, cooperative processes for creating sustainable change. The idealism of the post-independence era was presented in the Alma Ata document as a testament for self-reliance at both the community and individual levels. The gap in inequality was focused



on health status between developed and developing countries and also within countries. The gap was described in terms of a presumed solidarity that saw health status inequality of “common concern to all countries.”

Promotion of health for all people, according to their socio-cultural and economic conditions was framed as an essential action for social development and for contributing to “a better quality of life and to world peace.” The sustained focus in this document on health as a requirement for achieving well-being suggests the document’s authors evident desire to link “health for all” to the “spirit of social justice.” The role of government as described in the Alma Ata Declaration was to provide “adequate health and social measures” that would result in “all peoples of the world” achieving a “level of health” that would allow people to “lead a socially and economically productive life.” The document makes explicit that this vision is linked with development with a social justice perspective. Development was tied to an expression that people would achieve “well being” according to their own country’s economic, social, cultural, and political framework. Thus national and cultural autonomy was voiced as a respectful goal and the definition of well-being was localized rather than globalized.

Within the vision of Alma Ata, the role of “people” is framed as a “right and duty” resonating with the post-colonial period of self-determination and self-reliance. The document states that “people have the right and duty to participate individually and collectively in the planning and implementation of their health care.” This participation would be supported through “appropriate education” that would provide skills for community organization and participation in the construction of programs for their own futures and well being.

The location of power and responsibility in Alma Ata is with countries and communities to achieve their own self-reliant processes and apply their own resources for defining and providing health measures for achieving social as well as economic aims. In comparison, the United Nations Millennium Declaration, a precursor to the adoption of the U.N. Millennium Development Goals, employs verbs that reflect a more conflicted environment. The verbs that drive the Millennium Declaration are those of struggle and militant efforts to bring about the “positive opportunities available from globalization” (United Nations, 2000). The authors of this document reflect the challenges of global cooperation in a historic period that attempts to give voice to “minority states” and concerns.

In contrast, for the Millennium Declaration, the United Nations General Assembly is highlighted as the “common house of the human family” and the signers of the document, the heads of states and government” will “give freedom” to “innocent people” and the “vulnerable populations.” Overall, the subject-author-actor of the document is “we” and the object of the actions is “the whole human race.” It is written from the view that “we” will “free” humanity so humanity can engage in development, but we do not know development towards what. It is a complex statement of multiple domains seeking to redress the divergent issues on the international agenda in the early 21<sup>st</sup> century. The focus is on “development” opportunities. There is recognition that we live in a world that is more interdependent and interconnected, but the central challenge expressed by the leaders who framed this document is to “ensure that globalization becomes a positive force for all the world’s people” (United Nations, 2000, p. 2). The United Nations Declaration describes the world’s populations with general terms such as “humanity”

“human being” and “the human race.” The result is that populations are envisioned as less personal and more segmented. For example, when the term “people” is used, it is modified with adjectives such as “innocent” and “vulnerable.”

The U.N. will play a central role in organizing the responsibility for economic and social development in the Millennium Declaration. The better-off countries have an obligation to support the less well-off countries. Inequality is constructed as a facet of the benefits of development without development ever being defined. It could be inferred that development is seen as lack of hunger and “freedom from want” but the notion of “development” is not explained. We do not know from this document the destination of “development.” A “right to development” is expressed and phrases that highlight “dehumanizing conditions of extreme poverty” do suggest the nature of the problem to be solved. But this is followed by a call to “free the entire human race from want” by creating an environment “conducive to development.” It is not clear what that would look like. Economies are “in transition” and while we think we have a picture that there are economies in the world who are not achieving performance levels of Europe, North America or Asia, it is not clear what that “development” holds for “the human race” in the future.

Efforts to establish a vision of a better world are expressed in the focus areas that are elaborated in a subsequent document and which we know as the Millennium Development Goals (MDGs). The least-developed countries are identified as having “special needs” and the remedy is a list of market interventions such as duty- and quota-free exports, debt relief, and increase in “development assistance” for countries that “are genuinely making an effort to apply...resources to poverty reduction.” Thus there is a

carrot and stick approach for engineering change in countries by tying funds to external judgments of “genuine efforts.” In reaching out to the conditions of “landlocked developing countries” there is a call for increased donor financial assistance to help these countries “overcome the impediments of geography” with resources to build transportation systems.

The Millennium Declaration is a more complex environment than the cooperative, self-reliant, self-determined communities imagined in Alma Ata. The call for decreasing preventable deaths due to infectious diseases in children pales in comparison with calls to address arms trafficking, including small arms trade, weapons of mass destruction, and land mines. Education is only mentioned in terms of the universal primary education target; otherwise health and education are competing with a more diverse, dangerous, and war-torn world. The remedy is to invest “more resources” but without an explanation of what impact this has on communities or how communities are supposed to survive.

*International obligations to development:* A third belief that binds the coalitions in the integration of adult education with public health policy involves how the international community reflects its obligations to development in poor countries. For example, UNESCO leads a worldwide commitment to Education for All that seeks to promote greater access to and quality of primary schooling, gender equity in access to schooling and increased adult literacy (UNESCO, 2007). Two international declarations emanating from Education for All international meetings were analyzed to reveal beliefs of the international educational development coalitions about what was needed for national policies. I conducted a comparison for language used in the 1990 Jomtien

Education for All Declaration with that used in the 2000 Dakar Education for All Declaration to appreciate any shifts in beliefs regarding the international influence on adult education in low income countries. The authors of the Jomtien Declaration are making a visionary statement, and the most frequently used terms in the Jomtien Declaration reflect the perspective of the authors in linking education with development and meeting learning and knowledge needs. The people addressed by the Jomtien Declaration live in “countries” and the responsibility for progress towards Education for All is with the “world.” A strong focus on mitigating the gap in providing basic education so that education is engaged throughout one’s lifetime was also a strong belief area expressed in the Jomtien Declaration. A target for increasing literacy rates was also included.

Table 5.6:  
*Comparison of most frequently used terms in the 1990 Jomtien Education for All Declaration and the 2000 Dakar Framework for Education for All*

Most frequently used terms in Jomtien Declaration 1990	Most frequently used terms in Dakar Framework 2000
Education	Education
Basic	Learning
Learning	National
Needs	Countries
Development	Development
Countries	International
World	Basic
Children	Goals
Knowledge	Strategies
Programs	Commitment

New words that appeared in the frequency analysis of the Dakar framework that did not appear in the Jomtien Declaration are: national, EFA, goals, strategy and commitment. The Dakar Framework underscores the vision of the Jomtien Declaration,

but the focus in Dakar shifted to a more concentrated understanding that strategic organization would be needed to create the right “policy environment” for inculcation of the Education for All goals into national education policies. The international coalition driving education policy as reflected in the words used in the Dakar Framework shifted their attention to the critical need for resources in achieving the goals. The other conceptual change revealed during comparison of word frequencies is suggested by the shift from the use of the metaphor “world” in the Jomtien statement to “international” in the Dakar Framework. The suggestion reflects perhaps a shift towards a more defined set of partners and actors.

To summarize, this section is about the core beliefs that bind coalitions. They include poverty eradication, community self-reliance, and the explicit role of international partners in shaping national health and education policies. Poverty eradication is the core belief that binds national policymakers with powerful international partners in the World Bank who fund national poverty eradication programs. The national coalition is influenced by the Alma Ata Declaration, a vision of community self-reliance as a development aspiration. More than twenty years later, the U.N. Millennium Declaration envisioned development as a shared responsibility between developed and developing countries. It calls for massive investment from countries in the developed world to be placed in less developed areas so that less developed areas could “enjoy the benefits of globalization.” The focus of Alma Ata was on locally appropriate interventions while the U.N. Declaration is on metric-based, single-area global goals that all the countries would adopt as policy in their own countries. The Alma Ata Declaration envisioned development as comprehensive and local while the U.N. Declaration

envisioned goals that were disaggregated from each other and focused on specific technical domains. In the education international sector, the Jomtien and Dakar Declarations represent a continuum of efforts to address primary as well as adult learning. By the time of the Dakar Framework, the focus centered on universal primary schooling, and on efforts to mobilize the significant resources required for implementation of Education for All.

### How The Interests Were Negotiated

In the previous section, findings from participant interviews and document analyses suggested that the interests related to the formation of an integrated public health and adult education policy in Uganda were to preserve constitutional stability, enhance social cohesion and protect each entity's influence on investments. This section describes findings about how those interests were negotiated during the formation and elaboration of this policy. The findings suggest that negotiation took place through individual and institutional relationships at the international, national and local levels. In this section, I will describe findings about the focus of decision-making for this policy: the emergence of a national champion and decisions about funding and implementation at international, national and local levels. Conflicts between government hierarchies and associations will also be described. (In the Advocacy Coalition Framework, policy learning emerges from conflict between coalitions. Cervero and Wilson (2006) would describe this as negotiation rather than conflict.)

Because the implementing agent for the integration of adult learning strategies and public health was the village health team, these findings reflect instrumental decisions related to implementation of those teams. The instrumental decisions were

about mandates, investments and delegation of authority (McDonnell & Elmore, 1994) that would permit the realization of the intended outcomes of the policy.

### *Emergence of a national champion*

The findings of this study pointed to the impact of structural relationships on decisions about how the policy mandate was presented to the public, how the details were delineated, and how instrumental factors (such as funding) affected compliance and implementation.

The location of a prominent advocate for this policy in a position of power significantly influenced the adoption and dissemination of the Village Health Team (VHT) policy. Dr. Njuba was a high level officer in the President's cabinet. Dr. Njuba was credited by participants for lifting the policy out of its written form and bringing the VHT policy to the attention of the public. "He was a strong character," said Dr. Olwaazi, "and passionate" about creating a "continuum between the local and national levels." Another participant, Ms. Alice, director of an international NGO, said that Dr. Njuba "really brought the idea to the public" and greatly influenced how the integrated adult education and public health policy took hold with the public. Dr. Njuba himself described his motives for using his prestige and power to implement the policy. He portrayed his interests in forming this policy as coming from a growing awareness during his medical practice with rural Ugandan communities. He talked about how his practical work led him to believe that social roles do impact health especially in poor communities in his country. As he considered the problem of the limited socioeconomic conditions in rural areas, he came to an understanding that:



People don't need to be dying. It is not God's will that we die from mainly preventable causes. We don't need to be dying like that. Also being healthy is a right unto itself. It is in the genes to be healthy.

Dr. Njuba said that he wanted to improve health-seeking behavior in Uganda. He said that he believed that education and community agents could bring about changes in how people viewed disease transmission and how they could take action in their own lives to prevent illness. His belief, he said, was grounded in concepts of health literacy as a pathway to improved health. For example, Dr. Njuba compared his view of what he saw as the Western experience with health literacy to the context of Ugandan communities. He said that:

People need to know health literacy, the things you do to stay well. You live in the West so you have very high health literacy and so high you aren't even aware of it. You hear and see messages on radio and TV about new drugs or what is healthy to do. But in developing countries, this is not so easy. There is a very low health literacy amongst people. The message is how to make people know the healthy ways. How can you remain healthy? But many people believe diseases are witchcraft and so we started to say, "Health is made in the home and repaired in the health facility."

Dr. Njuba proposed that health teams would be chosen from the community. People recruited for the team should be able to have some ability read and write, he said, and be respected members of the community. These teams would become a link between the national and village levels in providing education, information and basic health services to the people in the villages. He envisioned this effort as part of "a massive

campaign” that would help people learn about the relationship between their actions and their health status. “They would be able to prioritize their health,” he said, “and not take it for granted.” Dr. Katonda, director of a Ugandan health institute who also took part in the policy formation process, felt that the VHT person should be “someone with previous service as a community health worker [with a] common background and understanding of the health service unit.”

Dr. Njuba mobilized support for the VHT policy by engaging stakeholders and other ministries. He held retreats with the Ministry of Health to work through how the policy objective would be designed and entered into the national health policy framework. As Dr. Njuba related:

A law was drafted to put some of these [village health team] changes into a legal framework. These involved things like requiring every household to build latrines, requiring immunizations, and so on.

The evolution of the policy was framed as “health for all” thereby echoing the international declaration at Alma Ata in 1978 and the incorporation of that spirit in the National Health Policy (Ministry of Health, 1999). Thus the village health teams were included in the policy as an implementation instrument for the broader policy to improve the socio-economic status of citizens in Uganda. According to Dr. Njuba, decision-making regarding the details for implementation of the policy was delegated to the Health Promotion Unit in the Ministry of Health. Other sectors such as the Functional Adult Literacy Program were also asked to take part, reported Dr. Njuba. The decision-making context thus shifted from a level of political prestige at the President’s cabinet level to a technical unit within the Ministry of Health.

*Funding relationships between international and national entities*

As described in Chapter Four, the World Bank and other international agencies play an influential role in policy decisions in developing countries. This was echoed in findings to this study when participants discussed the dilemma of needing external funding while at the same time realizing that external funding would open up a greater share of influence over what policies would be enacted within the country. “This [integrated health and adult education policy implemented by village health teams] is internally driven,” said Dr. Olwaazi, medical director of a regional health policy center. “But we are so dependent on external funding that things that are internally generated, internally created, are avoided by the outside.” He lamented that internal policies languish because “we are so dependant on external funding.” In spite of the fact that the VHT is essentially an internally driven policy formed by the powerful role of Dr. Njuba, it didn’t attract intensive funding. As stated by Dr. Olwaazi:

The VHT is internally driven. OK, maybe it is not implemented, but it is internally driven, and generally, well, we are so dependent on external funding that things that are internally generated are in need of funding from the outside.

Dr. Olwaazi held that “these kind of internally driven proposals” are usually “shunned” by the World Bank. To illustrate how external forces guide policies in developing countries, Dr. Olwaazi discussed experiences in the early 1990s in drafting the initial Government White Paper on Health (Ministry of Health, 1993). The original document, he said, presented internal priorities and goals of the Ministry of Health to rebuild curative facilities. This national vision was thwarted, he said, due to the push from the World Bank during the 1990s to have “Health Sector Reform” including

imposition of “user fees” for health services and redirection of curative services to private providers. Dr. Olwaazi strongly objected at the time to the model as it was based on ideologies from “rich countries” and did not reflect the abject poverty of most rural communities in Uganda. Dr. Olwaazi underlined that user fees eventually were dropped because data showed an increase in disease incidence rather than reduction with the imposition of user fees. “Most people were unable to pay the user fees and it resulted in an increased burden of disease,” he said. Health sector reform was a lost opportunity, said Dr. Olwaazi. “I mean, the whole impetus of this health sector reform had to be abandoned eventually. It was so ridiculous.” Dr. Olwaazi summed up the loss of time and resources that resulted when he said:

They [the World Bank] said what this country needs is a reform of the health system whatever that meant [*laughter*] and the change hasn't happened and we still have no money and that's what I mean about policy driven from the outside.

Dr. Olwaazi’s experience with Health Sector Reform and his advocacy for national over international priorities may have accounted for his assessment that “the VHT policies are not going to be implemented because most of our internal funding is driven by market forces.” As he saw the situation, “the Ministry of Finance has become a champion of market-driven policies.” The Ministry of Finance makes the spending priorities, as described by the participants and supported by documentation related to the PEAP (Ministry of Finance, 1999a). Since funding decisions for all the Ministries comes from the Ministry of Finance, and the Ministry of Finance is closely allied with the World Bank, Dr. Olwaazi reported that “the ministry of finance has been colonized by the World Bank.” The impact of the power enjoyed by external forces on definition of

national policy results contributed to disjointed policy development and weak implementation at national levels. According to Dr. Olwaazi:

This is why we have this diversity of policies. One set is driven from our side [within the country] and another set is driven from the outside. The internal ones are only partially implemented like this one of village health teams.

“In fact,” said Dr. Olwaazi, “when the country asserts its preferences, the international partners drop out.” This was illustrated in an example given by Mr. Ekitabo from the perspective for the Functional Adult Literacy (FAL) program’s relations with external donors. He explained the desperate loss of resources to the FAL program when UNICEF dropped its funding for FAL because it objected to the Ugandan government’s “basket funding” approach. In the mid-1990s, when literacy was identified as a need by the communities through the Uganda Poverty Assessment Participatory Plan (UPPAP), there was a ten-fold increase in funding to the FAL from the World Bank and UNICEF, according to Mr. Ekitabo. Shortly after this period, the government of Uganda (specifically the Ministry of Finance) implemented basket funding to consolidate funding for poverty eradication (Ministry of Finance, 1997). In “basket funding,” donors give funds directly to the government’s general fund or “basket.” In this way, the government is able to assert decision-making over the allocation of funds. While donors are encouraged by the government to make use of the “basket funding” mechanism, they also have the choice to support a program directly. This is often the preference of bilateral donors (for example, national foreign assistance from Western governments): to support programs directly to better target their interests. Consequently, international partners created mechanisms for circumventing the “basket funding” requirement. This ability

serves efforts of bilateral government partners to side-step the basket funding which gives the Ugandan government control over how the funds are allocated. Using other mechanisms, the donor country can deal directly with an intermediate or non-governmental organization that targets the particular development area of interest to the donor partner. The benefit to the donor country is the assurance that funds will be mostly used for the intended activity; the consequence to the government is that national priorities are left unfunded and equity of services is not served.

As a result of UNICEF's conflict over basket funding, UNICEF decided to no longer provide funding through the "basket." Consequently, the FAL lost an important source of funds which has greatly limited its programs to this day. According to Mr. Ekitabo:

Donors have dropped out because of basket funding because the allocation doesn't match what the donors or the department has said is their priority. The donors started asking, 'how come this [funding for this activity] isn't allocated when it is on the priority list?' UNICEF does not support the basket funding and so they no longer support us.

In another example from Mr. Ekitabo, he described his experience with a northern European country's funding to the FAL. The northern European country wanted to support literacy programs at district levels. They chose a district that was affiliated with the fishing industry and have since expanded to other similar fishing districts which export fish to markets in the European country. The donor country chose not to take part in "basket funding" so that they could fund their projects directly in areas that served their interests.

Another example of how international donors circumvent national funding preferences was cited by Dr. Katonda from the Ugandan NGO. His NGO has been a partner with a North American health agency in supporting a VHT project in a western district of Uganda. Funding for the project came directly from the North American public health program to the sub-district through an account with an international, European-based bank. The normal funding process through the “basket funding” was by-passed so that funds could be provided directly to the officials who were implementing the program. This approach served, according to Dr. Katonda, to by-pass any barriers from the national level that would retract funding from reaching the local levels. The availability of funds at the local level created autonomy for local officials who wanted to be seen as leading the VHT effort.

*Funding relationships at the national level*

The negotiation of national interests and power not only involves external partners like the World Bank, but also takes place laterally across and within Ministries. Participants described how the relationships between and within Ministries affected the likelihood that the VHT would be fully implemented. While participants felt that technical level support was adequate between and within Ministries, they also stated that the lack of resources presented a barrier for implementation of the VHT policy. “At the technical levels, their [partner Ministry’s] arms are open, but even there they will tell you they have limited resources,” said Dr. Enyanja.

As in any enterprise, commitment is evidenced by the extent of funding that is accorded the activity. As Dr. Olwaazi said, “As far as I’m concerned, you cannot tell me something is a priority and then not put money to it.” Ms. Alice commented on

cooperative efforts across Ministries in the government. She found that “there is a lot of good will, but basically no resources.” But the question of who determines the priorities is very much a factor in whether the VHTs receive adequate funding to achieve their intended goals and objectives. The dominant force in creating the budget priorities in Uganda is the Ministry of Finance (linked with the World Bank as described earlier in this chapter.) The Ministry of Finance makes decisions on funding and develops priorities for government spending in a deliberation with the Ministries. For example, the Ministry of Health also coordinates all stakeholder involvement with delivery of health interventions. Each year, the Ministry’s Department of Planning and Policy prepares a budget proposal for submission to the Ministry of Finance, Planning and Economic Development. The priorities of the Ministry of Health are weighed against other sector priorities and funding decisions are made by the Ministry of Finance, Planning and Economic Development.

Yet there are difficulties in coordination for the VHT at national levels because of how otherwise companionable programs are situated within their own hierarchies. From the perspective of a local NGO, Dr. Katonda said that the VHT is located in the Ministry of Health’s Health Promotion Unit. As a result, the “role of the VHT is governed by the Ministry of Health.” He saw this as a dilemma for actual integration of social, education and health programs since the partner Ministries do not have direct supervisory links with the VHTs. Dr. Enyanja gave another example showing how the location of key programs affects the likelihood that a program is actually implemented. While the various collaborators and partners subscribe to the policy belief for using the VHT to address



socioeconomic factors that contribute to health, there are difficulties in reaching across the indicated domains. For example, Dr. Enyanja presented her view that:

The factors governing this policy are really outside the influence of this [health] sector. In this policy you touch on religion, tribal things, insecurity of women, gender problems, power relationships, which health workers are outside this package of things. It's a negotiation sort of thing.

The relative influence of a program on funding decisions was suggested by descriptions of where programs sat within the government structure. For example, the FAL program sits in the MGLSD rather than the Ministry of Education as the result of an ownership struggle during the time of transition to the current government policies in the early 1990s, according to Mr. Ekitabo. When the 1992 White Paper on Education was written, it was recommended that literacy training would be placed in the Ministry of Education and Sports. But to this day, the FAL remains in the Ministry of Gender, Labor, and Social Development (MGLSD). Its influence is limited given its low position even in the MGLSD. The rationale for placing the FAL in department dealing with disabled and vulnerable populations was that it is essentially an out-of-school program addressing "vulnerable groups" such as women, youth (ages 15-24), disabled, elderly, and out-of school illiterates. The rationale provided by Mr. Ekitabo was that the Ministry of Education was occupied with "pedagogy" while the FAL in the MGLSD was concerned with programs based on "androgogy." Additionally, "pedagogic services" are available for youth less than 15 years of age from the Ministry of Education

While the MGLSD was successful in keeping the FAL program in its Ministry, there was never adequate bureaucratic support for a Directorate level position (personal

communication from A. Okech, 2008) and so the FAL program was given a corner office and its visibility was low. In spite of this low visibility, support from a European government facilitated a process review of the FAL in 2006 (Ministry of Gender, Labor and Social Development, 2007). One of the findings from that review was that the lack of monitoring data about the program achievements made further advocacy a challenge. So funding from this government to the FAL has been provided and a data management station has been added to the FAL in the MGLSD offices.

Given its reduced visibility, the FAL funding deficit severely impacts program responses. This was described by Mr. Ekitabo who talked about a demand from learners, especially those between 18 and 30 to have programs that provide equivalency certification with the formal education system (based on the British system with O and A level exams marking achievement of secondary education curriculum goals and leading to directions for tertiary study at either university or advanced technical training institutions). Mr. Ekitabo phrased the situation as a question from the students who asked, “Can’t we have equivalency of O level or A level so we are able to continue and get degrees?” Mr. Ekitabo said he recognized that the students wanted to move forward, but he reported:

Because of their inability to write and read, you know, they are slow, but once they know how to write and read, they move faster. We would like to have a program which is parallel to the other one [the formal system] so they [the young learners] get the equivalencies...that is it...that is one where we are about to study and see how it can be done.

A major limitation, of course, is visible from the Ministry of Gender, Labor and Social Development project description for the FAL which records that “a donor is being sought” (MGLSD, 2007). There is no funding for the program’s general mission and thus resources are not in sight for how to expand the program to realistically meet learner demand. This is an example of the structure of the system limiting opportunities for advancement and limiting opportunities for both men and women.

*Funding relationships between national and local levels*

The tension between “empowering communities” and preserving the central role of national ministry headquarters is reflected in the issues surrounding remuneration for the Village Health Teams (VHTs). The problem of remuneration is an ongoing issue for any community worker, highlighted Dr. Mulingi. Providing incentives to the village health teams is a major point of negotiation of interests. An NGO official echoed the importance of motivation for the village health teams and cited it as an area for improvement. According to Ms. Alice, the Ministry of Health acknowledges the VHT as providing a service. In village areas where the international NGO is working, village health teams are provided with umbrellas and boots as incentives for the VHT’s service. Dr. Katonda’s consideration of the question of incentives for VHT realized the importance of reinforcing the service and role that VHTs play in a national health system. In his view, “We’ve got to be innovative in how we make use of donor funds. We could provide certificates and give recognition to the volunteers, you know, tell them they are making communities healthier.”

As envisioned by Dr. Njuba, the VHT would provide an essential link between the national and local levels. This would help to mitigate the problem that, as he saw it,

communities had no way to interact with the national level and villages didn't have a way to interact with the national health system. To achieve this benefit of linking the national and local levels, the policy was delineated so that the VHTs would interact with local politicians and administrative structures (the Local Council 1) "so they could express themselves at local levels during planning and priority setting," reported Ms. Ekimuli from the international NGO. Consequently, the VHT would "play a role in organizing communities," said Dr. Katonda.

Integration of the policy was seen as a function for local action, according to Ms. Ekimuli. At the national level, tacit support for integrated implementation emanates from the Sector Wide Approach (SWAP), an implementing strategy (and thus policy belief) for delivery of socioeconomic services to citizens of Uganda. It calls for integration of Ministry objectives from agriculture, health, education, and economic sectors. In theory, reported the participants, there is supposed to be interaction at the national level, but several participant observations were in agreement with Ms. Enkoko who said "actual integration takes place at the local level." Actual integration of the policy targets the local level as described by Ms. Mwezi who manages a VHT program at the international NGO. This integration "is a priority," said Ms. Enkoko, "but we are only in the beginning phase."

The community development officers are tasked with implementing the literacy and adult education activities at local levels. This expertise is transmitted to village health teams in their joint training and implementation activities, she said. This is because, she said, these officers know how to "handle adults." The Ministry of Health,

she said, “leave[s] it to the local level to care for the adult learning. Ms. Enkoko viewed this as important when she said:

[Adults] have little time for learning. They have too many things to do, and we need to really help them to learn, and it is by the help of this community development officer who does what? Who makes sure we know how to help adults to learn.

Ms. Nalongo from the Ministry of Health saw integration as delegation of tasks. For her, an example of integration is when the parish chief goes to a district meeting, “he can take the record book with him.” Her view suggested integration as a convenience rather than a systematic practice.

Instances of conflicts to be resolved were part of the findings about relationships between national and local levels. While VHT are not trained medical personnel, they are consistently told that they are the link to the health system, they are HC I, they are the ones to take care of their communities. On the other hand, the teams encounter resistance from other health workers at the national and other levels. In one example from the local level, participants reported that sometimes the VHT are not recognized by the health staff as being part of the “real” local health team. For example, Ms. Alice said that “when the VHT go to report their data to the district health staff, they are told to stand in line like everyone else and they are not recognized as fellow health workers.” From the national level, the VHTs may be viewed by the medical establishment as untrained and thus not safe sources of care, said Dr. Dan. I visited a village health team operating in a district in western Uganda where I also attended a training graduation ceremony for the VHTs in that area. After the formal meetings, I met with one local VHT and asked about the

changes they thought would help them improve their jobs. One of them responded that if they could have a supply of thermometers, they could record temperatures of patients rather than reporting the screening criteria of “a high fever” or “feels hot.” In the interview, my colleague from the Ministry of Health, a physician, interrupted the VHT to say, “It is only your job to tell us if someone is sick; you don’t need a thermometer. You tell us at the Ministry and we will take care of the patient.” This tension contrasts the way in which the national level views village health teams with how the teams are seen by their communities. From the community view, the VHT are selected because they are community assets with experience in HIV/AIDS care and support, health education and community organizing.

Interestingly, the clan system is implicated in how the national government relates to the local levels. Members of the VHT are likely to be part of the same clan, since a village is usually comprised of members from the same clan. “So,” said Ms. Nalongo, when you are a VHT, you are taking care of your own community, your own uncle, cousin, extended family. You have a collective responsibility towards the economics, health and agricultural status of the village.”

While the clans present a social opportunity for advancement of the VHT policy, a counter force is the relationship between the clans and the national government. The national government views the kingdoms as a threat to its existence, said Ms. Ekimuli. Ms. Alice described how the national government wants to keep power in the center and has created competing political structures for administrative purposes in the designation of “districts.” The politicians and civil servants working in the districts take their salary from the central level and so their loyalty is to the source of their salary as discussed by

Dr. Enyanja. Dr Olwaazi further highlighted this interest to ensure loyalty when he said that “In fact, the priorities of the Ministry of Finance are to pay salaries first.”

To further affect the balance of clan power, new districts were recently formed increasing the number of districts from fifty-six to seventy-seven, said Ms. Alice. As a result, the tax structure is stretched in trying to add the salaries for the new cadres of political and civil servants who were hired to staff services in the newly created districts. The number of political and civil servants is about 50 per district. This increase in districts and demand on the limited budget of Uganda has the potential to “collapse” the finances of the government, according to Ms. Alice, who viewed the situation from an outsider’s perspective.

#### *Funding relationships at the local level*

Participants gave examples of conflicts that impacted decisions about implementation of the VHT. One example of the mistrust between localities was reported by Dr. Dan who attended the Ebola outbreak in western Uganda in 2007. He described an instance where one group thought Ebola was about being poisoned by a less friendly clan because almost all of the cases occurred in one group, and not in another. “They thought this was some kind of planned effort,” said Dr. Dan, “to poison their village.” In another example of conflict to be resolved, there are jealousies between local administrators and the VHT. Ms. Enkoko shared this story with me:

In [the district] where you came [for a visit], there was a complaint. The village health teams complained for the LC executives because the LC 1 executive team members, some of them are not in favor of the VHT because it appears to them that the VHTs are called upon quite often to

carry out a lot of activities and as a result they don't give full support and the LC 1 complains. The village health teams say that some of the LC 1 are sabotaging them, not appreciating what they are doing.

A final example is from an observation made during my visit to the VHT in a district in western Uganda. During a formal meeting with national and local authorities, the chair of the village health team presented his yearly report. The meeting was attended by approximately 50 community members and local administrators from multiple sectors. During the report, the chair of the local VHT cited the achievements of his team from the last several months. The achievements included completion of a household survey to assess the extent of latrine coverage in the village, a national target set in the Poverty Eradication Assessment Plan (PEAP) as a measure of improved hygiene. The VHT chair reported to the assembled group that "on average, we found that 47% have got well cleaned toilets." He reported that the team's follow up action was to intervene with those households who had yet to build latrines within the household's compound to conduct education and community organizing to provide help to those households still without a latrine. This achievement was praised by the national authorities, and the VHT's role as a linkage to the formal health system was reinforced. "You are Health Center 1," said Dr. Katonda.

Of interest to this study, however, was the list of challenges that the VHT chair cited requiring action and support from the national and local authorities. The chair stated publicly that ongoing problems included having adequate transport, sufficient quantities of teaching materials and books for recording data from the villages, and, moreover, according to the chair of the VHT:



There is no way how we can be identified in the community when doing this work. Nothing like motivation is given to us yet the distance covered from the village to the sub-county when submitting the monthly reports is very long, for example, [this] village to the [district headquarters] can cost 12,000 Shillings [about US \$7].

The VHT chairperson continued his presentation with recommendations that “motivation allowances” should be paid for the VHT members. Responses to this felt-need of the VHT for incentives or remuneration are countered by the national authorities in several ways. For example, in the public gathering where the VHT chairperson made the recommendation for some payment and recognition to the VHTs, Dr. Katonda responded in the public gathering that the cost of providing some identifying badge or T-shirt as an incentive would be too expensive.” He continued by saying that “there will never be enough money to do this.” The solution that Dr. Katonda proposed was for the VHT to charge households 1,000 Shillings if the VHT thought that they needed an incentive.

Several participants described the situation of remuneration as a challenging area. The uneven distribution of incentives is problematic for ensuring some consistent performance across the country or at least in the districts where the VHTs are working. In some counties or sub-counties, the VHT are given umbrellas, rubber boots, and T-shirts for their work while other VHT in other areas get nothing. Those teams don’t work because they say, “why should we when we don’t get anything for our efforts...” Participants generally expressed understanding of this situation, but reflected on the

limited resources. The cost of T-shirts for every VHT member in every district of Uganda was seen to be too costly.

Ms. Nalongo, from the Ministry of Health, reacted strongly when I asked her about the request from VHTs for incentives. She felt that the VHT who ask for incentives do not have the “volunteer spirit.” She said that members of the VHT shouldn’t be selected if they are looking for a “job” and that the Local Council Level 1 (LC 1) should instead select people who will work without expectation of remuneration. She said:

I tell the LC I, I would say, look, you see? He [the one requesting the incentive] wants a bicycle, a T-shirt, this is not a job. They don't know what it is to volunteer. These people are doing a good job but they picked the wrong people, these are idlers and laggards. You see this is just a young man looking for a job. He should look for someone who is already involved in thankless service, a mother who is sewing or working, she will know about the volunteer spirit..."

The VHT who served in the December 2007 Ebola hemorrhagic fever outbreak provided another example of how the question of remuneration and incentives impacted performance. As Dr. Dan reported, their participation required considerable commitment as they were not paid, and had to walk some distance (in terms of time and terrain) to reach the contact point with the international and national outbreak team, sometimes as long as two hours. In feedback from the VHT as to what motivated them to participate, they reported that it was for the “good of our communities.”

To summarize this section, negotiations about the formation and implementation of this policy took place through emergence of a champion who had power and prestige to

disseminate the policy and through structural relationships within the hierarchies of the Ministry of Health. Conflicts about payment for the VHT were also a point of negotiation.

### What Learning Did Policymakers Need To Undertake?

This section will present findings about the third research question in this study: what learning did policy makers need to undertake to effect the integration of adult education and public health policies. Policy learning in this study includes the outcomes of negotiations that impacted the behavior or understanding of the members of the international, national and local policy coalitions. The findings about policy learning focused on two broad areas: (1) how to integrate resources to achieve policy objectives and (2) how to sustain implementation at the local level.

#### *How to integrate resources to achieve policy objectives*

An integrated public health policy that makes use of adult education approaches by definition requires integrated resources. As well, not being able to carry out the policy runs a risk for ruling political parties. Thus a central implementation activity discussed by the participants centered on how to execute the integrated public health and adult education policy in spite of limited resources. Areas of policy learning involved coordination with multiple sectors, influences from external institutions, and hierarchal barriers to coordination. Participants also described ways in which they advocate for resources with high level policy makers and donors.

The value of having adequate funding for a comprehensive socio-economic intervention was vividly illustrated by Ms. Alice from the international NGO. She offered:

If donors actually put up what they say are \$110 (US) per citizen per year, [communities] will be able to solve banking issues, deal with agriculture, education, health, you know, all of it. And you could actually get people to a point where they would build roads.

The required resources for this level of development are not extraordinary when one is in a resource-rich environment. But in a low-resource environment, adding new programs without new resources places a demand on the program implementers who must try something regardless of the funds available. Thus because resources are limited, expressed Ms. Enkoko, “the threat [to this policy] is about the resources.” Dr. Enyanja said those directly responsible for the policy’s implementation have to “learn as we go.” In disseminating the policy, Dr. Njuba left the details of the policy to a technical unit of the Ministry of Health to delineate. The unit’s experience in learning as they go meant that they had to “incorporate all the things we think we can do in the simplest possible way” and make use of current funding, according to Ms. Nalongo. Their strategy also included adding the VHT activities through existing linkages because “we did not want to come [across] as though there was nothing to build on,” said Ms. Enkoko.

The need for integration is keenly felt by the officers charged with implementing the policy. Dr. Enyanja described how Uganda has seen a great deal of engagement from external government and non-governmental development institutions and agencies. “Everybody was trying to do something in the communities to empower communities,” she said highlighting that the external partners had a common goal. The extensive engagement, however, presented an organizational problem for policy makers, according

to Dr. Enyanja who described the need to find ways to link up and coordinate with the multiple organizations and programs.

Coordinating across Ministries at the national level is one integration approach the participants described, although it has challenges, said Ms. Enkoko. For example, Ms. Enkoko illustrated the difficulty for integration when policy is set at national level but the real integration takes place at the local level. In her example, she discussed the health behavior of hand washing. This prevention objective is part of the health education carried out by the village health teams. She described the situation where it is “difficult to make sure that hand washing has been done.” This is because there may not be a water supply in the community. Ensuring clean water is the responsibility of another Ministry and out of the domain of the Ministry of Health. Yet reliable water supply is essential for meeting the desired community behavior change. Water supply is not a responsibility of the Ministry of Health and so unless the corresponding Ministry has funds for improving water supplies, the Ministry of Health is limited in its impact. Thus engaging this multi-sectoral cooperation remains an area of policy learning for the coalitions. This provides a challenge to “motivate other sectors and ministries like agriculture, education, economics,” said Dr. Malingi, director of a maternal health program in the Ministry of Health. “But,” she said, “We are learning all the time. We have some basic things we can do because they have been tested elsewhere. We can try to apply [them] with a few adaptations here and there.” Additionally, Dr. Enyanja said that “Some principles are being learned, and so we are further refining the package so we are seeing ourselves in a sort of evolving process.”

Cooperation from external partners was a challenge for implementing the integrated policy because of the hierarchical relationships within the various ministries. For example, Dr. Malingi wondered “how do we identify the linkage between disease programs and the team of nine to ten people whom we propose to carry out the entire health package?” In trying to solve the question, Dr. Enyanja reflected:

The people we needed to discuss these issues were the level that doesn’t usually come to meetings. And yet in their ministries, these are the ones who would make a difference in implementation. For things to happen, you need to be discussing at that level.

Participants discussed the difficulty in coordinating common objectives across Ministries when not all Ministries have a good understanding of the role of social determinants on health outcomes. According to Dr. Enyanja, investments are preferred in activities that generate results that can be counted. “[Incorporating social objectives] is frustrating for those who want to count numbers and usually the investment is in that area,” said Dr. Enyanja. Part of the limitation is that those programs that could be potential partners for contributing resources and strategies see the social needs as “an obscure area and you sometimes also see that the road to reaching [success through an intervention to address the social determinants of health] is long and tedious.” As an example, the specific programs of giving immunizations or distributing insecticide nets require counting of coverage of distribution as a measure of success. Thus there is small interest in taking on something that would require more complicated measures and thereby threaten potential future funding. Another barrier to integration of resources has to do with the strong demand on countries from international programs to respond to

performance-driven measures (the Millennium Development Goals, for example, as well as specific, individual goals for health and education programs). The demand to meet limited performance-driven measures linked to external funds makes it difficult for national program managers to use funds in more integrated ways.

Some resistance is encountered by potential partners because social outcomes are not seen as part of the health sector's responsibility. For example, Ms. Enkoko did not recognize the health centers as the appropriate place for instating programs and activities to address social determinants of health. "We see the source of the problem is happening elsewhere," she said, and "so the best people to address these [social determinants] are outside the health facilities." In another example, Dr. Malingi focused on how culture is a barrier to integration of activities and funding. She recognized, she said, that the social and cultural role of being female in Uganda places women at risk (for example, gender roles, low literacy, and gender violence), but there are real difficulties in designing health interventions that "go beyond traditional reproductive health issues." She reported that the international agency is beginning to incorporate reduction of gender-based violence in health programming, but it is difficult. "We cannot touch on many things [that have to do with] social behavior things, with social behavior problems."

Finally, in efforts to understand how to mobilize adequate resources, participants described how they strategize to get attention of the high level policy makers and donors. For example, Dr. Katondo said that he "contact[s] policy makers by speaking at conferences. That's how I got in touch with the [North Americans] who funded the site you visited in western Uganda." Dr. Enyanja, who is a policy elite, said it was important to "make this debate heard at higher levels." She engages with parliamentarians, and she

tells them, “You know, for maternal health, there is a community part.” Generally, she says, they begin to see what needs to happen and that the problem must be seen in a multi-sectoral view.

Dr. Katondo that policy makers needed to better understand what they mean when they say “economic growth.” He said, “This is what they need to understand in order to change policies. They say “the economy is growing.” What does that mean? What has influenced the change?” A cost-benefit analysis would help, he said. Economic data would be able to demonstrate the impact of enhanced social and health interventions and could persuade the policy makers to mobilize sufficient resources.

Another view of how to influence policy makers and mobilize resources was given by Dr. Njuba. He said that policy makers need to know that being healthy is a right unto itself and that people can be “led to good health.” His view is that “how you live and how you die is one in the same. You are responsible.” Dr. Olwaazi, on the other hand, was not optimistic. “I’m not positive that policy makers will learn anything. They aren’t interested in the community work. They won’t understand.” Ms. Nalongo had a similar pessimistic view about what policy makers needed to learn. She saw advocacy for improved funding through exposing national professionals to the community level. “People at high levels need to experience the community level.” She felt they were distanced from “reality” and thus they were not able to understand “these issues.” “They haven’t had the ground level experience, she said. “For doctors, this is all abstract. They are not trained in the social barriers.”

In summary, how to mobilize resources in a low-resource environment is a robust need for policy makers’ learning. Mechanisms such as leveraging funding and



infrastructure from existing programs continue to be explored, but participants mentioned often that they are “learning as they go.” The need to carry on in situations where resources and support are limited was illustrated in an observation from Dr. Olwaazi. He related his version of the “learn as you go” spirit that guided Uganda’s response to the early days of the HIV epidemic. He reported:

Evidence that something works doesn’t always translate into policy. For example, our AIDS policy was not driven by evidence from the ground. We didn’t have anything to guide policy. We said, “This is what we need to do,” and we adjusted as we went along. There is an obsession with evidence but research should come later, once you have done something.

*How to sustain engagement at the local level*

The link between education and community well-being is well understood by the members of the policy coalition. For example, Ms. Nalongo, a nurse in the Ministry of Health, described the devastating impact on children that come from a lack of the mother’s education and literacy acquisition. She compared her own experience as an educated woman with the context of an illiterate woman.

[My friends and I] are educated women. I can have *quality* children [her emphasis]. I can decide how many children to have, how to feed them. I can send them to school, I can pay the fees. I know the importance of immunizations and nutrition. I have resources and I know what do. The illiterate woman has too many children. She can have twelve children who are headed for death. She can’t feed them. She can’t send them to school.

The value of the village health teams (VHT) as implementing agents of the integrated public health and adult education policy was reinforced by participants suggesting that they were committed to its implementation in spite of the challenges. Yet the success of the VHT could also be its ruin, as indicated by Dr. Dan who said that “I can see how easy it would be to overload the VHT system or lose that voluntary spirit by asking them to do too much.” In describing the value of the VHT, however, Ms. Mweti related that the village health team “helps a lot in educating the community to make sure they are using all the available health services.” There is a practical element as well to figuring out how to sustain the village health teams. Dr. Katonda related that turnover of health staff at the national level is frequent, but at village level, the people remain. Thus the VHT are the continuity of the health system. The VHTs were also seen as providing a valuable link between the communities and the national health system. Dr. Katonda at a graduation of the VHTs from the district in the western part of Uganda told the new VHTs, “You are elected by your community. You have to tell us [the Ministry of Health structure] what are all the needs of the community.”

The issue of payment and incentives is an issue where solutions continue to be explored. Because the Ministry of Health would like the VHT to serve as volunteers encouraged by community spirit, I wanted to better understand the motivation of the VHT members. I found that village health team (VHT) members enjoy and feel the prestige of their positions by being agents of change for their community. For example, during my visit to the VHT in a district in western Uganda, I spoke with several VHT members through the Community Administration Officer (CAO), who was an official in the LC 1. He translated my questions and their answers as we talked. I initially asked

several of the VHT to give examples of what changes they saw in themselves when they became VHT members. Most cited the respect they felt from their communities when they were elected. Their connection to their communities was evident in their responses about the opportunities they now had to “show the love I have for my community” and to be “a role model in the village for other people to follow.” The aspect of service to their community was inferred when one of the VHT talked about the actual change he could see since he started his service. He said that “when I started, many people were not going to school. Now they go to school. I feel very encouraged when I see this change.” Another VHT member reported a similar realization that she’d seen many changes since the team had started. “Roads have been cleared, water sources have been cleared, and pregnant women are going for antenatal care.”

One experience I had in a conversation with a VHT member involved the hierarchal barriers that impact morale. For example, during my visit with the VHT members, I asked about what they would like to learn to improve their abilities to do their jobs. Topics they mentioned included having better information and communication materials like video cartridges and better teaching materials. They expressed a desire for more training in how to access drugs and medical attention. They can give advice, they said, but they don’t have drugs to treat simple conditions. They wanted to know if they could get thermometers to take temperatures. But the reaction from the two government officers with me – one from the National Ministry of Health and the other, the CAO, both responded that the village health team should not expect to do more than mobilize communities and refer sick people to the health facilities.

When I started to ask the team about other training needs they had, the CAO interrupted to say that the adult education for “this team” should be topics such as communication skills. He felt the team could improve its own literacy levels. He said he felt they should have some public relations skills so they learn how to better work with others and how to work as a team. I interpreted this interaction as a worker expressing learning needs so he or she may do the job better, but the administrative hierarchy rejected the voice of the VHT and overrode the learning wish of the VHT. This is an example of the use of power in negotiation of learning needs, and highlights the dilemmas in sustaining local engagement.

Because the Ministry of Health believes that the VHT should be motivated by community service rather than an expectation of payment, I asked the VHT members why they wanted to be VHTs. Their responses certainly involved a desire for community service and wanting to help others. Several of the comments reflected a desire to learn more so they could be better teachers but also a desire to learn more on their own behalf. For example, one VHT member said that he “listened to the radio about the problem with Ebola. Other information came to us from the outside, and I was not aware. Of these diseases and I wanted to learn more.” They saw themselves as being able “to help families and households in my village” and to be able to make communities aware of problems and “counsel them and lead them to good health.”

In asking about their backgrounds, the VHT revealed their previous experience in working with their community. They reported that many had previously worked in the village with HIV/AIDS orphans and counseling patients, and distribution of the malaria “homepack.” One village health team member said he was working on a vital events

registry program (recording births and deaths) and he wanted to find out more about the health of his community. An older woman had been a traditional birth attendant (TBA). She said she had also been a teacher of “the Word of God” and had been preaching against the idea of “bewitching” as a source of illness and death in the community. The community, she reported, holds her in esteem and she feels proud of the love the community has for her. “I have been elected so the community can be better guided...” From the perspective of the VHTs as those closest to the community, they intuitively understood the socioeconomic impact on health.

Solutions to this problem of payment and incentives were not clearly evident from the participants. Ms. Alice asserted that “there needs to be some sort of local funding for local activities.” Dr. Katondo urged the VHTs who complained about the lack of payment to charge the local families for services. But there was no proposal in any of the participant responses about how to solve this problem. The findings suggest that VHTs, where they work well, are motivated to serve their communities because of intrinsic rewards. But they also would like to be recognized for their service through some incentive (a badge or T-shirt) or payment (reimbursement for travelling from the village to the parish health center).

To conclude this section, the learning that policy makers need involves strategies for mobilizing resources and integrating objectives across Ministries. As well, efforts to sustain local engagement of the VHTs are becoming evident, because the VHT are placing the topics on the agenda. But progress with solving the problem is not evident. The answer may involve a return to traditional structures as suggested by Ms. Mweti from the international NGO. She said that:

In Uganda, the community is the strength. Let me give you an example. A couple of years ago, we started a post-HIV test club, but now it has no funding. But the group still meets and whenever someone needs to have CD4 count done, they pool their money and do it, and when a baby needs milk, they get it. The answer lies with the communities and not with the central government in our country

### Chapter Summary

The purpose of this study was to understand how the process of policy formation in Uganda led to integration of adult education strategies within the national health policy. Adult education confers protective factors on the health of women and their children in low resource areas by enabling access to health care, ensuring compliance with prevention strategies, and fostering participation in community decision-making. Thus the explicit adult education strategies integrated within the policy activities for health education and health promotion serve to strengthen community participation so that social issues related to gender and health may be carried out.

This study used a case study approach to qualitative research. Research questions that guided this study were: (1) What interests shaped the integration of adult education approaches within the national health policy, (2) How were the interests negotiated during the policy making process, and (3) What learning did policymakers need to undertake to effect the integration of these policies? Interviews and document analyses assisted in defining the coalitions involved in this instance of policy formation as well as identifying their interests. How those interests were negotiated and learning needs encountered by the policymakers were also revealed in the interviews and documents.

The coalitions involved in this instance of policy formation were comprised of international, national and local agencies and institutions. Each entity represented particular interests in the policy formation process. These interests included preservation of constitutional stability, increasing human resources, strengthening social cohesion and protection each entity's investments. The core beliefs that bound the coalitions together incorporated the commitment by the political leadership in Uganda, the international partners and local communities to poverty eradication as a goal for improved education and health. Community self-reliance was another belief shared across the international and national health and education domains. Finally, examination of international declarations and documents illuminated the obligations felt by international entities to support development in low resource countries.

Negotiation of these interests took place through the emergence of a national champion. This illustrated the role of power and positionality in affecting change. Even though there was a long chronology of efforts to define the solutions for using adult education strategies to improve poverty and poor health, it took the decision to act of a single, powerful national champion to put the policy into place. In presenting findings about the interests, the first interest was how the policy was framed as an element of the government's poverty eradication program.

The data in this study provided information to describe the policy subsystem involved in the integrated public health and adult education policy was a complex system consisting of government and non-government entities representing international, national and local interests including major United Nations agencies and their donor partners in industrialized countries. At the national level in Uganda, three government

Ministries and representatives from non-governmental organizations were identified as national entities in the policy subsystem. The local level was represented by local government administrators as well as local health and education providers. Traditional clan structures were also implicated. Each of the coalitions involved in the policy subsystem shared a common belief about poverty eradication and economic prosperity as national goals for Uganda's public policy. As a result, poverty eradication is entrenched in the vision and goals of the government so that the National Health Policy and adult education programs are designed with poverty eradication as the organizing principle.

The government and non-governmental interests identified in the interviews and document analyses related to constitutional stability, socio-cultural cohesion, and influences on investments. The data suggested that implementation of the integrated policy using village health teams highlights the government's interest in preserving and strengthening the hierarchical structure that connects local, intermediate and national levels. A strong interest at the national level for governmental stability was a factor in using village health teams to link hard-to-reach rural areas with government services. Focusing implementation of the integrated policy on the village health teams gave visibility to local communities of the government's desire for structural stability and being seen as being a provider of services. Social cohesion was an interest stated by several participants when they discussed the importance of building social capacities so that communities could identify and solve their own problems. Data also suggested that the government's administrative hierarchy appeared to run parallel to traditional hierarchies that bind the traditional clan structures. A final interest was the desire by international donor partners to protect and direct the use of their investments in Uganda.



For example, participants from the Ministry of Health and Ministry of Gender, Labor and Social Development often reflected on how the potential for implementation of locally generated policy initiatives was hampered by the financial directions from external entities.

Many of the participants interviewed during this study reflected on the learning needs that developed during the policy formation process. The main concern they expressed was how to integrate resources in a way that would support achievement of the policy objectives. Improving coordination across ministries was another topic discussed by participants as an area where they had to learn how to connect with potential allies and supporters in parliament and in compatible ministry programs. Additionally, the participants felt that developing advocacy strategies for reaching high level decision makers was instrumental in getting political commitment for the policy. A final area of learning for the policy makers centered on the challenge of sustained engagement at the local level. The village health team, a system that makes use of community volunteers, is the implementing agent for the integrated adult education and public health policy. The issue of payment and incentives for the volunteers remains a challenge for the government. The budgetary resources are low, and there is not enough money. At the same time, the extreme poverty of rural areas makes the question of some monetary or other incentive a critical question for ensuring sustainability of the policy implementation.

## CHAPTER 6

### CONCLUSIONS, DISCUSSION AND RECOMMENDATIONS

#### Introduction

Deaths in children in low income countries occur mostly in families who are poor and whose mothers are the least educated (United Nations, 2007). As a result, children's chances in life are limited starting at the moment of birth. This situation is brought into focus in the following case extracted from a review of patient charts for pregnant women from a health district in a low income country:

Patient was a 37-year old woman at 40 weeks of gestation. 1 pre-natal visit at 7 months in the health facility and 7 pre-natal visits at home. Did not want pre-natal visit at the health facility because of "religious objections." Four hours of labor at home with her husband as attendant. Single vaginal birth on 9/15 at 1630. After 30 minutes, patient began to bleed. Placenta not expelled. Husband walked 8 km (1 hour) to [*nearest town*] to find help. They had no ambulance. Took another hour to find help. Returned with ambulance 2 ½ hours later. Patient died at home 9/15 at 2210. No education, married, planned pregnancy (CDC unpublished report, 2006).

The death of this woman bears witness to the impact of social determinants on the health of vulnerable communities. Factors that adversely affected this family's well being included: lack of confidence in navigating the health system, lack of access to a

trained birth attendant, lack of community infrastructure for transportation, and lack of access to community services including urgent health care. There was no lack of desire on the part of the woman's family to do all it could to help her; unfortunately, the social context of their life circumstances left this family with inadequate capacities and power to act. The well being of communities are not served when health policies only stipulate biomedical interventions without taking into consideration the social determinants that underlie the causes of ill health (Gordis, 2000; Marmot, 2005). Public policies that integrate adult education strategies with public health interventions, such as the village health team policy in Uganda, attempt to improve community capacities for identifying and solving problems that contribute to the health well-being of communities.

This study sought to examine how adult education strategies were integrated with the National Health Policy of Uganda (Ministry of Health, 1999). The research questions guiding this study were: (1) What interests shaped the integration of adult education approaches within a national health policy, (2) How were the interests negotiated during the policy making process, and (3) What learning did policy makers need to undertake to affect the integration of these policies? A case study approach to qualitative research was used to investigate the research topics. The data collection methods included interviews, document analysis, and observations. Eleven participants with knowledge of how the policy was formed or implemented were interviewed. Nine of the participants were Ugandan nationals. The interview data was analyzed through inductive methods using constant comparison. Several key documents were analyzed using variables from the Advocacy Coalition Framework (Sabatier & Jenkins-Smith, 1999). Word frequency analyses were also performed for key documents.

Five findings emerged from this study of a complex policy subsystem comprised of international, national and local entities. First, the policy problem of poor health was defined within the Ugandan government's goal as related to activities for poverty eradication and economic prosperity for the country as a whole. Second, each entity was motivated by interests related to constitutional stability, increased human resources, socio-cultural cohesion and control of investments. Third, using an analytic approach based on the Cervero and Wilson (2006) program planning theory and the Advocacy Coalition Framework by Sabatier and Jenkins-Smith (1999), poverty eradication, community self-reliance and multinational commitments to development were identified as core beliefs that bound the coalitions. Fourth, the core beliefs were translated into policy actions through the intersection of power from the technical, political and ethical domains within each coalition's interests. Negotiations around the social policy issues were across international, national, and local boundaries operating both within and between each entity. Finally, learning needs for policy makers involved creating functional mechanisms for integration of resources and understanding how to more effectively engage the implementing agent at the local level. This chapter presents four conclusions based on these findings and discusses those findings in context of the literature. Implications for practice and recommendations for future research conclude the chapter.

### Conclusion and Discussion

The results of this study suggest four conclusions: (1) International forces play a major role in guiding public policy formation in Uganda, (2) One's position in the institutional or social hierarchy impacts one's influence on policy making, (3)

Negotiation topics engaged secondary aspects of the policy rather than the core beliefs that broadly underpin the policy, and (4) Learning needs of the policy makers consisted of how to mobilize resources and how to integrate goals across sectors.

*Conclusion 1: International forces play a major role in guiding public policy formation in Uganda:*

In this discussion, “public policy” is used generically to encompass both adult education and public health policies. This is to take into account that Uganda does not have a “stand alone comprehensive policy on adult education” (Ministry of Gender, Labour and Social Development [MGLSD], 2008, p. 14). Instead, policies that include adult education components are scattered across the education, health and other sectors (MGLSD, 2008). The most visible government office associated solely with adult education is the Functional Adult Literacy Program (FAL) situated in the Ministry of Gender, Labour and Social Development. In contrast, adult education in the National Health Policy (Ministry of Health, 1999) is an identified strategy for the provision of health education for promoting disease prevention, health seeking behaviors, community organization, and gender equity in terms of access to care. Community and adult education are also essential components of disease-specific control and prevention programs for immunizations, environmental health, epidemic and disaster preparedness, nutrition and mental health services.

The findings of this study fit with literature that examined the policy environment for developing countries in general and Uganda in particular. In general, the findings of this study focused on the role of international forces in shaping policy topics and placing them on the national government’s policy formation agenda. (A summary of those forces

is presented in Figure 4.1 in Chapter 4 of this study.) The findings reflected those of several authors who have described the international influence on national health policies in Uganda specifically (Jeppsson, Birugi, Ostergren & Hagstrom, 2004; Okuonzi, 2004a and developing countries in general (Gostin & Powers, 2006; Kickbusch & Leeuw, 1999). In addressing the question generally, Rist (1997) indicates that the allocation of funding from external sources is under the control of international agencies largely funded by richer industrialized countries. Rich countries hold considerable influence over the policies of poor countries through funding of international agencies such as the World Health Organization (WHO) and the World Bank (Walt and Gilson, 1994). Loans and grants come from international agencies with specifications for performance and accountability. In a study of UNICEF's funding for literacy programs in developing countries, Wickins and Sandlin (2007) found that specifications about how funds from international agencies may be used in effect control how policy is developed and communicated in those countries. Similarly, the findings in this study show that the influence of international forces on public policy formation in Uganda was affected by Uganda's dependence on external resources and by domestic political impulses from donor nations.

*Dependence on external resources:* One of the participants in this study, Dr. Olwaazi, reported how nationally generated initiatives are rarely implemented because of dependency of Uganda on external funding. Two other studies framed this finding by stating that political independence had been achieved in Uganda, but that economic independence remained elusive (Nabyonga-Orem et al., 2004; Okuonzi, 2004a). The privileging of international over Uganda priorities is the focus of a study by Ssengooba

(2006) in an economic analysis of the budget allocation process in Uganda. He argues that the national budget is insufficient to meet national priorities, and, as a result, national policies are sensitive to the latest international initiatives and “fashions” (p. 14). Consequently, the condition occurs where international initiatives with extensive funding levels such as the Global fund to Fight HIV, TB, and Malaria in effect subverts the national budget process away from identified health priorities of communities and shifts the priorities towards the latest international initiative (Ssengooba, 2006). In another study focusing on Uganda, Okuonzi and Macrae (1995) emphasized the consequences to countries arising out of the dependency on external funding. The result, according to these authors is that national policy priorities are undermined and dependency on external control is created.

The threat to the national public policy environment with external funding is that policies and programs are formed and implemented as parallel rather than cohesive systems. This was seen in this study with the fragmented condition of the Functional Adult Literacy (FAL) program and its lack of national coordination with the Ministry of Health. While the FAL contains critical conceptual assets for deployment on behalf of healthier communities, there is no formal linkage between the FAL and the Ministry of Health. Studies by Okuonzi and Birungi (2000) and also Sanders, Todd and Chopra (2005), and Seya (2005) examine how international strategies and declarations confuse and overwhelm fragile systems in such a way that priorities are distorted and country-led approaches are undermined. These studies discuss how local communities are weakened because national ministries respond to the agendas of international agencies rather than to the needs of their own communities. National sovereignty is also implicated (Okuonzi &

Macrae, 1995) because the influence of the international agency such as the World Bank absorbs any national policy direction in favor of ideological and economic theories developed in and for Western countries (Jeppsson, et al., 2004; Okuonzi, 2004b). Within the Advocacy Coalition Framework, a sovereign entity is vital for ensuring stability so that coalitions can form. That national sovereignty is weakened through the influence of international forces on national priorities suggests that the role of the sovereign power is dependent on the dynamics between it and the international agencies involved in international assistance to Uganda. From the perspective of the Advocacy Coalition Framework, this is a distinction with implications for clarifying the requirements of the sovereign power when applying this framework in policy analysis for developing countries. For example, the consequence of international involvement within government financing structures of developing countries including Uganda is the creation at the national level of fragmented and chaotic policy environments. This was seen in this study when participants and documents presented the structure of parallel policy streams created by the international agencies (for example, from World Bank to the Ministry of Finance, from WHO to the Ministry of Health, and from UNICEF and World Bank to the Ministry of Gender, Labor and Social Development). By taking on the international development priorities, Uganda decreases its capacity to apply its resources in any locally defined policy direction.

Innocent (2007) examines the threats that come with external funding in Uganda and concludes that the social context and tradition of community responsibilities are at risk. In an economic study, Shiffman (2006) shares a distinction between how funding from external sources is driven by the donor's domestic policies rather than the felt needs



of the developing countries. The influence on which diseases are funded and how other major causes of death, disability and illness are made is less of a priority (Shiffman, 2006).

As described in the findings of this study, Uganda's engagement in the Poverty Eradication Assessment Program (PEAP) serves to guide the budget allocation process for all of the Ministries and is endorsed by the World Bank. The World Bank's participation with Uganda was grounded in promotion of the World Bank's goal to achieve product-oriented, market-based economies in developing countries (Giroux, 2004; Hill, 2004). In the case of Uganda, Okuonzi's (2004) study describes the impact of the World Bank's pressure on Uganda to demand systems reform that included privatization of the health system. The reformed system in effect failed due to its lack of connection to the socioeconomic, cultural and political context of Uganda.

The findings in this study found that topics appear on national policy agendas through the imposition of internationally declared goals and targets such as the Millennium Development Goals and Education for All targets. In Rist's (1997) view, the "common good" is usually cited as the central purpose of development and international declarations that promote implementation of "technical measures outside the political debate" (p. 78). That is, international declarations assert their grounding in a philosophical basis that implicates a common benefit, and then frames the declaration's goals as not political. Unfortunately, the imposition of international interests does not take into account the local context. For example, several authors (Innocent, 2007; Sanders, Todd & Chopra, 2005; Segall, 2003) have examined how development models generated in international centers in Europe and the United States are seen as less

relevant than models based on local practices and community models. The economic focus of the international declarations failed to take into account the context of local practices and dynamics for interacting with health workers in their own communities (Nabyonga-Orem et al., 2008). That is, it is not enough to have Millennium Development Goals or Education for All goals without also specifying the “driving forces” (Parris & Kates, 2003) that will facilitate action. It is not enough to say that reducing childhood illness is an adequate target without also laying out the instrumental steps for achieving that goal. For example, literacy and adult education are consistently cited as drivers for change in achieving these targets (Archer, 2005; Buor, 2003; Kickbusch, 2001), but unfortunately these adult education activities are the least well funded and understood (Jjuuko, 2007; Kickbusch, 2001).

Findings from this study illustrated the distortion of the World Health Organization’s agenda when the World Bank and its donors shifted their financial support away from institution of community-based, comprehensive services and towards more limited, technically based programs. This mechanism of funding threatens not only the autonomy of the national clients but also other international organizations. For example, a study by Calain (2006) suggests that WHO continues to be under threat given the elevation of health as foreign policy driven in large part by domestic security policies of the United States. The specific instance mentioned by Calain (2006) involves revision of the International Health Regulations (IHR). For example, a yellow fever immunization requirement for travelers is one of the IHR. Every member state of the United Nations from wealthy, functional states like Norway to more fragile and poor states like Sierra Leone are governed by the IHR. In partial response to the global nature of the 2003

SARS epidemic, WHO resolved to update and revise the IHRs in 2005. At the same time, the United States policies were intensely focused on domestic security, and the United States Congress passed legislation that tied funding for international epidemic detection and response to bioterrorism and chemical and nuclear threats (Calain, 2006). These legislative actions had an influence on WHO and how the IHRs were designed. Consequently, the United States security interests have created a “prioritization of epidemic hazards significant for the West at the expense of the far more prevalent diseases affecting the developing world” (Calain, 2006, p. 8).

Not all of the international influence is negative, according to the participants in this study. International agencies such as WHO and UNICEF provided national level professionals with opportunities to take part in international networks, travel abroad for training, and take part in international meetings and conferences that served to strengthen their advocacy for national programs. Other authors including Okech (2005), Walt and Gilson (2000), and Walt (1994) also highlight the benefits that accrue to countries by providing professionals in the health and education sectors with access to emerging ideas and concepts in other parts of the world.

As another benefit, this study illustrated how shared interests around the Alma Ata Declaration influenced how health education, community development and public health programs were conceived and developed into the National Health Policy both in Uganda (Innocent, 2007) and throughout the developing world (Hall and Taylor, 2003; Italian Global Group, 2008). For example, Innocent (2007) details the impact of Alma Ata on Ugandan health policy in that Alma Ata framed public health and community organization as a social justice issue.

Virtually no studies examine the formation of a dedicated adult education policy in Uganda. Scholarly work reported in this study by Okech (2004) traces the history of adult education in Uganda from its pre-colonial roots in traditional societies through colonial and post-colonial periods. But the literature does not speak to how those findings are implemented as policy. Jjuuko (2007) laments the ongoing deficit of policy action for adult education in Uganda. According to Jjuuko (2007), one cause for the slow progress towards a national adult education policy is that adult education has not been adequately defined for Uganda (Atim & Okech, 2000; Jjuuko, 2007).

*Conclusion 2: One's position in the institutional or social hierarchy impacts one's influence on policy making.*

The findings in this study emerged through analysis from the perspective of program planning theory (Cervero & Wilson, 2006) that accounts for the influence of relationships of power on policy decision making. The appearance of a champion or powerful change agent was a finding that highlighted how one's position in the institutional hierarchy is seen in relationship to the extent of influence on the eventual decisions made about the policy. One finding dealt with the relationship between power and positional interactions with the appearance of a champion or powerful change agent. Other findings had to do with the consequences of power and position in the interactions between ministries, and the working situation of the village health teams who were identified as implementers of the integrated adult education and health policy.

In the first example of the impact of position and power on public policy making, the final decision to include the village health teams within the national health policy was due to the actions of a single advocate, Dr. Njuba. After more than a decade of

government white papers, international declarations, and advocacy efforts from coalitions, Dr. Njuba, a member of President Museveni's cabinet, made the decision to enact village health teams as the implementing agents of an integrated public health and adult education policy. Dr. Njuba's action took place because he had sufficient power and position through his social class and political connections. Dr. Njuba's role in the policy formation process corresponds to literature surrounding agents of change in organizations. The role of champion is described by Rogers (2003) in his discussion of how innovations are diffused through social structures. According to Rogers (2003), "the presence of an innovation champion contributes to the success of an innovation in an organization" (p. 414). Cummings and Worley (2005) supplement the notion of "champion" as a powerful change agent that has sufficient attributes to affect change due to the champion's knowledge, personality and high political support. This definition adequately described conditions that made Dr. Njuba's actions possible.

In another example, structural relationships that are defined by institutional hierarchies definitely affect the policy making environment and communication linkages between ministries. It became clear during the data collection phase of this study that horizontal articulation of the literacy and community education strategies between the Ministry of Gender, Labor and Social Development and the Ministry of Health were not functional. In spite of the written documents highlighting the coordination of Ministry activities, there was very little routine communication between the two Ministries. In some cases, I became the bearer of information from one institution or ministry to the other about activities or common interests. This resulted in some elements of dissonance in the findings because participants generally subscribed to the value and importance of

cross-ministry planning, but there was not a great deal of evidence that this happened frequently. The asymmetry of structural relationships could account for the lack of functional communication between these two key ministries. The Functional Adult Literacy program (FAL) is located within the Ministry of Gender, Labor and Social Development within a department dealing with the disabled and elderly. Consequently, it is a program within another department and without its own visibility. This makes coordination challenging since bureaucracies appear to interact and coordinate horizontally with counterparts at similar levels or responsibility and authority. Additionally, the lack of visibility of this program handicaps it from being seen as a serious competitor for budgetary funding (personal communication from A. Rogers, August, 2008). There is no plan for the FAL to assume a Director level status, and as such, it has been confined to an invisible place in the hierarchy.

Asymmetrical relationships of power are well described in the critical theory literature (Brookfield, 2005; Forester, 1989) and suggest how communication is distorted or avoided altogether. From the perspective of Cervero and Wilson (2006), the FAL situation is one where the departments and directorates within the Ministry of Gender, Labor and Social Development have an interest (perhaps competition for resources) in keeping the FAL in a relatively invisible location as suggested by Mr. Ekitabo. In critical theory, the status quo benefits the privileged while efforts to change the dynamic are met with enormous resistance (Baumgartner, 2006). Structural barriers limit participation of actors in decisions that directly affect them.

An additional finding in this study involved village health teams and their communications with the national levels. Motivational messages for the village health

teams stated that they were vital to the functioning of the entire health system. “You are Health Center One,” said Ms. Enkoko to them during a visit I observed. Because the VHT were the closest to the problems of the community level, the advocacy and training messages for them were necessary for communicating their vital contribution to ensuring delivery of health and education services to their own communities. In contrast to this encouragement, the village health teams were not generally provided with any payment or incentives. As a consequence, during a visit from the national leaders, the village health team had an opportunity to bring the problem of payment to the attention of the national level during an official visit. In that public venue, the leader of the village health team made a request for incentives for the team to assist with the costs of travel to the parish headquarters to deliver data each month. They also asked for supplies and equipment to help them assess problems in the village. The national level representatives denied all of the requests. In the national response, the speaker suggested that only the volunteer spirit was of value, and that providing incentives was not affordable. As to the supplies, another participant reminded them that they could not have thermometers; they should only tell people to go to the health center where a doctor or medical assistant could care for the problem. Even though the question of incentives is an expressed need from the village health teams, the resistance of the national level suggests policy change permitting incentives will not take place at any time in the near future.

The assertion of dominance by the national level characterized this request as the request of someone who did not have “the volunteer spirit.” The empowerment of the local level is a stated objective of the national health policy, but the objective is not matched by actions from the national level. The advocacy and motivational messages

provided to the teams serves to encourage them to meet the national level's needs, but does not incorporate what the community is asking for. This finding regarding distortion of messages is similar to Forester's (1989) discussions about the political use of information through its distortion by more powerful parties in the communication process. The relatively low social and institutional status of the village health teams in comparison to national level leadership leaves the village health teams without an advocate for their needs.

The findings about community organization and the impact of asymmetrical power relations fit with the perspectives on community relationships of power stated by Maruatona (2006), Brookfield (2005), and Cervero (2005). Maruatona's (2006) study of literacy policy in Botswana suggests the antidote to structural hegemony is the strengthening of capacities for democratic participation at community levels. Brookfield (2005) emphasizes the value to improved problem solving at the community level through the critiquing of power and hegemony that influences the fair and equitable allocation of resources. Speaking specifically to disease transmission in African contexts, Cervero (2005) asserts the importance of "structural context" of individuals in understanding their risk for disease by noting the "pathways of power and powerlessness defined by economic wealth, gender, and race" (p. 6).

*Conclusion 3: Topics for negotiation involved secondary aspects of the policy rather than the core beliefs that broadly underpin the policy.*

Using perspectives from Cervero and Wilson (2006) and the Advocacy Coalition Framework (Sabatier & Jenkins-Smith, 1999), the findings of this study included identification of the major beliefs and interests that bound the coalitions involved in



public policy formation in Uganda. Through analysis of key international and national documents, poverty eradication was identified as a core belief and priority of the policy coalitions. A corresponding belief was that poor people's input should be actively sought and applied to the formation of policies for eradicating poverty. As seen in this study, negotiation of the integrated adult education and public health policy took place around common interests of the international, national and local coalitions related to economic prosperity and health, constitutional stability, and social cohesion. Secondary aspects of the policy formation (including the designation of village health teams as the implementing agents) were categorized as implementing activities grounded in the core beliefs. For example, the deep core belief of poverty eradication underpins concrete targets set in national documents such as the National Health Policy (Ministry of Health, 1999) and the Poverty Eradication Assessment Plan (Ministry of Finance, 1997a). These targets drive implementation of activities across several sectors with the hope of improving access to social services for education and health. A stated secondary aspect of the PEAP is the application of adult education as a tool for human development. Success in meeting performance targets for these actions is designed to contribute to the overall goal of poverty eradication, a core belief of the international, national and local coalitions. The message designed for the public's acceptance of village health teams' role in health and education services - "health begins in the home" - concentrated the coalitions' core beliefs about locating poverty eradication strategies within communities and across all development sectors.

According to a hypothesis of the Advocacy Coalition Framework (Sabatier & Jenkins-Smith, 1999), the members of a policy coalition will demonstrate "substantial

consensus on issues pertaining to the policy core, although less so on secondary aspects” (p. 32). Each party coming to the planning table is supported by beliefs, values and interests that affect how decisions are made (Cervero & Wilson, 2006). Sabatier and Jenkins-Smith (1999) also highlight that planning is not a rational process given that coalitions act from their platform of shared core beliefs in how they see the world and how public policy can affect the change they seek. In fact, changes in these core beliefs are unlikely to change “as long as the...coalition that instituted the program remains in power” (p. 33). In fact, as suggested in the chronology of health, education and development documents in Figure 4.1 of this study, progress in organizing around the health and education policies did not accelerate until the early 1990s and the Museveni regime. This regime has remained in power for more than 15 years permitting a period of relative stability that is conducive to the formation of public policy.

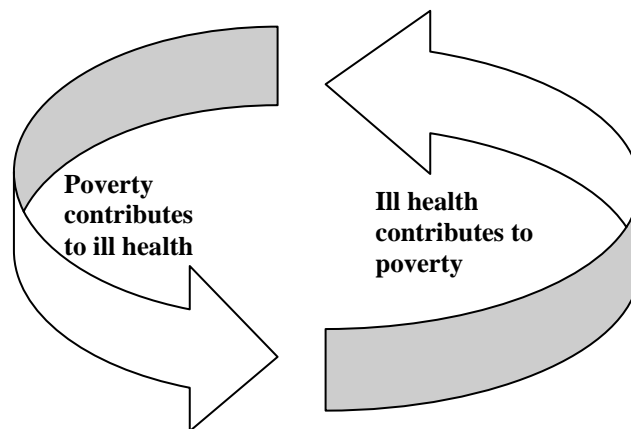
In viewing the findings of this study from the theoretical perspectives of policy formation and planning, there is a suggestion that the underlying core beliefs of the coalitions share a dissonant condition across the policy subsystems. This suggestion considers whether contradictory beliefs may serve to limit efficacy of program recommendations. For example, The World Health Organization’s core beliefs are grounded in the Alma Ata Declaration of 1979 with the message of “health for all” and broader visions of community development that address social determinants of health. However, actual policy development by the WHO is confined to limited biomedical interventions (Kickbusch, 2001). While WHO espouses the close connection between social determinants of health, it relies on external funding that is limited to narrowly defined, single-disease health programs (Italian Global Group, 2008). In the domain of

international education advocates, the Dakar Framework for Education for All (UNESCO, 2000) states that “no countries seriously committed to Education for All will be thwarted in their achievement of this goal by lack of resources.” When this promise is compared to funding allocations, however, nearly three-fifths of the available funding is going to primary education. The priority for funding adult education is clearly reduced in favor of universal primary education.

In another example of discordant core beliefs seen in the findings to this study, a core belief of the World Bank is to achieve economic prosperity in developing countries. That is, the World Bank’s financial support to developing countries is towards achieving economic prosperity in a way that demands financial efficiency and focus on productivity. At the same time, the World Bank also states a core belief in “participatory poverty reform” (World Bank, 1999). The tension between the impulse for top-down demands for market-oriented economic reform in developing countries and the concurrent strategy for bottom-up “participatory poverty reform” is repeated in how World Bank influences budget allocations in Uganda for poverty eradication. People in poor districts are assessed regularly to observe whether there are changes in the targets for improved social services, and those results are used to measure whether the government is achieving its poverty eradication strategy. At the same time, the World Bank continues to promote reduced public sector spending and market forces developed in and by Western economies (Okunzi & Birungi, 2000; Youngman, 2000). A study by Innocent (2007) contrasted the inefficiency of the budget allocation process in Uganda in its efforts to carry out the World Bank’s market-based philosophies with the expressed needs, social context and tradition of Ugandan communities. As discussed by Kickbusch

(2000), such top-down policies do not take into account the reality and existence of socio-cultural factors in creating healthy communities. Consequently, competing core beliefs impede the likelihood for forming relevant and appropriate activities to implement the policy.

In addition to coalitions holding contradictory beliefs, they may also hold mirrored beliefs that circumscribe the problem in such a way that novel actions are not possible. For example, several participants in this study reported on the role of the Poverty Eradication Assessment Plan (PEAP) (Ministry of Finance, 1997a) as guiding how budgets are allocated. Documents also revealed that the two guiding beliefs of Uganda's public health policy and adult literacy program were grounded in findings from the PEAP that poverty contributes to ill health, and ill health contributes to poverty. These two guiding beliefs were derived from the UPPAP government survey carried out in poor districts in Uganda (Figure 6.1).



*Figure 6.1:* Intersecting core beliefs

While the effort is to establish a core belief for addressing social determinants of health, the result of the intersection of discordant beliefs about public health and poverty is an endless loop that does not open the space for examining other solutions to improved

socio-economic outcomes. For example, with the framing of the policy so tightly linked to this endless loop, there is no room for discussion of what else could be done to improve livelihood and well being of fragile communities. There is no way to account for inclusion of other more focused activities for addressing social determinants such as intensified efforts to increase adult literacy and community autonomy.

*Conclusion 4: Learning needs of the policy makers consisted of how to mobilize resources and integrate goals across sectors*

In a discussion of the need for accountability and evaluation for public policy, Majone (1989) states that the complexity of the policymaking process means that “improving the learning capacity of the various organs of public deliberation” may be more effective than focusing attention on achieving policy goals and targets (p. 183). An example of the value of enhancing the learning capacity of the various coalitions was given by Dr. Olwaazi who described how Uganda had to “learn as we go” to find effective prevention strategies when HIV/AIDS first appeared in Uganda. Consequently, understanding the policy-oriented learning including the learning needs of policy makers required during policy formation is critical for this study of policy formation in Uganda. The findings of this study support Majone’s (1989) view in demonstrating how the learning that went on in the coalitions enhanced the ability of the integrated policy to be implemented through the village health teams. As well, the findings in this study about the learning needs of the policy makers fit with the definition of “policy-oriented learning” as a result of the experiences in policy makers’ efforts to achieve the policies that emanate from the core belief systems (Sabatier and Jenkins-Smith, 1999, p. 42). In

other words, policy-oriented learning is an ongoing process throughout the policymaking environment.

The learning needs of Ugandan policymakers identified in this study focused principally on skills for negotiating resource mobilization, building coalitions with other partners, and sustaining local engagement. These identified learning topics align with Sabatier and Jenkins-Smith's (1999) framework that behavior change is more likely around secondary aspects dealing with implementation of the policy rather than in any modification of the core beliefs. Learning needs about resource mobilization meant that policy makers developed skills for understanding international trends and the budget allocation process. Integration of resources was a learning need associated with discovering how policy makers should interact in the budget making process. Findings in this study referred to the need of policy makers to learn how to sustain the interest of the community in conducting the activities prescribed by the policy. As alluded to in the findings, in places where payment was not forthcoming, village teams did not operate as effectively. Thus, the question of adequate funds is a critical issue to deliberate and resolve as it affects the sustainability of the program. Learning needs involved how resources can be leveraged and how objectives can be streamlined to address multiple needs, a topic also explored by Calain (2006).

Another need involved strengthening skills for creating and building coalitions. For example, Dr. Katonda developed funding opportunities for advancing the village health teams in a district in Western Uganda through careful negotiation and alignment of his project with the goals of the North American health agency. In contrast, the mechanisms for sustaining the engagement of the village health teams with the national

health policy goals remains a challenging area for developing solutions given the limitations of the national budget. Still, without some indication of their worth and value, the village health teams may lapse into inactivity. Participants in this study stated how examples from other countries informed and broadened their thinking as to how to solve this problem. In these instances, the skills of policy makers involved negotiations around the secondary aspects of implementation rather than the focus on the deep core belief for poverty eradication.

While there are limited studies on implementation of public policy in Uganda, both Okuonzi (2004) and Jesspersen et al.(2004) detail the burden placed on national governments when international policies are inserted into national policy. The result is that the policy is adopted, but there is no guidance or information on how to adapt the policy to the local situation. For example, even though there was extensive national and international experience over time in developing the inclusion of community strengthening in the National Health Policy, the actual mechanism for carrying out that policy had not been defined. The adoption of the village health teams as the implementing agent for the integrated policy was defined by Dr. Njuba. He drew on his experiences in a previous posting in a rural hospital in Uganda where he had experience with patients suffering from conditions that were largely preventable.

Policy advocates expressed the need to find out how they could better reach the Ugandan law makers and political leadership who would be able to convey the desired policy changes into law. As an example, the frustration in reaching those law makers and decision makers about community needs was a finding in this study. One participant said that the community level was “too abstract” to the doctors. The participants themselves

admitted they were not close to the community context since they normally spent their time in close collaboration with national counterparts, international technical experts and binational aid representatives. These situations were seen in work by Shiffman (2006) and Walt (1994) who described the lack of critical information about the community policy context in addressing public policy. This learning need is particularly challenging given the shifting international priorities, a topic also examined by Walt, Shiffman, Schneider, Murray, Brugha, and Gilson (2008). In addressing theoretical and methodological recommendations for conducting health policy analyses in developing countries, they underscore the importance of examining issues of positionality during policy analysis as a means for uncovering the context of community levels.

In the realm of adult education as a subsystem in Uganda, learning needs involved collaboration with other key ministries and overcoming structural barriers. Jjuuko (2007), a Ugandan adult education advocate, addresses this learning need specifically in noting that a lack of a precise definition for adult education prevents the ability of advocates to market their programs and acquire the funds they need. A critical learning need in the public policy arena is, therefore, the need to carve out the role of adult education in Ugandan public policy deliberations and demonstrate its value to policy makers.

This study supports the view that evaluations directed from external sources do not result in policies that match a country's needs. Stronks, Arah and Plochg (2006) suggest that improving the availability of evidence to drive policy formation is less valuable than focusing more on the process of policy formation and assessing its feasibility for success. The findings of this study support that view in that the formation



of Uganda's integrated health and education policy evolved from a long process of national and international advocacy; the role of quantitative evidence as guiding policy decisions was not evident in this study. Evidence to inform the poverty eradication strategy was developed from the UPPAP and the PEAP surveys. The UPPAP itself sought to find out "why some people move out of poverty and others remain trapped" (Ministry of Finance, 1997b). The question guided the needs assessment in aiming to identify causes of poverty. The results did serve to highlight the desperate conditions conferred by poverty on the population and provided base line information for monitoring the implementation of government activities designed under the poverty eradication strategy.

In contrast, evidence can be inadequately understood if a broader conceptual framework is not deployed in analyzing the results. For example, the FAL was evaluated by an external partner. The participants in that study reported that they wanted to improve their literacy so they could write their own letters and read the Bible (MGLSD, 2007). Concurrent with those finding were results that became a set of confounding factors for cohesive policy development. That is, participants in the literacy evaluation reported that they had electricity only infrequently and, when fuel was available, made use of kerosene lanterns for household lighting (MGLSD, 2007). The target population for the policy defined their needs in terms of their personal experiences and socio-economic context, but their entire context was not considered. As a result, the recommendations did not address the infrastructure needs that would make writing and reading in a household possible.

## Implications For Practice

Many studies present evidence that adult education has a positive relationship with health outcomes, especially in low resource areas. In fact, adult education is a vital implementation strategy for advancing improved socioeconomic objectives in developing countries. As expressed by Seya (2005) in a discussion of the role of adult education in African development, adult education has the potential to equip adults “with the knowledge and cultural elements required for their self-fulfillment and active participation in the social, economic, and political life of their societies” (p. 97). Specifically, adult education leading to enhanced community capacities is essential for achieving success in public health interventions for infectious diseases that are the leading causes of illness and death in African communities. The skills and knowledge accrued through adult education that address infectious disease threats to African communities involve the use of insecticide-treated bed nets, access to safe water, compliance with drug treatments, knowledge of safe sexual practices, hygienic practices in the household, and confidence in navigating health systems to seek care. Accordingly, mitigation of the social determinants of health is inherently linked with the benefits of adult education and learning in low resource areas.

The purpose of this study was to understand how adult education strategies are integrated with public health policy in Uganda. By focusing on an instance of public policy formation in Uganda, this study sought to identify how the process of policy formation resulted in an integrated adult education and public health policy. Given the positive potential of adult education strategies to achieve improved health outcomes in low resource areas, the results of this research on integrated policy making in Uganda

provide practical implications that may guide practice for international adult education, public health and development practitioners and their counterparts in developing countries. One practical area relevant to practitioners suggested by this study is to appreciate the complex nature of public policy formation and how international interests affect national priorities and budgets. Too often health and education development projects are created that do not take into account the political, positional and ethical relationships that are embedded in the policy formation environment. Adult education and development professionals may be engaged with well-intentioned projects (improved adult literacy, for example) which may ultimately fail because there has not been adequate understanding of how and in whose interests the broader policy has been formed. In other words, as seen in this study, external funding for an adult literacy program was given to extend the economic interests of a donor country in contrast to the need for literacy expressed by the local communities. The results of this study may encourage adult education and development professionals to see project design for developing countries in relationship to a more complex environment of international, national and local entities.

This study confirms a practical suggestion for enhancing negotiation skills of adult education practitioners inferred from Cervero and Wilson's (2006) program planning theory. That is, adult educators involved in program planning for developing countries may use their understanding of power relationships and democratic negotiations to anticipate interests and locate opportunities for ethical interventions and opportunities to ensure that the felt- and expressed-needs of the target population are addressed. For example, even though developing country public policies are largely influenced by

international forces, those forces may also be used to support national and local goals.

The eventual adoption of village health teams in Uganda as implementing agents of the integrated adult education and public health policy stemmed from nearly thirty years of adherence to the spirit of the World Health Organization and UNICEF statement of community-based social development expressed in the Alma Ata Declaration. Being familiar with the objectives and interests of international forces, adult educators have an opportunity to find language and occasions to present proposals or modifications of projects that address the expressed needs of the local communities.

Another pragmatic suggestion from this study is to consider the role of culture in forming and implementing public policy in developing countries. While one interest of the national policy was to foster social cohesion, the national written health policy did not give voice to the presence of the clan system in Uganda. This lack of clan visibility in the formal policy meant that the central government developed an administrative hierarchy that in effect ran in parallel with the traditional clan-based hierarchy. Elements within the value systems of the clans have potential to strengthen successful conduct of the policy such as the reliance on the word of the king in mandating behavior. Secondly, the community cohesion fostered by the clan system is an enabling factor for success of the village health teams. The kinship networks and resulting clan responsibility for caring for one's kinship group is parallel to the goals of the village health teams to assist communities in organizing themselves to identify and solve issues related to their social well-being. Thus it is pragmatic for practitioners to consider the cultural context in policy processes so that all assets for achieving improved well-being are considered.

Finally, for adult education and public health practitioners in developing countries, this study suggests that the two professional fields have much to gain from integrating resources and objectives. Fostering compliance with health promoting behaviors is a common goal of adult education and public health initiatives. In the developing country policy formation context, competing interests from international agencies result in fragmented policies so that commonly shared beliefs do not always result in coherent policies. More importantly, scarce resources are not used to their best advantage. At a very practical level, the international development context will be affected by the global financial crisis with reduced dollars available to achieve development outcomes. Consequently, the need for integrated policies is acute for extending common objectives across sectors, ministries and international agencies. This need could be met with more concrete involvement from both adult education and public health in joint planning, implementation and evaluation of common objectives. Because national policies in developing countries are influenced by international agencies and wealthy donor countries, advocacy for aligned and integrated policies could be promoted at high levels through policy briefs, presentations and publications that disseminate the value of integrated resources for improving the well-being of African countries.

#### Recommendations for Future Research

Because very few studies have examined the integration of public health and adult education policies in developing countries, there are many directions for further exploration of this and related topics.

1. Because this study focused principally on the role of Uganda's national level in policy making, repeating this qualitative study with participants from the

community or local levels would provide valuable insights that that could contribute to a fuller understanding of the policy environment.

2. Given that Uganda has not formally adopted a national adult education policy, the data collection for this study around adult education as its own domain was limited to international declarations and literacy program evaluations. Broad support for adult education is embedded in the Poverty Eradication Strategy in Uganda, but there is no formally adopted adult education policy in Uganda at this time. Conducting a qualitative case study exploring the potential for such a policy in Uganda would provide useful insights about how adult education is viewed in the public policy environment.
3. Uganda is a well organized country and is considered an early adapter of many international strategies and initiatives. As well, it is one of the leading countries economically in sub-Saharan Africa. Repeating this study in another country would serve to validate the methodology and contribute to generalizations about common issues surrounding the development of integrated adult education and health policies. This is particularly important given that the standard responses to preventing and controlling public health threats to African communities implicate community and individual learning about life-saving changes in behavior. Further, capacity building for democratic engagement is also served by understanding how public policies can be more integrated and cohesive. Therefore, identifying a similar country and conducting a qualitative case study for a similar policy would be valuable to increasing understanding of the policy environment and its potential to integrate policies for social determinants.

4. The theory of change associated with this study states that education is a mitigating factor on the social determinants of health. While this association is supported in literature, there are very few empirical studies that examine how the social determinants are realized in a community. For example, the village health teams in Uganda help to implement the requirement that every household have a latrine. The conceptual support for this requirement is not complex. Safe disposal of waste limits transmission of disease. But the social support required for achieving this requirement takes into account cultural practices and gender roles. Because digging the latrine is considered men's work, a woman who has been widowed or who has no male in her household will not be able to easily comply with the requirement. Accordingly a descriptive case study examining how social determinants in a village or community setting are actually realized could be useful in more concrete understandings of the social context of community members.
5. To support the broader use of advocacy products for generating funding for public policies, a costing or cost-effectiveness study could be conducted to compare the possible savings involved in integrating adult learning with public health policies. Given that the results of this study suggest empirical evidence does not always result in policy formation and policy change, data about costs could be developed to persuade decision-makers at international levels about the relative cost-savings that might result from integrated health and education policies.

## Chapter Summary

The findings from eleven participant interviews and analyses of key documents were used to develop four conclusions about how adult education strategies were integrated in Uganda's National Health Policy. First, international forces play a major role in guiding public policy formation in Uganda. Second, one's role in institutional or social hierarchies influences the extent of one's influence on the process of policy formation. Third, negotiation took place around secondary or implementation beliefs of the coalitions rather than with the core beliefs that served to bind the coalitions. Lastly, how to mobilize resources and integrate them across sectors were the major learning needs of the policy makers identified in the findings of this study.



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## APPENDIX A

### Interview Questions

#### *Semi-Structured Interview Guide:*

Before each interview began, I introduced myself and explained the purpose of the study. The consent form was given to the participant to read and sign. I emphasized that their responses were confidential and that pseudonyms would be used in the analysis of the data. Each interview began with questions to gather information about the participant's responsibilities and experiences with policy formation. Questions from the interview guide aided the researcher in checking that each topic was addressed, but often additional questions were asked to gather information based on the participant's experiences, professional role, and interests. Several times, follow up questions grew from or were adapted to respond to the participant's responses or level of responsibility.

*Research question #1: What issues shaped the integration of adult education approaches within the national health policy?*

1. What is your role in this [*institution, group or agency*]?
2. From your view, who were the key persons, groups or agencies involved in defining the issues around the inclusion of adult education approaches in the National Health Policy? Who do you think were the main supporters? The opponents?
3. Who do you think (people or organizations) were the main people or groups that should be credited with getting the idea of village health teams on the agenda?

4. What problem do you think the village health team policy was designed to solve?  
How was the problem defined?
5. Who had influence on the content of the policy?
6. How were alternatives and possible solutions to the policy problem developed?  
How were they promoted?
7. How was the policy implemented?
8. Has the policy succeeded, in your opinion? What criteria would you use to make this judgment about its success?

Research question #2: *How did the policy makers negotiate the external and internal interests during national policy making?*

1. Who do you think were the main actors involved in creating the integrated policy?
2. What role did each actor play in the process? [*probe for external actors and for internal actors*]
3. How was the community or local level represented during the process? Can you give me an example about how local organizations were involved in the process?
4. Please tell me about how decisions were made during the process. Can you give me an example of one instance?
5. Whose priorities do you think were reflected in the final form of this policy?
  - a. Were any of the priorities of the [*institutions, agencies, groups or persons mentioned in earlier questions*] more dominant than others during the process? How did the other actors respond?
6. What interests do you think were most important or most influential during the formation of this policy? Why do you think these views prevailed?

7. Please give me an example of how [*institution, agency, group or person*]'s interests were represented.
8. Was there a time in the process when a difference of priorities was evident? How was it resolved? Whose views prevailed?

*Research question #3: What learning did policy makers need to undertake to affect the integration of these policies?*

1. What kinds of evidence [*for example: information, anecdotal evidence, research, etc.*] did you find persuasive in considering this policy?
2. Can you tell me about how the people involved in forming the policy realized they needed more information? What kinds of information or did they ask for? Did they get it?
3. What do you think were significant topics that the politicians needed to understand during the adoption of this policy?
4. Can you tell me about a time in the process when you realized that more information was needed? What did you do to find out more about a missing piece of information?
5. Do you think this policy should be revised? Why? How?
6. If this policy should be revised, what kinds of information would you like to have available?

## APPENDIX B

### Consent Form

I (name of participant), \_\_\_\_\_, agree to participate in a research study titled “Integrating Adult Education and Public Health Policy: A Case Study of Policy Formation in Uganda” conducted by Helen N. Perry from the Adult Education Department at the University of Georgia (706-542-4018) under the direction of Dr. Sharan Merriam, Department of Adult Education in the College of Education, University of Georgia. I understand that my participation is voluntary. I can refuse to participate or stop taking part without giving any reason, and without penalty. I can ask to have all of the information I provide returned to me, removed from the research records, or destroyed.

The purpose of this study is to understand the process of integration of adult education strategies into national health policies. Specifically, this study wants to understand how the benefits of maternal literacy and other adult education strategies on reduced rates of childhood mortality due to preventable diseases can be emphasized in national public health policies. The results of this study will be included in a doctoral dissertation and a synthesis of the results will be used to develop briefing papers for increasing awareness in other countries in Africa about the role of adult education in affecting the social determinants of health.

No risk is expected, except for the time away from my other duties when I take part in this interview. A digital recording of the interview will be made by the researcher and a transcription prepared. The transcription will be shared with me for my review and comment. As an incentive, I will receive a copy of a book, “Control of Communicable Diseases Manual” for taking part in the interview. Even if I stop taking part in the interview, I will still receive a copy of the book.

No information about me, or provided by me during this research, will be shared with others without my written permission. I will be assigned an identifying number and this number will be used on any records or transcriptions of my interview.

The investigator will answer any further questions about the research, now, or at any future period in the course of this research. Contact information for the researcher is below. I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

Name of researcher: Helen N. Perry  
Telephone: 404 639 3683  
E-mail: [hap5@uga.edu](mailto:hap5@uga.edu)

\_\_\_\_\_  
Signature and date

Name of participant:

\_\_\_\_\_  
Signature and date