

# **Sector Monitoring and Evaluation Systems in the context of Changing Aid Modalities: The case of Uganda's Health Sector**

**Nathalie Holvoet and Liesbeth Inberg**

**O\* Platform Aid Effectiveness  
Institute of Development Policy and Management  
University of Antwerp**

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## Abbreviations

AHSPR	Annual Health Sector Performance Report
BTC	Belgian Technical Cooperation
DFID	Department for International Development
GAVI	Global Alliance on Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
GNI	Gross National Income
HDI	Human Development Index
HIPC	Heavily Indebted Poor Countries
HIS	Health Information System
HMIS	Health Management Information System
HSSIP	Health Sector Strategic & Investment Plan
HSSP	Health Sector Strategic Plan
IDA	International Development Association
IMF	International Monetary Fund
IHP+	International Health Partnership+
JANS	Joint Assessment of National Strategies
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MTEF	Medium Term Expenditure Framework
NIMES	National Integrated M&E strategy
ODA	Official Development Aid
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
PEAP	Poverty Eradication Action Plan
PEPFAR	President's Emergency Plan for AIDS relief
PMES	Poverty Monitoring and Evaluation Strategy
SMER	Supervision, Monitoring, Evaluation and Research
SURE	Supporting Use Research Evidence
SWAp	Sector Wide Approach
UBOS	Uganda Bureau of Statistics
UNMHCP	Uganda National Minimum Health Care Package

## Executive summary

### Introduction

With the aim to increase aid effectiveness development partners and recipients signed the 2005 Paris Declaration which sets out a reform agenda around the core principles of 'ownership', 'alignment', 'harmonisation', 'managing for results' and 'mutual accountability'. The indicator for measuring progress in the 'management for results' principle is the "number of countries with transparent and monitorable performance assessment frameworks to assess progress against (a) the national development strategies and (b) sector programmes". The recent 2011 Paris Declaration Monitoring Survey shows considerable improvements in the development of results-oriented frameworks: while the 2010 target of 36% was not met, 21% (15 out of 76) of the countries participating in the 2011 survey have results-oriented frameworks that are deemed adequate, compared to 6% (3 out of 54) in the 2008 survey. While most countries do have a number of M&E activities and arrangements in place, especially at sector level where progress is generally stronger than at national level, one of the most persistent weaknesses is the lack of coordination between different components of an M&E system. Having a properly functioning nationally owned M&E system is crucial for the use of information for decision-making and results delivery towards development goals. Notwithstanding the importance of M&E for 'accountability' and 'evidence-based policy-making', strengthening of country's M&E systems has long remained a largely neglected issue in partner countries and among development partners. This neglect of M&E capacity development is particularly surprising from the perspective of budget support donors who are supposed to rely on country M&E systems for their own accountability purposes.

While there is gradually an increasing acknowledgement of the importance of M&E system development, there is so far little strategic engagement in this area, even amongst those aid agencies that mention it in their mandates. The O-platform aid effectiveness<sup>1</sup> aims to contribute to this challenging and policy-relevant research agenda and has invested in particular in the elaboration of a diagnostic instrument and stocktaking exercises of M&E systems at central and sector level in various countries. This focus on diagnosis and stocktaking starts from the assertion that, regardless of the approach adopted, an important first step in any M&E capacity-building effort is to take stock of what already exists at the M&E supply and demand side. This is consistent with the idea that small incremental changes to existing systems might be more feasible and workable than radical and abrupt changes that seek to impose blueprints from the outside.

This study focuses in particular on M&E in the health sector and uses the checklist which has been elaborated to diagnose, monitor and evaluate the quality of sector M&E systems (see annex 2). The same checklist has been applied earlier to the health sector M&E systems of Niger and Rwanda. In order to counter the criticism that M&E is often narrowed down to a focus on technicalities, our checklist broadens the spectrum and gives a broad overview of

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<sup>1</sup> O\*platforms are policy advisory research platforms initiated by the Flemish Interuniversity Council (VLIR) and constitute a flexible collaboration arrangement between researchers and actors of development cooperation. The objective of Research Platform Aid Effectiveness is to inform, train and advise Belgian policy makers and aid managers and in this way to inspire a more effective development cooperation policy. For an overview of the output of the O\* platform aid effectiveness, please see [www.ua.ac.be/bos](http://www.ua.ac.be/bos).

the quality of M&E systems alongside six dimensions, including i) policy, ii) indicators, data collection and methodology, iii) organisation (split into iiia: structure, and iiib: linkages), iv) capacity, v) participation of actors outside government and vi) use of M&E outputs. These criteria are further subdivided into 34 questions and assessed using a five-point scoring system: weak (1), partially satisfactory (2), satisfactory (3), good (4) and excellent (5). The stocktaking draws upon a combination of secondary and primary data and combines quantitative with qualitative assessment. As the sector M&E system does not operate in a vacuum, a brief overview of the general Ugandan setting and its health system is given prior to a discussion of the findings on Uganda's health sector M&E system.

### **The Ugandan setting**

While Uganda's economic growth has been rather high in recent years and improvements have been made in reducing the percentage of the population living in poverty, Uganda is still classified amongst the countries with the lowest human development (value 0.422, rank 143/169 in 2010). Impediments to further economic growth and poverty reduction are weak public sector management and administration, inadequate financial services to the private sector, weak infrastructure, insufficient production inputs and gender inequality.

Uganda's first Poverty Eradication Action Plan (PEAP) (1997) served as an inspiration for the World Bank to launch Poverty Reduction Strategy Papers in the context of the Heavily Indebted Poor Countries (HIPC) initiative. In 2000 an updated version of the PEAP (PEAP II) became Uganda's first Poverty Reduction Strategy Paper and Uganda was the first country to receive HIPC support. While the first two PEAPs benefitted from a high level of political support and commitment, this support and commitment weakened with the introduction of multi-party politics (2005). In 2010 the successor of the PEAPs, the National Development Plan 2010/11 – 2014/15, was elaborated on the basis of an extensive and broad-based country-driven consultative process and with hardly any influence of development partners. Uganda's country report of the second phase of the Paris Declaration evaluation criticises the National Development Plan for its lack of prioritisation, as a result of which development partners can easily choose to support their own interests, which are not necessarily Uganda's main development priorities, while still being aligned to the National Development Plan.

From 1998 onwards, the Medium Term Expenditure Framework (MTEF) has been formally established as a key tool for the integration of budgeting and planning by translating policy priorities into resource allocation. The link between the MTEF and the PEAP was hampered by the inclusion of non-PEAP originated initiatives and by the fact that the MTEF is based on sectors and the PEAP on a pillar structure. Three-year rolling Budget Framework Papers, which set out planned outputs and their related costs in the medium term, are formulated at national, sector and local government levels. For the implementation of the PEAPs committees/ working groups at four levels have been responsible, for the implementation of the National Development Plan additional structures and systemic changes are foreseen. One of the most important challenges will be the actual implementation of the National Development Plan, as Uganda is known to be the country with the largest implementation gap in the world.

It is this same phenomenon of policy evaporation which might be responsible for Uganda's declining score on the 'management for results' principle as measured by indicator 11 (do countries have monitorable performance assessment frameworks) in the recent 2011 Paris Declaration Survey. Uganda was one of the only two countries (besides Mozambique) whose score decreased from a 'B' (largely developed) to a 'C' (action taken towards achieving good practice). This decrease is not completely in line with the Paris Declaration country evaluation report on Uganda, which assessed the 'management for development' principle in Uganda as successful, as a result of a better integration of results-based management principles into planning, budget tracking and national M&E. Along the same line, various interviewees in Uganda stress that the performance assessment framework has improved in the previous years with the inclusion of stronger sector performance indicators.

Two recent M&E documents describe M&E arrangements in Uganda: the 'M&E strategy for the National Development Plan' and the 'National Policy on Public Sector Monitoring and Evaluation'. The relation between the policy and strategy are not entirely clear and the two documents do not refer to each other. This same lack of coordination is also obvious in reality when it comes to the M&E coordination and oversight at central level. Over the past decade, central M&E coordination and oversight has moved from one authority to the other. It is currently scattered over three different authorities, i.e. the National Planning Authority, the Office of the Prime Minister and the Ministry of Finance, Planning and Economic Development, and particularly the division of responsibilities between the National Planning Authority and the Office of the Prime Minister is unclear. If anything, such patterns of ever changing institutional arrangements and competition amongst agencies to control M&E is not unique to the Ugandan case and related to the fear that some ministries or units will become too powerful. As will be discussed below, it also complicates linkages among central and sector level M&E.

While the M&E strategy and policy clearly outline the importance of the 'monitoring' and 'evaluation' function, in reality, the focus is on 'monitoring' while the 'evaluation' function is largely neglected. This is not entirely surprising and understandable from the perspective of a 'sequencing approach' whereby the set-up of a monitoring system is a logical first building block. However, a consequence of this lack of more analytical evaluative exercises is that underlying reasons for non-performance are not revealed. While this is politically safe in the short run, it leads to analytically shallow performance reports (the main input into joint reviews), learning deficits and eventually to a lack of results on the ground. The recently established Government Evaluation Facility (GEF) within the M&E department of the Office of the Prime Minister (OPM) might offer some opportunities to address the shortfall of systematic and institutionalised evaluation.

The result framework included in the M&E strategy, which links indicators with the themes, the objectives and the (other) key results, is an improvement compared to the results framework under the NIMEs. The latter was limitedly focused on outcomes, which undermined the value of the national M&E system as products of this system could not easily be used to improve the performance of government. The usefulness of data for decision making is still constrained, however, by the overdependence on outcomes and impacts data retrieved from the Uganda Bureau of Statistics (UBOS) surveys. Uganda survey data is

widely appreciated for being among the most reliable and it is useful to inform decision-makers at strategic and policy-making levels. However, this data is less useful for decision-making and implementation at lower levels which draws more on information from management information systems which are generally less well developed (see below for the health sector).

While M&E capacity is inadequate, which has been acknowledged in the National Development Plan, a coherent M&E capacity development plan does not yet exist, as a result of which M&E capacity strengthening has not been coordinated. Important outside government actors in the M&E system are Parliament (supported by the Office of the Auditor General), civil society organisations and development partners, whose roles and responsibilities in the national M&E system are described in the M&E policy. Parliament is still not considered an effective watchdog and is hardly involved in decision making on government activities. However, since the instalment of a new Parliament, which has a larger percentage of younger Parliamentarians, a move towards a more qualitative and objective debate has been observed. Moreover, these younger Parliamentarians have a higher reading culture, which increases the probability that information from M&E reports will at least be read.

While effective use of data is especially limited at lower government levels, underutilisation of available information is a generally noted phenomenon and also applies to the more central government levels as well as to actors outside government. This lack of an active demand side has serious implications for the set up, maturing and sustainability of the M&E system as it is particularly the M&E demand side which creates incentives for M&E supply. The move towards a more performance-oriented (budgeting) system might partly remedy this deficient M&E demand side. However, without supervision and control an increased focus on results could also lead to a number of side-effects, such as gaming, goal replacement, etc. From this vantage point, it is best to combine performance monitoring with a strong evaluation function. Evaluation is helpful for identifying reliable and valid performance measures and outcomes; it might detect unintended causes of performance measurement, and could induce more balanced analysis of (lack) of achievements involving issues of attribution.

Development partners in Uganda, including non-traditional partners, are supposed to participate actively in the Local Development Partners Group or act under its umbrella. Development partners who supply general and sector budget support have to join the Joint Budget Support Framework. The Joint Budget Support Framework development partners and the Government of Uganda agreed on a Joint Assessment Framework to be used for the assessment of government's performance. While the 2011 Paris Declaration survey has shown some improvements in several alignment and harmonisation indicators since 2005, not all of the 2010 targets for the alignment indicators were met while none of the 2010 targets for the harmonisation indicators was reached. In reaction to several challenges in the area of harmonisation and alignment, the Government of Uganda decided to strengthen mechanisms for partnership management and elaborated the Uganda Partnership Policy in 2010.



## **Uganda's health sector**

Uganda has low scores on most of the health-related Millennium Development Goals indicators and for almost half of the indicators (8/17) Uganda scores worse than the African average. While on paper Uganda is committed to primary health care, in practice too many resources are provided to hospitals at the detriment of primary health care. A first National Health Policy was approved in 1999 (for a period of ten years), a second one was elaborated during a participatory process in 2009/10. Simultaneously with the National Health Policy II, the Health Sector Strategic & Investment Plan (HSSIP) 2010/11- 2014/15 was elaborated. The HSSIP is criticised for its high costs which are not aligned with the available resources; the lack of prioritisation and unrealistic targets; the lack of clarifying and strengthening the link between the HSSIP and the decentralised planning processes; and the lack of specification of mechanism for accountability of the stakeholders involved. Civil society organisations involved in Uganda's health sector also point to the lack of policy implementation so far.

The health sector is decentralised, which means that districts and health sub-districts have an important role in the delivery and management of health services. In practice the decentralisation of the health sector has not been successful due to the earmarking of central level transfers in the form of conditional grants, the increase in the number of districts (from 56 to 112) with new management teams, inadequate facilities and the abolition of graduated taxes. Specific human capacity challenges include the low average sector staffing level, low morale, absenteeism, staff attrition caused by poor remuneration, poor support and supervision of health workers and enticement of health professionals from clinical practice into desk jobs by development partners. The value added of the private-not-for-profit health facilities, which are supplying the full minimum package despite getting less support from the government, is also considered not to be sufficiently recognised by the Ministry of Health.

Uganda's Health Information System (HIS) consists of several data sources which can be classified in three main categories: population-based statistics, health services-based statistics and research. The Health Management Information System (HMIS) is one of the health service-based statistics related to the health service delivery for public and private-not-for-profit health facilities. Weekly, monthly and yearly HMIS reports are produced at health facility, health sub-district and district level. The HMIS has recently been revised and includes now specific indicators for e.g. the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance on Vaccines and Immunization (GAVI) Alliance (interviewees), but as the tools are not yet printed and distributed, the revised HMIS is not yet in use (except by the Uganda Catholic Medical Bureau who printed and distributed the tools with its own means). The National Health Policy II and the HSSIP include objectives and strategies for the strengthening of the HIS.

The health sector is financed by the government, by user fees in private health facilities and by health development partners through a Sector Wide Approach (SWAp). Despite an increase in health funding (due to relatively new funding initiatives including the GAVI alliance, the GFATM, the President's Emergency Plan for AIDS relief (PEPFAR) and the President's Malaria Initiative), Uganda's health sector is still underfunded, with only 10 USD per capita health funding instead of the 28 to 42 USD per capita needed for financing the HSSIP. Development partners in the health sector meet monthly in the health development

partners Group, which is, however, not considered to be very effective, amongst others due to high staff turnover. Dialogue with the Ministry of Health takes place through the Health Policy Advisory Committee, which meets monthly as well. Belgium and Sweden are the only development partners providing sector budget support to Uganda's health sector, the Department for International Development (DFID) of the United Kingdom is taking health sector budget support into consideration. While the health SWAp, introduced in Uganda in 1999, used to be considered a good practice case, the SWAp performance declined later on as a result of several factors, including decreased government spending on health, changes in aid modalities, weakened government leadership and poor governance. As some of these factors are addressed in the National Health Policy II, the HSSIP and the Country Compact for implementation of the HSSIP between Uganda's government and health partners, a new impulse to the health SWAp might be created (or is already being created).

### **Assessment of the health sector's M&E system**

As far as M&E arrangements at health sector level are concerned, conclusions of the World Bank evaluation on six health sector wide approaches (SWAps) which point to the fact that there is often a neglect of M&E capacity investment as compared to investments in the design of procurement, disbursement and financial management systems (Vaillancourt, 2009) also apply to the case of Uganda. In Uganda this lack of interest in M&E is e.g. demonstrated by the fact that despite the relatively long existence of the health SWAp, the M&E plan has only recently been elaborated. While the current Ministry of Health should be applauded for the elaboration of this M&E plan which will be particularly important for the coordination of largely fragmented health sector M&E arrangements, its implementation is challenged by the lack of funds available for the activities included in the plan (demonstrating as well the lack of interest of development partners in M&E). Given Uganda's track record in policy evaporation (implementation gap), it is of utmost importance to monitor the implementation of the M&E plan.

#### *M&E plan and policy*

The new M&E plan pays attention to both M&E goals of 'accountability' and 'learning' and highlights the importance of dissemination of M&E findings. In practice more attention has so far been paid to (upwards) accountability (towards the central M&E system and donors) as compared to downward accountability towards citizens. While the M&E plan makes a distinction between 'monitoring' and 'evaluation' (and review), links between them are not clearly spelled out. Moreover, in line with the M&E system at central level, the focus has been on 'monitoring' at the expense of the more analytical 'evaluative' exercises. While interesting research on the health sector is done at universities, studies do not systematically feed into the health sector M&E system. The proposed introduction of performance based financing in the health sector might strengthen the link between budgets (inputs) and results, however, without a proper data supervision/control mechanism side effects such as crowding-out and gaming are a real possibility. It is therefore recommended to introduce performance based financing in the health sector on a limited 'pilot' scale and to evaluate its effects before generalising it throughout the sector.

### *Indicators, data collection and methodology*

Our stocktaking exercise demonstrates that the ‘indicators, data collection and methodology’ is by far the strongest component of the health M&E system. Strengths include the limited number of core performance indicators (26) in the Health Sector Strategic & Investment Plan (HSSIP) (which hints at the fact that the need to be selective is well understood), the definition of criteria for the selection of these core performance indicators, the identification of baselines and targets (which are however not always realistic) as well as the identification of data sources for each core performance indicator. Moreover, the M&E plan also links objectives, clusters and strategic interventions with indicators (not the core performance indicators), which clearly highlights which indicators are supposed to monitor which strategic intervention. A weaker element is the lack of disaggregation of indicators. While the Health Sector Strategic & Investment Plan (HSSP) points to the need for disaggregation of indicators by income, literacy level, gender and security level, the Annual Health Sector Performance Report (AHSPR) does not include any disaggregated indicator. Moreover, specific evaluation methodologies are not clearly identified in the HSSIP or the M&E plan. As highlighted above, the quality of data from census and population-based surveys is generally more adequate than the quality of facility based data (including the HMIS) and there is so far little cross-reading among survey and facility based data.

### *Systemic issues and Capacity*

M&E coordination and oversight in the health sector is embedded within one department of the Ministry of Health, i.e. the Quality Assurance Department. However due to its location under the Directorate of Planning and Development its power is likely to be curtailed; coordination and oversight logically entail a location higher in the hierarchy. Moreover, the Quality Assurance Department is still understaffed and the proposed M&E unit within the Quality Assurance Department is not yet operational. The weak M&E capacity is not unique to the (central) Ministry of Health, it is observed at all levels of the health system and has been further hampered by a frequent change of personnel and the enticement of staff to donor agencies. Initiatives to strengthen M&E capacities exist, yet they are not adequately coordinated.

Many technical working groups have not been functional, in particular their links with policy dialogue are poor. This deficient linkage undermines the quality of policy dialogue which partly depends on the level of technical sector knowledge. The joint sector review, i.e. the Ugandan Joint Review Meeting, is considered satisfactory; there is broad-based participation from different stakeholders and room for criticism and discussion. However, there is a lack of attention for the more systemic issues while it are particularly insights into the underlying systemic issues which might help to understand a lack of progress in health sector outcomes. While the quality of the health sector M&E system strongly affects the quality of the sector performance report (one of the major inputs into the joint review), diagnosis and follow-up of the health sector M&E system itself did so far not figure on the agenda of the Joint Review Meeting. The quality of the health sector M&E system (e.g. data quality and data use) was also not an issue covered during the pre-Joint Review Meeting missions. This lack of attention for the quality of the M&E system itself is all the more surprising from the perspective of the budget support donors as they primarily rely on the outputs of the M&E system for their own accountability towards their constituencies.

Government ownership of M&E is currently on the increase and might become stronger in the future if the new minister and top management staff are keeping up with expectations. Incentives for using data are not institutionalised, but this might change in the context of the increased emphasis on performance (see e.g. the district league table and the presidential retreats).

The link between the Ministry of Health and the Uganda Bureau of Statistics (UBOS) is relatively strong. The importance of UBOS for health sector M&E is acknowledged within the Ministry of Health and in order to steer the linkage among both entities, a UBOS employee has been installed within the ministry's Resource Centre. Vertical integration, both upwards (with the Office of the Prime Minister, Ministry of Finance, Planning and Economic Development, National Planning Authority) and downwards (with districts) is satisfactory, at least on paper. However, in practice the upward vertical integration is hampered by the complex interaction between the different national players responsible for part of the central level coordination and oversight (see above). Downward vertical integration is challenged by the poorly coordinated and planned supervision visits from the Ministry of Health to the districts and by the weak functioning of the health centres IV (health sub-districts). While health centres at this level are responsible for the compilation of data from lower levels, they are not always functional enough to accomplish this responsibility (e.g. due to lack of computers to facilitate analysis). Linkages with donor project M&E are stimulated through the agreements in the Long Term Institutional Arrangements which are expected to contribute in countering challenges related to fragmentation, duplication and weak coordination. Horizontal integration (among different sub-components of the sector) is weaker as this integration is circumvented by the fact that different health departments receive direct support from different health development partners. This direct targeting of funds gives them power to elaborate their own systems and reduces incentives to adhere to one coherent health sector M&E system.

#### *Participation of actors outside government*

In the M&E plan the role of Parliament, the Office of the Auditor General, civil society and development partners are acknowledged and responsibilities of each of them are identified. They are represented in technical working groups and participate during the National Health Assembly and Joint Review Meeting. While members of the Social Service Committee of Parliament have appreciated the health SWAp and use of budget support, many of them only come into action when issues are raised concerning their own districts. The Office of the Auditor General has been important in carrying out financial, value for money and other audits, which have been sent directly to Parliament. While the majority of civil society organisations participating in the SWAp are weak (e.g. poor quality of input which mainly relies on anecdotal evidence), several health organisations have collaborated in writing a report which summarises their perspectives on performance in the health sector. Moreover, organisations such as the Uganda Debt Network are engaged in community based monitoring, which supplies a continuous flow of information on local level realities. In practice (some) development partners have relatively more influence in the M&E of the health sector (e.g. the WHO, GFATM and GAVI Alliance were involved in the elaboration of the M&E plan) as compared to the national outside government stakeholders. In spite of their higher influence in health sector M&E, development partners do not seem to be interested much in

M&E capacity strengthening which is generally less visible than investment in specific disease control.

Linkages among different actors outside government also tend to be largely underdeveloped in spite of the fact that these different actors have different comparative advantage when it comes to (steering) M&E. Civil society organisations for instance have easier access to local level data collection (reality checks), universities have more analytical capacity, parliament has more access to the political arena and donors to the policy level. So far however outputs of community-based monitoring exercises are for instance hardly used by parliament and development partners. What might be particularly interesting for development partners is to support domestic accountability actors within a framework of a portfolio approach, whereby developing capacity of domestic accountability actors is combined with increasing the room of manoeuvre of these domestic accountability actors as well as with using information from the local level monitoring exercises in their (development partners) own policy dialogue with government at sector level.

#### *Use of M&E outputs*

While the quality of the Annual Health Sector Performance Report (AHSPR), one of the most important outputs of the M&E system, has improved over time, it still shows several shortcomings, particularly with regard to the analytical quality. The lack of analysis in the AHSPR as well as in lower level performance reports affects their quality and immediately puts into perspective the usefulness of these reports. Several initiatives to improve data quality have been taken and recently the Ministry of Health has elaborated a National Quality Improvement Framework and Strategic Plan, with the aim to harmonise amongst these different initiatives.

As highlighted above, M&E findings generally remain underutilised and this deficient M&E demand side affects M&E supply and sustainability of the system. Particularly at the local level there is little interest in M&E findings (and accuracy of data is also often not checked).

In short, while the recent elaboration of the health sector M&E policy is an important first step in strengthening the M&E system, it is particularly its implementation which is of paramount importance. Elements which might steer the implementation of the plan and the set up and sustainability of a health sector M&E system are the effective instalment of the M&E unit within the Quality Assurance Department, the funding of activities included in the M&E plan, investment in M&E capacity at all levels and the creation of incentives to use the data. Implementation might also be stimulated through monitoring of the progress in the establishment and functioning of the health sector M&E system itself. This might be done in the context of the Supervision, Monitoring, Evaluation and Research (SMER) technical working group and the Joint Health Review Meeting. Our diagnostic checklist might be useful in this respect.

# 1. INTRODUCTION

With the aim to increase aid effectiveness donors and recipients signed the 2005 Paris Declaration which sets out a reform agenda around the core principles of 'ownership', 'alignment', 'harmonisation', 'managing for results' and 'mutual accountability'. In 2008 commitments have been reaffirmed through the Accra Agenda for Action. Measurement of progress in the implementation of the Paris Declaration/ Accra Agenda for Action is based upon 12 indicators (OECD/DAC, 2005). The indicator for measuring progress in the 'management for results' principle is the "number of countries with transparent and monitorable performance assessment frameworks to assess progress against (a) the national development strategies and (b) sector programmes" (OECD/DAC, 2005: 10). The indicator is composed of three sub-components, i.e. 'stakeholder access to information', 'quality of information' and 'coordinated country-level monitoring and evaluation (M&E)'.

While commitments of donors in the area of 'results-orientation' are not captured in an indicator, donors promised to "link country programming and resources to results and align them with effective partner country performance assessment frameworks, and to refrain from requesting the introduction of performance indicators that are not consistent with partners' national development strategies" (OECD/DAC, 2005: 8). Additionally, they committed themselves to "work with partner countries to rely, as far as possible, on partner countries' results-oriented reporting and monitoring frameworks" (OECD/DAC, 2005: 8) and to "harmonise their monitoring and reporting requirements, and, until they can rely more extensively on partner countries' statistical, monitoring and evaluation systems, [work] with partner countries to the maximum extent possible on joint formats for periodic reporting" (OECD/DAC, 2005: 8). Moreover, donors and partner countries jointly committed to "work together in a participatory approach to strengthen country capacities and demand for results based management" (OECD/DAC, 2005: 8).

Interestingly, the recent Paris Declaration evaluation (phase II) (Wood et al., 2011) concluded that the relevance of the 'managing for results' principle has been weakened due to a narrow focus on the technicalities of results-oriented frameworks and indicators. At the outset a broader interpretation of the principle was foreseen: "using information to improve decisions; strengthening performance on the delivery of results towards clearly defined development goals" (Wood et al., 2011: 53).

As regards the development of results-oriented frameworks, some progress has been made recently. While the 2008 Paris Declaration survey reveals that only 3 (Mozambique, Tanzania and Uganda) out of 47 countries surveyed (6%) had results-oriented frameworks that were deemed adequate (OECD, 2011a: 86), this number increased to 15 countries<sup>2</sup> out of the 76 countries (21%) included in the 2011 Paris Declaration survey (OECD, 2011a: 86). Explanations for the recorded progress include the enclosure of stronger results frameworks in new national development strategies and the increased use of M&E in decision making

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<sup>2</sup> Tanzania retained its B score. Seven countries of the 32 countries which constituted the baseline for 2005 improved their scores to a B: Egypt, Ethiopia, Honduras, Kenya, Moldova, South Africa and Viet Nam. From the 45 other countries seven countries received a B score: Cameroon, Colombia, Indonesia, Jamaica, Nepal, Pakistan and Ukraine.

(OECD, 2011a). Despite this progress, the target of 36% of the countries having a result-oriented framework in 2010 is not met (OECD, 2011a). Most countries do have a number of M&E activities and arrangements in place, especially at sector level where progress is generally stronger than at national level (Wood et al., 2008), but there is often a lack of coordination between different components of a system (co-ordinated M&E is only largely developed in 16% of the countries, Wood et al., 2011). Moreover, M&E outputs, such as performance reports, are frequently incomplete and often include inaccurate data, which affects their utility (Nash et al., 2009). Donors, from their side, are reluctant to rely on systems which are only partially developed. This simultaneously blocks the further elaboration and maturing of recipient systems. In order to escape this persistent chicken-and-egg-dilemma, a pragmatic two-track approach could be a possible way forward. It combines the set-up and/or strengthening of recipient M&E systems (long-term) with complementary M&E activities fulfilling the existing M&E needs in the short and middle run (see Holvoet and Renard, 2007; Holvoet and Inberg, 2009).

Having an appropriate organisation of a national M&E system is crucial for a performance assessment framework to be nationally owned and properly functioning (technical interpretation of the 'managing for results' principle) as well as for the use of information for decision-making and results delivery towards development goals (original broader interpretation of the 'managing for results' principle). Such a national M&E system should have a clear division of responsibilities between different levels and layers of government and clearly identified information streams and accountability structures between central and line ministries and between the local and national level. While strengthening M&E systems does not seem to be a priority of many donors and partner countries, it is obvious that more efforts are needed to strengthen and use recipient M&E systems if donors want to make progress on the 'alignment' and the 'managing for results' principles. Strengthening recipient M&E systems generally leads to an improvement of accountability and learning, which may ultimately lead to increased performance and results on the ground. Along the same line, it has been observed that the quality of joint sector reviews largely depends on the quality of the underlying sector M&E system (Holvoet and Inberg, 2009). Strengthening sector M&E systems will contribute to an improvement of the quality of joint sector reviews in the short run and change its outlook over time. In the long run, joint sector reviews can evolve towards a kind of meta-evaluation instrument which monitors and evaluates the existing M&E system (including some reality checks on the ground) instead of being only an M&E instrument of activities and outputs.

Prior to the development or upgrading of an M&E system, it is important to assess the quality of existing systems or arrangements, taking into account both the M&E supply and demand side. A harmonised M&E diagnostic instrument does not exist so far, but there are some interesting independent and donor-led assessments and studies, e.g. the evaluation capacity building diagnostic guide and action framework (Mackay, 1999), the highly similar readiness assessment (Kusek and Rist, 2002), the diagnostic instrument elaborated in Bedi et al. (2006), the checklist used by Booth and Lucas (2002) in their diagnosis of Poverty Reduction Strategy Paper related M&E systems in 21 countries and the checklist used by Holvoet and Renard (2007) in their diagnosis of Poverty Reduction Strategy Paper related M&E of 11 Sub-Saharan Africa countries. While these tools are mainly used for the assessment of central M&E

systems, they could also guide assessment exercises of sector M&E systems. The scope of a sector diagnosis is obviously more limited, but key components and guiding principles of a sector M&E system largely overlap with those of a central M&E system. An important specific issue within a sector diagnosis is the contribution of sector M&E activities to a central M&E system (Mackay, 2007).

In the context of the O\*Platform Aid Effectiveness<sup>3</sup> (see annex 1 for the Terms of Reference), we elaborated a checklist to diagnose and monitor the quality of sector M&E systems (see annex 2). So far, we have applied this checklist to M&E arrangements in the health sectors of Niger (Holvoet and Inberg, 2011a) and Rwanda (Holvoet and Inberg, 2011b). The current report highlights the main findings of the stocktaking exercise in Uganda's health sector. Readers who are interested in general background information on M&E in the health sector (focus on health information systems and joint sector reviews) or recent global developments within the health sector (specifically focused on the development of Sector Wide Approaches and on evidence-informed health policy and systems) are referred to the Niger working paper (see Holvoet and Inberg, 2011a).

The checklist we used to assess the health sector's M&E systems focuses on six dimensions: i) policy, ii) indicators, data collection and methodology, iii) organisation (split into iii.a: structure, and iii.b: linkages), iv) capacity, v) participation of actors outside government and vi) use of M&E outputs. These criteria are further subdivided into 34 questions and assessed using a five-point scoring system: weak (1), partially satisfactory (2), satisfactory (3), good (4) and excellent (5). The assessment draws upon secondary data, including official documents provided by the government of Uganda, academic and grey literature on Uganda and health information systems, and on primary data (interviews with different stakeholders directly involved in and responsible for M&E in the health sector at district and central level as well as users of the M&E output). Interviews were conducted between the 19<sup>th</sup> and 25<sup>th</sup> of October 2011. In this period we participated as well in the pre-Joint Review Meeting field mission to Jinja (19 and 20 October), the National Health Assembly (24 November) and the first day of the Joint Review Meeting (25 November).

The structure of this document is as follows: section two presents general background information on Uganda, including a description of the national M&E system alongside the six dimensions which are also used for the assessment of the health sector M&E system. Section three focuses on the health sector of Uganda and provides some information on the health policy and strategic plan, the health systems and health financing. Section four provides an overview of the assessment of the M&E system in Uganda's health sector and section five concludes.

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<sup>3</sup> O\*platforms are policy advisory research platforms initiated by the Flemish Interuniversity Council (VLIR) and constitute a flexible collaboration arrangement between researchers and actors of development cooperation. The objective of Research Platform Aid Effectiveness is to inform, train and advise Belgian policy makers and aid managers and in this way to inspire a more effective development cooperation policy. For an overview of the output of the O\* platform aid effectiveness, please see [www.ua.ac.be/bos](http://www.ua.ac.be/bos).



## 2. Uganda: general background

Uganda is a land-locked country in central Africa with an estimated population of 30.7 million in 2009, of which the majority (88%) lives in rural areas (Ministry of Health, 2010). The economic growth has been rather high in recent years, 7% between 2005 and 2010 (Republic of Uganda, 2010a), and improvements have been made in reducing the percentage of the population living in poverty (Uganda is on track for meeting the first Millennium Development Goal<sup>4</sup>) (Republic of Uganda, 2010b). Especially the percentage of poor people in rural areas decreased considerably from 42.7% in 2002/03 to 27.2% in 2009/10, but it is still much higher than the percentage of poor people living in urban areas (9.1% in 2009/10) (Muwonge, 2011). Moreover, high variations exist between the different regions, with in 2009/10, 75.8% of the population in the North East being poor compared to 4% in Kampala (Muwonge, 2011). In the Human Development Index (HDI) Uganda is classified amongst the countries with the lowest human development (value 0.422, rank 143/169 in 2010). Table 2.1. gives an overview of the scores on the sub-indicators of the HDI.

Table 2.1. Scores on the sub-indicators of the HDI

Sub-indicator	Uganda	SSA
Life expectancy at birth (2010)	54.1	52.7
Mean years of schooling (2010)	4.7	4.5
Expected years of schooling (2010)	10.4	9.0
Gross National Income (GNI)/capita (PPP 2008 \$)	1,224	2,050

Source: UNDP, 2010

The GNI/capita minus HDI rank is 5 which highlights that Uganda, compared to countries with a similar level of GNI/capita, is effective in translating its growth to human development.

In the 2010 Human Development Report the Gender-related Development Index and the Gender Empowerment Measure are replaced by the Gender Inequality Index which measures “the loss in achievements due to gender disparities in the dimensions of reproductive health, empowerment and labour force participation” (UNDP, 2010: 26). The Gender Inequality Index values range from 0, perfect equality, to 1, total inequality. The value for Uganda is 0.715, which ranks the country at place 109 out of 138 countries. Table 2.2. gives an overview of the sub-scores of the Gender Inequality Index.

Table 2.2. Scores on the sub-indicators of the Gender Inequality Index

Sub-indicator		Uganda	SSA
Maternal mortality ration (2003-2008)		550	881
Adolescent fertility rate (1990-2008)		150.0	122.3
Seats in parliament (%) (2008)	F	30.7	17.3
Population with at least secondary education (% ages 25 and older) (2010)	F	9.1	23.9
	M	20.8	38.1
Labour force participation rate (%) (2008)	F	80.5	63.8

<sup>4</sup> MDG 1: Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day.

	M	91.2	82.3
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Source: UNDP, 2010

Even though gender equality is secured in the constitution of Uganda (World Bank, 2010a) and progress has been made in reducing gender inequalities and empowering women (Republic of Uganda, 2010b), gender inequality is still persistent and slowing down economic growth. Key gender-based barriers to economic growth and poverty reduction include:

- Marginalisation of women in business ownership, skills development, access to financial resources, non-agricultural employment, and inheritance rights;
- A marked gender gap in access to and control over productive resources;
- A lower access of women to health and education services;
- Early marriages and low girl primary school completion and secondary school enrolment, contributing to a high fertility rate and a high maternal mortality rate (World Bank, 2010a).

Other impediments to economic growth and poverty reduction are weak public sector management and administration, inadequate financial services to the private sector, weak infrastructure and insufficient production inputs (BTC, 2011).

Uganda is divided in districts, counties, sub-counties and parishes (Ministry of Health, 2010). In the nineties the Government of Uganda initiated a decentralisation programme, which is described by Jeppsson (2004) as “one of the most radical and comprehensive decentralization programmes ever attempted on the African continent” (Jeppsson, 2004: 15). According to Jeppsson, decentralisation resulted in a strong and well/structured government system at local level with local governments having political and administrative authority (Jeppsson, 2004). Francis and James (2003), however, conclude that mechanisms of decentralisation are established and functioning on the surface, but do not comprise a real participatory system of local governance. Their conclusion is among others based on the fact that most of the transfers from central level to local level are of a conditional nature, as a result of which local levels do not have real control over their resources: “the participatory planning process is thus more a matter of form than substance – a ritualized performance simulating local decision making” (Francis and James, 2003: 334). More recent evidence from the health sector (see 3.2.) shows that problems with the decentralisation process continue to exist.

In 2006 the Ministry of Local Governance elaborated a Decentralisation Policy Strategic Framework with the aim to consolidate all policy aspects of different decentralisation documents into a single policy framework that can be used by government, development partners and other stakeholders in the implementation of the decentralisation policy (Republic of Uganda, 2006a).

## **2.1. Policy, budgeting and implementation**

### ***Policy***

In 1997 Uganda elaborated its first Poverty Eradication Action Plan (PEAP), which served as an inspiration for the World Bank to launch Poverty Reduction Strategy Papers in the context of the Heavily Indebted Poor Countries (HIPC) initiative. In 2000 an updated version of the

PEAP (PEAP II) became Uganda's first Poverty Reduction Strategy Paper and Uganda was the first country to receive HIPC support (Republic of Uganda, 2008a). The first two PEAPs profited from a high level of political support and commitment. This support and commitment weakened, however, with the introduction of multi-party politics (2005) after which political leaders stopped referring to the PEAP in their national policy agendas (Republic of Uganda, 2008a). The PEAP scored quite positive in the 2006 and 2008 Paris Declaration surveys. In both surveys Uganda scored a B<sup>5</sup> for indicator 1 (i.e. do countries have operational development strategies), which means that the PEAP is largely developed towards achieving good practice (OECD/DAC, 2007 and 2008).

In 2010 the successor of the PEAP, the National Development Plan 2010/11 – 2014/15, was elaborated on the basis of an extensive and broad-based country-driven consultative process (IDA and IMF, 2010) and with hardly any influence of development partners (Republic of Uganda, 2011a). Ownership within government for the National Development Plan has been strengthened due to cabinet discussions prior to the presentation of the final National Development Plan to Parliament (IDA and IMF, 2010).

With a vision of “a transformed Ugandan society from a peasant to a modern and prosperous country within 30 years” and the theme “growth, employment and socio-economic transformation for prosperity” (Republic of Uganda, 2010c), the National Development Plan has the following objectives:

- Increasing household incomes and promoting equity;
- Enhancing the availability and quality of gainful employment;
- Improving stock and quality of economic infrastructure;
- Increasing access to quality social services;
- Promoting science, technology, innovation and information and communication technology to enhance competitiveness;
- Enhancing human capital development;
- Strengthening good governance, defence and security;
- Promoting sustainable population and the use of environmental and natural resources (Republic of Uganda, 2010c).

In the 2011 Paris Declaration survey (based on the National Development Plan), Uganda retains its B score (OECD, 2011a) and it thus did not reach its 2010 target to obtain an A score on Paris Declaration indicator 1. Uganda's country report of the second phase of the Paris Declaration evaluation criticises the National Development Plan for its lack of prioritisation, as a result of which development partners can easily choose to support their own interests, which are not necessarily Uganda's main development priorities, while still being aligned to the National Development Plan (Republic of Uganda, 2011a).

### ***Budgeting***

While Uganda's budget is generally considered credible, risks for fiduciary and corruption are high (conclusions of the Public Expenditure and Financial Accountability Assessment and

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<sup>5</sup> The highest possible score is A (National Development Strategy substantially achieves good practice), the lowest possible score is E (National Development Strategy reflects little action toward achieving good practice) (OECD, 2007).

draft Health Sector Fiduciary Risk Assessment, see BTC, 2011). Uganda introduced the Medium Term Expenditure Framework (MTEF) in 1992. Since 1998 the MTEF has been formally established as a key tool for the integration of budgeting and planning by translating policy priorities into resource allocation (Republic of Uganda, 2010d). The 2008 Paris Declaration survey refers to Uganda as one of the only four countries (out of 43) which managed to make an effective link between the national development strategy and the budget. The independent evaluation of the PEAP (Republic of Uganda, 2008a), however, concludes that the MTEF and the PEAP increasingly moved apart as the MTEF had to include non-PEAP originated initiatives. The fact that the MTEF is based on sectors and the PEAP on a pillar structure further complicated the link between the MTEF and PEAP (Matheson et al, 2008). The government of Uganda acknowledges the need for improved linkage and will revise the MTEF on the basis of the National Development Plan in order to better link expenditure priorities of the National Development Plan to the MTEF (Republic of Uganda, 2010c). A taskforce with representatives from the National Planning Authority, the Ministry of Finance, Planning and Economic Development and the Office of the Prime Minister is set up with the responsibility to initiate a framework for aligning the National Development Plan to the 2011/12 budget (concept note: linking the NDP to the MTEF, s.a.).

At national, sector and local government levels three-year rolling Budget Framework Papers are formulated, which set out planned outputs and their related costs in the medium term (Ministry of Health, 2010).

### **Implementation**

As regards the implementation of PEAPs, committees/working groups at four levels have been responsible. Table 2.3. presents an overview of the chair, members and responsibilities of the committees/ working groups at each level. For the implementation of the National Development Plan additional structures and systemic changes are foreseen (Republic of Uganda, 2010c).

Table 2.3. Chair, members and responsibilities of the committees/ working groups responsible for the PEAPs' implementation specified per level

<b>Level</b>	<b>Name</b>	<b>Chair</b>	<b>Members</b>	<b>Responsibilities</b>
1	Policy Coordination Committee (sub-committee of Cabinet)	Prime Minister	Cabinet members	- review progress on implementation across government - review new and obsolete policies and plans
2	Implementation Coordination Steering Committee	Head of Public Service/ Secretary to Cabinet	Permanent Secretaries	- ensure effective implementation of decisions made by the Cabinet and Policy Coordination Committee
3	Technical Implementation Coordination Committee	Permanent Secretary of the Office of the Prime Minister	- Directors and commissioners from all ministries, departments and agencies;	- coordinate implementation of actions of the Implementation Coordination Steering

			<ul style="list-style-type: none"> <li>- Representatives of non-governmental organisations;</li> <li>- Representatives of private sector;</li> <li>- Representatives of development partners.</li> </ul>	<ul style="list-style-type: none"> <li>Committee;</li> <li>- conduct relevant analysis on key constraints;</li> <li>- monitor the performance of Government.</li> </ul>
4	Sector Working Groups (16)	Lead institution in the respective sector	All ministries, departments and agencies	<ul style="list-style-type: none"> <li>- develop and implement five-year Sector Strategic Investment Plans</li> <li>- coordinate and oversee monitoring and evaluation (M&amp;E) activities at sector level</li> </ul>

Source: Republic of Uganda, 2010c and 2010g

According to the National Development Plan itself, important factors for its success are broad-based ownership of the plan, political will at the national and local government levels, sustained annual and quarterly planning, commitment of resources, increased private sector capacity, behaviour change, patriotism, progressive reduction of corruption and effective monitoring and evaluation to support implementation (Republic of Uganda, 2010c).

A real challenge will be the actual implementation of the National Development Plan. According to the Annual Report on Corruption Trends in Uganda (Republic of Uganda, 2010e), Uganda is good in establishing laws and regulations, but is known to be the country with the largest implementation gap in the world. Interviewees confirmed that this implementation gap not only applies to anti-corruption initiatives, but also more generally to laws and policies.

## 2.2. Monitoring and Evaluation

In the 2006 and 2008 Paris Declaration surveys Uganda was one of only two and three countries respectively who obtained a B-score for indicator 11<sup>6</sup> (i.e. do countries have monitorable performance assessment frameworks). This indicates that Uganda's performance assessment framework was largely developed towards achieving good practice (OECD/DAC, 2007 and 2008). Uganda obtained this score for all three sub-indicators of indicator 11: 'quality of development information', 'stakeholder access to information' and 'coordinated country-level M&E' (World Bank, 2007). The recent Paris Declaration country evaluation report assigns a score 2 for the 'managing for development' principle, which is indicative of the fact that it is considered successful<sup>7</sup>. Uganda received this positive score as a result of a better integration of results-based management principles into planning, budget tracking and national M&E (Republic of Uganda, 2011a). In the Paris Declaration evaluation (Wood et al.,

<sup>6</sup> Tanzania scored a B as well in both 2006 and 2008 surveys, Mozambique in the 2008 survey.

<sup>7</sup> Possible scores are 1: very successful; 2: successful; 3: some problems; 4: serious deficiencies (Republic of Uganda, 2011a).

2011) Uganda is mentioned as one of the four countries<sup>8</sup> which demonstrates evidence of strong national capacity in planning, managing and implementing results-driven national strategies. Uganda's Paris Declaration evaluation country report explicitly states in this regard that "performance in relation to management for development results has improved. The Paris Declaration (PD) has made a contribution in encouraging development partners to increasingly focus on development outcomes and the need to work together and also with the government in improving national statistics and poverty monitoring. However, other factors have been equally important. Prior to PD, Uganda's concern for development results was already strong" (Republic of Uganda, 2011a: 64 in Wood et al., 2011: 35).

In the recent 2011 Paris Declaration survey, however, Uganda's score on indicator 11 decreased to a C score, meaning that the performance assessment framework degraded from being 'largely developed' to 'action taken towards achieving good practice' (OECD/DAC, 2007). The Paris Declaration survey does not give any explanation for this decline (neither for the similar decline in Mozambique). It is neither possible to get more insight into the underlying sub-indicators of indicator 11 (access to information, quality of information, level of coordination) as, contrary to the 2006 and 2008 PD survey, no Comprehensive Development Framework report has been published prior to the 2011 PD survey<sup>9</sup>. Given Uganda's generally noted weak implementation track record (see 2.1.), a lack of implementation of the results-oriented framework could possibly explain the decline in Uganda's score. Differences among the assessments in the Paris Declaration monitoring survey and Paris Declaration evaluation might be related to the criticism of the evaluation that the 'managing for results' principle has been interpreted too technically in the Paris Declaration survey (see 1.). While the survey is particularly focussed on the existence of performance assessment frameworks, the evaluation is more comprehensive and takes the broader interpretation of the principle into consideration (see above). Some of the interviewees we met in Uganda neither agree with the deterioration in Uganda's score on indicator 11 and stress that the performance assessment framework has been improved in the previous years with the inclusion of stronger sector performance indicators, which resulted in improvements in performance reporting.

In this section the central M&E system of Uganda is presented alongside the different key components of an M&E system, i.e. policy; indicators, data collection and methodology; organisation; capacity; participation of actors outside government; and use of information from M&E. The most important documents which are used for the stocktaking include the M&E chapter of the National Development Plan, the M&E strategy for the National Development Plan, the National Policy on Public Sector Monitoring and Evaluation and a document elaborated by the National M&E Technical Working Group which describes suggestions for updating the National Integrated Monitoring and Evaluation Strategy (NIMES) for the National Development Plan.

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<sup>8</sup> The other three countries are Colombia, Mozambique and South Africa (Wood et al., 2011: 35).

<sup>9</sup> As a B score for two of the sub-indicators is sufficient for a total B score, it means that a deterioration (from B to C) has been observed for at least two sub-indicators.

### 2.2.1. M&E policy

Under the second PEAP the Poverty Monitoring and Evaluation Strategy (PMES) was introduced, which resulted in the identification of indicators and the assignment of responsibilities to individual institutions. However, “the PMES has done little to provide clarity on how institutions relate to each other; how information flows between them; what mechanisms exist to fine-tune various M&E systems to the data needs of the PEAP; and what incentive structure is in place for organisations to collaborate in the implementation of the strategy” (Canagarajah and van Diesen, 2011: S141). With the aim to provide a coordinated framework for M&E of not only the PEAP but also of other national plans, the government of Uganda launched the NIMES (Republic of Uganda, 2008a), which became the centre of M&E for the third PEAP (Canagarajah and van Diesen, 2011).

In April 2010 the M&E strategy for the National Development Plan was released as an addendum to the National Development Plan. Objectives of the strategy include the coordination and facilitation of ministries, departments and agencies, local governments and other stakeholders to regularly and systematically track progress of the implementation of priority initiatives of the National Development Plan; provision of an early warning system for potentially challenging areas or processes of implementation; provision of sustained technical backstopping and training for M&E; and facilitation of continuous learning by ministries, departments and agencies, local governments and other actors during the implementation of the National Development Plan (Republic of Uganda, 2010f).

One could expect that this M&E strategy for the National Development Plan would replace the NIMES, but the ‘National Policy on Public Sector Monitoring and Evaluation’ elaborated by the Office of the Prime Minister and released in November 2010 (but not yet approved by the Cabinet) became the successor of the NIMES. The relation between the policy and strategy are not entirely clear and the two documents do not refer to each other. The purpose of this national M&E policy is to: “Improve the performance of the public sector through the strengthening of the operational, coordinated, and cost-effective production and use of objective information on implementation and results of national strategies, policies, programmes and projects.” (Republic of Uganda, 2010g: 3). Specific objectives of the policy include:

- Embedding M&E in the management practices of ministries, departments and agencies and local governments;
- Expanding the coverage of public policy and programmes that are subjected to rigorous evaluation to ensure policy makers know what works and what doesn’t;
- Clarifying the roles and responsibilities of the various actors in the assessment of public policies and programmes;
- Strengthening the coordination of public and private institutions in the supply and demand of M&E;
- Strengthen the capacities of ministries, departments and agencies and local governments in terms of skilled personnel, requisite infrastructure, and policy environment to manage and implement the policy (Republic of Uganda, 2010g).

The M&E policy provides directives for the elaboration of a monitoring strategy for all sectors, which should be based on a matrix of performance indicators, with for each indicator an identification of source, timing, location and data collection methods. In addition, all ministries, departments and agencies are supposed to prepare and implement a five-year evaluation plan including a description of the different categories of evaluation to be conducted, an overview of the methodologies to be used, roles and responsibilities and a dissemination and follow-up strategy.

While the M&E strategy for the National Development Plan distinguishes between monitoring and evaluation in its description of what an M&E system is supposed to do (monitor the implementation of national development initiatives and evaluate their impact), the Office of the Prime Minister's M&E policy elaborates more on the differences and relationship between monitoring and evaluation. Definitions are provided for the notions of 'monitoring' and 'evaluation', as well as for other assessment functions, including 'review', 'inspection', 'control', 'audit' and 'value-for-money audit'. Moreover, the relationship of these assessment functions with the results chain is made explicit in a framework (Republic of Uganda, 2010g). In practice, however, hardly any evaluation is done, despite the fact that an Evaluation Coordination Working Group was set up under the NIMES (Republic of Uganda, 2008a). A consequence of the focus on monitoring at the expense of evaluation is that underlying reasons for (non)-performance are not revealed (see Holvoet and Renard, 2007). Recently, however, within the M&E department of the Office of the Prime Minister a Government Evaluation Facility has been initiated with three full time staff which will focus on public policy evaluations (interviewee)<sup>10</sup>.

Several references in both the M&E chapter of the National Development Plan and the M&E policy of the Office of the Prime Minister are made to the need for M&E to be independent and objective. Accountability is one of the guiding principles of the M&E policy as well as 'ethics and integrity': "to ensure the credibility and usefulness of M&E, impartiality, compliance with international standards in data collection, analyses and reporting and independence of evaluators should be respected" (Republic of Uganda, 2010g: 10).

The National Development Plan acknowledges that findings of M&E have so far not been shared across government and stakeholders and that feedback is still inadequate. The M&E strategy for the National Development Plan specifies the key stakeholders, including the Office of the Prime Minister, secretariat of the National Development Plan, parliament, ministries, departments and agencies, local governments, development partners, private sector and civil society and indicate that M&E findings should be communicated through quarterly, semi-annual and annual performance progress reports (Republic of Uganda, 2010f). The National Development Plan M&E chapter provides an overview of the reports that should be provided by different actors, see table 2.4. for an overview.

Table 2.4. Overview of reports to be provided by different actors

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<sup>10</sup> The Government Evaluation Facility has two roles: to design, conduct, commission, and disseminate evaluations on public policies and major investments (as directed by Cabinet); and to oversee improvements in the quality and utility of evaluations conducted across Government at a decentralized level (Office of the Prime Minister, 2011).



<b>Actor</b>	<b>Report</b>	<b>Frequency</b>
ministries, departments and agencies	- strategic performance report (outputs, outcomes) - budget performance report (outputs, expenditures) - sector performance reports	quarterly quarterly annually
local governments	- strategic performance report (outputs, outcomes) - budget performance report (outputs, expenditures)	quarterly quarterly
Ministry of Finance, Planning and Economic Development	- budget performance report - fiscal performance report	six-monthly annually
National Planning Authority	- national government performance report - national development report	six- monthly annually
Office of the Prime Minister	performance report (output to outcome)	annually

Source: Republic of Uganda, 2010c, National M&E Technical Working Group, 2009

The strategic performance reports and the budget performance reports of the ministries, departments and agencies and local governments are used as an input to the national government performance report of the National Planning Authority and the budget performance report of the Ministry of Finance, Planning and Economic Development respectively. In practice not all ministries', departments' and agencies' reports are finalised on time, as a consequence of which not all of them are represented in the national government and budget performance reports (interviewees). The national government performance reports and budget performance reports are to be used as an input for the performance report of the Office of the Prime Minister, in addition to amongst others the annual sector performance reports (only produced by a third of the sectors) and survey data of the Uganda Bureau of Statistics (UBOS) (National M&E Technical Working Group, 2009). The performance report of the Office of the Prime Minister is to be submitted to the Policy Coordination Committee and to Parliament and the national development report to the National Planning Forum which is chaired by the President of Uganda (Republic of Uganda, 2010c).

Uganda is given as example, together with Tanzania, for having established relatively clear links between strategic planning, resource allocation and performance data (World Bank, 2007). In order to feed into the planning and budget processes, the M&E policy prescribes that joint sector reviews have to be completed by mid October<sup>11</sup> and that "data producers should ensure that the production is synchronized with the policy and budget cycle and, hence, inform the planning and budget cycle" (Republic of Uganda, 2010g: 10).

<sup>11</sup> The National Development Plan mention that Joint Sector Reviews should be held for all sectors in August/ September (Republic of Uganda, 2010c: 412).

### **2.2.2. Indicators, data collection and methodology**

The National Development Plan identifies ten key indicators related to its different themes (growth, employment and socio-economic transformation for prosperity), including:

- Per capita income;
- HDI;
- Employment levels;
- Labour force distribution in line with sectoral Gross Domestic Product (GDP);
- Life expectancy;
- Skilled manpower level;
- Proportion of manufactured exports to total exports;
- Share of industry in GDP;
- Level of urbanisation;
- Country's competitive index (Republic of Uganda, 2010c).

Baselines and some targets for these key indicators and for indicators identified for the monitoring of the objectives of the National Development Plan are presented in the National Development Plan. However, no distinction is made between the different levels of indicators, as a result of which no clear program theory behind the interventions can be distinguished. In this respect, the Joint (International Development Association (IDA) and International Monetary Fund (IMF)) Staff Advisory Note on the National Development Plan mention that “for effective tracking and reporting on National Development Plan implementation and results, a coherent results framework needs to be developed which defines measurable indicators with baseline and targets for each intended sector objectives with clear linkages to suggested intervention” (IDA and IMF, 2010: 9). The National Development Plan acknowledges that the success of the strategy for M&E is dependent on, amongst other things, a coherent performance and results matrix which defines the inputs, strategies, outputs and outcomes (Republic of Uganda, 2010c). The M&E strategy for the National Development Plan, which was released one month after the National Development Plan includes a results framework consisting of four categories: the theme level results framework, the objective level results matrix, the key results areas matrix and the other key results areas matrix (Republic of Uganda, 2010f). The results framework includes indicators which are linked with the themes, the objectives and the (other) key results.

Comparing the results framework of the M&E strategy and that of the NIMES shows improvement. Under the NIMES the choice was made to focus predominantly on outcome indicators, with the underlying idea that the principal value of having a national M&E system is informing decision-makers at strategic and major policy-making levels (Matheson et al., 2008). Moreover, the authors of the PEAP had the idea that most stakeholders outside government and sector working groups are only interested in outcome indicators (Booth and Nsabagasani, 2005). However, others (see Matheson et al., 2008, see also 2.2.6.) highlight that the limited focus on outcomes undermined the value of the national M&E system, as products of this system could not easily be used to improve the performance of government.

As the number of key indicators in the National Development Plan is low, the need to set priorities and limit the number of indicators is apparently understood. It is not clear, however,

how these indicators were selected and who was involved in the selection process. Neither is it clear which methodologies are/will be used to monitor and evaluate progress on these indicators.

The M&E strategy for the National Development Plan lists the main tools and techniques for the collection of data that feeds into M&E. These include administrative records, baseline surveys, other surveys, case studies, field visits, macro-economic studies, document reviews, stakeholder meetings and workshops, review forums and the Geo Information System (Republic of Uganda, 2010f). According to the National Development Plan, M&E is too much dependent on information from surveys of the Uganda Bureau of Statistics (providing information on outcomes and impacts) which is due to an underdeveloped M&E function in the public sector (Republic of Uganda, 2010c). Even though several ministries have developed management information systems, these different parallel systems are not coordinated, as a result of which harmonisation is difficult (Republic of Uganda, 2010g). Ministries with the most comprehensive management information systems are the ministries of health, education, water and environment<sup>12</sup> (Republic of Uganda, 2010d).

### **2.2.3. Organisation**

The Office of the Prime Minister is responsible for the overall coordination and oversight of M&E of government policies and programmes<sup>13</sup> through the National Monitoring and Evaluation Technical Working Group, which has members from senior technical officers from sectors, development partners and civil society organisations (Office of the Prime Minister, 2011). Booth and Nsabagasani (2005) refer to a conflict of mandates between the Office of the Prime Minister and the National Planning Authority, which is responsible for the M&E of the effectiveness and impact of development programmes and the performance of Uganda's economy. According to the 2007 Comprehensive Development Framework progress report (World Bank, 2007), however, Uganda is one of four countries<sup>14</sup> which consolidated and clarified M&E responsibilities within government structures at central and local levels. This is also evident from the recent National Development Plan and M&E policy which provide an overview of the responsibilities of each actor in the M&E system (see annex 3 for an overview). However, despite the extensive description of responsibilities of different actors involved, both documents do not make clear how these actors are exactly linked. The lack of clarity on linkages and data flows between different actors involved in M&E was already an issue the PMES was criticised for (see 2.2.1, Canagarajah and van Diesen, 2011).

For a well functioning M&E system it is essential that the central M&E unit has linkages with the statistical office, M&E units of semi-governmental institutions, sector M&E units and M&E

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<sup>12</sup> In contrast to the discussion paper used for the formulation of the M&E policy (Republic of Uganda, 2010d), an input paper for the evaluation of the PEAP (Matheson et al, 2008) refers to the absence of a management information system in the environment sector.

<sup>13</sup> Booth and Nsabagasani (2005) and Canagarajah and van Diesen (2011) refer to the existence of a Poverty Monitoring and Analysis Unit within the Ministry of Finance, Planning and Economic Development, paid for by development partners and with the production of the PEAPs as prime responsibility. The Poverty Monitoring and Analysis Unit is recently transformed into the Budget Monitoring and Analysis Unit, still located within the Ministry of Finance, Planning and Economic Development (Republic of Uganda, 2011a).

<sup>14</sup> The other three countries are Mozambique, Nepal and Tanzania.

mechanisms of donors. Not all of these units might be inclined, however, to cooperate towards a functioning national M&E system, as, according to Booth and Nsabagasani (2005), government units as well as donors consider M&E of their activities as their own territory. Monitoring activities are attractive for ministries, departments and agencies and their staff, due to related allowances, and most donors consider their approach to M&E as more advanced. From this vantage point, Booth and Nsabagasani advise to “beware of seeing coordination of monitoring activities and data supply as a technical problem, subject to simple administrative solutions (convene a new committee, agree a capacity-building programme, etc.). In particular, adopting such solutions without addressing the systemic incentives to defend and extend existing monitoring activities is likely to increase the level of duplication, waste and over-load. The better approach involves having moderate expectations, and being smart about cultivating incentive change” (Booth and Nsabagasani, 2005: 34). Recently progress has been made in creating incentives for M&E, especially as a result of the introduction of half-yearly retreats with the president, the ministers and Permanent Secretaries. During these retreats performance of the different ministries is discussed (naming and shaming) on the basis of the output oriented budget tool developed by the Ministry of Finance, Planning and Economic Development (linking budget monitoring of the Ministry of Finance, Planning and Economic Development and real sphere monitoring of the Office of the Prime Minister), which also stimulates the improvement of the quality of performance reports (the more technical aspect of M&E) (interviewee).

As important data is supplied through the UBOS surveys and censuses, the UBOS plays an important role within the national M&E. According to the World Bank (2010a), the UBOS is one of the most professional and transparent statistical offices in Africa. In addition to the production of data, the UBOS is responsible for:

- Coordination, support, validation and designation of any statistics produced by UBOS, ministries, departments and agencies and local governments;
- Harmonisation and dissemination of statistical information;
- Strengthening of statistical capacity of planning units in ministries, departments and agencies and local governments for data production and use;
- Attention to best practice and adherence to standards, classification and procedures for statistical collection, analyses and dissemination in ministries, departments and agencies and local governments (Republic of Uganda, 2010g).

Similar to most of the low income countries borrowing from IDA (71 out of 79 countries) and as agreed upon during the 2004 Second International Roundtable on Managing for Development Results, Uganda elaborated a National Strategy for the Development of Statistics (OECD, 2011a). The UBOS was responsible for the coordination of the elaboration of Uganda’s National Strategy for the Development of Statistics (i.e. the Plan for National Statistical Development (2006/7 – 2010/11) (Republic of Uganda, 2006b).

At sector level sector working groups are responsible for coordination and oversight of M&E activities. Sector working groups develop and implement five-year Sector Strategic Investment Plans, including a results-orientated monitoring matrix and a 5-year evaluation plan, and annual Sector Budget Framework Papers derived from the Sector Strategic Investment Plans. The sector working groups also organise bi-annual internal reviews and

annual joint sector reviews in October. The joint sector reviews focus on the assessment of performance of the previous year and on the actions and budgets for the coming year (Republic of Uganda, 2010g). The most important inputs to these joint sector reviews are the sector performance reports. Issues raised during the joint sector reviews as well as cross-cutting issues are discussed during the National Planning Forum (Republic of Uganda, 2010c), which takes place in November (Republic of Uganda, 2010g). So far joint sector reviews cover only less than one third of the sectors (Office of the Prime Minister, 2011).

In 2009 the organisation of annual events at sub-county level, so-called 'barazas', was piloted to enable the public to hold public officials accountable for service delivery. The pilot was organised in four districts and eight sub-counties (June 2009) and lessons from the organisation of these pilot 'barazas' were fed into the introduction of 'barazas' nationwide<sup>15</sup> (National Monitoring and Evaluation Technical Working Group, 2009). The focus during these 'barazas' is on services related to health, education, water, agriculture and roads and brings together policy makers (central government), public service providers (local government) and public service users (citizens). By September 2011 24 districts had hosted at least two fora per district and in the financial year 2011/2012 all districts are expected to organise 'barazas' in two sub-counties (Republic of Uganda, 2011b). The Office of the Prime Minister, which is responsible for the implementation of the 'barazas', documented the issues raised during the 'barazas' in the 24 districts and concludes that the 'barazas' have shown to be a tool for strengthening the decentralisation policy and democratisation process (Republic of Uganda, 2011b).

Ownership and the utilisation of incentives are essential for the development of a successful M&E system. While ownership is considered as a prerequisite for all development interventions (see e.g. the Paris Declaration), the utilisation of incentives is particularly important for stimulating the use of data, as the demand side is even more important than the supply side. As Mackay (2007: 54) puts it "if demand for M&E is strong, then improving supply in response can be relatively straightforward, but the converse does not hold"<sup>16</sup>. In Uganda, however, there is a lack of ownership of the national M&E system, as it to a large extent driven by donors (Republic of Uganda, 2010c), and incentives are not used to stimulate use of results information by public sector players (Republic of Uganda, 2008a). Recent policy documents do refer to the importance of ownership and the use of incentives. The M&E policy includes ownership as one of the guiding principles and emphasises that M&E should be guided by national priorities and planned, coordinated and managed within national systems (Republic of Uganda, 2010g). The National Development Plan and M&E strategy refer to the need to establish a strong incentive system, which should be linked to performance contracts of Permanent Secretaries and Chief Administrative Officers (Republic of Uganda, 2010c). According to Booth and Nsabagasani (2005) incentives for using data and for an improved coordination should come from the budget/MTEF process (Budget Framework Papers), sector working groups and reviews, the Fiscal Decentralisation Strategy and the joint review

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<sup>15</sup> Some of these 'barazas' were organized together with the Ugandan Debt Network who have a track record in community based monitoring (see 4.5).

<sup>16</sup> Mackay (2007) distinguishes three types of incentives: *carrots*, which provide encouragement and rewards for M&E and utilizing the findings; *sticks*, which give punishments to ministries or individual civil servants who do not take performance and M&E seriously; and *sermons* which involve high-level statements of endorsement and advocacy with regard to the importance of M&E.

of the Poverty Reduction Support Credit<sup>17</sup> (in the mean time replaced by the annual high-level forum of the Joint Budget Support Framework, see 2.3.). The move towards a performance-oriented budget already led to a stronger demand for and production of qualitative data (World Bank, 2007). Also the half-yearly retreats with the president, the ministers and Permanent Secretaries stimulates the improvement of the quality of performance reports (see above).

#### **2.2.4. Capacity**

The currently present M&E capacity is inadequate, as e.g. M&E positions do not yet exist and statisticians are not well represented across public services (Republic of Uganda, 2010g). A discussion paper which was used for the formulation of the M&E policy (Republic of Uganda, 2010d) refers to the fact that several agents in M&E units received some training on M&E, which was however insufficient to be really useful. Moreover, due to high staff turnover, trainings are continuously needed. The discussion paper refers as well to the fact that capacity constraints are higher at district level, where M&E functions are conducted by technical and administrative officers. Important capacity strengthening is especially needed in the areas of data management, analytical skills, results monitoring, impact evaluation, internet skills, network skills and collection and management of administrative data (Republic of Uganda, 2010d).

Weaknesses of the present M&E system are explicitly acknowledged in the National Development Plan which states that “the current national M&E arrangements are weak and comprise only a few functional systems at sector level. They are characterised by fragmentation; duplication; weak co-ordination; lack of a clear results chain; poor definitions, tracking and reporting of outcomes and results; use of different formats and approaches with no common guidelines and standards; lack of national ownership; inadequate feedback and sharing of results across Government and other stakeholders; poor use of the data generated; problems related to capacity and resourcing; and are donor driven” (Republic of Uganda, 2010c: 407).

While an M&E capacity plan does not exist, the M&E policy highlights the importance to recruit one or more monitoring, statistics and evaluation specialists in units at all levels: project, local government Planning Unit, Ministry Planning Unit and Sector Working Group Secretariat (Republic of Uganda, 2010g). The authors of the evaluation of the implementation of the Paris Declaration in Uganda (Republic of Uganda, 2008b), plead for a coordinated strengthening of M&E capacity with donors providing funds through a basket and government setting out a clear strategy.

#### **2.2.5. Participation of actors outside government**

Important outside government actors in the M&E system are the Parliament (supported by the Office of the Auditor General), civil society organisations and development partners. The Parliament is officially responsible for:

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<sup>17</sup> The PRCS is a lending instrument from the World Bank which provides lending for implementation of Poverty Reduction Strategy Papers.

- Scrutinising various objects of expenditure and the sums to be spent on each;
- Assuring transparency and accountability in the application of public funds;
- Monitoring the implementation of Government programmes and projects (Republic of Uganda, 2010g).

Uganda's report of the second phase of the evaluation of the Paris Declaration concludes that "Parliament is still to be fully accorded its space to make critical decisions on new and existing aid, including monitoring its impact on the population and holding sector ministries and development partners to account" (Republic of Uganda, 2011a:xii). Wild and Domingo (2010) also mention that the Parliament is not considered an effective watchdog and is hardly involved in decision making on government activities. According to interviewees most parliamentarians are mainly interested in their own constituencies. They respond when there are issues in their own district or region, but not when there are general issues on which they do not necessarily win votes. While the research department within parliament is fairly well staffed (17 staff members), it is underused by parliamentarians. They mainly use this department when issues are discussed related to budget matters or which affect their own district. In May 2011, however, a new Parliament has been installed including many relatively young parliamentarians. According to one of the interviewees, these younger parliamentarians have a higher reading culture which increases the probability that information from M&E reports will be read and used. While it is too early to assess, it has so far resulted in a more objective and qualitative debate, despite the fact that a large majority of parliamentarians is from the ruling party. Contacts between Parliament and development partners are very minimal as development partners do not show much willingness to involve Parliament in an early stage of their negotiations with the government (interviewees). Whereas contacts between Parliament and civil society organisations are also limited, a kind of liaison within Parliament will be established in order to stimulate contacts between Parliament and civil society organisations (interviewees).

The Office of the Auditor General ensures that Parliament is involved in the monitoring and management of public finances, by delivering annual expenditure reports directly to different commissions of Parliament (Wild and Domingo, 2010). The main functions of the Office of the Auditor General include undertaking financial audits of all public accounts, carrying out value for money audits for projects involving public funds and carrying out revenue and expenditure inspections at local levels (Office of the Auditor General of Uganda, 2006). According to Wild and Domingo (2010) the Office of the Auditor General is poorly resourced, which negatively affects its effectiveness, and, even more importantly, it also seems to lack independence.

The M&E policy describes the role of civil society organisations and development partners in the national M&E system as follows:

- Provide an external perspective on Government performance and results;
- Provide feedback to domestic and international constituencies on Government performance and results;
- Assist Government through financial, technical and other forms of assistance to strengthen its performance (Republic of Uganda, 2010g).

The documents do not exactly make clear in which committees/ working groups civil society organisations and development partners participate.

Examples of civil society organisations involved in the preparation, implementation and monitoring of national policies are the Uganda Debt Network<sup>18</sup> and the Uganda National Non-Governmental Organisation Forum<sup>19</sup> (Canagarajah and van Diesen). Civil society organisations' role in holding government and development partners accountable have been weakened recently as a result of the global international crisis, which caused a decline in civil society organisations financing (Republic of Uganda, 2011a).

Development partners play a key role in commissioning and managing evaluations of public policies and programmes: only 10 out of 85 evaluations conducted in Uganda between 2005 and 2008 were commissioned and/or co-managed by the Government of Uganda (Office of the Prime Minister, 2011). The recently established Government Evaluation Facility is expected to change this dominance of development partners.

#### **2.2.6. Use of M&E outputs**

The M&E strategy describes its expected main outputs and outcomes. Outputs include basic statistical data on activities, resources, outputs and beneficiaries; regular updates on key performance indicators; performance reports; a functional government-wide unified integrated, harmonised and well coordinated M&E system with effective and timely feedback to stakeholders; and a national infrastructure for M&E (Republic of Uganda, 2010f). Outcomes include the achievement of the overall goal of the National Development Plan; enhanced transparency and accountability in the use of public resources; and increased efficiency and effectiveness in public sector delivery (Republic of Uganda, 2010g).

In their research on the institutionalisation of M&E in Uganda, Booth and Nsabagasani (2005), conclude that there is a poor match between data needed by decision makers and data produced by the M&E system. The poor quality of administrative information and therefore the overdependence on data from surveys and censuses (see 2.2.2.) might be an underlying reason for this poor match as data from surveys and censuses are mainly on outcome and impact level. According to Booth and Nsabagasani (2005) a narrow focus on outcomes and impact leads to the disregard of data because, "feedback about outcomes and impact is, in the best circumstances, very easily dismissed as somebody else's responsibility, or no one's. When general incentives improve, policy makers will be much more likely to make serious use of data about things that move quickly and over which they have a reasonable degree of control and/ or which are significant in an intended chain of events that they themselves have adopted as strategy" (Booth and Nsabagasani, 2005: 28).

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<sup>18</sup> The mission of the Uganda Debt Network is "To promote and advocate for pro-poor policies and full participation of poor people in influencing poverty-focused policies, monitoring the utilization of public resources and ensuring that borrowed and national resources are prudently managed in an open, accountable and transparent manner so as to benefit the Uganda people" (<http://www.udn.or.ug/aboutus.htm>).

<sup>19</sup> The mission of the Non-Governmental Organisation forum is "To provide a sharing and reflection platform for Non-Governmental Organisations to influence governance and development processes in Uganda, and enhance their operating environment" ([http://ngoforum.or.ug/index.php?option=com\\_content&view=article&id=19&Itemid=27](http://ngoforum.or.ug/index.php?option=com_content&view=article&id=19&Itemid=27)).



Matheson et al. (2008) refer to the fact that quarterly and annual performance reports (see table 2.4.) are hardly used for learning at the level of policy and management issues due to the overload of details in these reports which limits the possibility to provide review and feedback to the authors. Moreover, these reports are mainly seen as a precondition for accountability towards donors and disbursement requirements (Matheson et al., 2008). The recent introduced half-yearly retreat between the president, the ministers and Permanent Secretaries, however, contributed to an improvement in the quality of the performance reports and therefore to the usefulness of these reports (see also 2.2.3.).

Since the existence of the Joint Budget Support Framework (2009) development partners increasingly use the data provided by the government (interviewees), including amongst others information generated through sector M&E systems (Republic of Uganda, 2008b). As highlighted in the Paris Declaration evaluation report, development partners also used expenditure tracking studies in their decision-making (Wood et al., 2008). A tracking study in the education sector (led by the World Bank) e.g., which provided particularly useful information on teacher absenteeism rates and pupil completion rates in primary schools, led to new initiatives to support the education management information system (Republic of Uganda, 2008b).

The M&E policy recognises the limited use of data and states that the development of an M&E system should start with an identification of the users at all levels and their information needs. It further refers to several initiatives which will be taken by the government of Uganda to ensure increased use of M&E outputs, including:

- Information accessibility and use: accessibility of M&E reports in a timely manner to all stakeholders including parliament and citizens;
- Accountability mechanisms: all ministries, departments and agencies and local governments will be held accountable for the use of resources under the Public Finance and Accountability Act and for the achievement of targets set and agreed upon annually. All accounting officers and senior managers will be held accountable for the use of resources set out in their Performance Contracts with respectively the Ministry of Finance, Planning and Economic Development and the Ministry of Public Service (and where relevant the related line Ministry);
- Learning mechanism: all performance reviews and evaluations will contain specific, targeted and actionable recommendations; all target institutions will provide a response to recommendations within a stipulated timeframe; all institutions will be required to maintain a Recommendations Implementation Tracking plan; and institutions with an oversight responsibility will monitor the implementation of agreed actions utilising the Recommendation Implementation Tracking Plan (Republic of Uganda, 2010d).

### **2.3. Development Aid**

In 2009 Uganda received 1,786 million USD Official Development Aid (ODA), which is an increase of 2.8% compared to the ODA received in 2007. The three most important development partners in terms of volume (2008/09 average) were the United States (260 million USD), IDA (289 million USD) and institutions of the European Union (193 million USD) (OECD and World Bank, s.a.). Uganda's dependence on ODA decreased significantly from

70% of government expenditure in 2003 to around 32.6% in 2009/10 (Republic of Uganda, 2011a).

Development partners in Uganda are organised through the Local Development Partners Group, which was set up after the Paris Declaration and which is chaired by the World Bank. The National Development Plan includes the requirement that all development partners, including non-traditional partners, should actively participate in the Local Development Partners Group or act under its umbrella (Republic of Uganda, 2011a).

The Uganda Government prefers aid to be disbursed through general budget support, as this modality “fully uses government systems thereby reducing transaction costs; allows dialogue between the Government and development partners to focus on policy commitments and priorities; gives the Government flexibility to implement the National Development Plan; and strengthens the Government’s accountability to Parliament, civil society and its citizens” (Republic of Uganda, 2010h: 3). Development partners who supply general and sector budget support have to join the Joint Budget Support Framework (Republic of Uganda, 2010h), which was approved in October 2009 (World Bank, 2010). The aim of this framework is to reduce budget support transaction costs, to increase predictability of disbursements and to create a stronger and more consistent policy dialogue which promotes mutual accountability consistent with the Paris Declaration and Accra Agenda for Action (World Bank, 2010a). The twelve Joint Budget Support Framework partners<sup>20</sup> are organised through the Development Partner Policy Committee which meets with the Uganda Government at an annual high-level forum, and through a Technical and Policy Dialogue Taskforce, which is responsible for the coordination of the design and implementation of the Joint Budget Support Framework and for the organisation of an annual performance assessment. The recent 8<sup>th</sup> Poverty Reduction Support Credit of the World Bank will be implemented, monitored and evaluated through the Joint Budget Support Framework (World Bank, 2010b).

The Joint Budget Support Framework development partners and the Government of Uganda agreed on a Joint Assessment Framework to be used for the assessment of government’s performance (World Bank, 2010). The Joint Assessment Framework consists of four sections: (I) preconditions for effective and efficient implementation of government policies; (II) improved value for money in service delivery through removal of barriers in public financial management and public sector management systems while reinforcing compliance with regulations and avoidance of leakages; (III) sector results matrixes (for the sectors health, education, transport and water and sanitation); and (IV) donor performance. The inclusion of donor performance improved Uganda’s score on mutual accountability (indicator 12) in the 2011 Paris Declaration survey (in 2006 and 2008 Uganda was not included in the list with countries with reviews of mutual accountability, see OECD/DAC, 2007 and 2008). Uganda’s country report of phase II of the Paris Declaration evaluation, however, assigns the lowest score possible to mutual accountability because of serious deficiencies and the need for better mechanisms for donors and partner countries to address mutual accountability (Republic of Uganda, 2011a). The annual performance assessment of 2009/10 shows that of

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<sup>20</sup> The twelve Joint Budget Support Framework partners are: African Development Bank, European Commission, World Bank, Austria, Belgium, Germany, Ireland, the Netherlands, Norway, Sweden and the United Kingdom.

the first section (preconditions) of the Joint Assessment Framework the anti-corruption precondition was not met. Of sections II and III only 41.2% of the indicators and 57.7% of the actions (excluding missing data ) were met, compared with 75.0% and 54% of the indicators and actions in the 2008/09 assessment (JBSF partners, 2010).

The 2011 Paris Declaration survey shows some improvements in several alignment and harmonisation indicators since 2005 (see table 2.5), but not all of the 2010 targets for the alignment indicators were met while none of the 2010 targets for the harmonisation indicators were met. Reasons for not reaching the targets could include the decrease of amounts of general budget support, related to the fact that development partners continue to be concerned about governance issues. According to the Overseas Development Institute (ODI) both development partners and the Government of Uganda should acknowledge this fact and should focus on other ways to make aid more effective in Uganda. The authors propose a shift from project aid to non-traceable sector budget support, as sector budget support is not considered as risky as general budget support and is more suitable in supporting service delivery (Overseas Development Institute, 2010). Another factor which negatively affects progress in harmonisation are several challenges with respect to partnership which still exist despite Uganda government's outline of partnership principles in 2003 and the signing of the Paris Declaration and Accra Agenda for Action by the Government of Uganda and most development partners. Challenges include the "strengthening of institutional capacities; increasing the alignment of development cooperation with Uganda's development strategy; harmonising development partner practices and enhancing the predictability of external assistance, as well as increasing its accountability and transparency" (Republic of Uganda, 2010h:1). Both the PEAP evaluation and Uganda's Paris Declaration evaluation conclude that one of the problems within the partnership is the overload of time senior managers and policy-makers have to spent on it at the expense of time needed to address implementation problems (Republic of Uganda, 2008a; Republic of Uganda, 2011a).

Table 2.5. Summary table of Paris Declaration monitoring survey

	<b>Indicators</b>	<b>2005</b>	<b>2007</b>	<b>2010</b>	<b>2010 Target</b>
<i>Alignment</i>					
3	Aid flows are aligned on national priorities	79%	98%	96%	90%
4	Strengthen capacity by co-ordinated support	42%	58%	76%	50%
5a	Use of country public financial management systems	60%	57%	66%	73%
5b	Use of country procurement systems	54%	37%	43%	NA
6	Strengthen capacity by avoiding Parallel PIUs	54	55	15	18
7	Aid is more predictable	84%	74%	74%	92%
8	Aid is untied	81%	85%	95%	>81%
<i>Harmonisation</i>					
9	Use of common arrangements or procedures	50%	66%	49%	66%
10a	Joint missions	17%	21%	24%	40%

10b	Joint country analytic work	35%	54%	56%	66%
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Source: OECD/DAC, 2008

In reaction to these challenges the Government of Uganda decided to strengthen mechanisms for partnership management and elaborated the Uganda Partnership Policy in 2010 (which still has to be approved by the Cabinet). The policy's objectives are:

- “Improve the effectiveness of development cooperation through greater government ownership and leadership;
- Strengthen economic management by increasing flows of development assistance through the budget, and coordinating off-budget flows;
- Increase transparency and accountability between the government and development partners and between the government and its citizens in the management of development cooperation; and
- Accelerate progress towards policy coherence in Uganda's relationships with its development partners” (Republic of Uganda, 2010h: 1).

The implementation of the Partnership Policy will be guided by a Memorandum of Understanding between the Ugandan Government and the development partners (Republic of Uganda, 2010h).

### 3. Uganda's health sector

While Uganda's health policy is quite optimistic on improvements in the health situation of its population over the last decade (e.g. the life expectancy increased from 45 years in 2003 to 52 in 2008; the HIV prevalence rate reduced from 27% in 2000/01 to 7% in 2007/08 and the under-five mortality rate decreased from 156 in 1995 to 137 per 1,000 live births in 2005) (Republic of Uganda, 2010a), other documents (Republic of Uganda, 2010b; Republic of Uganda, 2011a; BTC, 2011) refer to the lack of performance in the health sector. Of the 25 indicators formulated in the second Health Sector Strategic Plan (HSSP II), performance declined for 5 of them, for 11 indicators an improvement was recorded which was however insufficient in view of their targets and for 9 indicators no comparable data was available (BTC, 2011). As table 3.1. shows, Uganda still has low scores on most of the health-related Millennium Development Goals (MDG) indicators. For almost half of the indicators (8/17) Uganda scores worse than the African average. The relatively best scoring indicators include maternal mortality rate (which is however still among the highest in the world, caused e.g. by high fertility rates and poor pre- and post-natal care, Republic of Uganda, 2011a)<sup>21</sup>, antenatal care coverage, tuberculosis mortality rate and population using improved sanitation.

Table 3.1. Performance of Uganda and average of Africa on the health-related MDG indicators (for which a regional average is available)

Indicators (a)	Uganda	African average
Children aged <5 years underweight (%)	16.4	
Under-five mortality rate (per 1000 live births), 2009	128	127
Measles immunization coverage among 1-year-olds (%), 2009	68	69
Maternal mortality (per 100,000 live births), 2008	430	620
Births attended by skilled health personnel (%)	42	
Contraceptive prevalence (%)	23.7	24.4
Adolescent fertility rate (per 1000 girls aged 15-19 years)	159	117
Antenatal care coverage (%): at least 1 visit	94	74
Unmet need for family planning (%)	40.6	24.8
Prevalence of HIV among adults aged 15-49 years (%), 2009	6.5	4.7
Males aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%)	38	33
Females aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%)	32	25
Antiretroviral therapy coverage among people with advanced HIV infection (%) 2009	39	37
Malaria mortality rate (per 100,000 population), 2008	103	94
Children aged <5 years sleeping under insecticide-treated nets (%)	9	17
Children aged <5 years with fever who received treatment with any antimalarial (%)	61	
Tuberculosis mortality rate among HIV-negative people (per 100,000 population), 2009	29	52
Population using improved drinking-water sources	67	61

<sup>21</sup> Uganda has elaborated a Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity, 2007-2015 (Republic of Uganda, 2010b).

(%), 2008		
Population using improved sanitation (%), 2008	48	34

Source: World Health Organisation, 2011

(a) For the indicators for which no specific year is given, the World Health Organisation (WHO) report mention 'the latest available data since 2000'

The main causes of mortality and morbidity in Uganda are malaria, malnutrition, respiratory tract infections, AIDS, tuberculosis and perinatal and neonatal conditions, which are all to a high degree preventable (Republic of Uganda, 2010a). Jeppsson (2002) refers in this respect to the focus of Uganda's strategic health plans on curative services (with an emphasis on constructing new regional hospitals and high-tech solutions) instead of a focus on preventive measures in e.g. areas of water and sanitation. The second HSSP (2005/06-2009/10), however, defines the Uganda National Minimum Health Care Package (UNMHCP), with a clear focus on prevention. The four clusters of the UNMHCP are:

- Health promotion, disease prevention and community health initiatives,
- Maternal and Child Health;
- Prevention and control of communicable diseases; and
- Prevention and control of non-communicable diseases (Ministry of Health, 2010).

Moreover, Uganda renewed its commitment to primary health care, including health system strengthening, at the Ouagadougou Conference in 2008. Referring to this commitment, the second National Health Policy (Republic of Uganda, 2010a) points to the need for investments in health promotion and disease prevention. However, various interviewees highlighted that in practice also nowadays too many resources are provided to hospitals at the detriment of primary health care.

Key structures of the Ministry of Health are the Top Management Committee, the Health Policy Advisory Committee (i.e. the forum for government, development partners and other stakeholders to discuss health policy and strategy implementation), the Senior Management Committee and eight technical working groups, which are linked with different units of the Ministry of Health<sup>22</sup>. However, not all the technical working groups are functional (BTC, 2010; interviewees).

### **3.1. Health Policy and Health Sector Strategic Plan**

A first National Health Policy was approved in 1999 (for a period of ten years), a second one was elaborated during a participatory process in 2009/10. A Task Force and twelve technical working groups (of which eight still exist, see above) were involved in the elaboration, together with members from the Ministry of Health, relevant other ministries, local governments, health development partners, the private sector and civil society organisations.

The National Health Policy II goal is to promote people's health to enhance socio-economic development, hereby contributing to the key goals of the National Development Plan: growth,

<sup>22</sup> These eight units include Health Sector Budget; Human Resources; Health Infrastructure; Medicines Management and Procurement; Supervision, Monitoring and Evaluation (M&E) and research; Public Private Partnership for Health; Basic Package; and Hospital and Health Centre IV (Government of Uganda and Health Partners, 2010).

employment and socio-economic transformation for prosperity. The National Health Policy II formulates 15 policy objectives with corresponding policy strategies on seven topics, including organisation and management of the national health system; the minimum health care package; supervision, M&E; research; legal and regulatory framework; health resources; and partnerships in health (Republic of Uganda, 2010a).

Simultaneously with the National Health Policy II, the Health Sector Strategic & Investment Plan (HSSIP) 2010/11- 2014/15 was elaborated, which is the successor of the HSSP I (2000/01 – 2004/05) and II (2005/06 -2009/10). The technical working groups were also involved in the elaboration of the HSSIP. An advanced draft of the HSSIP was reviewed by a joint assessment mission of the International Health Partnership+ (IHP+), which is a partnership established in 2007 with the aim to promote and guide the application of the Paris Declaration principles in order to improve health results (Vaillancourt, 2009). For this assessment the IHP+ used the Joint Assessment of National Strategies (JANS) tool (IHP+, 2011a). According to a report of the OECD Task Team on Health as a Tracer Sector (OECD, 2011b), the use of the JANS tool has triggered ownership due to the promotion of a wider consultation among government and national constituencies. Moreover, the JANS tool has been aligned to country processes and timeframes for national health plan development. In Uganda it has particularly stimulated the involvement of civil society (OECD, 2011b). Recommendations of the JANS assessment have been taken into account in the final version of the HSSIP (BTC, 2010).

The HSSIP goal for the period 2010/11-2014/15 (derived from the National Health Policy II goal) is “to attain a good standard of health for all people in Uganda in order to promote a healthy and productive life” (Ministry of Health, 2010: 52). To achieve this goal the health sector will address five objectives:

- “Scale up critical interventions for health, and health related services, with emphasis on vulnerable populations;
- Improve the levels, and equity in access and demand to defined services needed for health;
- Accelerate quality and safety improvements for health and health services through implementation of identified interventions;
- Improve on the efficiency, and effectiveness of resource management for service delivery in the sector;
- Deepen stewardship of the health agenda, by the Ministry of Health” (Ministry of Health, 2010: 52).

The HSSIP links these five objectives with the National Development Plan policy objectives and defines for each objective strategies and interventions, indicators with targets and implementation arrangements.

Despite the fact that the HSSIP has set clear and appropriate core priorities and is of better quality than the previous HSSPs, the Belgian Technical Cooperation (BTC, 2011) criticises the HSSIP for the high costs of the plan which are not aligned with the available resources; the lack of prioritisation and unrealistic targets; the lack of clarifying and strengthening the link between the HSSIP and the decentralised planning processes; and the lack of specification of

mechanism for accountability of the stakeholders involved. Civil society organisations involved in Uganda’s health sector point to the lack of policy implementation so far. They refer to the fact that “policies exist more in name than in practice” (Action Group for Health, Human Rights, and HIV/AIDS, et al., 2010: 33) and call upon Uganda’s government and the Ministry of Health to commit themselves to effective policy implementation and progress reporting (Action Group for Health, Human Rights, and HIV/AIDS, et al., 2010).

### 3.2. Health systems

Health services are provided by the public and the private sector. Private health providers include private-not-for-profit providers (facility based and non-facility based), private health practitioners and traditional and complementary medicine practitioners (Ministry of Health, 2010). The health sector is decentralised with districts and health sub-districts playing an important role in the delivery and management of health services<sup>23</sup>. In practice, however, the decentralisation of the health sector has not been successful, as a result of which the districts have not sufficiently been able to provide health service delivery. Reasons for the failing decentralisation include the earmarking of central level transfers in the form of conditional grants, the increase in the number of districts (from 56 to 112) with new management teams, inadequate facilities and the abolition of graduated taxes (BTC, 2011). This abolition increased the reliance of local government on intra-governmental transfers from central government and therefore weakened local government’s responsiveness to local citizens (Wild and Harris, 2011). Specific human capacity challenges include the low average sector staffing level of 56% (some districts even only 30%), low morale, absenteeism<sup>24</sup>, staff attrition caused by poor remuneration, poor support and supervision of health workers (Republic of Uganda, 2011a) and enticement of health professionals from clinical practice into desk jobs by development partners (Action Group for Health, Human Rights, and HIV/AIDS et al., 2010)<sup>25</sup>.

An overview of the health facilities at different levels and their responsibilities and number are provided in table 3.2.

Table 3.2. Responsibilities and number of public health facilities

Level	health facility	Responsibilities	Number
Central (semi-autonomous)	National Referral Hospital	<ul style="list-style-type: none"> <li>- Comprehensive specialist services</li> <li>- Health research and teaching</li> <li>- Services provided by general hospitals and regional referral hospitals</li> </ul>	2

<sup>23</sup> The Ministry of Health still has the responsibility for: mobilising resources and budgeting; policy formulation and policy dialogue with health development partners; strategic planning and regulation; advising other ministries on health matters; setting standards and quality assurance; capacity development and technical support; provision of nationally coordinated services (e.g. epidemic control, co-ordination of health research and monitoring and evaluation of overall sector performance) (Republic of Uganda, 2010a).

<sup>24</sup> According to the Minister of Health absenteeism is also caused by the high number of workshops targeting the same people (speech during Joint Review Meeting, 2011).

<sup>25</sup> Salaries can be 2,5 times higher according to interviewees.



Central (Ministry of Health)	Regional Referral Hospital	<ul style="list-style-type: none"> <li>- Specialist clinical service (e.g. psychiatry, ophthalmology, higher level surgical and medical services)</li> <li>- Teaching and research</li> <li>- Services provided by general hospitals</li> </ul>	11
District	General Hospital	<ul style="list-style-type: none"> <li>- Preventive, promotive, curative, maternity, in-patient health services, surgery, blood transfusion, laboratory and medical services;</li> <li>- In-service training, consultation and operational research in support of community-based health care programs.</li> </ul>	52
County	Health Centre IV*	<ul style="list-style-type: none"> <li>- Same services provided by health centres III plus</li> <li>- In-patient health services</li> </ul>	164
Sub-county	Health Centre III	<ul style="list-style-type: none"> <li>- Preventive, promotive and curative care;</li> <li>- Supervision of the community and HC II under their jurisdiction.</li> </ul>	832
Parish	Health Centre II	<ul style="list-style-type: none"> <li>- Outpatient care;</li> <li>- Community outreach services;</li> <li>- Linkages with the Village Health Teams.</li> </ul>	1562
Village	Village Health Teams	<ul style="list-style-type: none"> <li>- Identification of community's health needs and taking appropriate measures;</li> <li>- Mobilisation of community resources and monitoring of utilisation of all resources for their health;</li> <li>- Mobilisation of communities for health interventions (e.g. immunisation, malaria control);</li> <li>- Maintenance of a register of household members and their health status;</li> <li>- Maintenance of birth and death registration;</li> <li>- Serve as the first link between community and formal health providers;</li> <li>- Community based management of common childhood illnesses (malaria, diarrhoea, pneumonia);</li> <li>- Management and distribution of any health commodities availed from time to time.</li> </ul>	

\* the health centres IV function as health sub-districts.

Source: Ministry of Health, 2010

Not all health centres IV function as foreseen: in 2010/11 only 18 out of the 88 health centres IV were fully functional (Republic of Uganda, 2011c). Reasons for underperformance are related to a lack of appropriate infrastructure, equipment and qualified health workers and the poor management capacity and limited interest in the functionality of the health centres IV of local governments (Republic of Uganda, 2011c). Health centres II should officially be present in every village, but in practice many of them are not operational due to the absence of health workers and a lack of medicines (interviewees). Many of the Village Health Teams, which

could be an important link between the state and local communities (Wild and Domingo, 2010), are not yet active (interviewees). Only 62% (69/112) of the districts have completely implemented the Village Health Teams strategy and only in 14 (out of the 112) districts the Village Health Teams have been trained (Republic of Uganda, 2011c).

The private sector is responsible for 65 hospitals (mainly private-not-for-profit), 13 health centres IV (mainly private-not-for-profit), 250 health centres III (mainly private-not-for-profit) and 1444 health centres II (mainly private health practitioners). The majority (75%) of the facility based private-not-for-profit facilities fall under the responsibility of one of the four umbrella organisations: the Uganda Catholic Medical Bureau, the Uganda Protestant Medical Bureau, the Uganda Orthodox Medical Bureau or the Uganda Muslim Medical Bureau. The non-facility based private-not-for-profit health facilities are run by a diversity of non-governmental and community based organisations and focus mainly on preventive services (Ministry of Health, 2010). According to several interviewees the private-not-for-profit health facilities, which are supplying the full minimum package in spite of the fact that they receive less support from the government, are not sufficiently valued by the Ministry of Health. During the 2009 National Health Assembly a resolution to develop a sustainable strategy to finance the private-not-for-profit health facilities was accepted. However, so far this was not been put into practice because the Ministry of Health decided to wait for approval of the general national policy on Public Private Partnership for Health (Republic of Uganda, 2011c).

The National Health Policy II includes in its policy objectives the strengthening of the organisation and management of national health systems. The HSSIP links this policy objective with the fifth HSSIP objective, i.e. deepen sector stewardship, and formulates three specific strategies:

- Improve the capacity of the national health system to respond and effectively deliver the minimum package;
- Intensify supervision, inspection, monitoring and evaluation of health services and ensure use of evidence for decision-making;
- Strengthen existing and widen the scope of partnerships in order to achieve the goals of the health sector (Ministry of Health, 2010).

In addition, the HSSIP formulates for each strategy key interventions and indicators with targets.

Recently (February 2011) the World Bank started the Uganda Health Systems Strengthening Project (130 million USD in the period 2011-2015) with the aim to deliver the Uganda National Minimum Health Care Package (UNMHCP).. The project has four components: improved health work force, improved health infrastructure of existing facilities, improved management and leadership and improved maternal, newborn and family planning services (World Bank, 2011).

### ***Health Information System***

Health information systems (HIS) are supposed to produce information for accountability and learning purposes (Health Metrics Network, 2008; World Health Organisation, 2009). However, in many countries these systems are very fragmented due to the involvement of many different institutions in the production and demand of health information and the various

requirements of disease-focused programmes (Health Metrics Network, 2008; IHP+, 2008; Kimaro et al., 2008). As a result, information is not easily accessible and data collectors are overloaded with reporting demands from several poorly coordinated subsystems (Health Metrics Network, 2008).

Uganda's HIS consist of several data sources which can be classified in three main categories:

- **Population-based statistics**
  - Population census
  - Vital Registration System
  - Population-based surveys (e.g. Uganda Demographic and Health Survey)
  - Community-based Disease Surveillance
  - Demographic Surveillance Sites
- **Health services-based statistics**
  - Integrated Disease Surveillance and Response
  - Health Management Information System (HMIS)
  - Human Resource Information System
  - Administrative records
  - Health facility surveys and mapping
  - Logistics Management Information System
- **Research** (Republic of Uganda, 2009)

The M&E plan also refers to the Supply Chain Management System, which will be established to strengthen the information systems for medicines and health supplies, and the Integrated Financial Management System, which was introduced by the government to promote efficiency, secure management of financial data and comprehensive financial reporting (Government of Uganda, 2011).

The HMIS is the routine reporting system related to health service delivery for public and private-not-for-profit health facilities. Weekly<sup>26</sup>, monthly<sup>27</sup> and yearly<sup>28</sup>, HMIS reports are produced at health facility, health sub-district and district level. The HMIS has recently been revised and includes now specific indicators for e.g. the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance on Vaccines and Immunization (GAVI) Alliance (interviewees). However, as the tools are not yet printed and distributed, the revised HMIS is not yet in use (Republic of Uganda, 2011c). According to the M&E plan the health information assistants of the health facilities are supposed to send their reports to the health sub-district, where all health facility reports are compiled into a single health sub-district report. The health information assistant of the health sub-district is supposed to send the health sub-district reports to the District Health Office. In the case of the Jinja district, however, all health facilities send their data directly to the District Health Office where the

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<sup>26</sup> Weekly HMIS reports at District Health Office, health sub-district and health facility level concerns Epidemiological Surveillance Reports (Government of Uganda, 2011)

<sup>27</sup> Monthly HMIS reports at District Health Office, health sub-district and HG level include the Monthly Inpatient Report.

<sup>28</sup> Yearly HMIS reports at e.g. District Health Office level include the District Epidemiological Summary, District Population Report, District Physical Inventory, District Equipment Inventory, District Staff Listing, District Profile and District Work Plan (Government of Uganda, 2011).

Biostatistician<sup>29</sup> compiles the health facility data and sends it to the Resource Centre<sup>30</sup> of the Ministry of Health<sup>31</sup>. The reason for bypassing the health sub-district in Jinja relates to the fact that not all health sub-districts used to compile and send their data to the District Health Office as a result of which reports of the District Health Office did not include data of all health facilities (which however sent their data on time to the health sub-district). Moreover, as health facilities had to bring their reports to the District Health Office anyway they had to pay twice for transport costs, so they prefer to bring it only to the District Health Office. Timeliness, completeness and accuracy of the reports is to be discussed officially during monthly meetings at health facility, health sub-district and District Health Office level, however in Jinja district these kinds of meetings have not taken place (so far). In addition to the HMIS reports, quarterly assessment reports are produced at all levels and annual performance reports at district and central level. The quarterly assessments reports are discussed during Quarterly Sector Performance Reviews (central level), quarterly meetings of the District Health Management Team (district level), quarterly health sub-district team meetings (health sub-district level) and quarterly Health Unit Management Committee meetings (health facility level). The annual performance reports are discussed during the Joint Review Meeting, the National Health Assembly (central) and stakeholders' fora at district, sub-district and sub-county level (see 4.3.1. for more information on the Joint Review Meeting, National Health Assembly and stakeholders' fora) (Government of Uganda, 2011).

Uganda's HIS was assessed using the Health Metrics Network framework, which is supposed to function as "the universally accepted standard for guiding the collection, reporting and use of health information by all developing countries and global agencies" (Health Metrics Network, 2008: v). The Health Metrics Network framework describes six HIS components, i.e. 'health information system resources', 'indicators', 'data sources', 'data management', 'information products' and 'dissemination and use' (see chapter 4 for some of the results of the assessment of Uganda's HIS). On the basis of this assessment, Uganda formulated a HIS Strategic Plan for the period 2009/10 – 2013/14, with the aim to provide timely, quality health and health-related data and information to all stakeholders. This plan, however, has not been validated and the Ministry of Health is in the process of formulating a new HIS strategy (interviewees). The National Health Policy II and the HSSIP also include objectives and strategies for the strengthening of HIS. The HIS related policy objective (under the heading 'supervision, monitoring and evaluation'), is: "To build a harmonised and coordinated national health information system with the Resource Centre of the Ministry of Health as national custodian, in order to generate data for decision making, programme development, resource allocation and management at all levels and among all stakeholders" (Republic of Uganda, 2010a:18). Similar to the policy objective for health system strengthening this policy objective

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<sup>29</sup> The District Biostatistician will review the data quality through Data Quality Audits (DQA) within districts at data collection, collation and analysis points (Government of Uganda, 2011).

<sup>30</sup> Within the Ministry of Health the Resource Center is responsible for: coordinating and operationalising the Health Sector Statistical System at all levels; strengthening capacity for collection, validation, analysis, dissemination and utilization of health statistical data at all levels; generating health statistical data on quarterly and annual basis; ensure that complete and approved M&E reports and health statistical data are made easily available to the public in a timely manner, while ensuring that the sharing of reports respects the *Access to Information Act* (Government of Uganda, 2011: 80).

<sup>31</sup> Technical staff of the Resource Center will review the data quality of districts through DQA at data collection, collation and analysis points (Government of Uganda, 2011).

is linked with the fifth HSSIP objective (i.e. deepen sector stewardship). The three corresponding strategies are:

- Institutionalise the notion of at least, age and sex disaggregation of health data, as appropriate, in order to expose sex/gender differences and factors that contribute to health inequities;
- Build capacity for effective data management dissemination at all levels;
- Strengthen the M&E system (Ministry of Health, 2010).

The strengthening of the HIS does however not automatically steer the institutionalisation of the HIS within the Ministry of Health, which is necessary for future sustainability (Kimaro and Nhampossa, 2005). A sustainable HIS is integrated in the daily work of the Ministry of Health, is flexible enough to adjust to changing user needs and aligns various interest of the Ministry of Health, software developers and donors (Kimaro and Nhampossa, 2005). Moreover, it is crucial that local data collectors and users participate in its design (Kimaro and Nhampossa, 2005; Piotti et al., 2006). Kimaro and Nhampossa (2005) as well as Piotti et al. (2006) advocate in this regard for the use of a 'cultivation approach', which implies gradual changes on the basis of existing technology and network of users.

### **3.3. Health financing**

The health sector is financed by the government, by user fees in private health facilities and by health development partners through a Sector Wide Approach (SWAp) (Republic of Uganda, 2010a). Users fees in public health facilities have been abolished since 2001 when Uganda adopted a free health care policy (BTC, 2011), but in practice patients still pay for services (Action for Global Health, 2010). Relatively new funding initiatives include the GAVI alliance, the GFATM, the President's Emergency Plan for AIDS relief (PEPFAR) and the President's Malaria Initiative. These initiatives contribute to an increase in health funding but are generally not aligned to the health sector policies and strategies (Ortendahl, 2007; BTC, 2011). Between 2008/09 and 2009/10 off-budget funding to the health sector increased with 5.3%<sup>32</sup>, with PEPFAR being responsible for 58% of the off-budget funds in 2008/09 (Action Group for Health, Human Rights, and HIV/AIDs et al., 2010). The GAVI alliance and GFATM, however, signed the recent (July 2010) compact between the Government of Uganda and partners for the implementation of the HSSIP (see below)<sup>33</sup>. Despite the increase in health funding, Uganda's health sector is still insufficiently funded, with only 10 USD per capita health funding instead of the 28 to 42 USD per capita needed for financing the HSSIP (BTC, 2011). According to Action for Global Health (2010), health is not a priority of Uganda's government as it is not a productive sector. At the same time Action for Global Health quotes a donor who brought up that: "without tracking the inefficiencies in the sector (health workers absenteeism, leakage of drugs – just to name the biggest system challenges) any additional

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<sup>32</sup> Of bilateral donors, off-budget funding of Danida, GTZ, Irish Aid, Italian Cooperation and DFID increased in this year. After this year Danida and DFID stopped funding the health sector (Action Group for Health, Human Rights, and HIV/AIDS et al., 2010).

<sup>33</sup> GFATM and GAVI suspended their financing due to corruption cases in 2005 and 2006 respectively. Financing restarted again in 2010/11 (BTC, 2011). In the case of GFATM more than 300 persons were involved, but in 2010 only four persons have been prosecuted (Action Group for Health, Human Rights, and HIV/AIDS et al., 2010).

funds would be wasted as well and have no real impact at the end of the day” (Action for Global Health, 2010: 17).

Table 3.3. gives an overview of the allocations of the Medium Term Expenditure Framework (MTEF) for the health sector in the HSSP II period.

Table 3.3. MTEF allocations for the health sector over HSSP II

Year	GOU budget UGX Bn	Donor project budget UGX Bn	Total budget UGX Bn	Annual budget increase GoU (%)	GoU health exp. % of total GoU exp. (%)
05/06	229.86	268.38	498.24	-	8.9
06/07	242.63	139.23	381.66	4.0	8.6
07/08	277.36	150.90	428.25	16.0	8.2
08/09	375.46	253.08	628.46	35.4	8.3
09/10	434.17	301.80	735.97	16.1	8.1

Source: BTC (2011) on the basis of the MTEF

Donors in the health sector meet monthly in the Health Development Partners Group. This group, however, is not considered to be very effective (Wild and Domingo, 2010; interviewees), amongst others due to high staff turnover (Wild and Domingo, 2010). Dialogue with the Ministry of Health takes place through the Health Policy Advisory Committee, which meets monthly as well (BTC, 2011). The Permanent Secretary of the Ministry of Health is chair of the Health Policy Advisory Committee. Members include the focal points of the technical working groups, the troika of the health development partners group, the medical bureaus, hospitals, private sector and three civil society organisations (umbrella organisations). Other stakeholders are allowed to be present, but not to participate in discussions. Belgium and Sweden are the only donors providing sector budget support to Uganda’s health sector, the Department for International Development (DFID) of the United Kingdom is currently considering to move to health sector budget support<sup>34</sup> (as a result of changes in UK government the earlier focus on general budget support is currently shifting to a preference for a mix of modalities with general budget support, sector budget support and projects) (BTC, 2011).

The SWAp concept in the health sector was introduced in the nineties as a result of a growing acknowledgement of the limitations of project support (e.g. fragmentation, transaction costs, lack of ownership) and programme aid (e.g. short term, linked to and therefore dependent on macro-economic reforms (Cassels, 1997) as well as the belief that progress in health outcomes is not possible without improving health systems (Hutton and Tanner, 2004; IHP+, 2008). The health SWAp in Uganda started in 1999 as one of the first in the world and was in the beginning rather successful (Republic of Uganda, 2011a). In 2004 Hutton described Uganda’s health SWAp experiences with the aim to help other countries in their development of a health SWAp. According to Hutton, important elements in the success of Uganda’s health

<sup>34</sup> This is in contradiction with the civil society organisations report (Action Group for Health, Human Rights, and HIV/AIDS et al., 2010), see note 31, which mentions that DFID will stop financing the health sector.

SWAP included the existence of a health sector strategic plan, the provision of budget support which strengthened government ownership and the set up of a Partnership Fund for meeting donor M&E requirements and financing additional technical assistance<sup>35</sup>. Nevertheless, as a result of several factors, including decreased government spending on health, changes in aid modalities (decline of budget support), weakened government leadership (due to changes in political leadership) and poor governance (increased corruption, poor coordination between ministries, decreased transparency), the SWAp performance declined in later years (Orthendahl, 2007).

The National Health Policy II, the HSSIP and the Country Compact<sup>36</sup> for implementation of the HSSIP between Uganda's government and health partners, might create (or already have created) a new impulse to the health SWAp. This is related to the fact that initiatives included in these documents address some of the factors that led to the decline in SWAp performance. Both the National Health Policy and the HSSIP include strategies to mobilise financial resources, e.g. the health sector aspires that government spending on health will increase again, from 9.6% to a minimum of 15% of the total budget of the government of Uganda by 2014/15 (Ministry of Health, 2010). This 15% was agreed upon by all African leaders in Abuja in 2001, but so far no African government has met this target (IHP+, 2011b). The HSSIP also describes specific strategies for the health development partners, including:

- Strengthen the partnership between the Ministry of Health and health development partners within the spirit of the Paris Declaration, the IHP+ and the Accra Agenda for Action;
- Strengthen the capacity at national and district levels for effective co-ordination of all development partners in health, eliminating duplication of efforts and rationalising health development partners' activities to make them more cost-effective (Ministry of Health, 2010).

The country compact is stimulated by the IHP+ which considers this an instrument which triggers country ownership (OECD, 2011b). The stakeholders who signed the Compact are quite heterogeneous, including the highly influential vertical funds (interviewees), multilateral and bilateral donors, private-not-for-profit organisations and civil society organisations. In the Compact both the Government of Uganda and the health development partners make several commitments. The Government of Uganda is e.g. committed to:

- Demonstrate its stewardship role in the health sector by initiating and coordinating all components of the HSSIP;
- Ensure that top management of the Ministry of Health is adequately and continuously equipped with skills and material inputs to provide leadership consistent with the demands of a major sector of the national economy<sup>37</sup>;

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<sup>35</sup> A review of the Partnership Fund concluded that the fund contributed to e.g. the functioning of the health policy advisory committee; a leading role of the Ministry of Health during the twice yearly joint review missions; M&E of the sector; flexible and timely access to necessary technical assistance; improved collaboration between health sector partners (Hutton, 2004). Meanwhile the fund does not exist anymore and the Ministry of Health is made responsible for financing SWAp-related expenses (BTC, 2011).

<sup>36</sup> Principles guiding the Compact are: ownership and leadership by government; alignment of all partner programmes, activities and funding to one national plan (HSSIP) and harmonized annual health plan; use of common management arrangements; value for money; and one monitoring framework to promote accountability (Government of Uganda, 2011).

<sup>37</sup> Recently political and technical leadership positions have been renewed.

- Continuously strengthen its functional links with the Office of Prime Minister, Ministry of Finance, Planning and Economic Development, Ministry of Local Government and other health-related sectors in order to function optimally (Government of Uganda and Health Partners, 2010).

According to Wild and Domingo (2010) the added value of the compact has not been recognised in Uganda, amongst others due to a lack of political leadership, in particular from donors, disillusionment with some vertical funds and unclear added value to the SWAp framework. According to the Ministry of Health itself challenges to the implementation of the compact include irregular technical working group meetings, poor attendance at the Health Policy Advisory Committee meetings, multiple parallel procurement systems, lack of transparency in funding, huge off budget expenditure and parallel systems for data collection (Aceng, 2011).

The need for the Ministry of Health to demonstrate stewardship and leadership is also called upon by several health sector civil society organisations in their 2009/10 health sector performance report, i.e. “We are calling on the Ministry of Health to demonstrate leadership and stewardship in pushing forward the recommendations of the AHSPR and the strategies outlined in the various policy documents” (Action Group for Health, Human Rights, and HIV/AIDS et al., 2010: 8). According to same report the lack of responsibility of the Ministry of Health for successes or failures of programs is a consequence of the SWAp, which led to an improved coordination of efforts, but which also involved ‘everyone’ (Action Group for Health, Human Rights, and HIV/AIDS et al., 2010). While the newly appointed minister and top management (who took office halfway 2011) show signs of improved leadership and stewardship, it is yet too early to judge (interviewees).

While the preference of the Government of Uganda for general budget support is indicated in the Compact, the health development partners do not make any commitments towards an increase in either general or sector budget support. The hesitance of health development partners for supplying general or sector budget support in the health sector does not only apply to Uganda. A study of the World Bank, OECD and WHO (2008) concluded that the Paris Declaration target of 65% of aid flows provided in the context of programme-based approaches will not be met in the health sector, as the amount of aid channelled through sector and budget support programmes remains low (World Bank et al., 2008). Moreover, nowadays a mix of modalities is increasingly promoted (Orthendahl, 2007; Walford, 2007; Overseas Development Institute and Mokoro, 2010), with project aid supplementing budget support in order to target e.g. system and capacity strengthening (Overseas Development Institute and Mokoro, 2010) or to promote civil society involvement (Walford, 2007).



## **4. Assessment of the health sector's M&E system**

It is increasingly acknowledged that strengthening monitoring and evaluation (M&E) systems is essential for the functioning of health service delivery providers. Along this line, a recent study by Björkman and Svensson (2009) showcases the existence of a direct relationship between ineffective monitoring systems (and weak accountability relationships) and non-functional health service delivery. Particularly within the context of a Sector Wide Approach (SWAp) a focus on strengthening and institutionalisation of the sector M&E system is expected to be high on the (donor) agenda as, in contrast to project aid, donors are no longer able to attribute their financial inputs to specific outputs. They rather have to justify their individual contributions in terms of progress against jointly agreed sector objectives (see Cassels, 1997). Notwithstanding its importance, the design of a sector M&E system is quite difficult, due amongst others to the use of different sets of indicators by different stakeholders (Peters and Chao, 1998). The fact that M&E system development is challenging and difficult may also partly explain the relatively limited attention it has received compared to the design of procurement, disbursement and financial management systems (Vaillancourt, 2009). As a consequence many SWAps (across different countries) have weak M&E systems and statistical institutions (Boesen and Dietvorst, 2007) resulting in an insufficient focus on results (Vaillancourt, 2009). A well-functioning M&E system within the health sector is expected to provide information on inputs (e.g. funding, plan), processes (e.g. capacity building), outputs (e.g. service delivery, health systems), outcomes (e.g. service utilisation, equity) and impact (e.g. child mortality, maternal mortality, morbidity) (IHP+, 2008).

Even though Uganda's health SWAp has a relatively long history (since 1999) and functioned in its earlier years as an example for other health SWAps (see 3.3.), the quality of the health sector's M&E system is only partially satisfactory, as the assessment in this section demonstrates. The M&E system is assessed alongside six main dimensions, including policy; indicators, data collection and methodology; organisation (structure and linkages); capacity; participation of actors outside government; and use of information. In order to structure the assessment and analysis, each of the dimensions is further broken down into sub-components (see checklist in annex 2).

The assessment below highlights that none of the 34 sub-components of Uganda's health sector M&E system scores 'excellent' while only three of them (the M&E plan, selection of indicators and data collection) score 'good'. The present M&E capacity and effective use of M&E by local level actors and by outside government actors are considered weak. If anything, the health sector M&E system currently scores better on its policy and indicators/data collection components than on the other four issues (capacity, participation of actors outside government, systemic issues and use of M&E outputs). The results of the quantitative assessment are provided in annex 6, the different sections in this chapter provide a more qualitative discussion structured alongside the six M&E key areas.

### **4.1. M&E policy**

When reviewing the M&E policy, we focus in particular on the existence of an overarching M&E plan, the way the policy distinguishes and links 'monitoring' and 'evaluation', the

(relative) importance given to the basic M&E functions of accountability and learning, the attention given to reporting and feedback and the way the latter is organised as well as the importance attached to alignment of M&E with planning and budgeting.

Recently, a task force of the Ministry of Health (including representatives of the Quality Assurance Department, World Health Organisation (WHO), Centres for Disease Control and the Planning Department) under the supervision of the Supervision, Monitoring, Evaluation and Research (SMER) technical working group<sup>38</sup>, developed an M&E plan for the Health Sector Strategic & Investment Plan (HSSIP). The task force received technical support from the WHO, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Global Alliance on Vaccines and Immunization (GAVI) Alliance (one week intensive support and continued feedback). While it is not clear how substantial the input and influence of these organisations has been during the elaboration process, the fact that they have explicitly highlighted that they will use the M&E plan for their own M&E purposes could trigger its implementation (see also section 4.3.1). The M&E plan was shared and discussed with sector stakeholders during the National Health Assembly in October 2011.

This M&E plan has been the first sector M&E plan since the introduction of the SWAp in the nineties. While this is somehow surprising, the situation is comparable to other countries with health SWAps, which neither have fully developed M&E strategies and plans (see Vaillancourt, 2009). With this plan the Ministry of Health responds to some of the M&E challenges (see 4.4.) of the previous health strategic plans, which were, according to the Ministry of Health, a result of the absence of an M&E plan. As presently several systems are operating in parallel<sup>39</sup>, the goal of the plan is “ to establish a system that is robust, comprehensive, fully integrated, harmonized and well coordinated to guide monitoring of the implementation of the HSSIP and evaluate impact” (Government of Uganda, 2011: 13). A budget of 44 billion Ugandan shilling<sup>40</sup> is needed for the implementation of the M&E plan, of which a large part is reserved for performance reviews (including the Joint Review Meeting, the National Health Assembly and quarterly review meetings at all levels) and surveys (see table 4.1.). At present, only funds for printing and dissemination of the M&E plan are available (interviewees).

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<sup>38</sup> Members of the SMERTWG include Ministry of Health officials, DPs, civil society, private sector and academia (Government of Uganda, 2011). Its Terms of Reference are: review and document sector performance (different levels and entities, and entire sector) by level using the HSSIP monitoring framework – quarterly, annually, midterm and end-term as appropriate; support the process of streamlining/harmonisation of various information systems in the health sector for improved efficiency and easy availability of information; regularly review the various support supervision mechanisms in the sector (Area Teams, Consultant’s Outreach Programmes, Technical Programme) with the view to determine their performance and recommend improvements; identify the research agenda for the health sector strategic plan and recommend mechanisms to fund and implement research for the health sector strategic plan; propose mechanisms for integrating and coordinating research activities at different levels of health service delivery (Government of Uganda and Health Partners, 2010).

<sup>39</sup> The systems specified in the M&E plan are the HMIS, the Performance Measurement and Management Plan (PMMP) of the Uganda AIDS Commission the LOGICS tools of the Ministry of Local Government, the Output Budgeting Tool of the Ministry of Finance, Planning and Economic Development, Office of the Prime Minister report, Joint Assessment Framework report, Ministry of Public Service performance report (Government of Uganda, 2011).

<sup>40</sup> Correspondents with 11,064,400 Euro (09/09/11).

Table 4.1. Division of the M&E budget on different activities

Activity	%
Compilation and submission of performance reports	2.5
Data Quality Assurance	1.5
Feedback	0.007
Performance Reviews	33.6
Surveys	39.9
Evaluation	3.2
Dissemination	7.8
Capacity building for M&E	6.3
M&E Plan Monitoring and Evaluation	4.5

Source: Government of Uganda, 2011

The HSSIP's chapter on supervision, monitoring and review does not (as is obvious from the title) pay any attention to evaluation or to the differences and links between 'monitoring' and 'evaluation'. The M&E plan does include a specific chapter on evaluation and is rather clear on the distinction between performance monitoring (focus on inputs, processes and outputs), review (focus on inputs, processes, outputs and outcomes) and evaluation (focus on inputs, processes, outputs, outcomes and impact). However, links between monitoring, review and evaluation are not clearly spelled out.

During the HSSIP a mid-term review and end term evaluation are foreseen. A Data Quality Assessment and Adjustment will be performed of the review and the evaluation in order to identify and account for biases which may result from incomplete reporting, inaccuracies and non-representativeness<sup>41</sup>. In addition to the mid-term review and end term evaluation, all health sector investment and intervention projects undertaken in the HSSIP period will be evaluated (but no budget is yet available, see above). More specifically, projects need to conduct a baseline study, a mid-term review and a final evaluation or value-for-money audit (Government of Uganda, 2011). In practice, unlike other health SWAps (see Vaillancourt, 2009), the focus has so far been on monitoring at the detriment of evaluation. Whereas tracking studies have been initiated and some in-depth assessments have been done, amongst others by Ugandan universities and research institutes (see e.g. Cruz et al., 2006), these remain rather isolated and ad-hoc exercises, which are not systematically linked to the sector M&E system (interviewees). This relative neglect of analytically in-depth and evaluative exercises leads to a lack of insights into underlying reasons for (non) performance of health care services (supply side) and limited knowledge about the factors which influence the demand for health services (see also Yates et al., 2006).

One of the interviewees hinted at the fact that evaluation is not a priority of the Ministry of Health nor of the health development partners, who are particularly interested in financing and monitoring disease specific interventions. According to the IHP+, the development and implementation of evaluation efforts in the health sector are generally hampered by several

<sup>41</sup> The Data Quality Assessment and Adjustment will focus on the assessment of the completeness of reporting by facilities and districts; assessment of the accuracy of district population denominators (obtained from UBOS); accuracy of coverage estimates from reported data; systematic analysis of facility based and household survey based indicator values (Government of Uganda, 2011).

obstacles, including the lack of incentives to invest in evaluation; the emphasis on randomised controlled trials<sup>42</sup>, which are particularly suitable to test the impact of pilot interventions but which are not necessarily first-best in the context of broad-based scaling-up of multiple health interventions<sup>43</sup>; and the inadequate investments in baseline data collection, systematic monitoring and health information system strengthening (IHP+, 2008).

The specific objectives listed in the M&E plan include both M&E goals of 'accountability' and 'learning'<sup>44</sup>. Accountability is also one of the social values guiding the implementation of the National Health Policy II. In practice the emphasis seems to be more on accountability than on learning and more on upward accountability than on downward accountability. This is evident from the fact that various oversight agencies (e.g. Office of the Prime Minister, Ministry of Finance, Planning and Economic Development, Office of the Auditor General) are requiring reports and are supervising lower levels. Also the district league table, initiated in 2002/03 to rank districts on the basis of their performance on 12 indicators<sup>45</sup> (Murindwa et al., 2006) is an example of an upward accountability instrument (although it might as well be used as a learning instrument). A reason for the focus on accountability might somehow be related to recent large-scale corruption scandals in the health sector. However, it is likely that (upwards) accountability will be undermined by a lack of data control (and thus unreliable data) and by the fact that the Quality Assurance Department, which is responsible for overseeing the M&E function (see 4.3.), is not independent nor located high enough within the ministry to execute its accountability function. The introduction of the Village Health Teams could be considered an example of an increased focus on downward accountability. However, as highlighted in section 3.2., only a fraction of the Village Health Teams are so far operational. Moreover, as highlighted by Wild and Domingo (2010) the government has made various efforts in the past to increase downward accountability (at least on paper), yet, in practice it has not fundamentally changed the balance of power or accountability relationships. Section 4.5 highlights some other initiatives of civil society organisations to increase downward accountability.

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<sup>42</sup> Alternatives for randomised controlled trials include two types of quasi-experimental design: a controlled before-after evaluation, in which the changes before and after programme implementations are compared to changes in areas where the programme was not implemented; and an interrupted time-series in which data are collected before, during and after the programme implementation (Fretheim et al., 2009).

<sup>43</sup> Randomised controlled trials maximize internal validity which often goes at the detriment of external validity. It are particularly evaluation designs which allow to draw sound conclusions regarding generalization (external validity) which are needed in a context of broad-based scaling-up.

<sup>44</sup> The specific objectives are: (1) To provide a health sector-wide framework for tracking progress and demonstrating results of the HSSIP 2010/11 – 2014/15 over the medium term. (2) To build capacity of the Ministry of Health, semi-autonomous institutions, local governments, private not for profit/Private facilities and civil society organisations to regularly and systematically track progress of implementation of the HSSIP. (3) To facilitate the Ministry of Health and other stakeholders assess the health sector performance in accordance with the agreed objectives and performance indicators to support management for results (evidence based decision making). (4) To improve compliance with government policies (accountability), and constructive engagement with stakeholders (policy dialogue). (5) To facilitate continuous learning (document and share the challenges and lessons learnt) by the Ministry of Health, semi-autonomous institutions, LGs and other stakeholders during implementation of the HSSIP 2010/11 – 2014/15. (6) To promote the use of locally generated health information.

<sup>45</sup> The indicators include eight coverage and quality of care indicators (pentavalent vaccine 3<sup>rd</sup> dose coverage; deliveries in government and private not for profit facilities; OPD per capita; HIV testing in children born to HIV positive women; latrine coverage in households; IPT2: ANC4 and TB cure rate) (75% of the score) and four management indicators (approved posts that are filled; HMIS reporting completeness and timeliness; DHMT meetings held as planned and medicine orders submitted timely) (25% of the score) (Republic of Uganda, 2011b).

Both the National Health Policy II and the HSSIP refer to the need of information dissemination and feedback for “purposes of improving management, sharing experiences, upholding transparency and accountability” (Republic of Uganda, 2010a: 19). The M&E plan includes a paragraph on data dissemination and describes some of the reports which have to be disseminated: the Annual Health Statistical Report, the Quarterly Performance Review Reports and the Annual Health Sector Performance Report (AHSPR). The AHSPR has been produced since 2000 and it is presented and discussed during the Joint Review Meeting and National Health Assembly (Ministry of Health, 2010).

According to the Health Metrics Network (2007) the use of information of the Health Information System (HIS) for planning, budgeting and resource allocation is adequate. While HIS data is used for planning at central and local level, doubts exist about the quality of the data (see also 4.2.), which limits its usefulness (interviewees). In line with the six health SWAps included in a World Bank evaluation<sup>46</sup> (Vaillancourt, 2009) the link between financing and results is weak, as a consequence of which priorities in the sector are not sufficiently financed. The World Bank evaluation refers in this respect to the relatively small budgets for maternal and reproductive health services, despite the high priority given to these issues in national documents. In Uganda the recent National Health Assembly (October 2011) included in its resolutions the introduction of performance based funding with the aim to improve performance at service delivery level (Quality Assurance Department, 2011a). Without a proper supervision/ control mechanism in place, however, many of the documented side-effects (e.g. ‘crowding-out’ effect and ‘gaming’<sup>47</sup>) are a real possibility.

#### **4.2. Indicators, data collection and methodology**

This section focuses on the use of indicators (selection, quality, disaggregation, selection criteria, priority setting and causality chain), data collection and methodologies used for M&E.

##### ***Indicators***

Partially overlapping health indicators are included in the National Development Plan, the Joint Assessment Framework and the HSSIP (see annex 4 for an overview). The 26 HSSIP core performance indicators include all eight indicators of the Joint Assessment Framework, but not all National Development Plan health indicators (not included are life expectancy and total fertility rate). The HSSIP core indicators were selected by the Ministry of Health on the basis of three criteria: reflection of all domains presented in the M&E conceptual framework, having broad information on important components of the indicator domain and alignment to existing sector monitoring commitments (Government of Uganda, 2011). While the Ministry of Health sets priorities by limiting the number of core performance indicators, the HSSIP does include 236 additional indicators for the monitoring of progress on strategies and key interventions formulated for each objective. The HIS strategic plan refers to the high number of indicators for which data has to be collected at health facility level, especially when taking

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<sup>46</sup> The six countries are: Bangladesh, Ghana, Kyrgyz Republic, Malawi, Nepal and Tanzania

<sup>47</sup> The ‘crowding-out’ effect is the diminishing or erasing of intrinsic motivation due to external rewards and ‘gaming’ is the focus on indicators that are in the system hereby neglecting non rewarded indicators or falsification of results to maximise reward (see Kalk et al., 2010).

into account the limited capacity to collect data (Republic of Uganda, 2009). While prioritising is important, the inclusion of operational indicators is necessary, as data on outcomes and impacts are easily dismissed as somebody else's responsibility (see Booth and Nsabagasani (2005) in 2.2.6). In order to increase the usefulness of indicators, selection processes at each level should optimally involve actors operational at the specific level.

Both the HSSIP and the M&E plan include an adapted version of the M&E framework for health system strengthening developed by the WHO, the GAVI Alliance, the GFATM and the World Bank<sup>48</sup> (see annex 5). This framework demonstrates the way inputs are supposed to lead to health impact and includes indicator domains for each level (input & process, output, outcome and impact)<sup>49</sup>. Except for indicators on workforce (2) and infrastructure (1), no process indicators (related to health sector systems and processes) are included among the core performance indicators. However, process indicators are included among the other 236 indicators, particularly under objective 5 (deepen sector stewardship). For an overview of the M&E related process indicators see table 4.2.

Table 4.2. M&E related process indicators under objective 5 (i.e. deepen sector stewardship)

Strategic intervention	Indicators
Strengthen the organisation and management of the national health system	<ul style="list-style-type: none"> <li>- Joint planning, monitoring and evaluation with various relevant sectors instituted by 2011/2012.</li> <li>- The proportion of districts that submit timely HMIS monthly and quarterly reports increased from 68% to 100% by 2014/2015.</li> <li>- The percentage of districts with operational VHTs increased from 31% to 100%.</li> </ul>
Enable evidence-based decision making, sector learning and improvement	<ul style="list-style-type: none"> <li>- The proportion of implementing partners (NGOs, CSOs, Private sector) contributing to periodic reports increased to 90% by 2015.</li> <li>- Community based HIS established and linked to HMIS by 2015.</li> <li>- The proportion of planned periodic review that are carried out increased to 100% by 2015.</li> <li>- HMIS timeliness increased to 100% by 2015.</li> <li>- HMIS completeness increased to 100% by 2015.</li> <li>- Proportion of planned validation studies that are carried out.</li> <li>- The proportion of sub national entities (districts, health facilities) that have reported on the key indicators as planned increased to 100% by 2015.</li> <li>- Selected data disaggregated by age &amp; sex with concomitant gender analysis.</li> </ul>
Create a culture in which health research	<ul style="list-style-type: none"> <li>- A policy and legal framework for effective coordination, alignment and harmonization of research activities developed</li> </ul>

<sup>48</sup> See WHO, GAVI, Global Fund and the World Bank (2009).

<sup>49</sup> The domains of input and process indicators are: governance; financing; infrastructure/ information and communication technology; health workforce, supply chain and information. The domains of output indicators are: intervention access and services readiness; intervention quality, safety and efficiency. The domains of outcome indicators are: coverage of interventions; prevalence risk behaviour and factors. The domains of impact indicators are: improved health outcomes and equity; social and financial risk protection; responsiveness.

<p>plays a significant role in guiding policy formulation and action to improve the health and development of the people of Uganda.</p>	<p>by 2012.</p> <ul style="list-style-type: none"> <li>- A prioritized national research agenda developed by 2012.</li> <li>- Institutions involved in conducting research identified by 2011.</li> </ul>
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Source: Government of Uganda, 2011

The M&E plan includes an annex with an overview of HSSIP’s objectives, clusters, strategic interventions and indicators, through which it is clear which indicators are supposed to monitor which strategic interventions. The core indicators are, however, not specifically linked to the objectives.

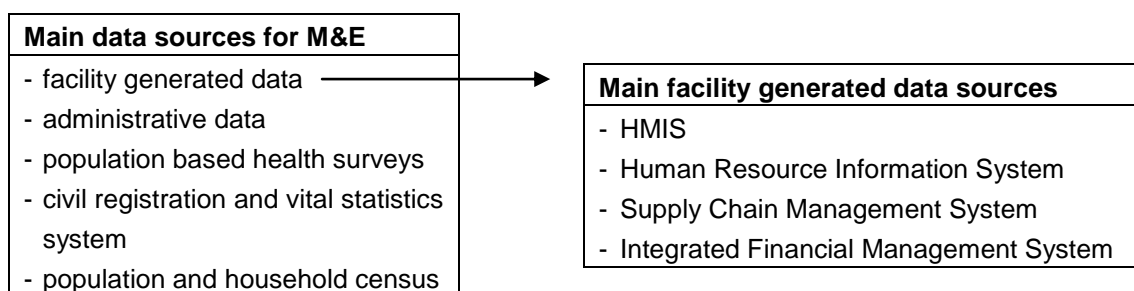
For the health indicators of the National Development Plan, indicators of the Joint Assessment Framework and HSSIP core indicators baselines and targets are included, but not all of the targets are realistic, e.g. the decrease of the maternal mortality rate from 435 in 2008/09 to 131 in 2014/15 (BTC, 2011). As far as disaggregation of indicators is concerned, the HSSIP prescribes that progress on the 26 core indicators needs to be disaggregated by income, literacy level, gender and security level in the AHSPR (Ministry of Health, 2010). The disaggregation of data by gender is particularly important given the fact that the health policy considers gender-based inequalities important hindrances towards improvements in health outcomes (Republic of Uganda, 2010a). The recent AHSPR (Republic of Uganda, 2011c), however, does not include a disaggregated overview of performance on the 26 core indicators or any other indicator, probably due to lack of availability of disaggregated data (Ministry of Health, 2010). While the lack of disaggregation currently blocks in-depth analyses, there exists some possibility for comparative analyses, e.g. using the district league tables. The AHSPR includes an overview of the 15 top performing and 15 bottom performing districts on the basis of the district league table, but due to a different set of indicators used for the performance assessment and the addition of 32 new districts, a comparison with previous years could not be made (Republic of Uganda, 2011c). While in-depth analysis of the underlying reasons for diverging district performance are lacking, the AHSPR does include some possible explanations for better and worse performing districts and refers in this respect to e.g. the presence of a regional referral hospital, the accessibility of the district and its staffing level.

#### ***Data collection and methodology***

The M&E plan indicates that data will be collected through a combination of quantitative and qualitative methods. No references are made to the different studies on Uganda’s health sector which use randomised controlled trials (see e.g. Bjorkman and Svensson, 2009) and which are also not integrated in the health sector’s M&E.

As mentioned in section 3.2. the sources through which data is collected can be divided in three main categories: population-based statistics, health services-based statistics and research. Figure 4.1. provides an overview of the main data sources for M&E, including the main facility generated data sources.

Figure 4.1. Main data sources for M&E



Source: Government of Uganda, 2011

In addition to the commonly used data sources, the M&E plan also lists other methods to complement M&E information. These include:

- (other) surveys
- questionnaires
- report formats
- case studies
- field visits
- standardised meeting formats
- geographical information system (Government of Uganda, 2011)

The data source for each core performance indicator is specified in the M&E plan. The most frequently data sources are the HMIS and the Uganda Demographic and Health Survey. Several additional surveys are planned to be conducted in the HSSIP period, including the antenatal HIV sentinel surveillance, the Uganda HIV/AIDS sero-behavioral survey, the malaria indicator survey and the client satisfaction survey (Government of Uganda, 2011).

The Health Metrics Network assessed three population-based data sources (census, vital statistics and population-based surveys) and three health-services-based data sources (health and disease records, health service records and administrative records) on a number of dimensions. Results of these assessments are presented in table 4.2.

Table 4.3. Health Metrics Network's assessment of data sources

Data source	Contents	Capacity & Practices	Dissemination	Integration and use	Overall
<b>Census</b>	Adequate	Present but not adequate	Adequate	Adequate	Adequate
<b>Vital statistics</b>	Present but not adequate	Present but not adequate	Not adequate	Present but not adequate	Present but not adequate
<b>Population-based surveys</b>	Highly adequate	Adequate	Adequate	Adequate	Adequate
<b>Health and disease records</b>	Highly adequate	Present but not adequate	Adequate	Present but not adequate	Present but not adequate



<b>(including HMIS, Integrated Disease Surveillance and Response and Demographic Surveillance System)</b>					
<b>Health service records (including human resources, logistics)</b>	Present but not adequate	Not adequate	Present but not adequate	Present but not adequate	Present but not adequate
<b>Administrative records</b>	Present but not adequate	Present but not adequate	Adequate	Present but not adequate	Present but not adequate
<b>Overall</b>	Adequate	Present but not adequate	Adequate	Present but not adequate	Present but not adequate

Source: Health Metrics Network, 2007

As the table demonstrates only the census and the population-based surveys (both population-based data sources) are considered adequate on all the dimensions. Highly adequate scores are only given to the content of population-based surveys and health and disease records.

Since 1985 several initiatives have been taken to implement the HMIS. In 2001 e.g. tools have been developed to support the collection of HMIS data for the Health Sector Strategic Plan (HSSP) indicators. Due to changes in indicators in the HSSP these tools needed to be reviewed in 2004. Therefore, on the basis of countrywide consultations with stakeholders, a manual has been elaborated for districts and health sub-districts as well as for health units (Republic of Uganda, 2004a and 2004b). New tools for the revision of HMIS in 2011 have not yet been printed and distributed (see 3.2.). As the Uganda Catholic Medical Bureau printed and distributed the tools with their own means, their health facilities are already using the new formats for their own reporting (to the dioceses), while they still have to use the old formats for their reporting to the health sub-district and the District Health Office (interviewees). Spero et al. (2011) refer to the limited success of HMIS implementation and point in particular at the technical and organisational challenges. As the HMIS does not get sufficient attention within the SMER technical working group, there are plans to launch a separate HMIS technical working group (including WHO, UNICEF, USAID and DFID). One of the potential drawbacks of this decision, however, could be a weaker linkage between HMIS and M&E.

An electronic Human Resource Information System was set-up with USAID-funding in 2005, which has been useful for verifying qualification of medical staff, for elaborating human resource reports, for advocating for more training and for expediting the recruitment process in the public sector (Spero et al., 2011). The Human Resource Information System related Health Workforce Advisory Board advises the technical working group on human resources, which was rather inactive prior to the involvement of the Advisory Board (Spero et al., 2011).

### **Data quality**

A HMIS data validation conducted by the Resource Centre of the Ministry of Health (referred to in Republic of Uganda, 2009) revealed that different mismatches exist between data in the Health Unit HMIS monthly reports and data in the health unit register; between data in the district database and data in the districts HMIS monthly reports; and between data reported to the Resource Centre and data kept in the district database. Reasons for these mismatches include incompleteness of registers; incomplete recording in the HMIS reports; poor handwriting in the registers; and poor filing practices (Republic of Uganda, 2009).

Against the background of Uganda's government objective to move towards more evidence-based policies, more attention has recently been given to the quality of data (interviewees). Within the Ministry of Health a task force of the SMER technical working group elaborated a National Quality Improvement Framework and Strategic Plan, with the aim to harmonise the multiple number of quality improvement initiatives. This framework and strategic plan still has to be approved by a stakeholders meeting, including representatives of the various quality improvement initiatives. Despite the increased focus on data quality (at least on paper), the data used for the 2011 AHSPR has not been validated due to a lack of funds (interviewees).

## **4.3. Organisation**

The assessment of the organisation of M&E is subdivided over two sections: structure (4.3.1.) and linkages (4.3.2.).

### **4.3.1. Structure**

In what follows attention is given to M&E coordination and oversight, joint sector reviews, sector working groups, the level of M&E ownership and the use of incentives to stimulate M&E.

The M&E policy describes the roles and responsibilities of key actors. However, these do not seem to have already been formalised as the formalisation of the M&E implementation structure with clear roles and responsibilities still figures among the AHSPR recommendations for the annual plan 2012/13 (Republic of Uganda, 2011c: 164). At present, the Quality Assurance Department, under the Directorate of Planning and Development, is responsible for the coordination and oversight of M&E activities in the health sector. In practice M&E is scattered over the different departments, which are responsible for the monitoring of their activities within the year plan. Recently responsibilities of the Quality Assurance Department have increased as several tasks which were previously under the Planning Department have been transferred to the Quality Assurance Department. However,

it is likely that the power of the Quality Assurance Department to fulfil its coordination and oversight function is curtailed by its position under the Directorate of Planning and Development. An M&E oversight function logically necessitates a positioning which is higher, e.g. directly under the Director General of Health Services, as M&E is sensitive by itself and necessitates a certain degree of independence. Independence might be triggered through a location which is high enough in the hierarchy, an independent budget or by leadership of the unit from a recognised authority in the topic. While it is highly likely that the present position of the Quality Assurance Department will jeopardize to some extent the fulfilment of the accountability objective, its positioning within the Directorate of Planning and Development should normally steer the feedback and use of findings in the ministry's planning. A specific M&E unit within the Quality Assurance Department (still to be established) will be specifically responsible for the coordination and implementation of the M&E plan. This unit will also be responsible for Data Quality Audits, for sector evaluations and Rapid Data Quality Assessments.

For specific technical areas the coordination and oversight is in the hands of the technical working groups. Their responsibilities include:

- Tracking and coordinating the implementation of the M&E plan and promoting joint monitoring and evaluation of the HSSIP 2010/11 – 2014/15 for the respective program areas;
- Participating in the Joint Review Meeting/ National Health Assembly and preparation of the AHSPR;
- Submitting reports for discussion during the monthly Senior Management Committee meetings and policy issues submitted for discussion in the Health Policy Advisory Committee meetings;
- Meeting regularly with partners to track progress of achievement of intended HSSIP 2010/11 – 2014/15 results;
- Conducting joint field monitoring to measure achievements and constraints that impede the realisation of the HSSIP 2010/11 – 2014/15 targets;
- Identifying and documenting lessons learnt;
- Identifying capacity development needs, particularly in areas of monitoring and evaluation (Government of Uganda, 2011: 80).

Not all the technical working groups function optimally and interviewees highlighted that particularly the linkage between the technical working groups and the policy dialogue is not straightforward. This tends to undermine the quality of the policy dialogue as the latter partly depends on the level of technical sector knowledge (otherwise the policy dialogue is not evidence-based). Technical working groups which are considered to be relatively active are the budget working group and the SMER technical working group, which is responsible for the coordination of the technical working groups. The malfunctioning of the technical working groups was addressed during the recent Joint Review Meeting, which accepted a resolution that the Director General of Health Services has to ensure that all technical working groups provide meeting schedules and provide regularly reports to the Senior Management Committee and policy implications to the Health Policy Advisory Committee (Quality Assurance Department, 2011b).

### **Joint sector review**

One of the main mechanism to assess performance in the health sector is the Joint Review Meeting, generally known as a joint sector review. A joint sector review could be described as “a type of joint periodic assessment of performance in a specific sector with the aim to satisfy donor and recipient’s accountability and learning needs” (Holvoet and Inberg, 2009: 205). ‘Performance’ is to interpreted broadly and could include a focus on substance at various levels (i.e. inputs, activities, output, outcome and impact) and on underlying, systemic and institutional issues. A World Bank review of six health SWAp (Vaillancourt, 2009) considers joint sector reviews to be an important step towards the consolidation of M&E efforts of governments and most development partners around a single set of program level objectives, targets and indicators. Several issues undermining the full potential of joint sector reviews are also highlighted in the report, including amongst others, the watering down of the Aide-Mémoires in order to find compromises among different signatories; the lack of implementation of recommendations; and the size and costs of the joint sector reviews in relation to their benefits (Vaillancourt, 2009).

Uganda’s Joint Review Meeting is organised by the Ministry of Health (Quality Assurance Department) in collaboration with the health development partners and aims to discuss the AHSPR against priorities agreed upon earlier; raise and respond to issues arising from the AHSPR; and identify and agree on sector priorities for the following financial year (Government of Uganda, 2011). Conclusions and actions agreed upon during the Joint Review Meeting are documented in an Aide Mémoire which is signed by the government and the health development partners (Government of Uganda, 2011). In his assessment, Hutton (2004) refers to the active participation of all stakeholders during the JRMs and the inclusion of visits to districts, but also to the high amount of time needed for the preparation of documents and the organisation of the Joint Review Meeting. Cruz and McPake (2010) conclude in their research on Uganda’s health SWAp in the period between 2002 and 2005 that the Joint Review Meeting lacks objective criteria. According to them satisfactory performance ratings were based on undertakings that were under-demanding, vaguely formulated and lacking quantitative benchmarks. More seriously, in case of clear poor performance, no penalties were applied, most likely due to disbursement pressure.

The most recent (17<sup>th</sup>) Joint Review Meeting took place on 25 and 26 October 2011, after a week of pre- Joint Review Meeting field missions (17-21 October) and the National Health Assembly (24 October)<sup>50</sup>. This Joint Review Meeting was the first which had not been postponed. While the health development partners insisted to postpone the Joint Review Meeting because of the insufficiently developed AHSPR, the Ministry of Health insisted to organise the Joint Review Meeting as originally scheduled (interviewees). While this is a sign of improved Ministry of Health leadership, the incompleteness of the AHSPR might have negatively affected the quality of the Joint Review Meeting, as it is one of its main inputs. The objectives of the 17<sup>th</sup> Joint Review Meeting were:

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<sup>50</sup> The differences between the Joint Review Meeting and National Health Assembly are not really clear except for the fact that the participation in the National Health Meeting is broader: e.g. all health districts officers are present, while during the Joint Review Meeting only a representation of good, medium and poor performing and hard-to-reach districts are participating.

- To receive and discuss the health sector performance report against the targets, actions and indicators set out in the 6<sup>th</sup> Joint Review Meeting Priority Actions; the compact for Implementation of the HSSIP 2010/11 – 2014/15 and the health related Millennium Development Goals 1, 4, 5 & 6;
- To identify priority activities, major inputs, indicators and targets;
- To garner support for mobilizing resources for health interventions;
- To recognise and to reward institutions and individuals for good performance (Nduhuura, 2011).

During the Joint Review Meeting and National Health Assembly presentations were given on e.g. the M&E plan, the National Health Accounts, the implementation of the Compact and progress on the implementation of priority actions of the 16<sup>th</sup> Joint Review Meeting. A specific session was devoted to the presentation of a very critical and frank financial and performance audit report of the Office of the Auditor General. While there was little time left for discussion, the audit report allows to get a better grasp of the strengths and weaknesses of the current health (budget) management systems. It might as well feed into a proper risk assessment as well as into an identification of remedying measures. The chair of the session emphasised that future JRMs should schedule a separate day for the discussion of the audit report, yet this suggestion was not included in the resolutions of the Joint Review Meeting.

During the pre- Joint Review Meeting mission eight teams visited 16 districts. We participated in one of these teams during its visit to Jinja district. Members of this team included three Ministry of Health staff members, a staff member of the USAID and a staff member of the University Research Co., LLC. In a time span of two days the team visited the health district, the regional referral hospital, health centres III and IV, a school and a homestead. During these visits questions were asked on the basis of a checklist elaborated by the Quality Assurance Department and issues such as the availability of running water, stock of medicines were checked. To our surprise, the checklist did not include topics related to data collection, use of data or feedback on data quality, despite the attention for (poor) data quality in Ministry of Health documents. The Joint Review Meeting clearly focuses on monitoring and local level reality checks and does not probe into underlying reasons for local non-performance. This leads to the fact that possible weaknesses or hindrances which are situated at other levels of the health system but which influence local level performance are not disclosed. Positive elements of the pre- Joint Review Meeting mission to Jinja included the fact that feedback and recommendations were given during interviews as well as the organisation of a short debriefing which allowed open discussion of the main findings and recommendations. Such discussion and negotiation is one of the ways in which effective use of M&E findings may be stimulated.

While the pre- Joint Review Meeting field visits do not bring into the picture what happens at central ministry level, the Joint Review Meeting itself does, e.g. through the presentation of the Office of the Auditor General report which also highlighted issues within central ministries and agencies. As non-government actors, including university researchers, were involved in the various presentations, there is clearly room for criticism from the outside. Vaillancourt's (2009) suggestions for improving the quality of joint sector reviews are, however, also applicable to Uganda's Joint Review Meeting: "There is an emerging consensus within and

across countries to assess the viability of less frequent and better planned reviews, more strategic coverage of themes and topics for review, and more strategic and selective attendance, while still ensuring adequate representation of actors and stakeholders and a participatory process” (Vaillancourt, 2009: 43).

Highly similar to what is happening at central level, health and health related issues are discussed at lower levels (i.e. regional, district, health sub-district and sub-country) on the basis of the annual district performance reports during broad-based stakeholders fora. Stakeholders at each level include people who have political, administrative and technical leadership functions, public and non public health providers, development partners, civil society organisations and representatives of health related sectors (Government of Uganda, 2011). At sub-county level M&E results are also expected to be used during the so-called ‘barazas’ (see 2.2.3.).

### ***Ownership and incentives***

During the presentation of the M&E plan at the National Health Assembly it was emphasised that the plan was elaborated on the initiative and by the Ministry of Health. However, substantial assistance has been given by the WHO, GFATM and GAVI Alliance and it is not clear to what extent this has influenced the substance of the plan (the M&E plan e.g. includes the indicators which these different agencies consider important for their own M&E). If anything, the fact that the M&E plan has been presented during the National Health Assembly is positive, as this demonstrates the importance the Ministry of Health attaches to this plan and the back-up by the health development partners might also promote the implementation of the M&E plan.

As mentioned in 2.2.3. the National Development Plan aims to establish a strong incentive system attached to the performance contracts of Permanent Secretaries and Chief Administrative Officers. In the health sector different vote holders<sup>51</sup> will be responsible for the achievement of the outputs and actions included in the performance contract and for the fulfilment of reporting requirements in an accurate and timely manner (Government of Uganda, 2011). No specific incentives for the production and use of data are mentioned in the documents, but in practice some instruments could function as an incentive. First, an indicator concerning completeness and timeliness of HMIS reporting is included in the district league table. Second, an incentive for data collection and data use at ministry and agency level is the increased emphasis on performance, in the context of which the half-yearly presidential retreats are held (see 2.2.3.). Within the Ministry of Health these retreats resulted in more attention for and use of data, which is amongst others obvious from the revision of the HMIS (including more data), the appointment of a staff member of the Uganda Bureau of Statistics (UBOS) (see 4.3.2.) within the resource centre of the Ministry of Health (see 4.3.2.) and the start of an e-HMIS project (interviewees). An increased use of performance data should however coincide with more attention to the supervision and evaluation function, as the risk of potential misuse of target setting and/or manipulation of data also increases (see e.g. Nielsen and Eljer, 2008; De Lancer Julnes, 2006). Evaluation could be helpful for identifying reliable

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<sup>51</sup> Vote holders include the Ministry of Health, the Uganda Cancer Institute, the Uganda Heart Institute, the NRHs, the RRHs, the Uganda Blood Transfusion Services, National Medical Scores, the Health Service Commission and each local government (Government of Uganda, 2011).

and valid performance measures and outcomes; it might detect unintended causes of performance measurement, and could induce more balanced analysis of (lack) of achievements involving issues of attribution.

As far as the Uganda Catholic Medical Bureau is concerned, the use of a certificate system, which exist since 2003, creates an incentive for the health facilities to submit their reports on time, as this is one of the criteria which has to be fulfilled in order to receive the certificate (other criteria include the provision of minimum services and the presence of licenses for the medical staff). Each year the Uganda Catholic Medical Bureau checks whether the health facilities fulfil the criteria, if not they do not obtain their certificate, which leads to a number of penalties such as the removal of the medicine discounts. If a health facility is not fulfilling the criteria three years in a row, they are excluded from the Uganda Catholic Medical Bureau system (interviewees).

#### **4.3.2. Linkages**

This paragraph discusses linkages with the UBOS, the Office of the Prime Minister, M&E units of different sub-sectors and semi-governmental institutions (horizontal integration), M&E units at decentralised levels (vertical integration) as well as linkages with donor M&E mechanisms.

The UBOS is responsible for the supply of health data through censuses and surveys and plays thus an important role in health sector M&E<sup>52</sup>. Within the Resource Centre of the Ministry of Health a staff member of UBOS has been installed recently (October 2011). This staff member of the UBOS Directorate of Statistical Co-ordination and Services has been placed within the ministry's Resource Centre as the quality of the HMIS has not sufficiently improved over time. UBOS's Directorate of Statistical Co-ordination and Services is responsible for streamlining data collection of ministries, departments and agencies according to centrally identified processes for statistics production and quality. In line with this mandate, the UBOS staff member within the Ministry of Health has to make sure that processes are coordinated and aligned to UBOS guidelines.

The M&E plan describes the M&E responsibilities of the Ministry of Health departments, national referral hospitals, regional referral hospitals and semi-autonomous institutions<sup>53</sup>, but

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<sup>52</sup> The M&E plan provides an overview of the responsibilities of the UBOS: (i) Coordinating, supporting, validating and designating as official any statistics produced by UBOS, ministries, departments, agencies and local governments. (ii) Coordinating and clearing all censuses and nationally representative household economic surveys. (iii) Ensuring production, harmonization and dissemination of statistical information. (iv) Strengthening statistical capacity of planning units in the Ministry of Health and local governments for data production and use. (v) Ensuring best practice and adherence to standards, classifications, and procedures for statistical collection, analysis and dissemination in the Ministry of Health and local governments. (vi) Ensuring that complete and approved M&E reports and health statistical data are made easily available to the public in a timely manner, while ensuring that the sharing of reports respects the *Access to Information Act* (Government of Uganda, 2011: 83).

<sup>53</sup> Responsibilities include: (i) Producing results orientated Development Plans and annual Budget Framework Papers. (ii) Ensuring proper coordination of monitoring activities at Departmental / Institutional levels. (iii) Providing timely and quality data on relevant performance indicators to the RC. (iv) Assigning one or more positions responsible for statistical production, monitoring and evaluation. (v) Training of health workers and managers in M&E. (vi) Maintaining a Recommendation Implementation Tracking Plan which will keep track of review and evaluation recommendations, agreed follow-up

their linkages with the Quality Assurance Department are not clearly described. Horizontal integration is circumvented by the fact that different departments dealing with specific topics (such as reproductive health, HIV/AIDS, malaria) are often supported by different projects, which gives these departments certain autonomy, hereby blocking the coherence within the ministry.

As far as linkages between the Ministry of Health and the Office of the Prime Minister ('vertical' upwards integration) are concerned, the Quality Assurance Department has to make sure that M&E activities are aligned to the National Policy on Sector M&E and related strategies, norms and guidance from the Office of the Prime Minister and other coordinating institutions (Government of Uganda, 2011). In practice, there is a complex interaction and competition among different players responsible for part of the central M&E coordination and oversight over different line ministries (see also 2.2.3.). While the Ministry of Finance, Planning and Economic Development used to be responsible for both budget monitoring and monitoring of the real (substance) sphere (outputs and outcomes), its responsibilities have been partly transferred to the Office of the Prime Minister. More specifically, the Poverty Monitoring and Analysis Unit has been transformed into the Budget Monitoring and Analysis Unit and it responsible for budget monitoring while the Office of the Prime Minister became responsible for M&E of the real sphere (outputs & outcomes). While separating M&E of the real and financial sphere into two different entities makes a move towards more performance-oriented budgeting systems (which aim at confronting inputs with outputs and outcomes) inherently more difficult, information from the two spheres is currently brought together during the six monthly retreats of different government agencies (see 2.2.3 and 4.3.1). What is even more challenging is the unclear division of M&E responsibilities over the Office of the Prime Minister and the National Planning Authority (see also 2.2.3.).

The M&E responsibilities of the districts are described in the M&E plan and include:

- Producing results orientated Local Government Development Plans and annual Budget Framework Papers;
- Ensuring proper coordination of monitoring activities at District and Lower Local Government levels;
- Training of health workers and managers in M&E;
- Providing timely and quality data on relevant performance indicators to the Ministry of Local Government, the Ministry of Finance, Planning and Economic Development and the Ministry of Health;
- Ensuring that all Local Government Planning Units assign one or more positions responsible for health statistical production, monitoring and evaluation;
- Maintaining a recommendation implementation tracking plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions;
- Utilising M&E findings to inform programme, policy, and resource allocation decisions (Government of Uganda, 2011: 81/82).

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actions, and status of these actions. (vii) Utilizing M&E findings to inform programme, policy, and resource allocation decisions.



As health centres IV are responsible for the compilation of data from lower levels, they are playing an essential role within the M&E system. However, as the case of Jinja shows (see 3.2.) not all health centres IV are sufficiently functional to accomplish this responsibility. Data compilation at this level is curtailed by the lack of computers (and software programmes such as excel), which corroborates data analysis. It is therefore essential to strengthen the M&E capacity of health centres IV as supervision to the lower level health facilities from this level is more direct and easier than from the district level. However, as long as this capacity is not yet strengthened, it might be preferable to proceed in the same way as Jinja. Supervision from the Ministry of Health to the districts takes place during quarterly area team visits (in October combined with pre- Joint Review Meeting field mission) and HMIS is among the topics discussed. However, according to various interviewees, these visits are very expensive, time consuming and not very useful. Moreover, Murindwa et al. (2006) refer to the supervision visits as being poorly coordinated, planned and not always implemented.

If anything, the M&E plan gives most attention to linkages with the M&E mechanisms of (donor) programmes and projects. Projects in the health sector are administrated through the Long Term Institutional Arrangements, with a focus on one country-led M&E platform, i.e. the Country Health Systems Surveillance platform, which is supposed to bring together the M&E of disease-specific programs (Government of Uganda, 2011). These arrangements could contribute to counter fragmentation, duplication and weak coordination (see 4.4.), as they determine e.g. that:

- “M&E shall be carried out within the National M&E framework using tools that consider outputs and indicators to be drawn from approved work plans and budgets for the HSSIP. Programme specific indicators from programme strategic and or M&E plans will be used to supplement the national level indicators in monitoring specific programme performance.
- There shall be strengthening of the M&E systems to include an agreed upon and costed M&E plan developed by the technical working groups and coordinated by the Directorate of Planning and Development. The Quality Assurance Department shall be the secretariat for the SMER technical working group and; will be responsible for implementation of the M&E plan. The Policy Analysis Unit shall be supported to undertake the role of evaluation.
- A mechanism shall be developed to ensure follow up action as needed from reviews and reports that indicate discrepancies or short comings with observed program results. This
- mechanism shall involve spelling clear timelines, responsibility centres and indicators.
- There shall be a transparent and documented process to ensure input of a broad range of stakeholders in the programme monitoring and evaluation. This shall involve joint monitoring visits.
- Programme managers will provide oversight for monitoring implementation of work plans and preparation of quarterly and annual performance reports.
- The M&E specialists will work under the overall stewardship of the SMER technical working group. They will be responsible for analyzing data and assembling reports that will be reviewed and verified by programme managers before submission to the working group. They will use information generated by the Resource Centre and monitoring reports form Area Team supervision visits” (Government of Uganda, 2011: 58).

#### 4.4. Capacity

With only four staff members out of a total of 542<sup>54</sup>, the Quality Assurance Department is currently heavily understaffed (Office of the Auditor General, 2010), which is expected to be strengthened after the ministry's reorganisation. Within the resource centre one person is responsible for the HMIS, who is since recently assisted by the UBOS staff member and occasionally by trainees. The limited number of staff available for M&E at all levels is further hampered by a frequent change of personnel and the enticement of staff to donor agencies. The limited investment in M&E capacity is in contrast to the discourse of the M&E policies and plans and it immediately puts into perspective the implementation of these plans and policies. It is not that there is no convincing evidence of the importance of having strong M&E capacity in the context of health SWAps. In her evaluation of six health SWAps, Vaillancourt (2009) demonstrates the beneficial effects of having strong M&E capacity on sector results achieved. In doing this, she compares to cases where the focus of capacity strengthening was on procurement, disbursement and financial management and where M&E capacity strengthening was neglected.

The M&E plan explicitly acknowledges the weaknesses and challenges of the M&E arrangements under the previous health strategic plans. It explicitly states that "the national M&E arrangements were weak and comprised only a few functional systems at program/project level. They were characterized by fragmentation; duplication; weak co-ordination; lack of a clear result chain; poor definitions; tracking and reporting of outcomes and results; use of different formats and approaches with no common guidelines and standards; lack of national ownership; adequate feedback and poor sharing of results across the sector and other stakeholders. Analysis of information was not carried out in a comprehensive manner, and communication of information was not tailored to the recipients of information – this was primarily left in reports, or scientific papers. In addition there was poor use of the data generated; problems related to capacity and resourcing" (Government of Uganda, 2011: 12).

The National Health Policy II includes under the policy objective of building a harmonised and coordinated national health information system (see also 3.2.), several policy strategies, which could be interpreted as capacity strengthening initiatives for the National Health Policy II period:

- Build sustainable capacity at all levels of the Ministry of Health, local governments, the private sector, facilities and communities to carry out supportive supervision, monitoring and evaluation of health interventions and disease surveillance;
- Re-conceptualise and re-organise the managerial and clinical support mechanisms and structure to districts and regional referral hospitals, including re-defining the role of the area teams, the Office of the Medical Superintendent and Hospital Directors, the Community Health Departments at regional referral hospitals and other facilities at regional, district and sub-district level;

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<sup>54</sup> The Ministry of Health has an approved structure of 644 staff members (Office of the Auditor General, 2010).

- Strengthen and ensure support for the HMIS at all levels through increased investments, including the development and use of appropriate information and communication technology for improving communication and information flow;
- Increase the training, recruitment and deployment of required human resource for effective data management and dissemination at all levels;
- Facilitate the establishment and operation of a community-based health information system;
- Ensure utilisation and dissemination of information to other stakeholders for purposes of improving management, sharing experiences, upholding transparency and accountability;
- Generate through periodic surveys, appropriate data for effective planning, management and delivery of health services;
- Ensure continuity of care, design appropriate medical records and improve their utilisation at community and facility level (Republic of Uganda, 2010a: 18/19).

The last five strategies are included as well in the HSSIP. Other interventions mentioned in the HSSIP for this policy objective are e.g. examination of feasibility of disaggregating and extension of the HMIS to the private sector (Ministry of Health, 2010) and the development and implementation of a comprehensive M&E plan for the health sector (see 4.1.),

As discussed earlier, the M&E plan has already been developed and endorsed (see 4.1), the next step is its implementation. At this stage it is too early to judge the likelihood of smooth implementation: whereas the increased ownership and support by a number of key health development partners could trigger effective implementation, the currently limited staff capacity and budget might be constraining factors. As long as the M&E plan is not implemented, all the weaknesses diagnosed in the M&E plan itself still apply to the current M&E arrangements. When it comes to specific capacity building initiatives, it will be of utmost importance to ensure coordination as this has also been one of the drawbacks in the past (see also BTC, 2011).

#### **4.5. Participation of actors outside government**

In this paragraph the participation of actors outside government, including parliament (with back up of the Office of the Auditor General), civil society and development partners is taken stock of.

In HSSIP's overview of the government and partnership coordination, Parliament (together with cabinet) is placed above the highest management level of the Ministry of Health, i.e. the Top Management Committee. The Ministry of Health usually meets with Parliament after the Joint Review Meeting with the aim to review sector progress in the previous year (Ministry of Health, 2010). The M&E plan further specifies that the health sector will work together with relevant committees of Parliament and cabinet in order to ensure overall political and policy oversight (Government of Uganda, 2011). Specific health related (post) evaluations of Parliament have particularly addressed corruption related incidents, such as the misuse of the GFATM funds (interviewees). Within Parliament the Social Service Committee (about 9 to 10 members) deals with education and health related matters, but there are plans to split this

committee into a health and an education committee (interviewees). The Social Service Committee's work on health included amongst others a visit to 16 districts in order to document health performance, on the basis of which the commission underlined e.g. the need for increased involvement of communities in decision-making (Wild and Domingo, 2010). In the past, the committee has been intervening on the basis of e.g. the evidence gathered by the Uganda Debt Network on the personal use of ambulances by the staff of a health centre IV (interviewees). Members of the Social Service Committee appreciate the health SWAp and use of budget support, as these tools increased their possibilities to hold the government accountable for the use of aid and other resources (Wild and Domingo, 2010). On the other hand, as already referred to in paragraph 2.2.5., parliamentarians, including those involved in the Social Service Committee, are particularly active when it comes to issues which specifically apply to their own district and they are generally less interested in issues which affect the country or the system as a whole. In fact, according to Wild and Domingo (2010), individual parliamentarians seem to be partly responsible for the fact that health funds are not directed towards the most pressing priorities.

As mentioned in section 2.2.5. the Office of the Auditor General ensures the involvement of Parliament in the monitoring and management of public finances by providing reports directly to Parliament and is as such an important actor of accountability towards the population. While Wild and Domingo (2010) point to a number of important weaknesses of the Office of the Auditor General (see 2.2.5), including its lack of independence, a frank and critical financial and performance audit report on the health sector was presented by the Assistant Auditor General at the occasion of the October 2011 Joint Sector Review Meeting (see 4.3.1.).

Civil society organisations and the private sector are represented in the Health Policy Advisory Committee and the technical working groups (Ministry of Health, 2010) and they participate in the stakeholders' fora at all levels. Civil society organisations involved in health service delivery and health development partners (through provision of technical, financial and/ or material support) contribute to the production (supply) and use of data (Republic of Uganda, 2009)<sup>55</sup>. The draft HIS Strategic Plan (Republic of Uganda, 2009) also refers to the role of academia and researchers in the production and use of data. Important health research is e.g. conducted by the Makerere University Institute for Social Research, the Uganda National Health Research Organisation<sup>56</sup> and the Uganda Virus Research Institute. While the draft HIS Strategic Plan provides an example on the use of anti-malarial drug sensitivity studies in the adoption of the Anti-malarial Drug Policy (Republic of Uganda, 2009), there is no indication that studies of universities are being used systematically. From this vantage point, an interesting initiative might be the 'Supporting Use Research Evidence

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<sup>55</sup> Other responsibilities of the health development partners include e.g. the provision of an external perspective; participation in the refinement of indicators, tools and processes; integration of DP's monitoring framework into the government system; and providing feedback to domestic and international constituencies on health sector performance and results. (Government of Uganda, 2011: 82). Other responsibilities of civil society organisations and the private sector include: participation in public sector planning processes at Local Government and sector level; and maintaining a Recommendation Implementation Tracking Plan in order to keep track of review and evaluation recommendations, agreed follow-up actions and status of these actions (Government of Uganda, 2011: 82).

<sup>56</sup> The UNHRO coordinates Uganda's health research activities and provides guidance for disaggregation of research data by sex, residence and wealth quintile (Ministry of Health, 2010).

(SURE) project which was presented by the College of Health Sciences of the Makerere University during the 2011 Joint Review Meeting (Asiimwe, 2011). The SURE project is build upon two existing initiatives (the Regional East African Community Health Policy Initiative and the Evidence-to-Policy Network Africa) and supported by the European Union. It aims to produce research syntheses and to build capacity of researchers, policy-makers and civil society in developing and implementing evidence-informed health policies (Asiimwe, 2011).

As far as participation of civil society organisations is concerned, according to Action for Global Health (2010), only a few prominent civil society organisation networks have linkages with the Ministry of Health, despite the importance of smaller civil society organisations in Uganda's health service delivery. Vaillancourt (2009) similarly concludes that health SWAps are not really successful in engaging with civil society organisations (and private sector), which has undermined service coverage and quality as these actors are often important health service delivers. A 2005 study on the involvement of sixteen reproductive health non-governmental organisations in Uganda's health SWAp (Mugisha et al., 2005) highlighted that none of the non-governmental organisations under study could be classified as actively engaged in the SWAp process, due to weaknesses in strategic planning, marketing, managing human resources and governance and to restricted funding possibilities. Some of the interviewees also referred to weaknesses of civil society organisations, including the poor quality of their M&E inputs which are often anecdotal. This particularly applies to civil society organisations operational at local levels. In 2010, however, around 30 civil society organisations (including three involved in Mugisha's study) active in the health sector elaborated through a participatory process, a report on "Civil Society Organisations Perspectives and Priorities Health Sector Performance FY 2009-2010". In this report perspectives of the civil society organisations on the health sector performance are documented and recommendations for different stakeholders are provided. As they mention themselves, with this report the civil society organisations show that they are intensifying their watchdog role: "We are not going to allow for compromises anymore. We are part of the sector, but we are increasingly going to hold duty bearers accountable. We urge you to play your part. Follow our recommendations, follow your recommendations, and together we will see change happening" (Action Group for Health, Human Rights, and HIV/AIDS et al., 2010). An important civil society organisation within the health sector is the Uganda National Health Consumers Organisation, which is a member of the Health Policy Advisory Committee. One of the important objectives of the Uganda National Health Consumers Organisation is to create linkages among civil society organisations to increase their effectiveness. Among their achievements are e.g. the introduction of the patient charter (see below) and the adjustment of the Terms of References for the health management committees at health facility level (interviewees).

In 2004/2005 an interesting randomized field experiment on community-based monitoring of public primary health care providers in Uganda took place, which has been documented by Björkman and Svensson (2009). The experiment resulted from the observation that lack of relevant information and knowledge on what could be expected from health service providers prevented (groups of) individuals to monitor the providers. Fifty public dispensaries and the health care users in the corresponding catchment area were included in the experiment, of which 25 were randomly selected to be part of the treatment group and the remaining 25

functioned as a control group. For both the treatment and control groups household and facility data were collected prior and after the intervention. The intervention included the dissemination of a report card (with information from the pre-intervention survey on utilisation, quality of services and comparisons with other health facilities), assistance in the formulation of a community contract and community-based monitoring. The community-based monitoring in the treatment group resulted in a higher involvement of the communities in the monitoring of the health service provider, higher efforts of health workers to serve the community and, even more importantly, a large increase in utilisation and improvements in health outcomes (e.g. child mortality and child weight) (Björkman and Svensson, 2009). In line with the idea that patients need to know what they can expect from the health service provider before they are able to monitor the providers, the Ministry of Health launched in 2010 the Patient's Charter, which defines the rights and responsibilities of patients and health care providers. Civil society organisations active in the health sector recommend all stakeholders to disseminate, promote and implement the Patient's Charter as this could be an instrument to empower Ugandans to interact more equally with the health care providers (Action Group for Health, Human Rights, and HIV/AIDS, et al., 2010). According to Booth (2011), however, "client 'voice' is a weak source of results-based accountability unless accompanied by strong top-down pressures of some kind" (Booth, 2011: 3).

Another case of experimentation with local downward accountability has been led by the Uganda Debt Network, an organisation which has been involved in community based monitoring since 2002 and which has recently started to implement the Community Based Monitoring System (Uganda Debt Network, 2009). Together with 15 Community Based Organisations the Uganda Debt Network has trained more than 6000 community monitors in 22 districts to monitor service delivery at village level, not only in health, but also in education, rural roads, agriculture and water and sanitation. The high number of community monitors creates a critical mass which increases the probability that local level monitoring becomes an effective accountability tool. Specific topics which are monitored include staffing levels, absenteeism, qualification of medical staff, availability of drugs, availability of staff housing and opening hours. On the basis of information provided by the community monitors, the Uganda Debt Network facilitates dialogue meetings at sub-county level. During these meetings the focus is not only on accountability, but also on learning. A positive element of community based monitoring is the continuous flow of information. However, even though the Ministry of Health seemingly appreciates the information emanating from community based monitoring, there is no commitment to use the information. Moreover, due to the heavily bureaucratized administration, there is often a serious time lag before the Ministry of Health is able to act upon information. Development partners also hardly use the information from the community based monitoring exercises. This is somehow surprising in a context where the importance of evidence (for policy dialogue) is widely acknowledged and where development partners (particularly those engaged in budget support) often have little independent information about implementation realities on the ground.

Similar to civil society organisations and the private sector, health development partners are represented in the Health Policy Advisory Committee and the technical working groups (Ministry of Health, 2010). So far, health development partners do not seem to be much interested to fund M&E (strengthening). Generally, they prefer to fund issues or departments

which are more visible such as specific disease control or system strengthening in the area of specific diseases (interviewees). Some health development partners (WHO, GFATM, GAVI Alliance and World Bank) were recently involved in the elaboration of the M&E plan (through on the job capacity building), which has amongst others led to the inclusion of indicators on which they need data. While this could trigger the implementation of the plan, and reduce the burden of additional data collection, so far, no health development partner has shown interest to finance the implementation of the M&E plan.

Budget support development partners (currently Belgium and Sweden) typically rely as much as possible upon the M&E arrangements of the government and additional joint M&E exercises, i.e. Joint Review Meetings. DFID intends to move towards health sector budget support in the near future and will rely upon the existing government M&E (interviewee). In line with DFID's general policy of increased focus on demonstration of evidence and impact (DFID, 2011), there will also be a higher investment in robust impact evaluations (including randomised controlled trials) in Uganda. The fact that many health development partners (particularly the project development partners) are still performing their own M&E and that some might (again) increasingly invest in additional monitoring, and particularly, evaluation is not necessarily negative as long as information feeds into the country's M&E systems and not only into the agency's own system. However, in practice, such coordination and feedback to the country systems hardly exists (interviewees). One way in which increased coordination of evaluation studies might be done is through the joint sector working groups. Within this context topics for in depth-study might be identified and distribution of findings to all stakeholders organised.

While development partners, and particularly those who supply budget support, are generally more focused on the government than on domestic accountability actors such as Parliament and civil society organisations (Wild and Domingo, 2010), the role of aid in stimulating domestic accountability is increasingly recognised (OECD, 2011b). In Uganda's health sector, domestic accountability has been enhanced through the National Health Assembly and through the participation of parliamentarians and civil society in the technical working groups (OECD, 2011b). While an increasing attention of development partners to strengthen domestic accountability is positive, the focus on the learning dimension of evaluation should not come under stress.

#### **4.6. Use of M&E output**

This paragraph provides an overview of the expected outputs of the M&E system and use of these outputs by central and local government and outside government actors (including development partners).

The M&E plan specifies outputs and outcomes of the M&E framework. Among the outputs the following are identified: a functional sector-wide unified integrated, harmonised and well coordinated M&E system with effective and timely feedback to stakeholders; performance reports; basic statistical data on health service delivery, resources, outputs and beneficiaries; regular updates on core performance indicators; and national infrastructure for M&E (Government of Uganda, 2011: 13). Outcomes of the M&E framework include: timely

reporting on progress of HSSIP implementation; timely meeting of reporting obligations to government, development partners and International Partners; objective decision-making for performance improvement, planning and resource allocation; accountability to government, development partners and citizens; policy dialogue with stakeholders; evidence-based policy development and advocacy; and institutional memory on HSSIP implementation (Government of Uganda, 2011: 14).

The AHSPR is an important output of the M&E system. This report is one of the main inputs into the Joint Review Meeting and it feeds into future policy-making and planning. Moreover, health development partners use this mechanism to make decisions regarding their (financial) contributions. The first AHSPRs were of very poor quality as they were mainly focused on activities (e.g. number of workshops held) (Cruz et al., 2006). The quality of the AHSPRs is however increasingly improving. Cruz et al. refer to the 2003/04 AHSPR as providing a good outline of the sector's performance at central and local level and interviewees consider the most recent AHSPR (2010/11) of better quality than the previous one. Nevertheless, information in the report is still weak and fragmentary, but as the report also includes an overview of the districts which did not provide information on time (naming and shaming), an incentive might be given to those districts to improve their timeliness of reporting in the future. While the report pays more attention to achievements on previous recommendations, analysis remains the Achilles heel. The lack of analytical quality in performance reports at all levels strongly affects their quality. Analysis helps to identify causal factors which influence phenomena that are recurrently being observed (e.g. absenteeism of health workers, non-functionality of health centres II, III, IV, heeling of drugs and medicines) but which are not tackled upon. Identifying causal mechanisms also highlights those factors that need to be addressed to bring about changes. An example of an analysis which could already be effectuated is related to the phenomenon of maternal death on which evidence is available in the maternal audits.

The M&E plan specifies the expected main users of the outputs of the M&E system. These include the Ministry of Health management, programs, local governments, health facilities, local and international partners and agencies (inside the health sector), Cabinet, Parliament, other Ministries/departments such as the Ministry of Finance, Planning and Economic Development, UBOS, Ministry of Local Governance, Ministry of Education and Sports, Health training institutions, individual researchers/students and the general public among others (outside the health sector) (Government of Uganda, 2011: 72). The Health Metrics Network assessment of the HIS presented in paragraph 4.2. shows that at present, data is being used but that the current level of usage is inadequate. Only the integration and use of data from census and population-based surveys are considered adequate. This is confirmed by interviews with staff members of the Ministry of Health who highlighted that HMIS data is currently not up-to-date, not reliable and that it should therefore not be used. Within the ministry itself, however, data has been used for planning and for performance reporting. Recently the ministry has elaborated a National Quality Improvement Framework and Strategic Plan, with the aim to harmonise different initiative to improve data quality (see 4.2.). The use of data at district level depends on personal motivation, qualifications, and capacity of staff. At health facility level data is currently not used and staff at this level do not seem to



be curious why data fluctuates between different months (at this level data is not only under-used but it is also not checked upon).

While use of health M&E by outside government actors seems to be limited, this does not apply to the health development partners. According to Cruz et al. (2006) the health M&E system has been used by all health development partners, even though some health development partners still demand additional information. A more recent OECD report (2011b) appreciates the AHSPR for its efforts to scrutinise sector performance, but it refers as well to the fact that several health development partners are still commissioning external monitoring reports because they do not have sufficient trust in government reports. This is certainly not a uniform position as those development partners who supply budget support (currently Belgium and Sweden) mainly rely upon information from the Ministry of Health and Joint Review Meetings without imposing additional M&E requirements. DFID which intends to move to health sector budget support considers the information provided by the health sector adequate and mainly uses triangulation among the different data sources (survey data, HMIS, independent studies) in order to increase data reliability (interviewees). It then comes as a surprise that health development partners who rely upon information from the country's health sector M&E arrangements do not engage in diagnostic exercises of the quality of these M&E arrangements.

## 5. Conclusions

The recent 2011 Paris Declaration survey demonstrates considerable improvements in the 'management for results' indicator (i.e. number of countries with transparent and monitorable performance assessment frameworks to assess progress against (a) the national development strategies and (b) sector programmes) for several countries. However, this does not hold for the case of Uganda, which is one of the only two countries (besides Mozambique) whose score decreased from 'largely developed' to 'action taken towards achieving good practice'. Reasons for this decrease are not listed but it is highly likely that the decrease is related to the lack of implementation of the performance assessment framework which is in line with Uganda's general weak 'implementation' track record.

Interestingly, the Paris Declaration evaluation country report for Uganda is more nuanced on Uganda's progress on the 'management for results' principle than the Paris Declaration monitoring survey. In fact, it criticises the Paris Declaration survey for narrowing down the 'management for results' principle to a focus on monitoring and evaluation (M&E) technicalities (with a particular focus on M&E indicators). It is particularly in order to counter this criticism that our study broadens the spectrum to provide a more comprehensive picture of M&E systems. Our checklist deliberately captures issues related to M&E policy, organisation, participation of outside government actors, M&E capacity and use of M&E outputs by different stakeholders and we complement the quantitative assessment with qualitative data. We consider a comprehensive diagnostic of what already exists a first important step into any M&E capacity building effort from the perspective that small incremental changes to existing systems might be more feasible and workable than radical and abrupt changes that seek to impose blueprints from the outside.

### ***National central M&E***

While the focus of our study is on the M&E system in Uganda's health sector, we also briefly reviewed the national central M&E system as there are obvious linkages among the two. Our stocktaking of the national M&E system amongst others highlights that the existing M&E policy and strategy documents provide a good overview of what to monitor and evaluate, why, how and for whom. However, there is remarkable lack of coordination among the 'M&E strategy for the National Development Plan', (elaborated by the National Planning Authority) and the 'National Policy on Public Sector Monitoring and Evaluation' (elaborated by the Office of the Prime Minister). The relationship between the policy and the strategy is not clear and the two documents do not refer to each other. This same lack of coordination is also obvious in reality when it comes to the M&E coordination and oversight at central level. Over the past decade, central M&E coordination and oversight has moved from one authority to the other. It is currently in hands of three different authorities, i.e. the National Planning Authority, the Office of the Prime Minister and the Ministry of Finance, Planning and Economic Development, and particularly the division of responsibilities between the National Planning Authority and the Office of the Prime Minister is unclear. If anything, such patterns of ever changing institutional arrangements and competition amongst agencies to control M&E are not unique to the Ugandan case and related to the fear that some ministries or units will become too powerful. As will be discussed below, it also complicates linkages among central and sector level M&E.

While the M&E strategy and policy clearly outline the importance of the ‘monitoring’ and ‘evaluation’ function, in reality, the focus is on ‘monitoring’ while the ‘evaluation’ function is largely neglected. This is not entirely surprising and understandable from the perspective of a ‘sequencing approach’ whereby the set-up of a monitoring system is a logical first building block. However, a consequence of this lack of more analytical evaluative exercises is that underlying reasons for non-performance are not revealed. While this is politically safe in the short run, it leads to analytically shallow performance reports (the main input into joint reviews), learning deficits and eventually to a lack of results on the ground. The recently established Government Evaluation Facility within the M&E department of the Office of the Prime Minister might offer some opportunities to address the shortfall of systematic and institutionalised evaluation.

When it comes to indicators and data, there is clearly a bias towards outcomes and impact data collected through the surveys of the Uganda Bureau of Statistics (UBOS). Uganda survey data is widely appreciated for being among the most reliable and it is useful to inform decision-makers at strategic and policy-making levels. However, this data is less useful for decision-making and implementation at lower levels which draws more on information from management information systems which are generally less well developed (see below for the health sector).

While M&E capacity is inadequate, which has been acknowledged in the National Development Plan, a coherent M&E capacity development plan does not yet exist, as a result of which M&E capacity strengthening has not been coordinated.

Important outside government actors in the M&E system are Parliament (supported by the Office of the Auditor General), civil society organisations and development partners, whose roles and responsibilities in the national M&E system are described in the M&E policy. Parliament is still not considered an effective watchdog and is hardly involved in decision making on government activities. However, since the instalment of a new Parliament, which has a larger percentage of relatively young Parliamentarians, there has been a more objective and qualitative debate. Moreover, these younger Parliamentarians have a higher reading culture, which increases the probability that information from M&E reports will at least be read.

While effective use of data is especially limited at lower government levels, underutilisation of available data is a generally noted phenomenon and also applies to the more central government levels as well as to actors outside government. This lack of an active demand side (or mismatch between supply and demand) has serious implications for the set up, maturing and sustainability of the M&E system as it is particularly the M&E demand side which creates incentives for M&E supply. The move towards a more performance-oriented (budgeting) system might partly remedy this deficient M&E demand side. However, without supervision and control an increased focus on results could also lead to a number of side-effects, such as gaming, goal replacement, etc. From this vantage point, it is best to combine performance monitoring with a strong evaluation function. Evaluation is helpful for identifying reliable and valid performance measures and outcomes; it might detect unintended causes of

performance measurement, and could induce more balanced analysis of (lack) of achievements involving issues of attribution.

### ***Health sector M&E system***

As far as M&E arrangements at health sector level are concerned, conclusions of the World Bank evaluation on six health sector wide approaches (SWAp) which point to the fact that there is often a neglect of M&E capacity investment as compared to investments in the design of procurement, disbursement and financial management systems (Vaillancourt, 2009) also apply to the case of Uganda. In Uganda this lack of interest in M&E is e.g. demonstrated by the fact that despite the relatively long existence of the health SWAp, the M&E plan has only recently been elaborated. While the current Ministry of Health should be applauded for the elaboration of this M&E plan, which will be particularly important for the coordination of largely fragmented health sector M&E arrangements, its implementation is challenged by the lack of funds available for the activities included in the plan (demonstrating as well the lack of interest of development partners in M&E). Given Uganda's track record in policy evaporation (implementation gap), it will be of utmost importance to monitor and review the implementation of the M&E plan itself.

### ***M&E plan and policy***

The new M&E plan pays attention to both M&E goals of 'accountability' and 'learning' and highlights the importance of dissemination of M&E findings. In practice more attention has so far been paid to (upwards) accountability (towards the central M&E system and donors) as compared to downward accountability towards citizens. While the M&E plan makes a distinction between 'monitoring' and 'evaluation' (and review), links between them are not clearly spelled out. Moreover, in line with the M&E system at central level, the focus has been on 'monitoring' at the expense of the more analytical 'evaluative' exercises. While interesting research on the health sector is done at universities, studies do not systematically feed into the health sector M&E system. The proposed introduction of performance based financing in the health sector might strengthen the link between budgets (inputs) and results, however, without a proper data supervision/control mechanism side effects like the crowding-out and gaming are a real possibility. It is therefore recommended to introduce performance based financing in the health sector on a limited 'pilot' scale and to evaluate its effects before generalising it throughout the sector.

### ***Indicators, data collection and methodology***

Our stocktaking exercise demonstrates that the 'indicators, data collection and methodology' is by far the strongest component of the health M&E system. Strengths include the limited number of core performance indicators (26) in the Health Sector Strategic & Investment Plan (HSSIP) (which hints at the fact that the need to be selective is well understood), the definition of criteria for the selection of these core performance indicators, the identification of baselines and targets (which are however not always realistic) as well as the identification of data sources for each core performance indicator. Moreover, the M&E plan also links objectives, clusters and strategic interventions with indicators (not the core performance indicators), which clearly highlights which indicators are supposed to monitor which strategic intervention. A weaker element is the lack of disaggregation of indicators. While the HSSIP points to the

need for disaggregation of indicators by income, literacy level, gender and security level, the Annual Health Sector Performance Report (AHSPR) does not include any disaggregated indicator. Moreover, specific evaluation methodologies are not clearly identified in the HSSIP or the M&E plan and existing studies which use randomised controlled trials are not integrated in the health sector M&E. As highlighted above, the quality of data from census and population-based surveys is generally more adequate than the quality of facility based data (including the HMIS) and there is so far little cross-reading among survey and facility based data.

### ***Systemic issues and Capacity***

M&E coordination and oversight in the health sector is embedded within one department of the Ministry of Health, i.e. the Quality Assurance Department. However due to its location under the Directorate of Planning and Development its power is likely to be curtailed; coordination and oversight logically entail a location higher in the hierarchy. Moreover, the Quality Assurance Department is still understaffed and the proposed M&E unit within the Quality Assurance Department is not yet operational. The weak M&E capacity is not unique to the (central) Ministry of Health, it is observed at all levels of the health system and has been further hampered by a frequent change of personnel and the enticement of staff to donor agencies. Initiatives to strengthen M&E capacities exist, yet they are not adequately coordinated.

Many technical working groups have not been functional and in particular links with policy dialogue are poor. This deficient linkage undermines the quality of policy dialogue which partly depends on the level of technical sector knowledge. The joint sector review, i.e. the Ugandan Joint Review Meeting, is considered satisfactory. There is broad-based participation from different stakeholders and room for criticism and discussion. However, there is a lack of attention for the more systemic issues. It is particularly insights into the underlying systemic issues which might help to understand a lack of progress in health sector outcomes. While the quality of the health sector M&E system strongly affects the quality of the sector performance report (one of the major inputs into the joint review), diagnosis and follow-up of the health sector M&E system itself did so far not figure on the agenda of the Joint Review Meeting. The quality of the health sector M&E system (e.g. data quality and data use) was also not an issue covered during the pre-Joint Review Meeting missions. This lack of attention for the quality of the M&E system itself is all the more surprising from the perspective of the budget support donors as they primarily rely on the outputs of the M&E system for their own accountability towards their constituencies.

Government ownership of M&E is currently on the increase and might become stronger in the future if the new minister and top management staff are keeping up with expectations. Incentives for using data are not institutionalised, but this might change in the context of the move towards more performance-oriented (budgeting) systems.

The link between the Ministry of Health and the UBOS is relatively strong. The importance of UBOS for health sector M&E is acknowledged within the Ministry of Health and in order to steer the linkage among both entities, a UBOS employee has been installed within the ministry's Resource Centre. Vertical integration, both upwards (with the Office of the Prime

Minister, Ministry of Finance, Planning and Economic Development, National Planning Authority) and downwards (with districts) is satisfactory, at least on paper. However, in practice the upward vertical integration is hampered by the complex interaction between the different national players responsible for part of the central level coordination and oversight (see above). Downward vertical integration is challenged by the poorly coordinated and planned supervision visits from the Ministry of Health to the districts and the weak functioning of the health centres IV (health sub-districts). While these health centres are responsible for the compilation of data from lower levels, they are not always functional enough to accomplish this responsibility (e.g. due to lack of computers to facilitate analysis). Linkages with donor project M&E are stimulated through the agreements in the Long Term Institutional Arrangements, which are expected to contribute in countering challenges regarding fragmentation, duplication and weak coordination. Horizontal integration (among different sub-components of the sector) is weaker as this integration is circumvented by the fact that different health departments receive direct support from different health development partners. This direct targeting of funds gives them power to elaborate their own systems and reduces incentives to adhere to one coherent health sector M&E system.

#### ***Participation of actors outside government***

In the M&E plan the role of Parliament, the Office of the Auditor General, civil society and development partners are acknowledged and responsibilities of each of them are identified. They are represented in technical working groups and participate during the National Health Assembly and Joint Review Meeting. The younger Parliamentarians of the recently installed Parliament have a higher reading culture, which increases the probability that information from M&E reports will at least be read. While members of the Social Service Committee of Parliament have appreciated the health SWAp and use of budget support, many of them only come into action when issues are raised concerning their own districts. The Office of the Auditor General has been important in carrying out financial, value for money and other audits, which have been sent directly to Parliament. While the majority of civil society organisations participating in the SWAp are weak (e.g. poor quality of input, anecdotal evidence), several health organisations have collaborated in writing a report summarising their perspectives on performance in the health sector. Moreover, organisations such as the Uganda Debt Network are engaged in community based monitoring, which supplies a continuous flow of information on local level realities. In practice (some) development partners have relatively more influence in the M&E of the health sector (e.g. the WHO, GFATM and GAVI Alliance were involved in the elaboration of the M&E plan) as compared to the national outside government stakeholders. In spite of their higher influence in health sector M&E, development partners do not seem to be interested much in M&E capacity strengthening which is generally less visible than investment in specific disease control.

Linkages among different actors outside government also tend to be largely underdeveloped in spite of the fact that these different actors have different comparative advantage when it comes to (steering) M&E. Civil society organisations for instance have easier access to local level data collection (reality checks), universities have more analytical capacity, parliament has more access to the political arena and donors to the policy level. So far however outputs of community-based monitoring exercises are for instance insufficiently used by parliament and development partners. What might be particularly interesting for development partners is

to support domestic accountability actors within a framework of a portfolio approach, whereby developing capacity of domestic accountability actors is combined with increasing the room of manoeuvre of these domestic accountability actors as well as with using information from the local level monitoring exercises in their (development partners) own policy dialogue with government at sector level.

### ***Use of M&E outputs***

While the quality of the Annual Health Sector Performance Report (AHSPR), one of the most important outputs of the M&E system, has improved over time, it still shows several shortcomings, particularly with regard to the analytical quality. The lack of analysis in the AHSPR as well as in lower level performance reports affects their quality and immediately puts into perspective the usefulness of these reports. As highlighted above, M&E findings generally remain underutilised and this deficient M&E demand side affects M&E supply and sustainability of the system. Particularly at the local level there is little interest in M&E findings (and accuracy of data is also often not checked).

In short, while the recent elaboration of the health sector M&E policy is an important first step in strengthening the M&E system, it is particularly its implementation which is of paramount importance. Elements which might steer the implementation of the plan and the set up and sustainability of a health sector M&E system are the effective instalment of the M&E unit within the Quality Assurance Department, the funding of activities included in the M&E plan, investment in M&E capacity at all levels and the creation of incentives to use the data. Implementation might also be stimulated through monitoring of the progress in the establishment and functioning of the health sector M&E system. This might be done in the context of the Supervision, Monitoring, Evaluation and Research (SMER) technical working group and the Joint Review Meeting. Our diagnostic checklist might also be useful in this respect.

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## **Annex 1: Terms of Reference O\*Platform Aid Effectiveness: assessing sector M&E systems**

### **Background**

The recent OECD/DAC peer review of Belgian development cooperation emphasises the need to increase efforts in the area of 'strengthening and using country systems' (see OECD/DAC, 2010, p. 72-73, 80). Belgium is not unique in this respect. The evaluation of the implementation of the Paris Declaration (Wood et al, 2008) highlights that improvements in the use of country systems is slow and largely limited to the area of financial management, audit and procurement. When it comes to the use of recipient monitoring and evaluation (M&E) systems, donors are generally more reluctant as they do not have enough confidence in the quality of these systems. This is not so surprising and justified by the fact that only 3 out of 54 countries included in the 2008 Paris Declaration survey had results-oriented frameworks that were deemed adequate (OECD/DAC, 2008).

While strengthening of M&E systems does not seem to be a priority of many donors and partner countries, if donors, and in particularly Belgium, want to make progress on the 'alignment' and the 'managing for results' principle, more efforts are needed to strengthen and use the recipient M&E systems. Strengthening recipient M&E systems generally improves accountability and learning which may ultimately lead to increased performance and results on the ground.

Along the same line, it has been observed that the quality of joint sector reviews largely depends on the quality of the underlying sector M&E system (Holvoet and Inberg, 2009). An assessment of the quality of sector M&E systems highlights to what extent further JSRs could rely on performance information from the recipient M&E system and indicate which components of the system need further strengthening in order to rely upon these systems in the future. Strengthening sector M&E systems will improve the quality of the JSR in the short run and change its outlook in the long run (JSR more as a monitoring and evaluation of the existing M&E system including some reality checks on the ground instead of being a monitoring and evaluation instrument of activities and outputs).

### **Objectives:**

A first step in strengthening M&E systems is the assessment/diagnosis of their quality. According to our knowledge, so far no (standard) instrument exists to assess the quality of M&E systems (which is in strong contrast to the existence and use of PFM assessment instruments). Therefore, the first objective of the study is

- To elaborate an assessment tool to diagnose/monitor/evaluate the quality of sector M&E systems.<sup>57</sup>

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<sup>57</sup> As far as we can judge from the technical note, our study will in particular help to tackle issue 2.5 in a more in-depth and systemic way. Results of the assessment will highlight to what extent the entire assessment exercise (e.g. assessment of performance) may rely upon the information from the recipient M&E system.



The second objective is:

- To apply this tool to a number of selected number of cases where Belgium is providing sector budget support.

Results of the assessment exercise should contribute to the M&E aspects of the Technical Notes and could be an input in Joint Sector Working Groups (in line with the harmonisation principle, it would also be a good idea to discuss the exercise ex-ante within the sector working groups dealing with M&E) and joint sector reviews.

## **Methodology and time estimation**

### *Elaboration of assessment tool*

On the basis of the checklist used by Holvoet and Renard (2007) in their diagnosis of PRSP M&E of 11 SSA countries, we will elaborate an assessment tool for sector M&E systems. For the elaboration we will consult several existing documents on assessment tools and scrutinize if other donors might already use tools to assess sector M&E systems.

Days: 2

### *Application of assessment tool*

The methodology of the application of the assessment tool in countries where Belgium is providing sector budget support will consist of both desk and field study. In consultation with BTC two sectors in four countries have been selected: the health sector in Niger and Rwanda<sup>58</sup>, the education sector in Uganda and Vietnam.

For each country we will examine documents available on the health respectively education sector, the (sector) M&E systems, the indicative cooperation programs etc. During the field study we will interview people directly involved in and responsible for sector M&E (preferably at central and district level), donors involved in strengthening the M&E system and users of sector M&E products.

The estimated days needed per country are:

Preparation	5
Fieldwork	5
Writing report	5
Debriefing	0.5
<b>Total</b>	<b>15.5</b>

Thus the total estimated days for the study are 64 days (4x15.5 +2).

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<sup>58</sup> As the field study to Niger has been postponed because of security issues, we added the health sector in Uganda. The field mission for the assessment of Uganda's M&E system in the health sector is scheduled for October 2011.

We will start with the desk studies for the health sector in the end of 2010, field studies in Niger<sup>59</sup> and Rwanda will take place in the first half of 2011. Decisions on the exact timing for the education sector studies are not yet made.

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<sup>59</sup> See previous note.

## ANNEX 2: CHECKLIST M&E SYSTEM AT SECTOR LEVEL

	Topics	Question
<b>1. Policy</b>		
1	M&E plan	Is there a comprehensive M&E plan, indicating what to evaluate, why, how, for whom?
2	M versus E	Is the difference and the relationship between M and E clearly spelled out?
3	Autonomy & impartiality (accountability)	Is the need for autonomy and impartiality explicitly mentioned? Does the M&E plan allow for tough issues to be analysed? Is there an independent budget?
4	Feedback	Is there an explicit and consistent approach to reporting, dissemination, integration?
5	Alignment planning & budgeting	Is there integration of M&E results in planning and budgeting?
<b>2. Indicators, data collection and methodology</b>		
6	Selection of indicators	Is it clear what to monitor and evaluate? Is there a list of indicators? Are sector indicators harmonised with the PRSP indicators?
7	Quality of indicators	Are indicators SMART (specific, measurable, achievable, relevant, time-bound)? Are baselines and targets attached?
8	Disaggregation	Are indicators disaggregated by sex, region, socio-economic status?
9	Selection criteria	Are the criteria for the selection of indicators clear? Is it clear who is involved in the selection?
10	Priority setting	Is the need acknowledged to set priorities and limit the number of indicators to be monitored?
11	Causality chain	Are different levels of indicators (input-output-outcome-impact) explicitly linked (program theory)? (vertical logic)
12	Methodologies used	Is it clear how to monitor and evaluate? Are methodologies well identified and mutually integrated?
13	Data collection	Are sources of data collection clearly identified? Are indicators linked to sources of data collection? (horizontal logic)
<b>3a. Organisation: structure</b>		
14	Coordination and oversight	Is there an appropriate institutional structure for coordination, support, oversight, analyses of data and feedback at the sector level? With different stakeholders? What is its location?
15	Joint Sector Review	Does the JSR cover accountability and learning needs for both substance and systemic issues? What is the place/linkage of the JSR within the sector M&E system? Does the JSR promote the reform agenda of the Paris Declaration?
16	Sector Working groups	Are sector working groups active in monitoring? Is their composition stable? Are various stakeholders represented?
17	Ownership	Does the demand for (strengthening of the) M&E system come from the sector ministry, a central ministry (e.g. ministry of

		planning or finance) or from external actors (e.g. donors)? Is there a highly placed 'champion' within the sector ministry who advocates for the (strengthening of the) M&E system?
18	Incentives	Are incentives (at central and local level) used to stimulate data collection and data use?
<b>3b. Organisation: linkages</b>		
19	Linkage with Statistical office	Is there a linkage between sector M&E and the statistical office? Is the role of the statistical office in sector M&E clear?
20	'Horizontal' integration	Are there M&E units in different sub-sectors and semi-governmental institutions? Are these properly linked to the sector's central unit?
21	'Vertical' upward integration	Is the sector M&E unit properly linked to the central M&E unit (PRS monitoring system)?
22	'Vertical' downward integration	Are there M&E units at decentralised levels and are these properly linked to the sector M&E unit?
23	Link with projects	Is there any effort to coordinate with donor M&E mechanism for projects and vertical funds in the sector?
<b>4. Capacity</b>		
24	Present capacity	What is the present capacity of the M&E unit at central sector level, sub-sector level and decentralised level (e.g. fte, skills, financial resources)?
25	Problem acknowledged	Are current weaknesses in the system identified?
26	Capacity building plan	Are there plans/activities for remediation? Do these include training, appropriate salaries, etc.?
<b>5. Participation of actors outside government</b>		
27	Parliament	Is the role of Parliament properly recognised, and is there alignment with Parliamentary control and oversight procedures? Does Parliament participate in Joint Sector Reviews and/ or sector working groups?
28	Civil Society	Is the role of civil society recognised? Are there clear procedures for the participation of civil society? Is the participation institutionally arranged or rather ad-hoc? Does civil society participate in Joint Sector Reviews and/ or sector working groups?
29	Donors	Is the role of donors recognised? Are there clear procedures for participation of donors? Do donors participate in Joint Sector Reviews and/ or sector working groups?
<b>6. Use of M&amp;E outputs</b>		
30	M&E outputs	Is there a presentation of relevant M&E results? Are results compared to targets? Is there an analysis of discrepancies? Is the M&E output differentiated towards different audiences?
31	Effective use of M&E by donors	Are donors using the outputs of the sector M&E system for their information needs? Is the demand for M&E data from donors coordinated?

32	Effective use of M&E at central level	Are results of M&E activities used for internal purposes? Is it an instrument of policy-making and/or policy-influencing and advocacy at central level?
33	Effective use of M&E at local level	Are results of M&E activities used for internal purposes? Is it an instrument of policy-making and/or policy-influencing and advocacy at local level?
34	Effective use of M&E by outside government actors	Are results of M&E used as an instrument to hold government accountable?

### Annex 3: Actors in the national M&E system and their responsibilities

Level	Actor	Responsibility
National	President	Overall oversight
	Office of the Prime Minister	<ul style="list-style-type: none"> <li>- Monitoring Government performance;</li> <li>- Six-monthly reporting to Cabinet on Government performance;</li> </ul>
	National Planning Authority	<ul style="list-style-type: none"> <li>- Establishing the results framework for the NDP;</li> <li>- Ensuring that relevant institutions of Government (and relevant non-state actors) develop results indicators that are consistent with the NDP;</li> <li>- Producing an overall annual national development report, capturing progress and issues pertaining to the strategic components of the NDP.</li> </ul>
	Ministry of Finance, Planning and Economic Development	<ul style="list-style-type: none"> <li>- Mobilising resources;</li> <li>- Formulating national budgets;</li> <li>- Disbursing NDP budgetary resources;</li> <li>- Financial accountability;</li> <li>- Budget monitoring and reporting.</li> </ul>
	Ministry of Public Services	<p>Providing human resources required to operationalise the strategy:</p> <ul style="list-style-type: none"> <li>- Recruiting M&amp;E specialists and statisticians;</li> <li>- Reviewing and capacitating existing M&amp;E sections/ units.</li> </ul>
	Ministry of Local Government	<ul style="list-style-type: none"> <li>- Assisting LGs in preparing results oriented plans and budgets;</li> <li>- Strengthening local governance and upwards reporting;</li> <li>- Overseeing LGs compliance with statutory requirements and adherence to national policies and standards.</li> </ul>
	UBOS	Providing core statistics critical for the monitoring and evaluation of NDP actions and results.
	Office of the Auditor General	<ul style="list-style-type: none"> <li>- Auditing and reporting on public accounts of all public offices and any public corporation or other bodies established by an Act of Parliament;</li> <li>- Conducting financial, value for money and other audits (e.g. gender and environment audits) in respect of any project or activity involving public funds.</li> </ul>
	Parliament	<ul style="list-style-type: none"> <li>- Scrutinising various objects of expenditure and the sums to be spent on each;</li> <li>- Assuring transparency and accountability in the application of public funds;</li> <li>- Monitoring the implementation of Government programmes and projects.</li> </ul>

Sector	Other ministries, departments, agencies	<ul style="list-style-type: none"> <li>- Monitoring performance;</li> <li>- Reporting on progress against BFPs and MPSs;</li> <li>- Consuming outputs and outcomes of M&amp;E strategy.</li> </ul>
	Sector Working Groups	<ul style="list-style-type: none"> <li>- Developing and implementing a five-year sector strategic investment plan (SSIP), containing a results orientated monitoring matrix and 5-year evaluation plan;</li> <li>- Producing an annual Sector Budget Framework Paper (SBFP) derived from the SSIP;</li> <li>- Establishing and maintaining a monitoring and evaluation function within the SWG secretariat;</li> <li>- Ensuring proper coordination and oversight of M&amp;E activities in their sector;</li> <li>- Holding biannual performance reviews to assess progress against targets, and for upwards reporting</li> </ul>
	Development partners	<ul style="list-style-type: none"> <li>- Providing financial and technical assistance;</li> <li>- Operationalising and maintaining the M&amp;E strategy;</li> <li>- Participating in refinement of indicators, tools and processes;</li> <li>- Participating in the implementation of M&amp;E activities;</li> <li>- Integrating monitoring frameworks into Government systems;</li> <li>- Building capacity for M&amp;E;</li> <li>- Using M&amp;E products.</li> </ul>
	Private sector	Contributing in the development of and adherence to the necessary codes and standards.
Local	Local governments	<ul style="list-style-type: none"> <li>- Monitoring frontline service delivery and accountability for results;</li> <li>- Reporting on progress of implementation and achievement of planned outputs.</li> </ul>
Community	Local councils, community based non-governmental organisations, administrative units at parish level, village councils	<ul style="list-style-type: none"> <li>- Providing information on delivery of various services, transparency and accountability of resources accorded and challenges and gaps experienced in delivery of various services;</li> <li>- Validate outcomes of NDP implementation.</li> </ul>
Household		<ul style="list-style-type: none"> <li>- Providing information on NDP implementation and delivery of target outputs;</li> <li>- Validating results;</li> <li>- Using M&amp;E results to demand for better service delivery and accountability (through 'barazas', see below)</li> </ul>

Source: Republic of Uganda, 2010c and 2010g

## Annex 4: HSSIP Core Performance Indicators

INPUT & PROCESS (4)		OUTPUT (5)		OUTCOME (12)		IMPACT (5)	
<i>Health financing Information, Governance</i>		<i>Service access and readiness</i>		<i>Coverage of interventions</i>		<i>Health status</i>	
1	General Government allocated on health as % of total government budget	5	% of new TB smear + cases notified compared to expected (TB case detection rate)	10	% pregnant women attending 4 ANC sessions	22	<b>Maternal Mortality Ratio (per 100,000 live birth)</b>
<b>Workforce</b>		6	Per capita OPD utilization rate (m/f)	11	<b>% of deliveries in public and PNFP (n° of deliveries/expected deliveries)</b>	23	Neonatal mortality rate (per 1000)
2	<b>Annual reduction in absenteeism rate (m/f)</b>	7	<b>% of health facilities without any stock outs of six tracer medicines</b>	12	<b>% children under one year immunized with 3<sup>rd</sup> dose pentavalent vaccine</b>	24	<b>Infant Mortality Rate (per 1000)</b>
3	<b>% of approved posts filled by trained health workers</b>	8	% HCs IV with a functioning theatre (providing EMOC)	13	% one year old children immunized against measles	25	<i>Under 5 mortality rate (per 1000)</i>
<b>Infrastructure</b>		<b>Service quality and safety</b>		14	% pregnant women who have completed IPT2	<b>Financial risk protection</b>	
4	% of villages/ wards with a functional Village Health Team, by district	9	% clients expressing satisfaction with health services	15	% of children exposed to HIV from their mothers accessing HIV testing within 12 months	26	% of households experiencing catastrophic payments
				16	% UFs with fever receiving malaria treatment within 24 hours		
				17	% eligible persons receiving ARV therapy		
				<b>Risk factors and behaviours</b>			
				18	% of households with a pit latrine		
				19	% U5's new visits with height /age above lower line (PR)		
				20	% children under 5 with weight /age above lower line (PR)		
				21	<b>Contraceptive Prevalence Rate</b>		

### Indicators included in the Joint Assessment Framework

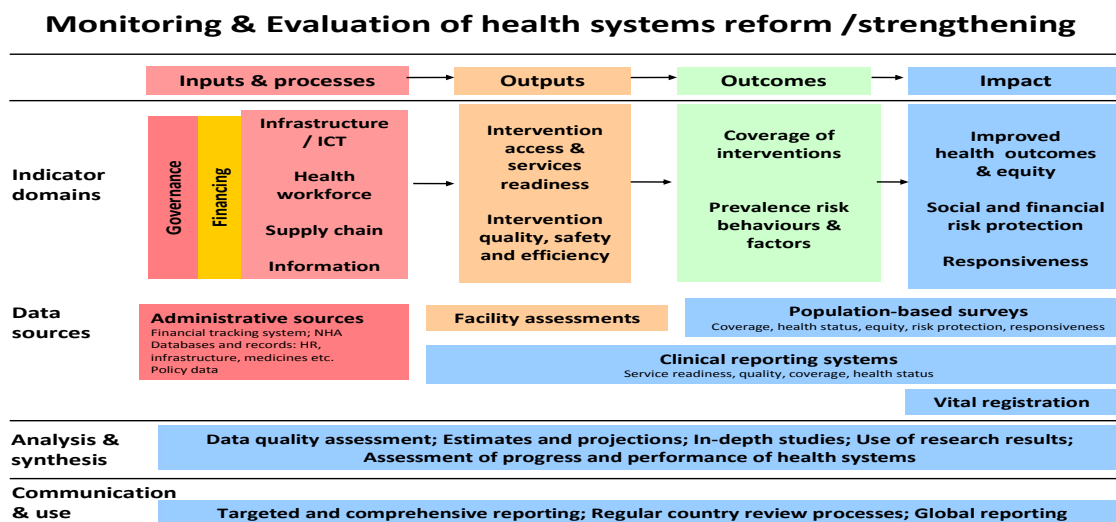
*Indicators included in the National Development Plan<sup>60</sup>*

Sources: Republic of Uganda, 2010c; Government of Uganda, 2011; Government of Uganda and JBSF Development Partners.

<sup>60</sup> Two other health indicators to monitor the objectives of the National Development Plan are life expectancy (one of the key indicators) and total fertility rate (Republic of Uganda, 2010c).



## ANNEX 5: Monitoring & Evaluation Framework WHO



Source: WHO, GAVI, Global Fund and the World Bank, 2009

## **ANNEX 6: UGANDA'S SCORE ON THE CHECKLIST FOR QUALITY ASSESSMENT OF AN M&E SYSTEM (HEALTH SECTOR)**

### **1. Policy**

	<b>Topics</b>	<b>Score</b>
1	M&E plan	4
2	M versus E	2
3	Autonomy & impartiality (accountability)	2
4	Feedback	2
5	Alignment of M&E with planning & budgeting	2

### **2. Indicators, data collection and methodology**

	<b>Topics</b>	<b>Score</b>
6	Selection of indicators	4
7	Quality of indicators	3
8	Disaggregation	2
9	Selection criteria	3
10	Priority setting	3
11	Causality chain	3
12	Methodologies used	2
13	Data collection	4

### **3a. Organisation: structure**

	<b>Topics</b>	<b>Score</b>
14	Coordination and oversight	3
15	Joint Sector Review	3
16	Sector Working groups	2
17	Ownership	3
18	Incentives	2

### **3b. Organisation: linkages**

	<b>Topics</b>	<b>Score</b>
19	Linkage with Statistical office	4
20	'Horizontal' integration	2
21	'Vertical' upward integration	3
22	'Vertical' downward integration	3
23	Link with projects' M&E	3

### **4. Capacity**

	<b>Topics</b>	<b>Score</b>
24	Actual capacity	1
25	Capacity problems acknowledged	3
26	Capacity building plan	2

#### 5. Participation of actors outside government

	Topics	Score
27	Parliament	2
28	Civil Society	2
29	Donors	3

#### 6. Use of information from M&E

	Topics	Score
30	M&E outputs	3
31	Effective use of M&E by donors	3
32	Effective use of M&E at central level	2
33	Effective use of M&E at local level	1
34	Effective use of M&E by outside government actors	1