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Christine Kirunga Tashobya, Bart Criel, Bruno Marchal and Freddie Ssengooba designed the study. Christine Kirunga Tashobya carried out the data analysis; outputs were reviewed by Valéria Campos da Silveira and Freddie Ssengooba. All authors gave critical inputs and reviewed and agreed on the submitted manuscript.

Table of Contents

Abstract

Decentralisation was introduced in Uganda in the early 90s, at a time when Uganda was recovering from several years of extensive conflict. Uganda is a low income country, with a high burden of disease. In 2003 the Uganda Ministry of Health (MoH) introduced the District League Table (DLT) which has been in use since. The DLT was necessitated by the different mandates of the Ministry of Health and districts in the health system given decentralisation. The MoH was indicated as responsible for policy formulation, strategic planning, resource mobilisation and allocation, and monitoring and evaluation. The districts were responsible for operational planning and management and delivery of health services within the national policy and strategic framework.

Most studies of Health System Performance Assessment (HSPA) have been of experiences in high income countries. The Uganda DLT has been implemented for the last 12 years, and has not been previously studied. The objectives of this study are to provide a review of the development and implementation of the DLT, with particular consideration of the interactions of the subnational HSPA framework and the Ugandan health system. The review is intended to contribute to national and global literature on HSPA and how tools like the DLT affect and are affected by other health policies and reforms; and to support the development of recommendations for improving Uganda's district HSPA. The study is part of a broader study on HSPA in which current international and Ugandan approaches to HSPA are being studied for the purpose of learning lessons and making recommendations for future HSPA in Uganda and similar contexts.

Health systems have been described as Complex Adaptive Systems (CASs), given their dynamic nature and the multiplicity of stakeholders with varying goals. This calls for a multipronged approach to health systems research. Historical analysis facilitated the telling of a story, providing the structure for narrating and interpreting events. Policy analysis using the policy analysis triangle model

supported in-depth analysis and the development of recommendations for adjustments in Uganda district HSPA. Data was collected through key informant interviews and grey and published literature. Key Informants (KIs) were selected from among those that were involved in the development and/or use of the DLT. A half of the KIs (15/30) were from the district level. An inductive-deductive approach was used for the analysis of data.

A story emerged of the introduction and implementation of the Uganda DLT since 2003 and the complex relationship this has had with the Ugandan health system. The story was related in three subsections covering: the development, implementation and adjustment of the DLT; the performance of the DLT against indicated objectives and current relevance; and highlights of experiences on the Uganda health system with particular relevance to HSPA and the DLT. The objectives of the DLT were: comparing performance of districts to determine good and poor performers, providing information to facilitate understanding of good and poor performance, enabling application of corrective measures, increasing local government ownership of achievements and encouraging good practices. The DLT included input, process and output indicators, and a composite index to rank districts. The DLT rank showed wide variation in district performance. The DLT rank was anecdotally noted to relate to district characteristics like presence of a hospital, recent history of conflict and cultural factors. However there was no analysis carried out to further understand this. There were challenges with the quality of data used for the DLT. A review of the DLT in line with its indicated objectives showed that the it was perceived as useful in comparing districts' performance and eliciting district ownership, but was noted not do well in terms of determining factors behind observed performance, instituting corrective measures and encouraging good practices. Over time, the overall perception of the usefulness of the league table declined.

Key themes that emerged of Uganda health systems' experiences with relevance to DLT implementation were: SWAp, decentralisation and integrated health services delivery; global health initiatives and the

Ugandan health system; and other changes in the Uganda health system. It was noted that reforms at the international level heavily influence reforms at the Ugandan level. During the late 90s and early 2000s a number of reforms were implemented that supported integrated decentralised health services delivery and system-wide performance assessment, which included SWAp and related budget support, and legal and institutional provisions for decentralisation. A number of reforms during the mid- and late 2000s were not supportive of district system wide initiatives like the DHT, including: the introduction of Global Health Initiatives (GHIs), stagnant public sector funding and changed implementation of decentralisation. The study noted a few experiments and innovations in performance assessment at the district level including generic local government approaches and those specific to the health system. Some experiences were reported around initiatives supporting capacity building for communities to demand accountability in relation to health services delivery.

The study considered how implementation of the league table was influenced by the interaction between the framework's content (design) and processes and the health system context and actors. The process of initial development and adjustment of the DLT is said to have involved mostly technical officials at national level with minimal involvement of district managers especially the political and administrative leaders, and other stakeholders key for performance assessment. The dissemination and follow up of DLT findings was noted to be limited to discussions at national level meetings and irregular meetings with district managers. The design of the DLT including the range of indicators and analysis done has been judged as lacking. The DLT includes a limited number of indicators to facilitate understanding of observed performance. The league table analysis has tended to treat all districts as the same despite marked differences between them. Recent efforts to stratify the districts along lines of remoteness, period of district existence and population size are deemed as inadequate.

The Uganda health system context was noted to have been markedly influenced by the history of conflict, the low levels of development and a high burden of disease. There is high dependence on international agencies for financial and technical support in the health sector, which is associated with multiple and frequently changing reforms. Often new reforms are introduced before lessons from the previous ones have been learnt. There is variation of power among health sector stakeholders, and over time, international actors in the era of GHIs wield more power than national actors, and the MoH has limited leverage over other national actors. The private sector including facility based private not for profit providers, civil society organisations and other private health services are a major player in the Ugandan health system. The Uganda health system is portrays the complexity and dynamism of a complex adaptive system. The potential of decentralisation and multiparty democracy to facilitate local governance and accountability in Uganda is yet to be substantially exploited.

The use of historical and policy analysis in this study facilitated the appreciation of the interaction of the DLT and the Uganda health system context, and brought out a number of lessons relevant at the global and Ugandan level. The study has noted that it is important for health system stakeholders to appreciate the characteristics of health systems as CASs, and to take the necessary steps to envisage possible effects of planned reforms or interventions beyond the intended benefits. Specific to HSPA the study provides a number of lessons for countries seeking to develop or adjust their frameworks.

District HSPA in Uganda was noted to even be more necessary today given the large number of districts with varied capacities and the increasingly dynamic and complex context. The design of the DLT emphasising accountability to the national level is not in alignment with the current Uganda health system context, with many players of varying power and lacking a single point of leverage. Rather a framework focusing on supporting decision making at the district level would align better with such a dynamic and complex context. Such a framework would enable districts react to prevailing circumstances to

optimise their performance. The possibility of how such a framework could incorporate aspects of accountability to the community is something to be explored. The adjusted framework should have a more inclusive development process and adjustments in design that include more explanatory indicators for district-led improvements, and stratified comparisons given the different capabilities of districts.

Keywords:
Decentralisation, SWAp, integrated health services delivery, district league table, historical analysis, policy analysis, health system performance assessment, reforms, global health initiatives, accountability, support for decision making.

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Conflict of Interest

The first author works at the Ministry of Health in Uganda and was part of the team that developed the Uganda district league table. We declare no other possible conflict of interest.

Acronyms

ACODE	Advocates Coalition for Development and Environment
AHSPR	Annual Health Sector Performance Report
ANC	Antenatal Care
AIDS	Acquired Immune Deficiency Syndrome
CAO	Chief Administrative Officer
CAS	Complex Adaptive System
CBO	Community Based Organisation
CDC	Centre for Disease Control
CS	Civil Society
CSO	Civil Society Organisation
DANIDA	Danish International Development Agency
DADM	District Administrative Manager
DENIVA	Development Network of Indigenous Voluntary Associations
DfID	Department for International Development (of the United Kingdom)
DHO	District Health Officer
DLT	District League Table
DPOL	District Political Manager
DTECH	District Technical Manager
EDF	European Development Fund
FDS	Fiscal Decentralisation Strategy
GAVI	Global Alliance to Vaccines and Immunisations
GFATM	Global Fund to fight AIDS Tuberculosis and Malaria
GHIs	Global Health Initiatives
GoU	Government of Uganda
HC I	Health Centre Level One
HC II	Health Centre Level Two
HC III	Health Centre Level Three
HC IV	Health Centre Level Four
HCA	Hierarchical Cluster Analysis
HIPC	Highly Indebted Poor Countries
HIV	Human Immune-deficiency Virus
HSD	Health sub-district
HPD	Health Planning Department

HMIS	Health Management Information System
HSDP	Health System Development Plan
HSPA	Health System Performance Assessment
HSSP	Health Sector Strategic Plan
HSSIP	Health Sector Strategic and Investment Plan
IA	International Agency
IHP+	International Health Partnerships and related Initiatives
IPT	Intermittent Presumptive Treatment
JMS	Joint Medical Stores
JRM	Joint Review Mission
KI	Key Informants
KII	Key Informant Interviews
LG	Local Government
LICs	Low Income Countries
LMICs	Low and Middle Income Countries
MAP	Multi-country AIDS Programme
MEEPP	Monitoring and Evaluation of Emergency Plan Progress
MHCP	Minimum Health Care Package
MO	Medical Officer
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
NDP	National Development Plan
NGO	Non- Governmental Organisation
NHA	National Health Assembly
NHP	National Health Policy
NMS	National Medical Stores
OPM	Office of the Prime Minister
PAF	Poverty Action Fund
PEPfAR	(United States) President's Emergency Programme for AIDS Relief
PHC CG	Primary Health Care Conditional Grant
PNFP	Private not for Profit
PPPH	Public Private Partnership for Health
PRSP	Poverty Reduction Strategy Paper
SIDA	Swedish International Development Co-operation Agency
SUO	Standard Unit of Output
SWAp	Sector Wide Approach to health development

UBOS	Uganda Bureau of Statistics
UCMB	Uganda Catholic Medical Bureau
UNASO	Uganda National AIDS Support Organisation
UNDP	United Nations Development Programme
UNHCO	Uganda National Health Consumer Organisation
UNMHCP	Uganda National Minimum Health Care Package
US	United States
USAID	United States Agency for International Development
WHO	World Health Organisation
WHR	World Health Report

Introduction

Measurement of the extent to which various aspects of the health system meet their key objectives, and use of this information in decision-making otherwise known as performance assessment, is a key tool for improving health systems. Performance assessment allows policy makers, health system managers and researchers to make comparisons within a system across time and different levels, and between systems and across various settings (Adab et al. 2002b; Smith 2002; Murray & Evans 2003; Loeb 2004). League tables have long been used to present performance data in industry and sports, by international agencies, and in public health (WHO 2000; Adab et al. 2002b; Marshall et al. 2004; Foro 2013; UNDP 2013). Decentralisation involving a variety of mechanisms to transfer authority from a central entity, such as the Ministry of Health (MoH), to alternate institutions has been promoted among low and middle income countries (LMICs) for some time now (Rondinelli & Cheema 1983; World Bank 1993). The rationale for decentralisation includes its perceived potential to improve efficiency, equity, accountability, local participation, and ownership (Bossert & Beauvais 2002). Decentralisation results in a number of sub-national units that are accountable to a central unit, creating the need for a framework within which to monitor whether decentralised units are performing as expected.

In the late 1980s to mid-1990s, a wave of reforms occurred across the world in the areas of government organisation, the coordination of health sector stakeholders, and health financing involving low income countries (LICs) in particular. Decentralisation was one of the early reforms, together with restructuring and downsizing central government ministries and agencies, and introduction of user fees in health facilities (World Bank 1993; Macrae et al. 1996; Gilson 1997; Bossert & Beauvais 2002). The late 1990s witnessed another wave of reforms, a number of which counteracted the effect of the previous ones. LICs were supported to develop poverty reduction strategy

papers (PRSPs) funded mostly by the proceeds from debt cancellation under the Highly Indebted Poor Countries' (HIPC) initiative. Many of the PRSPs prioritised the health sector (Gupta et al. 2002; Laterveer 2003). A need for improved coordination led to the concept of sector-wide approach to health development (SWAp) and the related provision of financial support by international partners through the national budgets of beneficiary countries, referred to as budget support (Sundewall & Sahlin-Andersson 2006; Peters et al. 2013).

Over the last 2 decades, increased attention has been given to Health Systems Performance Assessment (HSPA) across the world (Sicotte et al. 1998; Arah et al. 2003; Kruk & Freedman 2008; Tashobya et al. 2014). In 2000, the World Health Organisation (WHO) produced a landmark publication on HSPA, the World Health Report (WHR) 2000 *Health Systems: Improving Performance*. The WHR 2000 proposed a framework for measuring health system performance and used data on a number of indicators to compare the health systems of member countries and ranked them according to a composite index (WHO 2000). This created a lot of international interest and controversy and the impetus for many experiments in HSPA (Almeida et al. 2001; Barron et al. 2005; Smith, Mossialos & Papanicolas 2009; Murray & Evans 2003).

Uganda is a sub-Saharan African country with low levels of socioeconomic development and high morbidity and mortality rates (UNDP 2013). The country emerged from extensive civil conflict in the mid-1980s, and since then has enacted various reforms including broad government reforms and those specific to the health sector. A new constitution was promulgated in 1995 and together with an Act of Parliament of 1997 established the parameters for decentralisation (GoU 1995; GoU 1997; Jeppsson & Okuonzi 2000). During the 1980s, economic performance was very low, with minimal public resources for social services. The health sector benefitted from donor projects that funded specific technical programmes (Macrae et al. 1996). Against this background, technical guidance from the World Bank, UNICEF, and WHO provided the basis for implementing user fees in public facilities (World Bank 1987; Gilson 1997; Nabyonga

Orem et al. 2011). Uganda's PRSP, locally referred to as the Poverty Eradication Action Plan (PEAP), was the first to be approved by the World Bank and had the health sector as one of the major priorities (MoFPED 1999; MoFPED 2004). The funds from government, international partners, and the HIPC Initiative supporting the PEAP were channelled into the Poverty Action Fund (PAF) and into conditional grants to the priority sectors. The health sector grant, the Primary Health Care Conditional Grant (PHC CG), was the main source of funding for district health services. In the late 1990s, user fees were a major point of debate at the international and national level and in 2001 were abolished in public health facilities across Uganda (James et al. 2006; Tashobya et al. 2006; Nabyonga Orem et al. 2011). This background highlights the dynamic and complex nature of the Ugandan health system context, which provides the environment in which interventions including those in HSPA have to be developed and implemented.

Uganda has implemented decentralisation for three decades now. In line with the sector stewardship role, the MoH developed an innovative approach for assessing the performance of health systems at the sub-national (district) level, the health sector District League Table (DLT). The Uganda health sector DLT was first prepared in 2003 and included in the Annual Health Sector Performance Report (AHSPR) (Ministry of Health 2003b; Murindwa et al. 2006). League tables have been used in industry, sports and in the social sectors. In the social sector league tables have been used by international agencies to compare different countries including in health (Adab et al. 2002a; WHO 2000; UNDP 2013). The development and implementation of the DLT as Uganda's district HSPA framework has not been studied yet. This provides a good opportunity for research, given the limited documentation on decentralisation and HSPA generally, and specifically in LMICs.

This study is nested in a broader research programme on HSPA. The first stage of this research was a review of the literature and international experiences on HSPA for the purpose of developing attributes of a normative HSPA framework (Tashobya et al. 2014).

The second stage is a critique of the DLT using various methodological approaches to provide a comprehensive picture. The study reported on here is a component of the second stage of the research programme. The objective of the current study is to provide a review of the development and implementation of the DLT, with particular consideration of the interactions of the subnational HSPA framework and the Ugandan health system. The review is intended to contribute to national and global literature on HSPA and how tools like the DLT affect and are affected by other health policies and reforms; and to support the development of recommendations for improving Uganda's district HSPA. The third stage of the broader research programme is the development of an appropriate HSPA framework for the district level in Uganda today.

Data and Methods

Health systems are now appreciated as Complex Adaptive Systems (CASs) with characteristics such as non-linearity, dynamism, learning and adaptation, lacking a single point of control, and being composed of independent agents with conflicting goals and behaviours (Rouse 2008). These characteristics call for multipronged approaches for health systems research (Begun et al. 2003; McDaniel et al. 2009).

This study adopted a combination of research approaches to tell the story of the Uganda DLT over the 12 years of its implementation and to provide an understanding of what happened over this period. The research approaches utilised here include historical analysis and health policy analysis.

Historical analysis, an aspect of historical research, entails interpreting and understanding various historical events, documents and processes (Berridge 2001; Mahoney & Rueschemeyer 2003). A number of researchers believe that it is necessary to deal with history in public health (Fee & Brown 1997; Kutty 2000; Wyche et al. 2006; Berridge 2010; van Ginneken et al. 2010). The goal of historical analysis is to develop a narrative on a specific topic. Historical analysis facilitates awareness of the complexity of health systems and enhances a critical view of events. In addition, historical analysis introduces the time perspective, whereby studying a broad time span facilitates an understanding of the current situation (Perdiguero et al. 2001; Fee & Brown 2002). The model of health policy analysis proposed by Walt and Gilson (1994) commonly referred to as the 'policy analysis triangle', has been used to study health policy and reform in various countries (Walt & Gilson 1994; Buse et al. 2005; Buse et al. 2007). This model organises the multitude of factors that have been recognised to affect health policy formulation and implementation into four key groups: content, context, process and actors.

Concepts and tools from the two fields of research have been used to study the Uganda DLT and enabled the weaving of a narrative, triangulating oral and written sources and the identification of critical

perspectives and emerging themes. Van de Ven (2007) has referred to this process as moving *"from event sequence to story narrative… from surface observations toward a process theory… and from description to explanation"* (Van de Ven 2007). The contributions of these different research approaches to this study are summarised in Table 1. Historical research facilitated telling the story and interpreting events around the development and implementation of the DLT. The policy analysis triangle provided the framework for in-depth analysis of the experiences of the DLT, including its interaction with the health system context and actors and supported the development of recommendations for the adjustment of Uganda district HSPA.

Table 1. Application of research approaches and analytical models to the study of the implementation of the Uganda District League Table

Research approach/analytical model	Contribution to study
Historical research/ historical analysis	• Situated the study of the DLT in a broader time span and supported the development of a narrative • Facilitated interpretation and understanding of various events related to the development and implementation of the DLT • Facilitated awareness of the complexity of health systems and enhanced a critical view of events relating to the DLT
Health policy analysis/ policy analysis triangle	• Facilitated the untangling of complex forces of actors, context, process, and content and their effect on the development and implementation of the DLT • Supported the process of formulating proposals for future sub-national HSPA through: o Identification of obstacles that undermined achievement of DLT objectives o Establishment of more realistic expectations for sub-national HSPA

Sources: Berridge 2001, 2010; Buse et al 2007; Fee & Brown 1997, 2002; Perdiguero et al 2001; Walt & Gilson 1994

The data used in this study was in the form of documents and Key Informant Interviews (KIIs). The documents pertained to the development and implementation of the DLT, as well as the policies, strategies and reforms within the Ugandan health system over the previous three decades deemed relevant to DLT development and implementation. Documents were retrieved from government databases and complemented with other grey literature. Published literature was scanned for relevant documents. Key Informants (KIs) were purposively selected from among health sector stakeholders from the national and local government, international agencies, academia and public and private sector players. The first author, based at the Ministry of Health since 1996, was involved in the development and implementation of the DLT and the technical backstopping of districts. This greatly facilitated the identification of KIs. Interviewees had experience with the development, implementation, and/or use of information from the DLT. A total of 35 interviews were attempted, and 30 were achieved. Half of the KIs were district managers (political, administrative and technical) as shown in Table 2.

Data was collected through in-depth interviews using an open-ended interview guide, attached as Annex 1. The respondents were requested to share their experiences with the development and utilisation of the DLT, whether they considered it successful in achieving the set objectives, which factors facilitated or inhibited this, and whether they thought the DLT was still relevant. All of the interviews were carried out by the first author, in English, between June and August 2012. The recorded interviews were transcribed, coded and analysed by the first author and the outputs were reviewed by two other members of the research team. An inductive-deductive process was utilised to tease out themes. This process was influenced by the research questions as reflected in the interview guide, DLT objectives, time sequence, key actors and major reforms in the Uganda health system.

Table 2. Institutional Affiliation and Responsibility of Key Informants

	Institution	Code
National Level	Ministry of Health	MoH 1
		MoH 2
		MoH 3
		MoH 4
		MoH 5
		MoH 6
		MoH 7
	International Agencies	IA 1
		IA 2
		IA 3
	Academia	ACAD 1
		ACAD 2
Local Governments	Political Leaders	DPOL 1
		DPOL 2
	Administrative Managers	DADM 1
	Technical Managers	DTECH 1
		DTECH 2
		DTECH 3
		DTECH 4
		DTECH 5
		DTECH 6
		DTECH 7
		DTECH 8
		DTECH 9
		DTECH 10
		DTECH 11
		DTECH 12
Civil Society		CS 1
		CS 2
		CS 3

Ethical approval was provided by the Institutional Review Board of the Institute of Tropical Medicine, Antwerp, Belgium (Ref. 12 25 5 828), and the Uganda National Council for Science and Technology (SS 2951). All KIs provided informed consent. The anonymity of KIs was maintained, with quotes identified only by organisation and responsibility of respondent.

Results

A historical approach was used to present findings of the study, resulting in a narrative of the Uganda DLT, presented here in three sections. The *first* sub-section focuses on the specifics of development, implementation and adjustment of the DLT. The *second* sub-section presents the performance of the DLT against the indicated objectives and its perceived relevance in recent times. The *third* sub-section covers three themes that emerged from the analysis of experiences in the Uganda health system with relevance to HSPA and specifically the DLT.

The Uganda District League Table – introduction, implementation, adjustments

This subsection relates a key component of this narrative, telling the story of the development, implementation and adjustment of the DLT. In the late 1990s, the MoH and health sector stakeholders utilised SWAp principles to develop the National Health Policy (NHP) and Health Sector Strategic Plan 2000/01 to 2004/05 (HSSP I) (Jeppson 2002). Key elements in these documents included the Uganda National Minimum Health Care Package (UNMHCP), functional decentralisation to the district and health sub-district (HSD) and Public Private Partnerships for Health (PPPH). The latter involved working closely with the private sector, especially the facility-based private not-for profit (PNFP) health service providers (Ministry of Health 1999; Ministry of Health 2000). A Memorandum of Understanding (MoU) spelled out the responsibilities and expectations of stakeholders, a set of indicators for sector monitoring (HSSP indicators), and the mode and frequency of reporting, including Joint Review Missions (JRMs) and National Health Assemblies (NHAs) (Ministry of Health 2000). The JRM and NHA (annual and biennial, respectively) are meetings of sector stakeholders representing public and private institutions, international agencies,

and central and local governments to discuss sector performance and establish priorities for the subsequent year. The AHSPR has been produced since 2001 for discussion at these meetings and has included the DLT since 2003 (Ministry of Health 2001; Ministry of Health 2003b; Cruz et al. 2006).

"The league table was introduced at the beginning of the SWAp and the MoU where the assessment of the sector would be presented to stakeholders – development partners and others. There was a requirement to present and synthesize the sector performance and understand what the challenges were and improve performance" (International Agency respondent [IA] 3)

The development of the DLT was spearheaded by the Health Planning Department (HPD) of the MoH. The HPD played a major role in the health sector given SWAp, leading priority setting, planning, and resource allocation; and monitoring including compiling the AHSPRs and preparing for JRMs and NHAs (Jeppson 2002). The JRM 2002 Aide Memoire indicated disaggregation of sector performance to the district level as a requirement. At this point in time Uganda had 56 districts (Ministry of Health 2003a; Ministry of Health 2003b). It was recognised that the average national performance against HSSP indicators masked variation between local governments. Other participants in the development of the DLT were representatives of international agencies, and a few representatives of the districts. Respondents provided mixed views on the adequacy of consultations for the DLT across the sector, with a number expressing the opinion that the consultation was inadequate.

"It was developed by staff of the Health Planning Department in the Ministry of Health. By very enthusiastic Senior Health Planners..." (MoH 1)

"Who was involved – MoH across different departments, development partners, PNFP, other stakeholders involved in the SWAp – I would say were involved as it was an institutional process. One could say that the consultation did not

go to the districts and health facilities, to all corners of Uganda – this was not possible at the time" (IA 1)

"I really participated in the development of the DLT. We had numerous indicators to choose from and needed to agree on which made sense" (District Technical Manager [DTECH] 1)

*"Maybe it should have been more consultative. We should have had, for example, UBOS (*Uganda Bureau of Statistics*) that computes some of these indicators, academic institutions… We should even have had more representation from the decentralized level that we were monitoring – to really tell us whether this was the best way to assess them"* (IA 2).

The purpose of the DLT was indicated as: comparing performance of districts to determine good and poor performers; providing information to facilitate understanding of good and poor performance thus enabling application of corrective measures; increasing local government ownership of achievements; and encouraging good practices. The DLT it was indicated was not meant to embarrass local government leaders of poorly performing districts but rather to raise questions on why such a district was performing poorly and how it could be supported to improve (Ministry of Health 2003b; Murindwa et al. 2006). The DLT was based on HSSP indicators, including input, process and output indicators, and was a combination of system-wide indicators (e.g., new outpatient department (OPD) attendance per capita and proportion of expecting women delivering in public and PNFP health facilities) and those highlighting programmes against disease conditions considered important due to their high contribution to morbidity and mortality (e.g., malaria, tuberculosis, HIV/AIDS control programme indicators) (Ministry of Health 2003b). Table 3 shows the DLT indicators as selected in 2003 and as they have changed over time. Annex 2 showing HSSP II (2005/06 to 2009/10) indicators provides an example of sector strategic plan indicators from which the DLT derives its indicators.

Table 3. Uganda District League Table indicators 2003-2015

	Indicator/item	Type of indicator	Data collection			DLT rank computation	
			2003-05	2006-10	2011-15	Year	Weight factor
1	Population	Descrip-tive	Yes	Yes	Yes		
2	No. of health sub-districts	Descrip-tive	Yes	Not in 05/06	No		
3	No. of hospitals	Input	Yes	No	No		
4	Total number of health units (excluding hospitals)	Input	No	Yes	No		
5	Total number of health units	Input	No	08/09 to 09/10	No		
6	Total (public) funding to health sector per capita	Input	Only 02/03	No	No		
7	Approved posts filled by trained health personnel	Input	Yes	No	Yes	2003-2005 2011-	5 10
8	District HMIS outpatient returns submitted timely	Process	Yes	Yes	Yes	2003 - 2010	5
9	District HMIS outpatient returns submitted complete	Process	Yes	No	Yes	2003-2005	5
10	PHC funds spent on drugs at NMS & JMS	Process	Yes	Yes	No	2003-2010	10
11	Quarterly financial requests submitted timely	Process	In 02/03	No	No	2003-2005	10
12	PHC funds disbursed that are expended	Process	Not in 02/03	Yes	No	2006-2010	5
13	FDS Flexibility Gain	Process	No	Yes	No	2006-2010	5
14	Children <1 received 3 doses of DPT as per schedule (DPT3)	Output	Yes	Yes	Yes	2003-2010 2011-	12.5 15
15	Government &PNFP OPD utilization per person per year	Output	Yes	Yes	Yes	2003-2010 2011-	12.5 10

16	Pit latrine coverage	Output	Yes	Yes	Yes	2003-2010 2011-	7.5 10
17	Deliveries in government & PNFP health facilities	Output	Yes	Yes	Yes	2003-2010 2011-	12.5 15
18	Proportion of TB cases notified compared to expected	Output	Yes	Yes	No	2003-2010	10
19	Pregnant women receiving 2nd dose Fansidar for IPT (IPT2)	Output	Yes	Yes	Yes	2003-2010 2011	10 5
20	HIV/AIDS service availability	Output,	No	Yes	No	2006-2010	10
21	HIV testing of children born to HIV positive mothers	Output	No	No	Yes	2011-	10
22	ANC 4th visit	Output	No	No	Yes	2011-	5
23	TB treatment success rate	Output	No	No	Yes	2011-	5
24	HMIS reporting composite	Output	No	No	Yes	2011-	5
25	Medicines orders submitted timely	process	No	No	Yes	2011-	5

ANC, antenatal care; ART, antiretroviral therapy; DPT3, 3rd dose of diphtheria, pertussis, and tetanus vaccine; HCT, HIV counselling and testing; HMIS, Health Management Information System; IPT, Intermittent Presumptive Treatment of malaria with sulphadoxine pyrimethamine (Fansidar); JMS, Joint Medical Stores; NMS, National Medical Stores; OPD, Outpatient Department; PHC, Primary Health Care; PMTCT, Prevention of Mother to Child Transmission of HIV; PNFP, Private Not for Profit

The indicators that constituted the composite index used to rank the districts in 2003 included input, process and output indicators. The input indicator that was included was the proportion of staff norms filled by qualified health workers. This was based on the understanding that although quotas for health workers were determined by the MoH, the district was responsible for the process of recruitment of health workers, and therefore could influence performance against this indicator. A number of process indicators

were included, deemed to represent decisions or actions taken by the local government that would influence health services delivery and uptake. These included: timely submission of financial requests; expenditure on essential medicines and health supplies at designated points (the National Medical Stores and Joint Medical Stores) as a proportion of indicative budgets reflecting district prioritisation of a key health services input; and management of health data as represented by timeliness and completeness of the district Health Management Information System (HMIS) submissions to the MoH.

The output indicators that were included in the DLT and used to compute the composite index represented a combination of district capacity to deliver services and the demand of the population for services. These included: the proportion of children that have received the third dose of the diphtheria-pertussis-tetanus (DPT3) vaccine by their first birthday; new OPD attendances per capita; proportion of expecting mothers delivering in public and PNFP health facilities; proportion of expected tuberculosis cases that are notified; proportion of pregnant women receiving the second dose of sulphadoxy-pyrimethamine for intermittent presumptive treatment of malaria in pregnancy (IPT2); and proportion of households with pit latrines as a measure of sanitation coverage. The HMIS was the main source of information for the DLT with a few indicators derived from district surveys (e.g., household latrine coverage representing sanitation) and administrative records (e.g., information on human and financial resources). The HMIS included data from all public and PNFP facilities, including all health centres and hospitals (Ministry of Health 2003b).

The AHSPR including the DLT was compiled by the HPD together with other departments and programmes at the MoH, especially the Resource Centre, which hosts the HMIS. A composite index of district performance was computed by weighting and combining some of the DLT indicators and used to rank the districts from the first 'best performer' to the last 'worst performer'. This was very similar to the process used by the WHO for member states in 2000 (WHO 2000). Table 3 shows the DLT indicators used to compute the

composite index and the weighting factors (Ministry of Health 2006; Ministry of Health 2011; Tashobya et al. 2015; Ministry of Health 2003b). The weights were determined by taking into consideration sector goals and priorities, and the extent to which it was deemed good performance on a particular indicator represented good district health system performance. For example high utilisation of ambulant services has been said to reflect a well-functioning health system (Berman 2000; Ministry of Health 2000). This is better understood when considered in the context that utilisation of basic services in the period prior to the development of the DLT was very low, with for example new OPD attendance per capita at 0.4; proportion of expecting women delivering in public and PNFP health facilities 25%; and proportion of children receiving DPT3 44% as the HSSP I baseline national figures (Ministry of Health 2003b). In view of this, new OPD attendance, proportion of expected deliveries taking place in public and PNFP health facilities and proportion of children that have received DPT3 by the first birthday were given the highest weight at 12.5 each.

On the other end of the spectrum the proportion of approved posts filled by qualified health workers, HMIS timeliness and completeness, and timely submission of quarterly financial requests were given the relatively low weight of 5. These latter indicators represented actions that facilitated the achievement of the desired sector outputs as represented by the former highly weighted indicators. The remaining indicators, a mix of process and output indicators had weight factors in between these extremes indicating moderate levels of perceived importance (Ministry of Health 2003b). An example of the output of the DLT for 2007/08 as is attached as Annex 3 (Ministry of Health 2008b). Most of the respondents thought the choice of indicators and weights was reasonable at the time of initial development.

"Developers looked at indicators at these different levels – inputs, processes, output and outcomes – for example staffing, financing, effective use of funds, management aspects such as completeness and timeliness of health information,

outpatient numbers, deliveries in hospitals, specific disease considered crucial – TB and HIV/AIDS" (Civil Society Respondent [CS] 2).

The performance of the sector, with a focus on HSSP indicators, was reported in the AHSPR and discussed at the JRM and NHA. From 2003 onward, in addition to global performance, the DLT in the AHSPR presented the performance of districts against a number of indicators and a composite index for ranking them. The districts showed a range of performance against the individual indicators and the composite index and rank. For example in 2003, Jinja the first district on the league table had a score of 85, Pader the last district had a score of 41.7, and the national average score was 63.1 out of a possible total of 100. The 'best performers' on the DLT (10, later 15 as the number of districts increased) were recognised and given tokens of excellence. The 'worst performers' (10, later 15) were noted, as were those that had improved or declined in the medium term (Ministry of Health 2003b; Ministry of Health 2008b). Our review of documents and interviews indicated that the stakeholders, including the district managers, found the DLT of great interest. The league table was a major topic of discussion at the NHA/JRMs, shifting the debate from mainly programmatic discussions before the introduction of the DLT to more system-wide concerns (Ministry of Health 2003a; Ministry of Health 2008a; Ministry of Health 2008c).

"From my experience, when I first came in contact with the league table, my district was at zero level of performance. We were at the bottom! Then the next year it was No.46 out of 56. We made a jump by 9 positions. Thoughts that were in my head were: We can actually improve. What are other areas of weaknesses? The following year, we made a bigger jump; we became No. 6. Then we asked ourselves: Did we actually make a big jump or not? One of the reasons I asked that was because I thought there were a lot of things to do with documentation, and when I came in, I loved documentation. This strengthened documentation and the HMIS and brought to the fore some of the things that were already existing" (DTECH 12).

Some attempts, it has been noted, were made to move the data analysis beyond ranking against the composite index and specific indicators. MoH staff noted that district performance as portrayed by the DLT ranking was related to a number of factors including district contextual and management characteristics. District contextual characteristics that were seen to have a relationship with DLT rank included: period in existence as a district, conflict status (current conflict, post-conflict, no recent history of conflict), presence of hospitals, and cultural practices that affected health seeking behaviour. District management characteristics that were noted to have a relationship to district DLT ranking were performance on the indicators of medicines budget utilisation and HMIS and financial management. However no particular efforts were made to scientifically analyse these relationships and most respondents viewed the analysis carried out as limited (Komakech 2005b; Tashobya et al. 2015). The national average rank on the DLT has vacillated over the 12 years as shown in Table 4. However given the changes in indicators and weights over time, it is not appropriate to compare performance over the entire 12 years of DLT implementation. When the most recent period with the same indicators and weights is considered, the years 2011 to 2015, the national average rank shows improvement in district performance from 58.4 out of a total possible 100 points in 2011 to 78.6 in 2015. This improvement is mostly due to improvements in the proportion of children borne of HIV positive mothers that are screened for HIV improving from an average of 30% to 95% and proportion of medicine orders submitted timely from 47% to 94% over the HSSIP period (Ministry of Health 2005a; Ministry of Health 2010a; Ministry of Health 2015a).

Table 4. Average ranking of Ugandan districts on the League Table 2003-2015

Strategic Plan Period	HSSPI 2001/02-2004/05			HSSP II 2005/06 – 2009/10					HSSIP 2010/11 – 2014/15				
Year	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15
Average Ranking	63.1	60.2	56.8	60.8	60.5	62.0	65.0	67.9	58.4	57.0	63.0	74.0	78.6

Sources: Ministry of Health 2005a; Ministry of Health 2010b; Ministry of Health 2015a

A number of challenges have been noted during the implementation of the DLT. In the mid-2000s, Gulu, a district from the north of the country that was experiencing marked conflict with the majority of the population living in internally displaced people's camps, rose to and maintained a position among the best performing districts on the DLT for several years. This brought the DLT up to scrutiny and controversy (Komakech 2005a; Ministry of Health 2008a). There have been concerns about the quality of data in the DLT. The main source of data for the DLT is the HMIS. The HMIS was first introduced in Uganda in 1985, and scaled up in its present form to cover the whole country in 1997. The HMIS has been a paper-based system until recently (2014), with submissions from districts reflecting varying degrees of completeness (Kiberu et al. 2014). A data validation exercise carried out by the MoH in 2008 showed marked discrepancies between data in health facility databases, district databases, and the MoH Resource Centre for some of the districts (Ministry of Health 2008c). Some stakeholders were of the view that this in some instances there was a deliberate effort to misrepresent district performance (Driwale 2005). Data on health financing (government and donor), human resources and health infrastructure is rarely available though it is supposed to be part of the DLT. When data is available, for some of the variables, it is challenging to use it for decision-making as data collection methods change over the years. For example, in some years data on human resources for health includes those employed in PNFP facilities and in others it does not.

Adjustments to the DLT

Since its inception in 2003, a number of adjustments have been made to the DLT, highlights of which are provided here. Adjustments were made in 2005 and 2010 at the time new sector plans and strategies were developed and in response to changes in the context. The adjustments are shown in Table 3. The adjustments were made largely by technical officers within the MoH in the Planning and Quality Assurance Departments and Resource Centre.

In 2005, with the development of the Health Sector Strategic Plan for 2005/06 to 2009/10 (HSSP II), some new indicators were introduced and adjustments made in computation of the composite index. This was in response to some of the changes in the context at that time. Districts had been noted to improve on a number of parameters, such as the submission of quarterly financial requests and completeness of HMIS returns, and these indicators were dropped from the computation of the composite index. On the other hand, there were new policies/interventions, such as the Fiscal Decentralisation Strategy (FDS), and with the introduction of global health initiatives (GHIs), HIV interventions were introduced and/or scaled up. It was argued that districts had a limited role to play on the proportion of posts filled by qualified staff as recruitment quotas were determined by the MoH and MoFPED, and this indicator was dropped from the computation of the composite index (Ministry of Health 2006).

With the development of the Health Sector Strategic and Investment Plan 2010/11 to 2014/15 (HSSIP), further adjustments were made to the DLT. The changes were intended to provide: new management indicators as most of the old ones were deemed obsolete; more sensitive service coverage indicators; and comparisons between similar groups within the larger group of 112 districts. Some of the process/management indicators that were deemed obsolete given changes in the Uganda health system include the indicator on health sector gain from FDS flexibility as the strategy had been suspended, and the proportion of PHC funds expended as virtually all districts

were spending all the disbursed funds. The process indicators that were reconfigured include: the indicator on essential medicines and health supplies which was changed from the proportion of budget used since the district no longer receives the funds, to timeliness of ordering from the NMS; the HMIS timeliness indicator was changed to a composite index that includes timeliness and completeness of district monthly reports, completeness of facility reports and completeness of district annual reports submitted to the MoH Resource Centre. A number of changes were made in regard to DLT output indicators, with the purpose of introducing more sensitive indicators. The indicator on TB was changed from case notification to treatment success rate; and the indicator on HIV/AIDS control was changed from a composite of service uptake to testing of children born to HIV positive mothers. A new output indicator was introduced on the proportion of pregnant women having their 4th antenatal care visit (ANC 4th) (Ministry of Health 2011).

Further adjustments were made in 2011 to the DLT by changing the weights of some of the indicators that constitute the composite index, and creating subgroups amongst the districts. As a reflection of the level of priority and desirability given to some of these services, the weight of the proportion of expecting women that deliver in public and PNFP health facilities and the proportion of children that have received the pentavalent vaccine by the first birthday were increased from 12.5 to 15. The pentavalent vaccine (against haemophilus influenza type B, whooping cough, tetanus, hepatitis B and diphtheria) replaced DPT3 for the immunisation of infants in the Ugandan schedule. On the other hand the weight factor for OPD attendance was decreased from 12.5 to 10. This was in view of concerns that the indicator on new OPD attendance puts too much emphasis on curative care, yet sector documents indicated preventive and promotive services as the more desirable (Komakech 2005a). The subgroups were created based on the criteria: hard to reach (remote districts that have challenges in attracting and retaining staff), newly designated districts; districts hosting national and regional referral hospitals; and districts with populations of less than 100,000.

Kampala City Council Authority, formerly Kampala district, has been recognised as markedly different from other districts and given special status in DLT analysis since 2011. The difference between Kampala City Council Authority and other districts include the urban environment and the presence of many health facilities, particularly those offering tertiary services (Ministry of Health 2011). Technical and financial support for these processes was provided by some of the partners, including WHO and the US Centre for Disease Control. The information management systems benefitted from upgrades.

"We adopted electronic web-based HMIS, which is an improvement. When a district enters its data it can see how it is performing along the year and indicators are computed automatically. Therefore, you see where you rank. It creates a lot of transparency because the data used is that entered by the districts. A form of ownership is obtained" (MoH 6)

"I will talk specifically about last year, because I was fully involved in the workshop to improve the DLT. We looked at the indicators to judge the appropriateness, sensitivity, and potential to inform performance monitoring, and how accurate the estimates were, revisited the weighting... Looking at different sources of data, international evidence, and estimates from surveys to come up with reasonable figures for baselines and targets. That improved the DLT in terms of more accurate data, more sensitive data, and more realistic ways of measurement" (IA 2)

DLT performance against objectives and current relevance

A number of objectives were indicated at the time of introducing the DLT in 2003. This subsection provides the findings of the study in terms of whether these objectives were achieved and whether the DLT is still deemed relevant in Uganda today.

Performance against DLT objectives

The documentary review and analysis of interviews provided a mixed picture of the performance of the DLT against the articulated

objectives. Overall, the DLT was acknowledged for its contribution to the Uganda health system. The DLT was recognised for facilitating the provision of data on a range of indicators for each district and making this an established process. The DLT contributed to the generation of system-wide discussions at the NHA, JRM and by researchers (Komakech 2005; Driwale 2005; Murindwa et al. 2006; Tashobya et al. 2015). The DLT was noted to have contributed to marked improvement in the management and use of routine data (HMIS) by all stakeholders, including local governments. We relate the findings according to each objective.

A number of the respondents expressed the opinion that the objective of *comparing performance thus determining good and poor performers* was achieved.

"Comparing performance, could reasonably tell good and poor performance. I can say that the objective was achieved to a good extent" (CS 2)

*"Comparing performance against districts has performed well" (*DTECH 1)

However, some noted that the DLT sought to compare entities that were not comparable (Komakech 2005a).

*"I think the comparison could have been refined over time through more robust stratification so that it resonates; for example, if I am in Moroto (*North East, remote, rural, post conflict) *and you compare me against Kampala* (central, highly urbanised) *I will disregard. The short coming then is we didn't have robust stratification criteria for some districts, and therefore it would not really make much sense"* (IA 2)

Most respondents were of the opinion that very little was done in terms of *providing information to facilitate analysis for factors behind observed performance* of the districts on the DLT. This was attributed to

the design of the DLT, specifically the indicators, and the capacity of the managers at the various levels to utilise the information.

"Relatively limited scope for the DLT to facilitate analysis because the few indicators were more signal indicators than indicators that look deeply into critical elements responsible for poor performance.... It did not provide enough in-depth information. This gave the MoH limited scope for corrective measures" (CS 2)

"As the DLT on its own is mostly based on statistical data focusing on coverage and outcome indicators...We found that information is not enough to facilitate detailed analysis" (MOH 4)

"I do not get the sense people get back and ask, 'Why was I in this position?' There are some districts which are on top but do not really work to be there" (DPOL 2)

Given the perceived failure to determine factors behind the observed performance, it is not surprising that respondents were of the opinion that there were limited instances when *corrective measures were applied*. In addition to the failure to determine factors underlying performance, the stagnant funding and limited flexibility of sector funding after the mid-2000s was noted to have played a role. However, some efforts were made. A case in point is that the MoH was able to identify hard-to-reach districts and put in place special measures for them, including special allowances for attracting and retaining staff (Ministry of Health 2008c). Similarly the challenges that districts in the conflict affected Northern Uganda were facing were recognised and subsequently special attention was given to them in sector documents and plans (Ministry of Health 2005b; Ministry of Health 2008c). During supervision by the area teams, performance on the DLT formed the basis of discussions with local governments, including organising special visits by members of the senior management of the MoH and joint pre-JRM visits by MoH and development partners to poorly performing districts (Ministry of Health 2008a).

"It (DLT) *has not done very well in focusing attention on poor performance. Providing additional resources – there is no basket of resources put aside to address this. Resource allocation is driven by a standard formula; beyond that formula it is not quite easy to play around. That is a challenge of course"* (*DTECH 4)*

"What did the DLT achieve –comparing performance across districts, identifying major factors behind good performance, improved reporting, improving the use and structure of data, encouraging good practices. It was an incentive –a 'stick and carrot' type of supervision. It influenced understanding and, indirectly, resource allocation. It created a sense of 'hard to reach, hard to stay' districts" (MoH 1)

Many of the respondents viewed the DLT as useful in *increasing local government ownership of achievements*, particularly through bringing the responsibilities regarding health service delivery to the attention of district managers (political, administrative and technical). Also, the DLT is said to have encouraged competition. However, a number of respondents made the point that the limited management capacity diminished the effect of this heightened local government ownership and that poor follow-up led to declining interest in the long-term.

When we started having the DLT at the national level, it was exciting to see what as an HSD manager one could do. The district made health a priority. [Financial] *requests were expedited i.e. for medicines, infrastructure, or human resources. Officials were coming from the national level to support us. It was very interesting. In the council, plaques* (given for good performance on the DLT) *were important. The DLT asked health workers to do more than they had been doing for their people. The* CAO (Chief Administrative Officer) *would task an MO (Medical Officer) who was not doing his work properly – as he was seen as dragging the district behind"* (DTECH 6).

"Increase LG (local government) *ownership – yes that one also worked quite well because ...the LGs are charged with providing services to their population,*

including health services. If it is good, well they celebrate and get more energized. If it is bad, they ask questions about what is wrong and find out whether the wrongs can be corrected through their own LG structure and, if not, take up action and find ways of addressing them through the MoH or other government offices" (DTECH 1)

"It was a good way of motivating people to provide service to the population" (DTECH 6).

"I think in the early years LGs picked interest in the findings of the LT, trying to see how their districts performed and asking the DHOs to explain why things were the way they were. Districts tried, even at the national level efforts were made with area teams trying to provide more support – although over the medium to long-term such waned – such focused efforts we see were not sustained" (IA 2)

Most of the respondents noted that the implementation of the DLT did not seem to e*ncourage the learning of good practices* from one district to another. This was said to be due to the limited analysis of the reasons why some districts performed better than others and the perception of many inherent differences between districts.

"Encourage good practices – in my view, it did not encourage good practice, and I think it came from comparing the incomparable. Because I heard comments like 'no wonder Mpigi is doing well, it has someone helping them, they have a lot of donor money'. Those were responses from District Health Officers" (IA 2).

Relevance of the DLT in Uganda today

All of the respondents indicated a current need for a tool to facilitate HSPA at the sub-national and particularly the district level in Uganda. A number of respondents felt that such a tool was more necessary today given the large number of districts and increased variation between them. However, the respondents indicated that a number of things need to change in regard to the DLT for it to fulfil the role, including the process of development and or adjustment and the design (content). In terms of the process of developing the tool, respondents recommended involving more stakeholders in the processes so they can contribute and understand what it is about. The proposals from respondents on the design of the DLT included the need to introduce more input and management indicators to support better understanding of the factors behind observed performance; and to create a subdivision of the districts into manageable groups of similar entities for the purpose of meaningful comparison. The respondents also urged the need to consider the changed environment, such as the presence of GHIs and the changed implementation of decentralisation. Some respondents pointed out that, for such a tool to influence decision-making, the findings needed to be linked to other structures supporting decentralised health service delivery, such as area teams and regional performance teams, and the dissemination of findings in an accessible manner.

"The DLT is now a long list because of the many districts existing today. We need to cluster the districts because of the number of districts" (DTECH 8)

"Might be important to change some of the indicators given the change in context of some of the diseases which we are tracking, like HIV/AIDS are funded largely by USAID" (CS 2)

"More analysis should be done for the local governments and put into a form like the popular version to make it better understood by the leaders" (DTECH 8)

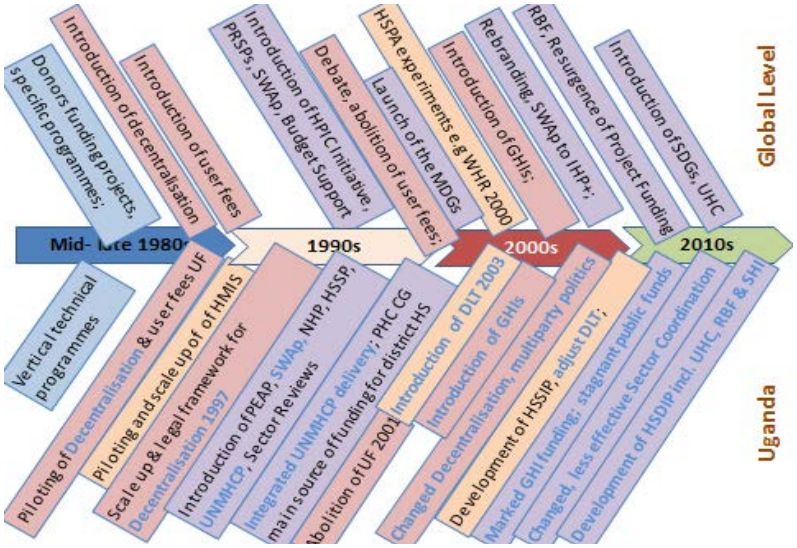
"Is the league table relevant and necessary today? I would say yes! However there is need to be careful for whom this information is useful, especially with the increasing number of districts. It has become more challenging when there are such high numbers. What we know and what we knew then has changed a lot…there is a need to be relevant and that should drive us towards a more explicit framework" (MoH 1)

"More indicators are required to measure management" (DTECH 5)

Ugandan health system experiences with relevance to the DLT

The three themes that emerged from the analysis relating to experiences in the Uganda health system considered relevant to the DLT are: SWAP, decentralisation and district health service delivery; global health initiatives and the Uganda health system; and other changes in the context with implications for HSPA and the DLT. The Uganda health system is heavily influenced by reforms and experiences at the global level. Figure 1 provides an illustration of key health sector reforms at global and Uganda health system levels. The relationship between the global and Ugandan health system reforms and between reforms at one level is colour coded and presented in chronological order. Each of the identified three major themes is elaborated here below.

Figure 1. Key reforms at the global and Uganda health system level 1980-2015



SWAp, decentralisation and district health services delivery

The major reforms identified in Uganda in the 80s and 90s with relevance to HSPA and the DLT are SWAp and decentralisation. In Uganda, decentralisation was one of the broad government reforms, with health sector specific adaptations. SWAp, on the other hand, was a health sector specific reform introduced in the late 90s in a number of LICs including Uganda (Jeppson 2002). This subsection provides highlights of the early implementation of decentralisation and SWAp and the implications for district health services delivery and the DLT. The aspects of the implementation of these reforms that emerged as particularly relevant to this study cover aspects of legal framework and policy formulation, provision of tools and structures, resourcing and monitoring.

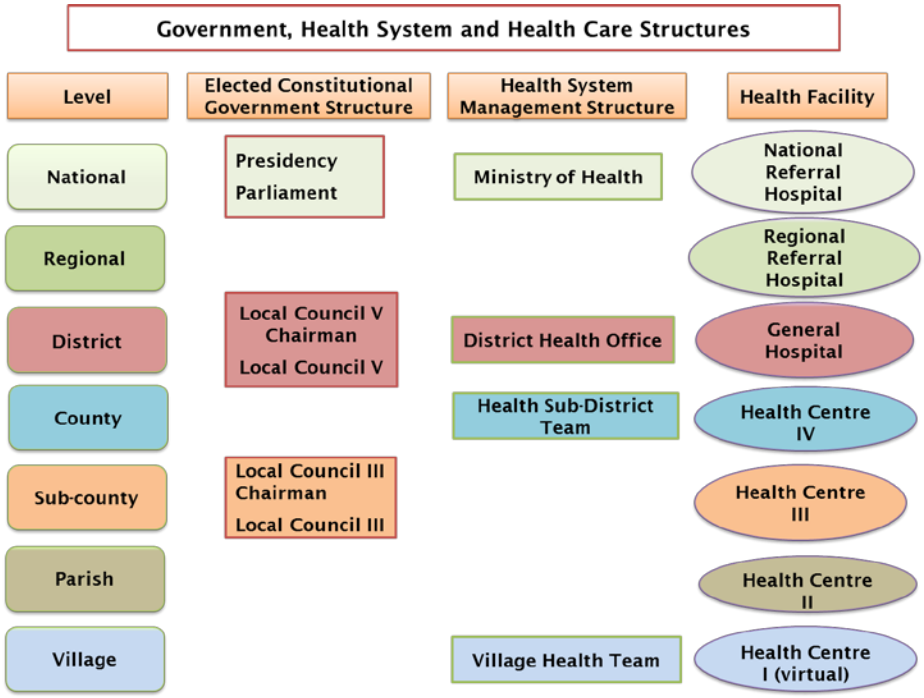
During the late 90s and early 2000s, several legal, policy and strategic documents, such as the Constitution, the Local Government Act, the National Health Policy (NHP), and the Health Sector Strategic Plan (HSSP), the health sub-district (HSD) concept paper

(which emphasised the how of decentralisation), as well as various other policy guidelines were developed to facilitate implementation of national and sectoral reforms (GoU 1995; GoU 1997; Ministry of Health 1999; Ministry of Health 2000). The model of decentralisation practiced in Uganda is *devolution*, with political and administrative authority at the national, district and sub-county levels (Rondinelli & Cheema 1983; GoU 1997; Jeppsson & Okuonzi 2000; Onyach-Olaa 2003). SWAp, by facilitating interactions amongst sector stakeholders including government (national and local government), development partners, civil society organisations and the private sector, supported coordination and participation of the different stakeholders in various health system activities. Our findings show that SWAp and decentralisation had major implications for responsibility for health sector actions. The central level of government was indicated as responsible for policy formulation, priority setting, resource mobilisation and allocation, setting standards, and sector monitoring. The local governments were indicated as responsible for the operational planning, management and delivery of services according to the national policy and the strategic framework. At the different levels government was expected to carry out its responsibilities in consultation and cooperation with other stakeholders.

The MoH together with health sector stakeholders developed guidelines, tools and structures to facilitate implementation of these reforms. The UNMHCP articulated a set of services to be provided in an integrated manner by level of health care. This was in marked contrast to the practice of the late 80s and early 90s, with marked verticalisation along technical programmes supported by different development partners and supported from the MoH, with minimal input by district management. The UNMHCP activity package by level of care by technical programme is shown in Annex 4 (Ministry of Health 2008d). The levels of service delivery are: national and regional referral hospitals (tertiary services), general hospitals (secondary services), and health centres (providing a range of tapered services from a combination of primary and secondary services at health centre level IV to only primary and preventive services at levels II and I). The

districts have responsibility up to the general hospital level (GoU 1995; GoU 1997; Ministry of Health 1999; Ministry of Health 2000). The relationship between the different levels of care, health system management and the government structures is shown in Figure 3. The national, district and sub-county levels require particular note here, as they have elected governments, and political and administrative authority. In contrast health system structures like regional referral hospitals and the health sub-district (HSD) do not coincide with any level of political or administrative authority. The DLT was developed as a tool to facilitate HSPA given the differing mandates of the national level (MoH) and the districts.

Figure 2. Uganda Government, Health System Management and Health Care Structures



Technical support was provided in the areas of strategic and operational planning, financial management and (technical) quality assurance. The support was initially provided as parallel functions but later amalgamated into area teams. Each team covered a designated part of the country and consisted of officials with the skills for technical backstopping given integrated delivery of the UNMHCP and SWAp. Short-term training was carried out by the MoH for district and HSD management teams in line with the responsibilities handled (Ministry of Health 2004; Murindwa et al. 2006; Quality Health International Consultants 2008). The AHSPR and DLT were some of the tools and sources of information used by the area teams and other supervisory teams for support supervision and mentoring of local governments. A number of development partners were involved in this process in a coordinated manner. Partners provided support to the MoH, including Danish International Agency for Development (DANIDA), Department for International Development (DfID) of the United Kingdom, Swedish International Development Cooperation Agency (SIDA), WHO and the World Bank; whereas a few provided direct support to the districts/regions like the European Union.

"We were part of the pioneers of the HSD (health sub-district). It was exciting to see how to improve. The EDF (European Development Fund Project) *facilitated us to meet frequently and share experiences"* (DTECH 6).

Efforts were made to provide resources to support the implementation of these reforms. The growth of the PAF and the PHC CG in late 90s and at the beginning of the 2000s provided the health sector with markedly increased resources to fund the priorities of the NHP, HSSP and UNMHCP. Funding to the district was prioritised by the sector and rose from 31% to 48% of the national health budget between 1998/99 and 2002/2003 (Ssengooba et al. 2006). The central level provided guidelines for grant management. Districts received various sector grants: wage, non-wage recurrent, development; specified for the public and PNFP sub-sectors; and hospitals and health centres. One of the DLT input indicators was the total public health funding to the

sector in each district. The districts had flexibility within but not across grants. The Ministry of Local Government spearheaded an intervention, the Fiscal Decentralisation Strategy (FDS), to negotiate for more flexibility for districts so as to be able to reallocate funds received from the national level across sectors and within sectors. This was considered necessary because local modalities for raising revenue were limited; poll tax and user fees in primary health and education facilities having been abolished. Yet district priorities often differed from those reflected in grant guidelines from the national level (Okuonzi & Birungi 2000; Kiwanuka 2013a; Tashobya et al. 2006). An indicator of the DLT introduced in 2005 was the proportion of conditional grants to other sectors that had been reallocated to health under the FDS.

The funds provided at the district level were used to provide much needed input to the delivery of the UNMHCP. For example the districts were able to recruit health workers, increasing the proportion of health workers to staff norms across the country from 33% to 54% between 1999 and 2003. The national level determined the wage budget for each district, whereas districts had the responsibility for recruitment and deployment of all government staff working in the health centres and general hospitals including determination of cadre mix and stations. Salaries of health workers were substantially increased – although from a very low baseline (Ssengooba et al. 2007; Murindwa et al. 2006; Ssengooba et al. 2006). The proportion of staff norms filled by each district was included as one of the DLT indicators to enable track changes in this area. The facility-based PNFP providers contribute an estimated 30% of the services as reported in the HMIS and included in the DLT. In line with the PPPH policy, from 1997 financial support was extended to the facility-based PNFP sub-sector. In 2003 for example,US$10 million estimated to be equivalent to 30% of the sub-sector requirements was disbursed to PNFP hospitals and health centres (Lochoro et al. 2006).

In the post-conflict situation of the 1980s and 1990s, the country relied on pre-packaged drug kits funded by the Danish Red Cross and distributed to the districts according to a nationally determined

formula – 'the push system'. In the early 2000s, a two-pronged system was introduced, the 'push-to-pull' reform, whereby districts could access medicines mainly from two channels. In one modality, districts could order against a centrally held credit line from the National Medical Stores (NMS) (public facilities) and Joint Medical Stores (JMS) (PNFP facilities), supported by the MoH and DANIDA. Under the second modality districts were expected to utilise 50% of the recurrent non-wage grant for the purchase of essential medicines and health supplies. Lists of essential medicines in line with the UNMHCP were provided, as well as training in rational medicine use and logistics management (Nazerali et al. 2006). Districts were expected to procure medicines using these funds, preferably from the NMS or JMS. This was intended to improve the availability of good quality essential medicines and health supplies at the district and health facility levels through increased funding and involvement of front line health workers and district managers in prioritisation, quantification and timely ordering. The related DLT indicator was the proportion of the indicative decentralised budget used by the district to purchase medicines at NMS and JMS, as a reflection of district prioritisation of a key input for health services delivery.

Key objectives of both SWAp and decentralisation were to improve sector functionality and performance and accountability to stakeholders. Performance assessment therefore was given significant emphasis in the implementation of these reforms. With SWAp, there was emphasis on common arrangements and a system-wide approach to perform assessment at the data collection, analysis, presentation and use of data for decision-making stages. Decentralisation necessitated the explicit consideration of the different levels of care in performance assessment. These requirements led to the production of the AHSPR including the DLT and the discussions of sector performance at the JRM/NHA (Ministry of Health 2003b; Ministry of Health 2006; Ministry of Health 2008c). Other innovations and interventions were carried out in this broad framework. In 2004 the MoH in collaboration with the WHO Uganda Country Office carried out a sub-national (district) health systems performance assessment,

using the approach documented in the WHR 2000 and related documents (Murray & Evans 2003; WHO 2000). Multiple sources of data were utilised and analysis relating district health system inputs, processes, outputs and outcomes was attempted (Ministry of Health & WHO Uganda Country Office 2004). This approach to district HSPA was done only this one time and has not been repeated since.

Another performance assessment innovation was initiated by the Uganda Catholic Medical Bureau (UCMB) which compared performance amongst the affiliated health facilities using the approach of a standard unit of output (SUO). A SUO was computed by weighting various outputs of a health facility to come up with a single variable per health facility. The health facilities were then compared using the SUOs (Mandelli & Giusti 2005). The MoH subsequently used this approach to compare the performance of different levels of health facilities – regional referral hospitals, general hospitals and health centres level IV (HC IV) across the country (Ministry of Health 2006). Data on specific technical programmes was collected in the HMIS and available at the Resource Centre and for programmatic analysis and decision-making.

Thus the districts were facilitated for the delivery of health services in an integrated manner through provision of the legal and policy framework; tools and structures; resources; and performance assessment frameworks. The district health system managers had some room to make decisions, and some were noted to carry out innovations, working within the given framework. Districts could affect their performance, and its measurement by the DLT. The decision-making space for district managers in this era though was considered to be limited by some, given the mode of decentralisation – devolution – that was supposed to be in operation (Bossert & Beauvais 2002; Jeppson 2002).

Global health initiatives and the Uganda health system

Global Health Initiatives (GHIs) as a major source of funding for health systems is one of the more recent major reforms in many LICs,

including Uganda. This section provides highlights of the interaction between GHIs and the Uganda health system with a focus on the aspects with implications for HSPA and the DLT. The areas of interest include: district health systems funding levels and modalities; focus on programme outputs; emphasis on vertical reporting; and the effects on governance and human resources for health management.

The GHIs including the Global Fund to fight AIDS, tuberculosis, and Malaria (GFATM), Global Alliance for Vaccines and Immunisation (GAVI), Multi-country AIDS Programme (MAP) by the World Bank, and the President's (US) Emergency Programme for AIDS Relief (PEPfAR), were developed at the international level in the early-mid 2000s to facilitate attainment of the Millennium Development Goals (MDGs). Uganda has been a beneficiary of GHIs since their inception. The effects of GHIs on health systems at the global level, and to a lesser extent on Uganda, have been described (Biesma et al. 2009; Samb et al. 2009; Tangcharoensathien & Patcharanarumol 2010; Stierman et al. 2013). The GHIs were treated similarly in this study, though we acknowledge that they do have differences.

The GHIs markedly increased health sector funding in Uganda. Half of the estimated US$600 million funding of the sector in 2009 was from GHIs (Stierman et al. 2013). The GHIs do not use the national budget as the channel for disbursement; the funds are managed by the institutions of their choice, among which the MoH may play a key role. However, accessing information about the amount of financial resources used for and within individual districts by the GHIs and their implementing partners is difficult. The funds are targeted to specific disease control programmes, especially HIV/AIDS, tuberculosis, malaria and vaccine-preventable diseases, and used to procure programme inputs (antiretrovirals, antimalarials, vaccines, bed nets, etc.) and support management of the programmes (Marchal et al. 2009; Uganda AIDs Commission 2012). A marked increase in service delivery has been noted in the GHI-related programmes since mid-2000s (Ministry of Health 2006; Ministry of Health 2008c; Ministry of Health 2011). The HIV service utilisation indicator was introduced on

the DLT in 2005 in light of the introduction and scale-up of a number of HIV/AIDS control activities with GHI support.

The GHIs focus on specific programme outputs and results-based funding (RBF) are at odds with the system-wide approach of SWAp and the DLT, in which a wide range of inputs is expected to produce a wide range of outputs. A related emphasis of the GHIs is on reporting and information systems, highlighting the quality of data and timeliness of reporting. This was noted to be good for HSPA and the DLT as it facilitated improvements in information management systems and the production of better quality data. On the other hand, this emphasis led to the development of parallel systems that require the health workers delivering these services to make multiple entries and/or report to different entities. A case in point, PEPfAR set up a specific institution the Monitoring and Evaluation of the Emergency Plan Progress (MEEPP), to collect and analyse data on the interventions it supports (Kalibala 2010). The other GHIs set up monitoring structures of varying complexity and degrees of separation from routine and system-wide sector monitoring (Boerma & Gore 2010).

The GHIs have also had implications for the Uganda health system in regard to governance and human resources for health management. At the implementation level, GHIs work mostly through non-governmental organisations (NGOs) and community-based organisations (CBOs), although most of the health facilities at which the services are actually provided are public. GHIs or their implementing partners choose districts and health facilities in which to operate. This sometimes leads to inequitable coverage and the blurring of lines of accountability and reporting at the national and local government levels and in between. Some of the questions this raises in respect to HSPA and the DLT are: who is accountable for delivery of the GHI-funded services within a district? What responsibility do the district public managers have in regard to GHI-supported services and what does it mean when one district does well with these services compared to another?

"With the Global Health Initiatives it becomes rather complicated. HIV/AIDS service delivery, for example, may not be a district thing – a high proportion of HIV/AIDS funding comes from donors. And there are some variations; for example, there was thinking that West Nile (region) *had low levels of HIV and did not require support"* (DTECH 2).

The GHIs have led to the creation of many new organisations and high attrition of health workers from the public sector to GHI-supported entities. These health workers are still active in the Ugandan health system and serve Ugandans, but they are usually the more experienced managers and clinicians and have left a gap in the public health system. Fifteen (>10%) District Health Officers (DHOs) left public service in 2012 alone, most of them for GHIs funded entities (Nassanga et al. 2012).

Other changes in context with implications for HSPA and the DLT

Since the mid-2000s, in addition to the introduction of GHIs, a number of other aspects of the Ugandan health system have changed. Some of the changes in the Uganda health system with particular relevance to HSPA and the DLT are reported on here. These changes relate to: overall health sector funding levels and modalities; changed implementation of sector coordination and decentralisation; re-introduction of multiparty politics; the increased role of the private sector including PNFP, Civil Society Organisations (CSOs) and other private health providers in health service funding and provision. In addition changes in sector goals and strategies have been noted in the Uganda health sector with the recent publication of the Health Sector Development Plan (HSDP) 2015/16 to 2019/20 (Ministry of Health 2015b). Some highlights of these reforms (or changed implementation of on-going reforms) and how they may have affected implementation of HSPA and specifically the DLT are noted in this subsection.

The National Development Plan (NDP) includes the health sector among its priorities (Government of Uganda 2010). However, core national priorities as shown by recent public funding trends are

infrastructure development, namely roads and energy. The public health budget has stagnated in absolute terms and declined as a proportion of the government budget and total sector resources since the mid-2000s. For example, of the funding to the health sector in 2009, only about US$100 million (17%) was from the Ugandan government and US$300 million (50%) from all on-budget sources (Stierman et al. 2013; Ministry of Health 2011). The PHC CG has stagnated in nominal terms and declined in real terms since the mid-2000s. The non-wage recurrent component of the PHC CG which funds operational activities within the district health system actually declined over the period 2010 to 2015 (MoFPED 2014; Ministry of Health 2015a). This stagnation has limited the ability and flexibility of district-integrated service delivery. For example, recruitment of health workers and pay reform are now sporadic and ad-hoc depending on obtaining a particular allocation from the Ministry of Finance Planning and Economic Development (MoFPED) (MoFPED 2014). There are minimal resources for routine activities, such as supervision and integrated support of local governments by the national level (MoH) has declined (Stierman et al. 2013).

"Health issues have become political; the biggest problem is that the allocation (government budget*) to health and education is not enough"* (District Political Manager [DPOL] 1)

Although no major adjustments have been made to the legal framework, the way decentralisation is implemented has changed over the last decade. The number of districts doubled in less than ten years, rising from 56 at the inception of the DLT in 2003 to 69 in 2006, 80 in 2009, and 112 in 2010. Recently an additional 23 districts were approved by parliament to be operationalized over 5 years (Ministry of Health 2015b). The proliferation of districts was due to demand from the population for new districts along minority groups, including ethnic lines, and the perceived opportunity for increased access to national resources and employment opportunities. The area and population covered by each district has decreased from an average of 4

HSDs per district to an average of 2, with a number of districts being one-HSD districts and 12 districts (more than 10%) having a population of less than 100,000 (Kiwanuka 2012; Ministry of Health 2011). The increase in administrative structures has led to an increase in running costs in an environment of declining public health sector budget – at both the national and district levels. There has been high turnover among district managers; many experienced managers have retired and others have moved on to other jobs including in the GHI sub-sector as noted above. The majority of new districts have only been able to recruit as managers individuals who have just completed their MPHs, with limited experience in health systems management.

"There have been many changes in the context: there are many new districts, the capacity of district managers is questionable, and resources are spread too thin" (IA 3).

"The area and population of the district is very small. There is fragmented funding for the district, with minimal public funding and mainly partners who fund districts directly. It is very difficult to get information about this funding" (MoH 2).

In 2009, a decision was made by the MoH and MoFPED to recentralise the procurement of medicines and health supplies in response to the less than expected availability of these commodities at health facilities, perception of poor prioritisation of their procurement by the districts and allegations of leakages (Ministry of Health 2008a; Ministry of Health 2010). The essential medicines and supplies credit lines were abolished, as was the disbursement of funds to districts for the procurement of medicines and supplies. All government funds for the purchase of essential medicines and supplies are now managed by the NMS. The districts' role is limited to making orders against a nationally held budget. FDS was suspended, as sectors kept arguing for ring-fencing of their grants. The decision-making space of the district which was deemed limited in the past given the mode of decentralisation, has further decreased (Kiwanuka 2013a).

Overall, the system-wide appreciation of the sector as espoused by SWAp seems to have declined. This has been attributed to: the huge influence of GHIs, high turnover among policy makers, and dissatisfaction among some of the donors that used to provide budget support. The last decade, has witnessed the departure from the sector, decreased visibility or policy shift, of the donors that championed SWAp and budget support including DANIDA, DFID and SIDA. There has been high staff turnover/attrition from the MoH especially at the higher levels of management and in the HPD (Örtendahl 2007; Ministry of Health 2008b; Stierman et al. 2013). More recent nomenclature for sector coordination has replaced the term SWAP with international health partnerships and related initiatives (IHP+). Although most of the tools and structures for sector coordination used under SWAp, such as the MoU (now referred to as the country compact) and JRMs have been maintained, their functionality is rather limited (Boerma & Gore 2010). Most GHIs currently include health systems strengthening (HSS) in their programme documents. However, understanding of HSS varies globally and within Uganda, and many of the HSS interventions refer to specific activities supporting one of the health system blocks, rather than efforts to support the Ugandan health system to function more effectively as a whole (Sundewall et al. 2011; Willis et al. 2012; Marchal et al. 2009; Stierman et al. 2013). Support provided by the MoH to districts in terms of visits, performance reviews, and planning and performance assessment meetings has decreased which has been attributed to limited staff and funding for such activities. These changes in the Ugandan health system over the last 10 years have had marked implications for integrated decentralised health service delivery, HSPA and the DLT.

"The people and institutions have changed over time or changed offices. I think a big part of the dream is lost. I could see how I fit into the bigger picture…Who is in charge of the dream? For the last three years we have been going to districts; they have the challenges, but they are also very interested; they need encouragement" (DTECH 6)

Uganda emerged from wide-spread conflict in the mid-1980s, but has only been free from localised conflict over the last decade. Efforts have been made over the last 30 years to build the legal, policy and institutional framework for governance. A key reform that has been enacted in this regard in the recent past is the reintroduction of multiparty democracy. Multiparty democracy was practiced in Uganda for brief periods in the past, the post-independence period of 1962-1971, and in the early 80s, 1981-1985. Both times the practice was disrupted by military take-overs. In 2006, following a national referendum, multiparty politics was reintroduced in Uganda. Leaders are voted by adult suffrage every 5 years at the presidential, parliamentary, district, sub-county and village levels (Mushemeza 2007; Kiwanuka 2013b). The rationale of multiparty democracy is to give people the freedom to choose their leaders and through this process the power to demand accountability and push for improvements in service delivery. Decentralisation and multiparty democracy are expected to work synergistically to stimulate the demand for accountability by the population and thus lead to substantial improvements in public service delivery, including health. To-date though it has been noted that this potential is yet to be extensively exploited. For example in the health sector the few observed instances of communities demanding for accountability are often limited to complaints about medicines availability and requests for more health infrastructure (Kiyaga-Nsubuga 2009; Tumushabe et al. 2010).

The Uganda health system has become more heterogeneous, over the last two decades, with an increase in the proportion of health services provided by the private sector including PNFPs, CSOs and other private health providers. In addition there is increased spending on health from the households, the bulk of which is out of pocket, spent in public, private and PNFP health facilities (National Health Accounts 2014). The private sector therefore is a key player in the district health system. The current mechanisms and tools for routine gathering and presentation of health system information focus on the public and PNFP subsectors only. For example only public and facility-based PNFP data is included regularly and comprehensively in the

HMIS and therefore in the DLT and other forms of regular and frequent HSPA. Similarly data on interventions at the community level, e.g. distribution of insecticide treated nets and contraceptives, is often not readily available to district health system managers until surveys are undertaken. This information therefore is usually unavailable in real time to feed into district health system decision making.

The recently published HSDP for the period 2015/16 to 2019/20 includes new sector goals and strategies, relating to reforms and new ways of doing things at the global level. Key reforms include the shift from MDGs to Sustainable Development Goals as the base development framework; the introduction of Universal Health Coverage as the sector goal; and inclusion of social health insurance and results based financing as major strategies for raising and managing health system resources (Ministry of Health 2015b). The HSDP strategies are yet to be implemented; however it is envisaged that individually and in combination they will have significant impact on the Uganda health system including the way HSPA is carried.

Discussion

This study has used a historical approach to tell the story of the implementation of the Uganda DLT over the last 12 years. A number of achievements of the DLT as Uganda's district HSPA framework have been noted. The DLT facilitated the availability of district data on several indicators in one database and encouraged system-wide discussions. In addition, the DLT increased the visibility of the HMIS and stimulated investment and improvements in data management. The objectives of comparing districts, determining good and poor performance, and encouraging local government ownership for health service delivery were achieved to some extent. On the other hand, the DLT is noted to have performed poorly in regard to the objectives of determining factors behind observed performance, instituting corrective measures, and enabling local governments to learn from good practices. Chronologically, the DLT was more likely to be perceived as useful and having achieved its objectives in the early days of implementation compared to the more recent past. The policy analysis triangle has been used to support the systematic consideration of various factors that have been noted to influence policy development and implementation in health systems (Walt & Gilson 1994). In this section the policy analysis triangle is used to analyse in further detail how the DLT processes, content/design, and their interaction with the Uganda health system context and actors led to the observed achievements.

The *process* of the DLT in this analysis includes its formulation/development, its introduction into sector structures, the collation of data, dissemination of results, feedback, and adjustments made since its initial development. The process of development (and adjustment) was largely approached as a technical matter, and handled by officials at the MoH, especially the HPD, representatives of international agencies and a few district technical managers. This is likely to have contributed to the limited ownership of the DLT among Uganda health system stakeholders. A participatory process for the

development of frameworks/tools has been indicated as vital for successful HSPA by a number of researchers (Smith, Mossialos, Papanicolas, et al. 2009; Tashobya et al. 2014). A number of challenges were also noted in the collation, dissemination, and provision of feedback to the district managers regarding DLT findings. Discussions in the crowded 1-2 day national level meetings (JRM, NHA) are not adequate for internalising the contents and implications of the DLT. The dissemination does not adequately take into consideration the interests and capacity of local government managers, which has implications for the use of findings in decision-making at the district and lower levels.

The *content* of the DLT refers to the indicators and the analysis, including the computation of a composite index used to rank the districts. The DLT is commended for having a range of indicators, including input, process and output indicators, both system-wide and for specific programmes that provided a framework for the collation of a range of district information in one database. The DLT provides managers and policy makers with a starting point for a comprehensive review of national and individual district performance. The performance of a district can be compared with all the others in a particular year and the trend of performance over years studied. A number of challenges though have been noted in regard to the content/design on the DLT and are briefly discussed here. A detailed analysis of the appropriateness of the content/design of the DLT from a quantitative perspective has been carried out as part of the broader research programme and reported on elsewhere (Tashobya et al. 2015). The DLT has been noted to include inadequate explanatory variables and to employ limited analysis to determine factors behind observed performance. For some of the indicators included in the DLT, information on district characteristics is not regularly and comprehensively collected. An example of this phenomenon is the gaps in health financing data, whereby information on the contribution by development partners including GHIs that is provided directly to districts and implementers within districts is largely unavailable. The lack of information on services provided by the

private health sector is another major challenge. This makes it difficult to undertake meaningful analysis relating observed performance and available resources.

Another major challenge is that all districts were initially treated as similar and were compared across the board, ranked from the 'best' to the 'worst' performer using the composite index. In reality districts are dissimilar, operating in different socio-economic, geographic, demographic, and health resource contexts. As a result, many district managers and stakeholders questioned the appropriateness of the DLT. The introduction of sub-groups for analysis and the recognition of Kampala City Council Authority as a peculiar local government are seen as an inadequate response. Similar concerns have been raised elsewhere about league tables and use of indicators in performance assessment. Some of the concerns raised by other researchers include the desirability to only use league tables to compare entities that are actually similar, and requirement for good quality data on the characteristics of entities to be compared (Freeman 2002; Leggat et al. 1998). These requirements as was previously noted have not been met in the implementation of the DLT. The objective of enabling districts to learn from each other's good practices was poorly achieved, largely because of the fore-mentioned.

The *context* of DLT development and implementation in Uganda is of a LIC with high burden of disease, which only emerged from extensive conflict thirty years ago. The country is in the early stages of democratic transition, with related challenges in governance, institutional development and the community's ability to demand accountability. There is high dependence on international agencies and external governments for financial and technical support. The study's broad perspective of the Ugandan health system over three decades revealed a frequent succession of reforms since the mid-1980s that tended to reflect global trends rather than local needs. This makes systematic national development and implementation of policies challenging, as a reform is often discarded and another put in its place before significant lessons have been learnt (Okuonzi & Macrae 1995; Yates et al. 2006).

International and national level reforms (decentralisation, PRSPs, PAF) and sectoral reforms (SWAp, NHP and HSSP) of the late 90s and early 2000s facilitated a coherent sector at the national level which supported an integrated approach to district health services management. This approach provided a conducive environment for district health system managers to implement and innovate; and facilitated a systems approach to performance assessment. The period of implementation of these reforms coincides with the early days of DLT implementation. However, a number of changes in context subsequently reversed many of these facilitating factors for HSPA and the DLT. These include the rise to prominence of the GHIs with programmatic focus and limited role in decision-making for public managers (central and district); the stagnation of the national budget for health; the proliferation of districts with the related increase of new and in-experienced managers; and decline in MoH generic technical and management support to the districts. These factors have had implications on both the performance of the system and the level of accountability that can be expected of the district health system managers. The shrunken decision-making space at the district is frustrating and de-motivating for the managers. The visibility and perceived importance of sector HSPA arrangements (JRM, NHA, AHSPR, and DLT) declined with time and became more of rituals than tools and structures to support decision-making.

The *major actors* in the development and implementation of the DLT included public and non-public actors. The different actors in the Ugandan health system have affected the development and implementation of the DLT in different ways. Here we analyse the power wielded by the different groups of actors over the last 3 decades, and note that there have been marked shifts in power among Ugandan health system stakeholders over this period.

The public actors include the Presidency, Parliament, MoFPED, MoH, and local governments, including political, administrative and technical managers. The Presidency and Parliament are major public power centres, playing key roles in defining national funding priorities, and implicitly and explicitly, determining how reforms like

decentralisation are implemented in the country. MoFPED manages the national budget and in consideration of funding from the GHIs, has given low prioritisation to the health sector while apportioning the national budget over the last decade.

The MoH the sector steward is limited by the minimal power to plan for and allocate sector resources, especially in the era of GHIs. Despite several attempts by the MoH to negotiate with the Presidency, Parliament and MoFPED, the district health sector budget has not grown in recent years and historical budgeting has been maintained. Thus, corrective measures with resource implications, as per the findings of the DLT, cannot be implemented. Given decentralisation, the MoH supervises districts and, in the case of inappropriate behaviour, is expected to implement sanctions. However, the range of sanctions is limited, especially those that do not harm the population (Kiyaga-Nsubuga 2009). Quite often nothing is done, or the decision that is made is drastic. A case in point is when some of the districts were noted to spend less than expected on essential medicines in the mid-2000s. For about 5 years nothing was done, and then the decision was made to recentralise the medicines budget, ignoring a number of achievements that had been noted with the reform and further decreasing district decision-making space (Ministry of Health 2010b; Ministry of Health 2008c). On the other hand, local governments feel very constrained and have limited flexibility, leading in many cases to a laissez-faire or defensive attitude towards efforts of sub-national HSPA, such as the DLT (Kiyaga-Nsubuga 2009; Kiwanuka 2013a). The political, administrative and technical managers at the district tend to view the DLT information differently, with political and administrative leaders blaming technical managers when the district health system is noted to be performing poorly. There are major gaps in capacity for HSPA among these managers, which are further exacerbated by the high turnover between districts and subsectors.

The non-public actors include international actors, communities and their advocates, and private health services providers. International agencies wield power through the resources they provide to the Ugandan health system and through the technical support that

is the mandate of some of them (Shiffman 2014). During the pre-SWAp era, the international agencies wielded a lot of power as they directly managed and controlled the financing of a number of technical programmes. In the era of SWAp, the power of the international agencies declined given the emphasis on country led policy formulation and strategic plan development and aligning resources to country systems. However, the more recent ascendancy of GHIs has reversed this scenario (Stierman et al. 2013). Private health providers play a major role in the Uganda health system by virtue of the magnitude of services they provide to the community. However they are not united and so do not actively wield a lot of power. Despite the inclusion of data from PNFPs in the HMIS and thus the DLT, this sub sector has not been proactive in regard to the DLT. Communities and civil society activists are expected to demand accountability in regard to health services from government and other stakeholders. In the last decade, a fairly active health consumers lobby has developed in Uganda. However communities and civil society activists have not been very active in performance assessment. This is not just a health issue, but has been noted across various sectors at the local government level, despite the legal and institutional provisions in place for decentralisation and multiparty democracy. This has been said to be due to the limited capacity amongst these stakeholders, but also a hang-over from the periods of political and armed conflict (Kiyaga-Nsubuga 2009; Mushemeza 2007).

In the recent past though, especially the last 5 years, a few performance assessment related innovations at the community level have been noted. Civil society organisations have provided capacity building for local government to carry out performance assessment, and communities to demand for accountability. Of particular interest is the work of Ugandan NGO Advocates Coalition for Development and Environment (ACODE), who in collaboration with Ministry of Local Government and Ugandan Local Government Association have developed a local government score card and implemented it in a number of districts (Tumushabe et al. 2010; Muyomba-Tamale et al. 2011; Muyomba-Tamale & Jones 2011). Ugandan NGOs

Development Network of Indigenous Voluntary Associations (DENIVA), Uganda National AIDS Support Organisation (UNASO) and Uganda National Health Consumers Organisation (UNHCO) have been involved in capacity building of communities to demand accountability in the health and HIV sectors. An example of the intervention supported by DENIVA in the area of performance assessment is shown in Annex 5 (New Vision 2012). The Office of the Prime Minister (OPM), which has the mandate to monitor and coordinate monitoring of all government programmes, has facilitated community meetings ('baraazas') to receive community views on public services delivery including health (OPM 2014).

Can the DLT be made more useful and relevant in Uganda today and in the future? The respondents in this study appreciated the need for a tool for district HSPA in Uganda and indicated that, given the marked increase in the number of districts and their diversity, such a tool is needed even more than before. Most HSPA frameworks that have survived over time have adapted to the prevailing circumstances with regular reviews and adjustments, as seen in Australia, Canada, the Netherlands, South Africa, and the WHO HSPA framework (Tashobya et al. 2014).What would be the best approach to sub-national HSPA in Uganda today and in the future? Historical analysis was used to tell the story of the development and implementation of the DLT and related experiences in the Ugandan health system; and the policy analysis triangle to identify the challenges to functionality of the DLT under the categories process, content, context and actors. In line with the identified challenges, we recommend adjustments relating to the process, content/design, context and actors of Uganda's district HSPA framework here below.

The *process* of adjustment of Uganda's district HSPA should involve broader stakeholder consultation, with an emphasis on local government managers so that they feed into the objectives and design of the tool for better understanding and ownership. At the national level, we recommend that the MoH needs to revive interest and broaden the network for district HSPA by involving UBOS, MoFPED, academia, and donors with particular emphasis on GHIs, private

health services providers including PNFPs, CSOs and others. Data should be used in the process of adjustment to justify the use of specific indicators and analytical approaches. Processes for dissemination of findings and follow up should be designed bearing in mind the capacities and interests of the various stakeholders. The *content/design* of the tool should be such that more input and process variables are included, to provide information on district characteristics, including socioeconomic, demographic, and health resources. Particular efforts should be made to get comprehensive information on district health system resourcing. In addition to the quantitative information, qualitative information on district management processes should be sought. The frequency of variable collection may vary – quarterly, annually, once in 3 or 5 years, depending on the purpose of the data and logistical capacity. The process of developing such indicators and identifying required pieces of data is likely to be challenging and will require a period of learning of what works and what does not work in close consultation with stakeholders. This process can benefit from examples of analytical work done at the national, regional and international levels (Massyn et al. 2014; Murray & Evans 2003; Tashobya et al. 2015). The South African District Health Barometer for example, was first developed in 2005, and since then has included more indicators and more sophisticated analysis as better quality data became available (Massyn et al. 2014).

Better availability of information on district characteristics should support improved analysis and facilitate understanding of the factors behind observed performance so that performance measurement can influence decision-making for better system outcomes. Furthermore, the tool should provide for comparisons between similar entities, utilising some form of clustering or stratification, as this is likely to be regarded as fair by district health systems managers and outputs of such analysis more acceptable for decision making. The clusters may be determined around socioeconomic, geographic, and/or health resource or performance characteristics. This process can build on the experience of clustering/stratification currently practiced within the

DLT. Analytical approaches, such as hierarchical cluster analysis (HCA) could be utilised in this process (Romesburg 2004; Day et al. 2008; Tashobya et al. 2015). The tools and processes of data management should be technically sound, but the outputs should be presented in such a way that they can be readily appreciated by policy-makers and managers at all levels including local government, and other stakeholders.

We noted that the health system context and *actors* have a lot of influence on the functionality of HSPA tools such as the DLT. Drawing a line between the different factors in the policy analysis triangle can be difficult, and in this case the response to both context and actors has been combined. The findings of this study of the Uganda health system support the argument that health systems are Complex Adaptive Systems (CASs) with multiple stakeholders with varying goals, lacking a single point of control, and that the system or aspects of the system adapt to prevailing circumstances (Rouse 2008). Uganda is a LIC, heavily dependent on international agencies for technical and financial support. Currently international agencies' power is higher than that of national public health system stakeholders. Many of the decisions that affect the health system, including individual district performance, are made beyond the districts, even beyond the MoH and often beyond the country. Even amongst the public stakeholders, the sector steward the MoH, has limited power and control. The situation though is not static as has been shown by the changes that have taken place over the last 30 years. The responses of the various stakeholders to reforms and interventions are closely interrelated and can be unpredictable. These characteristics of the Uganda health system further resonate with CASs properties of dynamism, stakeholders being massively entangled, and their interaction creating new ways of doing things (emergent) (Begun et al. 2003; Rouse 2008). In the short, medium and even long term, various reforms and interventions are likely to be introduced to the Uganda health system. A number of reforms have already been indicated in the new sector strategy document the HSDP. Another relevant finding is the fact that routinely available data on district

health systems only covers public and facility based PNFP in a context of marked involvement including funding from international agencies and the Ugandan private sector.

HSPA is important because of the need for accountability and to support decision making. These are related but different objectives of HSPA (Freeman 2002; Smith, Mossialos & Papanicolas 2009). Various experiences and research have shown that it is challenging to put equal emphasis on accountability to higher levels (upward accountability) and support for decision-making (with emphasis at the local level) in one tool or one approach. A tool focusing on upward accountability and emphasising 'command and control' may have been relevant/appropriate in Uganda 10 years ago. The country had just emerged from extensive political and armed conflict, and in the early stages of implementing decentralisation. There was a perceived need for establishing a significant level of national control. However the context has since changed. Accountability, which places trust in the system/tool rather than the managers, is rather difficult to achieve and sustain. The league table approach to district HSPA does not resonate with the Uganda health system today. The challenges noted here have been noted elsewhere with the use of league tables and other HSPA approaches that utilise performance indicators (Freeman 2002).

We recommend that the adjusted district HSPA tool should be designed in such a way as to be responsive in this complex and dynamic context. We argue that in the Uganda health system context the emphasis of a district HSPA tool should be to support decision-making and facilitate 'learning and adapting' (Freeman 2002). The tool should be intended for building the local government's capacity to withstand external shocks to health systems management which can come with the introduction of reforms including new policies and changes in resourcing arrangements. The tool should be focused on enabling learning at the local government level, with accountability to the national level as a secondary and lesser objective. The national level would use findings of district benchmarking for the purpose of learning more about what influences performance at this level and to

determine districts that require particular support. More emphasis would be on the use of findings for peer learning, self-assessment and assessment of entities below the district – the HSDs and sub-counties. We propose that efforts should be made to explore how HSPA can be used for downward accountability. This we argue is particularly desirable given the objectives of decentralisation and multiparty democracy, and the existing legal and institutional framework for communities to play a key role in demanding for better service delivery. Explicit care should be taken to learn from the various performance assessment experiences in the country including local government score cards, and technical programme and health facility performance assessments. The experiences of civil society organisations in local government performance assessment and capacity building of communities to demand downward accountability should provide lessons and inspiration.

We argue that the approach just highlighted is more likely to make the tool useful for district health systems decision-making in the short, medium and even long-term. Such a tool would require the MoH to lead (influence) rather than attempt to manage the districts, and to encourage innovation and agility among district managers. Such approaches have been indicated as more appropriate in the stewardship of CASs (Rouse 2008). We argue that such an approach is more likely to get buy in of stakeholders and sustain the interest of political, administrative and technical managers at the local government level. It would be essential to build the capacity of managers at the MoH and districts', including supporting their appreciation of what the tool is meant to achieve. Support from the MoH to the districts would be key for the success of such a tool and would be in the form of analytical work to underpin the chosen approaches, encouraging innovation, and providing feedback. The interaction between the MoH and the districts should emphasize support and influence rather than a contractual relationship highlighting control. Given the number of districts in the country, sub-national mechanisms would be required for some of these tasks to ensure a close and supportive relationship between the centre and the

district. We recommend that the MoH should build on the experiences of teams that have been put in place to support a number of districts like the area teams and the regional performance monitoring teams. This approach would simultaneously require substantial investments in the health information system to provide the necessary pieces of data as previously highlighted.

The study has noted the high power and influence of international agencies and the effect this has had on the Uganda health system including HSPA and the DLT. In a CAS, even well intentioned reforms and interventions can lead to undesirable and unexpected consequences. It is our recommendation that national governments and international agencies should endeavour to comprehensively map the possible effects of any planned reforms, beyond the main intended ones, before introduction of new reforms or changed implementation of reforms. Sterman asserts that '"side effects" are not a feature of reality, but a sign that the boundaries of our mental models are too narrow, our time horizons to short' (Sterman 2006). The implementation of decentralisation in Uganda illustrates this. The legal and policy framework and the institutions for the implementation of decentralisation have been put in place at great cost to Ugandan tax payers. However the legal provisions and the institutions are not enabled to function due to a number of factors some of which have been discussed in this paper and elsewhere (Kiyaga-Nsubuga 2009; Kiwanuka 2012; Kiwanuka 2013a). The diminished decision space and the related lack of discretionary funds are of particular concern. These have contributed significantly to the failure to realise objectives of the reform in a generic and health system perspective (Kiwanuka 2013a; Kiwanuka 2013b). In addition extensive reviews of the achievements and short comings of existing reforms should be carried out before new ones are introduced. This recommendation applies to reforms and interventions like social health insurance and results based financing intended for implementation in Uganda and elsewhere.

Limitations of the study

The first author and researcher on this study was involved in the development and implementation of the DLT. Efforts have been made to minimise any bias this may have introduced into the study through a team approach at the various stages of the study including conceptualisation, development of tools, data analysis and report writing. The long time period over which respondents were expected to remember, 10 years and beyond, may have introduced bias. Triangulation of data, using a combination of oral and written sources including published and grey literature, was used to minimise recall bias.

Conclusion

The 12 years of experience with structured district HSPA in Uganda in the form of the DLT provides a great opportunity for review and learning lessons on sub-national HSPA for Uganda and the global community. We have used historical analysis to tell this story which has facilitated awareness of the complexity of the situation and enhanced a critical view of events. Policy analysis has enabled better understanding of this complex picture, particularly highlighting the interaction between the DLT and the Uganda health system.

The story that emerges is that the DLT was perceived as useful in its earlier days, particularly in regard to comparing districts and eliciting local government ownership. However, it did not do well in terms of determining factors behind observed performance, instituting corrective measures and encouraging good practices. In time, the perception of the usefulness of the DLT declined, and in the more recent past has been viewed by many as a ritual. The achievement of DLT objectives was heavily influenced by the interaction of the tool's content (design) and processes with Uganda health system context and actors. Particular note was made of frequent changes in the implementation of reforms which are mostly initiated by international agencies. The reforms of late 1990s and early 2000, including SWAp and budget support, were supportive of the implementation of the DLT given their health system focus. However, later reforms, including the programme focus of the GHIs, stagnant public sector funding and changed implementation of decentralisation, combined to create a less than conducive environment. The power of international agencies relative to national public actors like the MoH is higher in the era of the GHIs compared to when the Uganda health SWAp was functional. Despite the legal and institutional framework for decentralisation, the decision space of the local governments in Uganda including districts is very narrow. Our study illustrates the Uganda health system as a CAS. The study shows that the DLT in its current design cannot deliver on its objectives in the Uganda health

system today and an understanding of why. The potential for HSPA to support decision making at local government level and accountability to communities provided by the legal and institutional framework for decentralisation and multiparty democracy in place is yet to be fully exploited.

The contribution of the study to international public health literature is at the generic and HSPA levels. The use of historical analysis and policy analysis to study the implementation of the DLT has highlighted the characteristics of the Uganda health system as a CAS and provided an illustration of some of the complex interactions that can take place between reforms and a health system. This has made it possible to appreciate the genesis of undesirable and unexpected consequences when new policies or interventions are introduced into a health system. Specific to HSPA, the study has facilitated better understanding of how HSPA frameworks interface and affect and are affected by the health systems. At the national level, the findings of this study can be used in the process of adjusting the Uganda district HSPA framework. District HSPA in Uganda is even more necessary in today's circumstances of a large and fast increasing number of districts. Recommendations for the adjustment of the Uganda district HSPA framework include a more inclusive development process, adjustments in design including the addition of more explanatory indicators/information, comparisons among smaller groups of similar districts; and consideration of the context and actors by emphasising a formative/learning approach for the districts rather than a summative approach focusing on accountability to the national level.

A lot is still unknown about HSPA and what works in various contexts especially in LMICs. More studies are required to document experiences and best practices in HSPA, given the complexity of health systems.

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Annexes

Annex 1: Key Informant Interview Guide

Name of Interviewer:

Date and Time of Interview:

Name of Respondent:

Title and Designation of Respondent:

Contact Information for Respondent:
Tel: E-mail:
Geographical Address:

Stakeholder Group or Sub-sector to which respondent belongs:

Stakeholder Groups Include:

- *Public – National level – Ministry of Health; Ministry of Finance; Ministry of Local Government;*
- *Public – District level – Health Managers- District and Hospital; Administrative Managers; Political Leaders;*
- *Private - Civil Society; Private Not for Profit Providers – Umbrella Body Officials; Health Facility Managers;*
- *Development Partner Officials;*
- *Researchers;*

1. **Please describe to me your current (and/or past if markedly different) role or work responsibility in your organisation.**
   Probe for qualifications, experience – level/aspect of sector; Performance Assessment involvement;

   Duration in position:-
   Years: ; Months ;

2. **Are you familiar with the notion of Health Systems Performance Assessment (HSPA)? If yes, what do you know/can you tell me about it? (If no, go to question 3)[2]**
   Generally;
   In Uganda;

3. **What can you tell me about the Uganda DLT from a historical/experience perspective?**
   When was it introduced? Year?
   Why was it introduced? Objectives? Background – what influenced the objectives?
   How was it introduced? Process – stakeholder involvement? utilisation of evidence?
   Who was involved? Why?
   What was in the DLT? How was it determined? Structure; Content; Dimensions; Programmes; Indicators (What is measured by the DLT? How does this relate to the following [if they exist] - Conceptual Framework for health and the health system; the district health system in the overall health system; aspects of the health system being measured; Strategic Plan strategies or Sector programmes).

4. **How has (is) the DLT been implemented?**
   Data collection
   Data analysis
   Utilisation of information
   Any adjustments made – what, why how?

5. **Have you been involved in one way or the other in the design, implementation, utilization,... of the Uganda DLT? If yes, please specify. If no, go to question 6.**
   Institutional
   Personal

6. **What do you think (perceptions) about the Uganda DLT – is it appropriate for its purpose?**

   Judged against the articulated objectives of the Uganda DLT;
   - *compare performance between districts and therefore determine good and poor performers;*
   - *provide information to facilitate analysis behind good and poor performance at districts and thus enable corrective measures;*
   - *corrective measures to range from increasing amount of resources (funding, HR, HI) to the LG or more frequent and regular supervision;*
   - *increasing LG ownership for achievements – through discussions at NHA etc;*
   - *encouraging good practices – good management; innovations; and timely reporting;*

   Judged against desirable attributes for a HSPA Framework for LICs – developed in the first sub-study of this doctoral programme, based on a review of international literature and input of an Expert Group
   - *Process of Development – inclusive; utilisation of data;*
   - *Embedded in explicit Health System Framework – clarity on determinants of health; system goals; elements & actors;*
   - *Relationship with Policy/Organisational Context; Societal Values and Principles; - the social, political and economic context; societal values & principles;*
   - *Elaboration of the HSPAF – purpose, dimensions, sub dimensions, indicators; regular & systematic application;*

- *Mechanisms for change – linkages: data - information – decision-making; packaging; fora; stakeholders; incentives;*

7. In what particular aspect(s) would you say the DLT was particularly successful? Why?

8. **In what particular aspect(s) was the DLT not successful/left a lot to be desired? Why?**

9. Do you have proposals on what can be done to improve the Uganda DLT?
Is there unutilized potential?
Are there gaps?
Is there particular need to respond to changes in the environment the DLT was introduced about 10 years ago – health system; other; what are these changes? How should the DLT be adjusted in view of this?

10. Any other thoughts or proposals on the Uganda DLT?

Annex 2: Indicators for Monitoring the Health Sector Strategic Plan II- 2005/06 to 2009/10

	Category	**Indicator**	**Purpose (what it measures)**	**Baseline Value 03/04**	**2009/10 target**	**Data Source**
1	Input	Percentage of Government of Uganda (GoU) budget allocated to health sector	Commitment of GoU to health	11.6%	13.2%	MOH/ MOF Reports
2	Input	Percentage of PHC conditional grants released on time to the sector (non-salary recurrent and capital)	Level of government honouring of its commitment to the health sector	97%	100%	MoH/MFPED
3	Input	Total public (GoU and donor) allocation to health per capita	Magnitude of resource allocation	$7.8	$18.0	MOH/ MOH Reports
4	Process	Percentage of disbursed PHC conditional grant that are expended	Absorption capacity at the district level	99%	100%	PHC monitoring reports
5	Process	Proportion of districts submitting Health Management Information System (HMIS) monthly returns to MoH on time	management capacity through timelines of reporting system	85%	100%	HMIS reports
6.	Process	Proportion of districts submitting quarterly assessment reports	Utilization of HMIS data	5%	90%	HMIS Reports
7	Process	Percentage of facilities without any stock outs of first line antimalarial drugs/ Fansidar , measles vaccine,Depo Provera, ORS and cotrimoxazole	Drug management protocols	40%	80%	HMIS/Reports/ Records review

8	Process	Percentage of the population residing within 5kms of a health facility (public or private not for profit)	Geographical access	72%	85%	1.Mapping of health facilities 2.Population based surveys
9	Process	Percentage of the health units by level providing all components of the National Minimum Health Care Package (NMHCP)	Functionality	survey to determine baseline		
10	Process	Percentage of Health units providing EMOC	Quality of obstetric care	14%	60%	HMIS Surveys
11	Output	Percentage of children < 1yr receiving 3 doses of DPT/Pentavalent vaccines	Utilisation (a PEAP indicator).	83%	90%	HMIS
12	Output	Proportion of approved posts that are filled by health professionals	Level of staffing – implementation of HRH policy	68%	90%	Annual HU/ District reports
13	Output	Couple Year Protection(CYP)	Utilisation of FP Services	223,686	494,908	HMIS
14	Output	Proportion of surveyed population expressing satisfaction with the health services	Quality of service delivery	Baseline to be decided before HSSP II	80%	Community surveys Client satisfaction Surveys
15	Output	Urban/rural specific HIV sero- prevalence rates	HIV infection	urban rural National	 4.4%	ACP reports ANC reports
16	Output	Percentage deliveries taking place in a health facility (GOU and PNFP) Deliveries supervised by a health professional	Utilisation	24.4% 38%	50% 60%	HMIS UDHS

17	Output	Total Gov. and NGO /Capita OPD utilization	Utilisation	0.72	1.0	HMIS reports/records review
18	Output	Caesarian Sections per expected pregnancies (Hospital)	Level of EmOC coverage	1.5%	10% Consult RH	HMIS reports/ Records review
19	Output	Proportion of Tuberculosis cases notified compared to expected	Effectiveness of surveillance system	49%	70%	NTLP reports
20	Output	Proportion of Tuberculosis cases that are cured	Quality of care	62%	85%	NTLP reports
21	Output	Proportion of children under 5 years with fever who receive malaria treatment within 24 hrs from a community drug distributor	Access to care	48%	70%	HMIS
22	Output	% of fever/uncomplicated malaria cases (all ages) correctly managed at health facilities	Access to effective malaria case management	60%	100%	facility based surveys
23	Output	Proportion of pregnant women receiving a complete dose of IPT2	No. of mothers covered	24%	75%	HMIS
24	Output	Percentage of Households with at least one ITN	Coverage with preventative Malaria interventions	23.5% (estimate in rural areas)	70%	House hold Survey

Annex 3: The Uganda District League Table for 2008

District	Population	HMIS returns submitted timely		Infants received 3 doses of DPT[1]		Govt & NGO OPD utilization per capita[2]		House-hold latrine Coverage		Deliveries in Govt & NGO health facilities		TB cases notified compared to expected		Pregnant women receiving 2nd dose IPT		PHC Medicine budget spent (at NMS & JMS)		PHC funds disbursed expended		FDS Flexibility Gain[3]		HIV/AIDS Service Availability*		Total Score	Ran-king
Max Score			5		12.5		12.5		7.5		12.5		10		10		10		5		5		10	**100**	
		%	Score	%	Score		Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		Score	%	Score		
Kampala	1480200	100	5	112	12.5	1.1	12.5	94	7	94	**11.7**	143	10	72	7	64	6	100	5	0.0	2.5	75	7	**87**	1
Lyantonde	74000	75	4	97	12.1	2.1	12.5	80	6	53	6.6	88	9	48	5	85	9	100	5	0.0	2.5	83	8	**79**	2
Nebbi	509200	83	4	107	12.5	1.0	12.5	78	6	66	8.3	41	4	48	5	86	9	98	5	0.0	2.5	67	7	**75**	3
Tororo	440000	100	5	94	11.7	1.2	12.5	82	6	45	5.7	55	5	46	5	86	9	0	0	0.0	2.5	91	9	**71**	4
Jinja	451000	92	5	96	12.0	1.0	12.5	71	5	56	7.1	68	7	74	7	54	5	0	0	0.0	2.5	78	8	**71**	5
Rukungiri	301700	100	5	81	10.1	1.6	12.5	99	7	47	5.9	61	6	31	3	49	5	95	5	0.0	2.5	80	8	**70**	6
Ibanda	230500	67	3	92	11.5	1.0	12.5	88	7	34	4.3	47	5	28	3	73	7	99	5	0.0	2.5	96	10	**70**	7
Bushenyi	823700	83	4	100	12.5	0.9	10.7	92	7	30	3.8	45	5	42	4	76	8	94	5	0.0	2.5	84	8	**70**	8
Kumi	345500	100	5	76	9.5	0.9	11.6	56	4	54	6.8	31	3	55	5	143	10	90	5	0.0	2.5	71	7	**70**	9
Mityana	291900	100	5	87	10.9	1.2	12.5	85	6	39	4.9	75	7	49	5	71	7	0	0	0.0	2.5	78	8	**69**	10
Gulu	353500	58	3	95	11.8	1.4	12.5	42	3	37	4.6	145	10	40	4	49	5	76	4	0.0	2.5	84	8	**69**	11
Kabarole	390500	42	2	95	11.9	1.0	12.5	88	7	45	5.6	79	8	35	4	32	3	109	5	0.0	2.5	72	7	**68**	12
Lira	626500	100	5	77	9.6	0.8	9.4	52	4	26	3.2	78	8	43	4	103	10	76	4	0.0	2.5	84	8	**68**	13
Pader	436000	100	5	96	12.0	1.1	12.5	38	3	32	3.9	68	7	48	5	54	5	98	5	0.0	2.5	69	7	**68**	14
Butaleja	192400	100	5	100	12.5	1.3	12.5	89	7	39	4.9	27	3	55	5	18	2	97	5	0.0	2.5	84	8	**67**	15
Mpigi	441900	67	3	113	12.5	0.9	11.7	55	4	40	5.0	64	6	35	4	43	4	99	5	0.0	2.5	83	8	**67**	16
Kabale	481700	92	5	86	10.7	1.1	12.5	91	7	19	2.4	24	2	35	3	61	6	100	5	0.0	2.5	73	10	**67**	17
Wakiso	1158200	100	5	119	12.5	0.9	11.8	73	5	35	4.3	42	4	59	6	39	4	104	5	0.0	2.5	56	6	**67**	18
Nakasongola	143600	92	5	77	9.6	1.1	12.5	71	5	30	3.7	31	3	42	4	84	8	102	5	0.0	2.5	65	7	**66**	19
Mbale	392900	92	5	93	11.6	1.4	12.5	65	5	41	5.2	77	8	20	2	65	6	18	1	0.0	2.5	71	7	**65**	20
Namutumba	196200	100	5	106	12.5	0.9	11.1	52	4	31	3.9	20	2	35	4	89	9	77	4	0.0	2.5	75	7	**65**	21
Bududa	154300	100	5	185	12.5	1.2	12.5	59	4	27	3.4	35	3	39	4	88	9	0	0	0.0	2.5	77	8	**64**	22
Arua	491500	83	4	92	11.5	1.0	12.5	57	4	49	6.2	58	6	46	5	47	5	110	5	0.0	2.5	30	3	**64**	23

[1] Performance above 100% on an indicator was given the maximum score

[2] Some of the values are shown rounded off to the nearest decimal point for ease of presentation. This may result in the presentation of apparently different scores for the same values but the computation uses the actual values

[3] There was no reallocation carried by districts on conditional grants in the Fiscal Year 2007/08 and a uniform score of 2.5 was given to all districts

Mbarara	409100	17	1	63	7.9	0.8	9.8	90	7	33	4.2	89	9	18	2	78	8	84	4	0.0	2.5	91	9	**64**	24
Bukedea	156900	92	5	125	12.5	0.8	10.1	60	5	41	5.2	21	2	73	7	92	9	97	5	0.0	2.5	7	1	63	25
Mukono	929200	100	5	80	10.0	0.6	8.0	81	6	41	5.1	41	4	53	5	31	3	100	5	0.0	2.5	91	9	**63**	26
Kalangala	50800	100	5	73	9.1	0.9	11.6	51	4	10	1.2	105	10	34	3	31	3	56	3	0.0	2.5	96	10	**63**	27
National Average	**29592700**	**79**	**4**	**82**	**10.2**	**0.8**	**10.4**	**63**	**5**	**33**	**4.1**	**50.2**	**5**	**39**	**4**	**54**	**5**	**94**	**5**	**0.0**	**2.5**	**75**	**8**	**62**	
Kiruhura	260800	83	4	66	8.3	0.8	10.4	76	6	10	1.3	22	2	25	2	98	10	113	5	0.0	2.5	115	10	**62**	28
Kamuli	670000	100	5	102	12.5	0.9	11.1	74	6	34	4.3	22	2	36	4	27	3	103	5	0.0	2.5	64	6	**61**	29
Ntungamo	436400	92	5	95	11.9	0.8	9.7	91	7	36	4.4	45	5	22	2	25	3	83	4	0.0	2.5	74	7	**61**	30
Kanungu	231600	83	4	85	10.6	0.7	9.3	90	7	24	3.0	47	5	29	3	24	2	99	5	0.0	2.5	93	9	**61**	31
Luwero	396500	100	5	59	7.4	0.8	9.4	73	5	31	3.9	62	6	56	6	41	4	99	5	0.0	2.5	62	6	**61**	32
Amuru	208300	67	3	87	10.8	1.0	12.5	34	3	23	2.8	63	6	40	4	62	6	0	0	0.0	2.5	91	9	**60**	33
Manafwa	320200	67	3	123	12.5	0.5	6.5	62	5	22	2.7	29	3	58	6	43	4	97	5	0.0	2.5	100	10	**60**	34
Kaberamaido	168100	67	3	85	10.6	1.0	12.5	52	4	31	3.9	29	3	63	6	70	7	0	0	0.0	2.5	68	7	**60**	35
Kayunga	330800	100	5	84	10.6	0.7	8.9	59	4	31	3.9	20	2	32	3	50	5	94	5	0.0	2.5	96	10	**60**	36
Kisoro	240000	67	3	94	11.7	1.3	12.5	75	6	60	7.5	13	1	13	1	10	1	98	5	0.0	2.5	76	8	**59**	37
Mayuge	399400	50	3	77	9.6	0.6	7.1	68	5	22	2.7	44	4	62	6	51	5	90	5	0.0	2.5	94	9	**59**	38
Adjumani	292100	92	5	54	6.8	0.8	10.0	63	5	42	5.3	32	3	60	6	72	7	100	5	0.0	2.5	34	3	**59**	39
Sironko	328800	100	5	92	11.5	0.8	9.8	57	4	25	3.2	31	3	24	2	50	5	101	5	0.0	2.5	63	6	**58**	40
Amolatar	113700	50	3	120	12.5	0.7	8.5	49	4	22	2.7	67	7	39	4	78	8	0	0	0.0	2.5	70	7	**58**	41
Kyenjojo	468100	100	5	59	7.4	0.5	6.5	76	6	17	2.1	48	5	17	2	102	10	98	5	0.0	2.5	65	7	**57**	42
Masaka	816200	92	5	69	8.6	0.7	8.2	95	7	17	2.1	71	7	23	2	48	5	0	0	0.0	2.5	104	10	**57**	43
Soroti	499800	83	4	77	9.7	0.7	8.4	68	5	40	5.0	32	3	46	5	30	3	157	5	0.0	2.5	67	7	**57**	44
Isingiro	374100	42	2	115	12.5	0.9	11.2	59	4	15	1.9	39	4	35	4	72	7	100	5	0.0	2.5	28	3	**57**	45
Kapchorwa	182300	100	5	53	6.7	1.2	12.5	58	4	19	2.4	24	2	47	5	120	10	0	0	0.0	2.5	63	6	**57**	46
Masindi	540500	67	3	81	10.2	0.8	10.0	51	4	28	3.6	33	3	57	6	40	4	94	5	0.0	2.5	56	6	**57**	47
Koboko	185100	58	3	109	12.5	0.7	9.1	61	5	18	2.3	22	2	54	5	83	8	0	0	0.0	2.5	70	7	**57**	48
Abim	54100	50	3	124	12.5	2.2	12.5	2	0	38	4.7	48	5	50	5	10	1	62	3	0.0	2.5	80	8	**57**	49
Hoima	453300	83	4	63	7.9	0.9	11.2	71	5	34	4.3	51	5	52	5	42	4	0	0	0.0	2.5	66	7	**57**	50
Pallisa	471700	83	4	106	12.5	0.7	8.5	60	5	44	5.5	22	2	39	4	48	5	55	3	0.0	2.5	50	5	**56**	51
Busia	265400	58	3	91	11.3	0.7	9.2	82	6	42	5.2	26	3	33	3	80	8	0	0	0.0	2.5	47	5	**56**	52
Iganga	661400	83	4	79	9.9	0.6	7.3	65	5	35	4.4	27	3	35	4	43	4	100	5	0.0	2.5	71	7	**56**	53
Katakwi	150300	67	3	81	10.1	0.8	9.7	55	4	21	2.6	37	4	33	3	83	8	29	1	0.0	2.5	67	7	**56**	54
Bundibugyo	282100	100	5	64	8.0	0.8	10.4	57	4	23	2.8	22	2	49	5	19	2	83	4	0.0	2.5	92	9	**55**	55
Kitgum	357000	100	5	59	7.4	1.3	12.5	19	1	35	4.4	44	4	48	5	47	5	0	0	0.0	2.5	81	8	**55**	56
Oyam	329600	50	3	71	8.9	0.5	6.6	53	4	19	2.4	72	7	72	7	53	5	0	0	0.0	2.5	83	8	**55**	57
Dokolo	159200	83	4	89	11.2	0.7	8.2	49	4	16	2.0	73	7	39	4	45	5	0	0	0.0	2.5	70	7	**54**	58
Kiboga	293300	100	5	78	9.7	0.6	7.8	58	4	24	3.0	43	4	49	5	56	6	0	0	0.0	2.5	70	7	**54**	59
Bukwa	62100	92	5	94	11.7	1.0	12.5	60	5	11	1.4	27	3	48	5	0	0	30	1	0.0	2.5	80	8	**54**	60
Rakai	449600	92	5	60	7.6	0.8	9.8	83	6	27	3.4	72	7	16	2	30	3	0	0	0.0	2.5	83	8	**54**	61
Amuria	291200	42	2	66	8.2	0.7	8.8	24	2	26	3.2	16	2	57	6	90	9	85	4	0.0	2.5	67	7	**54**	62
Moyo	303800	58	3	30	3.8	0.8	9.8	74	6	21	2.6	26	3	68	7	91	9	149	5	0.0	2.5	30	3	**54**	63

Mubende	525300	83	4	65	8.2	0.4	5.5	74	6	21	2.6	35	4	32	3	48	5	99	5	0.0	2.5	80	8	**53**	64
Apac	507200	83	4	38	4.8	0.7	8.3	53	4	16	2.0	56	6	28	3	55	5	85	4	0.0	2.5	91	9	**53**	65
Sembabule	202300	83	4	77	9.7	0.7	8.3	55	4	16	2.0	40	4	33	3	47	5	0	0	0.0	2.5	104	10	**53**	66
Kibaale	551400	75	4	35	4.3	0.5	5.7	65	5	21	2.6	52	5	52	5	64	6	115	5	0.0	2.5	67	7	**52**	67
Nakaseke	166800	100	5	43	5.3	1.1	12.5	74	6	51	6.4	51	5	56	6	0	0	0	0	0.0	2.5	39	4	**52**	68
Kotido	179300	92	5	80	10.0	0.8	9.4	2	0	12	1.5	26	3	44	4	76	8	0	0	0.0	2.5	90	9	**52**	69
Kaliro	188600	100	5	69	8.7	0.6	8.1	86	6	18	2.2	25	2	24	2	23	2	100	5	0.0	2.5	67	7	**52**	70
Moroto	265300	67	3	75	9.3	0.5	6.5	10	1	13	1.7	53	5	63	6	29	3	103	5	0.0	2.5	75	8	**51**	71
Kamwenge	302300	75	4	95	11.9	0.7	9.0	71	5	11	1.4	51	5	31	3	15	2	0	0	0.0	2.5	74	7	**51**	72
Yumbe	398100	92	5	55	6.8	0.5	5.8	63	5	37	4.6	13	1	66	7	14	1	107	5	0.0	2.5	55	5	**49**	73
Kasese	646300	58	3	63	7.9	0.5	6.0	81	6	16	2.0	26	3	45	4	65	7	0	0	0.0	2.5	80	8	**49**	74
Nakapiripirit	217500	42	2	60	7.4	0.7	8.4	3	0	4	0.4	42	4	90	9	58	6	0	0	0.0	2.5	60	6	**46**	75
Bugiri	543900	42	2	52	6.5	0.4	5.5	65	5	14	1.7	30	3	42	4	71	7	0	0	0.0	2.5	83	8	**46**	76
Buliisa	73200	67	3	101	12.5	0.6	6.9	49	4	28	3.5	25	3	44	4	30	3	0	0	0.0	2.5	20	2	**44**	77
Budaka	160100	42	2	79	9.9	0.8	10.0	60	5	25	3.2	35	4	30	3	41	4	0	0	0.0	2.5	3	0	**43**	78
Kaabong	301200	100	5	46	5.7	0.7	8.2	2	0	4	0.5	6	1	30	3	34	3	78	4	0.0	2.5	100	10	**43**	79
Nyadri	364100	0	0	14	1.7	0.1	1.9	57	4	9	1.1	21	2	11	1	0	0	100	5	0.0	2.5	65	7	**26**	80

Annex 4: UNMHCP Activity Package for District Health System by Level of Care

1.0 Community Level/Health Centre I

NMHCP Elements	Expected Living/Performance Standards
Communicable Disease Control Malaria HIV/AIDS TB and Leprosy	• Malaria preventive measures like environmental sanitation and use of ITNs, especially for <5s and pregnant mothers • Community support for Home Based Management of Fever
	• Community participation in Home Based Care for AIDS patients
	• Community support for CB DOTS • Identification of persons with chronic cough
IMCI	• Active participation in CB IMCI
Sexual and Reproductive Health and Rights	• Recognition and referral of complex pregnancies • Hygienic deliveries at home • Appropriate referral for mothers in obstetric emergencies
Immunisation	• Community mobilization for outreach services • Organisation and participation in outreach services
Environmental Health	• Houses should have a latrine, adequate housing, separate animal houses and safe refuse disposal facilities • Latrines in public places like markets, churches, schools etc. • Households have access to water within one km • Organise annual sanitation days
Health Education and Promotion	• Community health literacy levels on appropriate nutrition, malaria control, immunisation, AIDS and STI prevention (ABC), hygiene and sanitation, ORT, TB, obstetric risk factors, home injuries and accidents, mental health and Zoonotic diseases
School Health	• Schools have adequate classroom space as per the national pupil-to-classroom ratio • Latrines be available in accordance with the national gender specific pupil – to - stance ratio

Nutrition	• Adequate food supplies • Conduct Community Based Growth Promotion monitoring • Health Education on appropriate nutrition practices by the CORPs
Mental Health	• Support persons with mental illness to receive appropriate treatment at an early stage • Public education on Mental Illness by CORPs • Provision of psychosocial support to patients with mental illness
Essential Clinical care and disability prevention	• First Aid services • Patient Referral arrangements (e.g Bicycle Ambulance) • Appropriate Health Seeking Behaviour • Community sensitisation on disability, injury, eye and ear care • Early identification of individual rehabilitation needs by the CORPs e.g Cataract mobilisers • Production of simple Assistive Devices by local artisans
Community Based Management Information System	• Registration of Births and Deaths • Documentation of Immunisation status of < 5s • Registration of Disabilities • Documentation of Household sanitation

2.0 Health Centre II

NMHCP ELEMENTS	MINIMUM SERVICE STANDARDS
Communicable Disease Control Malaria	• Proper diagnosis of malaria cases • Treatment following national standard treatment guidelines • Appropriate referral • Health education • Case follow up where indicated • Acts as a focal point for the HBMF initiative
STI/HIV/AIDS Services	• Diagnosis and treatment of STIs according to the standard guidelines, with referral where indicated • Health Education on STIs • Promotion and provision of condoms to prevent STIs • Provision of Home Based Care for HIV/AIDS patients
TB and Leprosy	• Case detection, treatment and referral • Health education and contact tracing • Tracing irregular attendees and defaulters • Provision of follow up treatment • Acts as a focal point for DOTS implementation
IMCI	• Growth Promotion and Monitoring • Treatment of childhood illnesses following IMCI guidelines • A functional ORT corner • Counselling caretakers and follow up of malnourished children and referral of severe cases • Health Education on control of diarrhoeal diseases, exclusive breast feeding for 4–6 months, nutrition. • Implementation of the 12 steps to successful breast feeding • Acts as a focal point for Community Based IMCI
Sexual and Reproductive Health and Rights Antenatal and Obstetric Care	• Registration, examination and BP recording • Identification of high risk cases • Promotion of good nutrition • Provision of iron, folic acid and TT immunisation

Post-natal Care Family Planning Services Adolescent Reproductive Health Services Violence against women	• Treatment of common illnesses in pregnancy • Intermittent Presumptive Treatment (IPT) for malaria • PMTCT Counselling • Conducting normal deliveries • Resuscitation and management of the newborn • Management of minor obstetric complications according to Life Saving Skills (LSS) guidelines • Referral system for obstetric emergencies (Radio call/ Village Ambulance) • Implementation of the 12 steps to successful breastfeeding • Vitamin A supplementation to mothers within 6 weeks post delivery • Provision of Family Planning counselling and selected FP methods • Health education on MCH/FP • Identification and management of minor gynaecological problems • Referral of Gynaecological problems where indicated • Provision of integrated ARH services (FP, STI/HIV/AIDS counselling, prevention and treatment, ANC, TT) • Counselling and treatment of minor physical and psychological trauma • Referral
Immunisation	• Immunisation (BCG, DPT/Pentavalent, OPV, Measles) daily and one outreach per week • Maintain Vaccine potency and minimise wastage • Increase community demand for immunisation services through improved awareness of the benefits of immunisation • Document and follow up the Adverse Effects after immunisation • Vitamin A supplementation according to the national schedules

Environmental Health	• Promotion of hygiene practices in households, institutions and public places • Promotion of construction of healthy housing • Surveillance of water and food quality • Community sensitisation to comply with environmental health laws and regulations • Support communities to organise annual sanitation days
Health Education and Promotion	• Conduct regular sessions to raise public awareness of personal and community responsibility for better health (Health Literacy) • Provision of IEC materials to the VHTs • Creation of community demand for the utilisation of health services
School Health	• Contribute to the implementation frame of the School Health Policy • Conduct health screening exercises on a termly basis • Provide regular health education sessions at schools • Build the capacity of the "health teachers" in the catchment schools
Epidemics and Disaster Preparedness and Response	• Accurate and complete data collection according to HMIS guidelines • Timely reporting as required (Weekly and monthly) • Setting up a community based surveillance system
Nutrition	• Nutrition education and demonstrated preparation of meals • Promotion of exclusive breastfeeding for 6 months and proper nutrition thereafter according to the guidelines • Provision of micronutrient supplements to < 5s and WRA • Conducting Growth Promotion and Monitoring • Setting up of demonstration gardens • Follow up of malnourished children through home visiting
Interventions against diseases for eradication/ elimination	• Health education for prevention and control of the targeted diseases • Provision of support to community programmes in the catchment area (Oncho, Guinea worm, MNTE) • Participation in active surveillance activities

Mental Health	• Conduct health education and awareness raising on mental health, neurological and substance abuse issues in the community • Case detection, provision of first line treatment and referral of cases. • Review and follow up patients with epilepsy • Follow up of patients with identified mental health problems in the community • Commemorate Mental Health Day every year
Essential Clinical Care Infection Control	• Proper sterilisation of instruments and equipment and maintenance of aseptic conditions • Proper disposal of medical and other wastes • Provision and use of hand washing facilities • Maintenance of high standards of cleanliness of infrastructure •
Care of Injuries and other common conditions	• Treatment of common diseases (communicable and non-communicable) following the national Standard Treatment Guidelines • Health education on common diseases and domestic injuries in the community • Provision of prompt and urgent treatment of injuries (including IV fluids if possible) • Appropriate referral where indicated.
Disabilities and Rehabilitative Health services	• Identification and referral of PWDs • Education on injuries • Provision of First Aid • Review and follow up of PWDs
Palliative Care	• Provision of symptomatic care for pain relief
Oral/Dental Health	• Promotion of public oral health care through health education • Pain relief for dental/oral problems, including simple extractions • Referral where indicated

3.0 Health Centre III

NMHCP ELEMENTS	MINIMUM SERVICE STANDARDS
Communicable Disease Control Malaria	• As for HC II but with laboratory diagnostic facilities
STI/HIV/AIDS	As for HC II plus • Voluntary Counselling and Testing (VCT) for HIV • Management of opportunistic infections
TB and Leprosy	As for HC II plus • Diagnostic laboratory facilities • Storage facilities for DOTS implementation
IMCI	As for HC II
Sexual and Reproductive Health and Rights	
Antenatal Care	As for HC II, plus • Lab. Tests for urine protein, urine sugar and syphilis screening (RPR – carbon antigen test)
Obstetric Care	As for HC II, plus • Post abortion care including MVA for incomplete abortions • Regular maternal and peri-natal mortality review meetings.
Family Planning	As for HC II, plus • Insertion and removal of IUDs • Norplant insertion and removal (mobile or static)
Post-natal Care	
Adolescent Repro. Health	As for HC II
Violence against women.	As for HC II

	As for HC II
Immunisation	As for HC II
Environmental Health	As for HC II, plus • Advocacy for the implementation of the Kampala Declaration on Sanitation (KDS) • Promote gender mainstreaming in environmental health • Mobilise the relevant authorities to implement some aspects of enforcement • Provision of the necessary technological support
Health Education and Promotion	As for HC II
School Health	As for HC II
Epidemics and Disaster Preparedness and Response	As for HC II
Nutrition	As for HC II, plus • Establishing supplementary feeding centres in emergency areas • Implement the Baby Friendly Hospital Initiative
Interventions against diseases for eradication/ elimination	As for HC II
Mental Health	As for HC II
Essential Clinical care Infection Control Care of Injuries and other common conditions Disabilities and Rehabilitative health Palliative Care Oral/Dental Health	 As for HC II As for HC II As for HC II, plus • In-service training on disability and its prevention • Data collection on disabilities As for HC II As for HC II

4.0 Health Centre IV

NMHCP ELEMENTS	MINIMUM SERVICE STANDARDS
Communicable Disease Control Malaria	As for HC III, plus • In-patient management including IV medication
STI/HIV/AIDS	As for HC III, plus • In-patient management and more sophisticated laboratory services
TB and Leprosy	As for HC III
IMCI	As for HC III, plus • In-patient management, including Oxygen therapy
Sexual and Reproductive Health and Rights	
Antenatal Care	As for HC III
Obstetric Care	As for HC III, plus • Simple Premature Unit services • Assisted deliveries (Breech, Vacuum extraction etc.) • Emergency surgical obstetric services • Expanded PAC with sharp curretage
Family Planning	As for HC III, plus • Long Term and Permanent Methods (LTPM) at static and outreach clinics
Post-natal Care	As for HC III
Adolescent Reproductive Health	As for HC III
Violence against women	As for HC III, plus • Provision of medico-legal services
Immunisation	As for HC III
Environmental Health	As for HC III, plus • Support supervision for the Health Assistants at Sub-

	county level • Conducting Operational Research
Health Education and Promotion	As for HC III, plus • Supervision of health education activities at Sub-county level
School Health	As for HC III, plus • Provision of back-up support for the Sub-counties
Epidemics and Disaster Preparedness and Response	As for HC III, plus • Technical support to Sub-county staff in investigation of epidemics
Nutrition	As for HC III, plus • Management of severely malnourished children • Promotion of intersectoral collaboration for improved nutrition
Interventions against diseases for eradication/ elimination	As for HC III
Mental Health	As for HC III, plus • Outreach services to HC III, II and the communities • In-service training • Formation of Support Groups for Epilepsy and other disorders
Essential Clinical care Infection Control Care of Injuries and other common conditions Disabilities and Rehabilitative health	 As for HC III As for HC III, plus • In-patient care • Selected surgical procedures (Avoid cold cases as much as possible) • Blood Transfusion services • Expanded laboratory services As for HC III, plus • Management of common disabilities • Identification and training of focal persons • Provision of CME on disability

Palliative Care Oral/Dental Health	• Organise rehabilitation therapist and special clinical outreach clinics • Purchase of assistive devices • Increase accessibility of PWDs to health units • Referral As for HC III As for HC III, plus • Surgical extractions • Scaling and polishing • Filling (where equipment is available) • Conducting outreaches to HC III • Screening organised community groups, especially schools, for oral disease • Conducting CME on dental health

5.0 District Hospital

NMHCP ELEMENTS	MINIMUM SERVICE STANDARDS
Communicable Disease Control Malaria	As for HC IV
HIV/AIDS	As for HC IV
TB and Leprosy	As for HC IV
IMCI	As for HC IV
Sexual and Reproductive Health and Rights	As for HC IV
Immunisation	As for HC IV
Environmental Health	As for HC IV
Health Education and Promotion	As for HC IV
School Health	As for HC IV
Epidemics and Disaster Preparedness and	As for HC IV

Response	
Nutrition	As for HC IV
Interventions against diseases for eradication/ elimination	As for HC IV
Mental Health	• In-patient management facilities • Management of psychiatric emergencies • Regular mental health clinics • Management of referred patients • Outreach services to the HC IV , HC III and communities • Services of a Psychiatrist once a month. • Conduct CME in mental health
Essential Clinical care	As for HC IV, plus • X-ray and Ultrasound investigations • Pathology procedures like cytological and histological specimen handling • More robust set of surgical interventions • Conducting Rehabilitation outreach clinics at HC 4 • Provision of dental support services to HC 4 • Production of dental IEC materials for communities and schools

Annex 5: DENIVA: supporting communities to demand accountability

Peoples Alternative Assemblies Come of Age in Uganda

Thanks to increasingly active membership the network efforts to establish a national alternative citizen's parliament that is organized and run by the citizens themselves got realised in August

Ordinary Ugandans need to understand the changes that are going on at all levels and how they have an impact on people's livelihoods e.g. climate change, credit crunch among others. However these issues are not being discussed by leaders at all levels. This poses the question of "Who is helping the ordinary people to survive? There is need to understand that we are all leaders and we have to understand these issues, such that we are able to help the people. We require platforms where such national and local issues can be discussed. Prof. JB Kwesiga

Rt.Hon. Speaker Rebecca Kadaga launching Balawoli NA in Kamuli.

2012.

Recently launched by DENIVA both at Sub County and National level, the 'Neighbourhood Assembly', **and 'National Alternative people's Assembly"** are an innovative community mobilization action for and by citizens where issues pertaining to the said community are identified, discussed and action demanded from leaders through a mock community parliament. It is informed by several community meetings that sieve issues and evidence right from the public service points to parish and to sub county for that level. These issues are aggregated by Peoples' delegates to regional and then national level Alternative Assembly.

In seeking to contribute to the transformation of Uganda through networking, DENIVA adopted the **"Neighbourhood Assemblies"** approach to community mobilization for action and decision making from Kisumu, Kenya in 2009 3years down the road, the initiative has evolved from just a parish platform to a national platform now code named the People's Alternative Assembly. The Neighbourhood Assemblies have been held by citizens in many Sub Counties in six districts of Kamuli, Rakai, Ntungamo, Kabale, Tororo and Kayunga and at national level.

Jane Nakintu and Patrick Kayemba, the chair and vice chair off DENIVA Board addressing citizens after one of the assemblies.

Alternative assemblies have enabled lots of successes and learning's. **For instance, in 2010 in the** Kyebisagazi **NAs in Kakuuto, Rakai,** citizens were exposed to information on health service provision in Local Governments and responsibility centers. They demanded for better health services at Kakuuto Health Centre, end to critical shortage of drugs, action on health workers siphoning drugs out of the health facility. The offending health workers were sacked while others were transferred. Local leaders negotiated with the MOH to expand Kakuuto Heath Centre and to provide more drugs.

Through the Neighbourhood Assembly in Balawoli, Kamuli in March 2012, the citizens were exposed to information on health service provision in Local Governments and responsibility centers. They were able to identify and question specific service delivery anomalies. Kiige Health Centre II had been closed for over six months due to lack of a pit latrine, which was supposed to have been dug by the Local Government. Within a month, the pit latrine was dug and the Kiige Health Centre re-opened. A mid-wife was posted to Kawaga Health Centre for the first time in 5 years.

The National Assembly in motion.

In the August, 2012 National People's Assembly over 300 local associations assembled at the Pope Paul Memorial Centre for a session on the implications of District Multiplication on Social service Delivery. The session was joined by some District leaders and representatives of Speaker of National Parliament and Chairperson of the Parliament Committee on Local Government. The recommendation of Peoples' alternative delegates from across the country fed into the on-going Parliamentary consultation on District multiplication.

Not that the method has not been challenged. In February 2012 East Jinja Parliamentary by-elections, an Assembly of Local Citizens sought to organize the first ever joint Parliamentary Candidates Debate. Assembled to make history and lead the definition of issues for candidates rather than the other way around, the RDC claimed that the Alshabaab terrorists were planning an attack on Jinja Municipality and on that account disbursed the Assembly of Local Citizens.

Despite such retrogressive and unpatriotic incidences, Alternative Peoples Assemblies at different levels are paying off. They have resulted in increased citizen consciousness, fear and responsiveness by local authorities and other leaders on service delivery. They are helping leaders to know what is happening at community level and to take appropriate action. The method empowers citizens to demand for accountability. More and more leaders are becoming more accountable and are eager to show that they

Deniva members on the launch of the National Alternative People's Assembly.

can take action about people's concerns. This is the age of power of local associational life which DENIVA strongly believes in. And we thank Action Aid International Uganda, Trocaire, Oxfam and the DGAP Program of the EU for the resources that continue to enable these actions to take place.

Challenges

1. LG leaders often perceive alternative assemblies as parallel power centers, and some technical staff do not feel that they should be accountable to the community.
2. The RDC Offices often harass association leaders and outlaw planned actions especially in the North and Eastern Uganda. Most suppression remains unreported due to distance from the mainstream national media.

Over the years DENIVA has leant invaluable lessons that other local accountability initiatives, Baraazas inclusive, and facilitators of development need to be consider;

1. All facilitators of development need to enable community conversation in direct, none elitist and un abstract language. For instance, instead of creating an abstract picture that corruption is the problem for Ugandans, it is important that it is made clear that the problem is public leaders who are thieves. This is an example of what is helpful in the process of arriving at practical solutions.
2. For effective citizen participation in governance, it is important for development facilitators to start with the citizens' lived realities and existing knowledge. Communities know the issues and often know the solutions but do not have the organisational ability to implement them. For instance local people in Bundibugyo will know, with evidence, that until cocoa processing commences they will remain in as much poverty. It is helpful to focus conversation on possibilities in view of this knowledge.
3. Due to civic illiteracy, people tend to get involved only when serious scandals in service delivery prevent access. It is essential that facilitators of development buttress action with civic education and employ low cost innovative techniques to increase/maintain participation in public life.
4. Success of people's alternative spaces requires active interaction with LG leaders from the points of service delivery, the Sub county and the District level. When the operating environment is hostile Local associations need to join the general Civil Society struggle to demand for an environment favourable for civic expression.