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EVALUATION

USAID/Uganda Strengthening Decentralization for Sustainability (SDS) Program

May 2016

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Richard Kibombo, Vincent Owarwo, Alfred Nuamanya, Nasreen Jessani, Kenneth Otikal and Patrick Mubangizi.

Cover Photo: A health worker captures details from a client during a health camp in Mityana district, Uganda. Courtesy of Photoshare

Evaluation of USAID/Uganda Strengthening Decentralization for Sustainability (SDS) Program

An Evaluation of the Strengthening Decentralization for Sustainability (SDS) Model, Its Influence on Local Governance and Service Delivery, and Lessons Learned

May 2016

The 6-year USAID/Uganda **Strengthening Decentralization for Sustainability (SDS) Program** (2010-2016) was designed to improve governance and service delivery in Uganda by strengthening the capacity of local governments to manage decentralized services. Using a combination of coordination activities, technical support and financial assistance, the primary implementing partner Cardno Emerging Markets USA, Ltd. engaged with a number of implementing partners to help achieve the objectives of the program which fall under USAID/Uganda's Development Objective (DO) 2: Democracy and governance systems strengthened and made more accountable, and DO 3: Improved health and nutrition status in focus areas and population groups.

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Global Health Performance Cycle Improvement Project

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20004

Phone: (202) 625-9444

Fax: (202) 517-9181

www.ghpro.dexisonline.com

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CONTENTS

Acronyms	vii
Executive Summary	xi
Introduction.....	xi
Methodology	xi
Key Findings.....	xi
Conclusions	xv
Recommendations	xv
I. Introduction	I
Evaluation Purpose.....	I
Evaluation Questions.....	I
II. Program Background	3
Decentralization in Uganda.....	3
The Role of USAID.....	3
Strengthening Decentralization for Sustainability (SDS)	4
III. Evaluation Methodology	5
Evaluation Approach.....	5
Criteria for Selection of Study Districts	6
Data Collection	7
Data Analysis.....	7
Limitations	8
IV. Findings	9
Changes in the Local Governance Systems as a Result of the SDS Program.....	9
Contribution of the Grants and Grants Management to Project Success.....	19
Effects of Transitioning from DBTA Health Care Management Activities to Districts Grants through SDS	32
The flexible/Adaptive Use of SDS by USAID/Uganda and its Effect on SDS Results.....	34
Relevance of the SDS model given the Current Operating Environment and USAID Uganda Priorities.....	37
V. Conclusions and Recommendations	49
Conclusions	49
Recommendations	50

ANNEXES

Annex I. Scope of Work	53
Annex II. Evaluation Methods and Limitations	81
Annex III. Persons Interviewed	95
Annex IV. Sources of Information	111
Annex V. Data Collection Instruments	115
Annex VI: Health systems strengthening	135
Annex VII: Disclosure of any Conflicts of Interest	141

BOXES

Box 1: SDS Evaluation Questions.....	2
Box 2: Core PBF Indicators.....	21
Box 3: SDS Performance Rewards and Sanctions	21
Box 4: Overview of SDS Model.....	37
Box 5: Nine Categories of Respondents for Key informant interviews	88

TABLES

Table 1: Districts Sampled for SDS Program Evaluation	7
Table 2: Auditor General's Opinion on the Financial Statements of the Districts.....	16
Table 3: Types of Audit Queries Raised by OAG on District Financial Statements for FY2014/15	17
Table 4: Performance of District Grants.....	20
Table 5: Total Number and Cadres of Health Workers Recruited and Supported by SDS As part of COPI2	22
Table 6: Health Worker Staffing Levels Across Sampled Districts (2011-2015).....	25
Table 7: League Table Indicators for Measuring Health Sector Performance.....	26
Table 8: District Health Sector League Table Performance Trends (2010-2015).....	27
Table 9: National League Table Scores for TB Treatment Success in Sampled Districts (SDS and non-SDS) – Score Out of 5	28
Table 10: Number of OVCs Served in the Evaluated Districts (SDS and non-SDS)	28
Table 11 : SDS Grants (UGX) to OVC Services Compared to Local Government Non-wage Conditional Grants (CGs) for CBS in the Sampled Districts	31
Table 12: Major Functional SDS Program Modifications	34
Table 13: SDS Contribution to Construction and/or Rehabilitation of WASH and Education Facilities	35
Table 14: Local Government Revenue as a Percentage of National Budget	44
Table 15: Summary Matrix: Evaluation Questions, Indicators, Sources and Methods	81
Table 16: Schedule of SDS Interviews and Site Visits.....	113
Table 17: District and Sub-county Meeting Schedule, Key Informants and Observations.....	114
Table 18: Summary of HRH Overall Staffing in the 35 SDS Districts— Mar 2013 vs Dec 2015.....	138

FIGURES

Figure 1: Overall Performance of District Councils	12
Figure 2: Percentage Change in Performance Score of District Councils between FY 2011/12 and 2014/15.....	13
Figure 3: Cumulative Number of Ordinances across all SDS Districts by Sector (Dec 2014)	14
Figure 4: Local Revenue Raised from 2011/12–2014/15.....	18

ACRONYMS

ACCLAIM	Advancing Community-Level Action for Improving Maternal and Child Health & Prevention of Mother-to-Child Transmission of HIV
ACODE	Advocates Coalition for Environment and Development
ACTs	Anti-Malaria Combination Therapies
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AOR	Agreement Officer's Representative
ART	Antiretroviral therapy
ASSIST	Applying Science to Strengthen and Improve Systems
BPO	Business Process Outsourcing
CAO	Chief Administrative Officer
CBDOTS	Community Based Directly Observed Therapies
CBS	Community Based Services
CDC	Centers for Disease Control
CDO	Child Development Officer
CFO	Chief Finance Officer
CHEW	Community Health Extension Worker
CLA	Collaborating Learning and Adapting
COP	Country Operational Plan
COR	Contract Officer's Representative
CORDAID	Catholic Organisation for Relief and Development Aid
CSO	Civil Society Organization
DANIDA	Danish International Development Agency
DBTA	District Based Technical Assistance
DCDO	District Community Development Officer
DDPs	District Development Plans
DEC	District Executive Committee
DEO	District Education Officer
DfID	Department for International Development
DHI	District Health Inspector
DHIS	District Health Information Software
DHMT	District Health Management Team
DHO	District Health Officer

DMC	District Management Committee
DMIP	District Management Improvement Plan
DOP	District operational plan
DOVCC	District Orphans and Vulnerable Children Committee
DREAMS	Determined Resilient Empowered AIDS-free Mentored and Safe
DTPC	District Technical Planning Committee
EDHMT	Extended District Health Management Team meetings
EDU	SDS Education intervention
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
eGRIP	Early Grade Reading Improvement Promotion
EMIS	Education Management Information System
EMTCT	Elimination of Maternal to Child Transmission of HIV
FANTA	Food and Nutrition Technical Assistance
FP	Family Planning
FY	Fiscal Year
GAPP	Governance Accountability Participation and Performance
GBV	Gender Based Violence
GH Pro	Global Health- Program Cycle Improvement Project
GoU	Government of Uganda's
HC	Health Centre
HCT	HIV Counselling and Testing
HF	Health Facility
HIV	Human Immunodeficiency Virus
HLG	Higher Local Government
HMIS	Health Management information system
HRH	Human Resources for Health
HUMC	Health Unit Management Committee
ICT	Information Communication and Technology
IDI	Infectious Disease Institute
IFMIS	Integrated Financial Management Information System
IGG	Inspector General of Government
IP	Implementing Partners
JARD	Joint Annual Review of Decentralization
KIIs	Key Informant Interviews
LC	Local Council

LG	Local Government
LGFC	Local Government Finance Commission
LGMSDP	Local Government Management and Service Delivery
LLG	Lower Local Government
LOGIC	Local Government Councils Induction
LQAS	Lot Quality Assurance Sampling Surveys
LR	Local Revenue
M&E	Monitoring and evaluation
MC	Municipal Councils
MEEPP	Monitoring and Evaluation of Emergency Plan Progress
MIS	Management Information System
MNCH	Maternal Newborn and Child Health
MoF	Ministry of Finance
MoH	Ministry of Health
MoLG	Ministry of Local Government
MRO	Medical Records Officer
MSH	Management Sciences for Health
MUWRP	Makerere University Walter Reed Project
NDI	National Democratic Institute
NDP	National Development Plan
NGO	Non-governmental Organization
NPPAs	National Priority Programme Areas
NUHITES	Northern Uganda Health Integrated Services
OAG	Office of the Auditor General
OBT	Output Budgeting Tool
OPD	Outpatient Department
OVC MIS	Orphans and Vulnerable Children Management Information System
OVC	Orphans and Vulnerable Children
PBF	Performance Based Funding
PDC	Parish development committees
PEA	Political Economy Assessment
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLE	Primary Leaving Examinations
PLWHA	People Living with HIV/AIDS

PMP	Performance Management Plan
PMTCT	Prevention of mother-to-child HIV transmission
PNFP	Private Not-for-Profit
RHITES-SW	Regional Health Integration To Enhance Services In South West Uganda
SAS	Senior Assistant Secretary
SCORE	Sustainable Comprehensive Responses
SDS	Strengthening Decentralization for Sustainability
SHRP	School Health and Reading Program
SMC	School Management Committee
SMP	Stop Malaria Projects
SOVCC	Sub-county Orphans and Vulnerable Children Committee
SSHC	System Strengthening and Health Commodities
STAR	Strengthening Tuberculosis and HIV&AIDS Responses
STRIDES	Strengthening Rehabilitation in District Environs
SUGAR	Strengthening Uganda's Anticorruption and Accountability Regime
SUNRISE	Strengthening Uganda's National Response for Implementation of Services for Orphans and other Vulnerable Children
SURE	Securing Ugandans' Right for Essential Medicines
TA	Technical Assistance
TASO	The AIDS Support Organization
TB	Tuberculosis
TC	Town Councils
ToT	Training of Trainers
TPC	Technical Planning Committee
UAUU	Urban Authorities Association of Uganda
ULAA	Uganda Local Authorities Association
ULGA	Uganda Local Government Association
USAID	United States Agency for International Development
USG	U.S. government
VHT	Village Health Team
VMMC	Voluntary Male Medical Circumcision
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
WISN	Workload Indicators of Staffing Need

EXECUTIVE SUMMARY

INTRODUCTION

The United States Agency for International Development (USAID) funded Strengthening Decentralization for Sustainability (SDS) program is a six-year program that aims to improve the results and sustainability of decentralized social service delivery. The program objectives were: i) improving coordination among all USAID-supported partners at the district level; ii) strengthening the capacity of districts and sub-counties to plan, budget, implement/coordinate, monitor, and evaluate decentralized services by efficiently utilizing the Government of Uganda's (GoU) administrative and fiscal decentralization framework; iii) provision of grants to districts to complement resources needed for effective and efficient management of programs and services; and iv) facilitating strategic innovations to improve district leadership and sustainable financing of health, HIV/AIDS, and other social sector services.

The program, which started in April 2010, is completing its sixth and final year of implementation. USAID/Uganda therefore commissioned an endline evaluation of the program in order to understand its contribution to decentralized systems and service delivery, as well as to assess the relevance of the SDS model and provide practical recommendations on how to further strengthen decentralization and good governance in Uganda.

METHODOLOGY

This was an endline (summative) evaluation covering 12 SDS program districts and two non-SDS districts; it employed mostly qualitative methods of data collection. Between November and December 2015, 161 in-depth interviews were conducted with a wide variety of stakeholders, including USAID/Uganda Mission Staff, managers of the SDS program and its implementing partners, political and technical leaders of the Higher Local Governments (HLGs) and Lower Local Governments (LLGs), and Level III and Level IV Health center in-charges. In addition, 10 group interviews were conducted including those with community members – the ultimate beneficiaries of decentralized service delivery. Document review was an additional source of information for verification and triangulation.

KEY FINDINGS

I. Changes in the local governance systems as a result of the SDS program

Coordination

Through the District Management Committees, SDS has greatly enhanced coordination of various key implementers in the local governments (LGs). This has reduced duplication of activities and built teamwork and synergies leading to improvement in deployment of the available scarce resources. However, coordination is largely limited to USAID Implementing Partners (IPs) and a few other key IPs in the supported districts.

Local Revenue Generation

With SDS support, districts were able to identify new revenue sources in order to widen their revenue base and be able to address unfunded priorities. However, due to systemic inefficiencies (such as lack of human resources); political interference, both locally and from the Central

Government; and outright corruption; these efforts have not generated much impact in terms of increased revenue.

Financial Management

Most SDS districts have registered some improvement in financial management as evidenced by the unqualified reports from the Office of the Auditor General. Unlike before, in Fiscal Year (FY) 2014/15, none of the SDS districts covered in this evaluation had a qualified report or unspent account balances due to failure to absorb funds. This improvement was mainly attributed to SDS' stringent accountability requirements. Despite this positive trend, only about a half of the SDS districts have performed consistently well in the previous financial years, implying that they are likely to need further support for financial prudence to take root.

M&E and MIS

SDS has helped to strengthen monitoring and evaluation (M&E) and management information system (MIS) capacity of the districts through training, mentoring, and coaching as well as provision of computer equipment. District M&E frameworks have been made functional using available MIS data and data from lot quality assurance sampling surveys (LQAS). In districts where bio-statisticians have been recruited, this has further improved data utilization. However, this data is mostly used for information dissemination to the public (on public noticeboards), internal departmental reporting at district level, and reporting to the line ministries rather than for decision-making, mainly due to limited fiscal discretion of LGs.

2. Contribution of Grants and Grants Management to the Success of SDS

SDS provided three types of performance based funding to the districts to support coordination and implementation of activities as well as innovations in service delivery.

Grants Management Reinvigorated the Local Government Accountability Norms

The robust SDS grants management and other financial accountability indicators were used to strictly assess district performance every quarter, with results determining eligibility levels for subsequent disbursements. However, in most districts, this was mainly applied to SDS grants, thus putting into question whether district overall ability for transparent and effective management of funds has been built for all sources of funding across the board.

SDS Grants Were, to a Very Large Extent, Conditional Grants

The SDS program granting mechanism, while predominantly conditional, was in line with LG financing protocols. The Performance Based Financing component helped to reinvigorate the accountability requirement that is intricately embedded in LG financing, but remained limited to the SDS funds only.

The Human Resources for Health (HRH) Support Targeted Critical Staff Cadres but their Absorption Rate Was Lower than Expected

The HRH component, and the principle of gradual absorption, proved to be an innovative method of supporting districts to progressively expand their Human Resources for Health base for improved health service delivery. The 54% public sector HRH absorption rate negates the benefits of this arrangement. However, the Mbale district experience, which has managed to absorb all the SDS-supported HRH, provides evidence that the district wage bill hurdle can be overcome.

SDS Grants Revived Community Based Services

SDS technical and financial assistance, in collaboration with the USAID-funded orphans and vulnerable children (OVC) District Based Technical Assistance (DBTA) programs, namely Strengthening Uganda's National Response for Implementation of Services for Orphans and other Vulnerable Children (SUNRISE) and Sustainable Comprehensive REsponses (SCORE), revived community based services (CBS) – making the dormant OVC committees at district and sub-county levels functional; operationalized OVC MIS; provided community development officers with relevant skills to provide OVC services; and increased awareness of OVC issues at all levels. This, however, has resulted in increased demand for services that districts are unable to meet. Furthermore, with the winding up of SDS CBS grants, activities to support OVCs have started slackening, raising questions regarding the sustainability of the interventions.

The Water, Sanitation, and Hygiene (WASH) and Education Interventions, that were Piloted in a Few Districts, were Quite Successful

WASH and Education interventions that were piloted in a few schools, in a few sub-counties, in a few districts, were found to be very beneficial in stimulating learning, and personal and environmental health. For example, the Education intervention addressed some of the district's critical concerns in quality education service delivery, such as training School Management Committee (SMC) members in school governance, leadership, management, and stewardship; training teachers in new teaching methodologies and local instructional materials; utilization of data for decision-making; and supporting districts to cascade the skills and good practices through establishing learning centers and facilitating peer-to-peer learning. These and similar activities should be part and parcel of the support package, in all the districts.

3. Effects of Transitioning from USAID-supported DBTA Health Care Management to District Grants through SDS

Whereas the Combined SDS and DBTA Arrangement was Successful in the CBS Sector, in the Health Sector it Yielded Suboptimal Results

The SDS program was a complementary mechanism for strengthening LG systems by providing financial as well as technical support to complement resources from the DBTA programs. Whereas this technical assistance (TA) arrangement worked well for the CBS sector, it met considerable challenges in the health sector. The main bottleneck was the conflicting principles between the program designs for SDS and the DBTA. Whereas SDS exercised performance based funding (PBF), with rewards and sanctions, the DBTA programs were designed to achieve defined volumes of service delivery outputs in a defined timeframe. Therefore, the synergy that was supposed to be realized from the two technical arms did not fully materialize.

4. Effect of the Flexible and Adaptive Use of SDS by USAID on Program Outcomes

The Program Modifications over the SDS Lifespan were Accommodated Appropriately but most were not a Result of Learning and Adapting

The original SDS program design was robust enough to accommodate all the modifications. However, LGs felt USAID Uganda used the flexibility of the program mainly to accommodate its policy and functional changes rather than the modifications being a product of program learning and adapting. This was so because LGs were not directly involved in identifying the required modifications despite the fact that some of the modifications, such as Local Government

Councils Induction (LOGIC), were made to address glaring LG needs. Such approaches run the risk of resistance from IPs due to lack of ownership.

There was no Clearly Defined Program Package Assigned to SDS across all the Supported Districts

In general, the modifications appear to have enhanced the performance of the districts in key areas of service delivery as well as strengthened the roles and responsibilities of political and technical personnel in the districts. For instance, the WASH and Education interventions helped the pilot districts tackle the service delivery issues in those respective sectors. And, as such, SDS was able to deliver more on its decentralization agenda in these districts. However, as a result of the multiple modifications, some in only a few pilot districts, the SDS model was distorted, and as a result, SDS failed to maintain a clear functional identity that would help propel the LGs to concrete end goal(s).

5. Relevance of the SDS model in the current Ugandan environment

Effectiveness of the SDS Approach

Under the SDS program, districts received both grants and TA aimed at strengthening decentralized systems and processes so as to enhance the LG's ownership, autonomy, and independence. The evaluation found that the program achieved varied levels of effectiveness. There are several factors that contributed to this, key among them being a robust Grants Management system characterized by timely disbursements and a comprehensive mechanism of checks and balances. The strictness with which SDS implemented the PBF laid a good foundation for a culture of accountable service delivery. Due to that support the districts, and in particular selected health facilities, have sustainable infrastructure and technologies like solar panels. The capacity of the districts has also been enhanced. LOGIC has left the district leadership very clear about their roles while the training of the para-socials empowered the community with invaluable capacity to handle OVC matters.

However, the insufficient support to weak districts, the closure of SDS regional offices, and the frequent transfer of Chief Administrative Officers unduly disrupted program implementation.

Relevance of the Model in the Current Operating Environment

The operating environment presents some risks as well as opportunities for strengthening governance systems in a decentralized set-up, the most prominent for the Uganda context being high levels of corruption, obstructive patronage, and the monetization of politics, which have created a culture of “what is in it for me?” – locally dubbed “Nfunira wa?” There is low stakeholder participation with most of the decisions affecting the districts originating from the center. Restrictions on taxation and the dwindling grants from the center limit the fiscal discretion available to the LGs to address local priorities. All these remain as major challenges to efforts geared towards strengthening decentralization.

Nevertheless, there are a number of opportunities that can be exploited to strengthen decentralization. The National Development Plan (NDP) II, for example, has proposed a number of interventions and strategies to address the key challenges stifling decentralized service delivery. There are also other complementary programs, such as Strengthening Uganda's Anti-corruption and Accountability Regime (SUGAR) and Governance Accountability Participation and Performance (GAPP), aiming at promoting good governance and accountability. Enhancing, supporting, and advancing such efforts in partnership presents an opportunity for future SDS-like

programs. Furthermore, there is an emerging local, non-state sector that can also be supported to provide alternative solutions to service delivery challenges and for strengthening civic engagement.

CONCLUSIONS

Changes in the Local Government Systems and Structures

SDS support to the districts has led to some improvements in the functionality of the LG systems, particularly in the areas of coordination, financial management, M&E, and MIS. However, these achievements may not be sustained, mainly due to frequent changes in the district civic and technical leadership. The fact that the central government and other donors do not apply similarly stringent accountability standards is another disincentive to sustaining the gains achieved.

Contribution of Grants and Grants Management to Program Success

The performance based SDS grants provided vital additional funding for LGs and generated some results across all the departments supported. However, the low to sub-optimal rate of absorption of HRH and lack of funding to fill the gap left by SDS remain key challenges that threaten to undermine the progress made.

Effects of Transitioning District Grants from DBTAs to SDS

The separation of financial accountability from TA resulted in better financial accountability given the PBF approach that SDS used and also boosted service delivery, particularly in child protection and OVC services. However, in the health sector, the anticipated synergy between the TAs did not fully materialize because of the conflicting principles and priorities between the program designs for SDS and the health sector DBTA programs. There is therefore a need to harmonize the approaches of the two TAs to enhance synergies.

Flexible and Adaptive Use of SDS by USAID

The SDS program design and objectives were broad enough to accommodate the modifications, and the leadership and management of SDS ably managed the rolling-out of the numerous modifications. The modifications, such as LOGIC, HRH, and the District Operational Plan (DOP), enhanced the performance of the districts in key areas of service delivery as well as strengthened the roles and responsibilities of political and technical personnel in the districts. However, these modifications were often perceived as a result of USAID policies and functional changes, which raises the question of ownership and sustainability.

Relevance of the SDS Model

The SDS Model was relevant insofar as it contributed additional resources and capacities and to the extent that it attempted to inculcate a culture of strict performance management and accountability. The model remains relevant in the context of the current USAID focus on regional integrated health services delivery that requires a strong decentralized system backbone. However, there is a need to harmonize principles and priorities between Granting and TA mechanisms.

RECOMMENDATIONS

- I. In order to consolidate the gains made in strengthening LG systems, USAID should continue providing technical and financial support to the districts. In the spirit of the PEPFAR impact

agenda of fostering sustainability through building the capacity of local institutions, systems, and the workforce, efforts should focus on strengthening the key tenets of a strong decentralized system, which include LG autonomy, civic participation and downward accountability, local economic development, and strengthening LG structures and systems.

2. The PBF principle should be maintained and embedded across all granting mechanisms. Districts that demonstrate compliance to the set PBF criteria should be given more discretionary funds to address locally identified priorities. The Government of Uganda should take the lead in promoting this approach to all granting agencies.
3. Modifications to future similar programs should, to the extent possible, involve the implementing partners right from the outset to ensure ownership and improve chances of sustainability. The modifications should also be reciprocally adaptive to changing LG circumstances.
4. In the future, in situations involving more than one TA arm, there is a need to synchronize policies and priorities so as to realize the intended synergies.
5. All national level players deemed critical for achieving program results should be fully integrated in the program design with clear roles, responsibilities, and expected outputs. The Ministry of Health should be responsible for supporting the districts to absorb program-supported HRH personnel, the Ministry of Local Government (MoLG) for approval of local tax proposals, the Uganda Local Government Association (ULGA) for sharing experiences, and the Local Government Finance Commission (LGFC) for lobbying the government on additional funds to the districts.
6. Future similar programs need to develop strategies to strengthen community participation and engagement so as to strengthen the demand side for better service delivery and improved downward accountability. One possible way would be to collaborate with Civil Society Organisations already involved in community mobilization.
7. In order to truly support participatory “bottom-up” planning, governance strengthening mechanisms should support districts to make their District Development Plans (DDPs) living documents that respond to their local needs, that are realistic and fundable, and that resonate with national aspirations as enshrined in the NDP II, with emphasis on provision of PBF grants to specifically fund gaps in the DDPs.

I. INTRODUCTION

EVALUATION PURPOSE

United States Agency for International Development's (USAID) Strengthening Decentralization for Sustainability (SDS) program has been underway in Uganda since May 2010. This external evaluation comes at a point when SDS will be completing its sixth and final year of implementation. The SDS Program design is a first of its kind for the USAID Kampala Mission. This evaluation (November 2015 – March 2016) provides insight on how to further strengthen decentralized systems and pursue strategic partnerships with local governments (LGs).

This evaluation aims to establish the effectiveness of the integrated governance and service delivery strengthening approach as implemented under the SDS program and the extent to which it supports both the U.S. government (USG) and the national vision for sustainable service delivery. It intends to inform two primary audiences – (a) and (b) – and one secondary audience (c):

- a) *The SDS program* – its staff and partners interested in understanding the outcomes of the program, areas of successes and challenges, and the factors that contributed to each
- b) *The USAID mission in Uganda* – its staff and partners interested in lessons learned across the various geographic regions and emerging promising practices that can be incorporated into future program designs and ongoing programs
- c) *The Ministry of Local Government (MoLG) and the districts in Uganda* – their staff and civil society that have been actively engaged and affected by USAID/SDS programming in their regions.

EVALUATION QUESTIONS

The evaluation was guided by a set of questions determined by USAID in the evaluation Scope of Work, which can be found in Annex I.

Box I: SDS Evaluation Questions

Q1. How have the local governance systems changed as a result of the SDS program?

With consideration for:

- Sustainability beyond the life of the project
- Influencing factors for success or failure across the districts

Q2. How did the grants and grants management (Incentives and Non-incentives) contribute to the project?

With consideration for:

- Unintended consequences (positive and negative) of the grants

Q3. What was the effect of transitioning for direct implementation of district-led health care management activities from DBTS projects to district grants through SDS?

Q4. How has the flexible or adaptive use of SDS by USAID Uganda hindered or enhanced the achievement of SDS results?

With consideration for:

- How the program itself adapted to the changes; what (dis)enabled the adaptations
- Effects of changes in SDS technical and geographic scope

Q5. To what extent is the SDS model still relevant given the current operating environment and USAID Uganda priorities?

II. PROGRAM BACKGROUND

DECENTRALIZATION IN UGANDA

The Government of Uganda (GoU) decentralization policy was launched in 1992 as the main strategy for improving service delivery, accessibility, and sustainability of public goods and services and for poverty eradication. The overall objective of the decentralization policy was to empower local communities to take control of their own development strategies through more efficient local authorities that would be capable of mobilizing local resources. The Decentralization Act of 1997, revised in 2003, mandates the higher local governments, i.e., the districts (LCV), to mobilize resources, plan, and deliver relevant services to the communities, including the social services (Education, Health, and Community-Based Services (CBS)).

The mandate to coordinate the implementation of decentralization rests with the Ministry of Local Government with responsibility to mentor and advise LGs. However, a lack of capacity as well as resources to fulfill this responsibility results in inadequate support to service delivery entities.¹ Furthermore, the hierarchical and authoritarian political (and social) culture as well as limited awareness of basic rights hinders empowered civic engagement and demand for accountability from leadership by citizens – a key aspect of governance.

Within the health sector, decentralization resulted in a tremendous increase in the number of health facilities, mainly at lower levels,¹ thereby improving access and utilization of services, particularly amongst the rural poor. However, lack of human, financial and infrastructural resources¹ as well as insufficient capacity at the district level has inhibited local needs-based planning due to (i) the stringent earmarking of budget allocations from the central level (and therefore continued centralization of power), and (ii) limited capacity to plan and effectively manage these limited resources for improved service delivery. Problems of corruption, accountability, and limited stakeholder participation reduce local influence on budget allocations for priorities in the district. Additionally, noncompliance with respect to distribution of locally generated revenue further compromises financial support for key services.¹

THE ROLE OF USAID

Recognizing the pivotal role played by LGs in service delivery, USAID made a deliberate choice to work with LGs and other stakeholders to address the capacity gaps affecting access, availability, and utilization of services. While USAID works with partners across the country, it selected 19 districts to focus the majority of investments in support of the three development objectives (mission-focus districts).

USAID introduced District-Based Technical Assistance (DBTA) to provide technical capacity in areas related to HIV/AIDS, Maternal and Child Health, Orphans and Vulnerable Children (OVC) and Family Planning, among others. Specific USAID-supported activities providing this support included: Strengthening Tuberculosis and HIV&AIDS Responses (STAR) in East, East Central, and South Western Uganda*; Northern Uganda Health Integrated Services (NUHITES)*; Strengthening Uganda's National Response for Implementation of Services for Orphans and other Vulnerable Children (SUNRISE)*; Strengthening Rehabilitation in District Environs

¹ Dexis Consulting Group - Learning and Knowledge Management (LEARN). (Oct 2015) *Ugandan Decentralisation policy and issues arising in the health and education sectors*. USAID.

(STRIDES) for Family Health*; and Stop Malaria* projects. Other USAID activities include programs such as: the Governance, Accountability, Participation and Performance (GAPP) Project (2012–2017); Advocacy for Better Health (2014–2019); the Regional Health Integration To Enhance Services In South West Uganda (RHITES-SW 2015-2020), Better Outcomes for and Livelihoods Development for Children and Youth in Eastern and Northern Uganda (2015–2020) and Sustainable Outcomes for Children and Youth in Central and Western Uganda (2015–2020).²

STRENGTHENING DECENTRALIZATION FOR SUSTAINABILITY (SDS)

In response to emerging development assistance coordination issues, governance and systemic challenges in the LGs, USAID launched the SDS program in May 2010. By 2014, SDS activities had been implemented in 64 districts: 35 core districts (of which 13 were mission-focus) and 29 Human Resource for Health (HRH) districts in Central, Eastern, Western and Northern Regions of Uganda. SDS expanded to an additional five districts in the Northern region in April 2015. The total cost of the program is expected to be approximately \$70 million by the end of 2016.

Key Program objectives³ included:

1. Improving coordination among all USAID-supported partners at the district level
2. Strengthening the capacity of districts and sub-counties to plan, budget, implement/coordinate, monitor, and evaluate decentralized services by efficiently utilizing the GoU's administrative and fiscal decentralization framework
3. Provision of grants to districts to complement resources needed for effective and efficient management of programs and services
4. Facilitating strategic innovations to improve district leadership and sustainable financing of health, HIV/AIDS, and other social sector services

SDS further operationalized these objectives using a district-based model encapsulated through direct engagement with LG structures. The underlying belief of this model was that direct technical and financial capacity strengthening to local governance district structures would enhance ownership, autonomy, and independence. Furthermore, there was an inherent assumption that working with the central government will foster changes at the district level. An inter-ministerial steering committee that included Ministry of Health (MoH), MoLG, Uganda Local Government Association (ULGA), Uganda Local Authorities Association (ULAA), among others, was thus created. It was hoped that this in turn would lead to more sustainable decentralized services as well as improved results in health and other social structures.

Key to harmonized programming was SDS' coordination efforts that required partnerships with other USAID implementing partners/DBTAs. This was in recognition of a multitude of organizations operating simultaneously in the districts, thereby leading to duplication of activities and unequal distribution of services. Additionally, the constraints that generally plague the public sector, such as poor distribution and shortage of personnel, shortage of critical drugs, limited logistical support, and less than desirable data for decision-making justified resource allocation to the district LGs through a coordinated mechanism.

² Concluded by the time of this evaluation.

³ GhPro. USAID-Uganda SDS Evaluation Final Scope of Work. 22 Oct 2015.

III. EVALUATION METHODOLOGY

EVALUATION APPROACH

This was an endline (summative) evaluation whose design and approach was guided by the evaluation questions. In the absence of several baseline indicators relevant to the evaluation questions, a true pre-post analysis was not appropriate. However, given that some data on the situation prior to the SDS intervention was available in key documents, secondary analysis of quantitative data for trend analysis, and a predominantly qualitative approach for primary data collection was chosen. Furthermore, a need to understand the specific contribution of SDS interventions versus those of other types of intervention in Uganda required comparison of SDS districts to non-SDS districts. Annex II provides details on data sources, sample sizes, analysis, and limitations to the evaluation approach, and an overview of dissemination activities.

SDS has also been the main implementing partner supporting the roll-out of a District Operational Plan (DOP) that provides a framework for planning and coordinating USAID assistance with districts to achieve shared development objectives through a more efficient and effective approach across 35 districts. The evaluation of the DOP is a separate exercise and not included in this report.

Methods and Data Sources

In order to ensure data validity and reliability, multiple types of data sources were consulted. These include document review, key informant and group interviews, and direct observations – all elucidated in Annex II.

Documents

Key national level, district level, and programmatic documents provided an objective source for some of the mechanisms employed for strengthening service delivery and governance as well as nuanced understandings of the contexts in which the program was operating. A full list of documents consulted can be found in Annex IV.

Key Informant and Group Interviews

In order to understand the varied experiences of a multitude of stakeholders, key informants were classified into nine categories: USAID, SDS, national level partners, district level partners, development partners, USAID implementing partners, Health Centre (HC)-III and HC IV/Hospital in-charges, community beneficiaries, and civil society (see Box in Annex II). In addition, due to the inclusion of Water, Sanitation, and Hygiene (WASH) and Education (EDU) programs by SDS a primary school as well as HCII were visited in Kanungu district in addition to interviews with District Education Officers (DEOs) across several districts.

Key informants were selected with a view to: *understand perceptions of key stakeholders* that may not arise in a group situation; *explore divergent experiences and “outlier” attitudes* that may vary between individuals; *permit “deep dive” discussions* and probe for meaning on select questions; and *provide a shortcut to community norms* – interviewing key district and community leaders provided overviews of community development, needs, and concerns. Group interviews were sought in instances when collective experiences were deemed necessary to enrich the evaluation, and/or in the event that time restriction required collective meetings; this was

particularly important when community input was invited. For details on the recruitment process, refer to Annex II.

Observations

While nonverbal cues were noted alongside interview transcripts, public displays of information as a proxy for transparency were also observed for validation of data in the study – for example, postings of district procurement plans, central government release of funds, trends in local revenues etc. Pictures of these were also taken to serve as evidence for reference purposes. Visits to HC IIIs and HC IVs allowed for observation of staffing, use of innovations, state of facilities, functioning of equipment, and processes for data collection/monitoring, among others.

CRITERIA FOR SELECTION OF STUDY DISTRICTS

SDS Districts

Exclusion of SDS districts with programming underway for less than a year (due to likelihood of insufficient data to draw lessons from) resulted in the exclusion of the 29 HRH specific districts as well as the Northern districts, which only joined the SDS in April 2015. In order to have a fairly representative sample across the SDS districts, three sub-categories of the remaining 35 within each region were deemed important: (a) Mission focus only; (b) Mission focus and DBTA; (c) Non-mission focus and non-DBTA/STAR. Districts in each of the sub-categories were chosen using simple random sampling.

Districts were further categorized as “new” or “old.” The use of “poor” and “good performing” districts as defined by SDS was deliberately avoided in selection criteria. The reasons for both these decisions as well as details on sampling are articulated in Annex II.

Non-SDS Districts

In order to ensure that comparisons relevant to the absence or presence of SDS could be elicited, two non-SDS districts – Mukono and Tororo – were chosen through convenience sampling. This was based on geographic location (close to SDS districts being visited), and age of district (mature districts with established governance mechanisms).

All sampled districts, with their various programmatic characteristics (including presence of other governance strengthening programs), are highlighted in grey in Table I below.

Table I: Districts Sampled for SDS Program Evaluation

Relevance to study	REGION	Age of district	District	USAID Mission focus	HRH	WASH	EDU	Grant C	DBTA/STAR	STRIDES	SUNRISE	Other governance programs	REGIONAL TOTAL		
SDS DISTRICT	WESTERN	OLD	Bushenyi	✓	✓				✓		✓		Mission Focus only	2	
			Kabale		✓	✓			✓		✓		DBTA Only	6	
			Kanungu			✓			✓					Mission	3
			Kisoro		✓	✓			✓					Non mission focus, non DBTA	1
			Ntungamo		✓				✓		✓				
			Rukungiri		✓				✓						
			Kasese	✓							✓	✓			
			Kamwenge	✓	✓							✓	✓		
		Kyenjojo										✓			
		Ibanda	✓	✓					✓	✓		✓			
		Isingiro	✓	✓						✓	✓		✓		
		Kirihura	✓	✓					✓	✓					
	TOTAL			5	10	3	0	2	9	2	9	0		12	
	CENTRAL	OLD	Bugiri	✓	✓				✓	✓	✓	✓		Mission Focus only	1
			Iganga	✓	✓					✓	✓	✓		DBTA Only	2
			Kamuli	✓	✓					✓	✓	✓		Mission Focus+DBTA	4
			Kaliro		✓				✓	✓	✓	✓			
			Luwero	✓							✓	✓		Non mission focus, non DBTA	6
			Kayunga		✓							✓	✓		
			Mpigi									✓			
			Nakasongola									✓	✓		
		Sembabule		✓							✓	✓			
		Kalangala		✓							✓	✓			
		Mayuge	✓	✓						✓	✓	✓			
		NEW	Mityana												
	Namutumba			✓					✓		✓				
	TOTAL			5	9	0	0	2	6	10	11	1		13	
	EASTERN	OLD	Mbale	✓	✓		✓	✓	✓	✓		✓		Mission Focus only	0
			Sironko	✓	✓		✓	✓	✓	✓		✓		DBTA Only	6
			Kapchorwa	✓	✓					✓				Mission Focus+DBTA	3
			Busia		✓					✓		✓			
			Kumi				✓					✓		Non mission focus, non DBTA	1
		NEW	Pallisa		✓						✓				
			Bududa		✓							✓			
			Budaka		✓		✓			✓	✓	✓			
Bukwo				✓						✓	✓				
Butaleja				✓							✓				
TOTAL			3	9	0	4	2	9	1	8	0		10		
OVERALL TOTAL			13	28	3	4	6	24	13	28	1		35		
NON- SDS DISTRICT	CENTRAL	OLD	Mukono			✓			✓		✓				
	EASTERN	OLD	Tororo							✓	✓				
	TOTAL			0	0	1	0	0	1	0	2	2			
GRAND TOTAL			13	28	4	4	6	25	13	30	3				

DATA COLLECTION

Document review occurred throughout the evaluation process totaling approximately 45. A full list of documents consulted can be found in Annex IV. A total of 19 national level key informant interviews (KIIs) and four group interviews were conducted. In the districts, 142 KIIs and 10 community discussions were conducted. For a full list of respondents see Annex III. Interview instruments can be found in Annex V.

DATA ANALYSIS

Document review, KIIs, and observations were all systematically documented for analysis. (Refer to Annex II for details on data analysis for each type of data source – documents, KIIs, observations).

The evaluation team prepared and reviewed summary matrices of all interviews in each district so as to extract themes and spur further investigation of respondent assertions/perspectives. This often required further research into policies, guidelines, and data from numerous published and unpublished sources. Inductive content analysis was utilized to determine emerging themes relevant to the evaluation question. Secondary data analysis focused on identifying quantitative trends in governance as well as service delivery indicators over the SDS program period.

Information garnered from interviews, document review, observations, and trend indicators were triangulated to provide a deeper understanding of what transpired in the various districts.

LIMITATIONS

Time and resource constraints limited the study to only 12 SDS districts and two non-SDS districts.

Social desirability bias and recall bias inherent to qualitative investigations likely influenced responses. Interviews were conducted with probes and variations in questioning to minimize the effects of these. Varied key informants' perceptions, while telling with respect to the variations in experience with SDS, often made it difficult to distinguish perception from reality. Efforts to untangle these using objectively verifiable data was not always possible due to the lack of quantitative data and indicators, particularly with respect to health outcomes.

Evaluating the impact and relevance of the SDS model as it was applied across the various districts presented analytical challenges due to the variations in the implementation as well as the varied contexts in which SDS was operating. SDS interventions were largely complementary, thereby making definitive statements on SDS attribution to change difficult for some (but not all) aspects. We therefore attempt to indicate the contributions that the SDS program has made in areas where direct cause and effect is unclear. No statistical tests of significance were possible.

Taking all these limitations into consideration, while making generalizable conclusions relevant across all SDS districts was not appropriate, a nuanced analysis on what worked and in what context lends perspective to the micro- and macro-level factors that affected SDS outcomes and learnings for future programs considering similar elements.

Extensive discussion on limitations to the study can be found in Annex II.

IV. FINDINGS

CHANGES IN THE LOCAL GOVERNANCE SYSTEMS AS A RESULT OF THE SDS PROGRAM

Over the past five years, the SDS program has provided Technical Assistance (TA) to districts to strengthen their management capacity in: coordination; leadership and governance; integrated planning and budgeting; integrated work planning; public financial management; ordinance formulation and enactment; revenue generation; procurement management; monitoring and evaluation (M&E); and management information systems (MIS). This evaluation attempted to establish the key system changes that occurred as a result of the program and their implications. This was done by assessing whether the SDS interventions has made the LG systems more effective and efficient as compared to before the introduction of the program in the participating districts.

Changes in Coordination

Before the introduction of the SDS interventions in the districts, Cardno – the implementing firm – conducted assessments in all the target districts in order to identify the required interventions as well as to establish baseline data that would be used to measure program progress and performance. These baseline findings indicate all districts did not have effective structures to coordinate district programs particularly with other key implementing partners (IPs). The district leadership used to interface with the IPs only during the annual budget conferences. Currently, through the District Management Committees (DMCs)/Extended District Health Management Committees and Extended District Technical Planning Committees, heads of departments, USAID IPs, and other major IPs meet at least once every quarter to discuss priority areas, harmonize activities, and integrate their work plans, which minimizes duplication and helps optimize deployment of the districts’ meagre resources. This contrasts sharply with the situation in the non-SDS districts where IPs are not coordinated and rarely (if at all) report to the districts, as highlighted by one official in the non-SDS district of Tororo. However, SDS districts were also experiencing challenges of non-attendance of meetings by key IPs (including USAID IPs) and district departments that do receive SDS funding.

“There are many players in the health sector, including World Vision, TASO, and others, but we have never come together to plan. We only converge during the budget conferences. The budgets and plans of other partners are not integrated in the district plans.”

District Official, Tororo

Changes in Leadership and Governance

Cognizant of the fact that about 70% of LG councilors lose their seats in every election,⁴ in 2011/2012, the SDS program, in collaboration with the Danish International Development Agency (DANIDA) and the Uganda Government, conducted an induction for all higher local government (HLG) and lower local government (LLG) councilors elected in 2011 to enable them to better appreciate their roles and responsibilities. This induction was also attended by all LG technical heads of departments. Further TA to strengthen leadership and governance was

⁴Cardno Emerging Markets USA, Ltd. Induction of Local Government Councillors: Final Training Report, July 2012

provided through executive leadership training, seminars, exposure/exchange visits, as well as through the various District Management Improvement Plan (DMIP) and DOP processes. For districts that had SDS education sector support, TA was provided to strengthen school-level governance, leadership, and management (School Management Committees, head teachers and teachers) through training, mentoring, coaching, and peer-to-peer learning, among others.

Findings reveal that these interventions have contributed to some improvements in governance and leadership across all SDS-supported districts albeit with varied success. On the political side, the major improvement reported in most districts was reduction in conflicts between the elected leaders and the technical managers, and this was mainly attributed to the SDS Local Government Induction of Councils (LOGIC) training that clarified roles and responsibilities between the two arms. This has helped improve the working environment and enabled the technocrats to do their work without undue political interference, which used to paralyze service delivery, particularly in the area of procurement. However, in a few districts such as Sembabule, political interference was reported to still be quite rife. Busia also had similar problems in the recent past but at the time of the evaluation the district had gotten new leaders (both political and technical) who were trying to normalize the situation.

“Political leaders have changed their thoughts. Initially, they used to be interested in money alone. Now, they think more about issues of service delivery. They would not sit in meetings if you didn't pay them but that has now changed. They would put your back against the wall and blackmail you. That has tended to change.”

Former District Official, Mbale

Despite the generally improved working relationship between the technical and political arms, it was reported across all districts that there was still a lot of infighting within the district councils, which affects council performance and, consequently, service delivery. Furthermore, due to monetization of politics, political leaders continue to make unjustifiable financial demands and often the technical managers have to find innovative ways of accommodating them to maintain a cordial working relationship and avoid jeopardizing service delivery. For example, the District Council of Kamuli had refused to pass the budget for the current financial year (2015/16) allegedly because they wanted their sitting allowances increased and arrears paid.⁵ It took the intervention and threats from the line Minister for the council to pass the budget. All these highlight the vital role that stable and committed political and technical leadership play in the achievement of program results.

⁵ The arrears were a result of council's decision to sit every month instead of once every two months.

Another area that was reported to have improved across all the districts was political monitoring and supervision of implemented activities. This was mostly attributed to the SDS's rigorous and regular validation of implemented activities in which some members of the District Executive Committee (DEC) also participate. District officials reported that SDS' vigilance and the participatory approaches used (such as the joint monitoring and supervision exercises) have generally enhanced team work, accountability, transparency, better appreciation of the community problems and needs, political advocacy, better targeting, and prioritization of needs. However, across all districts, officials registered disquiet over the fact that SDS did not provide funding for political supervision and monitoring, which forced implementing departments to look for resources to cover the gap. Where departments failed to facilitate the politicians, like in the case of the Busia District Community Based Services department, there was open animosity between the elected leaders and the department's technical staff, and political monitoring and supervision was not done. So, while SDS' decision not to fund political monitoring and supervision was a correct one (since it is part of the mandate of elected officials), in general, all districts lack the funds to support conducting this activity on a regular basis. This raises serious doubts about the continuity of regular political monitoring and supervision once the program winds up its activities in these districts.

SDS trained leaders on their roles and responsibilities, M&E, and on the use of reporting formats. Formerly there was only desk reporting. SDS introduced the concept of validation to ensure that social services have been delivered. This has helped the district to improve its performance. Budaka DLG was No. 78 in the LG Annual Assessment but it is now No.7.”

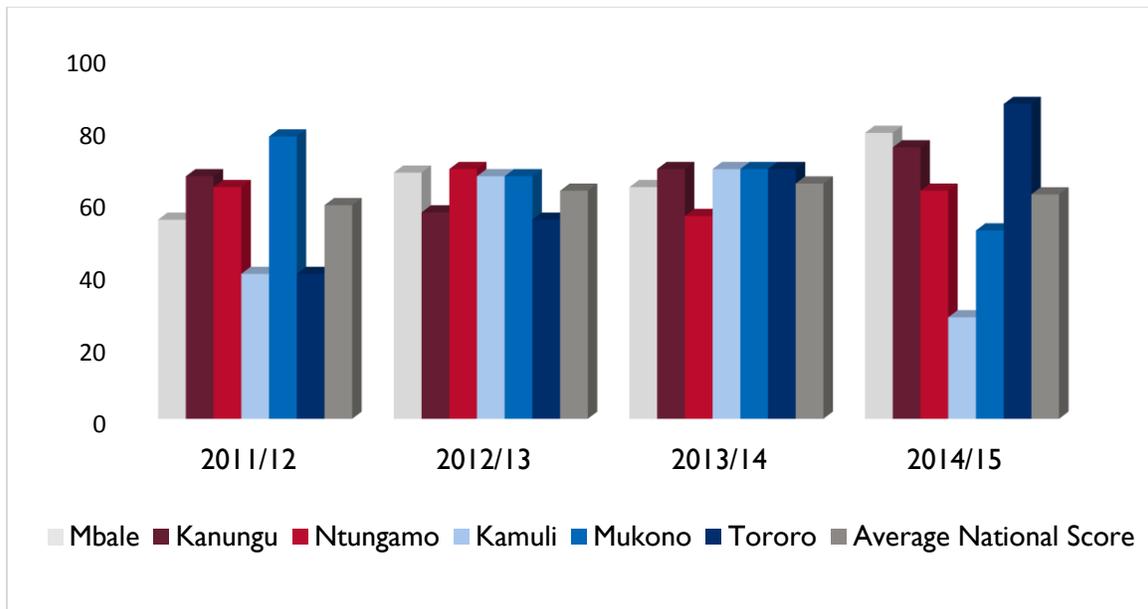
DEC Members, Budaka District

A look at the results of Advocates Coalition for Environment and Development (ACODE)'s Annual Local Government Councils Scorecard, which Cardno also used to assess district leadership and governance prior to the introduction of the SDS interventions, further shows there is some improvement in the district councils' performance of their core roles and responsibilities (Figures 1 and 2).⁶ The overall performance of the district council is an aggregate score based on council's performance in its core roles of legislation; accountability to citizens; planning and budgeting; and monitoring of national priority programme areas (NPPAs).⁷ The maximum a council can score is 100. Figure 1 shows that, overall, the performance of the councils in SDS-supported districts was only slightly above the average national score by the end of FY2013/14. However, in FY2014/15, all SDS district councils performed well above the national average, except in Kamuli where there was a sharp decline – perhaps due to the political bickering reported earlier. It is worth noting that the non-SDS district of Tororo, which was a poor performer in 2011, has been improving steadily and by 2015, it was performing better than the SDS districts covered in the Scorecard. From the qualitative interviews conducted, Tororo's good performance was mainly attributed to the current Chief Administrative Officer (CAO)'s “no nonsense” style of leadership, which clearly underscores the central role of the district's top leadership (CAO and LCV Chairperson in particular) in promoting good governance within their districts.

⁶ Complete data for FY2011/12 through FY2014/15 was available for only six out of the 14 study districts.

⁷ The current NPPAs are primary education, health, water and sanitation, agriculture, and road transport.

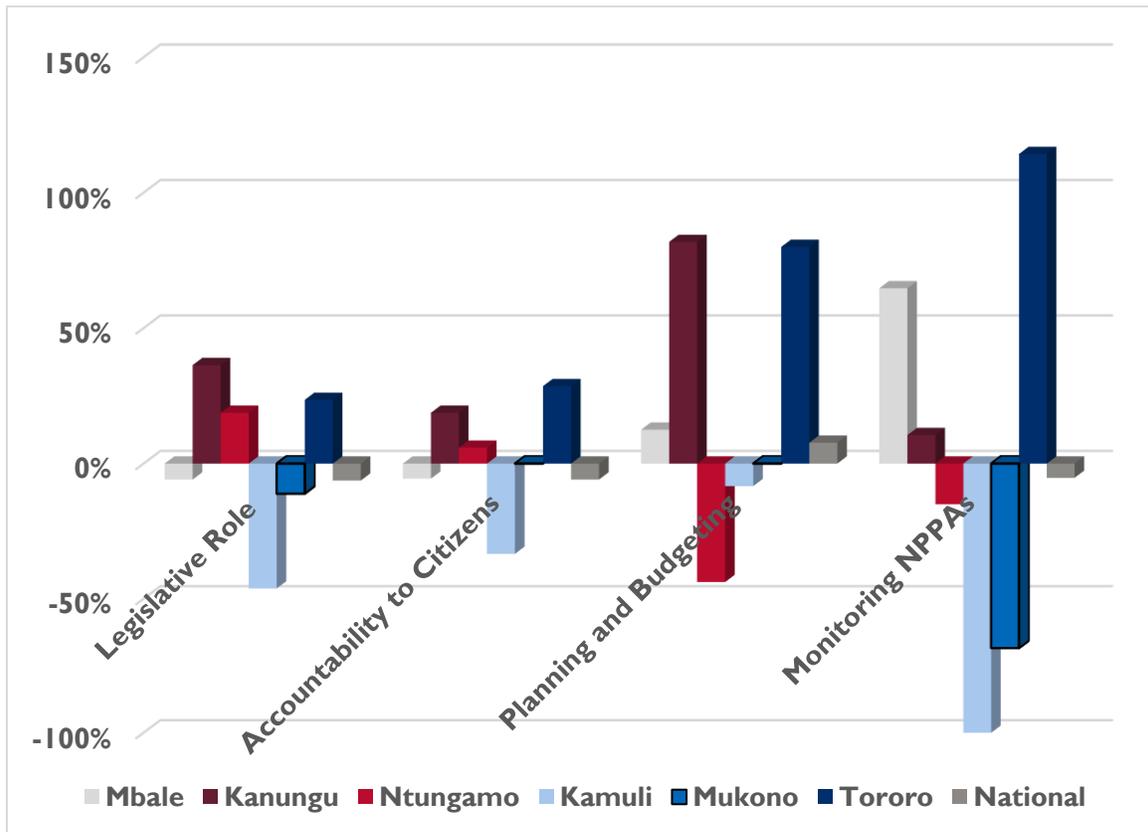
Figure 1: Overall Performance of District Councils



Source: ACODE Uganda Local Government Councils Scorecard Reports for FY2011/12 - FY2014/15

Figure 2 shows the percentage change in the performance of the various district councils in their various core roles during FY2014/15 as compared to FY2011/12 when the programme had just started. The data clearly shows that most SDS districts have made improvement in some areas but not others. Only the district councils of Kanungu and the non-SDS district of Tororo performed consistently better across all areas while Kamuli retrogressed in all areas. It is worth noting that while political supervision and monitoring was reported to have improved across all the SDS districts, according to the results of the ACODE Scorecard, many of them did not perform well in monitoring the NPPAs. This seems to suggest that, in many districts, political monitoring and supervision was more pronounced in SDS-supported sectors where facilitation was more readily available – which further confirms concerns about sustainability.

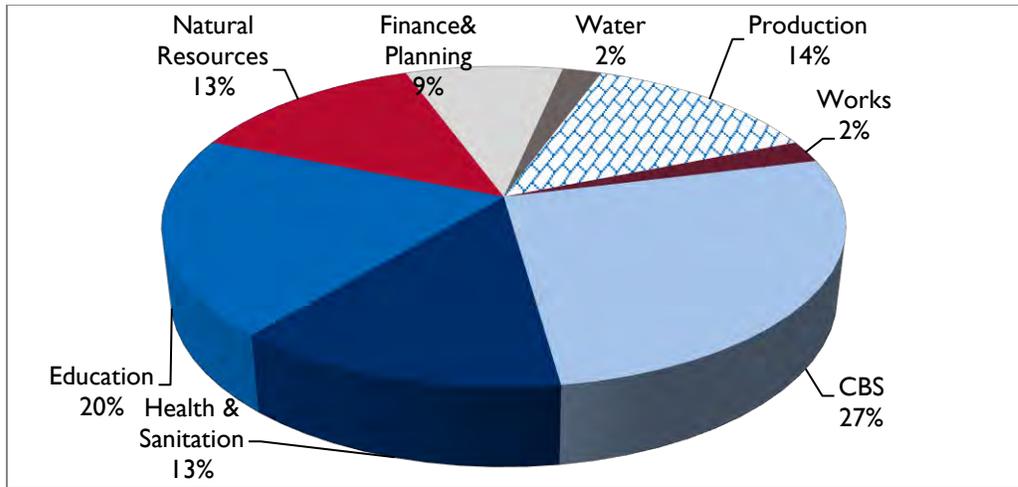
Figure 2: Percentage Change in Performance Score of District Councils between FY 2011/12 and 2014/15



Source: ACODE Uganda Local Government Councils Scorecard Reports for FY2011/12 and FY2014/15

It was further reported that because of the increased awareness of their roles and responsibilities and with SDS financial and technical assistance, elected leaders had formulated ordinances and by-laws to address various unique situations pertaining in their respective districts (Figure 3). At the time of the evaluation, the ordinances were at different stages of enactment with about 18% of them already approved by the relevant Minister. In some of the districts where these ordinances and by-laws are being implemented, they have yielded some positive results. For, example, local officials in Busoba Sub-County in Mbale District reported that school attendance had tremendously improved after putting in place a by-law which fined parents whose children are found not to be attending school.

Figure 3: Cumulative Number of Ordinances across all SDS Districts by Sector (Dec 2014)



Source: SDS Report

On the management side, there were major sectoral improvements, especially in the CBS departments, which had been completely marginalized before SDS due to severe underfunding. SDS funding, together with SUNRISE support, has enabled the CBS departments to carry out a wide range of activities including mapping of OVCs, reviving of the OVC MIS, training of community development officers (and other key stakeholders such as the police, health workers, para-socials, and Centre Coordinating Tutors) in child protection issues, operationalization of the District Orphans and Vulnerable Children Committee (DOVCCs) and Sub-county Orphans and Vulnerable Children Committee (SOVCCs).

“Child protection and OVC activities which had long been abandoned by the central and local government were supported. Home visits, training of CDOs and para-social workers was done with SDS funds.”
District Official, Kiruhura

These activities have led to increased awareness of OVC issues at all levels and community demand for OVC services has also subsequently increased. LGs have also responded by formulating ordinances and by-laws to protect OVCs as well as linking them to relevant service providers since the districts themselves often don’t have the resources to provide the required services. In a few districts, like Mbale and Budaka, CBS departments are now being allocated some funding (albeit small) from the districts’ internally generated revenues although this was largely attributed to SDS’ requirement for district co-funding of supported programs. In general, there is improved community access to OVC services because of the training and facilitation (in terms of transport allowance) to Child Development Officers (CDOs) who are based at sub-county level. Previously, only a few communities were able to access OVC services since they were only available at district level.

However, without continued SDS funding and support, districts are unlikely to sustain the gains so far made in the OVC sector. By the time of the evaluation, the regularity of OVC monitoring visits, reporting of OVC cases, updating the OVC database, as well as holding DOVCC and SOVCC meetings had started to decrease in all the districts.

In the districts of Mbale and Budaka that received support for the education sector (only four out of 39 SDS districts received support for the education sector), leadership, governance, and management capacity has been built among school managers (School Management Committees) and head teachers to prioritize school development planning, resource mobilization and financial management, accountability, and reporting. This has enabled beneficiary schools to develop school development plans and, through community mobilization, they have initiated school feeding programs and making of classroom furniture. These districts also reported sharing of these good practices through peer-to-peer learning. Some of the non-SDS schools are replicating similar initiatives, such as providing school lunch and making their own furniture.

“Teachers and school managers came for training and by the time they went back, they had started thinking outside the box. For example, there is this particular school, Bubirabi. Every time every report we received from this school was ‘we need desks, we need desks’ but when they went back they made 80 desks on their own. In the same school, they now have a school garden for the school feeding program and have mobilized the community to participate in the school initiatives. After we had seen that, the peer-to-peer learning came on, we took other schools to this school to see. And guess what, when they went back, another school (Mahongye) went straight to make desks without waiting for the district, other schools (Bufukura and Namasaali) constructed pit latrines. These are the results we are seeing and we feel that this intervention has made a difference.”

District Official, Mbale

“Reporting has improved. Each school makes a quarterly report, an end of term report and an annual report. This practice was there but was not being taken seriously. With SDS monitoring this has improved.”

District Official, Budaka

Another key improvement reported was in the way district meetings are conducted. Unlike before, all meetings now have action points which are expected to be followed up in later meetings and if they are not implemented, those responsible are put to task to explain. This has the potential of helping to improve efficiency, accountability, transparency, and ultimately, service provision.

“Having action points is good practice because you know next time you have to report on them and it motivates you to work and have something tangible to report in the next meeting instead of being just broad.”

District Official, Kaliro

Changes in Financial Management

SDS, through Tangaza, and in collaboration with the Office of the Auditor General (OAG), provided technical assistance to all the SDS districts and a select number of LLG officials in public financial management, accounting, and audit in order to strengthen internal audit, audit follow-up, accountability, timely and accurate reporting, and overall resource management.

In nearly all SDS districts covered, key informants reported improvement in financial management and accounting. This was attributed to the PBF and the strict financial controls instituted by the SDS program, in addition to the TA provided. Most districts reported that, unlike before, they now get unqualified audit reports from the OAG. However, OAG records (Table 2) indicate that while all the districts indeed got unqualified

“There is more transparency in financial management. However, where people are crooks they can still connive to commit fraud. Districts that had never had unqualified audit reports have now had good unqualified reports in the last two years. There are tighter controls as well as better skills among the accounts cadre.”

District Official, Budaka

reports for the FY2014/15, only about a half of the SDS districts have consistently achieved that performance for at least two consecutive financial years over the last four years and only Mbale maintained an impeccable record over the period.

Table 2: Auditor General's Opinion on the Financial Statements of the Districts

District	FY2011/12	FY2012/13	FY 2013/14	FY2014/15
Budaka	Qualified	Qualified	Qualified	Unqualified
Busia	Unqualified	Qualified	Qualified	Unqualified
Kaliro	Unqualified	Disclaimer	Unqualified	Unqualified
Kamuli	Qualified	Unqualified	Qualified	Unqualified
Kamwenge	Qualified	Qualified	Qualified	Unqualified
Kanungu	Qualified	Unqualified	Qualified	Unqualified
Kayunga	Qualified	Unqualified	Unqualified	Unqualified
Kiruhura	Qualified	Unqualified	Unqualified	Unqualified
Mbale	Unqualified	Unqualified	Unqualified	Unqualified
Namutumba	Unqualified	Unqualified	Qualified	Unqualified
Ntungamo	Qualified	Qualified	Unqualified	Unqualified
Sembabule	Unqualified	Unqualified	Qualified	Unqualified
Tororo	Unqualified	Qualified	Qualified	Unqualified
Mukono	Qualified	Unqualified	Unqualified	Unqualified

It was further reported in most SDS districts that procurement has improved due to the training that was provided and this has had a positive impact on service delivery. Before SDS, many districts used to send unutilized funds back to the Central Government due to botched-up procurements.

“The SDS training on procurement was focusing on trying to improve on the planning to enable timely implementation so that we do not have unspent balances. Unlike before, we now do prequalification before the financial year begins. This has improved service delivery and implementation.”

District Official, Kamuli

Data from the OAG in Table 3 seems to confirm that opinion. Only a quarter of the SDS districts evaluated had any audit queries on procurement and none had unspent funds that were supposed to be sent back to the treasury.

Table 3: Types of Audit Queries Raised by OAG on District Financial Statements for FY2014/15

District	Has Unspent Balances	Has unaccounted for funds	Has Procurement Anomalies
Budaka	No	Yes	No
Busia	No	Yes	Yes
Kaliro	No	No	No
Kamuli	No	No	No
Kamwenge	No	Yes	No
Kanungu	No	Yes	Yes
Kayunga	No	No	No
Kiruhura	No	Yes	No
Mbale	No	Yes	No
Namutumba	No	No	Yes
Ntungamo	No	No	No
Sembabule	No	No	No
Tororo	No	Yes	Yes
Mukono	Yes	Yes	Yes

However, all districts acknowledged there was more vigilance with regard to SDS funds due to the Performance Based Financing (PBF) criteria where non-compliance attracts stiff penalties. Consequently, any serious queries raised on SDS funds becomes a concern of all implementing departments as well as the entire district leadership. All this implies that most districts need to be supported for at least a few more years in terms of coaching and mentoring for the culture of financial prudence to take root.

However, in some districts, financial prudence is being further enhanced by other ongoing interventions, such as the Integrated Financial Management Information System (IFMIS), which curtails districts from financial transactions before clearing any pending financial queries.

Revenue Generation

SDS provided TA to enhance LG capacity to generate additional local revenue in order to supplement funding from the Central Government and donors. The underlying assumption was that it provides discretionary funding that would assist LGs to address unfunded priorities and strengthen decentralization. The SDS interventions provided a stimulus for the LGs to widen their revenue base. Districts were supported to identify potential/alternative revenue sources and revenue databases were created in some districts, such as Ntungamo.

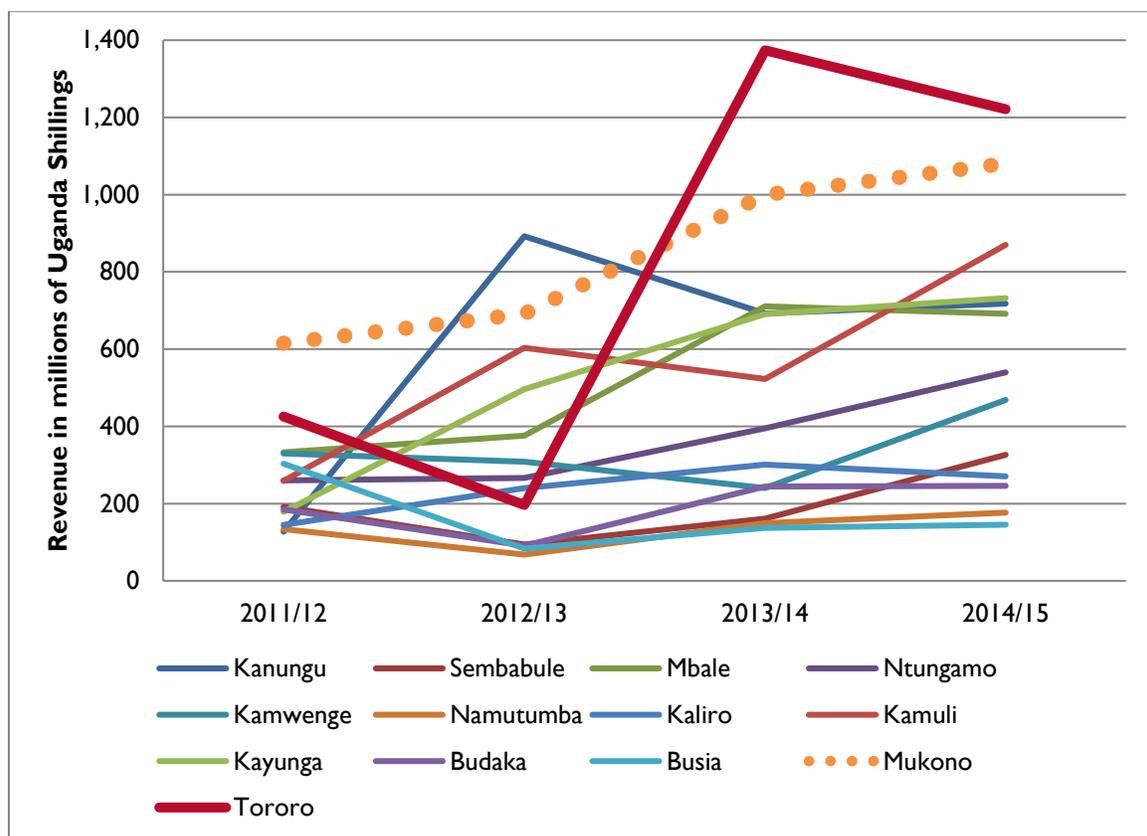
The evaluation findings, however, show minor improvement across all districts. SDS and non-SDS sampled districts show similar trends, implying that the SDS intervention did not make a significant difference (Figure 4). The major reason

“There is still a long way to go. Many things are left on paper but actual collections are not happening as they should. This is affected by staffing. There are few officers to follow the LLGs to ensure that collected revenue is remitted.”

District Official, Budaka

cited for failure to substantially increase local revenue collections across all districts was political interference from both local and from the central government. In some cases, it was a result of further fragmentation of districts as well as re-centralization of some tax sources, such as taxes from fishing landing sites. It was further pointed out that the Central Government enforces tax collection using a gun yet LGs are expected to do so without even using a baton!

Figure 4: Local Revenue Raised from 2011/12–2014/15



Source: Ministry of Finance, Planning and Economic Development

Monitoring and Evaluation and Management Information Systems

Monitoring and evaluation is one of the core functions of the DTPC and the district council. All districts are expected to have an M&E Framework for monitoring and evaluating the performance of their district development plans (DDP). However, according to the SDS baseline findings, districts were not systematically evaluating their development activities and even had no budgetary provision for it. Although all districts had some information systems in place (such as the HMIS and the EMIS), they lacked adequate skills to analyse the data and had little interest in utilizing concrete data for evidence-based decision making. The MIS in place were essentially

being used to meet the information needs of the Central Government. At the time of the SDS baseline, some of the districts like Budaka and Kaliro did not even have computerized MIS, which severely limited the capacity of the districts to utilize the data.

SDS, through the Infectious Diseases Institute (IDI), provided training to the districts in M&E as well as MIS so that they can monitor and evaluate their development activities and be able to utilize their resources more effectively and efficiently. The training aimed at enhancing the capacity of districts to use their data for planning, change actions, and for the development of district performance management plans (PMPs) for the health, CBS, and education sectors. SDS also provided computer equipment to support the MIS function.

SDS support in M&E and MIS was widely recognized across all the SDS districts in strengthening their capacity to manage and utilize data. Many district officials (particularly the district planners) reported that the skills they received have helped them particularly for the OBT (Output Budgeting Tool) for purposes of budget performance reporting where, every quarter, all departments have to report their achievements, failures, challenges, and way forward. They also reported that they routinely use the data for information dissemination as well as for reporting both internally (to various committees and the district council) and externally to the line ministries and the general public. Indeed, during the data collection for this assessment,

“Before the SDS training, we did not have any systems in place. We had a training in M&E and in the aspects of project monitoring, data collection, analysis, and linking it with the planning. These are skills we are using in the day-to-day analysis.”

District Official, Kaliro

we observed locally prepared wall charts in and outside LG offices, health facilities, and schools, showing data on access and utilization of various services. Some districts, such as Ntungamo, are also able to annually evaluate the performance of their programs and a synthesis report is prepared and presented to the district council for follow-up.

In the health sector, records management was reported to have improved greatly because of the training that SDS provided to the medical records officers (MROs) from various health facilities. The training (of MROs) is further complemented by ongoing support and supervision by the bio-statisticians who were recruited with support from SDS. The bio-statisticians are not only supporting the health sector in data management and processing but also other departments due to the fact that most districts do not have district statisticians.

SDS also supported the mapping of OVC households across all the SDS districts and the data was entered in an OVC MIS database which is used for planning and prioritizing OVC needs. This database is also used by other IPs in identifying OVC priority areas that need attention. With SDS funding, the OVC database used to be updated regularly but this has stopped after funding to the sector ended. This means the database will soon become obsolete, making planning for OVC very difficult.

CONTRIBUTION OF THE GRANTS AND GRANTS MANAGEMENT TO PROJECT SUCCESS

Overview of the Granting Process

Fiscal transfers from the central to the district Local Governments are predominantly in the form of Conditional Grants (89 % in 2010/11 Financial Year), mainly for paying salaries and

wages. Districts are very constrained in terms of financial resources, and so any additional operational funds are very welcome. SDS grants, the most tangible component of the program, were designed to complement resources needed for effective and efficient management of programs and services in the health/HIV, and CBS sectors. Overall, the grants comprised 22% of the total SDS budget. All the grants were managed through PBF principles, and cascaded as follows:

Grant A: Coordination and critical services that were also supported by District Based Technical Assistance (DBTA) programs like STAR – SW, STAR – EC, STAR – E and SUNRISE.

Grant B: Targeted at enhancing management and other systems strengthening capacities in health and other social services, including HRH, WASH, and EDU.

Grant C: Innovation grants reserved for “high performing” districts.

Overall Performance of the Granting Component

Table 4 shows the performance of the various grants, in terms of budgetary allocations versus disbursement to the districts (UGX), as derived from SDS financial reports. In all the sampled districts, there was unanimous agreement on the timely quarterly disbursement of Grant A funds. Performance of this grant

category (67.7%) can be explained by (i) performance-based sanctions that prohibited some districts to access all the funds allocated to them, and (ii) the two months’ difference between the Awards period (up to December 2015), and the disbursements period (through October 2015).

Table 4: Performance of District Grants.

GRANT	Budgetary Allocation	Amount Disbursed to Districts	Grant Performance
A	26,091,978,172	17,660,314,227	67.70%
B	4,669,434,635	3,673,677,955	78.70%
C	905,178,975	248,095,875	27.40%

District access to Grant B funds was fairly high (78.7 %), largely due to the HRH component, and the fact that funding for activities like the WASH program in Kanungu, Kisoro, and Kabale lasted only one year. As for Grant C funds (27.4%) received by Mbale, Sironko, Kiruhura, Ibanda, Kaliro, and Bugiri districts, the initial estimate of \$200,000 per district was finally reduced to \$50,000. Furthermore, the greater portion of the grants was used for infrastructure items that were procured centrally by SDS. At the time of the evaluation, all the grant C beneficiaries were still in the process of implementing the funded activities, and so it was not possible to assess the impact of those grants at this point. It is of interest to note that Kasese district, which had qualified to receive Grant C, was later disqualified because the USAID partner program, STRIDES, was coming to an end. This implementation modality affected grant C performance, and also defeated the PBF concept as, while Kasese district had proven beyond reasonable doubt that it was a good performer, it could not access the grant due to the absence of a USAID partner. This was also a missed opportunity, to see how a district could perform in the absence of direct oversight from a USAID Implementing Partner.

Performance Validation Criteria

SDS had a set of validation criteria and indicators that were applied regularly to assess the performance of the districts. The core PBF indicators were:

Box 2: Core PBF Indicators

- % of action points resulting from quarterly extended DHMT meetings resolved during the period
- % of action points resolved during the reporting period as reported in the functional DOVCC meeting
- % of key action points implemented during the reporting period that were identified during the integrated Health Support Supervision
- % of eligible children (OVC) provided services in one or more Core Program Areas
- % of action points resulting from extended District Technical Planning Committee (DTPC) Secretariat meetings resolved during the reporting period
- % of non-SDS revenue expended on social services sector as a proportion of the budgeted amount planned to be released.

These and other financial accountability indicators were used to strictly assess district performance every quarter, with results determining eligibility levels for subsequent disbursement (see Box 3). As a result, SDS funds were commonly referred to as “difficult money.” This implies that there was “easier money” where rigorous accountability requirements did not apply, therefore putting into question whether district ability for transparent and effective management of funds has been built. However, the evaluation team established that the minimum PBF conditions established by the SDS program were similar to those imposed by the Local Government Management and Service Delivery Program (LGMSDP), and were therefore in agreement with the expected LG procedures.

Box 3: SDS Performance Rewards and Sanctions

- Aggregate performance of 75% or more: 100% disbursement
- Performance between 50-74%: 80% disbursement
- Performance between 40-50%: 50% disbursement
- Score less than 40% for two consecutive quarters: SUSPENSION

District Local Government Experiences and Challenges

The district LGs appreciated the granting process but identified a number of challenges:

- Grant A funds, tagged to services that were also supported by DBTA partners, came in the form of a Conditional Grant, with no discretion to address district identified priorities.
- The application of the PBF criteria, with the resultant rewards and sanctions, led SDS money to be labelled “difficult money” due to the strict accountability procedures.
- Interpretation of the monitoring criteria varied between assessment teams, thus leading to cases of unfair sanctions, including monetary refunds.
- Inadequate preparation of the recipient departments for the rigorous monitoring process, especially the education department that was involved at a later stage.

- District co-funding, initially at 10% and later at 7%, was a challenge in the face of low local revenue collections.
- Closure of the SDS Regional Offices resulted in delays in resolving outstanding grant management issues as well as reduced relationship maintenance.
- Tagging of grants to the presence of an active USAID partner meant that when some programs like STRIDES and SUNRISE ended, so did the granting process. This raises the question as to whether the PBF mechanism was meant for the USAID partner or for the district?

Impact of Grants on the Health Sector

SDS financial data shows that from 2011/12 to 2014/15, Grant A health sector expenditure was 65.6 % of the total monies disbursed, thus making it the biggest beneficiary of the grants provided to the 35 SDS districts. The funds were largely used to support integrated outreach services for the hard-to-reach areas, provision of support supervision to the health facilities, and the recruitment of health workers for the public and private not-for-profit (PNFP) health facilities.

Human Resources for Health Support

SDS introduced an HRH program following a modification of March 2013. All 12 of the SDS-sampled evaluation districts and none of the non-SDS districts had benefitted from independent contracting of health care personnel by SDS or other entities to supplement identified gaps in the districts. Mukono district however had benefitted from seven health personnel recruited by Makerere University Walter Reed Project (MUWRP). As shown in Table 5, SDS supported the recruitment, contracting, and payroll management for a total of 828 health workers, 528 in the public and 300 in the PNFP health facilities in 69 districts. The support was extended to include provision of uniforms, for all the staff at every SDS supported facility.

Table 5: Total Number and Cadres of Health Workers Recruited and Supported by SDS as Part of COPI2

Staff Cadre	No. Recruited for the Public Sector	No. Recruited for the PNFP Facilities	TOTAL
Enrolled Midwife	220	85	305
Enrolled Nurse	132	111	243
Clinical Officer	26	49	75
Lab. Technician	48	13	61
Biostatistician	46	-	46
Lab. Technologists	24	4	28
Medical Officers	10	16	26
Nursing Officers	7	17	24
Sample Transporters	12	-	12
Dispenser	3	-	3
Pharmacy Tech./Assistant	-	3	3
Anesthetic Officer	-	1	1

Staff Cadre	No. Recruited for the Public Sector	No. Recruited for the PNFP Facilities	TOTAL
Anesthetic Assistant	-	1	1
TOTAL	528	300	828

Source: SDS HRH Report

While the HRH intervention contributed to increasing the numbers of critical service delivery, and health management staff, especially midwives (305), laboratory staff (89), and biostatisticians (46), many districts voiced their limited involvement in determining the selected cadres of health workers, and their placement within the districts. It is also important to note that at the time of the evaluation, only 54% of the SDS-supported staff had been absorbed onto the district payrolls. The PNFP facilities, with a low revenue base, had considerably greater difficulties in absorbing the staff, and the 6% absorption was through transfers to the public sector, and not the PNFP facility payrolls. SDS-supported health workers, whose contracts were expiring at the end of December 2015, were plagued by feelings of job insecurity and anxiety.

While absorption of all SDS-recruited personnel in the public system had been successful in some districts such as Mbale, Kaliro, and Ntugamo by December 2015, challenges remain in others such as Kiruhura and Budaka. In the majority of districts, respondents cited wage bill oversubscription as the reason for absorption failure. However, Mbale demonstrated that this was more of a myth than a reality: The district used the Workload Indicators of Staffing Need (WISN) methodology to determine the number and type of health workers required in each health facility, and made a submission to Ministry of Health, Ministry of Public Service, and Ministry of Finance (MoF). As a result, 100% of the SDS supported staff has been absorbed, with space for more.

Incentives – financial, material as well as professional – based on performance, and the use of timesheets, did seem to play an important role in health worker motivation and accountability unique to SDS recruits in the LG as well as PNFP facilities.

“Salaries are only paid upon timely submission of timesheets. Before people were being paid without evidence of them working. We have tried to roll out this system to other staff (not SDS-supported) that are paid through other sources. Some facility managers wanted to adopt this and institutionalize it. We have about 50% of the facilities that have taken on the system of timesheets.”

Senior leadership, Uganda Protestant Medical Bureau

Absorption of SDS-supported staff into the government payroll however, has resulted in the abandonment of this mechanism, which threatens to result in SDS-supported health workers adopting the existing ethic and culture of government health workers. Some PNFPs have attempted to retain the timesheets, as noted in the quote in the text box on this page.

Factors other than the programs present in these districts (and their incentive mechanisms) affect health worker attraction, recruitment, and retention. These include location, health care infrastructure, availability of staff accommodation, job security (open position versus contractual), and perceived working conditions, among others. For instance, district officials in Mukono indicate that the proximity to Kampala makes recruitment easier, unlike remote locations such as Busia. District officials in non-SDS districts such as Tororo cited poor health sector leadership as well as delayed payment of wages by government as reasons for high rates

of attrition. Interviews with PNFP respondents indicated that wages pegged slightly higher than government ceilings contributed to staff attraction and low rates of attrition. Fee for services in the PNFP facilities permits long-term sustainable retention, unlike in public facilities. It would be interesting to see whether the absorption of SDS-recruited staff into the public system faces the same challenges of non-wage payment and attrition down the line and therefore, whether the SDS contribution to strengthening the HRH base of health system is restricted to recruitment without long-term structures for retention.

SDS Support versus District HRH Needs

Table 18 in Annex VI reflects the 35 SDS districts' HRH staffing levels as of December 2015 compared to the levels of March 2013, the start of HRH program support. The data shows that of the 28 core SDS districts that received HRH support, 50% registered an improvement in the overall HRH staffing levels between 2013 and 2015. Of the seven core SDS districts that did not receive HRH support, only 43% registered an improvement in the HRH staffing levels. The practical difference is not very significant, leading us to note that HRH impact attributable to the SDS program was not always possible, partly due to other national HRH recruitment initiatives, mainly targeting reproductive health services.

It is important to note that the data in Annex VI refers only to the 54 % staff that have been absorbed onto the district payrolls. From the overall HRH staffing levels,⁸ one can infer that the improvement registered against the individual cadres supported is likely to be even higher. Taking the example of the biostatisticians, the 46 districts that were supported registered 100% improvement with respect to that cadre. The changes in staffing levels for the sampled districts are presented in Table 6.

⁸ Ministry of Health Annual Health performance report (2009/10 – 2014/15)

Table 6: Health Worker Staffing Levels across Sampled Districts (2011-2015)

District	Staffing level (%)					
	2010	2011	2012	2013	2014	2015
Kaliro		76	82.7	87	89	82.3
Kayunga		63	61.6	73	78	69.4
Kamuli		49	50.1	64	64	74.3
Namutumba		54	54.8	52	61	58.6
Busia		34	38.4	42	71	45.7
Mbale		64	44.3	82	76	76.2
Kanungu		48	55	57	60	63.6
Kamwenge		74	67.1	78	76	72.8
Ntugamo		63	72.1	64	71	71
Kirihura		31	30.5	28	74.8	42.5
Budaka		58	58	73	82	57.5
Tororo*		49	48.1	46	55	49
Mukono*		52	78.2	78	80	79.1

*= non SDS district

Source: Ministry of Health Annual Health performance report (2009/10 - 2014/15).

The increase in health workers in the districts was met with unanimous support due to recognition of a better distribution of workload amongst staff; in some cases, greater efficiency of services (especially in instances of laboratory staff available to run diagnostic tests); and better management of data (due to hiring of biostatisticians).

However, the impact on worker attitudes (and therefore, perceptions of improved quality), and staff absenteeism was not as clear. For instance, interviews with sub-county leadership in Kamuli district indicated that several interventions have led to complete erasure of poor health worker attitudes and absenteeism. However, upon visiting one of the HCIVs, the evaluation team found no health care personnel for several hours and a growing line of patients.

Health Services Management and Delivery

The grants in the health sector were largely targeted at strengthening the health management systems for more efficient and effective service delivery, with emphasis on:

- Provision of technical support and backstopping to the health sub-districts and lower level facilities
- Monitoring the implementation of district health service delivery
- Improved coordination between the various district health sector stakeholders

The combined effect was intended to result in a strengthened district health services management and delivery system.

The coordination efforts by SDS as well as financial support from the grants were key in mobilizing integrated outreach efforts for prevention of mother-to-child HIV transmission (PMTCT)/ antiretroviral therapy (ART), Tuberculosis, antenatal care (ANC), sanitation, and immunization. These were considered critical for reducing redundancy, enhancing efficiency of care, minimizing cost, and extending services to hard-to-reach populations. It is likely that these interventions played an important role in improving key health indicators in the districts but withdrawal of SDS funding and the departure of other DBTAs has rendered this approach unsustainable for most. Those who have managed to absorb some SDS activities into their PHC activities, such as Namutumba District, may be able to sustain the outreach efforts but at a reduced (monthly rather than quarterly) frequency.

“We are reaching 75% mothers who are delivering at health facilities compared to the national average of around 48%. Immunization was 87% in 2013. Now it is 120%, indicating we are also immunizing children in neighboring catchment areas. Village Health Teams (VHTs) never had registers but now they do. HIV infection rate was at 7.4% but now this has gone down to 4.1%.”
District official, Busia District

In addition to the contribution of health care personnel to improved access to care, the relationship between SDS and the government was considered critical in securing more health centers.

At the national level, district health sector performance is measured annually using the indicators in Table 7. For purposes of this evaluation, this was used as a proxy measure of strengthening the district health services management and delivery system.

“The Government had banned the opening of HCII but they were willing to accept SDS’ recommendation. SDS coordinators went to MOH to advocate on behalf of the district.”
District councilor, Kaliro

Table 7: League Table Indicators for Measuring Health Sector Performance

OPD Per Capita	Deliveries in Government and PNFP facilities
4 ANC Visits	HIV testing in exposed infants
DPT 3 Vaccine Coverage	Medicine Orders Submitted Timely
IPT 2	HMIS Reporting: Completeness and Timeliness
TB Treatment Success Rate	Latrine coverage in households
Approved Posts that are filled	

A review of trends in district League Table rankings, with a focus on the 12 sampled core SDS districts (Table 8) provided no evidence of the impact of SDS support to overall health services management and service delivery, with only 17 % of the sampled districts showing persistent improvement in District League Table rankings over the period 2010 to 2015. The League Table ranking data also shows no difference between SDS and non-SDS districts.

Table 8: District Health Sector League Table Performance Trends (2010-2015)

District	District League Table Ranking					Comments
	2010/11	2011/12	2012/13	2013/14	2014/15	
Mbale	16	6	38	11	12	Improved
Busia	93	40	45	22	59	Improved
Budaka	27	45	24	24	72	Deteriorated
Namutumba	34	76	46	56	56	Deteriorated
Kaliro	85	49	92	63	96	Stagnated
Kamuli	29	19	14	51	45	Deteriorated
Kayunga	41	38	56	38	47	Stagnated
Kanungu	38	79	50	39	31	Stagnated
Ntungamo	35	34	55	46	55	Deteriorated
Kamwenge	28	30	15	6	36	Stagnated

*= non SDS district

Source: Ministry of Health Annual Health Sector Performance Reports (2010/11 - 2014/15).

Given the multitude of actors in the district health sector, and the multiplicity of the district League Table indicators, attribution to any one actor is challenging. However, there is evidence of important contributions. One area supported by SDS was CB DOTS, targeted at improving tuberculosis (TB) treatment completion and success rates. Data from the District League Tables for the period 2010 to 2015, as shown in Table 9, indicates that 58.3% of the sampled SDS-supported districts registered an improvement in this indicator, and were above the national average, while another 16.7% maintained high performance rates through the period. This could be attributed to the SDS activities in support of DOTS. The two non-SDS districts in this evaluation, however, performed below the national average for the same indicator, over the same period.

Table 9: National League Table Scores for TB Treatment Success in Sampled Districts (SDS and Non-SDS)—Score Out of 5

	2010/11	2011/12	2012/13	2013/14	2014/15
Mbale	4.1	3.8	3.6	3.6	3.9
Busia	3.4	3.9	3.9	4.2	4.2
Budaka	4.7	4.7	4.8	4.8	4.7
Namutumba	3.7	4.2	4.4	4.5	4.8
Kaliro	4	4.2	3.8	4.5	4.2
Kamuli	3.3	4.2	4.1	4.2	4.2
Kayunga	3.7	3.3	3.1	3.9	3.2
Kanungu	3.5	4.1	4	4.5	4.4
Ntungamo	4.5	4.4	4.4	4.5	3.7
Kamwenge	4.3	0	4.7	4.8	4.6
Kiruhura	3.2	3.3	3.7	4.2	4.4
Sembabule	4.9	4.8	4.9	5	5
Tororo*	3	1.3	3.4	2	2.7
Mukono*	3.3	3.5	3.2	3.5	3.3
National Avg					4

*= non SDS district

Source: Ministry of Health Annual Health performance report (2009/10 - 2014/15).

Impact of the Grants on other Sectors

The Community Development and Probation Services, which had been chronically underfunded, appear to have benefitted the most from SDS grants, at the district and sub-county levels. Significant increases were registered in (i) the demand and supply of child protection services, and (ii) OVC services availability, management, and utilisation (Table 10)⁹. This is likely due to substantial SDS financial inputs into child protection and OVC services: 77% in 2011/12 and 87% in 2014/15 compared to the LG non-wage Conditional Grants for CBS as seen Table 11.

Table 10: Number of OVCs Served in the Evaluated Districts (SDS and Non-SDS)

DISTRICT	OVC SERVED				
	2011	2012	2013	2014	2015
Mbale	2533	1858	1191	3364	No data
Busia	3166	3131	3151	3219	3233
Budaka	21	2172	2670	4229	1939
Namutumba	18	120	879	1494	No data
Kaliro	2053	2135	569	1550	No data
Kamuli	461	1657	6325	7087	3344
Kayunga	3183	3151	2099	3421	2978
Kanungu	2113	2998	1218	3019	3818
Ntungamo	46	3143	2545	3905	6394
Kamwenge	8	1816	2776	3058	5955

⁹ MEEPP APR Reports – 2011 to 2015

DISTRICT	OVC SERVED				
	2011	2012	2013	2014	2015
Kiruhura	6228	3287	498	3416	3991
Sembabule	3847	2143	720	431	584
Tororo**	2524	2619	2225	2682	2594
Mukono**	2609	3213	5998	9293	8212

Source: MEEPP APR Reports—2011 to 2015

** Non SDS district

The OVC DBTA programs, namely SUNRISE and SCORE, also made a significant contribution to the achievements. However, district stakeholders could not differentiate between SDS and the OVC DBTA contributions. The similar OVC performance trends in the sampled non-SDS districts can perhaps be explained by the presence of CEM/Private Health Support Program and MUWRP OVC funded programs in Tororo and Mukono respectively. Overall there is a decline in OVC served in 2015, and this can be attributed to the closure of the OVC programs, and is indicative of a weak sustainability framework.

Part of Grant B funds were used to support WASH and Education activities in a few pilot districts. WASH activities in schools were supported in three districts: Kanungu, Kabaale, and Kisoro; and within selected schools in a subset of sub-counties. Although the grants galvanized pupil participation in personal hygiene and environmental sanitation, these behaviors were short-lived. The evaluation team observed that, in all the primary schools visited, hand washing, and refuse disposal facilities had been set up the day before the visit.

Education interventions were in select schools in Mbale, Budaka, Kumi, and Sironko. They focused on support supervision, school feeding programs, innovative learning initiatives, peer-to-peer learning, and identification of Centres of Excellence as examples for other schools. The evaluation team found that the Support Supervision tool had already been integrated into the school inspectorate package. However, in the absence of SDS support, other innovations like peer-to-peer learning will be difficult to sustain.

Unintended Results of the Grants

There were a few indirect benefits of the grants outlined below

- Partners like Baylor, used OVC databases that were compiled in each of the beneficiary districts to select beneficiaries for their pediatric HIV interventions.
- Despite the poor program penetration of the sub-county local governance structures, the training of the CDO and funding of the Community Development activities at the Sub-county level strengthened decentralized management capacity, and had a multiplier effect on the delivery of decentralized services like roads, and rural water supplies.
- Penalties on individuals rather than the LG as a result of changing SDS policies on non-reimbursable items under the grants undermined the tenets of program governance resulting in scapegoating and/or finger pointing rather than constructive accountability

- Confusion at the sub-county and community level with respect to source of interventions and grants due to SDS, SUNRISE and other programs operating simultaneously led to undue credit or undue discredit to the program
- Grants for innovation and HF infrastructure that was aimed at improving access to service delivery (e.g. solar panels) also resulted in increased safety and security of health workers, increased motivation, better job satisfaction, among others

Table II : SDS Grants (UGX) to OVC Services Compared to Local Government Non-wage Conditional Grants (CGs) for CBS in the Sampled Districts

District	2011/12		2012/13		2013/14		2014/15	
	SDS funds for OVC	LG CG for CBS	SDS funds for OVC	LG CG for CBS	SDS funds for OVC	LG CG for CBS	SDS funds for OVC	LG CG for CBS
Kanungu	23,754,503	21,752,000	44,130,810	15,592,000	54,365,165	15,615,000	47,295,505	15,615,000
Kiruhura	48,087,550	-	28,769,510	-	56,038,971	-	67,004,916	-
Ntungamo	57,739,000	4,898,000	34,126,212	5,246,000	33,928,196	5,232,000	47,587,115	5,232,000
Kamwenge	62,429,474	3,939,000	51,364,977	5,246,000	36,845,573	9,222,000	14,621,802	3,929,000
Kaliro	28,889,902	19,946,000	32,896,233	9,222,000	34,791,232	9,232,000	91,125,653	9,232,000
Kamuli	43,440,169	3,352,000	29,753,556	5,212,000	37,815,608	5,200,000	29,344,183	5,200,000
Kayunga	37,083,105	39,122,000	37,627,240	13,860,000	48,833,525	13,876,000	63,345,534	13,876,000
Namutumba	31,995,476	1,805,000	50,052,389	2,453,000	37,862,358	2,447,000	41,294,021	2,448,000
Budaka	44,878,888	3,644,000	44,363,068	3,644,000	18,360,943	11,468,000	45,622,598	11,468,000
Mbale	62,948,990	5,674,000	32,145,642	4,386,000	25,780,847	4,375,000	89,206,043	4,376,000
Busia	46,969,392	51,090,000	44,337,194	51,090,000	7,591,500	20,708,000	33,433,350	20,708,000
Sembabule	27,772,864	2,064,000	38,977,247	2,064,000	14,198,608	2,596,000	42,790,982	2,596,000
TOTAL	515,989,313	157,286,000	468,544,078	118,015,000	406,412,526	99,971,000	612,671,701	94,680,000
GRAND TOTAL	673,275,313		586,559,078		506,383,526		707,351,701	
SDS CONTRIBUTION	77%		80%		80%		87%	

Source: SDS Financial Reports

EFFECTS OF TRANSITIONING FROM DBTA HEALTH CARE MANAGEMENT ACTIVITIES TO DISTRICTS GRANTS THROUGH SDS

The Transition Process and Justification

The SDS program commenced 1.5 years after the USAID STAR program in Eastern as well as East Central districts. (i.e. STAR-E and STAR-EC), as a supplemental mechanism. STAR-SW, however, began concurrently with SDS. Prior to the introduction of SDS, STAR-E and STAR-EC provided support to the districts in the form of direct TA and indirect grants. Indirect grants refer to funding of planned activities directly without transferring funds to the district accounts. This permitted DBTAs to meet the planned targets and outputs as defined in their agreement with USAID, with some challenges, as indicated in the quote in the text box on this page.

“Districts could get challenges like Chief Administrative Officers being transferred and recovering accountability from districts was cumbersome for IPs. There were other things districts wanted to do which the districts thought they could handle when given resources. Districts felt they did not have control of the funds to IPs. SDS came to solve such things.”
STAR E official, Mbale District

As a result, SDS took on the role of coordination between all USAID implementing partners and managed the transfer of funds through district financial accounts. The transition, however, was rather challenging with an initial lack of clarity on the different roles of the DBTAs and SDS. In addition to managing the grants, SDS supported the following:

- Coordination activities – Extended District Health Management Team meetings (EDHMT)
- Empowering the sub-county health workers to support TB patients (CBDOTS)
- Integrated support supervision from district to health sub district to health facilities
- Health Management Information System (HMIS) review meetings on a quarterly basis
- HIV Counselling and Testing (HCT) outreach to the communities
- Lab sample transportation from health facilities to hubs

The DBTAs concentrated on providing TA. They also maintained their role of monitoring and supervision activities in districts until SDS was able to provide staff to fill this role.

Unfortunately, the realigning of work plans and budgets to accommodate the entry of SDS slowed down implementation of health-related activities implemented by the STARs at the districts. However, this was streamlined after the introduction

“Not everything was taken over by SDS yet we had a lot of activities. SDS couldn’t fund all those activities. STARs could not run the granting mechanism anymore and passed it to SDS to handle grants. USAID said that STARs should concentrate on TA activities and leave others to SDS yet SDS could not take in all activities.”
SDS official

of the District Operational Plan where the STARs and other IPs were again coordinated. Through the DOP, the STARs reabsorbed some of the activities relegated to SDS. However, lack of resources for the DBTA resulted in a deceleration of services once again.

For districts, direct receipt and management of grants was an exciting mechanism due to its potential for providing autonomy, ownership, and responsibility to the LGs. However, the grant eligibility process, SDS evaluation mechanisms, and LG delays in accountability often incited conflict. This appeared to have stabilized over time as expectations became clearer.

Effect of Having Two Technical Assistance Arms

The SDS program has a robust grants management system with a strict validation mechanism. This significantly enhanced reporting and delivery of outputs by the districts. Additionally, SDS' coordination efforts permitted districts to have better control and coordination of IPs. Districts were empowered to generate their own work plans with direct support of resources from SDS. In the health sector, the activities such as integrated support supervision have benefited from the tripartite relationship where the District Health Officer (DHO) has financial support from SDS and full technical support from the DBTA.

“Without SDS, SUNRISE would not have achieved better results because of limited grants to the districts. If you compared to other districts like Zombo, they had no coordination meetings. The performance was better in SDS districts in the area of OVC cases. Performance grants are very good. SDS came up with other grants which we couldn't envision in our lifetime.”

Former SUNRISE M&E manager

Overall, the dual TA arrangement resulted in:

- Better financial accountability due to the PBF protocols
- Better coordination (distribution of effort and reduced duplication of activities)
- More capacity building for the technical and political leadership at the district and sub-county levels

A sub-analysis of the TA arrangement indicated that in the CBS sector, there was significant complementarity and results enhancement in OVC and child protection services. This could be attributed to the non-complexity of the CBS management and delivery chain. On the ground, the district and sub-county CBS staff viewed SDS and SUNRISE or SDS and SCORE as one entity. However, the results enhancement was not as expected in the health sector due to the complex nature of the district health system, and the differences in TA program designs and approaches. Whereas SDS exercised PBF, with rewards and sanctions, the DBTA programs were designed, under PEPFAR (United States President's Emergency Plan for AIDS Relief), to achieve defined volumes of service delivery outputs in a defined timeframe. The sanctions of PBF tended to negatively affect the DBTA outputs, thus triggering substitute financing by the DBTA partners, and thus defeating the basic tenets of PBF. Therefore, the synergy that was supposed to be realized from the two technical arms did not fully materialize.

There were occasional disagreements between SDS and the DBTAs, which affected the district planned activities such as HRH capacity building in Mbale: *“We had planned to train in leadership and management (for the district managers) training for Health Management Committees, trainings for health facility in-charge set but SDS and IntraHealth (DBTA) could not agree on the modalities,”* said one district official. This situation can only be avoided by having the DHO take charge of the coordination function for all the health sector stakeholders, a function that was largely taken over by SDS.

THE FLEXIBLE/ADAPTIVE USE OF SDS BY USAID/UGANDA AND ITS EFFECT ON SDS RESULTS

Overview of the modifications

Originally, the SDS program was structured with a heavy concentration on health and CBS delivery. The design was robust enough to accommodate all the 14 modifications that occurred throughout the program period, nine of them for increased obligation. There were four major program modifications that introduced governance and management components, among others (Table 12).

Table 12: Major Functional SDS Program Modifications

Modification	Date	Purpose	Comments
# 1—LOGIC	Sept. 2011	Induction of Local Councilors (Whole Country)	Reportedly improved management of District Councils BUT with little service delivery benefits
# 2—DOP	March 2012	Improve coordination of USAID partners	Improved capture of partner contributions to district plans BUT not Integration of the planning process
# 4—HRH/WASH/ED.	March 2013	Boost HRH and Social Services	HRH levels improved. WASH and Education activities were in a few districts and had little impact—too thin
# 11—Northern Uganda	March 2015	Gap Filling for NU-HITES	SDS now shifted to service delivery DBTA support

Although USAID was appreciative of the Prime Partner’s flexibility and receptivity to program changes, it is important to note that these program modifications were made more often as a result of USAID policy and functional changes and central-level government needs.

Effect of the modifications

It is not common for a program to undergo 14 modifications, including four major ones, under a Cooperative Agreement arrangement. The modifications were useful to the whole program; however, they overstretched the staff of SDS and the other partners handling the activities.

“There were no additional resources for the STARS. We had to innovate and work within the resources and this put some strain on us. More time had to be devoted for other activities like support supervision and TAs. The re-absorption slowed service delivery because STARS did not absorb the activities immediately.”

SDS official

LOGIC: Local Government Induction of Councilors (LOGIC) was implemented on a country-wide basis, to increase capacity of councilors’ ability to respond to citizens’ demands and to ultimately improve service delivery. LOGIC increased the profile of SDS at the district level and created a better working relationship between politicians and technocrats. As a result of SDS support, 45 ordinances were passed, largely in support of the community based sector and local revenue generation. The evaluation team however failed to elicit the spillover effects of this modification into improved health and CBS delivery.

DOP: Prior to DOP there was insufficient knowledge at district level of the number of partners that support health and other social services, activities, and their annual contributions to the

sectors in the form of budgets, outputs, and outcomes. Although the DOP was the subject of a separate evaluation, our rapid assessment showed that through this modification, the SDS program enhanced the sharing of strategic and operational plans and budgets, including those of the implementing partners. SDS brokered the discussions between districts and USAID-supported, and other USG implementing partners such as Baylor College of Medicine, World Vision, Management Sciences for Health (MSH), and Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), resulting into improved coordination of health and community based services at the district level.

HRH: To Increase Capacity of LGs to Deliver Health Services

The SDS program conducted an assessment of the gaps and worked with district authorities to recruit essential personnel for the district. The categories of staff that were prioritized include nurses, midwives, laboratory technicians/technologists, and biostatisticians. The biostatistics personnel were essential for district-level strategic information management and reporting, which included including monitoring data collection activities and maintenance of the LQAS and HMIS. Laboratory technicians, nurses, and midwives were posted in areas that had an acute lack of personnel within the district, especially the laboratory hubs and the PNFs, contributing to increased service delivery. SDS paid the staff salaries and other benefits in accordance to the government pay scales.

WASH and Education

WASH and Education activities were supported in districts that had other development partners. The activities were beneficial to the communities, including contributing to the improvement in WASH and Education indicators but the SDS support was short-lived. The beneficiary districts expected this support to run the full length of program implementation, but it lasted only one year. SDS supported districts through grants to celebrate Global Handwashing and Menstrual Hygiene Management days, and training water committees and school/health units in the operation and maintenance of WASH facilities. In collaboration with Kanungu, Kisoro, and Kabale districts, SDS completed the construction or rehabilitation of 27 roof rainwater harvest systems, 10 hand-washing facilities, and 22 VIP latrines in 33 selected schools and 24 health centers.¹⁰

Table 13: SDS Contribution to Construction and/or Rehabilitation of WASH and Education Facilities

District	Schools	Health Centers	VIP latrines	Rain Water Harvesting	Handwashing facilities
Kabale	17	1	10	10	
Kisoro	9	15	5	9	10
Kanungu	7	8	7	8	

Source: Wash End of project report 2015

The exact contribution of WASH program to the indicators cannot be quantified, as seen in the WASH indicators in the SDS and non-SDS districts, but respondents expressed the benefits of improved hygiene in the communities, reduced absenteeism in schools due to menstrual periods, and community-led ownership of the facilities.

¹⁰ WASH End of Project Report 2015

Support to Basic Education complemented other USAID programs that provided education technical support. The two-year intervention (March 2014-December 2015) was implemented under the Early Grade Reading Improvement Promotion (eGRIP) initiative and designed to support early grade learning in four SDS partner districts: Budaka, Kumi, Mbale, and Sironko. The main objective was to strengthen district activities in support of improved early grade reading processes for pupils in grades Primary 1 to Primary 4, through coordination, capacity building, systems strengthening, and community engagement.

Capacity building and technical assistance activities borrowed quite a lot from the Collaborating, Learning and Adapting (CLA) framework. It included basic elements like: identification of the appropriate technical assistance; promotion of local solutions; collaboration amongst the district internal and other stakeholders, mainly IPs; creating teams of head teachers, teachers, and some School Management Committee (SMC) members as change agents through training of trainers (ToT); designing suitable cascading down strategies; creating learning centers at schools with excellent change agents who have practically implemented various skills and practices gained at the training workshops; facilitation of the peer-to-peer learning through exposure and benchmarking visits; and supporting new innovations by the change agents, among others.

Major trainings and TA was in the areas decentralizing education management information system and utilization of data for decision making at the respective levels; education financial management, accountability and reporting; school level governance and leadership as well as school development planning and resource mobilization; new teaching methodologies and local instructional materials for the early grade learning. This was augmented by the youth innovative approaches to early grade reading.

Program Adaptation to the Changes

Use of Consultants

The SDS program made use of a pool of consultants to accommodate the additional workload due to the modifications. These local consultants provided the technical expertise to districts and supported activities such as development of plans and training on several technical areas.

CLA – Collaborating Learning and Adapting

The modifications fell within the broad framework of SDS objectives. However, as indicated in section 5.4.1, all the modifications were a result of USAID policy and functional changes rather than being a product of program Learning and Adapting.

“SDS required a ‘rapid response mechanism’ or ‘quick thinking and adaptation’ because it evolved rapidly. Cardno put in place an incubator of consultants to support USAID’s agenda for localization. For example, LOGIC activity for training 23,000 personnel was a quick adaptation as a project created in SDS, which was six months old.”

Cardno Director

RELEVANCE OF THE SDS MODEL GIVEN THE CURRENT OPERATING ENVIRONMENT AND USAID UGANDA PRIORITIES

Overview of the SDS Model

Key aspects of the SDS Model are summarized in the box below:

Box 4: Overview of SDS model

- Direct support to the District Local Government staff
- Financial support through performance based grants (PBF)
- Technical support and capacity strengthening through technical assistance from SDS, local partner organizations, and consultants on LG Leadership and Governance; Coordination; Human Resources; Planning and Budgeting; Monitoring and Evaluation; Management Information Systems; Financial Management, Accounting and Audit; and Procurement Planning and Management
- Flexible/adaptive to accommodate changes necessary for sustaining social sector service delivery
- Focused on improving results and sustainability of decentralized service delivery in health and other social sectors in health and other social service delivery

The initial emphasis of the program was on health and HIV/AIDS services with some involvement in governance through strengthening of the District Health Management Team (DHMTs). Over time, SDS focused on LG governance as it sought to strengthen decentralized systems and processes. The program complemented GoU efforts with the overall belief that direct technical and financial capacity strengthening to LGs would enhance ownership, independence, and autonomy of the LGs, hence improving service delivery in key social sectors such as health and HIV/AIDS.

Effectiveness of the SDS Model

SDS' multi-pronged approach to program delivery rendered varied levels of effectiveness across the different aspects of the model. These aspects are described below taking into consideration the facilitating and impending factors relevant to the district LGs.

Factors Facilitating the Effectiveness of the SDS Program

a) Additional Resources to the Districts: Grants were used to fill different resource gaps in the system, strengthen governance capacity, and build on improved district performance through innovative projects. Grant B focused to a great extent on district-identified priorities and contributed significantly in addressing the chronic HRH shortages plaguing the districts, consequently strengthening health service delivery in several districts. Increase in the HRH resource base has enabled absorption and retention of key cadres into the public and private health systems. Grants disbursement from SDS was timely except in instances where there were queries. Grant C was critical in providing districts with sustainable infrastructure and technologies like solar panels, generators, and motorcycles that will surpass the life of the project and continue to contribute to enhance service delivery in the health as well as CBS

sectors. Frequent supervision and support from SDS to the districts in managing the grants further enhanced the success.

b) Strict PBF mechanism: The process of awarding rewards and penalties was strictly enforced and validation exercises played a very important role in ensuring accurate reporting and compliance – with respect to financial accountability at the district level as well as professional accountability at the health facility level with respect to SDS-recruited staff. The PBF aspect of the grants was not an entirely new concept to the districts. For example, health facilities in districts such as Kamuli received direct performance-based grants from the Catholic Organisation for Relief and Development Aid (CORDAID). The LGMSDP from MoLG is also subject to PBF in all LGs. While districts were likely more amenable to the conditions of PBF grants, SDS applied these conditions with more rigor, which has contributed to a culture of strict accountability in districts where the Chief Administrative Officer (CAOs) were supportive. For instance, one DBTA respondent informed the evaluation team that the CAO of Budaka forced staff to refund unaccounted-for money and they complied and moved on while the same could not be done in Butaleja. In districts positively absorbing the PBF approach, as was the case in Mbale, Kiruhura, and Kamuli, the practice of strict compliance has laid a good foundation for enhancing a culture of timely accountability and reporting, that is critical for enhanced service delivery beyond the lifespan of the SDS program.

c) Capacity Strengthening: SDS used different approaches to deliver direct TA to the districts. The “Surge” approach involved use of overlapping teams of consultants that could be deployed in different regions. This ensured that consultants with varied expertise were available to support the identified district needs. The trainings were clustered either at the regional level or in one central place depending on the time of the training, size of the group undergoing the training, and resource considerations. This clustering approach guaranteed continued interaction while mentorship provided hands-on support and direct interaction with the district officials.

“What we liked was that they trained the people in the districts and funded them to carry out the activities rather than do direct implementation. This is good for capacity building.”

District Official, Kaliro.

TA in health worker supervision and use of HMIS contributed to enhancing the governance as well as information aspects of the health system. Another key strength of the SDS model was its ability to go beyond the health sector to impart relevant management skills and attitudes in other complementary departments. The TA in key areas such as grants management and local revenue (LR) generation generated some considerable interest within the districts. Skills acquired in child protection were highly appreciated and used by CDOs across all districts. LOGIC clarified the distinct roles and responsibilities of Councilors and the technical team. The dissemination of the TA resources, including uploading them on the SDS web-based Knowledge Resource Centre, is an invaluable contribution of the program towards strengthening decentralization. The Resource Centre needs to be linked to the Policy Unit of MoLG and other institutions of higher learning for future reference.

Factors Impeding the Effectiveness of the SDS Program

a) Insufficient support to weak districts: By labeling districts as “good” or “poor” performers SDS missed the opportunity to recognize sub-areas of possible high performance in the so-called poor performing districts. Emphasis on final scores on indicators (set jointly by SDS and DBTAs with concurrence from districts) ignores improvements in indicators within districts. This results in penalizing rather than strengthening poor areas of performance, which consequently demoralizes staff working hard within difficult contexts.

“The rewards mechanism motivates the best performers but is not always motivating for poor performers. We are judged on all health facilities (HFs) so we need to bring all up and with PBF the focus is on some, not all. There must be other mechanisms besides PBF to help the lower ones. In the end, the community will suffer if we don't step in on the poor performances. It will also create an immeasurable demand on the good HFs as they will have solar, etc...”

District officer, Kaliro

The system of rewards and penalties was applied across the program (and across the districts) regardless of baseline capacity or enhanced TA. This resulted in mixed outcomes: “Weak” districts became worse and, labeled “poor performing,” eventually suspended from the program, while strong districts complied and worked hard. It is worth noting that while penalties are effective as a corrective measure they may not be the most appropriate approach for system strengthening. In Busia district, for instance, the poor performance of the OVC grant was a result of a poor supervisory system in a setting of a political impasse that could not help resolve the staff issues. It was noted that over time there were varied levels of targeted support that led to the lifting of the suspension of disbursements for some districts, including Mbale, Budaka, and Busia among the districts sampled. The time for resolution of issues largely depended on the responsiveness of the district leadership, with some suspensions lasting less than a month, as was the case for Mbale. There were also cases of waiving suspension in the event that the impending factors were beyond the control of the district.

b) Closure of SDS Regional Offices: District officials expressed concern about the level of interaction with the program following the closure of the regional offices in 2013. The most cited example was the desk reviews where SDS regional staff used to support the district teams. After the closure of regional offices, SDS interaction was limited to validation exercises. While this may seem like a more efficient way of utilizing staff, it hindered relationship-building and trust, introduced misunderstandings of the district context, and compromised effective communication. This led to reduced monitoring of the Grant A activity implementation. The subsequent introduction of SDS Desks at Mbale and Ntungamo was a useful attempt to address this gap but could not substitute for the perceived presence of SDS in the regions, as had been the case when the regional offices were operational.

c) Coordination of consortium members and other partners: SDS was implemented by a consortium of members with Cardno as the lead agency. Consortium members were assigned tasks in areas where they had a niche. However, the coordination of consortium members and other partners in implementation of their prescribed roles and responsibilities was not well managed. For example, IDI, originally contracted based on their M&E expertise, were later released in preference to QED. Similarly, there seems to have been no clear clarification of the roles between SDS and IntraHealth. This impeded the roll-out and use of Performance Management by the health workers.

d) Delayed procurement: Whereas procurement planning and management was one of the components of the SDS TA, districts were restricted in their procurement options under SDS. There were delays in the procurement of motorcycles and other centrally procured items under the Grant C. This affected the districts' abilities to meet their performance goals.

e) Demoralization of district staff due to changing funding conditions: SDS had indicated to districts that funding would be based on their priorities. Grant B and Grant C were predominantly based on district DMIPs and priority-setting activities. However, after efforts into what was considered a participatory “bottom-up” process, it eventually resulted in a typical “top-down” decision by SDS on what could and could not be funded. Furthermore, the changes in budget envelopes for these activities was drastically reduced – particularly for Grant C – as well as unannounced “disallowable costs” in the last year, left the majority of staff bitter, demoralized, and disenchanted, once again, with donors. The sudden decisions on disallowable costs hindered effective roll-out of programs underway. For instance, failure to reimburse airtime meant that communities could not be mobilized for education campaigns and outreach while reduction of transport costs meant scaling back on outreach activities and support to OVCs.

“Problem: “[SDS] would tell us ‘you have qualified, you have budgeted for this’... but then there would always be changes in the budget. It would be slashed downwards.”

District official, Kaliro

“Guidelines were changed after the release was utilized by the district. Yet the district has to refund the money since SDS has insisted that this is a USAID policy.”

District official, Namutumba

f) Limited use of Collaborating, Learning, and Adapting approach: Continuous learning is key in complex programs such as SDS. Although the CLA concept was often mentioned in the program documents and an impact study undertaken in 2014, there is limited evidence that this formed an integral part of the SDS program approach. Regional workshops were organized in which both progress and prospective changes were discussed. This was indeed helpful but they were more of dissemination than reflection. This resulted in missed opportunities to deal with district-specific contexts and peculiarities. A mid-term evaluation would have enabled learning opportunities for the latter part.

If CLA had been embedded, system bottlenecks such as failure to fill vacancies existing in the establishments of the districts would have been identified, isolated, and possibly followed up with the relevant ministries. The same was true in regard to the LR sources that were stopped by MoLG. Other areas that could have benefitted from the CLA approach are revitalizing the Parish Development Committees (PDCs), as their functionality was one of the parameters in the PMP. The inputs of CSOs, such as FOWODE in Busia District, that were already conducting dialogues were not well integrated in the SDS approach for strengthening civic engagement – yet this is in line with the USAID Local Systems Framework that places greater emphasis on direct partnerships with local change agents with invaluable local knowledge.

g) Disrupted (and at times disruptive) leadership: Districts as well as SDS staff expressed concerns over the frequent transfer of CAOs. Eight of the 12 (75%) sampled SDS districts (Budaka, Busia, Kaliro, Kamuli, Kamwenge, Kayunga, Mbale, and Ntungamo) had CAOs who spent less than one year in office. The average tenure in all the 12 districts was 11 months. This does not augur well with relationship- and system-strengthening. As one of the CAOs remarked: “There is a general guideline about transferring CAOs every three years but this is not

usually followed mainly due to politics and performance.” Change in leadership that has not received governance training sets back progress made and introduces new modes of operation and values. It was clear that when the new CAO was from an SDS district, as was the case in Budaka and Busia, there was less interruption of the program.

The SDS Model was therefore effective insofar as it contributed additional resources and capacities and to the extent that it contributed to inculcating a strict culture of performance management and accountability. However, there were factors – both programmatic and LG-based – that limited the program from being fully effective in strengthening district systems.

Relevance of the SDS Model in the Current Ugandan Environment

The previous section highlighted strengths as well as weaknesses of the SDS program. This section presents a short description of the USAID/ PEPFAR priorities before focusing on the challenges facing decentralization as well as the opportunities in the environment that would favor programs such as SDS.

USAID Uganda Internal Environment

Democracy and good governance is a top USG objective in Uganda. The USAID Mission in Uganda aims to improve economic growth, governance, and health outcomes by working through local solutions in agriculture, biodiversity, health, education, accountability, conflict mitigation, and political processes.¹¹

USAID continues to use the Regional Programs to implement activities across districts. The results of such programs have to be reported through the government systems at the district level. It is therefore important that systems and structures at the district and lower local government levels continue to be strengthened if such programs are to achieve their intended results.

PEPFAR Priorities

The PEPFAR goal of creating an AIDS-free generation is anchored on five interlinked principles:¹² i) scaling up core HIV prevention, treatment, and care interventions; ii) working with different stakeholders to effectively mobilize, coordinate, and efficiently utilize resources to expand high impact strategies; iii) focus on women and girls to increase gender equality in HIV services; iv) end stigma and discrimination against People Living with HIV/AIDS (PLWHA) and key populations to improve their access to and uptake of comprehensive HIV services; and v) set benchmarks for outcomes and programmatic efficiencies through regularly assessed planning and reporting processes to ensure goals are being met.

Shifting PEPFAR priorities during the course of the SDS program as well as these articulated goals require SDS-like programs to focus more on HIV/AIDS while trying to work across the entire health system. Integrating vertical programming into a horizontal approach can be challenging and at times can undermine efforts at strengthening governance, equity, access to care, HRH, and service delivery more holistically. However, the emphasis on coordination shines a beacon on SDS as a model with coordination aspects that could serve for replication, adaptation, and learning.

¹¹ USAID (March 2011) Uganda Country Development strategy 2011–2015.

¹² PEPFAR (February 2015) PEPFAR Country Regional Operational Plan (COP/ROP) 2015 Guidance.

In reflecting on the macro environment in which SDS operates, we draw upon a Political Economy Assessment (PEA)¹³ conducted in 2015. We refer the reader to the aspects of the analysis that are relevant to the SDS model both in terms of risks as well as opportunities.

Limited Response to Local needs

The PEA identified lack of human, financial, and infrastructural resources as well as insufficient capacity at the district level has inhibited local needs-based planning due to: the stringent earmarking of budget allocations from the central level (and therefore continued centralization of power); and limited capacity to plan and effectively manage these limited resources for improved service delivery. The non-existence of PDCs in the visited districts limited formal mechanisms of engaging the communities in the planning process. Unfortunately, although SDS encouraged districts to prioritize their needs, several “unfunded priorities” left district plans wanting and leaving the needs of the local communities unmet. The confidence of those participating in generating their needs erodes over time as a result, hence undermining their motivation in participatory planning – a key tenet of enhanced governance within a decentralization framework.

In an environment where this is fairly ubiquitous, SDS interventions in revitalizing the functionality of PDCs as interlocutors of participatory planning, local revenue mobilization, and lobbying for increased funding for LGs would be imperative. However, such interventions need increased engagement with the MoLG and MoF to ensure that the conditions that have inhibited the functionality of PDCs are adequately addressed. The TA aspect of the SDS model would need to provide refresher training at relevant intervals and ongoing mentoring to these committees.

High levels of corruption: Transparency International’s Corruption Perception Index ranked Uganda 142nd out of 175 countries in 2014 with a score of 26/100.¹⁴ In a survey conducted by Uganda Bureau of Statistics in 2014, 82% of Ugandans showed concern over increasing corruption¹⁵ while 73% of Ugandans felt corruption had either increased or remained the same.¹⁶ The East African Bribery Index rated Uganda as the country with the highest likelihood of bribery in East Africa for the years 2012 and 2013. With corruption being inherent within the psyche of the majority citizens, there is a role for governance programs to engage with citizens and their organizations, LGs, and LLGs to determine innovative ways to tackle bribery and reduce system leakage in areas such as LR collection and distribution, procurement planning, and drug shortages, amongst others.

Although corruption remains a major concern, the recently passed Anti-Corruption Act (2013) introduces stiffer penalties like confiscating the assets of those involved in corruption. There are also efforts to enforce the Leadership Code in a stricter manner. The re-institution of charges against pension suspects after court had closed their case¹⁷ provides some evidence that the OAG and Inspector General of Government (IGG) reports are being acted upon. Such efforts

¹³ Dexis Consulting Group - Learning and Knowledge Management (LEARN). (Oct 2015) *Ugandan Decentralisation policy and issues arising in the health and education sectors*. USAID.

¹⁴ Corruption Perception Index by Transparency International accessed from the Transparency International website

¹⁵ Trends Analysis Report (2010 – 2014) East African Bribery Index by Transparency International Kenya Chapter

¹⁶ Trends Analysis Report (2010 – 2014) East African Bribery Index by Transparency International Kenya Chapter

¹⁷ NBS TV News of 19th August, 2015.

give assurance that USAID investments would generate good value as resources are likely to be put to proper use.

It is worth noting that following the corruption scandals in the Office of the Prime Minister many development partners suspended direct support to the GoU. As such many partners are not able to introduce PBF in the districts they operate in because they are not directly granting to these districts.

Obstructive patronage, Monetization of politics and the “Nfunira wa” culture:

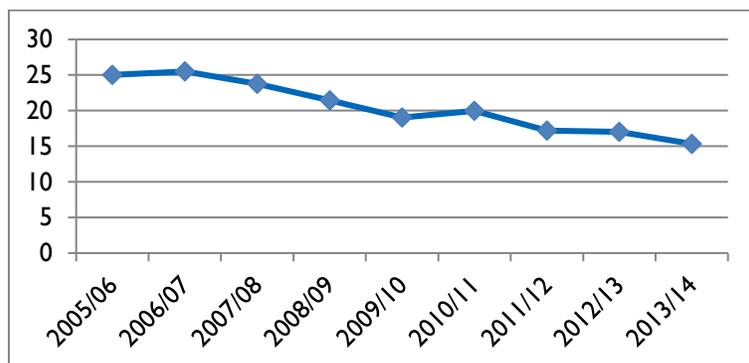
Uganda has been governed by the same political party since 1986. Government services have therefore been associated with particular individuals encouraging a system of patronage. One example of obstructed decentralization is the decision in April 2015 to raise the LG Councillors’ allowance from UGX100,000 – 250,000/month following a meeting between LG Councilors and the President. On the local scene, cases of politicization of key services include Members of Parliament’s personal ownership of ambulances, as is the case in Busia and Budaka districts.

Politics in Uganda is viewed as largely transactional. A culture of “what is in it for me?” – locally dubbed “Nfunira wa” – is prevalent across the political cadres. However, exceptions can always be found. Given that elected Local Councillors at both the district and sub-county level are responsible for the oversight of service in all development work in their areas, such a culture could bring in councils who are interested in “a return on their investment.” Such councils would most likely not make improving service delivery their top priority. While enhanced systems of accountability as well as defined roles and responsibilities through SDS interventions such as LOGIC have demonstrated improvement in this area, such a culture risks undermining SDS efforts in the long term. The SDS model therefore needs to take into consideration more long-term strategies for institutionalizing civic engagement. The engagement should go beyond participation of citizens in planning and budgeting meetings to a level where the competence of citizens to demand for accountable service delivery from the duty bearers is enhanced. SDS relied mainly on engaging with the Health Unit Management Committees (HUMCs) and VHTs instead of re-vitalizing the functionality of PDCs and establishing close linkages with other actors like local NGOs that were already active in civic engagement. Nevertheless, all is not lost as a fairly strong non-state sector is emerging. The private sector, in particular, is playing a very important role and could be one channel of offering alternative means of providing essential social services. Private schools, universities, hospitals, radio stations, telephone companies, as well as security agencies already exist. These may help mitigate the effects of a strong patronage system. Initiatives like the Etoofari (brick) project spearheaded by the Buganda kingdom Prime Minister and the private sector-led Pakasa Forums provide good examples of the ability to organize citizens for development outside the government structures. The civil society, although a bit fragmented, has often challenged the government excesses and is showing signs of better collaboration. Initiatives such as Black Monday under the auspices of Uganda National NGO Forum, Civil Society Budget Advocacy Group, and the Citizen Election Observers Network all attest to this. Engaging in public private partnerships that go beyond the bilateral partnership that USAID has with the government could open up new avenues for innovative interventions as well as financing.

Limited funding for districts: The taxation system is highly centralized with almost all taxes collected by the national level Uganda Revenue Authority. The abolition of graduated tax, which was the main source of LR for the LGs, coupled with other restrictions imposed by the Centre, leaves very little room for LGs to generate their own sources of LR. Some of the LR sources

identified by districts with support from SDS, such as Cess on produce, development tax, Bodaboda, and bicycle tax were halted by the MoLG. LGs therefore have neither the discretion and autonomy nor the required resources to respond to the local needs and priorities. The LG Finance Commission estimates that LR currently accounts for less than 3% of the LG budget.¹⁸ The central government transfers, mainly in the form of conditional grants, have also been declining as a proportion of the national budget falling from 25% in 2005/06 to 15% in 2013/14.¹⁹

Table 14: Local Government Revenue as a Percentage of National Budget



Source: Local Government Finance Commission Report, 2014.

Unless resources are channelled to districts through donor and other private sector grants, service delivery in critical social sectors like health and nutrition may be suffocated. SDS focus on local revenue mobilization and good fiscal management as well as providing grants for the resource constrained LGs was very helpful. It is regrettable that some of the efforts and innovations, initiated by SDS in LR generation were later curtailed by MoLG. There could be a role for SDS to engage better with MoLG and other central government agencies on such issues providing perhaps an evidence-informed cost-benefit analysis of LR in the districts and their effect on improved service delivery.

Fractioning of districts: The push for bringing services nearer to the people has resulted in the creation of more districts – and therefore more LLGs: sub-counties, town councils or even municipal councils – that are not economically viable due to significant increases in administrative cost overheads of service delivery.²⁰ Despite this, in September 2015 Parliament approved an additional 23 districts that will be operational in the next four years bringing the total to 135 districts.²¹ These LLGs in turn demand for HFs to meet the MoH Service Standards. Lower HFs are then upgraded before planning for their HRH and drug procurement plans. For example, in Mbale, three HC IIIs in Busiu Health Sub District (Bumasike, Bukasaja, and Bukiende) were not receiving drugs because they are not yet approved in the National Medical Stores system. Two new HC IIIs in Budaka District had no staff at the time of this evaluation. The regression in service delivery and frustration to perform while under-resourced has therefore led key sectors like Education, Health, and Agriculture to advocate for the re-centralization of their services. Creation of Town Councils and municipalities reduces LR from parent districts. Such fractionation threatens progress made by USAID in the districts.

¹⁸ Report on the Review of LG Financing by Local Government Finance Commission.

¹⁹ Local Government Finance Commission Annual Report, 2014.

²⁰ National Development Plan II, page 277.

²¹ New Vision of 4th September, 2015.

Any initiative such as SDS that seeks to strengthen decentralization must collaborate with different stakeholders to lobby concerned agencies to clearly define and enforce an agreed criterion for creation of new districts and other lower administrative units. Furthermore, initiatives like SDS would need to take into consideration these macro-level changes when assessing district performance on key indicators.

Limitations to civic voice: The PEA indicates that public awareness of individual rights and obligations amongst the general citizenry was low, partly due to limited capacity of the majority who seek public services and the reluctance of most Ugandans to commit to discharging their citizen obligations like paying of taxes. There are also concerns about the shrinking governance space and limitations to self-expression. The Public Order Management Act has often been quoted by Human Rights groups as limiting the space for civic expression and has been challenged in the courts of law by CSOs. The recently passed NGO Act (2016) has also attracted mixed responses from different CSO actors.

Although there were efforts to enhance civic voice through barazas organized by the Office of the Prime Minister as well as other IPs like the International Justice Mission and GAPP, SDS interventions have been predominantly at the district rather than the LLG level with hopes of trickle-down effects with respect to governance. However, SDS took advantage of existing opportunities, such as integrated outreaches to enhance civic voice. This approach, although efficient, may not be very effective given that the target audience of the engagement would have come primarily to access services from the very party they are expected to engage. Capitalizing on existing initiatives outside of the direct remit of SDS-like activities is strategic and such opportunities should continue to be leveraged.

Citizen apathy, especially in rural Uganda, remains a big challenge, yet effective civic engagement is very important for ensuring accountability of government services to the public and would play a key role in the realization of the PEPFAR principles, such as ending stigma and discrimination against PLWHA and key populations to improve their access to and uptake of comprehensive HIV services. This is an area where a program like SDS can ably intervene to strengthen accountability systems and structures at the local level.

“Uganda has had 22 years of decentralization and it has been a learning journey. The LG Act has been amended a record 13 times, the latest being September 2015.”

MoLG official

Decentralization Complexity: Decentralization remains the modality for delivering subnational development in Uganda. There is an elaborate legal and policy framework for decentralization as enshrined in the Constitution as well as the LG Act. Under the decentralized form of governance, LGs remain the frontline agents for service delivery where implementation of most of the government programs takes place. Districts and sub-counties therefore remain key to the successful delivery of essential social services.

Nevertheless, the decentralization set-up is complex in nature. The various levels of decentralization from the grassroots Local Council I up to the national level all have to work as an efficient system for decentralization to be effective. SDS mainly focused on the strengthening systems and structures at the district level with minor interventions at the sub-county level. Efforts to tackle such complex systems would need to permeate all the subsystems, which would call for a lot of effort and ample time.

The NDP II recognizes such challenges and has set out a number of priorities to address them. The priorities for LGs include, among others: i) improving the functionality of LGs for effective service delivery; ii) improving local economic development, and iii) improving governance at LG level.²² Some of the proposed interventions present good opportunities for dealing with bottlenecks that have affected SDS Program results. Key among these are: harmonizing LG policies, laws, and regulations with those at the national level; promoting transparency and accountability under decentralized governance; building partnerships with other stakeholders to promote and advocate for equity, transparency, and fairness in the resource allocations for LGs; building technical capacity and increasing staffing levels of LGs; promoting good governance at LGs for improved service delivery; and the review of the decentralization policy with the view of rationalizing structures and institutions in LGs. The proposed intervention of providing extension services for increased agricultural production and productivity is important as it is in line with the USAID objective of Economic Growth. A program to further strengthen decentralized service delivery can find the space to make its own imprint into the decentralization agenda.

Government efforts to improve the health sector: The NDP II has put more emphasis on infrastructure development in the health sector. Even within the sectors most government resources are put into facility construction, which provides support for areas in which SDS only had some resources through Grant C. In the Health Sector the NDP lists renovations of 25 selected general hospitals and mass treatment of malaria for prevention as the major priority area.²³ Other areas in the sector identified include health infrastructure development, equipment, and maintenance; scaling up training of critical health cadres in short supply; Community Health Extension Workers (CHEWs) Strategy; support implementation of PHC; and improve effectiveness and efficiency in the HSD. These interventions aimed at strengthening the health systems would lay a firm foundation upon which USAID priorities can be anchored.

Complementary programs: Other governance and accountability efforts that complement the fight against corruption include Strengthening Uganda's Anti-corruption and Accountability Regime (SUGAR), GAPP, and System Strengthening and Health Commodities (SSHC) for logistics management for drug supplies. Other initiatives from civil society include the Black Monday campaign that mobilizes citizens against theft of public resources as well as ACODE's LG Scorecard on the performance of LG councils.

The DOP experience of coordinating the efforts of different partners operating in a particular district points to the accrued benefits of harmonized approaches. This needs to go beyond USAID-supported IPs to cover the entire spectrum of all development actors operating in the districts. Enhancing, supporting, and advancing such efforts in partnership could be an opportunity for USAID. Aligning of approaches would be important in order to avoid concerns of competition, attribution, and conflicting values.

USAID's intention of ending poverty and building resilient democratic society will be achieved from adopting a more holistic approach to supporting districts. This will require making the DDPs living documents that reflect not only the development priorities of the central government but the needs and aspirations of the local citizens as well. The DMIPs could serve as good entry points in undertaking such an intervention. The TA support should also be able to

²² National Development Plan II, page 278.

²³ National Development Plan II, page 154.

help districts better position themselves and their citizens to take advantage of government programs such as the Operation Wealth Creation that is operational in all districts of Uganda. The SDS approach of mentorship would be most relevant for such an undertaking as it would enable “moving along” with the districts on their development pathway.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The Strengthening Decentralization for Sustainability program has, in accordance with the program design, registered considerable achievements in the areas of coordination, financial management, M&E, and MIS. These achievements have laid a good foundation for strengthening decentralization systems and structures in the supported districts. However, autonomy, adequate resourcing, accountable leadership, and citizen apathy, remain major challenges to functional decentralization. The underlying lesson is that strengthening decentralized systems is a complex process that requires more time, effort, and resources than what was available in the lifespan of the SDS mechanism.

Changes in the Local Government Systems and Structures

SDS support to the districts has led to some improvements in the functionality of the LG systems. Major changes included clarification of roles and responsibilities between the political and technical teams; re-activation of strict financial accountability; and coordination of Implementing Partner activities. Districts that had strong and stable leadership and the right caliber of technical staff generally performed better than others. However, the changes that have taken place may not be sustained due to frequent changes in the district civic leadership, the low capacity of the districts to retain key staff and limited local revenue to fill the financing gap left by SDS. The fact that the central government as well as other donors do not apply similarly stringent accountability standards is another disincentive to systems strengthening and sustainability.

Contribution of Grants and Grants Management to Program Success

Districts are resource-constrained and so any additional funds are highly appreciated. The performance-based SDS grants were a good additional funding source and they generated some positive results. However, the grants were predominantly conditional, further limiting financial discretion to address the LGs' identified priorities. The PBF component helped to reinvigorate the accountability requirement as evidenced by the declining number of audit queries and unqualified reports received by about a half of the SDS districts from the Auditor General's Office. However, without additional support in terms of mentoring and coaching, these gains may not be sustained given the frequent changes in leadership and the fact that government and other funders are not applying stringent PBF and accountability procedures.

The HRH component, and the principle of gradual absorption, was an innovative method of supporting districts to progressively expand their HRH base for improved health service delivery. Recruitment of and compensation for key HRH in the districts has demonstrably alleviated the burden on the health sector and arguably improved access to care and access to data in the supported districts. Agreements with the local governments and the PNFP facilities to absorb staff onto their respective payrolls upon contract completion has provided job security for several staff as well as provided a more permanent solution to staff shortage. However, the absorption rate remains suboptimal and threatens to undermine the progress made.

The grants significantly boosted service delivery in the hitherto chronically underfunded department of Community Development and Probation Services, with a significant increase in the demand and supply of child protection services, OVC services availability, management, and utilization.

Grants for WASH and Education interventions were found to be very beneficial in stimulating learning, personal, and environmental health. However, these interventions were implemented in a few districts and funding lasted only one year, which makes it difficult to draw conclusions on their beneficial applicability elsewhere.

Effects of Transitioning District Grants from DBTAs to SDS

The purpose of the transition was to separate financial accountability from TA and this was achieved as SDS focused on grants management and the DBTAs focused on providing service delivery TA. This resulted in better financial accountability given the PBF approach that SDS used, and also boosted child protection and OVC services in the Community Development and Probation Services sector. However, in the health sector, the anticipated synergy between the TAs did not fully materialize because of the conflicting principles and priorities between the program designs for SDS and the health sector DBTA programs. Whereas SDS exercised PBF, with rewards and sanctions, the DBTA programs were designed to achieve defined volumes of service delivery outputs in a defined timeframe. There is therefore a need to harmonize the approaches of the two TAs to enhance synergies.

Flexible and Adaptive Use of SDS by USAID

The SDS program design and objectives were broad enough to accommodate the modifications, and the leadership and management of SDS ably managed rolling out the numerous modifications. The modifications, such as LOGIC, HRH and the DOP enhanced the performance of the districts in key areas of service delivery as well as strengthened the roles and responsibilities of political and technical personnel in the districts. However, these modifications were often perceived as a result of USAID policies and functional changes which raises the question of ownership and sustainability.

Relevance of the SDS Model

The SDS Model was relevant insofar as it contributed additional resources, capacities, and to the extent that it attempted to inculcate a culture of strict performance management and accountability. The model remains relevant in the context of the current USAID focus on regional integrated health services delivery that requires a strong decentralized system backbone. However, there is a need to harmonize principles and priorities between Granting and TA mechanisms.

RECOMMENDATIONS

- I. In order to consolidate the gains made in strengthening LG systems, USAID should continue providing technical and financial support to the districts. In the spirit of the PEPFAR impact agenda of fostering sustainability through building the capacity of local institutions, systems, and the workforce, efforts should focus on strengthening the key tenets of a strong decentralized system which includes LG autonomy, civic participation and downward accountability, local economic development, and strengthening LG structures and systems.

2. The PBF principle should be maintained and embedded across all granting mechanisms. Districts that demonstrate compliance to the set PBF criteria should be given more discretionary funds to address locally identified priorities. The Government of Uganda should take the lead in promoting this approach to all granting agencies.
3. Modifications to future similar programs should, to the extent possible, involve the Implementing Partners right from the outset to ensure ownership and improve chances of sustainability. The modifications should also be reciprocally adaptive to changing LG circumstances.
4. In the future, in situations involving more than one TA arm, there is a need to synchronize policies and priorities so as to realize the intended synergies. Where that is not possible, the TA should have distinct programs with clear results for each of the TA.
5. All national level players deemed critical for achieving program results should be fully integrated in the program design with clear roles, responsibilities, and expected outputs. The Ministry of Health should be responsible for supporting the districts to absorb program-supported HRH personnel, MoLG for approval of local tax proposals, ULGA for sharing experiences, and LGFC for lobbying the government on additional funds to the districts.
6. Future similar programs need to develop strategies to strengthen community participation and engagement so as to strengthen the demand side for better service delivery and improved downward accountability. One possible way would be to collaborate CSOs already involved in community mobilization.
7. In order to truly support participatory “bottom-up” planning, governance strengthening mechanisms should support districts to make their DDPs living documents that respond to their local needs, that are realistic and fundable, and that resonate with national aspirations as enshrined in the NDP II, with emphasis on provision of PBF grants to specifically fund gaps in the DDPs.

ANNEX I. SCOPE OF WORK

Assignment #: 136 [assigned my GH Pro]

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Modification #1

Date of Submission: 07/13/15
2/16/2016

TITLE: Strengthening Decentralization for Sustainability Program (SDS)
Evaluation

Requester / Client

USAID Country or Regional Mission
Mission/Division: Uganda / Program Office

Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

- | | |
|--|---|
| <input checked="" type="checkbox"/> 3.1.1 HIV | <input type="checkbox"/> 3.1.6 MCH |
| <input type="checkbox"/> 3.1.2 TB | <input type="checkbox"/> 3.1.7 FP/RH |
| <input type="checkbox"/> 3.1.3 Malaria | <input type="checkbox"/> 3.1.8 WSSH |
| <input type="checkbox"/> 3.1.4 PIOET | <input type="checkbox"/> 3.1.9 Nutrition |
| <input type="checkbox"/> 3.1.5 Other public health threats | <input type="checkbox"/> 3.2.0 Other (specify): |

Cost Estimate: GH Pro will provide a final budget based on this SOW

Performance Period

Expected Start Date (on or about): October 23, 2015
Anticipated End Date (on or about): May 13, 2016

Location(s) of Assignment: (Indicate where work will be performed)

Uganda

Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

Performance Evaluation (Check timing of data collection)

Midterm Endline Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

Process Evaluation (Check timing of data collection)

Midterm Endline Other (specify):

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation *Outcome Evaluation* determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

Economic Evaluation (PEPFAR) *Economic Evaluations* identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of

alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

BACKGROUND

If an evaluation, Project/Program being evaluated:

Project/Activity Title:	Strengthening Decentralization for Sustainability (SDS)
Award/Contract Number:	AID-617-A-10-00003
Award/Contract Dates:	May 2010 – April 2016
Project/Activity Funding:	\$54,990,018
Implementing Organization(s):	Prime: Cardno Emerging Markets Group (USA) Subs: Development Info structure (DEVIS), Infectious Disease Institute (IDI), and Tangaza Cinema
Project/Activity AOR/COR:	Rose Okot-Chono, COR

Background of project/program/intervention:

Government of Uganda (GoU) adapted decentralization in the 1980s as the main strategy for improving service delivery, accessibility and sustainability of public goods and services and for poverty eradication. The overall objective of the decentralization policy was to empower local communities to take control of their own development strategies through more efficient local authorities that would be capable of mobilizing local resources. The Decentralization Act of 1997 and revised 2003 mandates the higher local government i.e. the districts to mobilize resources, plan and deliver relevant services to the communities including the social services (education, Health and Community based services).

Within the health sector, decentralization was intended to take services closer to the people and improve access and utilization, particularly to the rural poor, but lack of resources and capacity of districts has inhibited the achievement of this objective. Constraints on local governments and district technical teams related to: (i) limited resources for local needs-based planning due to the stringent earmarking of budget allocations from the central level; and (ii) limited capacity to plan and effectively manage these limited resources for improved service delivery. Problems of corruption, accountability, and limited stakeholder participation reduce local influence on budget allocations for actual priorities in the district.

Recognizing the pivotal role played by local governments in the service delivery supply chain, USAID has made a deliberate choice on working with local governments and other stakeholders to address the capacity gaps affecting access, availability and utilization of services. USAID introduced the District Based Technical Assistance (DBTAs) to provide technical capacity in areas related to HIV/AIDS, Maternal and Child Health, Orphans and Vulnerable Children (OVC) and Family Planning among others. Specific USAID supported activities providing this support include the Strengthening Tuberculosis and HIV/AIDS Responses (STAR) Projects implemented in East, East Central and South Western Uganda, Northern Uganda Health Integrated Services (NUHITES), Strengthening Uganda's National Response for Implementation of Services for Orphans and other Vulnerable Children (SUNRISE), STRIDES for Family Health and the just concluded Stop Malaria projects. Other USAID activities operate at the central level to support the development of national systems and create the conducive environment for decentralized service delivery.

In response to emerging development assistance coordination issues, governance and systemic challenges in the local governments, USAID launched the Strengthening Decentralization for Sustainability (SDS) Program in May 2010 geared at improving the results and sustainability of decentralized service delivery in 35 core districts. Key project objectives include; (1) improving coordination among all USAID supported partners at the district level, (2) strengthening the capacity of districts and sub-counties to plan, budget, implement/coordinate, monitor and evaluate decentralized services by efficiently utilizing the GOU's administrative and fiscal decentralization framework, (3) provision of grants to districts to complement resources needed for effective and efficient management of programs and services, and (4) facilitating strategic innovations to improve district leadership and sustainable financing of health, HIV/AIDS and other social sector services.

USAID has over the years made modifications to this scope of work to accommodate new strategic initiatives that support local governments. These modifications have included support to Local Government Councils Induction, District Operational Plan, Nutrition, Early Grade reading, Human Resources for Health, and Water Sanitation and Hygiene (WASH). By 2014, SDS activities have been implemented in 64 districts (35 core and 29 Human Resource for Health districts) Central, Eastern, Western and Northern Regions of Uganda. The total estimated cost of the project increased from 40 to 56million dollars by 2014. The project will end in April 2016.

SDS is implemented by Cardno Emerging Markets Group (USA) in partnership with Urban Institute and the Development Info structure (DEVIS) and two local partners Infectious Disease Institute (IDI) and Tangaza Cinema.

SDS works and collaborates closely with pertinent government institutions like the Ministry of Local Government, the Local Government Finance Commission, and other relevant line ministries, local governments. Because of the complimentary nature of the SDS interventions in strengthening decentralized systems, SDS also works closely with other USAID implementing partners both at the district and national level.

As part of its capacity building initiatives, SDS provides performance-based grants to fund health and social sector activities. These grants have in built incentives and rewards based on progress made on agreed benchmarks.

SDS, has also been the main implementing partner supporting the roll out of District Operational Plan (DOP) that provides a framework for planning and coordinating USAID assistance with districts to achieve shared development objectives through a more efficient and effective approach across 35 districts. The DOP is a key USAID Mission initiative that provides a platform for ensuring that USAID "focus" districts (i.e. 13 of the 35 SDS supported districts where considerable multi-sectoral resources are prevalent) implement complimentary development efforts that are aligned with Uganda's district development planning practices, as outlined in USAID/Uganda's Country Development Coordination Strategy (CDCS) 2011-2015. In these districts, SDS supports coordination across all USAID IPs including those in other sectors outside Health. The DOP process is implemented in six additional districts in Northern Uganda with variations in support arrangements. USAID intends to conduct an evaluation of the DOP approach and determine lessons and recommendation going forward. This evaluation will amongst others examine collaboration efforts and changes in relationships between local governments, USAID and implementing partners that can be linked to better coordination.

USAID implements similar local government strengthening activities through other activities like the Governance, Accountability, participation and Performance (GAPP) activity. The USAID Advocacy for Better Health complements SDS activities of strengthening systems for service delivery by improving the citizen action and demand side.

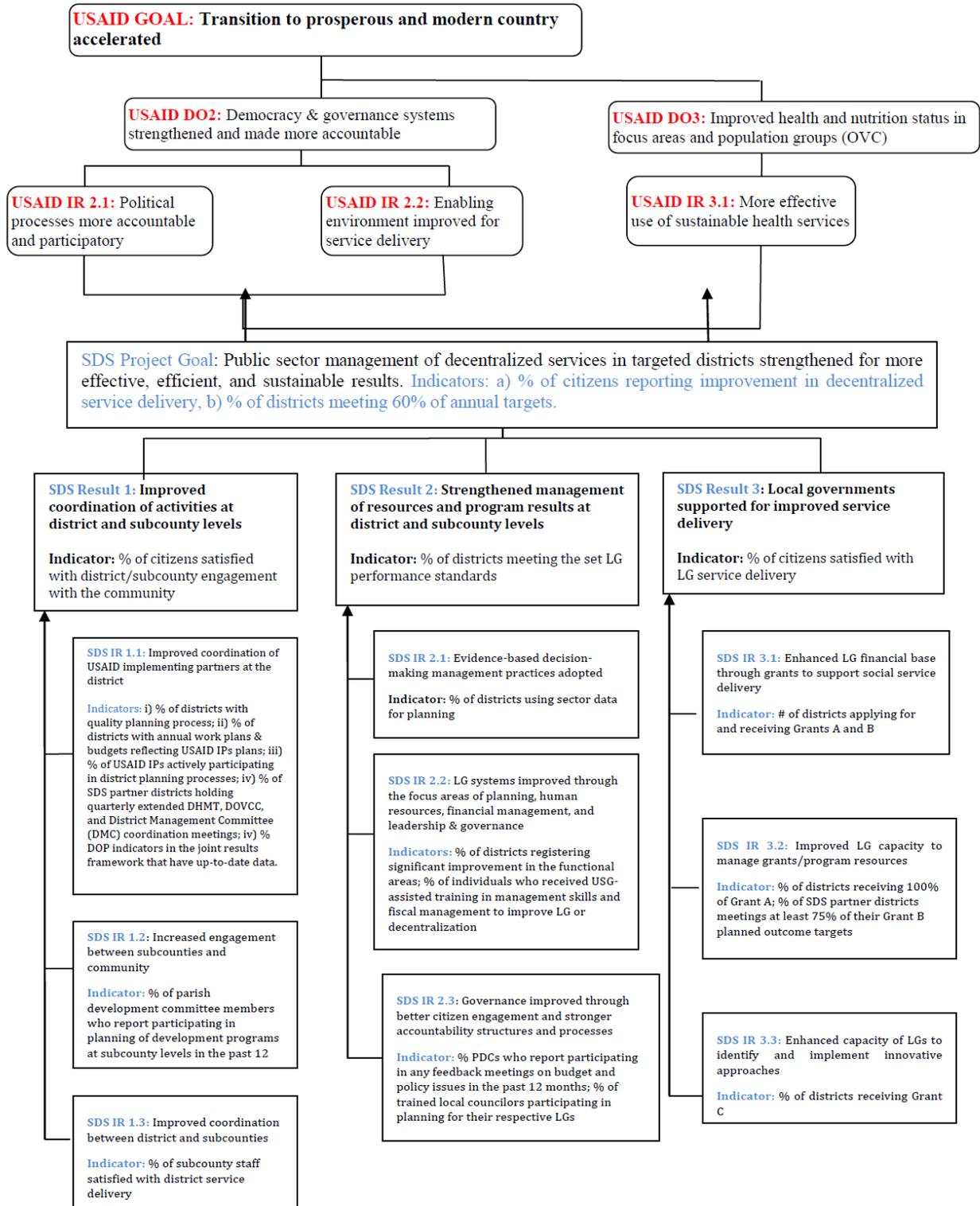
Key project objectives:

- 1) Improving coordination among all USAID supported partners at the district level
- 2) Strengthening the capacity of districts and sub-counties to plan, budget, implement/coordinate, monitor and evaluate decentralized services by efficiently utilizing the GOU's administrative and fiscal decentralization framework
- 3) Provision of grants to districts to complement resources needed for effective and efficient management of programs and services
- 4) Facilitating strategic innovations to improve district leadership and sustainable financing of health, HIV/AIDS and other social sector services

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

64 districts (35 core and 29 Human Resource for Health districts) Central, Eastern, Western and Northern Regions of Uganda. (See Annex 1)

Strategic or Results Framework for the project/program/intervention (paste framework below)



SCOPE OF WORK

- A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

This external evaluation comes at a point that SDS will be completing their 6th and final year of project implementation (by April 2016). This evaluation is expected establish the effectiveness of the integrated governance and service delivery strengthening approach as implemented under the SDS program and the extent to which it supports both the US government and the national vision for sustainable service delivery.

Given USAID interest and support for decentralized systems, this evaluation is expected to generate lessons and what are emerging promising practices that can be incorporated into future program designs and ongoing programs. The SDS project design is a first of its kind for the USAID Kampala Mission, and therefore this evaluation shall provide insights on how to further strengthen decentralized systems and pursue strategic partnerships with local governments.

- B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The primary user of the evaluation findings is USAID/Uganda Mission staff, other United States government agencies; USAID funded implementing partners (IPs), Ministry of Local Government, Ministry of Health and other national and international stakeholders with interest in systems strengthening as part of decentralization processes.

- C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

Findings from this evaluation will be used to inform the design of a planned Health systems strengthening activity and other decentralized health systems strengthening activities.

- D. **Evaluation/Analytic questions:** Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**

	Evaluation/Analytic Question Note: The Contractor may propose amendments to these questions during the Team Planning Meeting for review and approval by USAID Uganda.
	How have local governance systems changed as a result of the SDS program? Things to consider: <ul style="list-style-type: none"> • Sustainability beyond the life of the project • Influencing factors for success or failure across the districts (Note: In this question the evaluators shall investigate how leadership and management, planning, coordination, revenue generation, relations within and between the districts and other development partners have changed and increased the district's ability/effectiveness to provide social services)
	How did the grants and grants management (incentives and non-incentives) contribute to the success of the project? Things to consider: <ul style="list-style-type: none"> • Unintended consequences (positive and negative) of the grants

	What was the effect of transitioning from direct implementation of district led health care management activities from the DBTA projects to district grants through SDS?
	<p>How has the flexible or adaptive use of SDS by USAID Uganda hindered or enhanced the achievement of SDS results?</p> <p>Things to consider:</p> <ul style="list-style-type: none"> • How the program itself adapted to the changes; what (dis)enabled the adaptations • Effects of changes in SDS technical and geographic scope
	<p>To what extent is the SDS model still relevant given the current operating environment and USAID Uganda priorities?</p> <p>(Note: The shifts here include the changing GoU/USG relationship and thereby nature of engagement, regional integrated health programs, new PEPFAR priorities, shrinking governance space and limitations to self-expression, low government prioritization of social services including health, and still high levels of corruption and limited enforcement of laws/punitive action against wrong doers.)</p>

Other Questions [OPTIONAL]

(**Note:** Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

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E. Methods: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

<p>The evaluation will apply cross-sectional design using mixed methods to address the evaluation questions. The evaluation team will in build before and after designs to understand changes that could be linked to the program.</p> <p>The evaluation team may consider use of other qualitative tools like outcome harvesting and most significant change to investigate some of the direct and indirect systemic changes that have occurred as a result of the program intervention.</p> <p><i>Sampling:</i> The evaluation team is expected to propose and use sound sampling techniques to determine districts, sub counties, and facilities to be visited as well as stakeholders that will be consulted.</p> <p><i>Data Collection Tools:</i> The evaluation team will develop tools and detailed guidance for data collection and work closely with SDS, District staff and USAID/Uganda to identify appropriate respondents. All data collection instruments and guides will be approved by USAID/Uganda prior to the beginning of fieldwork.</p> <p>Suggested methods for this evaluation include:</p> <ol style="list-style-type: none"> 1) Social Return on Investment (SRoI) (http://betterevaluation.org/resources/guide/starting_out_on_sroi). The evaluators may also explore the use of Social Return on Investment (SRoI) approach to facilitate understanding of the hidden benefits of the capacity building and training components of the program 2) Outcomes Harvesting (http://betterevaluation.org/plan/approach/outcome_harvesting) 3) Political Economy Analysis
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4) Systems/Complexity Analysis

Document and Data Review *(list of documents and data recommended for review)*

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. There are several program related documents that have been produced by SDS, other USAID IPs, local governments, government and other actors, including:

From USAID:

- Original Request for Applications and modifications
- Evaluation reports including the STARS evaluation report.
- DOP Evaluation report.
- Uganda Country Cooperation Development Strategy 2011-2015
- Evaluation of District Based Technical Assistance programs and SUNRISE.

From SDS:

- Coordination, progress reports and other documentation such as DoP methodology, Grant A desk reviews and validation results
- Monitoring and Evaluation related documents (Approved PMP and modifications, , Development Hypothesis, Baseline/survey reports, Annual work plans, Monitoring reports/ Annual and quarterly reports, District Management Improvement Plans, among others

SDS major studies reports;

- Organization effectiveness Analysis (OES) baseline and follow up reports.
- Annual survey on the Citizens engagement consolidated reports.
- Grant A quarterly performance assessment reports.
- Grant B annual performance assessment report.
- CLA consolidated reports.

Grants Management and Technical assistance documents

- Program Management and Operations documentation.
- Documentation on the special initiatives such as LOGI, HRH, WASH, Education, M&E internship and CLA.
- Any other relevant reports and information as required and available

From MOH:

- Annual district performance reports (past 3 years over duration of SDS)
- Sector review performance reports for the relevant periods
- Human Resources for Health Bi-Annual report

From MOLG

- Annual district performance reports and any other reports that could indicate performance in social sector services.
- Local government sector investment plans for the ten years

Others:

- 5 year National Development Plan for Uganda

Secondary analysis of existing data *(list the data source and recommended analyses)*

Data Source (<i>existing dataset</i>)	Description of data	Recommended analysis

■ Key Informant Interviews *(list categories of key informants, and purpose of inquiry)*

The evaluation team will conduct in-depth interviews and group discussions with program staff, partner organizations, stakeholders from the districts, MoLG, Ministry of Health, USAID, IPs, non-government organizations and health facility managers on their views and perceptions of the SDS program and the kind of changes that have resulted from the program intervention.

Note: Key informants can be grouped together into a Group Interview, for efficiency, as long as they are from or associated with the same representative group, and there are no power differentials among the participants in the group that could influence how other participants in the group respond.

Focus Group Discussions *(list categories of groups, and purpose of inquiry)*

■ Group Interviews *(list categories of groups, and purpose of inquiry)*

Some Key Informants (see above) can be clustered into a group and interviewed. The Evaluation Team will be cognizant to avoid any power differentials within a group, to insure that all participants in a group feel comfortable sharing their opinions.

Client/Participant Satisfaction or Exit Interviews *(list who is to be interviewed, and purpose of inquiry)*

Facility or Service Assessment/Survey *(list type of facility or service of interest, and purpose of inquiry)*

Cost Analysis *(list costing factors of interest, and type of costing assessment, if known)*

■ Survey *(describe content of the survey and target responders, and purpose of inquiry)*

A set of structured questions will be asked through a survey to representatives from:

- USAID supported partners at the district level
- Recipients of SDS district grants to district
- district leaders working directly or indirectly with SDS

This can be incorporated as part of the Key Informant Interviews, or, if/when feasible, this can be a web-based survey, such as Survey Monkey.

Observations *(list types of sites or activities to be observed, and purpose of inquiry)*

Data Abstraction *(list and describe files or documents that contain information of interest, and purpose of inquiry)*

■ Case Study *(describe the case, and issue of interest to be explored)*

The Evaluation Team should explore the opportunity to develop a Case Study prior to data collection. The Case Study would be built on data gathered through the existing data collection methods existing in this evaluation.

Verbal Autopsy (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)

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Rapid Appraisal Methods (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

--

Other (list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry)

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If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

Yes No

List or describe case and counterfactual”

Case	Counterfactual

HUMAN SUBJECT PROTECTION

The Evaluation Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

The evaluation team will propose data analysis strategies and tools for both the qualitative and quantitative data. The team will be expected to conduct trend analysis; comparisons of performance across districts; older versus newer districts, districts with DBTAs and those without, mission focus districts and non-mission focus districts and where possible districts in Northern region where SDS does not have as an active presence. The evaluation team will also conduct other comparisons that could highlight achievement or lack of achievement of positive effects of these projects. Data disaggregation and analysis by gender and age to establish the differential effects of the project on men, women and different age groups will also be expected. The team will propose other analysis approaches. The evaluation team shall describe the type of software for quantitative and qualitative data analysis they propose to use.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, MICS, HMIS data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include SDS proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Pre-TPM planning – Prior to arriving in country, the evaluation team will meet virtually and will hold a virtual in-brief via teleconference or desktop video conferencing (DVC) with USAID. The evaluation team will also correspond with SDS to access background on the program and make plans site selection and travel. The evaluation team will prepare an evaluation plan that includes detailed evaluation design and methodology, draft data collection tools, sampling, an analytic plan, and a tentative schedule. The report will also include an overview of the methodology that will be used to select respondents/informants to be interviewed and also showing the areas to be visited. This evaluation plan is due to USAID before arrival in country.

Team Planning Meeting (TPM)

The TPM will be split in two. Initiating before the Team convenes in Uganda, and the completed once all the Team members are in Uganda The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation plan and questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines

- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Train Data collectors
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Prior to convening in Uganda, the Team will meet virtually to develop a draft Evaluation Workplan that includes methods and protocols for each method, timeline, and draft evaluation tools. To develop this workplan the Team will reach out to both USAID and SDS as needed to obtain information needed to develop the workplan. This draft workplan will be presented to USAID prior to the Team convening in Uganda.

In-country TPM – The Team will convene in Uganda, prior to data collection, to finalize the Evaluation Workplan following feedback from USAID.

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID and SDS. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- Evaluation **launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- As part of the virtual TPM, the Team will have a **virtual in-brief with USAID** to obtain needed information from USAID as part of the planning process, and to discuss their plans as they submit the draft workplan to USAID.
- **In-Country In-brief with USAID**, as part of the TPM. This briefing may be broken into two meetings: a) at the **beginning of the TPM**, so the Evaluation Team and USAID can discuss expectations and intended plans; and b) at the **end of the TPM** when the Evaluation Team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-brief will be the format and content of the Evaluation report(s). The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- The Team Lead (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A Preliminary debrief following field work and initial analysis. The team will present preliminary findings and conclusions to USAID through an in-person presentation.
- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present their findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during

the debrief in the evaluation report. (**Note:** *preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)

- **Stakeholders’ debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be deemed sensitive by USAID.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Evaluation Report – The Evaluation Team under the leadership of the Team Lead will develop a report with evaluation findings and recommendations (see Analytic Report below).

Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USIAD separate from the Evaluation Report.

DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
■ Launch briefing	By October 28, 2105
■ Virtual in-brief with Mission (could be combined with the Launch, if necessary)	by October 30, 2015
■ Draft Workplan (prior to arrival in country)	November 6, 2015 (prior to arrival in country)
■ Workplan with timeline	November 11, 2015
■ Analytic protocol with data collection tools	November 11, 2015
■ In-Country in-brief with Mission	November 9, 2015
■ Weekly updates by Email	Weekly
■ Learning Brief	March 25, 2016
■ Preliminary Out-brief with Mission or organizing business unit with Power Point presentation	December 3, 2015
■ Secondary Out-brief with Mission or organizing business unit with Power Point presentation	Mid-January 2016
■ Draft report	February 2, 2016
■ Final Draft report	February 29, 2016

<input checked="" type="checkbox"/> Final report (Edited/Formatted) - electronic	March 25, 2016
<input checked="" type="checkbox"/> Raw data	February 1, 2016
<input checked="" type="checkbox"/> Cleaned Data Sets	March 31, 2016
<input checked="" type="checkbox"/> Post Report to the DEC	April 15, 2016
<input type="checkbox"/> Dissemination activity	
<input type="checkbox"/> Other (specify):	

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, as well as for the individual team members.

The evaluation will be conducted by external evaluators; including international and Ugandan team members. The team will have complementary expertise and experience in the following areas: decentralized governance and service delivery; organizational development, evaluation management; management and tracking of performance based financing; international health program planning; governance with a strong background in social service, systems strengthening and research methodology. It is also desirable that at least one member of the Team has a background in financial analysis and granting programs to implement Social Return on Investment (SRoI) evaluation methodology.

Edit as needed to the Team Lead's position description.

Team Lead: This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations/analytics.

Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations.

Qualifications:

- Minimum of a Master's degree in public health, governance of local governments, development studies, applied research or related fields.

- Minimum of 10 years of experience in public health, which included experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/analytcs, utilizing both quantitative and qualitative s methods
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in [Country] is desirable
- Familiarity with USAID
- Familiarity with USAID policies and practices
 - Evaluation policy
 - Results frameworks
 - Performance monitoring plans

Key Staff I Title: Health Systems Strengthening Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise on decentralization and health systems strengthening (HSS), covering the six building blocks to HSS. S/He will participate in evaluation planning, data collection, data analysis, and report writing.

Qualifications:

- Advanced degree in an area related to public health, public administration, health management, development studies, governance or business management
- Over ten years of experience in Decentralized Health Service Delivery, including health care financing and capacity strengthening
- Knowledge of local governance structures in Uganda
- Experience evaluating and analyzing local government systems, and Government to Government (G2G) activities in Uganda.
- Expertise working with health system strengthening in developing countries, with a firm understanding of the six building block for HSS
 - i. leadership/governance
 - ii. health care financing
 - iii. health workforce
 - iv. medical products & technologies
 - v. information and research
 - vi. service delivery
- Experience in individual and organizational capacity development related to health system strengthening
- Experience in conducting USAID evaluations of health programs/activities is preferred
- Experience in stakeholder engagement
- At least 5 years' experience in USAID health program management, oversight, planning and/or implementation
- Able to work well on a team
- Good interpersonal communication skills
- Good writing skills, specifically technical and evaluation report writing experience
- Proficient in written and spoken English

Number of consultants with this expertise needed: 1

Key Staff 2 Title: Evaluation Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- At least 10 years of experience in M&E
- At least 5 years managing evaluations
- Familiarity with USAID M&E procedures and implementation is very desirable
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Proficient in English
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID and PEPFAR M&E policies and practices
 - Evaluation policies
 - Results frameworks
 - Performance monitoring plans

Number of consultants with this expertise needed: 1

Key Staff 3 Title: HIV Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in HIV and HIV/TB, particularly on effective health in Uganda and East Africa. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- Advanced degree in an area related to public health, or related field
- At least 7 years' experience with design and management of HIV projects; USAID project implementation experience preferred

- Knowledgeable about HIV and TB issues and programs; with experience in Uganda and East Africa (desirable)
- Substantial knowledge and experience on developmental aspects of HIV/AIDS, related policies, strategy development, and programming, including targeted interventions for vulnerable groups.
- Familiar with PEPFAR guidelines and policies, including
 - PEPFAR Next Generation Indicators Reference Guidance
 - PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide
 - PEPFAR Evaluation Standards of Practice
 - Capacity Building and Strengthening Framework
 - GENDER STRATEGY
 - Country Operational Plans (COP)
 - Site Improvement through Monitoring System (SIMS)
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Participated in a minimum of five evaluations.

Number of consultants with this expertise needed: 1

Key Staff 4 Title: Local Governance Expert (Local Consultant preferred)

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in local governance and decentralization, particularly in Uganda and East Africa. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- Master's in Public Administration and Management, Development Studies, or related fields.
- Minimum of seven years' experience implementing and evaluating local government development programs in Uganda and or similar settings.
- Technical expertise in strengthening local government systems.
- Must demonstrate knowledge and experience with the functioning of decentralized local governments in Uganda.
- Good understanding of capacity development, especially in the public sector with districts and sub-counties aimed at planning, budgeting, program implement/coordinate, monitoring services, etc.
- Experience in grantsmanship (provision, management and monitoring), particularly with grants in the health and public sectors is desired
- Familiar with systems and approaches to enhance sustainable financing for health in the public sector
- Demonstrated experience in conducting evaluation of project(s) similar content and magnitude.
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Demonstrated experience in conducting evaluation of project(s) similar content and magnitude.

Number of consultants with this expertise needed: 1

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local Evaluation Logistics /Program Assistant (*1 consultant*) will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.

Local Evaluators (*2 consultants*) to assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The Local Evaluators will have a good command of English and local language(s). They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

Yes – If yes, specify who:

No

Staffing Level of Effort (LOE) Matrix (Optional):

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- b) Immediately below each staff title enter the anticipated number of people for each titled position.
- c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
- d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in **days** for each Evaluation/Analytic Team member

Activity / Deliverable	Evaluation/Analytic Team					
	Team Lead / Eval Spec	HSS Specialist	HIV Specialist	Local Governance	Logistics / Admin Coordinator	Local Evaluator / Researcher
Number of persons →	1	1	1	1	1	2
1 Launch Briefing	1					
2 Desk review	5	5	5	5		3
3 Virtual Team Planning Meeting with draft Workplan	3	3	3	3		
4 Virtual in-brief with Mission	0.5	0.5	0.5	0.5		
5 Preparation for Team convening in-country	2				2	
6 Travel to country		2				
7 In-Country Team Planning Meeting	3	3	3	3	3	3
8 In-brief with Mission with prep	1	1	1	1	1	1
9 Data Collection DOA Assurance Workshop (protocol orientation for all involved in data collection)	4	3	3	3	2	3
10 Prep / Logistics for Site Visits	1	1	1	1	2	1
11 Data collection / Site Visits (including travel to sites)	21	15	21	21	16	21
12 Data analysis	7	5	5	5	6	5
13 Preliminary Debrief with Mission with prep	2	1	1	1	1	1
14 Stakeholders' Debrief Workshop with prep	2.5	1	1	1	1	1
15 Depart country		2				
16 Draft report(s)	14	10	10	10		2
17 Secondary Mission Debrief with Prep	3	1.5	1.5	1.5		
18 GH Pro Report QC Review & Formatting						
19 Submission of draft report(s) to Mission						
20 USAID Report Review						
21 Learning Brief	3	2	2	2		
22 Revise report(s) per USAID comments	3	2	2	2		
23 Finalize and submit report to USAID						
24 508 Compliance Review						
25 Upload Eval Report(s) to the DEC						
Sub-Total LOE	76	58	60	60	34	44+38
Total LOE	76	58	60	60	34	82

If overseas, is a 6-day workweek permitted Yes No

Travel anticipated: List international and local travel anticipated by what team members.

SDS office(s), USAID and site visits conducted in the different districts, line ministries, institutions and health facilities currently supported by the SDS program. During the virtual TPM, the Team will determine the sites for data collection.

LOGISTICS

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

USAID Facility Access

Specify who will require Facility Access:

Electronic County Clearance (ECC) (International travelers only)

GH Pro workspace

Specify who will require workspace at GH Pro:

Travel -other than posting (specify):

Other (specify):

GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.
 - Develop SOW.
 - Peer Review SOW
 - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.

- **Meeting Space.** Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- **Meeting Arrangements.** Assist the team in arranging and coordinating meetings with stakeholders.
- **Facilitate Contact with Implementing Partners.** Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.

After Field Work

- **Timely Reviews.** Provide timely review of draft/final reports and approval of deliverables.

ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See [How-To Note: Preparing Evaluation Reports](#))

The **Evaluation/Analytic Final Report** must follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the [USAID Evaluation Policy](#)).

- a. The report must not exceed **30 pages** (excluding executive summary, table of contents, acronym list and annexes).
- b. The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The preliminary findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 4 pages);
- Table of Contents (1 page);
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions (1-2 pages)
- Project [or Program] Background (1-3 pages)
- Evaluation/Analytic Methods and Limitations (1-3 pages)
- Findings
- Conclusions
- Recommendations
- Annexes
- Annex I: Evaluation/Analytic Statement of Work

- Annex II: Evaluation/Analytic Methods and Limitations
- Annex III: Data Collection Instruments
- Annex IV: Sources of Information
 - o List of Persons Interviews
 - o Bibliography of Documents Reviewed
 - o Databases
 - o [etc]
- Annex V: Disclosure of Any Conflicts of Interest
- Annex VI: Statement of Differences [if applicable]

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](#) and [Checklist for Assessing USAID Evaluation Reports](#)

 The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be provided to GH Pro and presented to USAID electronically to the Program Manager. All data will be in an unlocked, editable format.

USAID CONTACTS

	Primary Contact	Alternate Contact I
Name:	May Mwaka	Lane Pollack
Title:	Monitoring and Evaluation Specialist/Program Office	Organizational Learning Advisor / Program Office
USAID Office/Mission	USAID Uganda	USAID/Uganda
Email:	mmwaka@usaid.gov	lpollack@usaid.gov
Telephone:	+256 414 306 518	+256 414 306 672
Cell Phone (optional)	+256 772 138 529	+256 772 138 517

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

	Technical Support Contact I
Name:	Diana Harper
Title:	Senior Evaluation and Program Advisor
USAID Office/Mission	Office of Policy, Planning and Programs USAID Bureau for Global Health
Email:	dharp@usaid.gov
Telephone:	571-551-7086
Cell Phone (optional)	571-228-3619

REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

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SOW Annex I: SDS Districts

Category	Western Region	Central Region	Eastern Region	Northern Region
35 SDS core districts (10 non HRH)	Bushenyi	Bugiri	Mbale	Gulu
	Ibanda	Iganga	Sironko	Amuru
	Isingiro	Kamuli	Kapchorwa	Nwoya
	Kasese	Luwero	Bududa	Oyam
	Kamwenge	Mayuge	Budaka	Apac
	Kanungu	Kalangala	Bukwo	Dokolo
	Rukungiri	Kaliro	Busia	Alebtong
	Ntungamo	Kayunga	Butaleja	Agago
	Kirihura	Mityana	Kumi	Pader
	Kisoro	Mpigi	Pallisa	Kitgum
	Kabale	Nakasongola		Lamwo
	Kyenjojo	Namutumba		
		Sembabule		
29 HRH districts	Buhweju	Buikwe	Amudat	Amolatar
	Kabarole	Bukomansimbi	Bulambuli	Arua
	Mitooma	Buyenda	Kibuku	Buliisa
	Rubirizi	Jinja	Kween	Kole
	Sheema	Kyankwanzi	Napak	Lira
		Luuka	Ngora	Moyo
		Lwengo	Serere	Nebbi
		Namiyingo		Otuke
		Wakiso		
	17	22	17	19

SOW ANNEX 2: ILLUSTRATIVE LIST OF LITERATURE TO BE REVIEWED

From USAID:

- Original Request for Applications and modifications
- Evaluation reports including the STARS evaluation report.
- DOP Evaluation report.
- Uganda Country Cooperation Development Strategy 2011-2015
- Evaluation of District Based Technical Assistance programs and SUNRISE.

From SDS:

- Coordination, progress reports and other documentation such as DoP methodology, Grant A desk reviews and validation results
- Monitoring and Evaluation related documents (Approved PMP and modifications, Development Hypothesis, Baseline/survey reports, Annual work plans, Monitoring reports/ Annual and quarterly reports, District Management Improvement Plans, among others

SDS major studies reports;

- Organization effectiveness Analysis (OES) baseline and follow up reports.
- Annual survey on the Citizens engagement consolidated reports.
- Grant A quarterly performance assessment reports.
- Grant B annual performance assessment report.
- CLA consolidated reports.

Grants Management and Technical assistance documents

- Program Management and Operations documentation.
- Documentation on the special initiatives such as LOGI, HRH, WASH, Education, M&E internship and CLA.
- Any other relevant reports and information as required and available

From MOH:

- Annual district performance reports (past 3 years over duration of SDS)
- Sector review performance reports for the relevant periods
- Human Resources for Health Bi-Annual report

From MOLG

- Annual district performance reports and any other reports that could indicate performance in social sector services.
- Local government sector investment plans for the ten years

Others:

- 5-year National Development Plan for Uganda

SOW ANNEX 3: USAID/UGANDA CRITERIA TO CHECK THE QUALITY OF THE EVALUATION REPORT

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by the Contracting Officer Representative in this evaluation, who is the USAID staff member responsible for administrative role.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included as Annexes in the final report.
- Evaluation findings will be gender sensitive i.e. assess outcomes and impact on males and females.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparison groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

ANNEX II. EVALUATION METHODS AND LIMITATIONS

EVALUATION DESIGN MATRIX

Table 15: Summary matrix: evaluation questions, indicators, sources and methods

	Evaluation Question	Sub Questions	Indicators	Data Sources	Data Collection	Type of Tool	Data Analysis Plan
I.	<p>How have local governance systems changed as a result of the SDS program?</p> <p>Things to consider:</p> <ul style="list-style-type: none"> Sustainability beyond the life of the project Influencing factors for success or failure across the districts <p><i>(Note: Evaluators shall investigate how leadership and management, planning, coordination, revenue generation, relations within and between the districts and other development partners have changed and increased the district's ability /effectiveness to provide social services)</i></p>	<p>How was the leadership and management, planning, financial management processes, coordination (IPs), revenue generation, M&E/MIS, civic engagement before 2010?</p> <ul style="list-style-type: none"> How is it now? What changed? What were the causes of those changes? <p>What have been the effect of these changes on:</p> <ul style="list-style-type: none"> Goal setting; Decision Making; Transparency and accountability; Responsiveness to local needs; and Service delivery? <p>How do you intend to maintain the positive changes</p>	<ul style="list-style-type: none"> -Proportion of extended DPTC meetings chaired by CAO/LCV Chair -Attendance at extended DPTC meetings by IPs and other CSOs -Proportion of local revenue allocated to service delivery -Participation in budget conferences by IPS and other CSOs -Public display of releases and procurements -PDC Planning meetings -Proportion of planned support supervision visits 	<p>Reports (baseline surveys, evaluations, LG Score Card, MoLGD Annual District Performance Reports, Annual Health Sector Performance Reports, District/sub-county/Facility notice boards) Meeting minutes (District/sub country) MoLG (Decentralization Secretariat), MFPED (Planning & Budgeting, Budget Monitoring), NPA (LG Planning unit), Planning Unit, CAO, District Executive</p>	<ul style="list-style-type: none"> Key informant interviews Group interviews Document Review Observation 	<p>Interview Guides/ Semi-structured questionnaires</p>	<ul style="list-style-type: none"> Trend analysis from secondary data, Inductive thematic analysis of the primary qualitative data Mapping and analysis of contextual factors between and within SDS and non-SDS districts Data triangulation Comparison across different types of districts

	Evaluation Question	Sub Questions	Indicators	Data Sources	Data Collection	Type of Tool	Data Analysis Plan
			<p>conducted per health facility</p> <ul style="list-style-type: none"> -Trends in number of audit queries - Changes in SDS performance indicators over time 	<p>Committee, LCV Chair, Secretary for Health, Implementing partners</p> <p>MGLSD, MOH, ULGA, LGFC, UAAU</p> <p>Senior Assistant Sec. in charge of sub-counties, LCIII Chair. General Public/PDC, In charge Health Units</p>			
2.	<p>How did the grants and grants management (incentives and non-incentives) contribute to the success of the project?</p> <p>Things to consider:</p> <ul style="list-style-type: none"> • Unintended consequences (positive and negative) of the grants 	<p>What is your experience of the SDS granting process?</p> <p>What are your reflections on the grant evaluation criteria?</p> <ul style="list-style-type: none"> • Pros & Cons of incentives & disincentives <p>How did the grant affect health care service management and delivery in terms of:</p> <ul style="list-style-type: none"> • Support Supervision • Health Infrastructure • HRH • Health Financing • M&E (HMIS Tools and Skills) 	<ul style="list-style-type: none"> -Proportion of planned support supervision visits conducted per health facility -Proportion of DMIPs priorities that were not fund -Amount allocated to (vs budgeted) the DMIPs priorities -Number of eligible OVC beneficiaries that received a service from at 	<p>Document review (Call for applications, PBF criteria, list of applicants, Grant C workshop minutes)</p> <p>Grant recipients (those who succeeded & continued, succeeded but later dropped and non-successful applicants)</p> <p>CAO, DHMT, USAID Project Team, SDS,</p>	<p>Key informant interviews</p> <p>Group interviews</p> <p>Document Review</p>	<p>Interview Guides/ Semi-structured questionnaires</p>	<p>Trend analysis from secondary data,</p> <p>Inductive thematic analysis of the primary qualitative data</p> <p>Data triangulation</p> <p>Comparison within and between across different types of districts</p>

	Evaluation Question	Sub Questions	Indicators	Data Sources	Data Collection	Type of Tool	Data Analysis Plan
		<ul style="list-style-type: none"> Logistics and Supply Chain Management Quality Assurance MCH Services TB/HIV Services OVC Services Nutrition services <p>What were the unintended results?</p>	<p>least one core program areas</p> <ul style="list-style-type: none"> -Trends in TB treatment completion rates [for SDS and non SDS districts] -Proportion of grant C recipients able to implement sustainable innovations - Trends in SDS performance indicators [SDS districts only] 	DBTAs, other IPs, Health Unit managers, TB/Leprosy Supervisor Secretary for Health, CDOs DFID, MoLG, ULGA, LGFC			
3.	What was the effect of transitioning from direct implementation of district led health care management activities from the DBTA projects to district grants through SDS?	<p>What has been the effect of having TA from SDS as well as DBTAs on:</p> <ul style="list-style-type: none"> Governance and systems strengthening Service delivery <p>What was the scope of the transition?</p> <p>How was the process managed?</p> <p>How did it affect service delivery?</p> <p>What challenges (if any) did the transition pose?</p> <ul style="list-style-type: none"> How did you respond to the challenges? 	<ul style="list-style-type: none"> -Existence of a transition plan -Participation of relevant stakeholders in planning of the transition -changes in time allocation for DBTA TA support to districts - changes in time allocation for DBTA TA support to health facilities - Changes in SDS performance indicators pre 	<p>Document review (progress reports, evaluations reports, Transition Plan)</p> <p>CAO, DHMT, USAID Project Team, DBTAs, DHMT, Managers of HUs.</p>	<p>Key informant interviews</p> <p>Group interviews</p> <p>Critical review of documents relevant to the evaluation questions</p>	<p>Interview Guides/ Semi-structured questionnaires</p>	<p>Trend analysis from secondary data,</p> <p>Inductive thematic analysis of the primary qualitative data</p> <p>Data triangulation</p>

	Evaluation Question	Sub Questions	Indicators	Data Sources	Data Collection	Type of Tool	Data Analysis Plan
		<i>*Note: only for districts & USAID IPs that underwent transition.</i>	and post transition				
4.	<p>How has the flexible or adaptive use of SDS by USAID Uganda hindered or enhanced the achievement of SDS results?</p> <p>Things to consider:</p> <ul style="list-style-type: none"> How the program itself adapted to the changes; what (dis)enabled the adaptations Effects of changes in SDS technical and geographic scope 	<p>What changes or adaptations have occurred in the program by USAID [NB: for USAID and SDS]</p> <p>What are the reasons / rationale for the change?</p> <p>There were several modifications to the program... [NB for expanded list of respondents]</p> <ul style="list-style-type: none"> How did they affect the implementation? How did they affect program outcomes? <p>How did the SDS program adapt to the changes?</p> <p>What are those factors that enabled or hindered implementation?</p> <p>How were the negative factors addressed?</p>	<p>- changes in SDS staffing levels</p> <p>-changes in budget to SDS program</p> <p>- changes in workload of key SDS staff (leadership)</p> <p>- changes in grant budget allocations to districts</p>	<p>USAID, SDS</p> <p>DHMT</p> <p>DBTA</p> <p>CAO, DHO, Implementing partners</p> <p>DEC</p> <p>LCV Chair</p>	<p>Key informant interviews</p> <p>Group interviews</p> <p>Critical review of documents relevant to the evaluation questions</p>	<p>Interview Guides/ Semi-structured questionnaires</p> <p>Document extraction matrix</p>	<p>Inductive thematic analysis of the primary qualitative data</p> <p>Compare planned results against final achieved results to determine extent of modification. Qualify those positive and those negative</p> <p>Extraction of critical junctures and modifications over the time period of SDS mapped against results and outcomes</p> <p>Data triangulation</p>
5.	<p>To what extent is the SDS model still relevant given the current operating environment and</p>	<p>How would you describe the SDS model?</p> <p>How is it different from other programs for</p>	<p>-Trends of LG Annual Performance Indicators (across the 3 decentralization</p>	<p>Document review (reports from DFID decentralization, GAPP reports, SDS reports)</p>	<p>Key informant interviews</p> <p>Group interviews</p>	<p>Interview Guides/ Semi-structured questionnaires</p>	<p>Inductive thematic analysis of the primary qualitative data</p>

	Evaluation Question	Sub Questions	Indicators	Data Sources	Data Collection	Type of Tool	Data Analysis Plan
	<p>USAID Uganda priorities?</p> <p><i>(Note: The shifts here include the changing GoU/USG relationship and thereby nature of engagement, regional integrated health programs, new PEPFAR priorities, shrinking governance space and limitations to self-expression, low government prioritization of social services including health, and still high levels of corruption and limited enforcement of laws/punitive action against wrong doers.)</i></p>	<p>strengthening decentralized systems?</p> <p>What factors could have affected the effectiveness of the model?</p> <ul style="list-style-type: none"> Political and macro environmental factors (National policies, Changes in development partner policies and interests, Actors, relationships and resulting power dynamics (national and international), Performance/Outcome Incentive system, Political environment in UG etc.) Micro environmental and organizational factors (National policies, Changes in development partner policies and interests, Actors, relationships and resulting power dynamics (national and international), Performance/Outcome Incentive system, Political environment in UG etc.) <p>What aspects of the model worked well?</p> <ul style="list-style-type: none"> What were the contributing factors? <p>What aspects of the model didn't work well?</p>	<p>programs – GAPP, SDS & Nu Health)</p> <p>-changes in district performance pre and post occurrence of discrete event</p>	<p>Wider literature review on decentralization (Political economy, health systems strengthening etc.)</p> <p>National documents (policy change relevant to decentralization)</p> <p>Other PBF models</p> <p>Other decentralization models</p> <p>USAID, SDS, DHMT, DBTA, CAO, DHO, IPs, ULGA, LGFC and LCV Chair</p> <p>USAID GAPP -</p> <p>DFID- NuHEALTH</p>	<p>Critical review of documents relevant to the evaluation questions</p>		<p>Comparisons against other decentralization strengthening programs within Uganda and other countries</p> <p>Mapping and analysis of contextual factors (changes in national policies, political effects, shifts in program design, org relevant changes (e.g. leadership) etc.</p> <p>Data triangulation</p>

	Evaluation Question	Sub Questions	Indicators	Data Sources	Data Collection	Type of Tool	Data Analysis Plan
		<ul style="list-style-type: none"> • What were the contributing factors? <p>Given the current context, what aspects of the model ideally should be retained? - Why?</p> <p>Which aspects would you want to drop? - Why?</p>					

SAMPLING

DISTRICT SELECTION

In addition to details provided in the main body of the report, we expand on the further stratification of districts as “old” and “new”. “New” districts are known to face markedly greater governance and health system challenges than “old” ones and may program outcomes. Regional core districts were therefore further stratified by age with “new” districts defined as those established post-July 2005: the 10-year period is considered reasonable for the establishment of basic administrative systems.

Furthermore, the use of “poor and good performing” districts as defined by SDS was deliberately avoided in selection criteria. The reasons for this are as follows:

- The adjudication of “good” and “poor” has varied over time for each district and therefore the evaluation team felt that approaching a district based only on its last performance score would not do justice to understanding the variations over time.
- Categorizing the districts pre-emptively could have resulted in unfairly prejudicing the evaluation. An unbiased opportunity to explore the variations in performance as well as the factors affecting performance was important particularly in light of the CLA report.

A 30% sample size from each of the SDS regional clusters, covering both new and old districts within each of the subcategories articulated in the main body of the report was deemed appropriate for capturing diversity as well as nuances amongst the various interventions with opportunity for triangulation and validation. A smaller percentage would not have permitted capture of the various permutations of the districts (e.g.: 3 different regions, old vs new, mission focus vs non, DBTA/STAR vs non, recipient of Grant C, HRH, WASH, EDU etc.). A larger sample size would have limited in-depth study in each of the sampled districts given the time and budget allocated to the evaluation.

Districts in each of the sub-categories were chosen using simple random sampling. Names of each of the districts were written on a separate piece of paper and put in a bowl for blind selection (lottery method). This resulted in selection of twelve districts: 9 from the SDS and DBTA/STAR supported districts, 1 from the Mission Focus only districts, and 2 from the Non Mission Focus and non DBTA/STAR Districts.

SUB-COUNTY SELECTION

Within each district 2 sub counties were purposively sampled. The main requirement was that between the 2 chosen sub-counties, there existed one with a district hospital or Health Center 4 (HCIV) and one with a Health Center 3 (HCIII). The ultimate choice was based on a combination of district leadership suggestions, accessibility due to weather and road conditions, distance and availability of the health-in-charges at the health facilities of interest.

DATA SOURCES

Documents, Key informants and group interviews, and direct observations were the primary sources of data for the evaluation.

DOCUMENTS

Key national, district and programmatic documents provided an objective measure for some of the mechanisms employed for strengthening service delivery and governance as well as nuanced understandings of the contexts in which the program was operating. A full list of documents consulted can be found in Annex IV.

KEY INFORMANTS AND GROUP INTERVIEWS

In order to understand the varied experiences of a multitude of stakeholders, key informants were classified into nine categories as shown in the box below:

Box 5: Nine Categories of Respondents for Key Informant Interviews

- 1) USAID: In depth understanding of the conceptualization, financing and administration of the program.
- 2) SDS: In depth understanding of SDS program implementation, support and supervision. Perspectives of the staff involved.
- 3) National level partners: In depth understanding of the governance structures, policy direction, partner collaboration, other decentralization efforts, complementary programming etc
- 4) District level partners: Perspectives and experiences with the operational and management practices related to SDS as well as the results and outcomes at the district and sub-county level.
- 5) Development partners: DANIDA: key partner in the LOGIC training. DFID: operate health governance activity in Northern Uganda.
- 6) USAID implementing partners: Perspectives and experiences of engagement with SDS.
- 7) HCIII and HCIV/Hospital in charges: Experiences with the SDS program, perspectives on changes at the health service level as a result
- 8) Community beneficiaries: Experiences with the SDS program, perspectives on changes in service delivery, governance and civic engagement from an alternate perspective
- 9) Civil society: Perspectives of the NGOs and CSOs subcontracted to implement SDS interventions

Key informants were selected with a view to: understand perceptions of key stakeholders that may not arise in a group situation; explore divergent experiences and “outlier” attitudes that may vary between individuals; permit “deep dive” discussions and probe for meaning on select questions; and provide a shortcut to community norms – interviewing key district and community leaders provided overviews of community development, needs, and concerns. Group interviews were sought in instances when collective experiences were deemed necessary to enrich the evaluation, and/or in the event that time restriction required collective meetings; this was particularly important when community input was invited.

The SDS logistics coordinator in concert with the SDS focal person for the evaluation facilitated requests for interviews with national level respondents, with USAID and SDS personnel, with those who were no longer involved with SDS (but critical to the study), with development partners, implementing partners and with the CAOs of each district. A standard letter of invitation including the purpose of the study as well as attachments of necessary documents such as letters from USAID were included. Evaluation team members followed up via email or in-person in order to confirm interview times.

There were potential privacy concerns related to contacting participants by phone or email. For public officials, however this concern was lessened due to publicly available email addresses and phone numbers. Furthermore, email is a fairly unobtrusive way to contact potential participants.

The evaluation team, with assistance from DHOs, identified sub counties with HCIVs and HCIIIs. DHOs mobilized relevant in-charges to meet with the evaluation team. Sub-county DCOs mobilized parish chiefs/community members to coincide with the team's visit.

DIRECT OBSERVATION

Direct observation provides opportunities to check for nonverbal expression of feelings, understand the nuances of relationships, grasp how participants communicate with each other, and check for how much time is spent on various activities²⁴. It also serves as a verification of information described in interviews, thereby alerting to evaluators to distortions or inaccuracies in description provided by those informants²⁵. Visits to HCIIIs and HCIVs allowed for observation of staffing, use of innovations, state of facilities, functioning of equipment and processes for data collection/monitoring, amongst others.

DATA COLLECTION

The Evaluation Team divided into three teams of two persons each in order to cover all 14 districts in the time allocated. Three days, on average, were spent in each district. The timetable of district visits as well as illustrative schedule of interviews can be found in Annex IV.

DOCUMENT REVIEW

SDS and USAID provided key documentation including project design, planning and management, evaluations to date, and available reports (including those of complementary/parallel programs (DBTA, STRIDES etc.)). Pertinent country documents included USAID/Uganda's Country Development Coordination Strategy (CDCS) 2011-2015, national policies, MoLG Annual District Performance reports, Health league tables, Local Government score cards, meeting minutes, protocols/guidelines and other documents identified by the evaluation team, respondents, and/or USAID/SDS. A full list can be found in Annex IV.

In the process of interviewing national and district respondents the evaluation team collected documentation that was deemed relevant to supporting the evaluation. Such documents included District Budgets, reports, supervision books, etc. Photographs of public displays of data (local revenue generation/spending, districts budgets, advertisements for health worker positions etc.) were taken for posterity purposes. In instances where necessary documents were not readily available, team members followed up via phone or email with relevant respondents.

KEY INFORMANT INTERVIEWS (KIIS) AND GROUP INTERVIEWS

In order to elicit emic responses to the evaluation questions, five semi structured interview guides were created - one each for USAID and SDS program key informants, National level key informants, district (and sub-county) level key informants, HCIII and HCIV/Hospital in charges, and PDC/community group meetings (see Annex III). KIIs ranged from 45-60mins depending on the interviewee. Except in circumstances requiring the evaluation team to divide further in the district, all instances of KIIs were conducted in tandem. Each interview was audio-recorded with participant consent (see consent details in section on Ethical Considerations below) and extensive notes taken for purposes of posterity. In instances where audio-recordings were

²⁴ Schmuck, Richard (1997). *Practical action research for change*. Arlington Heights, IL: IRI/Skylight Training and Publishing.

²⁵ Marshall, Catherine & Rossman, Gretchen B. (1995). *Designing qualitative research*. Newbury Park, CA: Sage.

refused quotes were not captured verbatim. KIIs were halted when theoretical data saturation was reached or when the pool of informants was exhausted.

DIRECT OBSERVATION

While nonverbal cues were noted alongside interview transcripts, public display of information as a proxy for transparency, were also observed for validation of data in the study. E.g.: postings of district procurement plans, central government release of funds, trends in local revenues etc.... Pictures of these were taken to serve as evidence as well as for reference purposes. Extensive notes on observations at district offices, HCIII and HCIV/Hospitals and community gatherings were taken.

DATA MANAGEMENT

The number of documents available from the various sourced (USAID, SDS, national level strategic partners, implementation partners, districts, sub counties etc.) were excessive in number and impossible to review all in detail. Those reviewed and consulted were noted in a tabular format for ease of reference (see Annex IV). Data gleaned from relevant documents used to support or refute other sources are referenced throughout the report.

All interviews (KII, group) were documented. Transcripts as well as audio-recordings were cross-checked by each sub-team in order to ensure accuracy of data capture. Final versions were uploaded on a private shared drive accessible only to the evaluation team. Each region's two-person team completed a standardized district and a sub-county level summary matrix. The matrix consisted of the 5 evaluation question entry points across each respondent type. It was understood that even though the summaries may not result in similar interpretations across all teams and even within all teams, they would be informative as long as each sub-team of two reached consensus. These were also uploaded on a shared repository for access to all members.

Notable observations were captured throughout the visits in evaluator notebooks and later transferred to computerized notes shareable with the team.

DATA ANALYSIS

Document review

Key documents were analyzed for references to shifts in approaches, coordination efforts, success, challenges and indicators outlined in the Performance Management Plan and the CLA report where pertinent. Relevant program reports, meeting minutes, facility protocol/guidelines etc. were consulted as validation (verification or refutation) of perceptions that exist amongst respondents with respect to the key evaluation questions. Secondary data from several sources (USAID/SDS, national government, districts) were consulted in order to measure quantitative changes in parameters of interest. These are captured in graphs and charts throughout the report.

Key informant interviews (KIIs)

Each interviewer documented critical reflections on his/her respective interviews. Team debriefs occurred twice a week to share and concerns, deviations to tools, and other issues pertinent to the analysis to assist with preliminary as well as final analysis. Inductive thematic analysis of

interview notes/transcripts permitted elicitation of major themes and emerging issues. A summary matrix of key findings for each evaluation question per respondent was created for every district. These matrices were perused to further elicit common themes, supportive and divergent views, contradictory information, and context-specific factors that contributed to understanding these variations. Quotes used for supportive purposes in the report are anonymized as per protocol on ethical considerations outlined below.

Direct Observation

Reflections from observations were shared amongst team members and validated. Observations were perused to complement as well as triangulate information from other data sources.

ETHICAL CONSIDERATIONS

CONSENT

The member(s) of the study team sought oral consent from each respondent prior to administering the interview. Participants were given the option of reading the informed consent document for themselves, or having it read out loud by the interviewer. In the case of group interviews with the community, a community member was invited to read and translate the oral consent script for the whole group.

The oral consent script outlined the purpose, format, request for audio-recording, risks and benefits of the study. Interviewers invited participants to ask any questions or clarifications prior to commencing the interviews. Oral consent (and data collection) was sought in the privacy of the participant's office or other venue as deemed appropriate by the participant and study team member. In the case of group interviews with the PDCs/community, all members within the group were requested to provide individual consent by raising their hands.

Participants had the option to refrain from answering any question they were uncomfortable with. Participation was voluntary and participants were reminded that they were free to discontinue the interview at any point.

REPORTING

Personal identifiers, such as name and contact information, were collected for the purpose of contacting participants to schedule interviews and are linked to any data reported. Job titles such as Health unit manager, CAO, or Minister of Health have been simplified into generic format such as Health Unit leadership, district leadership or Government official for reporting purposes in instances when respondents are being quoted. This is so as to retain context but eliminate potential for direct identification.

LIMITATIONS

Time and resource constraints limited inclusion of non-SDS districts to two. This introduced some restrictions in the ability to compare SDS interventions and their effects to districts where there were no such interventions. We have tried to overcome this limitation by taking into consideration the findings of the CLA report, which covers all districts. However, not all the results in the CLA report were relevant to this particular evaluation.

Evaluating the impact and relevance of the SDS model as it was applied across the various districts presented analytical challenges due to the variations in the implementation as well as the varied contexts in which SDS was operating. SDS interventions were largely complementary thereby making definitive statements on SDS attribution to change difficult for some (but not all) aspects. Furthermore, the various modifications in the program as well as the varied distribution of these modifications across SDS districts, rendered attribution of change directly to SDS inappropriate. We have however attempted to take into consideration these variations and the context surrounding them to better understand how and why particular change occurred for the purposes of learning.

With elections slated for early 2016, campaigning was vibrant in many districts during the time of this evaluation. This affected availability of some respondents, particularly members of the DEC and may have contributed to response bias.

Access to key leadership at the national level was not always possible. Follow up requests were made before reaching out to other members of the relevant institutions. Given that majority of our data emanates from KIIs, we are cognizant of social desirability and recall biases inherent to the process. We have tried to minimize these through constructive probing and triangulation of source respondents.

Variations in perceptions from key informants, while telling with respect to the variations in experience with SDS often made it difficult to distinguish perception from reality. Efforts to untangle these using objectively verifiable data was not always possible due to the lack of quantitative data in several aspects relevant to the evaluation, particular with respect to service delivery. The fact that our primary data is qualitative means that there are no tests of significance on the results and any generalizations are made with caution.

The roads in certain sub-counties were compromised due to the heavy rains in Uganda at the time of the evaluation, oftentimes dictating the choice of sub-county.

DISSEMINATION

ORAL PRESENTATIONS ON PRELIMINARY FINDINGS

Preliminary findings were presented to a small group of USAID technical team and program managers on 17 December 2015 immediately after the evaluation team's return from the field. The short timeframe resulted in inadequate opportunity for the team to consolidate its thinking and engage in any conclusive analysis of findings. Upon the USAID Team's request, a second presentation to a wider group of USAID/Uganda Mission Staff was held on 13 January 2016. Preliminary findings were presented and participants were provided the opportunity to clarify, validate and identify remaining information gaps for the team to address in the evaluation report.

Stakeholders jointly identified by USAID, SDS and the Evaluation team, were invited to a debrief on the evaluation findings on 11 February 2016.

FIRST DRAFT EVALUATION REPORT

Responding to information gaps identified in early December's discussions and the January presentation to USAID, the 1st Draft Evaluation Report was submitted on 27 January 2016.

FINAL DRAFT EVALUATION REPORT

The evaluation team, incorporating comments from USAID and other stakeholders submitted this final report to GH Pro on 2 March 2016.

ANNEX III. PERSONS INTERVIEWED

Name	Organization	Title	Contact (phone or email)	Type
KAMPALA / NATIONAL LEVEL				
Charles Magala	DANIDA	Senior Programme Advisor-Governance	chamag@um.dk	GI
Majbrit Holm Jakobsen	DANIDA	Counsellor	majjak@um.dk	
Joyce Ngaiza	DFID	Governance Advisor	J-Ngaiza@dfid.gov.uk	KII
Ella Hoxha	Cardno Emerging Markets	Director - Governance	Ella.hoxha@cardno.com	KII
Juliana Pigey	Former SDS sub-contractor	Urban Institute	Jpigey@aol.com	KII
Peter Epstein	Former SDS subcontractor	Urban Institute	pbepstein@gmail.com	KII
Michele Cato	Cardno Emerging Markets	Director - Health	michele.cato@cardno.com	GI
Richard Dangay	Cardno Emerging Markets	Managing Director	richard.dangay@cardno.com	
Denis Okwar	SDS	Chief of Party	denis.okwar@uganda-sds.org	
Swizin Mugyema	Ministry of Local Gov't	Assistant Commissioner	smugyema@hotmail.com	KII
Lydia Wasula	OVC Implementation Unit	Head	lydia.wasula@gmail.com	KII
James Mugisha	Ministry of Health	Senior Economist	mugishajab@yahoo.co.uk	KII
Othieno Odoi	NPA		oothieno@npa.ug	KII
Pinchwa Joseph	Office of Inspector General of Gov't	Planner	pinycwa@gmail.com	KII
Brenda Shenute Namugumya	fhi360 -FANTA	Nutrition Specialist	Bnamugumya@fhi360.org	KII
Gad Tukamushaba	fhi360-FANTA	Technical Officer	-	GI
Hanifa Bachou	fhi360 - FANTA	Chief of Party	Hbachou@fhi360.org	

Name	Organization	Title	Contact (phone or email)	Type
Tom Kyakwise	GAPP	KII	tkyakwise@uganda-gapp.rti.org	KII
Jannet Opio Apalamit	ACLAIM	Managing Director	opiojanet@gmail.com	KII
Doreen Alaro		DOP Consultant	paldo22@yahoo.co.uk	KII
James Kakooza		Former SDS M&E Advisor		KII
Martin Kaleeba	STAR-EC	Director Program Operations	mkaleeba@starecuganda.org	KII
Jacqueline Kwesiga	IDI	SDS Team Lead	jkwesiga@idi.co.ug	GI
Catherine Odooi	IDI	Deputy Team Lead / Grants Specialist	codoi@idid.co.ug	
Gilbert Matabi	QED	M&E specialist Democracy & Governance	gmatabi@qedgroupllc.com	KII
Francis Abwaimo	SDS	Deputy Chief of Party-Programs	Francis.abwaimo@uganda-sds.org	GI
Robert Kalemba	SDS	Senior Director for Sustainability	Robert.kalemba@uganda-sds.org	GI
Madina Nakibirige	SDS	Grants Director	Madina.nakibirige@uganda-sds.org	GI
Henry Kamau Kuria	SDS	Senior Grants Advisor	henry.kuria@uganada-sds.org	GI
Godfrey Wabwire	SDS	Senior Program Manager	Godfrey.wabwire@uganda-sds.org	GI
	Finance			KII
	Ministry of Health			KII
	MEEP-PEPFAR			KII
	National Planning Committee			KII
MUKONO DISTRICT				
Dr. Elly K Tumushabe	Mukono District	District Health Officer	elly_tumushabe@yahoo.com	KII
Musa Kiggundu	Mukono District	District Vice Chairperson	kiggundumusa@33-com.ug	KII
Vicent Baraza	Mukono District	District Education Officer	vicentbaraza2015@gmail.com	GI
Jonathan Mukose	Mukono District	Deputy Chief Administrative Officer	caomukono@yahoo.com	
Christine Ampaire	Mukono District	Deputy Chief Administrative Officer	xampaire@yahoo.co.uk	
William Jjumba	Mukono Kayunga HC	Senior Clinical Officer	williamsjjumba@yahoo.com	

Name	Organization	Title	Contact (phone or email)	Type
Martin Balyejjusa	Mukono Kojja HC III	Senior Health Inspector	martinbalyejjusa@yahoo.com	
Esterics Kyegombe	Nama Subcounty	Community Development Officer	782676365	GI
Sarah Namakula	Nama Subcounty	Senior Assistant Secretary	774056290	
Priscilla Nakato	Ntenjeru subcounty	Community Development Officer	782329139	
Abbey Senyanja	Bakyala Kwagalana Farmers Group Ntenjeru	Group Leader	751930415	
Lawrence Matovu	Village Health Team-Ntenjeru subcounty	VHT Parish Supervisor	752717744	
Dianah Nalongo Serwadda	Kojja Health Centre IV	Counsellor	783072074	
Edward Mutimba Mwebe	OMINMED Group	VHT focal person	edward.mutimba@gmail.com	
Patrick Kabuus	OMINMED Group	Vice Chairperson	777876533	
Julius Kaziba	Agalya wamu Group	Chairperson	752359871	
Paul Walyambaka	APPCAN	Child Protector	754063498	
Gonzaga Kawuma	Ntenjeru Subcounty	Parish Chief	772932373	
Edward Kyawula	Kabira Youth Development & Social Care Program	Director	704109751	
Barbra Nantongo	Vanilla F	Treasurer	757432879	
Joyce Dralega	Kyosimba Onanya	Secretary	756721664	
Clement Mutabaaro	Kisowera	Parasocial worker	774644182	
Imelda Nnambuusi	Kibooba Village, Nama Subcounty	Village Health Team member	774888545	
Geofrey Lutabi	Bulika Parish, Nama Subcounty	Parasocial worker	782010679	
Margaret Nampweo	Namawojjolo village Nama subcounty	Parasocial worker	772188579	

Name	Organization	Title	Contact (phone or email)	Type
Alex Kisaata	Namubiru Parish, Nama Subcounty	Community Member	788679865	
Twaha Kasasa	Mabya Local Council	Community Member	755971368	
Herbert Ssentongo	Bulika Parish Wakiso Local Council	Community Member	752202094	
John Nsubuga	Lukujjo Parsih Mpoma Parish	Parasocial worker	704376161	
Abdallah Kagizi	Kasenge Village Nama subcounty	Village Health Team Member	752636351	
David Pierson Muyunga	PDC	Chairperson	712945568	
KAMULI DISTRICT				
BEN OTIM OGWETTE	Kamuli District Local Gov't	CAO	ogwette.otim@gmail.com	KII
Dinah Nakyanda	Kamuli District Local Gov't	DHO	dinabusiku@hotmail.com	KII
Paul Tenywa	Kamuli District Local Gov't	Senior Clinical Officer	tenywapaul@rocketmail.com	KII
Robert Banafamu	Kamuli District Local Gov't	Planner	banafamurobert@yahoo.com	KII
Joshua Mboizi	Kamuli District Local Gov't	SPMO	mboizij@yahoo.com	KII
Juma Ngobi Ali	Kamuli District Local Gov't	Head of Finance	ngobiajuma@gmail.com	KII
Leo Mmerewoma	Kamuli District Local Gov't	Community Development Officer	mmere2@yahoo.com	KII
Joseph Musoke	Kamuli District Local Gov't	Senior Education Officer	musokeez@yahoo.com	KII
Peter Olweny	Namwendwa Subcounty	Senior Assistant Secretary	712306721	KII
Moses Mitala	Kamuli District Local Gov't	Community Development Officer	mitalamoses@yahoo.com	KII

Name	Organization	Title	Contact (phone or email)	Type
Fred Duku	Namwenda HC IV	Medical Officer	fdduku@gmail.com	KII
Susan Namukose	Butansi Subcounty	Community Development Officer	susannamukose@gmail.com	
Nakyomu Lucy Harriet	Butansi HC III	Community Development Officer	harrietjack2008@yahoo.com	
Ngobi Moses	Naibowa Parish Butanzi Subcounty	PDC Member	775834318	GI
Steven Mubiru	Naluwoli Parish, Butanzi subcounty	CPC/LAV	781472670	
George Mwiseke	Butansi Parish	PDC Member	755545442	
Grace Waiswa	Naluwoli, Butansi subcounty	PDC Member	782977457	
Esereda Kawuna	Butansi Parish	Child Protection Committee Member/VHT	788092772	
Rose Alisek	Butansi Parish	Child Protection Committee Member/VHT	780172967	
Jane Kirimala	Butansi Parish	Child Protection Committee Member/VHT	771616907	
Harriet Katono	Butansi Parish	Child Protection Committee Member/VHT	786662030	
Nubu Tibhadamwa	Butansi Parish	Vice chairperson PDA	777089159	
Richard Waiswa	Bugeywa PDC	Secretary	754661207	
Joseph Balyejusa	Butansi S/C	Senior Assistant Secretary	753124314	
Nathan Kitimbo	Bugeywa PDC	Chairman-PDC	753544281	
Creg Balongo	Nalwoli PDA	Chairperson	772659316	
Robert Lubandi	Naibowa Parish Butanzi Subcounty	Vice chairperson PDA	754240295	
Richard Batwala	Namwendwa Subcounty	Finance -Parish Development Community	774541105	
Rebecca Mukyala	Namwendwa Subcounty	PDC Member	751809117	

Name	Organization	Title	Contact (phone or email)	Type
Alex Luwale	Namwendwa Subcounty	Chairperson Ndwa	789946883	
Damali Kitamirike	Namwendwa Subcounty	Member PDC	778119526	
Najib Kitimbo	Namwendwa Subcounty	Member PDC	773203527	
Mubarak Tigatoola	Namwendwa Subcounty	Agricultural Officer	782764783	
Fred Kunduba	Namwendwa Subcounty	Member PDC	752813122	
Wilson Muwoya	Namwendwa Subcounty	Member PDC	779985469	
Babra Mirembe	Namwendwa Subcounty	Member PDC	774225302	
Siida Byobona	Namwendwa Subcounty	Member PDC	786077093	
James Mwase		Vice chairperson PDC	788984071	
KAYUNGA DISTRICT				
Matovu Ahmed	Kayunga District Local Gov't	District Health Officer	ahmedmatovu@yahoo.com	KII
James Luzige	Kayunga District Local Gov't	Clinical Officer	jamluzige@yahoo.com	KII
Steven Dagadu	Kayunga District Local Gov't	DCO	776945027	KII
Henry Lubwama Ssebagala	Kayunga District Local Gov't	Assistant CAO	392902440	KII
Jimmy Ddungu	Kayunga District Local Gov't	Biostatistician	ddungujimmy@yahoo.com	KII
Fatuma Naava	Kayunga District Local Gov't	Ag District Planner	fnaava@gmail.com	KII
Daris Kaggwa	Kayunga District Local Gov't	Clerk to Counsel	772440498	KII

Name	Organization	Title	Contact (phone or email)	Type
Emmanuel Mukwadhanga	Kangulumira HC IV	Senior Clinical Officer	779430243	KII
Kulabako Faridah Sebunya	Kangulumira Subcounty	Subcounty chief	fsebunya@yahoo.com	KII
Florence Nakayenga	Nazigo subcounty	Senior Assistant Secretary	florencenakayenga@gmail.com	KII
Mariam Nansubuga	Nazigo subcounty	Community Development Officer	773280438	KII
Roseline Agutu	Kangulumira Subcounty	Community Development Officer	772040616	KII
KALIRO DISTRICT				
Kharuna Kamba	Kaliro District Local Gov't	Chief Administrative Officer	kambakharuna@yahoo.com	KII
Kasewa Sarah	Kaliro District Local Gov't	District Health Officer	kasewasarah@yahoo.com	
Lawrence Tidhomu	Kaliro District Local Gov't	District Health Educator	lawrencetidhomu@yahoo.com	
Wyclif Ibanda	Kaliro District Local Gov't	Local Councilor V	ibandawyclif@gmail.com	
Moses Mukuba	Kaliro District Local Gov't	SDS project Accountant	mukubamoses@gmail.com	
Tom Wankya	Kaliro District Local Gov't	District Planner	wankyatom@gmail.com	
Harriet Alibwa	Kaliro District Local Gov't	District Community Development Officer	atiibwaharriet@yahoo.com	
Ronald Balyejjusa	Bumanya Subcounty	Asst. Community Development Officer	754647872	
Simon Peter Gabula	Bumanya S/C	Senior Assistant Secretary	gabspeter@gmail.com	
Robinah Kasango	Bumanya HCIV	Senior Anesthetic Officer/Midwife	kasangorobina@gmail.com	
Joshua Wambuza	Gadumire subcounty	Community Development Officer	782731125	GI
Christoper Lyadda	Gadumire subcounty	Community Member	779562497	
EGM Ngobi	Gadumire subcounty	Development Answers Committee	774544573	
Fred Guma	Gadumire subcounty	Community Member	775131645	

Name	Organization	Title	Contact (phone or email)	Type
Edward Gamole	Gadumire subcounty	Community Member	773584186	
Milton Kansi	Gadumire subcounty	Direct Infant Orphans Care Centre P/S	775609812	
Eseza Nakikwenza	Gadumire subcounty	Gadumire Development Community	780952163	
Stephen Kabwire	Gadumire subcounty	Community Member	784196771	
James Mulelewo	Gadumire subcounty	Community Member	773732865	
Suly Mukunya	Gadumire subcounty	Community Member	781537225	
Kevin Gonza	Gadumire subcounty	Community Member	7885596913	
Sara Namuganza	Gadumire subcounty	Community Member	779488708	
Susan Kafuko	Gadumire subcounty	Parasocial worker	774369188	
Rebecca Kitibwakye	Gadumire subcounty	Parasocial worker	787436668	
Moses Isooba	Gadumire subcounty	Community PRW	787663901	
Henry Nakolantya	Gadumire subcounty	Parish Chief	777025128	
Eriya Musasizi	Gadumire subcounty	Community Development Officer	783268842	
Grace Tulilinya	Gadumire subcounty	Community Member	779267655	
Moses Tsubira	Gadumire subcounty	Community Member	788514031	
David Isooba	Gadumire subcounty	OVC Member	783951475	
Justine Namusubo	Gadumire subcounty	Mentor Mother	788618384	
Anne Kawala	Gadumire subcounty	Community Member		
Davson Musiba	Gadumire subcounty	Parish Chief	753561676	
Bannuli Nairrima	Gadumire subcounty	Community Member	787132713	
Ronald Balyejjusa	Gadumire subcounty	Community Development Officer	704647872	
MBALE DISTRICT				
John Waniaye	Mbale District Local Gov't	District Health Officer	772503598	KII
Bernhad Maumbe	Busui HC IV	Medical Officer	772851265	KII

Name	Organization	Title	Contact (phone or email)	Type
Ronald Tusiime	MSH/Star-E	Senior Technical District Health Advisor	rtusiime@msh.org	KII
Noel Lukoda	MSH/Star-E	Director Technical Programs	nlukoda@msh.org	KII
Agatha Wegosasa	Busoba	Senior Assistant Secretary	wegotha77@yahoo.com	KII
Betty Nabuuma	Busoba	Community Development Officer	bethtinl@yahoo.com	KII
Margaret Duca	Mbale District Local Gov't	Population Officer	ducamargaret@gmail.com	KII
Meresi Mutonyi	Mbale District Local Gov't	Senior Probation and Welfare Officer	mekakayi@yahoo.com	KII
Constance-Lydia Musungu	Mbale District Local Gov't	District Inspector of Schools	lydiamusungu@yahoo.com	KII
Rose Wakituma	Bunambutye village Busoba subcounty	VHT (Village Health Team)	779464272	GI
Goretti Wamono	Butunde, Busoba subcounty	VHT	784900048	
Doreen Wananda	Bumasikye Mako, Busiba subcounty	VHT	774432059	
Harriet Mutuwa	Bunanimi Busoba subcounty	VHT	771314961	
Ronald Wangwe	Bunambutye village Busoba subcounty	VHT	783806237	
Norah Khabakha	Bunambutye village Busoba subcounty	VHT		
Ambrose Waniaye	Butunde, Busoba subcounty	VHT		
NAMUTUMBA DISTRICT				
Henry Naabye	Namutumba District Local Gov't	District Planner	naabyehenry@gmail.com	KII
Esther Nardase	Namutumba District Local Gov't	Senior Probation Officer	nandaseesther@gmail.com	KII
Charles Mwesigwa	Namutumba District Local Gov't	Senior Nursing Officer	mwesigwacharles4@gmail.com	KII

Name	Organization	Title	Contact (phone or email)	Type
Dina Sande	Nsinze subcounty	Parish Chief	787231972	GI
Tom Isabirye	Nsinze subcounty	VHT	777302534	
Stephen Mwanja	Nsinze subcounty	VHT	788885702	
David Kurya	Nsinze subcounty	VHT	782044999	
Fauza Mulawo	Nsinze subcounty	VHT	779736644	
BUDAKA DISTRICT				
Roseline Adongo	Budaka District Local Gov't	Chief Administrative Officer	772370348	KII
Francis Munghono	Budaka District Local Gov't	Secretary for Education Promotion	774365696	KII
Rachel Nsubira	Budaka District Local Gov't	Secretary for Health	773175870	KII
Okia Oletum	Budaka District Local Gov't	Inspector of Schools	782222946	KII
John Kasolo	Budaka District Local Gov't	Tuberculosis Focal Person/Program Officer	782759367	KII
Fatuma Katooko	Kakule subcounty	Community Development Officer	fkatoko@gmail.com	KII
Paul Koire	Budaka District Local Gov't	Senior Labour Officer	koirepaul@gmail.com	KII
Joseph Ndoboli	Budaka District Local Gov't	Accountant	777601732	KII
Joseph Ayiasiga	Budaka District Local Gov't	Medical Laboratory Technologist		KII
Nasuru Masaba	Budaka HC IV	Senior Clinical Officer		KII
Stephen Wajobi	Budaka HC IV	Clinical Officer		KII
Musenero Kalebo	Iki Iki subcounty	Enrolled Midwife		KII
Speciaoza Naigina	Iki Iki subcounty	Community Development Officer		KII
BUSIA DISTRICT				
Steven Wanyama Oundo	Busia District Local Gov't	District Chairman	704914749	KII

Name	Organization	Title	Contact (phone or email)	Type
Phionah Sanyu	Busia District Local Gov't	Chief Administrative Officer	phionahsanyu@yahoo.co.uk	KII
Ernest Wafula	Busia District Local Gov't	District Community Development Officer	702500776	KII
Patric Wakooli	Busia District Local Gov't	Chief Finance Officer	772395364	KII
Julius Ocallo	Busia District Local Gov't	Senior Probation and Welfare Officer	772453520	KII
Dr Oumo	Busia District Local Gov't	Senior Medical Officer		KII
Reverend Barnabas Muniala	Busia District Local Gov't	District Education Officer		KII
Olivia Tebaise	Busia District Local Gov't	Secretary- Works		KII
Harriet Namakwa	Busia District Local Gov't	Vice Chairperson		KII
Francis Masinde	Busia District Local Gov't	Busia District Local Gov't	700692265	KII
Lam Mayende	Busia District Local Gov't	District Educator	701928297	KII
Godfrey Mukiide	Busia District Local Gov't	Environment Health Assistant	772325703	KII
John-Mike Ebu	Busia District Local Gov't	Subcounty Chief	777774736	KII
Annette Atim	Busia District Local Gov't	Nursing Officer	772510935	KII
Patrick Wabwire	Busia District Local Gov't	Planner		KII
Hellen Nabwire	Lumino Subcounty	Village Health Team Member	783365923	GI
Grace Sitanga	Lumino Subcounty	Village Health Team Member	771455013	
Margaret Ouma	Lumino Subcounty	Village Health Team Member	773085535	
Grace Nyota	Lumino Subcounty	Village Health Team Member	787772494	

Name	Organization	Title	Contact (phone or email)	Type
Harriet Mugenyi	Lumino Subcounty	Village Health Team Member	784398788	
NAMUTUMBA DISTRICT				
Hissa Bumali Kiwajja	Nsinze subcounty	Community Development Officer	779215192	KII
Hassan Higenyi	Nsinze subcounty	Senior Assistant Secretary	772191350	KII
Geofrey Isiko	Magada subcounty	Subcounty chief	782887276	KII
Isabirye Mugulwa	Magada subcounty	Village Health Team Member	781814060	GI
Nathan Wakabi	Magada subcounty	Parish Chief	787041863	
Fatuma Mulesa	Magada subcounty	Parasocial worker	785324937	
Imaamu Navuuka	Magada subcounty	Parasocial worker	774566999	
Moses Gamali	Magada subcounty	Village Health Team Member	775752950	
James Mugulwa	Magada subcounty	Parasocial worker	754257857	
TORORO DISTRICT (NON SDS)				
Lilian Adiru Ogeno	Tororo District Local Gov't	ECN	700690981	KII
Meshack Okware Dan	Tororo District Local Gov't	Senior Assistant Secretary	701676033	KII
William Mulyaba	Tororo District Local Gov't	District Planner	702829061	KII
David Okumu	Tororo District Local Gov't	District Education Officer	772457360	KII
Oswan V.K.	Tororo District Local Gov't	Chief administrative officer	772546955	KII
Emanuel Osuna	Tororo District Local Gov't	Chairperson-Local Council level 5	772452421	KII
Jox Omor	Tororo District Local Gov't	Secretary-Works	782661607	KII
John Odoi	Tororo District Local Gov't	Secretary Health & Education	782306597	KII
Rose Dinah Atim	Kisenyi HC III	Nursing Officer	782470956	KII

Name	Organization	Title	Contact (phone or email)	Type
KANUNGU DISTRICT LOCAL Gov't				
Atuhaire Innocent	Kanungu District Local Gov't	District Planner		KII
Dr Steven Sebudde	Kanungu District Local Gov't	District Health Officer		KII
Benon Kansiime	Kanungu District Local Gov't	DHI		KII
Nyirazirikana Charlotte	Kanungu District Local Gov't	Education Officer	772878312	KII
Ezra Ndizeye	Kanungu District Local Gov't	Senior Probation officer		KII
Hope	Kanungu District Local Gov't	District HR Officer		KII
Canon Bizimana Irene		Headmistress Kishuro		KII
Ahimbisibwe Hope	Kateete Parish	Headmistress Mpangango		KII
Nsima Mukama Simon	Kateete Parish	Senior Assistant Secretary		KII
Katungi Godfrey	Kateete Parish	Health Asst Kateete	787732234	KII
Bigambwamukama Geoffrey	Kateete Parish	PDC member		GI
Rev Nuwamanya Peace	Kateete Parish	PDC member		
Canon Twinamatsiko Charles	Kateete Parish	PDC member	771825529	
Ahimbisibwe hope	Kateete Parish	PDC member	782352660	
Tweheyo Charles	Kateete Parish	VHT	772409500	
Simon Ninsiima	Kateete HC III	Lab Asst/TB focal person	782809560	KII
Public transport cyclist	Kateete Parish	Cyclist - Samples transportation		KII
Vicent Ndagijimana	Bukorwe Primary School	Assistant Head teacher		KII

Name	Organization	Title	Contact (phone or email)	Type
Mugisha Abraham and Boona Christine	Bukorwe Primary School	Senior Man Teacher		KII
Boona Christine	Bukorwe Primary School	Senior Woman Teacher		KII
Tusingwire Linus	Kazinga Primary School	Head teacher		KII
China	Kazinga	Senior Woman Teacher		KII
Naftali Moses	Kazinga Helath Centre II	Enrolled Nurse		KII
Mpeirwe Gift	Kazinga Health Centre II	Laboratory Assistant		KII
Muremye Benson	Nyanga Subcounty	Community Development Officer		KII
NTUNGAMO DISTRICT LOCAL Gov't				
Nuwamanya Bannex	Ntungamo District Local Gov't	Chief Finance Officer		KII
Byamukama Topher	Ntungamo District Local Gov't	Assistant District Health Officer & SDS-Health Focal person		KII
Kabeije Jenniffer	Ntungamo District Local Gov't	Sec for social services		KII
Mugume	District	District Probation officer		KII
Atukwase Cranious	Subcounty	Community Development Officer		KII
Ayebazibwe Keneth	Subcounty	Rubaare HCIV in charge		KII
Turyatunga Amos	Subcounty	HCIII health Inspector Ruhaama		KII
Amanya Joshua	Subcounty	Clinical Officer Kagamba HC III PNFP		KII
Community Members	Rubare Subcounty	Rubaare village		KII
Ritah Kayinza	Subcounty	CDO Rubaare		KII
KIRUHURA DISTRICT LOCAL Gov't				
Benon Muganzi	Kiruhura District Local Gov't	District Information Officer/focal person		KII
Dr Kamy	Kiruhura District Local Gov't	District Health Officer		KII

Name	Organization	Title	Contact (phone or email)	Type
Oliver Busingye	Kiruhura District Local Gov't	Senior Nursing Officer		KII
Fred Kakuru	Kiruhura District Local Gov't	District HR Officer		KII
Twinomujuni Alex	HCIV	In charge HCIV Kiruhura HC IV		KII
Health Centre Staff	HCIV	Lab focal person/acting in charge		KII
Namanya Bright	Kanyaryeeru Subcounty	CDO Kanyaryeru		KII
Henry Muhangi	Town Council	SCDO Kiruhura Town council		KII
Muhoozi Benon/ Dorothy Nakafeero	Nyakasharara HCIII	Health information Asst and Midwife		KII
SEMBABULE DISTRICT LOCAL Gov't				
Seruyange Ramathan	Sembabule District Local Gov't	District Planner		KII
Dr Kasibante	Ntusi subcounty	Ntusi HC IV		KII
Bashir Ntambazi	Mateete Sub county	Community Development Officer		KII
Twaha Musoke	Sembabule District Local Gov't	Probation officer		KII
Francis Ssengaali	Mateete HC III	HC III In charge		KII
Joanita Nakityo	Sembabule District Local Gov't	Former Acting Chief Administrative Officer		KII
Edward	Mbarara District	STAR SW		KII
Levi Musinguzi		Chief Administration Officer		KII
Rauben Arinaitwe		PAS		KII
Tumuhimbise Oliver		District Probation Officer		KII
Turyamureeba Vincent		Labour Officer		KII
KAMWENGE DISTRICT LOCAL Gov't				
Health Centre IV staff	Rukonyu HC IV	Head of records/In charge and Nursing Assistant		KII

Name	Organization	Title	Contact (phone or email)	Type
Okumbuke Shaban	Sembabule District Local Gov't	Community Development Officer		KII
Bazaraki Vicent	Sembabule District Local Gov't	HMIS focal person		KII
Kiza Benyina	Sembabule District Local Gov't	District Planner		KII
Moses Bashaija	Kahungye subcounty	Community Development Officer	775317512	KII
Kemirember Consolata	Mpanga Parish	Secretary for Finance local council II	775317512	KII
Kayira Bameka	Mpanga Parish	Chairperson local council level I	773265893	KII
Byamukama Parkus		Senior Assistant Secretary	776819541	KII
Rev Judith Mbabazi	Mpanga III	Secretary for Women	777836626	KII
Amos Turinawe	Mpanga III	Secretary for Youth	773653541	KII
Centenary Specioza	Kanaara Parish	Community Development Officer		KII
Emily Siima	Ntaara HC IV	Enrolled Nurse		KII

ANNEX IV. SOURCES OF INFORMATION

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32. District Health Supervisory Authority (DHSA) Technical Assistance Synthesis Report
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SCHEDULE OF INTERVIEWS AND SITE VISITS

Table 16: Schedule of SDS Interviews and Site Visits

Region	District	Date
Central	Kaliro	23/11 – 25/11/2015
	Kamuli	26/11 – 28/11/2015
	Kayunga	30/11 – 02/12/2015
	Mukono	03/12 – 05/12/2015
Western	Kanungu	23/11 – 25/11/2015
	Ntugamo	26/11 – 28/11/2015
	MBARARA – STAR S.W	11/12 /2015
	Kamwenge	30/11 – 02/12/2015
	Kiruhura	03/12 – 05/12/2015
	Sembabule	07/12 – 09/12/2015
Eastern	Busia	23/11 – 25/11/2015
	Tororo	26/11 – 27/11/2015
	Mbale	30/11 – 02/12/2015
	MBALE – STAR –E	03/12 – 05/12/2015
	Budaka	07/12/2015
	Namutumba	08/12 – 10/12/2015
	JINJA – STAR-EC	11/12/2015
National	SDS, USAID, IPs	16/12 – 20/12/2015
	SDS, Implementing partners	07/12 – 09/12/2015

ILLUSTRATIVE SCHEDULE OF DISTRICT/SUB-COUNTY MEETINGS, KEY INFORMANTS AND OBSERVATIONS

Table 17: District and Sub-county Meeting Schedule, Key Informants and Observations

DAY	ACTIVITY
One	Courtesy Call on the CAO, interview if possible
	Courtesy Call on the Chair LC 5, interview if possible
	Group Discussion with the Extended DTPC (observation if possible)
	Group Meeting with the Extended DHMT (observation if possible)
	Interview District Community Development Officer
	Interview District Health Officer
	Interview District Planner (often also SDS Focal Person)
	Interview District Chief Financial Officer/Grants manager
	Interview Officer In-Charge of other programs (WASH, EDU, STAR, GAPP etc)
Interview District Education Officer	
Two	Visit to the first sub-county
	Interview Senior Assistant Secretary
	Interview Health Unit In-Charge of the HC 4 or HC 3 (visit facility and observe)
	Interview Sub-county Community Development Officer
	Group discussion with the selected PDC
	Return to district for any remaining interviews
Three	Visit to the second sub-county
	Interview Senior Assistant Secretary
	Interview Health Unit In-Charge of the HC 4 or HC 3 (visit facility and observe)
	Interview Sub-county Community Development Officer
	Group discussion with the selected PDC
	Return to district for any remaining interviews
	<i>Debrief the CAO and depart</i>

ANNEX V. DATA COLLECTION INSTRUMENTS

INTERVIEW GUIDE FOR USAID & SDS PROGRAM LEVEL KEY INFORMANTS

INTRODUCE YOURSELF TO RESPONDENT(S) AND BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF THEY WOULD BE WILLING TO ANSWER SOME QUESTIONS REGARDING THE SDS PROGRAM.

Good Morning/Afternoon. I am [NAME OF EVALUATOR] and I am here on behalf of USAID to undertake an evaluation of the SDS program.

CONFIRM ORAL CONSENT AT THIS POINT

Date: ____/____/____

Name (s) of Key Informant (s):

Organization and position:

PREAMBLE:

- i. What is your role in the SDS program? How long have you been playing this role?

A. CHANGES IN THE LOCAL GOVERNANCE SYSTEMS AS A RESULT OF THE SDS PROGRAMME?

- I.1 What changes have occurred in the following decentralized management functions as a result of the SDS program?

Management Function (Probe only those aspects respondent is familiar with)	Status as of 2010	Current status
Leadership and Management		
Integrated Planning and Budgeting		
Financial Management (accounting, audit, procurement etc.)		
Coordination		
Revenue Generation		
M&E and MIS		
Civic Engagement		

- I.2 What have been the effect of these changes on:

- Goal setting;
- Decision Making;
- Transparency and accountability;

- Responsiveness to local needs; and
- Service delivery?

I.3 Which of these changes do you think the local governments can sustain without SDS support? Why do you say so?

I.4 Which changes do the local governments find most challenging? Why?

B CONTRIBUTION OF THE GRANTS AND GRANTS MANAGEMENT TO THE SUCCESS OF THE PROJECT?

2.1 What is your experience with the SDS grant implementation process?

- RFA released
- Proposal Development Assistance
- DIP
- Grants Management Training
- Grants Award
- Year 1 Performance Validation
- Output to Outcome Performance
- Increase IP integration
- Year 2 Performance Validation

2.2 What are your opinions on the grant evaluation criteria?

- Action points resolved from the DHMT meetings
- Action points resolved as reported in DOVCC meetings
- Key Action points implemented from integrated Health Support Supervision
- Eligible OVC provided with 1 or more Core Program Areas
- Action points resulting from extended DTPC meetings
- Percentage of Non-SDS revenue expended on Social Services sector as a proportion of the budgeted amount

2.3 How did the grant implementation process affect project outcomes?

2.4 To what extent did the grants meet the health care workforce needs of the district?

2.5 How did the grant translate into health care service management and delivery, especially in the areas of:

- Support Supervision
- Health Infrastructure
- HRH
- Health Financing
- M&E (HMIS Tools and Skills)
- Logistics and Supply Chain Management

- Quality Assurance
- MCH Services
- TB/HIV Services
- OVC Services
- Nutrition services

2.6 How did the grant impact on the service management and delivery in other sectors (such as education)?

2.7 What were the unintended results?

C WHAT WAS THE EFFECT OF TRANSITIONING FROM DIRECT IMPLEMENTATION OF DISTRICT LED HEALTH CARE MANAGEMENT ACTIVITIES FROM DBTA PROJECTS TO DISTRICT GRANTS THROUGH SDS?

3.1 What has been the effect of having TA from SDS as well as DBTAs on:

- Governance and systems strengthening
- Service delivery

3.2 How are the two Technical Assistance arms coordinated?

3.3 How do they complement each other?

3.4 What are the challenges of having two TAs?

[ONLY RELEVANT FOR STAR –E and STAR – EC]

3.5 What was the scope of the transition?

3.6 How was the process managed?

3.7 How did the transition to the SDS program impact on the work of the district in terms of:

- performance management?
- human resources?
- service delivery?
- infrastructure development?
- coordination with other partners?

3.8 What challenges (if any) did the transition pose?

- How did you respond to the challenges?

D EFFECT OF THE FLEXIBLE OR ADAPTIVE USE OF SDS BY USAID UGANDA ON THE ACHIEVEMENT OF SDS RESULTS?

4.1 What changes or adaptations have occurred in the program by USAID [NB: for USAID and SDS)

4.2 What are the reasons / rationale for the change?

4.3 There were several modifications to the program... [NB for expanded list of respondents]

- How did they affect the implementation?
- How did they affect program outcomes?

4.4 How did the district / SDS program adapt to the changes?

4.5 What are those factors that enabled or hindered implementation?

4.6 How were the negative factors addressed?

E EXTENT TO WHICH THE SDS MODEL IS STILL RELEVANT GIVEN THE CURRENT OPERATING ENVIRONMENT AND USAID UGANDA PRIORITIES?

5.1 How would you describe the SDS model?

5.2 How is it different from other programs for strengthening decentralized systems?

5.3 What factors (macro environmental) have promoted the effectiveness of the model?

- National policies
- Changes in development partner policies and interests
- Actors, relationships and resulting power dynamics (national and international)
- Performance/Outcome Incentive system
- Political environment in UG etc.

5.4 What factors (macro environmental) have hindered the effectiveness of the model?

- National policies
- Changes in development partner policies and interests
- Actors, relationships and resulting power dynamics (national and international)
- Performance/Outcome Incentive system
- Political environment in UG etc.

5.5 What factors (micro environmental) have promoted the effectiveness of the model?

- District/Organizational leadership
- Performance/Outcome Incentive system
- Changes in district/organizational processes
- Roles of other actors (development partners, CSOs etc)
- Changes in district/organizational legislations (by-laws etc)

5.6 What factors (micro environmental) have hindered the effectiveness of the model?

- District/Organizational leadership

- Performance/Outcome Incentive system
 - Changes in district/organizational processes
 - Roles of other actors (development partners, CSOs etc)
 - Changes in district/organizational legislations (by-laws etc)
- 5.7 What aspects of the model worked well?
- What were the contributing factors?
- 5.8 What aspects of the model didn't work well?
- What were the contributing factors?
- 5.9 What aspects of the model would you recommend to be replicated in future programmes?
- Why?
- 5.10 What aspects of the model would you recommend to be dropped in future programmes?
- Why?

CONCLUSION:

- 6.1 What do you think should have been done differently for the program to have better outcomes?
- 6.2 What other suggestions do you have that would help inform the designing of similar programs that aim at strengthening decentralized service delivery?

Thank you for your time and sharing your views.

INTERVIEW GUIDE FOR NATIONAL LEVEL KEY INFORMANTS (MOLG, MOF, MOH, ULGA)

INTRODUCE YOURSELF TO RESPONDENT(S) AND BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE /SHE WOULD BE WILLING TO ANSWER SOME QUESTIONS REGARDING THE SDS PROGRAM.

Good Morning/Afternoon. I am [NAME OF EVALUATOR] and I am here on behalf of USAID to undertake an evaluation of the SDS program.

CONFIRM ORAL CONSENT AT THIS POINT

Date: ____/____/____

Name (s) of Key Informant (s):

Organization and position:

PREAMBLE :

- ii. Could you kindly provide an overview of the SDS program in this district?"
- iii. What is your role in the SDS program? How long have you been playing this role?
- iv. What SDS program activities has your Ministry/organization engaged in?

A.CHANGES IN THE LOCAL GOVERNANCE SYSTEMS AS A RESULT OF THE SDS PROGRAMME?

- I.5 What changes have occurred in the following decentralized management functions since 2010 (or since you assumed your role),
- I.6 In your opinion, what were the reasons for those changes (if any)?

Management Function (Probe only those respondent is familiar with)	Status as of 2010	Current status	Contributors to change
Leadership and Management			
Integrated Planning and Budgeting			
Financial Management (accounting, audit, procurement etc)			
Coordination			
Revenue Generation			
M&E and MIS			
Civic Engagement			

- 1.7 Which of these changes are a result of SDS?
- 1.8 Which ones do you consider vital/positive? Why?
- 1.9 Which ones do you consider challenging?
- 1.10 What have been the effect of these changes on:
 - Goal setting;
 - Decision Making;
 - Transparency and accountability;
 - Responsiveness to local needs; and
 - Service delivery?
- 1.11 How do you intend to maintain the positive changes?
- 1.12 Who is responsible to ensure that this happens?

B CONTRIBUTION OF THE GRANTS AND GRANTS MANAGEMENT TO THE SUCCESS OF THE PROJECT?

- 2.1 Are you familiar with the SDS Grants Management process and criteria? **(If Yes : Continue; If No: Skip to 2.4)**
- 2.2 What is your experience with the SDS grant implementation process?
 - RFA released
 - Proposal Development Assistance
 - DIP
 - Grants Management Training
 - Grants Award
 - Year 1 Performance Validation
 - Output to Outcome Performance
 - Increase IP integration
 - Year 2 Performance Validation
- 2.3 What are your opinions on the grant evaluation criteria?
 - Action points resolved from the DHMT meetings
 - Action points resolved as reported in DOVCC meetings
 - Key Action points implemented from integrated Health Support Supervision
 - Eligible OVC provided with 1 or more Core Program Areas
 - Action points resulting from extended DTPC meetings
 - Percentage of Non-SDS revenue expended on Social Services sector as a proportion of the budgeted amount
- 2.4 How did the grant implementation process affect project outcomes?
- 2.5 To what extent did the grants meet the health care workforce needs of the district?
- 2.6 How did the grant translate into health care service management and delivery, especially in the areas of:
 - Support Supervision
 - Health Infrastructure

- HRH
- Health Financing
- M&E (HMIS Tools and Skills)
- Logistics and Supply Chain Management
- Quality Assurance
- MCH Services
- TB/HIV Services
- OVC Services
- Nutrition services

2.7 How did the grant impact on the service management and delivery in other sectors (such as education)?

2.8 What were the unintended results?

C WHAT WAS THE EFFECT OF TRANSITIONING FROM DIRECT IMPLEMENTATION OF DISTRICT LED HEALTH CARE MANAGEMENT ACTIVITIES FROM DBTA PROJECTS TO DISTRICT GRANTS THROUGH SDS?

3.1 What has been the effect of having TA from SDS as well as DBTAs on:

- Governance and systems strengthening
- Service delivery

3.2 How are the two Technical Assistance arms coordinated?

3.3 How do they complement each other?

3.4 What are the challenges of having two TAs?

D {SKIP THIS – NOT RELEVANT HERE} EFFECT OF THE FLEXIBLE OR ADAPTIVE USE OF SDS BY USAID UGANDA ON THE ACHIEVEMENT OF SDS RESULTS?

E EXTENT TO WHICH THE SDS MODEL IS STILL RELEVANT GIVEN THE CURRENT OPERATING ENVIRONMENT AND USAID UGANDA PRIORITIES?

5.1 How would you describe the SDS model?

5.2 How is it different from other programs for strengthening decentralized systems?

5.3 What factors (macro environmental) have promoted the effectiveness of the model?

- National policies
- Changes in development partner policies and interests
- Actors, relationships and resulting power dynamics (national and international)
- Performance/Outcome Incentive system

- Political environment in UG etc.
- 5.4 What factors (macro environmental) have hindered the effectiveness of the model?
- National policies
 - Changes in development partner policies and interests
 - Actors, relationships and resulting power dynamics (national and international)
 - Performance/Outcome Incentive system
 - Political environment in UG etc.
- 5.5 What factors (micro environmental) have promoted the effectiveness of the model?
- District/Organizational leadership
 - Performance/Outcome Incentive system
 - Changes in district/organizational processes
 - Roles of other actors (development partners, CSOs etc)
 - Changes in district/organizational legislations (by-laws etc)
- 5.6 What factors (micro environmental) have hindered the effectiveness of the model?
- District/Organizational leadership
 - Performance/Outcome Incentive system
 - Changes in district/organizational processes
 - Roles of other actors (development partners, CSOs etc)
 - Changes in district/organizational legislations (by-laws etc)
- 5.7 What aspects of the model worked well?
- What were the contributing factors?
- 5.8 What aspects of the model didn't work well?
- What were the contributing factors?
- 5.9 What aspects of the model would you recommend to be replicated in future programmes?
- Why?
- 5.10 What aspects of the model would you recommend to be dropped in future programmes?
- Why?

CONCLUSION:

- 6.1 What do you think should have been done differently for the program to have better outcomes?

- 6.2 What other suggestions do you have that would help inform the designing of similar programs that aim at strengthening decentralized service delivery?

Thank you for your time and sharing your views.

INTERVIEW GUIDE FOR DISTRICT LEVEL KEY INFORMANTS (CAO, LC V, DEC, DTPC, DHMT) AND DBTA MANAGERS

INTRODUCE YOURSELF TO RESPONDENT(S) AND BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE /SHE WOULD BE WILLING TO ANSWER SOME QUESTIONS REGARDING THE SDS PROGRAM.

Good Morning/Afternoon. I am [NAME OF EVALUATOR] and I am here on behalf of USAID to undertake an evaluation of the SDS program.

CONFIRM ORAL CONSENT AT THIS POINT

Name of District: _____ Date: ____/____/____

Name (s) of Key Informant (s):

Organization and position:

PREAMBLE:

- v. Could you kindly provide an overview of the SDS program in this district?"
- vi. When did the SDS program become operational in this district?
- vii. What kind of activities has the SDS program supported in the district?
- viii. What is your role in the SDS program? How long have you been playing this role?

A.CHANGES IN THE LOCAL GOVERNANCE SYSTEMS AS A RESULT OF THE SDS PROGRAMME?

- I.13 What changes have occurred in the following decentralized management functions since 2010 (or since you assumed your role) ,
- I.14 In your opinion, what were the reasons for those changes (if any) ?

Management Function (Probe only those respondent is familiar with)	Status as of 2010	Current status	Contributors to change
Leadership and Management			
Integrated Planning and Budgeting			
Financial Management (accounting, audit, procurement etc)			
Coordination			
Revenue Generation			
M&E and MIS			
Civic Engagement			

- I.15 Which of these changes are a result of SDS?
- I.16 Which ones do you consider vital/positive? Why?
- I.17 Which ones do you consider challenging?

1.18 What have been the effect of these changes on:

- Goal setting;
- Decision Making;
- Transparency and accountability;
- Responsiveness to local needs; and
- Service delivery?

1.19 How do you intend to maintain the positive changes ?

B CONTRIBUTION OF THE GRANTS AND GRANTS MANAGEMENT TO THE SUCCESS OF THE PROJECT?

2.1 What is your experience with the SDS grant implementation process?

- RFA released
- Proposal Development Assistance
- DIP
- Grants Management Training
- Grants Award
- Year 1 Performance Validation
- Output to Outcome Performance
- Increase IP integration
- Year 2 Performance Validation

2.2 What are your opinions on the grant evaluation criteria?

- Action points resolved from the DHMT meetings
- Action points resolved as reported in DOVCC meetings
- Key Action points implemented from integrated Health Support Supervision
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- Action points resulting from extended DTPC meetings
- Percentage of Non-SDS revenue expended on Social Services sector as a proportion of the budgeted amount

2.3 How did the grant implementation process affect project outcomes?

2.4 To what extent did the grants meet the health care workforce needs of the district?

2.5 How did the grant translate into health care service management and delivery, especially in the areas of:

- Support Supervision
- Health Infrastructure
- HRH
- Health Financing
- M&E (HMIS Tools and Skills)
- Logistics and Supply Chain Management
- Quality Assurance
- MCH Services

- TB/HIV Services
 - OVC Services
 - Nutrition services
- 2.6 How did the grant impact on the service management and delivery in other sectors (such as education)?
- 2.7 What were the unintended results?

C WHAT WAS THE EFFECT OF TRANSITIONING FROM DIRECT IMPLEMENTATION OF DISTRICT LED HEALTH CARE MANAGEMENT ACTIVITIES FROM DBTA PROJECTS TO DISTRICT GRANTS THROUGH SDS?

- 3.1 What has been the effect of having TA from SDS as well as DBTAs on:
- Governance and systems strengthening
 - Service delivery
- 3.2 How are the two Technical Assistance arms coordinated?
- 3.3 How do they complement each other?
- 3.4 What are the challenges of having two TAs?

[ONLY RELEVANT FOR STAR –E and STAR – EC]

- 3.5 What was the scope of the transition?
- 3.6 How was the process managed?
- 3.7 How did the transition to the SDS program impact on the work of the district in terms of:
- performance management?
 - human resources?
 - service delivery?
 - infrastructure development?
 - coordination with other partners?
- 3.8 What challenges (if any) did the transition pose?
- How did you respond to the challenges?

D EFFECT OF THE FLEXIBLE OR ADAPTIVE USE OF SDS BY USAID UGANDA ON THE ACHIEVEMENT OF SDS RESULTS?

- 4.1 What changes or adaptations have occurred in the program by USAID [NB: for USAID/ SDS]
- 4.2 What are the reasons / rationale for the change?
- 4.3 There were several modifications to the program... [NB for expanded list of respondents]

- How did they affect the implementation?
- How did they affect program outcomes?

- 4.4 How did the district / SDS program adapt to the changes?
- 4.5 What are those factors that enabled or hindered implementation?
- 4.6 How were the negative factors addressed?

E EXTENT TO WHICH THE SDS MODEL IS STILL RELEVANT GIVEN THE CURRENT OPERATING ENVIRONMENT AND USAID UGANDA PRIORITIES?

- 5.1 How would you describe the SDS model?
- 5.2 How is it different from other programs for strengthening decentralized systems?
- 5.3 What factors (macro environmental) have promoted the effectiveness of the model?
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 - Actors, relationships and resulting power dynamics (national and international)
 - Performance/Outcome Incentive system
 - Political environment in UG etc.
- 5.4 What factors (macro environmental) have hindered the effectiveness of the model?
- National policies
 - Changes in development partner policies and interests
 - Actors, relationships and resulting power dynamics (national and international)
 - Performance/Outcome Incentive system
 - Political environment in UG etc.
- 5.5 What factors (micro environmental) have promoted the effectiveness of the model?
- District/Organizational leadership
 - Performance/Outcome Incentive system
 - Changes in district/organizational processes
 - Roles of other actors (development partners, CSOs etc)
 - Changes in district/organizational legislations (by-laws etc)
- 5.6 What factors (micro environmental) have hindered the effectiveness of the model?
- District/Organizational leadership
 - Performance/Outcome Incentive system
 - Changes in district/organizational processes
 - Roles of other actors (development partners, CSOs etc)
 - Changes in district/organizational legislations (by-laws etc)

- 5.7 What aspects of the model worked well?
 - What were the contributing factors?
- 5.8 What aspects of the model didn't work well?
 - What were the contributing factors?
- 5.9 What aspects of the model would you recommend to be replicated in future programmes?
 - Why?
- 5.10 What aspects of the model would you recommend to be dropped in future programmes?
 - Why?

CONCLUSION:

- 6.1 What do you think should have been done differently for the program to have better outcomes?
- 6.2 What other suggestions do you have that would help inform the designing of similar programs that aim at strengthening decentralized service delivery?

Thank you for your time and sharing your views.

INTERVIEW GUIDE FOR MANAGERS OF DISTRICT HOSPITALS/ HEALTH CENTER IV & HEALTH CENTRE IIIS

INTRODUCE YOURSELF TO RESPONDENT(S) AND BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE /SHE WOULD BE WILLING TO ANSWER SOME QUESTIONS REGARDING THE SDS PROGRAM.

Good Morning/Afternoon. I am [NAME OF EVALUATOR] and I am here on behalf of USAID to undertake an evaluation of the SDS program.

CONFIRM ORAL CONSENT AT THIS POINT

Name of District: _____ Date: ____/____/____

Name (s) of Key Informant (s):

Organization and position:

PREAMBLE

1. What kind of activities has the SDS program supported in this health facility?
2. How have you been involved in these SDS-supported activities? For how long have you been involved?

A. CHANGES IN THE LOCAL GOVERNANCE SYSTEMS AS A RESULT OF THE SDS PROGRAMME?

- I.20 What changes have occurred in the following management functions since 2010 (or since you assumed your role) ,
- I.21 In your opinion, what were the reasons for those changes (if any) ?

Management Function (Probe only those respondent is familiar with)	Status as of 2010	Current status	Contributors to change
Leadership and Management			
Integrated Planning and Budgeting			
Financial Management (accounting, audit, procurement etc)			
Coordination			
Revenue Generation			
M&E and MIS			
Civic Engagement			

- I.22 Which of these changes are a result of SDS?
- I.23 Which ones do you consider vital/positive? Why?
- I.24 Which ones do you consider challenging?
- I.25 What have been the effect of these changes on:
 - Goal setting;

- Decision Making;
 - Transparency and accountability;
 - Responsiveness to local needs; and
 - Service delivery?
- 1.26 How do you intend to maintain the positive changes?
- 1.27 Who is responsible to ensure that this happens?

B. CONTRIBUTION OF THE GRANTS AND GRANTS MANAGEMENT TO THE SUCCESS OF THE PROJECT?

- 2.1 In what ways (if any) has the SDS support improved health care service management and delivery, especially in the areas of:
- Support Supervision
 - Health Infrastructure
 - HRH
 - Health Financing
 - M&E (HMIS Tools and Skills)
 - Logistics and Supply Chain Management
 - Quality Assurance
 - MCH Services
 - TB/HIV Services
 - OVC Services
 - Nutrition services
- 2.2 How can these improvements be maintained?
- 2.3 Who is responsible to ensure that this happens?

C EXTENT TO WHICH THE SDS MODEL IS STILL RELEVANT GIVEN THE CURRENT OPERATING ENVIRONMENT AND USAID UGANDA PRIORITIES?

- 3.1 How would you describe the SDS model?
- 3.2 How is it different from other programs for strengthening decentralized systems?
- 3.3 What factors (micro & macro environmental) have promoted the effectiveness of the model?
- 3.4 What factors (micro & macro environmental) have hindered the effectiveness of the model?
- 3.5 What aspects of the model worked well?
- 3.6 What were the contributing factors?
- 3.7 What aspects of the model didn't work well?
- 3.8 What were the contributing factors?
- 3.9 What aspects of the model would you recommend to be replicated in future programmes?

- 3.11 What aspects of the model would you recommend to be dropped in future programmes?

CONCLUSION:

- 5.1 What do you think should have been done differently for the SDS program to have better outcomes?
- 5.2 What other suggestions do you have that would help inform the designing of similar programs that aim at strengthening decentralized service delivery?

Thank you for your time and sharing your views.

GROUP INTERVIEW GUIDE FOR PARISH DEVELOPMENT COMMITTEES/COMMUNITY MEMBERS

INTRODUCE YOURSELF TO RESPONDENT(S) AND BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE /SHE WOULD BE WILLING TO ANSWER SOME QUESTIONS REGARDING THE SDS PROGRAM.

Good Morning/Afternoon. I am [NAME OF EVALUATOR] and I am here on behalf of USAID to undertake an evaluation of the SDS program.

CONFIRM ORAL CONSENT AT THIS POINT

Name of District: _____ Date: ____/____/____

Name of Sub-county: _____ Parish: _____

Name (s) of Key Informant (s)

Name	Position

PREAMBLE:

- i. Have you heard about the SDS Program?
- ii. When did you first hear about the SDS program?
- iii. Could you kindly share what you know about the program?
- iv. What kind of activities has the SDS program supported in your district/unit?

A.CHANGES IN THE LOCAL GOVERNANCE SYSTEMS AS A RESULT OF THE SDS PROGRAMME?

- 1.28 What changes have occurred in the following decentralized management functions since 2010 (or since you assumed your role),
- 1.29 In your opinion, what were the reasons for those changes (if any) ?

Management Function (Probe only those respondent is familiar with)	Status as of 2010	Current status	Contributors to change	How do you participate?
Leadership and Management				
Integrated Planning and Budgeting				
Revenue Generation				
Civic Engagement				

- 1.30 [IF FAMILIAR WITH SDS] Which of these changes are a result of SDS?
- 1.31 Which ones do you consider vital/positive? Why?
- 1.32 Which ones do you consider challenging?
- 1.33 How do you intend to maintain the positive changes?

B. CONTRIBUTION OF THE GRANTS AND GRANTS MANAGEMENT TO THE SUCCESS OF THE PROJECT?

- 2.1 To what extent has the delivery of the following services improved over the past five years?
- 2.2 What factors contributed to this?
- 2.3 To what extent are you satisfied with the services?

Health Care Service	Status (2010)	Current Status	Contributing Factors	Level of satisfaction	Reasons for satisfaction/ dissatisfaction
MCH					
HIV Prevention, Care and Support					
OVC					
Nutrition					
Other areas					

- 2.4 What else needs to be done to further improve above services in your area?

Thank you for your time and sharing your views.

ANNEX VI: HEALTH SYSTEMS STRENGTHENING

OVERVIEW

The WHO Health Systems Framework²⁶ outlines six (inter-dependent and complementary) building blocks: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship).

While the SDS program did not directly target interventions in all of these areas, the strengthening of local governments was hoped to reflect an ultimate improvement in health service delivery in particular. Some of the underlying beliefs were:

- Enhancing Local Revenue would result in increased budgets for health services
- Increasing the number of health care personnel would translate into better health access, coverage and quality of service delivery
- Strengthened governance of local government (both political as well as technical) would result in a trickle down capacity strengthening of lower local governments
- Coordination of USAID DBTAs in the districts would encourage integrated health service delivery

Health Service Delivery

Please refer to section IV.2.5 for extensive discussion on this aspect of the health system.

Health Workforce (Human Resources for Health—HRH)

Please refer to section IV.2.5 for extensive discussion on this aspect of the health system.

Information

The hiring and value placed on biostatisticians in 5 out of 12 SDS districts visited (Mbale, Budaka, Kamwenge, Kanungu, Kayunga) demonstrates a greater interest in the use of data for decision-making. This was particularly notable at the district level. In places such as Kaliro biostatisticians already existed. There seemed to be limited trickle down effects to the health facilities whereby the interest and use of performance indicators to interrogate services was mixed. There were however some instances where trends in ANC attendance, malaria diagnosis, HIV treatment etc were present in the health manager's offices, for instance in Bumanya subcounty HCIV, Kaliro district (SDS) but also in non-SDS districts such as the DHO's office in Mukono and also on the walls of the Kojja HCIV facility in Ntenjeru subcounty, Mukono district. The sub-optimal quality of the charts however belies utility and use of the data.

Challenges related to information sharing and management is linked to insufficient infrastructure support such as computers, printer cartridges, internet access, and intermittent electricity. While little can be done for the latter, SDS provision of computers for instance to the district planning office in Kaliro has alleviated some but not all challenges. In June 2014, MUWRP

²⁶ World Health Organisation. (2007) *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva.

provided document centers and two Desktop computers to the DHO offices in Kayunga (SDS district) and Mukono (non-SDS) with ongoing support for maintenance and support to the equipment, Internet access and supply provisions like cartridges amongst others²⁷. District planners, CFOs and other staff often had difficulty in locating documents needed by the evaluation team – a frustration also felt by a district official in Kaliro: “We have had very many computer changes and so I will have to look in different places for the documents” Better practices in data management is therefore also required with establishment of central repositories of generally accessible information.

Training on software required for effective information management however remains an ongoing challenge. For instance, training on the District Health Information Software (DHIS2) - a facility and community based data aggregation system introduced by the MOH in 2012 - appeared to be a general request despite MOH completion of training of all 112 DHTs and cascades training to all 4200 health facilities²⁸. There appeared to be no integration or cross-use of the various sector management information systems (MIS) (eg OVC-MIS, EMIS and HMIS). Integrated health care planning therefore depends solely on relationships as well as alignment of priorities between the health, education and community based services sectors.

Medical Products, Vaccines, and Technologies

SDS Grant C has been particularly helpful to districts able to utilize the “innovation fund” for critical infrastructure and capacity building needs²⁹. The purchase of solar panels in Kaliro, for example, have contributed to several aspects of improved health service delivery due to its impact on efficiency, safety, quality and accessibility of health care.

Steady power sources have permitted operationalization of fridges for medicine storage. Investments in tangible products and capital through Grant C such as solar panels in Kaliro, a projector and generators in Kiruhura (although officials claim the primary request was for a motorcycle), and a neonatal oxygen concentrator in Kamuli (although officials claim that this was not their preferred choice of technologies) received the highest appreciation due to their sustainability beyond the project.

“We carried out the activities that were funded [by Grant C] like establishing and training transport referral committees (consisting about 6 people) at each sub-county level. We also trained our health workers in emergency obstetric care in order to reduce maternal and infant mortality rates.” – District official, Mbale District

*“Because there is more light [due to solar panels], there is better security.... now the equipment is now secure and cant be stolen. We no longer have accidental pricks to health workers instead of the patient and so there are less chances to get infected with HIV. We used to be afraid of snakes at night and also we used to worry about being accosted but with light we’re no longer worried”
Gadumire sub county HCIII personnel, Kaliro District*

This need for sustainable infrastructure support was echoed in Kamuli where CORDAID has supported the establishment of a shed for ANC and FP care. Unfortunately, many innovations that were envisioned and plans made remained unrealized due to changes in SDS priorities for

²⁷ Makerere University Walter Reed Project. MUWRP Document center Handover. <http://www.muwrp.org/> Retrieved 23 Jan 2016.

²⁸ Uganda Ministry of Health. eHMIS. <http://www.health.go.ug/oldsite/node/76>. Retrieved 22 Jan 2016.

²⁹ SDS. Grant C implementation brief.

funding as well as the funding envelope for Grant C leaving district staff disappointed and demoralised. Other infrastructure improvements that contribute to improved service delivery were provided by the government, STAR and STRIDES.

Reductions in drug shortages and improved oversight of stocks seems to have been under the original remit of Securing Ugandans' Right for Essential Medicines (SURE) project followed by the Uganda Health Supply Chain (UHSC) project, but complements the efforts of SDS.

Improved drug supply management (due to SURE) and increased health workforce (SDS, MUWRP) have also enhanced the quality and efficiency of health services. However, these work in tandem with other health systems challenges and subject to contextual influences as well as other development partners in the region. Meetings with community members indicate that there is still a concern about drug stock outs. However, health personnel indicate that this has improved. Visits to the health facilities indicated that priority drugs seemed well stocked in general (ART, ACTs) but there was indeed a gap between what was needed and what was available. Challenges of private health care facilities siphoning public sector drugs, however, continues to be a concern to community members as well as health providers.

Attempts to improve medical waste management through Green Label Services, an SDS-subcontracted company, was noted as critical in Budaka but unfortunately unreliable in Kamuli and discontinued in Kaliro for reasons unknown to district and health facility officials.

A notable observation was that activities and support by SDS was well understood by the districts. At the subcounty and community level respondents were often unsure of who was responsible for interventions attributing credit or blame unknowingly.

Financing

The notable effects of Grant C on financing aspects of health care infrastructure have been noted above. While SDS staff were paid based on performance, the absorption of staff into district systems challenges the sustainability of work ethic benefits achieved through this financing structure. Kamuli district and subcounty staff voiced similar concerns with respect to a PBF model introduced by CORDAID, which provided financial incentives for services rendered resulting in substantially increased resources for the health facility.

The financial facilitation support for outreaches, TB hub riders and meetings related to health have undoubtedly contributed to improved health services. However, temporary gains are at risk of slipping when the program withdraws. There was little evidence of SDS activities being absorbed under the PHC budget in districts and little evidence on whether generation of local revenue has contributed to increased allocation of funds to the health sector.

Governance and leadership

While SDS' engagement at the community level was envisioned predominantly through trickle down effects from the district level, several other initiatives to enhance governance have been underway in the various regions. In particular, strategies to increase the demand for health services included community meetings (Kimezas, barazas), and in some districts loudspeaker announcements by implementing partners. Communities were provided opportunities to express their health service needs and challenges with district and subcounty officials being held accountable for progress in these areas. Meetings with community groups across the districts indicated an awareness of health rights, managed expectations of quality of health services, as well as knowledge of policies and activities in place by officials to affect change. While Barazas

hosted by the Office of the Prime Minister occur nationally, they were deemed expensive, infrequent and insufficient. In SDS districts (and in districts where GAPP and International Justice Mission prevail) community dialogue activities have contributed to enhanced community demand. The challenge now lies in social services supply meeting the increased demand.

With respect to leadership in the health sector, district officials had received several types of training over the years that contributed to capacity strengthening and notable outcomes as a result.

“Given the skills which I had acquired with SDS and Intra Health, I had already developed a HRH plan that indicated the staffing levels and staffing gaps. I had also developed another plan called a workload indicator of staffing norms plan... At that point in time, we moved from 49% [staffing level] to about 75% that year.” – District official, Mbale District

SDS as well as by district personnel noted that intense support supervision efforts of health workers were critical in enhancing performance management. For those recruited into the public system by SDS, training was done by ACLAIM. This has in turn contributed to better service delivery. Enhanced quarterly supervision by health facility managers and audit of supervisors has also resulted in promoting a culture of accountability, pride, and stewardship. However, this is cost, time and human resource intensive and therefore risks abandonment with the withdrawal of SDS. Furthermore, performance standards introduced by SDS, while effective with respect to staff accountability and motivation, are likely to be dropped unless the government as a whole considers adopts a pay for performance model for health (and other social service) personnel. This is contrary to SDS assertions on successful institutionalization of performance management³⁰.

For conclusions and recommendations relevant to HSS see section IV.2

Table 18: Summary of HRH overall Staffing in the 35 SDS Districts—Mar 2013 vs Dec 2015

No.	District	Total No. of Units	Total Norms	Filled	% Filled as of Dec 2015	% Filled as of March 2013
1	Bushenyi	35	425	284	66.82%	80 %
2	Kabale	97	1252	812	64.86%	61 %
3	Kanungu	30	609	387	63.55%	57 %
4	Kisoro	39	797	498	62.48%	66 %
5	Ntungamo	42	797	566	71.02%	64 %
6	Rukungiri	48	650	455	70.00%	61 %
7	Kasese*	92	1777	980	55.15%	57 %
8	Kamwenge	29	427	311	72.83%	78 %
9	Kyejonojo*	23	507	337	66.47%	60 %
10	Ibanda	43	696	445	63.94%	48 %
11	Isingiro	55	819	393	47.99%	48 %
12	Kiruhura	45	790	336	42.53%	28 %
13	Bugiri	36	662	376	56.80%	43 %
14	Iganga	42	768	643	83.72%	91 %

³⁰ Cardno Emerging Markets USA, Ltd. SDS 5yr Annual Report. Uganda: July 2015 (pg 21).

No.	District	Total No. of Units	Total Norms	Filled	% Filled as of Dec 2015	% Filled as of March 2013
15	Kaliro	14	203	167	82.27%	87 %
16	Kamuli	38	699	519	74.25%	44 %
17	Luwero*	42	663	515	77.68%	71 %
18	Kayunga	21	526	365	69.39%	73 %
19	Mpigi*	30	447	258	57.72%	58 %
20	Nakasongola*	31	425	336	79.06%	64 %
21	Ssembabule	23	323	159	49.23%	52 %
22	Kalangala	17	289	183	63.32%	46 %
23	Mayuge	35	441	294	66.67%	64 %
24	Mityana*	37	751	438	58.32%	60 %
25	Namutumba	26	321	188	58.57%	52 %
26	Mbale	37	671	511	76.15%	82 %
27	Sironko	31	505	321	63.56%	72 %
28	Kapchorwa	21	438	327	74.66%	76 %
29	Busia	26	525	240	45.71%	42 %
30	Kumi*	15	584	226	38.70%	57 %
31	Pallisa	25	573	349	60.91%	64 %
32	Bududa	16	393	226	57.51%	32 %
33	Budaka	16	281	198	70.46%	73 %
34	Bukwa	18	410	225	54.88%	53 %
35	Butaleja	25	510	257	50.39%	50 %
	Mukono**	39	560	446	79.64%	78 %
	Tororo**	59	1000	493	49.30%	46 %

Source: Human Resources for Health – Biannual Reports. March 2013 and December 2015

*SDS Core but Non HRH District

**Non SDS District

ANNEX VII: DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

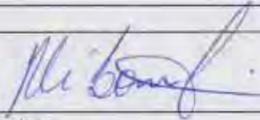
Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date November 3rd 2015

Richard Kibombo

Name

Title Evaluation Methods Specialist

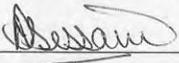
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

	14 October 2015
Signature	Date
NASREEN JESSANI,	DR.
Name	Title

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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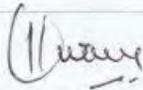
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

09/28/2015

Name

Dr. Owarwo V. M.

Title

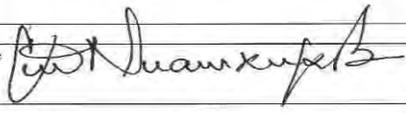
CONSULTANT

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- Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature		Date	10/21/2015
Name	NUAMANYA ALFRED BUHIYA	Title	

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

ASIMWE
Signature

Date NOV-06th-2015

ASIMWE CAROLINE
Name

Title MS

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
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 - (ii) becomes available to me in a manner that is not in contravention of applicable law; or
 - (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Ken Otikal OTI

Signature

Date 1st October 2015

Ken Otikal

Name

Title **Researcher**

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
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 - (ii) becomes available to me in a manner that is not in contravention of applicable law; or
 - (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

27/10/15

PATRICK TIBASIMWA MUBANGIZI

Name

Title

For more information, please visit
www.ghpro.dexisonline.com

Global Health Performance Cycle Improvement Project

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20004

Phone: (202) 625-9444

Fax: (202) 517-9181

www.ghpro.dexisonline.com