**THE CONTRIBUTION OF MONITORING AND EVALUATION TOWARDS QUALITY HEALTH SERVICE DELIVERY IN LOCAL GOVERNMENTS: A CASE STUDY OF KASESE DISTRICT, UGANDA**

**BY**

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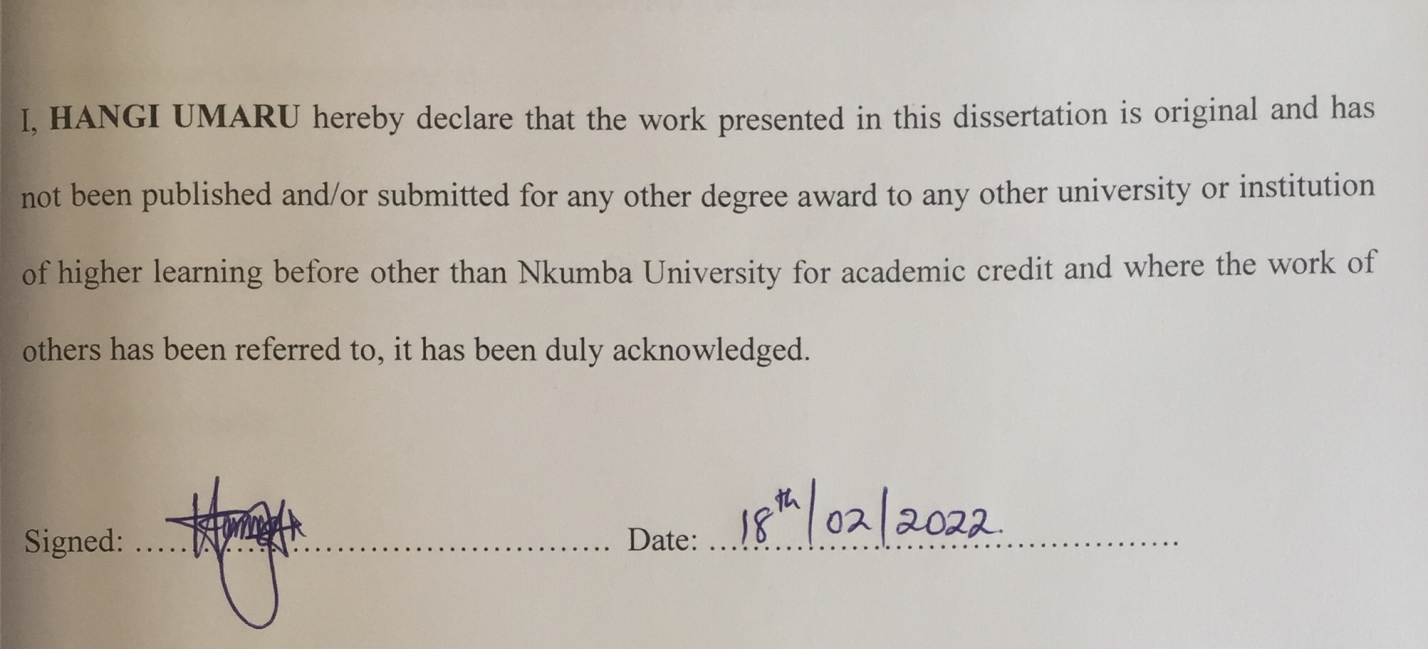
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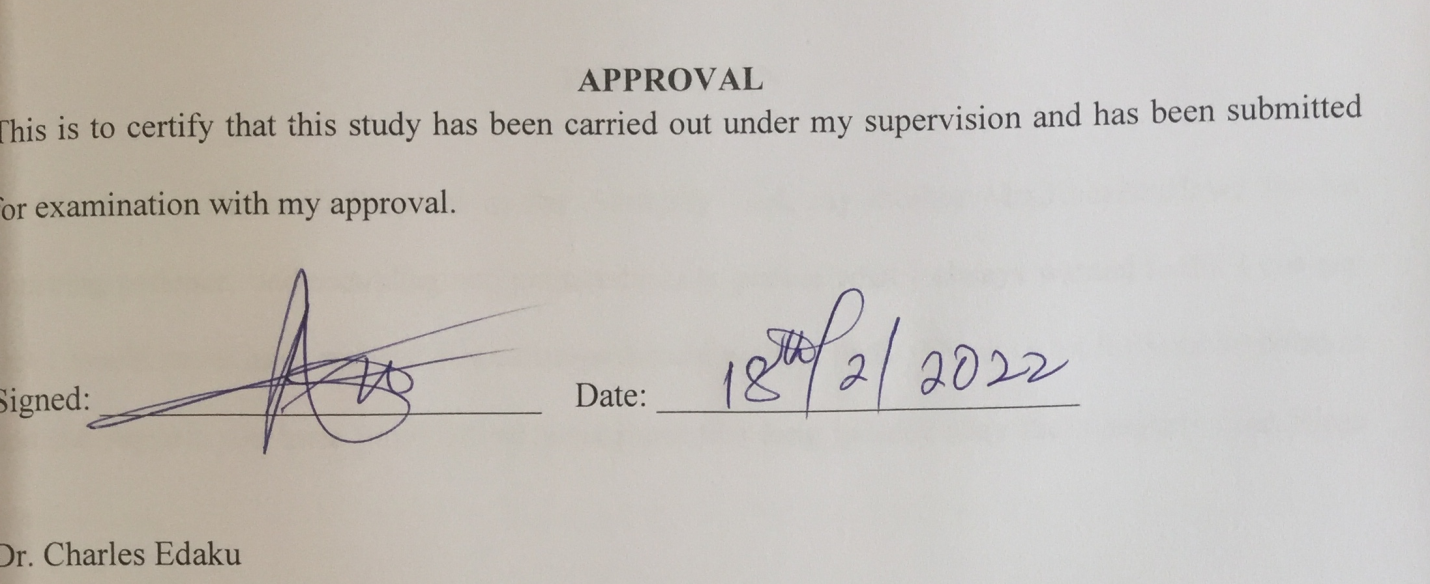
# **STUDENT’S DECLARATION**

I, **HANGI UMARU** hereby declare that the work presented in this dissertation is original and has not been published and/or submitted for any other degree award to any other university or institution of higher learning before other than Nkumba University for academic credit and where the work of others has been referred to, it has been duly acknowledged.



# **APPROVAL**

This is to certify that this study has been carried out under my supervision and has been submitted for examination with my approval. \



# **DEDICATION**

I dedicate this Research Proposal to the Almighty God, my motherMrs.KacancuHawa forher enduring patience, understanding and preparedness to pursue what I always wanted to do. I can say that I would never have realised this accomplishment without them. Thanks a lot for your inspiration and the support you have provided me throughout this long journey May the Almighty God Bless you.

# **ACKNOWLEDGEMENT**

Undertaking the role of monitoring and evaluation in quality health service delivery in local governments: a case study of Kasese district, Uganda was truly challenging although incredibly rewarding journey and there is no more joyous moment than finally reaching the final destination. I found that being a student again was an incredible isolating experience. Had it not been for some special people who made enormous sacrifices and contributed huge amounts of support, I may not have survived this ordeal and been able to accomplish my goal. Therefore, there are several people I would like to acknowledge and thank for their tremendous support.

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**TABLE OFCONTENTS**

[STUDENT’S DECLARATION i](#_Toc92891549)

[APPROVAL ii](#_Toc92891550)

[DEDICATION iii](#_Toc92891551)

[ACKNOWLEDGEMENT iv](#_Toc92891552)

[LIST OF TABLES ix](#_Toc92891553)

[LIST OF FIGURES x](#_Toc92891554)

[LIST OF ABBREVIATIONS xi](#_Toc92891555)

[ABSTRACT xii](#_Toc92891556)

[CHAPTER ONE 1](#_Toc92891557)

[INTRODUCTION 1](#_Toc92891558)

[1.1. Background to the Study 1](#_Toc92891559)

[1.2.1 Historical Background. 1](#_Toc92891560)

[1.2.2 Theoretical Background 5](#_Toc92891561)

[1.2.3 Conceptual Background 6](#_Toc92891562)

[1.2.4 Contextual Background 9](#_Toc92891563)

[1.3 Statement of the Problem 11](#_Toc92891564)

[1.4 Main of the Study 12](#_Toc92891565)

[1.5 Objectives of the Study 12](#_Toc92891566)

[1.6 Research Questions 12](#_Toc92891567)

[1.7 Hypotheses of the study 13](#_Toc92891568)

[1.8 Conceptual Framework 14](#_Toc92891569)

[1.9 Significance of the Study 14](#_Toc92891570)

[1.10 Justification of the study 15](#_Toc92891571)

[1.11 Scope of the Study 15](#_Toc92891572)

[1.11.1 Content Scope 15](#_Toc92891573)

[1.11.2 Time Scope 15](#_Toc92891574)

[1.11.3 Geographical Scope 16](#_Toc92891575)

[1.12 Definition of key Terms 16](#_Toc92891576)

[CHAPTER TWO 17](#_Toc92891577)

[LITERATURE REVIEW 17](#_Toc92891578)

[2.1 Introduction 17](#_Toc92891579)

[2.2 Theoretical Review 17](#_Toc92891580)

[2.3 Compliance Monitoring and Evaluation and Quality of Health service delivery 19](#_Toc92891581)

[2.3.1 Output Oriented Budgeting Reporting and Quality of Health service delivery 19](#_Toc92891582)

[2.3.2 Government Annual Performance reporting and Quality of Health service delivery 20](#_Toc92891583)

[2.3.3 Auditor General’s report and Quality of Health service delivery 21](#_Toc92891584)

[2.3.4 National assessment of minimum conditions and performance measures for local governments and Quality of health service delivery 22](#_Toc92891585)

[2.4 Social Accountability Monitoring and Evaluation and Quality of Health service delivery 23](#_Toc92891586)

[2.4.1 Public Expenditure Tracking Surveys (PETS) 25](#_Toc92891587)

[2.4.2 Public Hearings 26](#_Toc92891588)

[2.4.3 Social Audit 27](#_Toc92891589)

[2.4.4 Citizen Report Cards (CRCs) 27](#_Toc92891590)

[2.4.5 Community Monitoring 28](#_Toc92891591)

[2.4.6 Community Score Cards (CSCs) 28](#_Toc92891592)

[2.5 Internal Monitoring and Evaluation and Quality of health service delivery 29](#_Toc92891593)

[2.6 Summary of the Literature Review 30](#_Toc92891594)

[CHAPTER THREE 31](#_Toc92891595)

[METHODOLOGY 31](#_Toc92891596)

[3.1. Introduction 31](#_Toc92891597)

[3.2 Research Design 31](#_Toc92891598)

[3.3 Study Population 31](#_Toc92891599)

[3.4 Determination of the Sample size 31](#_Toc92891600)

[3.5 Sampling Techniques and Procedure 33](#_Toc92891601)

[3.6 Data Collection Methods 33](#_Toc92891602)

[3.6.1 Questionnaire Survey 33](#_Toc92891603)

[3.6.2 Documentary Review 33](#_Toc92891604)

[3.6.3 Interviewing 34](#_Toc92891605)

[3.7 Data Collection Instruments 34](#_Toc92891606)

[3.7.1 Questionnaires 34](#_Toc92891607)

[3.7.2 Key Informant Interview guide 34](#_Toc92891608)

[3.8 Validity and Reliability 35](#_Toc92891609)

[3.8.1 Validity 35](#_Toc92891610)

[3.8.2 Reliability 35](#_Toc92891611)

[3.9 Procedure of Data Collection 36](#_Toc92891612)

[3.10 Data Analysis 36](#_Toc92891613)

[3.10.1 Quantitative Data Analysis 36](#_Toc92891614)

[3.10.2 Qualitative Data Analysis 36](#_Toc92891615)

[CHAPTER FOUR 37](#_Toc92891616)

[PRESENTATION, INTERPRETATION AND DISCUSSION OF FINDINGS 37](#_Toc92891617)

[4.1Introduction 37](#_Toc92891618)

[4.2Response rate 37](#_Toc92891619)

[4.1 Background of the Respondents 38](#_Toc92891620)

[4.4. Descriptive Analysis 40](#_Toc92891621)

[4.4.1 Findings on the effect of compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 40](#_Toc92891622)

[4.4.2 Findings on the effect of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 45](#_Toc92891623)

[4.4.3 Findings on the effect of internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 51](#_Toc92891624)

[4.4.4 of Monitoring and Evaluation on quality-of-health service delivery 57](#_Toc92891625)

[CHAPTER FIVE 1](#_Toc92891626)

[SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 1](#_Toc92891627)

[5.1 Introduction 1](#_Toc92891628)

[5.2 Summary 1](#_Toc92891629)

[5.2.1 Effect of compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 1](#_Toc92891630)

[5.2.2 Effect of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 2](#_Toc92891631)

[5.2.3 Effect of internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 2](#_Toc92891632)

[5.3 Conclusions 3](#_Toc92891633)

[5.3.1 Effect of effect of compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 3](#_Toc92891634)

[5.3.2 Effect of effect of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District 3](#_Toc92891635)

[5.3.3 Effect of internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 4](#_Toc92891636)

[5.4 Recommendations 4](#_Toc92891637)

[5.5 Limitations of the study 5](#_Toc92891638)

[5.6 Areas recommended for further study 6](#_Toc92891639)

[REFERENCES 7](#_Toc92891640)

# **LIST OF TABLES**

[Table 4. 1: Showing the response rate 45](#_Toc92291773)

[Table 4. 2: Gender of the respondents 46](#_Toc92291774)

[Table 4. 3: Age of the respondents 46](#_Toc92291775)

[Table 4. 4: Descriptive Statistics on the effect of compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 40](#_Toc92291776)

[Table 4. 5: Descriptive Statistics on the effect of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 42](#_Toc92291777)

[Table 4. 6: Descriptive Statistics on the effect of internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District. 44](#_Toc92291778)

[Table 4. 7: Hypotheses of the study 46](#_Toc92291779)

[Table 4. 8: Model Summary 47](#_Toc92291780)

[Table 4. 9: Analysis of Variance (ANOVA) 48](#_Toc92291781)

# **LIST OF FIGURES**

[Figure 1: Level of education of the respondents 47](#_Toc92291819)

[Figure 2: Years Worked with Kasese district. 47](#_Toc92291820)

# **LIST OF ABBREVIATIONS**

**ANOVA :** Analysis of Variance

**C.V. I :** Content Validity Index

NIMES : National Integrated Monitoring and Evaluation Strategy

LGs : Local Governments

MDAs : Ministries, Departments, Agencies

**CRCs :** Citizen Report Cards

**CSCs :** Community Score Cards

**DAC :** Development Assistance Committee

**M&E :** Monitoring and Evaluation

**NRM :** National Resistance Movement

**OECD :** Organization for Economic Cooperation and Development

**PETS :** Public Expenditure Tracking Surveys

**PSRRC :** Public Service Review and Reorganizations Commission

**SPSS :** Statistical Package Social Scientists

# **ABSTRACT**

This study was carried out to examinethe contribution of Monitoring and Evaluation towards quality service delivery in Local Governments in Uganda using the case of Kasese District Local Government. The objectives that guided the study were: to establish the extent to which compliance Monitoring and Evaluation on quality-of-service delivery in Kasese District, to assess the influence of social accountability Monitoring and Evaluation on quality-of-service delivery in Kasese District, to establish the contribution of internal Monitoring and Evaluation on quality-of-service delivery in Kasese District.The study adopted a cross sectional research design, which involved the collection of data from Kasese District using both qualitative and quantitative approaches. The study covered a population of 455 respondents comprising of 20 Staff at Kasese District Local Government headquarters, 15 Leaders who from the District Executive Committee and 420 Citizens of Kasese District and a sample size of 234 respondents participated. Purposive sampling technique was used to select staff at Staff at Kasese District Local Government headquarters and Leaders who from the District Executive Committee while Simple random sampling technique was used to select Citizens of Kasese District. The study findings revealed that there is a moderate positive significant relationship between Compliance Monitoring and Evaluation and Quality of Service Delivery, that there is also a moderate and significant relationship between Social Accountability Monitoring and Evaluation and Quality of Service Delivery and there is a moderate positive correlation between Internal Monitoring and Evaluation and Quality of Service Delivery. It was hence concluded in order to achieve high levels of Quality of Service Delivery the Kasese district M and E function ought to uphold the efforts by the Inspector General of Government which are useful in deterring to staff to committing fraud, the Kasese district management ought to work on improvement of the district work plans, budgets and reports in accordance with the Public Finance Management Act and the value in Auditor General efforts in promoting Accountability in the District, the district management ought to work on provision of Kasese residents with reliable information on their entitlements, performance of government services, value by Civil society organizations (CSOs) in the delivery of social services and Civil society organizations (CSOs) efforts have a role in social accountability and the district management ought to work upon social accountability initiatives to strengthen accountability relationship between governments and citizens, Involving Kasese residents in monitoring government projects builds transparency and accountability.

# **CHAPTER ONE**

# **INTRODUCTION**

## **Background to the Study**

Institutions and governments have to increase effectiveness through various resources which include, money, men and machines. Key amongst all the resources are people (Kehinde, 2012). Institutions today are highly ranking monitoring and evaluation so that they make sure that they enhance the quality of health service offered to the customers. This enables the organisations to maximise the resources for improved healthservice quality of the Institution. In line with Devine (2008), monitoring and evaluation comprises effective compliance, Social Accountability and internal process flows. Evaluation. In this study, monitoring and evaluation will be the independent variable whereas the dependent variable was quality of health service delivery. The background to the study is presented in a format prescribed by Amin (2005) which includes the historical, theoretical, conceptual and contextual background.

### **1.2.1 Historical Background.**

Medieval and early modern central governments were mainly occupied in effective control over territory. Central governments merely performed extractive (finance), monitoring (legislative, judicial) functions while the provision, and production of public services was left to local governments(Raadschelders, 2020). However, with the advent of the welfare state (1880—1930), both local and central governments experienced an intensification of as well as an extension of public services in response to citizens’ needs (Bohne et al., 2014; Raadschelders, 2020). The welfare state was created to reverse the adverse effects of the “anti-welfare society,” which was unable to provide its people with the minimum living standards, security, or stability(Amsler& Foxworthy, 2014; Bovaird et al., 2014).

The welfare state, which had been in preparation since the nineteenth century, was formed in earnest after the 2 Second World War(Fujimura, 2000; Kim, n.d.; MOSLEY, 2009). As earlier mentioned, citizen needs were served primarily at the local level until the end of the nineteenth century after which public health service delivery became a mixed central-local responsibility(Raadschelders, 2020).

Fujimura (2000)adds that the welfare state has five basic components and they include: a social security system(Fujimura, 2000); central and local governments as the managerial core of the system(Fujimura, 2000); social recognition and legislation of fundamental human rights, which support the system’s establishment at the ideological level(Fujimura, 2000); the justification of state intervention in the economic sphere to achieve full employment(Fujimura, 2000); and the realization of mass democracy based on the principle of parliamentary decision making in the political sphere(Fujimura, 2000). Most governments have since developed elaborate systems of public service delivery hinged on division of labor between central and local governments(Bohne et al., 2014; Raadschelders, 2020).

The shortcomings and criticism of the welfare state as a vehicle for health service delivery led to a shift in state ideology in advanced capitalist nations since the late 1970s towards New Public Management (NPM)(Amsler& Foxworthy, 2014; Haque, n.d.; Mudge, 2008), a neo-liberal framework which rejects the welfare state, opposes a large public sector, doubts government capacity, blames public bureaucracy, believes in private sector superiority, and emphasizes market competition in service delivery (Fakhrul, 2015; Haque, n.d.; Mudge, 2008).

In the developing world, the NPM model has not only taken root in relatively advanced economies in Asia and Latin America, it can also be noticed in some of the poorest African countries like Uganda, Zimbabwe, Tanzania, Malawi, Ghana and Zambia(Fakhrul, 2015; Franke, 2014; Haque, n.d.). Under the pressure of neo-liberal policy preferences in advanced capitalist nations, international agencies such the World Bank, the International Monetary Fund, the World Trade Organization, the African Development Bank, Asian Development Bank embraced an anti-state policy stance and imposed market-based public sector reforms (in line with the NPM model) on developing nations during the 1980s and 1990s (Fakhrul, 2015; Franke, 2014; Haque, n.d.; Mudge, 2008).

Public health service delivery in Uganda, on the other hand, has its roots in the colonial era in 1900s characterized by public servants that were foreigners to Africa(Kyarimpa, 2009; Olum, 2004). The primary purpose though was to consolidate the colonial rule while serving as representatives of the colonial governments and serving interest for the colonialists as opposed to those of the natives. Interestingly, the postcolonial Public Service also inherited the culture of serving narrow interests as opposed to serving the broader citizenry (Kyarimpa, 2009; Olum, 2004; Ramadhan, 2014). Studies asserts that the gains that the Public Service in Uganda had enjoyed after independence in 1962 to 1971 were eroded when Idi Amin Dada took over state power. The collapse of the public administration machinery was quickly followed by economic decay, civil strife, and political instability(Olum, 2004; Ramadhan, 2014).

In 1986 when President Museveni’s National Resistance Movement (NRM) ascended to power, his government inherited a largely dysfunctional public service. Among the problems in the Public Service as diagnosed around 1987 when the NRM came to power; were difficulties in the delivery of social services to the citizens, inefficient functions of Central Government, over-centralized Public Service and generally compromised health service delivery by corrupt management of the ministries and public enterprises(Muhumuza, 2009). Further, the Public Service was bloated or over-expanded without justification, run down in terms of training, tools and equipment and had poorly remunerated employees who pretended to work(Baguma, 2017).

In a bid to reverse the above negative trend, the NRM government set up the Civil Service Reform Programme (CSRP), initiated in 1988 and operationalized in 1989, with the setting up of the Public Service Review and Reorganizations Commission (PSRRC) under the CSRP. Between 1992 and 1997, the Government of Uganda streamlined and reduce the government ministries from thirty-eight (38) to twenty-two (22)(Baguma, 2017; Muhumuza, 2009).

The staff numbers were reduced from 320,000 on the payroll to nearly half. The functions of the centre were to some extent devolved 4 through the Decentralization Statute No. 15 of 1995, the Local Governments Act, 1997, and the 1995 Constitution. The main aim of this second wave of reforms was to develop a Public Service that delivers timely, high quality and appropriate services to the citizens while facilitating the growth of a wealth-creating private sector. These reforms were largely based on the principles of new Managerialism.

The need for the reform of the Public Service (1997- 2002) therefore was indicative of the short falls of the earlier reforms(Olum, 2004). One such reform was the building of a whole-of-government M&E system, which was meant to support evidence based decision-making(Mackay, 2007) (Mackay, 2006). Evaluation on the other hand is a very young discipline but a very old practice(Mackay, 2007).

The modern discipline of evaluation, emerged from social science research which is based on the scientific method(Morra Imas & Rist, 2009). The roots of evaluation can be traced as far back as 5,000 years ago where monitoring of grain and livestock production was carried out by ancient Egyptians. In the public sector, formal evaluation was evident as early as 2000 BC, when Chinese officials conducted civil service examinations to measure the proficiency of applicants for government positions followed by evaluation of education and social programs in several Anglo-Saxon countries in the 1800’s (Morra Imas & Rist, 2009).

Morra-Imas&Rist (2009) add that in the early 1900’s, formal evaluation and applied social research grew rapidly in the United States’ due to the need to evaluate recovery programs that were implemented following the Great Depression of the 1930s and more so during and after World War II, as more large-scale programs were designed and implemented. In the 1950’s and 1960’s, evaluation became more routinely used in the United States and Europe leading to publication of numerous articles and books on evaluation in the United States and some Organization for Economic Cooperation and Development (OECD) countries in the late 1960’s and early 1970’s (Morra Imas & Rist, 2009).

In Africa, Monitoring and Evaluation (M&E) has seen a steep climb – in terms of practice, profession and academic study since the early 1990s following the pioneering work of the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) in 1987(Basheka& Byamugisha, 2015; Kabuye & Basheka, 2017a). There are currently over 30 national evaluation associations in Africa with the oldest having been established in Ghana in 1997(Basheka& Byamugisha, 2015; Kabuye & Basheka, 2017b). Relatedly, posit that the demand for M&E in Africa was created by the rise of New Public Management (NPM), which was constructed around key philosophies that emphasized improvement of service delivery through outputs and outcomes, transparency and accountability(Kabuye& Basheka, 2017b; Musumba et al., 2015).

Uganda’s alignment to results on the other hand commenced in the late 1980s, when a series of economic reforms were put in place. These reforms included a civil service reform that worked toward reducing the size of the civil service and reorienting it toward a Results Oriented Management System(Baguma, n.d.; Musumba et al., 2015). Poverty monitoring, introduced in 1999, provided the foundation for assessing the impact of public policy on poverty and welfare in Uganda(Booth & Nsabagasani, 2005). This was followed by the introduction of a National Integrated Monitoring and Evaluation Strategy (NIMES) in 2006 which defined broadly the policy, capacity and infrastructure required to strengthen performance assessment(Booth & Nsabagasani, 2005; Ojok & Basheka, 2016). The follow up to the NIMES was the National Policy on Public Sector Monitoring and Evaluation (2013) that aimed at addressing shortcoming of NIMES which included absence of management information systems and annual sector reviews in some Ministries, Departments, Agencies (MDAs) and Local Governments (LGs), weak utilization of M&E findings and few and irregular evaluations(Ojok& Basheka, 2016).

Recent budget reforms have enabled MDAs and LGs to report quarterly on spending and progress towards stated output targets as the basis for the next financial releases. This has been strengthened by introduction of a mechanism of reviewing and reporting on Government performance twice a year to provide timely information to Cabinet for decision making (Baguma, n.d.; Ojok & Basheka, 2016). Reforms introduced under the National Policy on Public Sector Monitoring and Evaluation require that local governments produce results orientated Local Government Development Plans and annual Budget Framework Papers, ensure proper coordination of monitoring activities at District and Lower Local Government (LLG) levels, provide timely and quality data on relevant performance indicators to MoLG, MFPED and line MDAs; ensure that all Local Government Planning Units assign one or more positions responsible for statistical production, monitoring and evaluation but also to utilize M&E findings to inform programme, policy, and resource allocation decisions(Baguma, n.d.; Ojok & Basheka, 2016).

### **1.2.2 Theoretical Background**

The study was guided by the New Public Management model whose theoretical foundations lie in public choice and principal-agent theory, which claim that individual self-interest drives bureaucratic behavior(Gruening, 2001). The principal-agent theory, advanced by Jensen and Meckling, (1976) identifies two parties in any given transaction(Eisenhardt, 1989; Jensen & Meckling, 1976). The principal is the party who wishes to provide services but lacks the necessary knowledge, skills or assets. The principal then employs an agent to provide the services and in so doing delegates some decision-making authority to the agent. If both parties to the relationship are utility maximizes, there is good reason to believe that the agent will not always act in the best interests of the principal(Jensen & Meckling, 1976).

The principal can limit divergences from his interest by establishing appropriate incentives for the agent and by incurring monitoring costs designed to limit the aberrant activities of the agent. The Principal-agent theory therefore provides a framework on how to get public servants (the agent) to act in the best interests of the citizenry, represented by the elected officials (the 7 principal). The principal-agent theory has been utilized to identify the compliance, internal and social accountability issues that monitoring and evaluation needs to consider for quality health service delivery. Put simply, with effective monitoring and evaluation service delivery through a principal-agent relationship is likely to be available, accessible, accommodative and acceptable to the end users(Eisenhardt, 1989; Jensen & Meckling, 1976).

### **1.2.3 Conceptual Background**

The study focused on the relationship between M&E and quality ofhealth service delivery. The relationship between M&E and quality of health service delivery is such that, M&E is a means or an input to achieving quality health service delivery, which in this case is the desired result or output. Put another way, M&E is an input whereas quality health service delivery is the result/output. M&E is divided into two yet complementary functions where “M” represents monitoring and “E” stands for evaluation. Monitoring means a continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds (OECD/DAC, 2012).

Evaluation on the other hand is the systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation and results aimed at determining the relevance and fulfillment of objectives, development efficiency, effectiveness, impact and sustainability (OECD/DAC, 2012). It is immediately evident that monitoring and evaluation are distinct yet complementary(Kusek& Rist, 2004). Olum (2004) contends that the purpose of monitoring and evaluation (M&E) is experience-focused learning for planning and allocating resources optimally for improved health service delivery(Olum, 2004). The concept of monitoring and evaluation, in the study, was approached from three dimensions; mandatory, civic and persuasive monitoring and evaluation as conceptualized by Naidoo (2012)(Naidoo, 2012). Mandatory Monitoring and Evaluation (MME) relates to compliance, and is the form of M&E where the express purpose is to ensure accountability. It describes the legislative and policy environment that has been put in place to ensure compliance with norms and standards and assesses how well Kasese District Local Government has responded to these imperatives.

This dimension shall be referred to as compliance M&E in this study The second dimension considered was that of civic M&E which examines how civic oversight contributes to better decision-making and how information generated by this sector can be used to improve performance and health service delivery ultimately. However, for the purpose of this study, social accountability M&E shall be adopted in place of civic M&E owing to the convergence of what Naidoo (2012) terms as civic M&E and social accountability(Naidoo, 2012). The third dimension considered was that of persuasive or internal M&E, by examining how M&E information, generated both internally and externally is utilized by management(Naidoo, 2012). The M&E objective or intent brought about by this form of M&E is learning, demonstrated through utility.

The aspect reviewed is thus utility, which should emerge if there is perceived value to the information generated. Given that performance information generally purports to bring about positive impacts, its use may be considered as important for improvinghealth service delivery(Naidoo, 2012). The term internal M&E was adopted for this study. Quality of Health service delivery on the other hand was conceptualized to include four (4) dimensions that is availability, accessibility, accommodation, and acceptability as conceived(Levesque et al., 2013; Ricketts & Goldsmith, 2005). Availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. Accessibility refers to geographic accessibility, which is determined by how easily the client can physically reach the provider's location. Accommodation reflects the extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client. 9 Of greatest concern are hours of operation, how telephone communications are handled, and the client's ability to receive care without prior appointments(Levesque et al., 2013).

And finally, acceptability captures the extent to which the client is comfortable with the more immutable characteristics of the provider, and vice versa. These characteristics include the age, sex, social class, and ethnicity of the provider (and of the client). For public services to be available, accessible, accommodative, and acceptable, the World Development Report (2004) proposes a health service delivery framework which defines accountability relationships between clients/citizens, providers and policymakers. The report explains the problem of health service delivery in developing countries, and especially the weak link between expenditures and health service delivery outcomes, using an accountability framework. The report notes that health service delivery outcomes are the result of not just the resources spent but by the nature of the accountability relationships between the actors in the healthservice delivery chain(*World Development Report 2004*, n.d.).

These actors include: clients or citizens; policymakers; and provider organizations and frontline providers (*World Development Report 2004*, n.d.). Clients/ (i.e., citizens) are the ultimate beneficiaries of a service, such as the students in the case of say primary education. But this category of actors also includes the general citizens who while they may not be direct beneficiaries of a particular service have the responsibility of financing as taxpayers or as voters who elect the representatives. Policymakers are normally elected by the citizens and are responsible for defining the policies and also for decisions concerning the allocation of funds. The other category of actors is provider organizations including all those agencies that are involved in organizing and monitoring the provision of services.

And finally, the frontline providers who are responsible for delivering the services and thus come into direct contact with the clients(*World Development Report 2004*, n.d.). For efficient health service delivery, the accountability framework posits that the actors in the health service delivery chain should be linked by well-functioning accountability relationships. The first accountability relationship is one between the clients and the policymakers, which is referred to as voice. The voice relationship implies that the policymakers are accountable to the clients and thus clients’ concerns and views should be heard and appropriately acted upon by the policymakers.

When clients/citizens have an effective voice, then policymakers are bound to be responsive to their demands. Such a relationship is strong in institutional arrangements in which the clients can effectively punish policymakers for failure to take into account the demands of the voters (World Bank, 2003). The other important accountability relationship is between policymakers and the provider organizations and is described as a compact. This relationship includes agreement on what the policymakers except the providers to do and also what the providers should expect from the policymakers. For the providers to be able to deliver services, they require policies, rules and guidelines that define their roles and operations. Likewise, policymakers are expected to provide the necessary resources necessary to affect the delivery of services – salaries, infrastructure, equipment, and so on.

Accountability requires that the policymakers be able to monitor and reward the performance of the providers(*World Development Report 2004*, n.d.). Finally, provider organizations and frontline providers should be accountable to clients and this is referred to as client power. Client power implies that the clients can directly hold the providers accountable. When the accountability relationships work well, services are provided efficiently. But this requires that all the actors in the health service delivery chain be motivated to achieve the same end goal that is quality services. However, health service delivery is characterized by the problem of agency which arises because the different actors have divergent interests. The health service delivery framework alludes to the fact that the network of principal-agent relationships associates with numerous incentive problems that impact on the efficiency of delivery. Agency problems are therefore the primary source of health service delivery failures(*World Development Report 2004*, n.d.)

### **1.2.4 Contextual Background**

Public services are what make the state visible to its citizens. Public services are citizens’ direct line to government. They make the state tangible through an almost daily interaction, direct or indirect. States are shaped by images and practices(Migdal & Schlichte, 2005). Governments have the obligation to provide services to their citizens and to steer economic growth and development through the provision of public services. The public service is the main implementing machinery for national development programmes and specifically, the delivery of public services. It is therefore very important for the public service to monitor and evaluate the delivery of public services and to obtain feedback from service recipients, regarding their efficiency and effectiveness (UBOS, 2008).

It clarifies, and strengthens awareness and interest in developing communities by focusing on results(Olum, 2004). Previous assert that experience around the world has demonstrated that generating and using information on the performance of service providers by both government and non-government actors can lead to substantial enhancement of public transparency and accountability which in turn fosters adherence to higher quality standards in health service delivery. Considerable efforts have been made to establish a strong and robust basis for assessing public spending, and its effects on development interventions over the past two decades in Uganda(Gaventa& McGee, 2013; Kabuye & Basheka, 2017b). To this end, M&E was enshrined in the National Development Plan, the Office of the Prime Minister (OPM) given the constitutional mandate to oversee reforms and health service delivery in all Local Governments, Ministries, Departments and Agencies and a National Integrated Monitoring and Evaluation Strategy (NIMES) developed.

Results Oriented Management and output-oriented budgeting were developed and annual public expenditure reviews put in place(Kabuye& Basheka, 2017b; Ojok & Basheka, 2016). Additionally, the National Policy for Public Sector Monitoring and Evaluation Policy was developed to provide a clear framework for strengthening the coverage, timeliness of assessment of public interventions. The policy was meant to enhance the performance of Public Sector through strengthening coordination and cost-effective production and use of objective information in the implementation of national interventions(Kabuye& Basheka, 2017b; Ojok & Basheka, 2016). Significant efforts were devoted to introducing results-based budgeting, developing the institutional capacity to design and implement plans but also capacity for M&E arrangements(Ojok& Basheka, 2016). M&E arrangements include National Assessment of Performance of Local Governments, Joint Annual Review of Decentralization (JARD) and monitoring and inspection of Local 13 Government programmes and activities. Ministries, Departments and Agencies (MDAs) and Local Governments (LGs) are also required to submit quarterly monitoring reports to Office of the Prime Minister. Under the decentralization framework, the Local Governments Act, 1997 establishes both technical and political structures responsible for Monitoring and Evaluation.

These include; the District Council, the District Executive Committee (DEC) and the District Public Accounts Committee which are composed of elected leaders. The technical structures on the other hand include; the District Technical Planning Committee, the Sub County Technical Planning Committee and the Parish Development Committee and the Resident District Commissioner (GoU, 1997). However, despite above efforts and availability of performance information, healthservice delivery in Kasese District remains unsatisfactory. For example, during the Financial Year 2013/14 only 39% of planned outputs by the district were achieved(Baguma, n.d.; Ojok & Basheka, 2016). In 2015 primary school completion rate in the district stood at 24.3%, far below the national average of 61% (MoESTS, 2015) while the district’s water, sanitation and hygiene were rated as weak with a score of 43% (MWE, 2015). The study therefore sought to examine the role the monitoring and evaluation function can play in improving quality of health service delivery in Local Governments in Uganda using the case of Kasese District Local Government.

## **1.3 Statement of the Problem**

Considering budget allocations to the MOH in Uganda [5.1% of the total annual budget in FY 2020/21 and 7.9% in FY 2019/2020 (The National Budget Framework FY 2020/21)]. And considering other support from development partners, it is expected that the quality of services offered to patients would be commensurate to the support. Ideally one would expect considerable improvements in supply of drugs, the facilities namely buildings and inherent equipment such as beds, laboratories. That the moral of health worker would be high and that patients would receive quality services and on time.

Unfortunately, Kabale district health system faces a huge challenge of service delivery to its clients considered to be below the minimum level. During the Financial Year 2018/19, only 39% of planned outputs by the district were achieved (OPM, 2020). In 2020 primary school completion rate in the district stood at 24.3%, far below the national average of 61% (MoESTS, 2020) while the district’s water, sanitation and hygiene were rated as weak with a score of 43% (MWE, 2020). While presiding over a ceremony at Katwe Primary School in Kasese town council, local politicians have wept due to the dilapidated classrooms. The study therefore sought to investigate the contribution of monitoring and evaluation in ensuring quality health service delivery. This unprecedented challenge is attributed to among others, weak M&E systems characterized by; limited utilization of M&E findings, weak coordination and harmonization, multiple and parallel data collection systems and weak management skills at local government levels (Lagarde et al., n.d.; Makara, 2009). In a bid to address this problem, the Government of Uganda responded by developing and implementing the National Integrated Monitoring and Evaluation Strategy (NIMES) across all Ministries, Departments and Local Governments (Lagarde et al., n.d.; *New Public Management*, 2018.,OPM, 2018). This study therefore investigated the contribution of M&E towards improving health service delivery in Kaseses district.

## **1.4 Mainobjective of the Study**

The main objective of the study was to investigate the contribution of Monitoring and Evaluation towards quality health service delivery in Local Governments in Uganda using the case of Kasese District Local Government.

## **1.5 Objectives of the Study**

1. To establish the extent to which compliance Monitoring and Evaluation enhances quality-of-health service delivery in Kasese District.
2. To assess the influence of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District.
3. To examine the contribution of internal Monitoring and Evaluation towards quality-of-health service delivery in Kasese District.

## **1.6 Research Questions**

1. To what extent does compliance Monitoring and Evaluation influence quality-of-health service delivery in Kasese District?
2. What is the influenceof social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District?
3. What is the contributionof internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District?

## **Hypotheses of the study**

H0: Compliance Monitoring and Evaluation,Social accountability andInternal Monitoring and Evaluation do not haveany significant effect on the quality-of-health service delivery in KaseseDistrict.

## **Conceptual Framework**

**Independent Variable: Dependent Variable:**

**Monitoring and Evaluation Quality of Health service delivery**

**Compliance Monitoring & Evaluation**

* Output Oriented Budgeting reporting
* Government Annual Performance reporting
* Auditor GeneralNational assessment of performance measures for local Governments

**Social Accountability Monitoring &Evaluation**

* Public Expenditure Tracking surveys
* Public Hearings
* Social Audit
* Citizen Report Cards Community Monitoring Community Score Cards

**Internal Monitoring and Evaluation**

* Technical
* Political
* Availability
* Acceptability
* Accessibility
* Accommodation

**Figure 2:***The conceptual framework shows the relationship between Monitoring and Evaluation and Quality of Health service delivery. Adopted, with modifications, from(Naidoo, 2012).*

## **1.9 Significance of the Study**

1. The study will contribute to the body of knowledge in monitoring and evaluation and more specifically the relationship between Monitoring and Evaluation and quality of health service delivery in local governments in Uganda.
2. The findings of the study will be used to improve the existing M&E arrangements in Kasese District Local Government and indeed other Local Governments in Uganda.

## **Justification of the study**

1. Monitoring and Evaluation can provide unique information about the performance of government policies, programs, and projects of individual ministries and agencies, and of managers and their staff. It can identify what works, what does not, and the reasons why.
2. National M&E arrangements are weak and comprise only a few functional systems at sector level. They are characterized by fragmentation, duplication, weak coordination, and lack of clear results chains, poor definitions, tracking and reporting of outcomes and results, use of different formats and approaches with no common guidelines and standards, lack of national ownership. Inadequate feedback and sharing of results across government and other stakeholders, poor use of data generated, problems related to capacity, resourcing, and M&E efforts are donor driven (GoU, 2010). Despite the importance of monitoring and evaluation but also local governments in health service delivery, very few studies have been carried out on M&E and how it relates to quality-of-health service delivery more so in local governments. The study therefore sought to contribute to bridging the identified knowledge gap.

## **1.11 Scope of the Study**

This section presents the boundaries or limits of the research in terms of the independent and dependent variables (content scope), the study area (geographical scope) and time span of the study (time scope).

### **1.11.1 Content Scope**

The content of the study was limited to; compliance M&E, social accountability M&E and internal M&E and how the three relate to and affect quality of health service delivery in Kasese District Local Government.

### **1.11.2 Time Scope**

The study will cover the period 2016 to 2019. The year 2016 will be chosen because it is the year the National Policy on Public Sector Monitoring and Evaluation, 2016 came into effect and its implementation in Kasese District is 4 years so a study of this magnitude will inform stakeholders on the successes and failures met.

### **1.11.3 Geographical Scope**

The study will be carried out in Kasese District which lies between latitudes 0o 12 South and 0o 26 North and longitudes 29o 42 East and 30o 18 East, with an average altitude of 1100 m-1400 m above sea level. The district has a total area of 3,389.8 square kilometers of which land area is 2911.3 square kilometers (86%). Kasese district boarders with the districts of Kabarole in the North East, Bundibugyo in the North, Democratic Republic of Congo in West Rubirizi in the South. The district headquarters are situated approximately 359 kilometers (223 mi), by road, west of Kampala, the Capital City of Uganda (Kasese District, 2016). Kasese district was chosen for the study because it was one of the first 39 districts to be decentralized under the then Resistance Councils Statute No. 15 of 1993 (Kasese District, 2016) and has participated in all the reforms aimed at improving health service delivery including the introduction of monitoring and evaluation.

# **1.12 Definitionofkey Terms**

**Evaluation**: The systematic and objective assessment of an on-going or completed project, programme or policy aimed at determining the relevance, efficiency, effectiveness, impact and sustainability.

**Monitoring:** The continuing process of data collection to provide management with information on progress and achievement of objectives.

**Quality**: The totality of features and characteristics of a service that bears its ability to satisfy stated or implied needs.

**Service Delivery**: Service delivery is the interaction between providers and clients where the provider offers a service, and the client either finds value or loses value as a result

# **CHAPTER TWO**

# **LITERATURE REVIEW**

## **2.1 Introduction**

This section presents a review of existing literature on role of Monitoring and Evaluation in promoting quality health service delivery in local governments in Uganda using the case of KaseseDistrict Local Government. The New Public Management model was used as an entry point to help understand the role of Monitoring and Evaluation in promoting quality health service delivery in Uganda. Empirical literature provides evidence from past studies related to M&E and quality of health service delivery and the gaps therein.

## **2.2 Theoretical Review**

The study was guided by the New Public Management model as the theoretical basis for understanding quality of health service delivery in Uganda’s Local Governments. The rise of New Public Management (NPM) is one of the most striking international trends in public administration, a paradigmatic break away from the traditional model of public administration(Fakhrul, 2015; Gruening, 2001). The NPM is a bundle of management practices and techniques borrowed from the private sector aimed at enhancing efficiency, productivity, accountability and improved health service delivery(Ojok& Basheka, 2016). NPM calls for a reduction in the exclusive reliance on public bureaucracy for health service delivery to a system that advocates for increased use of the private sector and Non-Governmental Organizations (NGO’s) as alternate mechanisms of health service delivery(Kabuye& Basheka, 2017b; Ojok & Basheka, 2016).

Studies set out the key doctrinal components of the NPM paradigm as follows; Hands-on professional management' in the public sector since accountability requires clear assignment of responsibility for action and not diffusion of power, Explicit standards and measures of performance which entails definition of goals, targets and indicators of success. Greater emphasis on output controls (focus on results rather than procedures) such that resource allocation and rewards are linked to measured performance. Shift to disaggregation of units in the public sector aimed at having manageable units, Shift to greater competition in public sector since rivalry leads to lower costs and better standards, Stress on private sector styles of management practice aimed at use 'proven' private sector management tools in the public sector(Gruening, 2001). Stress on greater discipline and parsimony in resource use so as to 'do more with less' Rhodes (1999), on the other hand argues that the NPM concept has two meanings: one, is the concept of new Managerialism and, two, is the concept of new liberal-institutional economics(Rhodes, 1999).

Managerialism refers to the introduction of private sector entrepreneurial management principles to the public sector. Managerialism means: hands-on professional management, explicit standards and measures of performance; managing by results; value for money management practices; and more recently, closeness to the customer as a focus for health service delivery(Lewiskin, n.d.; Olinga, n.d.; Rhodes, 1999). The new institutional economics, on the other hand, refers to the introduction of incentive structures such as competition, participatory management, and customer care into the public service provision. It stresses desegregating bureaucracies; greater competition through contracting-out; and quasi-markets. Market competition is exemplified by introducing competitive provision of services like contracting-out projects, and non-core activities and programmes to local and international contractors. These services were hitherto being provided by direct labor of public employees in a monopolistic way that was inefficient, uneconomical with no meaningful impact on the citizens’ welfare, and devoid of consumer choice(Rhodes, 1999).

Studies assert that New Public Management was meant to make public services competitive, economic, efficient, effective, value for money oriented, transparent and accountable to the people(Fakhrul, 2015; Gruening, 2001). However, some critics have criticized the New Public Management concept of treating people as “customers” rather than “citizens” as an inappropriate borrowing from the private sector model, which does not have a firm position in the public administration standing. The argument is that because businesses see customers as a means to an end (profit), rather than as the proprietors of government (the owners). In New Public Management, while people are viewed as economic units, in public administration, the same citizens are seen as democratic participants. In fact, they are regarded as owners of government and civil servants and politicians are simply agents and should be subordinate to civilian authorities(Ojok& Basheka, 2016). The other criticism for NPM involves a paradox of centralization through decentralization. Researchers argue that giving public managers more authority to manage programs may result in concentrating decision making in them and hence centralizing decision making rather than encouraging decentralization which NPM emphasizes(Fakhrul, 2015; Mongkol, 2011).

## **2.3 Compliance Monitoring and Evaluation and Quality of Health service delivery**

Kusek&Rist (2004) assert that, as a first step in building an M&E system, developing countries must first have, or establish, a basic foundation— a traditional implementation-focused M&E system(Kusek& Rist, 2004). Traditional implementation-focused M&E systems are designed to address compliance—the “did they do it” question. Did they mobilize the needed inputs? Did they undertake and complete the agreed activities? Did they deliver the intended outputs? Compliance Monitoring and Evaluation (CME) is the form of M&E where the express purpose is to ensure compliance and accountability(Kusek& Rist, 2004). CME is performed by central oversight bodies, each of which assumes responsibility for a particular part of the overarching accountability framework. The CME bodies are characterized by clear guidelines and have the power to sanction, and/or withhold resources and produce results without censorship. They generally have a strong monitoring capability and can insist on upward reporting(Naidoo, 2012).

The presumed effect is that they increase transparency and accountability, and may as a secondary effect improve organizational learning and health service delivery. This form of M&E has a strong judgmental nature, and is linked to punitive measures, which may be in the form of publically showing up performance or more serious sanction which is initiated either by the M&E institution or forums where such M&E results are presented(Naidoo, 2012). If M&E is mandated primarily for accountability (did the organization spend its funds wisely in pursuit of organizational goals?) then the best place for the M&E function may be outside the primary organization(Kusek& Rist, 2004).

### **2.3.1 Output Oriented Budgeting Reporting and Quality of Health service delivery**

For a brief period in the late 1980s and early 1990s, the New Zealand public sector was widely seen at the forefront of reforming public financial management. There were several reforms, but “Output budgeting” was undoubtedly one of the more innovative ones and it remains a core element of the New Zealand budget process 15 years on(Webber, 2006). Proponents of Output Oriented Budgeting (OBB) claim benefits over an input system stating that if government knows the full cost of outputs; it is then able to set targets; and is able to compare the cost-effectiveness of alternatives and consequently help governments to improve health service delivery, service quality and decision making(Vatjanapukka, n.d.).

Experience to date has also shown that politicians are beginning to question 25 the rationale of implementing certain activities as opposed to focusing on just inputs as was the case in the past (Lencucha et al., 2020). The limitation of OBB is that budgets focusing on outputs obscure the importance of outcomes(Lencucha et al., 2020). It is difficult to assign input costs to outputs and it is normally impossible to assign output costs to outcomes. A study by Carlin and Guthrie (2008) also indicated that in practice, the OBB documents in Queensland and New Zealand provided less useful information than traditional input-based budgets.

Additionally, Guthrie and Carlin (2009) argued that, there was no reason to expect that a change in the format and content of external budget documents would lead to improvement in health service delivery without shift in internal management(Carlin & Guthrie, 2009). In Uganda, the Ministry of Finance, Planning and Economic Development introduced the concept of results into the MTEF process in 1998 with the introduction of Output Oriented Budgeting (OOB), on a sector basis. Sector expenditure decisions are supposed to be justified in terms of past performance, and expenditure levels in terms of the specific outputs they intend to achieve. Overall, the application o(Williamson et al., 2003)f results-based frameworks within local governments appears more widespread although this does not necessarily translate into better local government performance across the board(Williamson et al., 2003).

### **2.3.2 Government Annual Performance reporting and Quality of Health service delivery**

Due to its mandate as leader of government business, the Office of the Prime Minister (OPM) produces the Government Annual Performance Report, which reports on performance of Government entities. The Government Annual Performance Report (GAPR) provides a comprehensive assessment of Government‘s performance and the results of public spending of 26 the Financial Year. The Report focuses on the performance of Ministries, Departments and Agencies (MDAs) and Local Governments (LGs) against output targets across all Sectors of Government and progress made in the implementation of key actions agreed during the last Government performance retreats (OPM, 2016).

The aim of the report is to provide a basis for accountability of the use of resources and the results achieved; to provide a basis for policy discussions within Government and to guide decisions on resource allocations in the Financial Year. The annual performance reports are important particularly in identifying deficits with the view to enhancing health service delivery. The review focuses on what has been achieved against what was planned and what difference this has made in terms of improvements in public health service delivery (OPM, 2016).

### **2.3.3 Auditor General’s report and Quality of Health service delivery**

The Office of the Auditor-General, also known as the Supreme Audit Institution of Uganda, was created by Article 163 of the 1995 Constitution and the National Audit Act, 2008 to act on behalf of the citizens of Uganda, in providing an independent assurance on the use of public resources (OAG, 2016). The Office of the Auditor General audits accounts of every local government and administrative unit on an annual basis and reports directly to Parliament another key entity in the accountability framework.

Also, important to note is that Parliamentary Committees such as the Public Account Committee (PAC), Committee on Statutory Authorities and State Enterprises (COSASE) and Local Government Accounts Committee do most of the work of Parliament. These provides oversight over local government accounts including summoning of local government officials to account for deficiencies in the Auditor General’s reports(Parliamentarian, n.d.; Mongkol, 2011; Ojok & Basheka, 2016; Olum, 2004). Audit reports on the performance of the government provides opportunity to the legislators, public servants, investors, business leaders, citizen groups, media, development agencies, academicians and other stakeholders to know how public funds are spent and to assess the quality of public administration. This allows public scrutiny of Government operations and generates pressure for honest and productive public servants and facilitates an accountable system of governance necessary for efficient health service delivery (OAG, 2016).

The CME institutions are external to local governments, protected by the Constitution or Acts of Parliament or both which allow them to insist on the provision of information, and are able to punish, through withholding resources or public admonishment, entities that do not comply. The cumulative impact of these CME players is the generation of a compliance culture(Naidoo, 2012). The focus of the work of these CME institutions therefore is to see whether there is accountability for resources allocated, and in this regard, there tends to be a bias towards assessing how financial resources, are used. The M&E efforts are seen as largely ensuring accountability, and driving compliance, which means that learning may be secondary. The thrust is external, and while the efforts may produce higher levels of transparency and greater amounts of performance information, this is more an outcome of the accountability drive than the main purpose of this type of M&E(Naidoo, 2012).

### **2.3.4 National assessment of minimum conditions and performance measures for local governments and Quality ofhealth service delivery**

In Uganda, the most comprehensive and systematic process of monitoring the performance of local governments is undertaken by the Ministry of Local Government. The Ministry undertakes an annual national assessment of minimum conditions and performance measures for local governments. The results from the assessment of minimum requirements are used to determine the local governments’ ability to access Conditional Grants especially the Local Development Grant and Capacity Building Grant. Generally the nature of local government assessment done by the centre in recent years focuses mainly on financial management particularly to determine LGs ability to access conditional grants (Tumushabe et al., 2013.; Wandera, 2014). However, performance monitoring and accountability to achieve effective delivery of public service and deepen governance must go beyond financial management.

Local governments (particularly district councils, the chairperson, speaker and councilors) should also be assessed on governance issues – political leadership, legislation, supervision of lower local governments (oversight), representation role, inter-local government exchange visits/collaboration, participation in communal and development projects(Tumushabe et al., 2013.; Wandera, 2014). A study conducted on the contribution of Uganda National Local Government Performance Assessments to improved health service delivery established that National Annual Assessments have helped local governments in performance monitoring, compliance with guidelines, capacity building, accountability, and resource mobilization. However, the shortcomings of the assessment lie in its focus on processes as opposed to outcomes or impact. The assessment also emphasizes compliance with standards mainly in terms of documentation and reporting rather than on the quality-of-health health service delivery (Kugonza, Namara, & Lwanga, 2012).

## **2.4 Social Accountability Monitoring and Evaluation and Quality of Health service delivery**

Social accountability Monitoring and Evaluation (SME) has emerged as an important weapon in the fight for better governance and healthservice delivery (World Bank, 2003). Social accountability examines performance from the lens of citizens, with the M&E imperative focusing on the social outcomes and impact of the work of the government(Naidoo, 2012). Social accountability includes a “broad range of actions and mechanisms” that can be used to hold government officials accountable to the citizens.

Traditional accountability relationships rely on top-down or external donor-driven monitoring of service providers and very often they fail(*World Development Report 2004*, n.d.). The World Bank (2004) argues that as a complementary strategy, social accountability strengthens citizens-clients to monitor and exert accountability. However, for social accountability to happen and therefore contribute to improvement in health service delivery, citizens must have reliable information on their entitlements and the performance of services, and they must be able to take actions based on that information to demand accountability(*World Development Report 2004*, n.d.). Accountability, and related transparency, comes from two quite different ideological streams(Haque, n.d.). On the one hand, New Public Management (NPM), which emerged in the 1990s, emphasized the use of market mechanisms in the public sector to make managers and providers more responsive and accountable.

On the other hand, and at the same time, the failure of democratic institutions to deliver for the poor also resulted in calls for deepening democracy through the direct participation of citizens in governance. Accountability took root as a central theme in debates after the World Bank’s, ground breaking report, “World Development Report 2004: Making Services Work for Poor People”, which identified failures in healthservice delivery squarely as failures in accountability relationships. By showing how the ‘long route’ of accountability via elected politicians and public officials through to providers was failing the poor, the report argued in favor of strengthening the ‘short route’ which involves direct accountability between users and providers(*World Development Report 2004*, n.d.). Achieving better services therefore requires improved governance, voice, and accountability(*World Development Report 2004*, n.d.). Add that, efforts by governments, donors, and civil society alike to improve governance, accountability, and development results on the ground have heightened attention to the idea that citizens can contribute to better public services by holding their policy 30 makers, providers, and program managers accountable.

Within the development community, interest in the potential for citizens to hold service providers accountable is closely linked with an increased focus on governance and its role in achieving better health service delivery(Ringold et al., 2011). A related development has been the recognition that civil society organizations (CSOs) can be important in the delivery of social services and in social accountability. Their participation may include initiating campaigns to inform citizens about their rights and what services they are entitled to, performing third-party monitoring through processes such as social audits, and conducting analyses. They may undertake analysis such as public expenditure tracking surveys (PETS) to “follow the money” from central government budgets through to service providers, or absenteeism surveys to monitor attendance of providers(Ringold et al., 2011).

Early social accountability initiatives aimed to improve the efficiency of health service delivery included citizen report cards and scorecards, community monitoring, participatory planning tools and social audits. The new social accountability mechanisms include participatory budgeting, public expenditure tracking, gender budgeting, citizen juries and other forms of public hearings, participatory monitoring of donor commitments to advance the MDGs and reporting to international treaty-monitoring bodies (UNDP, 2013). Support for social accountability mechanisms in rural Sub-Saharan Africa has increased over the past decade and is becoming firmly anchored in government policies and donor and NGO strategies largely due to its contribution to improving public service provision, increasing local participation in democratic governance and holding states accountable(Cold-Ravnkilde& Hansen, 2013). UNDP (2013) asserts that social accountability has contributed to improved budget utilization, exposure of government failure and corruption; facilitated links between citizens and local governments in the context of decentralization but also constructed new democratic spaces for political engagement and ensured that existing spaces are used to the best possible effect.

Social accountability initiatives have on the whole enhanced development outcomes by strengthening links between governments and citizens thereby improving the efficiency of public health service delivery (UNDP, 2013). Social accountability mechanisms can be affected using a number of tools as detailed below;

### **2.4.1 Public Expenditure Tracking Surveys (PETS)**

Pioneered in Uganda in 1996 to track the amount budgeted for schools and clinics(Reinikka& Ablo, 1999), Public Expenditure Tracking Survey (PETS) is a quantitative survey that tracks the flow of public funds to determine the extent to which resources actually reach the target groups. The unit of observation is typically a service facility rather than a household or an enterprise.

The survey collects information on transfer procedures, amounts and timing of released resources. When used along with qualitative surveys on consumer perception of health service delivery, PETS can be very influential in highlighting the use and abuse of public money(*World Development Report 2004*, n.d.). In a survey of PETS in Africa Gauthier (2006) notes that in almost all cases, they have highlighted the leakage of resources reaching facility levels. In Malawi, PETS survey information was used to successfully resist the closure of teacher training colleges, get teacher salaries paid on time and to make budget allocations for students with special needs whereas in Tanzania PETS carried out for health and education spending over two periods (1999 and 2001) suggest that corruption has reduced considerably(Arinaitwe et al., 2015). In Uganda, Public Expenditure Tracking Surveys are a model for participatory expenditure tracking.

A public expenditure tracking survey (PETS) to gauge the extent to which public resources actually filtered down to the schools showed that in the mid-1990s, the average school received only around 20% of central government spending on the program. Most 32 schools received nothing and the bulk of the grants was captured by local government officials (and politicians) in charge of disbursing the grant to the schools(Arinaitwe et al., 2015; Reinikka & Ablo, 1999). A follow up PETS carried out in 2002 found that the average school received more than 80% of its entitlement in 2001. Even more significant, while the median school received nothing in the mid-1990s, it received 82% of its entitlement in 2001. The change in fortunes was attributed to a newspaper campaign aimed at providing information on disbursement of funds to school in response to the problems identified in the first PETS. These findings resonate with an argument by Reinikka&Svensson, (2004) that public access to information can be a powerful deterrent to capture of funds at the local level.

### **2.4.2 Public Hearings**

Public hearings are formal meetings at the community level where local officials and citizens have the opportunity to exchange information and opinions on community affairs. These meetings are open to the general public and are therefore an important tool for citizens to raise their concerns in front of elected officials and bureaucrats. On the one hand, public hearings enable officials to obtain important feedback but also to gain a better understanding of the citizens’ views and experiences (*World Development Report 2004*, n.d.). In India, the NGO Mazdoor Kisaan Shakti Sangathana (MKSS) pioneered the strategy of using jansunways (public hearings) to hold public officials accountable for local level implementation of programmes. Jan sunways operate by first gathering information about budgets and expenditure in public programmes and presenting and verifying these in a public gathering at which all relevant stakeholders - public officials, elected leaders, private contractors and workers - are present. These early public hearings had significant impact in exposing corruption in public works programmes, and in some instances even getting public officials to return the money that they had misappropriated. Relatedly, a grassroots Delhi 33 organizations called Parivartan has also held public hearings on the implementation of the Public Distribution System (PDS), a large food subsidy programme intended for the poor. The depth of corruption exposed through the process led to improvements in the operation of PDS as well as institutionalization of a system of monthly ‘opening of the books’ for public scrutiny (Pande, S., 2008).

In Uganda, the Baraza initiative was introduced by the Government of Uganda in 2009, following a Presidential directive, as a means of strengthening governance and downward accountability within the public sector and ensuring that there is adequate space for the ordinary citizens to participate in planning, monitoring and demanding for accountability of the use of public resources in the delivery of services at Local Government level. The initiative brings together; Government (policy makers), public service providers and public service users to share relevant public information and develop corrective strategies to outstanding challenges / issues that affect their livelihood (OPM, 2014a). The Baraza initiative is hailed for increasing demand driven health service delivery, financial accountability and public participation in budgeting and providing adequate space for the ordinary citizens to participate in planning and monitoring of Government services in their local communities (Labeja, 2014).

### **2.4.3 Social Audit**

Since the 1950s, the concept of Social Audit has evolved from a corporate management tool to its present form as a means of feedback and participation for increased state accountability and transparency(Fakhrul, 2015; Mongkol, 2011). A Social Audit, also referred to as Social Accounting, is a process that collects information on the resources of an organization. The information is analyzed and shared publicly in a participatory manner. Although the term “Audit” is used, the central concern of a social audit is how resources are used to meet social objectives. Social Auditing therefore goes beyond just examining costs and finance (*World Development Report 2004*, n.d.). A social audit 34 usually records and interprets the experience of the clients or citizens the organizational entity is meant to service. A study conducted in Andhra Pradesh, India (where the state has taken a lead in institutionalizing social audits) found that social audits had led to a statistically significant increase in employment generated, as well as an increase in the exposure of corruption within the Public Distribution System (PDS), a large food subsidy programme intended for the poor, and a significant amount of programme funds being recovered(Arinaitwe et al., 2015).

### **2.4.4 Citizen Report Cards (CRCs)**

The use of citizen report cards, as performance monitoring and feedback mechanisms, has also gained currency since the late 1990s. Citizen report cards evaluate different service providers from a user perspective and thereby make the service providers more accountable to the citizen (Ahmad, 2008). Citizen Report Cards (CRCs) are participatory surveys that solicit user feedback on the performance of public services. CRCs can significantly enhance public accountability through the extensive media coverage and civil society advocacy that accompanies the process. Citizen Report Cards are used in situations where demand side data, such as user perceptions on quality and satisfaction with public services is absent. By systematically gathering and disseminating public feedback, CRCs serve as a “surrogate for competition” for state-owned monopolies that lack the incentive to be as responsive as private enterprises to their client’s needs. They are a useful medium through which citizens can credibly and collectively ‘signal’ to agencies about their performance and advocate for change (World Bank, 2006). In a rigorous impact study of a community-based monitoring program of health services in Uganda, Björkman and Svensson (2009) found clear evidence that community-based 35 monitoring increased both the quality and quantity of primary health-care provision and resulted in significantly improved health outcomes. Relatedly, a local Non-Governmental Organization, Advocates Coalition for Development and Environment (ACODE) has since 2009 been implementing the Local Government Councils’ Score-card Initiative (LGCSCI) in partnership with the Uganda Local Governments Association (ULGA). The purpose of the initiative is to strengthen citizens’ demand for good governance and effectiveness in the delivery of public services, as well as boosting the professionalization and performance of local government councilors (Muyomba, Luba, &Ssempala, 2013). The underlying theory of change is that if citizens are informed about the performance of their councils and councilors, their demand for effectiveness in the delivery of public services would be channeled upwards through the local government councils system creating an upward spiral of demand for accountability and better governance up to the national level(Kim, n.d.; Tumushabe et al., n.d.; Wandera, n.d.).

### **2.4.5 Community Monitoring**

The focus of Community monitoring is to monitor ongoing activities of public agencies as opposed to rating outcomes which is the central theme of CRCs. More often than not, community monitoring is focused on observable features of ongoing activities and is aimed at ensuring that performance meets standards for example teacher attendance, quality of construction in facilities or appropriate procedures being followed(Baguma, 2017). Community monitoring can often improve the quality of services. In an experiment in Uganda, we found that when local NGOs encouraged communities to engage with local health services, they were more likely to monitor providers(Cold-Ravnkilde& Hansen, 2013; Kyarimpa, 2009; Ricketts & Goldsmith, 2005). As a result, provider absenteeism declined and responsiveness increased in terms of 36 shorter waiting times and greater efforts to respond to community needs. Usage of public health services also increased, and was reflected in better health outcomes such as reduced child mortality.

### **2.4.6 Community Score Cards (CSCs)**

Community Score Cards (CSCs) are also increasingly being used by several groups to assess the performance of local public services. CSCs are a hybrid of Community Report Cards (CRCs), community monitoring and social audits. Besides assessing levels of service satisfaction by users, a CSC process involves community meetings in which performance of public services is discussed among providers, users and other stakeholders and includes self-evaluation of performance by providers, as well as the formulation of an action plan based on scorecard outputs. A key feature distinguishing CSCs is the collective engagement of both providers and users in designing and using the cards(Joshi, 2013). The use of CSCs in primary health care services in Andhra Pradesh, India found stark discrepancies between self-evaluation by providers and the evaluation of providers by communities. Subsequently an action plan was developed by both provider and users. Providers agreed to undergo training to improve their interactions with users, to change timings of the health centre to better meet community needs, to institutionalize a better grievance redress system and to publicly display medicine stocks. The result of the engagement process was increased user satisfaction and better understanding of the constraints providers face. References to social accountability as demand-side interventions can be misleading, as they require cooperation with the supply side at various levels of government. For example, scorecards require effective interactions between citizens and frontline service providers and program managers(Joshi, 2013; Ringold et al., 2011).

## **2.5 Internal Monitoring and Evaluation and Quality of health service delivery**

Monitoring and evaluation (M&E) is still too often used, albeit narrowly, as an approach to account for the results achieved by development projects or programmes rather than for reflection and learning. When used for learning purposes, M&E can help project managers and team members to improve project performance thereby delivering better services to beneficiaries (Baguma, 2017; Naidoo, 2012).

It is to this end that Internal Monitoring and Evaluation (IME) is geared towards. The importance of learning in and by organizations has long been recognized by organization scientists. Over the last two decades interest in organizational learning has been growing, as evidenced by a continuously increasing output in journals and books and an increasing number of reviews of the field (Baguma, 2017; Naidoo, 2012). Over the last 15 years learning in public sector organizations (PSOs) increasingly has received attention following previous emphasis within business organizations(Baguma, 2017; Naidoo, 2012).

The change in attention has largely been driven by trends towards reinventing government and New Public Management. The adoption of NPM practices meant that PSOs now increasingly face public and political pressures to become more efficient and effective in health service deliverywhile being transparent and accountable in their administrative processes(Baguma, 2017.; Fakhrul, 2015; Naidoo, 2012). In order to adapt to this wave of change, PSOs have increasingly incorporated learning in their business processes, researchers agree that performance information should be used to bring about critical self-reflection and learning from mistakes rather than apportioning blame.

Evaluation therefore presents opportunities for improving organizational learning. Learning comes about only when there is communication based on self-reflection and dialogue (Baguma, 2017.; Fakhrul, 2015; Naidoo, 2012). The use of M&E therefore would tend to emphasize the “learning” or information aspect.

## **2.6 Summary of the Literature Review**

Countries the world over have been grappling with the challenge of increasing efficiency and effectiveness in the delivery of services. The above state of affairs has been attributed, to among others, to weak M&E systems. Governments and other stakeholders have been responding to this state of affairs through institutionalization of M&E to address health service delivery gaps. Governments have also increased transparency initiatives; increased engagement of stakeholders in monitoring health service delivery; strengthened accountability relationships, and is working towards building a performance culture in government.

Despite the efforts, little progress has been made in health service delivery. From the review of literature, a number of studies have been undertaken to understand the effectiveness of Public Sector M&E in Uganda. However, none of these has focused on the role of M&E in enhancing quality health service delivery in Local Governments. The study sought to contribute to addressing this knowledge gap using the case of Kasese District Local Government.

# **CHAPTER THREE**

# **METHODOLOGY**

## **3.1. Introduction**

This chapter presents the methodology that will be used during the study. It includes; research design, study population, sample size determination and selection, sampling techniques and procedures, data collection methods, data collection instruments, quality control, data collection and analysismeasurement of variables and finally the steps which were considered in ensuring reliability and validity the study instruments.

## **3.2 Research Design**

This study will use a cross-sectional and correlation research study designs. A cross sectional study is used to gather data from a sample of a particular population at a time(Setia, 2016). Correlation is aimed at determining whether and to what degree a relationship exists between two or more variables(Njoki et al., 2019; Setia, 2016). The study will employ a mixed-methods approach where both qualitative and quantitative approaches to data collection will be used. Using both qualitative and quantitative methods is advantageous because both methods supplement each other in those qualitative methods provide in-depth explanations while quantitative methods provide the data needed to test hypotheses.

## **3.3 Study Population**

The study population involved all the key players in the health service delivery framework who include; staff at Kasese District Local Government headquarters, elected leaders who from the District Executive Committee (policy makers/ politicians) and the citizens of Kasese District.

## **3.4 Determination of the Sample size**

The sample size of the participants will be calculated using the Leslie Kish formula (Kish, 1965).Following the prevalence of Mpigi local district in a study conducted on M&E in Uganda(Moses, 2018). The prevalence of employees was found to be 20%(Moses, 2018). This study assumed the same prevalence for with a 95% confidence level and ±5% precision. The resulting sample size was calculated using Kish’s formula as follows. The purpose of this sample size is to enable us choose participants who are eligible for the research.

n = Z**2**pq

e**2**

Where:

*p*= proportion of the population with characteristics under the study =20/100=0.2;

*q*= 1-p = 1-0.2= 0.8;

e = Random Sampling error = 0.05; and

Z=statistics of normal distribution = 1.96.

Since pq=0.2 x 0.8 = 0.16,

n=0.16 x (1.96) **2**

(0.05) **2**

This gives n= 246

Thus, the sample size of the study is 246 participants.

**Table 3.1: Categories of Respondents and their Totals:**

|  |  |  |  |
| --- | --- | --- | --- |
| Category of Respondents | Population | Sample size | Sampling Technique |
| Staff at Kasese District Local Government headquarters | 20 | 19 | Purposive |
| Leaders who from the District Executive Committee | 15 | 14 | Purposive |
| Local community of Kasese District | 420 | 213 | Simple random |
| Total | 455 | 246 |  |

**Source: *The Kasese District Local Government Staff Database (2020/21)***

## **3.5 Sampling Techniques and Procedure**

The study will employ purposive and simple random sampling methods to choose participants for this research. Purposive sampling technique was used to obtain expert opinions for the study. The technique was used since purposive sampling involves identifying and selecting individuals or groups of individuals that were knowledgeable about or experienced with a phenomenon of interest(Krejcie & Morgan, 1970; Morra Imas & Rist, 2009). Simple random sampling wasused to boost the credibility to a sample involving many individuals. A simple random sample is a subset of a statistical population in which each member of the subset has an equal probability of being chosen(Hayes, n.d.).

## **3.6 Data Collection Methods**

In this study, primary data will be collected using questionnaires, and interview guide. While secondary data will be collected though documentary review.

### **3.6.1 Questionnaire Survey**

The questionnaire method will be used to ask subjective questions within a short time. A questionnaire as a form consisting of interrelated questions prepared by a researcher about a research problem under investigation(Bolarinwa, 2016). The questionnaire survey will be used to obtain information and opinions/perceptions of the respondents to questions relating to both the independent and dependent variables but also to explain relationships between the study variables.

### **3.6.2 Documentary Review**

The researcher will also acquire some of the necessary information through documentary review. Information obtained from documents will include; The Second National Development Plan (NDP II) 2015/16-2019/20, the Kasese District Development Plan 2015/16- 2019/20, National Policy on Public Sector Monitoring and Evaluation (2019) and Government Annual Performance Reports among other documents. Documentary review will provide information on the health service delivery legal and institutional framework, policies in place, health service delivery trends and past efforts in improving health service delivery.

## **3.6.3 Interviewing**

Key Informant Interviews will be used to get in-depth understanding of the study variables from the perspective of the respondents. Saunders, et.al. (2009) defines an interview as a purposeful discussion between two or more people(Saunders et al., 2009). This method of collecting data involves presentation of oral –stimuli and replies in terms of oral verbal responses (Kothari, 2004). This method is preferred because of flexibility in terms of adapting, adopting, and changing the questions as the researcher proceeds with the interview(Sekaran & Bougie, 2016). Interviewing will serve the purpose of obtaining detailed qualitative data and information to explain the findings of the questionnaire survey.

## **3.7 Data Collection Instruments**

The study will use Questionnaires, a documentary review checklist and Key Informant Interview guide for data collection.

### **3.7.1 Questionnaires**

Self-administered questionnaires will be employed for the study. The respondents will be asked subjective questions to know their opinions/attitudes. The Likert scale (5 point) will be used because of its ability to measure attitudes. The questionnaire will have different sections of questions. The questions will include; background Information about the respondents, perception on Mandatory Monitoring and Evaluation. Social Accountability Monitoring and Evaluation, internal monitoring and evaluation, Health service delivery.

### **3.7.2 Key Informant Interview guide**

The guide will have fivesections, which include a section for each of the three independent variable dimensions, one section for the dependent variable and one section for M&E challenges and proposed solutions. The key Informant Interview guide will also be used to probe the respondents since they have the knowledge and information required for the current study.

## **3.8 Validity and Reliability**

### **3.8.1 Validity**

Validity is the most important criterion and indicates the degree to which an instrument measures what it is supposed to measure(Kothari, 2004). Validity is the most important because inferences cannot be made from data that has been collected with instruments not serving the purpose for which the instruments are intended(Aila & Ombok, 2015; Kothari, 2004; Saunders et al., 2009). Of the three measures of validity (face, content, construct), the study will only focus on content validity. Face validity is important when little on nothing is known about the variable being measured whereas construct validity is important if the investigator believes the instrument reflects a particular construct to which are attached certain meanings which isn’t the case for this study.

Content Validity Index (CVI) is determined by expert judgment. Each of the items in the data collection instruments will be subjected to expert judgment by three experts and the Content Validity Index computed was 0.8 using the formula below; CVI = Number of items declared valid Total number of items According to Amin (2005), for an instrument to be valid, the Content Validity Index should be between 0.7 and 1.0.

### **3.8.2 Reliability**

Reliability on the other hand is concerned with the ability of an instrument to measure consistently. The reliability of an instrument is closely associated with its validity. An instrument cannot be valid unless it is reliable. Reliability of the instruments was measured by Cronbach’s coefficient alpha (𝛼) since items were scored using the Likert scale, which has five different possible responses.

According to Amin (2005), Cronbach’s coefficient alpha is used when items are not scored dichotomously. The Cronbach’s coefficient alpha of 0.929 was obtained during pretesting using the formula (in built in IBM ® SPSS ® Statistics Version 23) below; 𝛼 = 𝑛𝑛 − 1 (1 − ∑ 𝑉𝑖𝑉𝑡) Where; n is the number of items 𝑽𝒕 is the variance of the test scores 𝑽𝒊 is the variance of the item scores after weighting (Cronbach, 1951).

## **3.9 Procedure of Data Collection**

Prior to study initiation, study procedures will be sent to Nkumba University Research Ethics Committee and Uganda National Council of Science and Technology (UNCST) for approval. The study will also seek a clearance and recommendation letter from the Dean of the School of Social Sciences. All these approvals will be availed to the relevant authorities at Kasese District Local Government.

## **3.10 Data Analysis**

Both qualitative and quantitative data analysis techniques will be used in this research.

### **3.10.1 Quantitative Data Analysis**

A data entry screen will be developed using EPI-Info version 16.0 and thereafter data entered. Data cleaning will be done using excel file to check for completeness and consistency of the dataset. Using SPSS 19, descriptive statistics (such as mean, median, mode, range, variance, standard deviation) aiming at describing and summarizing the data in a meaningful way and inferential statistics (hypothesis testing, correlation, regression) aiming at establishing relationships, drawing conclusions and generalizations on the population.

### **3.10.2 Qualitative Data Analysis**

Qualitative data will be obtained from key informant interviews and documentary review on the other hand will be organized by identifying and differentiating between the questions the study sought to answer from those that are simply included in the interview guide.

The researcher will use Dedoose a mixed methods data management computer web application software program(*Home | Dedoose*, n.d.)To analyze the qualitative data which will then be repeatedly sorted and reviewed to identify a broader set of concepts? The categories are constructed from this, more general set of concepts through assignments descriptive labels, formulation of operational definitions and selection of illustrative citations from the data. Once the categories are placed, they will form a basis for comparative analysis across phases and the intervention to identify similarities and differences in interview responses.

# **CHAPTER FOUR**

# **PRESENTATION, INTERPRETATION AND DISCUSSION OF FINDINGS**

# **4.1Introduction**

This chapter presents findings of the study which was conducted to investigate the role of Monitoring and Evaluation in quality health service delivery in Local Governments in Uganda using the case of Kasese District Local Government. The study established the effect of compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District, effect of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District and the the effect of internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District. This chapter starts by explaining the response rate as indicated below.

# **4.2Response rate**

Table 4. 1: Showing the response rate

|  |  |  |  |
| --- | --- | --- | --- |
| Respondents | Sample size | Frequency | Percentage |
| Staff at Kasese District Local Government headquarters | 19 | 19 | 100% |
| Leaders who from the District Executive Committee | 14 | 14 | 100% |
| Citizens of Kasese District | 201 | 201 | 100% |
| Total | 234 | 234 | **100** |

**Source*: Field Data, 2021***

201 questionnaires were administered and 100% were returned. On the side of interviews, 33 interviews were conducted which equalled to 100%. On overall, 100% managed to reply. This response rate of 100% deemed good because it was over and above the 70% recommended by (Kabir, 2017)

* 1. **Background of the Respondents**

This study asked respondents to respond about their gender, age, education level, and time they had taken working with the institute. These are illustrated below.

Table 4. 2: Gender of the respondents

|  |  |  |  |
| --- | --- | --- | --- |
|  | | N | Percent |
| Valid | Male | 98 | 48.8 |
| Female | 103 | 51.2 |
| Total | 201 | 100.0 |

**Source*: Field data, 2021***

Majority of respondents in the study were females constituting 51%. Males on the other hand, constituted 49% of the respondents. The implication of this finding was that no matter the disparity in percentage of males and females who attended the study, at least views of both males and females were captured which is too vital in making a critical analysis the role of monitoring and evaluation in quality health service delivery in local governments: a case study of Kasese district, Uganda.

Table 4. 3: Age of the respondents

|  |  |  |  |
| --- | --- | --- | --- |
|  | | N | Percent |
| Valid | 20-29 | 59 | 29.4 |
| 30-39 | 81 | 40.3 |
| 40-49 | 42 | 20.9 |
| 50- above | 19 | 9.5 |
| Total | 201 | 100.0 |

**Source*: Field data, 2021***

The study findings above with the distribution statistics offer an implication from this finding is since the majority of respondents were aged 30 years and above, they were expected to have enough knowledge regarding the role of monitoring and evaluation in quality health service delivery in local governments: a case study of Kasese district, Uganda.

Figure 1: Level of education of the respondents

**Source*: Field data, 2021***

The Majority staff among Kasese District officials had attained a degree (25%). 47% had a Master’s degree and those with other levels of education took 22%%. PHD level of education took 6%. Basing on the above findings, given the fact that the study was conducted amongeducated respondents, this provides a balanced perspective required by the study as per the mental and cognitive capacity of the respondents.

Figure 2: Years Worked with Kasese district.

**Source*: Field data, 2021***

Figure 4.3 above indicates that various respondents had been working with Kasese district for over 1-3 years and these amounted to 55%. 19% had been working with Kasese district for 4-6 years and 6% of the respondents had been at with Kasese district 7-10 years. 20% represented those working for less than 1 year. This thus implies that as per the number of years most respondents had the required experience to inform the study.

# **4.4. Descriptive Analysis**

Study findings were thus obtained on effect of compliance Monitoring and Evaluation, social accountability Monitoring and Evaluation and internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District.

# **4.4.1 Findings on the effect of compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District.**

To assess the effect of compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District., the responses were interpreted basing on the 5-likert scale typing employed in the study, where SD meant Strongly Disagree, D meant Disagree, N meant Neutral, A meant Agree and SA meant Strongly Agree. Table below has more details.

**Table 4. 4: Descriptive Statistics on the effect of compliance Monitoring and Evaluation on** **quality-of-health service delivery in Kasese District.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | N | SD | D | NS | A | SA | M | STD |
| The prepared performance reports add value to the district work operation during benchmarking exercises | 201 | 1%(3) | 1%(3) | 11%(22) | 55%(111) | 32%(62) | 4.12 | 0.774 |
| The Quarterly performance reports required by the Ministry of Finance, Planning and Economic Development aid in better management our budgets. | 201 | 1%(3) | 2%(4) | 7%(15) | 68%(136) | 22%(44) | 4.07 | 0.678 |
| There is value by the Office of the Resident District Commissioner | 201 | 2%(5) | 2%(5) | 6%(13) | 62%(125) | 28%(53) | 4.07 | 0.806 |
| Efforts by the Inspector General of Government are useful in deterring to staff to committing fraud. | 201 | 2%(5) | 4%(9) | 14%(28) | 48%(96) | 32%(63) | 4.01 | 0.927 |
| District management has prepared work plans, budgets and reports in accordance with the Public Finance Management Act | 201 | 0% | 2%(5) | 29%(59) | 47%(94) | 22%(43) | 3.87 | 0.770 |
| There is value in Auditor General efforts in promoting Accountability in the District | 201 | 1%(3) | 7%(14) | 29%(59) | 50%(101) | 13%(25) | 3.66 | 0.822 |
| Total Average mean and SD |  |  |  |  |  |  | 3.96 | ?0.796 |

**Source*: Field Data, 2021;*** where SD meant Strongly Disagree, D meant Disagree, N meant Neutral, A meant Agree and SA meant Strongly Agree, M meant Mean and STD meant Standard Deviation

The results above revealed that effect of compliance Monitoring and Evaluation is highon quality-of-health service delivery in Kasese District. This is because above 50% of statements were either agreed or strongly agreed on many of respondents with means above the total average mean of 3.96 and standard deviation of 0.796. Among the items that confirmed this claim included; the prepared performance reports add value to the district work operation during benchmarking exercises with a mean of (4.12) this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that prepared performance reports add value to the district work operation during benchmarking exercises which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service delivery, the Quarterly performance reports required by the Ministry of Finance, Planning and Economic Development aid in better management our budgets with a mean of (4.07)this implies that the majority of respondents who answered this attributewere in approval or strongly agreed that Quarterly performance reports required by the Ministry of Finance, Planning and Economic Development aid in better management our budgets which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service delivery, there is value by the Office of the Resident District Commissioner with a mean of (4.07) this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that there is value by the Office of the Resident District Commissioner which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service deliveryand efforts by the Inspector General of Government are useful in deterring to staff to committing fraud with a mean (4.01)this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that efforts by the Inspector General of Government are useful in deterring to staff to committing fraud which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service delivery

The above statements reflect that the effect of compliance Monitoring and Evaluation is high on quality-of-health service delivery in Kasese District. At Kasese districtprepared performance reports add value to the district work operation during benchmarking exercises, the District Local Government adheres to approved work plans and budgetsand theQuarterly performance reports required by the Ministry of Finance, Planning and Economic Development help us to better manage our budgets.

On the other hand, some of the items seemed to indicate that the effect of compliance Monitoring and Evaluation was not convincing and below the total average mean of 3.96 and these included; the district management has prepared work plans, budgets and reports in accordance with the Public Finance Management Act with a mean (3.87)this implies that the majority of respondents who answered this attribute were not in approval or did not agreed that the district management has prepared work plans, budgets and reports in accordance with the Public Finance Management Act which clearly is an indication that needs to be worked upon by the Kasese District Local Government to enhance quality health service delivery, there is value in Auditor General efforts in promoting Accountability in the District with a mean of (3.66) this implies that the majority of respondents who answered this attribute were not in approval or did not agreed that there is value in Auditor General efforts in promoting Accountability in the District which clearly is an indication that needs to be worked upon by the Kasese District Local Government to enhance quality health service delivery. These meant that the district needs to do some work on the above aspects. These threaten the effect of compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District.

**Findings from in-depth Interviews**

Interviewees opined that at Kasese District, that compliance Monitoring and Evaluation is hugely appreciated. One of the interviewees explained that: “*Our employees value compliance Monitoring and Evaluation because it is very cardinal in aidingtheachievement the desired outcomesand sense of accountability, service delivery of health services in the district…”*

The above quotation tells us that Kasese District, through the compliance Monitoring and Evaluation function is taken seriously for the community development need, in the service delivery programmes of the district so that the citizens receive services as expected.

One of them added: “*this strategy has been worked upon very well as this is critical in proper planning and management of the available resources as this is very vital for accountability of resources …”*

Another key informant added “*Kasese District has been very much different because from beginning of every month employees are informed of the auditing which will be needed and done thus, they are cognizant of this concept and uphold it very well…”*

The above findings from primary research tools were generally in congruent with the data obtained from the documents reviewed. The above findings show that District local government has a good yardstick in drawing effort for compliance Monitoring and Evaluation function thus a key avenue for enhancement of quality health service delivery.Additionally, the findings were in line with some interviewees which posited that compliance Monitoring and Evaluation on quality-of-health service delivery have become precious commodity; therefore, how organisations manage Monitoring and evaluation to greatly impact on their quality-of-health service delivery. The study findings were in line with Kusek&Rist (2004) assert that, as a first step in building an M&E system, developing countries must first have, or establish, a basic foundation a traditional implementation-focused M&E system(Kusek&Rist, 2004). Traditional implementation-focused M&E systems are designed to address compliance the “did they do it” question. Did they mobilize the needed inputs? Did they undertake and complete the agreed activities? Did they deliver the intended outputs? Compliance Monitoring and Evaluation (CME) is the form of M&E where the express purpose is to ensure compliance and accountability (Kusek&Rist, 2004). CME is performed by central oversight bodies, each of which assumes responsibility for a particular part of the overarching accountability framework. The CME bodies are characterized by clear guidelines and have the power to sanction, and/or withhold resources and produce results without censorship. They generally have a strong monitoring capability and can insist on upward reporting (Naidoo, 2012).

The presumed effect is that they increase transparency and accountability, and may as a secondary effect improve organizational learning and health service delivery. This form of M&E has a strong judgmental nature, and is linked to punitive measures, which may be in the form of publically showing up performance or more serious sanction which is initiated either by the M&E institution or forums where such M&E results are presented (Naidoo, 2012).

The next theme will go in details to analyses the relationship between social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District using correlation and regression.

# **4.4.2 Findings on the effect of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District.**

To assess the effect of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District the responses were interpreted basing on the 5-likert scale typing employed in the study, where SD meant Strongly Disagree, D meant Disagree, N meant Neutral, A meant Agree and SA meant Strongly Agree. Table below has more details.

Table 4. 5: Descriptive Statistics on the effect of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | N | SD | D | NS | A | SA | M | STD |
| Kasese residents are provided with reliable information on their entitlements | 201 | 2%(4) | 5%(11) | 7%(14) | 44%(88) | 42%(85) | 4.19 | 0.915 |
| Kasese residents receive reliable information on performance of government services | 201 | 2%(4) | 5%(11) | 26%(52) | 25%(51) | 42%(83) | 3.99 | 1.037 |
| There is value by Civil society organizations (CSOs) in the delivery of social services | 201 | 3%(5) | 6%(12) | 11%(22) | 58%(117) | 22%(45) | 3.92 | 0.891 |
| Civil society organizations (CSOs) efforts have a role in social accountability | 201 | 0% | 5%(11) | 15%(31) | 65%(130) | 15%(29) | 3.88 | 0.711 |
| Social accountability initiatives have strengthened the accountability relationship between governments and citizens | 201 | 1%(2) | 5%(11) | 29%(59) | 50%(101) | 15%(26) | 3.71 | 0.822 |
| Involving Kasese residents in monitoring government projects builds transparency and accountability | 201 | 2%(4) | 24%(48) | 12%(25) | 32%(64) | 30%(60) | 3.64 | 1.197 |
| Total average Mean and SD |  |  |  |  |  |  | 3.88 | 0.928 |

Source*: Field Data, 2021*

where SD meant Strongly Disagree, D meant Disagree, N meant Neutral, A meant Agree and SA meant Strongly Agree, M meant Mean and STD meant standard deviation

Findings above indicated that there isan effect of social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District that was shared by majority staff. This is because vital statements as were given to respondents were agreed on with means above the Total average Mean of 3.88 and standard deviation of 0.928. This is exemplified in the following statements; Kasese residents are provided with reliable information on their entitlements with a mean of (4.19)this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that Kasese residents are provided with reliable information on their entitlements which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service delivery, Kasese residents receive reliable information on performance of government services with a mean (3.99)this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that Kasese residents receive reliable information on performance of government services which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service delivery, there is value by Civil society organizations (CSOs) in the delivery of social services with a mean of (3.92) this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that there is value by Civil society organizations (CSOs) in the delivery of social services which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service deliveryand Civil society organizations (CSOs) efforts have a role in social accountability with a mean of (3.88)this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that Civil society organizations (CSOs) efforts have a role in social accountability which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service delivery.

Other findings showed that, Kasese District has some issues around social accountability Monitoring and Evaluation on quality-of-health service deliverythat was shared by some staff which include; Social accountability initiatives have strengthened the accountability relationship between governments and citizens with a mean of (3.71)this implies that the majority of respondents who answered this attribute were not in approval or did not strongly agreed that Social accountability initiatives have strengthened the accountability relationship between governments and citizens which clearly is an indication that needs to be worked upon by the Kasese District Local Government to enhance quality health service delivery and Involving Kasese residents in monitoring government projects builds transparency and accountability with a mean of (3.64)this implies that the majority of respondents who answered this attribute were not in approval or did not strongly agreed that Involving Kasese residents in monitoring government projects builds transparency and accountability which clearly is an indication that needs to be worked upon by the Kasese District Local Government to enhance quality health service delivery.

The above reportage concurred with what key informants indicated in the interview. For instance, a good number of key informants showed that the Kasese District has a well adhered social accountability Monitoring and Evaluation direction which is periodically checked, evaluated and assessed to ensure that it is followed to its depth. They reported that the board at least sits thrice annually to oversee the quality health service delivery in local governments by employees. They indicated that many of the changes which are seen and currently being implemented were ideas of the board.

**Findings from in-depth Interviews**

They opined that the district council sits to review the social accountability Monitoring and Evaluation plan on quality-of-health service delivery plan while assessing weakness and successes registered. For instance, key informant 2 said,

*“As a council we are very active because we periodically review whether our goals and objectives as a district are achieved…and we always make serious recommendations that have seen our quality-of-health service delivery improve…”*

Further, key informant 1 said that,

*“The district council has operated for a good number of years and I think we need to be given a credit because our district has thrived…we have endured and set standards which makes our quality-of-health service delivery a bit unique and compelling to service delivery…we still act as an example and inspiration to other districts in Uganda…”*

The above verbatim is interpreted to mean that the council has been highly involved in governing of the quality-of-health service delivery which has been a basis for improved quality-of-health service delivery returns. This is further reflected in the interview done with Key informant 6 while saying, *“We have always sat to assess whether the vision and mission statement of the district is being achieved…and we always recommend changes in the quality-of-health service delivery and M and E function/Plan in the human resource to ensure that our goals are achieved as set…I think as the council we have always regarded as ourselves as the engine for the performance desired…that is why I totally believe the quality-of-health service delivery has continually been going high…”*

The above findings show that Kasese District Local Government needs to uphold the criteria of setting perfomance standards for M and E staff which is well understood and apprecited by the staff at the district centre as a key indicator in quality-of-health service delivery returns and enhancemnet. Additionally, the findings were in line with some interviewees which posited that the most valuable asset in an organization is the social accountability Monitoring and Evaluation and any organization that wishes to accomplish its missions and objectives have to start its planning from there. The study findings were in line with the World Bank (2004) argues that as a complementary strategy, social accountability strengthens citizens-clients to monitor and exert accountability. However, for social accountability to happen and therefore contribute to improvement in health service delivery, citizens must have reliable information on their entitlements and the performance of services, and they must be able to take actions based on that information to demand accountability(*World Development Report 2004*, n.d.). Accountability, and related transparency, comes from two quite different ideological streams(Haque, n.d.). On the one hand, New Public Management (NPM), which emerged in the 1990s, emphasized the use of market mechanisms in the public sector to make managers and providers more responsive and accountable.

On the other hand, and at the same time, the failure of democratic institutions to deliver for the poor also resulted in calls for deepening democracy through the direct participation of citizens in governance. Accountability took root as a central theme in debates after the World Bank’s, ground breaking report, “World Development Report 2004: Making Services Work for Poor People”, which identified failures in health service delivery squarely as failures in accountability relationships. By showing how the ‘long route’ of accountability via elected politicians and public officials through to providers was failing the poor, the report argued in favor of strengthening the ‘short route’ which involves direct accountability between users and providers(*World Development Report 2004*, n.d.). Achieving better services therefore requires improved governance, voice, and accountability(*World Development Report 2004*, n.d.). Add that, efforts by governments, donors, and civil society alike to improve governance, accountability, and development results on the ground have heightened attention to the idea that citizens can contribute to better public services by holding their policy 30 makers, providers, and program managers accountable.

The next theme will go in details to analyze the relationship between internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District correlation and regression.

# **4.4.3 Findings on the effect of internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District.**

To assess the effect of internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District the responses were interpreted basing on the 5-likert scale typing employed in the study, where SD meant Strongly Disagree, D meant Disagree, N meant Neutral, A meant Agree and SA meant Strongly Agree. Table below has more details.

Table 4. 6: Descriptive Statistics on the contributionof internal Monitoring and Evaluation towards quality-of-health service delivery in Kasese District.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | N | SD | D | NS | A | SA | M | STD |
| The M&E function of Kasese District Local Government has an existing organizational structure | 201 | 0% | 4%(8) | 14%(29) | 63%(127) | 19%(36) | 3.94 | 0.726 |
| The M&E function of Kasese District Local Government is adequately staffed | 201 | 2%(4) | 3%(5) | 13%(26) | 66%(133) | 16%(31) | 3.90 | 0.771 |
| The District Technical Planning Committee conducts regular monitoring of government projects and programs | 201 | 0% | 5%(10) | 28%(57) | 49%(98) | 18%(35) | 3.78 | 0.809 |
| The District Council conducts regular monitoring of government projects and programs | 201 | 1%(2) | 26%(52) | 6%(13) | 51%(102) | 16%(31) | 3.53 | 1.082 |
| Findings of M&E activities are shared with the concerned departments for action | 201 | 2%(4) | 21%(42) | 41%(82) | 20%(40) | 16%(32) | 3.26 | 1.041 |
| Monitoring reports are discussed and recommendations used to improve programs and projects | 201 | 1%(2) | 39%(79) | 16%(33) | 30%(61) | 14%(26) | 3.15 | 1.112 |
| Total Average Mean & SD |  |  |  |  |  |  | 3.59 | 0.923 |

**Source*: Field Data, 2021***

where SD meant Strongly Disagree, D meant Disagree, N meant Neutral, A meant Agree and SA meant Strongly Agree, M meant Mean and STD meant standard deviation

Findings above indicated that the district had a clear internal Monitoring and Evaluation on quality-of-health service delivery that was shared by majority of staff. This is because, many statements as were given to respondents were agreed on with means above total average mean of 3.59 and standard deviation of 0.923. This is exemplified in the following statements; the M&E function of Kasese District Local Government has an existing organizational structure with a mean (3.94)this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that the M&E function of Kasese District Local Government has an existing organizational structure which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service delivery, the M&E function of Kasese District Local Government is adequately staffed with a mean (3.90)this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that the M&E function of Kasese District Local Government is adequately staffed which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service delivery and the District Technical Planning Committee conducts regular monitoring of government projects and programs with a mean of (3.78)this implies that the majority of respondents who answered this attribute were in approval or strongly agreed that the District Technical Planning Committee conducts regular monitoring of government projects and programs which clearly is an indication that needs to be uphold by the Kasese District Local Government to enhance quality health service delivery.

Other findings showed that, Kasese district has some issues around internal Monitoring and Evaluation that was shared by majority of staff which include; the District Council conducts regular monitoring of government projects and programs with a mean of (3.53) this implies that the majority of respondents who answered this attribute were not in approval or did not strongly agreed that the District Council conducts regular monitoring of government projects and programs which clearly is an indication that needs to be worked upon by the Kasese District Local Government to enhance quality health service delivery , findings of M&E activities are shared with the concerned departments for action with a mean of (3.26) this implies that the majority of respondents who answered this attribute were not in approval or did not strongly agreed that the findings of M&E activities are shared with the concerned departments for action which clearly is an indication that needs to be worked upon by the Kasese District Local Government to enhance quality health service delivery and monitoring reports are discussed and recommendations used to improve programs and projects with a mean of (3.15) this implies that the majority of respondents who answered this attribute were not in approval or did not strongly agreed that the findings of monitoring reports are discussed and recommendations used to improve programs and projects which clearly is an indication that needs to be worked upon by the Kasese District Local Government to enhance quality health service. These are presumed to be the basis for internal Monitoring and Evaluation.

**Findings from in-depth Interviews**

The above reportage concurred with what key informants indicated in the interview. For instance, a good number of key informants showed that Kasese district has a well adhered strategic internal Monitoring and Evaluation direction which is periodically checked, evaluated and assessed to ensure that it is followed to its depth. They opined that the below are some facets they agreed with.

For instance, key informant 4 said, “*As a staff member the strategic internal Monitoring and Evaluation direction builds a sense of meaning to us and the community at large. This is shows ho well observant and how much effort is put in our functions as employees to deliver on the on quality-of-health service delivery in Kasese District.*

Further, key informant 3 said that, “*At district council level the* strategic internal Monitoring and Evaluation direction *is a key recognitionprogramme every month for every staff member who has exceeded our departmental objectives they are recognized with a voucher on how they have enhanced the Internal M and E…”*

The above verbatim is interpreted to mean that the district has been highly involved in strategic internal Monitoring and Evaluation directionin Kasese District which has been a basis for improved on quality-of-health service delivery in Kasese District. This is further reflected in the interview done with Key informant 6 while *saying, “The Top management makes sure it involves itself in aspects of strategic internal Monitoring and Evaluation direction as the human resource makes sure all projects are competitively advertised and fairly contested by both Internal and external applicants in the district…”*

The above findings show that stakeholders have to take this indication with keenness in totality as it resonates well with improving on quality-of-health service delivery in Kasese District thus leading to enhanced quality and welfare in their different staff working roles and responsibilities in the district.Additionally, the findings were in line with some interviewees which posited that poor internal Monitoring and Evaluation this affects every organisation without regard to industry, and that this comes from the fact that the projects may not be followed up well. The study findings were in line with Baguma, 2017; Naidoo, (2012) who posit that that Internal Monitoring and Evaluation (IME) is geared towards the importance of learning in and by organizations has long been recognized by organization scientists. Over the last two decades interest in organizational learning has been growing, as evidenced by a continuously increasing output in journals and books and an increasing number of reviews of the field (Baguma, 2017; Naidoo, 2012). Over the last 15 years learning in public sector organizations (PSOs) increasingly has received attention following previous emphasis within business organizations(Baguma, 2017; Naidoo, 2012).

The change in attention has largely been driven by trends towards reinventing government and New Public Management. The adoption of NPM practices meant that PSOs now increasingly face public and political pressures to become more efficient and effective in health service delivery while being transparent and accountable in their administrative processes(Baguma, 2017.; Fakhrul, 2015; Naidoo, 2012). In order to adapt to this wave of change, PSOs have increasingly incorporated learning in their business processes, researchers agree that performance information should be used to bring about critical self-reflection and learning from mistakes rather than apportioning blame.

Evaluation therefore presents opportunities for improving organizational learning. Learning comes about only when there is communication based on self-reflection and dialogue (Baguma, 2017.; Fakhrul, 2015; Naidoo, 2012). The use of M&E therefore would tend to emphasize the “learning” or information aspect.

Table 4. 7: Correlation analysis of the relationship between Compliance Monitoring and Evaluation, Social Accountability Monitoring and Evaluation, Internal Monitoring and Evaluation and Quality of Health service delivery in KASESE DISTRICT, UGANDA

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Correlations** | | | | | |
|  | | Quality Of Health service delivery | Compliance Monitoring and Evaluation | Social Accountability Monitoring and Evaluation | Internal Monitoring and Evaluation |
| Quality Of Health service delivery | Pearson Correlation | 1 |  |  |  |
| Sig. (1-tailed) |  |  |  |  |
| N | 201 |  |  |  |
| Compliance Monitoring and Evaluation | Pearson Correlation | .581\*\* | 1 |  |  |
| Sig. (1-tailed) | .000 |  |  |  |
| N | 201 | 201 |  |  |
| Social Accountability Monitoring and Evaluation | Pearson Correlation | .679\*\* | .560\*\* | 1 |  |
| Sig. (1-tailed) | .000 | .000 |  |  |
| N | 201 | 201 | 201 |  |
| Internal Monitoring and Evaluation | Pearson Correlation | .434\*\* | .526\*\* | .535\*\* | 1 |
| Sig. (1-tailed) | .000 | .000 | .000 |  |
| N | 201 | 201 | 201 | 201 |
| \*\*. Correlation is significant at the 0.01 level (1-tailed). | | | | | |

**Source*: Field Data, 2021***

As shown in Table 4.7, there is a significant moderate correlation between Compliance Monitoring and Evaluation and Quality ofHealth service delivery with (r=.581\*\*), there is a high significant relationship between Social Accountability Monitoring and Evaluation and Quality ofHealth service delivery with (r=.679\*\*), there is a weak significant relationship between Internal Monitoring and Evaluation and Quality ofHealth service delivery with (r=.434\*\*) This implies that the linearity assumption was therefore, satisfied. After the assumptions, the study established the effect of Monitoring and Evaluation on quality-of-health service delivery in Kasese District.

# **4.4.4Monitoring and Evaluation on quality-of-health service delivery**

Multiple linear regression analysis was used to test the formulated hypotheses. First, the model summary was analysed to establish the strength of the conceptualized Monitoring and Evaluation principles in predicting quality-of-health service delivery.

Table 4. 8: Model Summary

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model Summary** | | | | | | | | | |
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Change Statistics | | | | |
| R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .721a | .520 | .513 | .33576 | .520 | 71.110 | 3 | 197 | .000 |
| a. Predictors: (Constant), Internal Monitoring and Evaluation, Compliance Monitoring and Evaluation, Social Accountability Monitoring and Evaluation | | | | | | | | | |

**Source: Field Data, 2021**

Results presented in Table 4.8 reveal that the three Monitoring and Evaluation principles namely; Internal Monitoring and Evaluation, Compliance Monitoring and Evaluation, Social Accountability Monitoring and Evaluation explains 51.3% of the variation in quality-of-health service delivery (Adjusted R Square = 0.513). Therefore, the remaining 49% is explained by other Monitoring and Evaluation principles not considered in the study. Second, the ANOVA output was examined to check whether the proposed model was viable.

Table 4. 9: Analysis of Variance (ANOVA)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ANOVAa** | | | | | | |
| Model | | Sum of Squares | df | Mean Square | F | Sig. |
| 1 | Regression | 24.049 | 3 | 8.016 | 71.110 | .000b |
| Residual | 22.208 | 197 | .113 |  |  |
| Total | 46.257 | 200 |  |  |  |
| a. Dependent Variable: Quality of health service delivery | | | | | | |
| b. Predictors: (Constant), Internal Monitoring and Evaluation, Compliance Monitoring and Evaluation, Social Accountability Monitoring and Evaluation | | | | | | |

**Source: Field Data, 2021**

Results shown in Table 4.9 reveal that the F-statistic was highly significant (F 71.110 p<0.05), this shows that the model was valid.The model determines whether the independent variables reliably predict the dependent variable. This is indicated by the sig, value associated by F i.e., 3, 197 = 0.000; p < 0.05. Thus, if the P-value is smaller than 0.05, you can conclude that*the independent variables reliably predict the dependent variable*.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Coefficientsa |  |  |  |  |  |  |  |  |
| Model |  | Unstandardized Coefficients | | Standardized Coefficients | T | Sig. | 95.0% Confidence Interval for B | |
|  | B | Std. Error | Beta |  |  | Lower Bound | Upper Bound |
| 1 | (Constant) | 0.917 | 0.221 |  | 4.155 | 0 | 0.482 | 1.352 |
| ComplianceMandE | 0.304 | 0.066 | 0.290 | 4.609 | 0 | 0.174 | 0.434 |
| SocialaccountabilityMandE | 0.465 | 0.057 | 0.513 | 8.092 | 0 | 0.352 | 0.578 |
| InternalMandE | 0.006 | 0.053 | 0.007 | 0.106 | 0.915 | -0.099 | 0.11 |
| **a. Dependent Variable:** **Quality of health service delivery** | | | | | | | | |

**Source: Field Data, 2021**

Results of the regression coefficients presented in Table above shows that the estimates of β values and give an individual contribution of each predictor to the model. The β value tells us about the relationship between Quality-of-health service deliverywith each predictor. The β value for Compliance Monitoring and Evaluation (.304), Internal Monitoring and Evaluation (.006), and Social Accountability Monitoring and Evaluation (.465) were positive. Therefore, from the results the model was then specified as: -



Quality of health service delivery= .304Compliance Monitoring and Evaluation +.006Internal Monitoring and Evaluation +.465Social Accountability Monitoring and Evaluation.

The coefficients for each of the variables indicates the amount of change one could expect in Quality-of-health service deliverygiven a one-unit change in the value of that variable, given that all the variables in the model are standardized basing on the standardized coefficients. Results reveal standardized regression coefficient for Compliance Monitoring and Evaluation (B1=0.304), implies that one unit of increase in Compliance Monitoring and Evaluation the quality-of-service delivery will increases by 0.304.

Moreover, standardized regression coefficient for Internal Monitoring and Evaluation (B2=0.465), implies that one unit of increase Internal Monitoring and Evaluation the quality-of-service delivery increases by 0.006. Likewise, one unit of increase in social accountability M&E, the quality-of-service deliveryincreaseby 0.465

# **CHAPTER FIVE**

# **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

# **5.1 Introduction**

This chapter entails study summaries, discussions of objectives set for the study, conclusions derived from the findings, and the recommendations that will help in improving quality health service delivery in local governments using a case study of Kasese district, Uganda based on the findings of the study. Limitations, contributions of the study and areas of further study are also suggested.

# **5.2 Summary**

The study established a number of findings, the summary of the findings is explained here under;

# **5.2.1 Effect of compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District.**

The study results showed there is a significant relationship between Compliance Monitoring and Evaluation and Quality of Health service delivery(r=.581). After, the above findings, a test of significance (p) was undertaken and it was established that compliance Monitoring and Evaluation is significantly related to quality-of-health service delivery in Kasese District (p = .000) since it was less than the recommended critical significance at 0.05. The implication of study findings was that the higher the board adheres to Compliance Monitoring and Evaluation, the higher the quality-of-health service delivery in Kasese District. This was further justified with adjusted R2= 0.513 which implied that Compliance Monitoring and Evaluation as one of the principles of Monitoring and evaluation accounts for the aggregated 51.3% of the variance in quality-of-health service delivery in Kasese District This implies that Compliance Monitoring and Evaluation significantly affects the quality-of-health service delivery in Kasese District.

# **5.2.2 Effect of** **social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District.**

The study results showed there is a positive significant relationship between social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District (r= .679). After, the above findings, a test of significance (p) was undertaken and it was established that social accountability Monitoring and Evaluation significantly contributes to quality-of-health service delivery in Kasese District.at (p = .000) since it was less than the recommended critical significance at 0.05. The implication of study findings was that the higher the engagement of the management on social accountability Monitoring and Evaluation, the higher quality-of-health service delivery in Kasese District. This was further justified with adjusted R2= 0.513 which implied that social accountability Monitoring and Evaluation as one of the principles of Monitoring and evaluation accounts for the aggregated 51.3% of the variance in quality-of-health service delivery in Kasese District This implies that Compliance Monitoring and Evaluation significantly affects the quality-of-health service delivery in Kasese District.

# **5.2.3** **Internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District.**

The study results showed there is a positive significant relationship between internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District (r= .434). After, the above findings, a test of significance (p) was undertaken and it was established that internal Monitoring and Evaluation significantly contributes towards quality-of-health service delivery in Kasese District at (p = .000) since it was less than the recommended critical significance at 0.05. The implication of study findings was that the higher the internal Monitoring and Evaluation, the higher the quality of quality-of-health service delivery in Kasese District. This was further justified with adjusted R2= 0.513 which implied that internal Monitoring and Evaluation as one of the principles of Monitoring and evaluation accounts for the aggregated 51.3% of the variance in quality-of-health service delivery in Kasese District This implies that internal Monitoring and Evaluation significantly affects the quality-of-health service delivery in Kasese District.

# **5.3 Conclusions**

# **5.3.1 Compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District.**

The study findings showed there is a positive significant relationship between compliance Monitoring and Evaluation on quality-of-health service delivery in Kasese District. It was thus concluded that quality-of-health service deliveryenhances with an improvement in adherence to compliance Monitoring and Evaluation by the management. This was taken into considerations with some lessons which included; Kasese district to uphold,the preparation of performance reports which add value to the district work operation during benchmarking exercises, uphold the Quarterly performance reports required by the Ministry of Finance, Planning and Economic Development aid in better management our budgets, also uphold the value by the Office of the Resident District Commissioner additionally uphold the efforts by the Inspector General of Government are useful in deterring to staff to committing fraudwhile some areas of improvement likein preparation of District management prepared work plans, budgets and reports in accordance with the Public Finance Management Act and the value in Auditor General efforts in promoting Accountability in the District.

# **5.3.2 Social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District**

The study findings showed there is a positive significant relationship between social accountability Monitoring and Evaluation on quality-of-health service delivery in Kasese District. It was thus concluded that quality-of-health service deliveryincreases with an increase in social accountability Monitoring initiatives undertaken by the Kasese districtmanagement. There were some lessons to uphold and others to work upon which included, provision of Kasese residents with reliable information on their entitlements, performance of government services, value by Civil society organizations (CSOs) in the delivery of social services and Civil society organizations (CSOs) efforts have a role in social accountability. Areas to work upon work on social accountability initiatives to strengthen accountability relationship between governments and citizens, Involving Kasese residents in monitoring government projects builds transparency and accountability.

# **5.3.3 Internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District.**

The study findings showed there is a positive significant relationship between internal Monitoring and Evaluation on quality-of-health service delivery in Kasese District. It was thus concluded that quality-of-health service deliveryincreases with an increase in internal Monitoring and Evaluation done by the board. There were lessons learnt which included, to uphold the M&E function of Kasese District Local Government has an existing organizational structure, to adequately staff the M&E function of Kasese District Local Government and for the district Technical Planning Committee conducts regular monitoring of government projects and programs.

# **5.4 Recommendations**

In light of the above conclusions, below are the suggested recommendations as per each study objective;

* The Kasese district M and E function ought to uphold the efforts by the Inspector General of Government which are useful in deterring to staff to committing fraud. This ought to be done aggressive sensitization and penalising of any culprits found at large through refunding the money or facing prison sentences
* The Kasese district management ought to work on improvement of the district work plans, budgets and reports in accordance with the Public Finance Management Act and the value in Auditor General efforts in promoting Accountability in the District. This should be through seeking out trainings and workshops to comprehend on how are practical yet meaningful work plans are done. This will improve their competence in this field.
* The district management ought to work on provision of Kasese residents with reliable information on their entitlements, performance of government services, value by Civil society organizations (CSOs) in the delivery of social services and Civil society organizations (CSOs) efforts have a role in social accountability. This should be organised through having quarterly district briefs and updates with Kasese residents in various counties and also get feedback from them as this will provide a two-way communication.
* The district management ought to work upon social accountability initiatives to strengthen accountability relationship between governments and citizens, Involving Kasese residents in monitoring government projects builds transparency and accountability. This can be done quarterly through various feedback session with resident in various counties to seek feedback and also to provide accountability to the residents
* Further, it is important that the district top management should to uphold the M&E function of Kasese District Local Government an existing organizational structure additionally to adequately staff the M&E function of Kasese District Local Government and for the district Technical Planning Committee conducts regular monitoring of government projects and programs.

# **5.5 Limitations of the study**

The study registered a number of limitations and these majorly included;

1. Some respondents deliberately failed to answer some questions. This gave the researcher hard time but she had to resource and replaced such people with the same people in the target population.
2. Secondly, some respondents wrongly filled the questionnaires. This came as a result of time constraints as some of them rushed to answer the questions and attend to their work. But the researcher managed to recover most of the questionnaires well filled. Those which were wrongly filled were ignored.
3. Time and the Covid-19 pandemic were key of the study’s major constraints as the researcher couldn’t meet some people as expected due to Covid-19. Since the study had a specified time, the researcher replaced such people with their personal assistants.

In spite of all these challenges however, the researcher did everything she could to undertake and complete the study successfully.

# **5.6 Areas recommended for further study**

1. Future research should follow the longitudinal approach to predict beliefs and behaviour over time since the model in this study is a cross sectional research design, which measures the intention only at a single point in time.
2. There is a need for another study covering other district in Uganda not only Kasese district to clearly obtain their views on how the role of monitoring and evaluation in quality health service delivery in local governments can be improved.

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