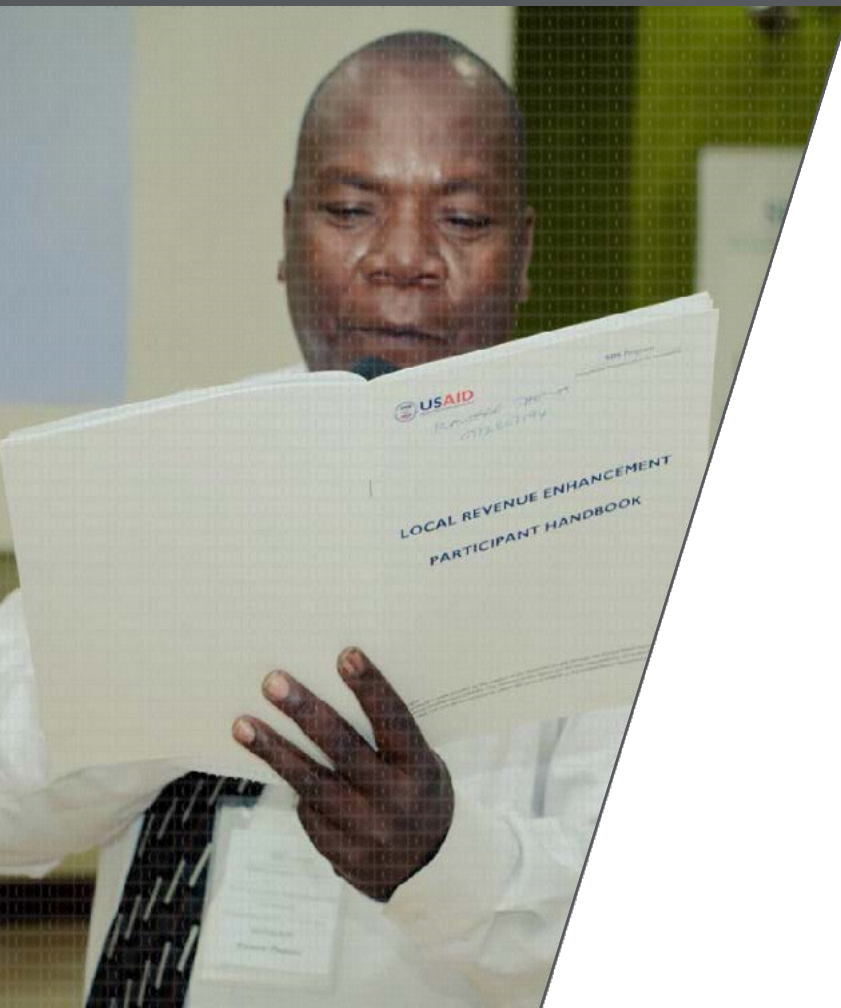![USAID FROM THE AMERICAN PEOPLE]

SDS Program
Strengthening Decentralization for Sustainability

Cardno®

THE STRENGTHENING DECENTRALIZATION FOR SUSTAINABILITY PROJECT IN UGANDA

A Collaborating, Learning, and Adapting (CLA) Case Study of an Early USAID Cross-Sectoral Integration Project and its Experience with USAID Forward

By Malcolm Russell-Einhorn and Patrick Meagher

February 22, 2017

Table of Contents

1 EXECUTIVE SUMMARY

This case study seeks to extract lessons learned from the USAID-funded Strengthening Decentralization for Sustainability (SDS) Project, a hybrid health, HIV/AIDS and governance project carried out by Cardno Emerging Markets USA, Ltd. (Cardno) that operated from 2010 to 2017 in fifty districts in Uganda (ultimately touching a total of 71 districts). SDS was one of the earliest projects to attempt large-scale integration of local governance capacity-building work into a major sectoral service delivery improvement initiative. SDS also demonstrated USAID's emerging concern for coordination of different streams of US development assistance at the local level, and its interest in working directly through local systems – principally by means of direct grants to sub-national (in this case, district)governments and hands-on technical assistance (TA). In many ways, SDS was a forerunner of several later large-scale sectoral service delivery projects in Africa and Asia funded by USAID that sought to provide significant local institutional strengthening assistance alongside some form of local aid coordination mechanism. However, unlike most of these later projects, SDS was designed and managed by a health team at USAID, not a democracy and governance team—which had important implications for the project's evolution, focus, and achievements.

More broadly, the SDS Project encapsulates USAID/Uganda's early embrace of several innovative approaches to development work later mainstreamed by the Agency as a whole via USAID Forward—including (i) an emphasis on greater program selectivity through country-specific strategies, together with s greater coordination and co-location of assistance; (ii) reliance on local systems and a heightened concern for sustainability; (iii) use of more adaptive management approaches and more flexible contracting vehicles; and (iv) greater integration of Democracy, Rights, and Governance (DRG) concerns and capacity-building interventions into sectoral service delivery projects. As such, the SDS project offers a unique window into the early uptake of these efforts and also some of the challenges it faced (and that many later projects continue to face). USAID/Uganda, moreover, was the pioneering Mission that originated the Agency's Collaborating, Learning, and Adapting (CLA) agenda, and adopted the first Country Development Cooperation Strategy (CDCS); SDS was among the Mission's earliest laboratories to test project alignment with both of these innovations. Yet, like other Missions, USAID/Uganda struggled to ensure that its projects were strategic and self-reflective. Insofar as the project's seminal experience and learning have yet to be analyzed or shared systematically, the present study sought to do so.

The full study, whose main findings are distilled in this Executive Summary, was supported by the Mission's then-CLA team, and designed with careful documentation and learning purposes in mind. It was shared with the Mission toward the end of the project, in early 2017. Beyond its immediate purpose, the study also sought to highlight, in the microcosm of a single project, both advances and challenges encountered through the USAID Forward experience (and progress made since its inception). Among the key questions this study addresses are the following.

- How much emphasis could be placed on strengthening and utilization of 'local systems' when the necessary capacity-building would have required a decade or more to show results (particularly in Uganda), and addressing immediate health care priorities and targets was usually granted precedence?

- How much genuine technical assistance and mentoring was feasible to deliver on a project whose work was spread across dozens of individual districts? Should USAID or other donors concentrate efforts of this kind in a smaller number of jurisdictions to ensure better capacity-building and sustainability?

- More broadly, how sustainable could a project like SDS be when district governments in Uganda (like many others around the world) lack significant administrative and financial authority? In a context of incomplete decentralization, to what extent should projects like SDS devote more attention to policy advocacy and engage central authorities to create a more favorable enabling environment?

- To what extent does a project like SDS, which prioritizes significant co-location and coordination of different USAID assistance streams at the district level, genuinely empower local governments and 'put them in the driver's seat,' as opposed to simply rationalizing or streamlining local USAID assistance streams, perhaps partly for bureaucratic convenience?

- How much DRG integration–and institutional strengthening––is possible when Mission DRG budgets and staff are dramatically smaller than those of their sectoral counterparts, and integrated projects are principally driven by sectoral service delivery objectives, funding mechanisms, and time horizons?

- How is CLA understood and used? How much are project staff encouraged to 'collaborate' and 'learn' from local counterparts? Does 'adaptation' respond more to the local environment or to USAID needs?

1.1. Context and origins/design of the project

Initially lauded by Ugandans and the international community alike in the 1990s, Uganda's decentralization reforms have largely failed to bring delivery of public services up to an acceptable standard. One fundamental problem is the system's asymmetry. It imposes unrealistic implementation responsibilities (and costs) on the lower levels of government, while strengthening state authority and revenue/spending decision-making at the center--at the expense of the districts. These entrenched conditions inevitably limited the SDS project's impact.

SDS was nevertheless designed as a hybrid project that would encourage an intensive and applied 'learning by doing' approach to local capacity building—in coordination with other USAID-funded health and social services projects operating in targeted districts. The core idea of SDS was to provide help in planning, budgeting, and oversight to 45 key districts across the country (later reduced to 35). USAID would provide financial inducements to local governments (via direct grants) to support certain health and social service needs. This would afford a degree of financial agency lacking in Uganda's system of conditional transfers and severely circumscribed local revenue raising authority. SDS would rely less on financial oversight at the central government level, and more on performance accountability by the districts to the SDS health implementing partners (IP) at the local level. And the project would seek to coordinate and align all USAID assistance at the local level with existing district priorities.

The SDS Project had four discrete components:

- Objective 1: coordination of all USAID-supported TA provided by district-based USAID IP's (so-called DBTAs);

- Objective 2: provision of TA to districts in such areas as planning, budgeting, procurement, and oversight to help them better manage their limited resources and achieve better social service delivery program results (all of this occurring within the framework of USAID-assisted and consensually developed multi-stakeholder District Management Improvement Plans (DMIPs) and in conformity with established Ugandan local government guidelines and existing District Development Plans (DDPs);

- Objective 3: issuance of performance-based grants to districts to address targeted non-recurrent financial needs in key health and other social service delivery areas (i.e., non-wage expenditures such as supplies, materials, vehicle operational costs, and staff per diems for travel) (so-called 'A' Grants), as well as particular cross-cutting capacity- building priorities (so-called 'B' Grants); and

- Objective 4: use of innovative organizational approaches to mobilize resources and sustain improvements in social sector service delivery (effected through both special TA and competitively-procured 'C' Grants).

1.2. The SDS implementation experience

The project had a rocky *first year*. Several factors contributed, including poor communication about the project to central and local authorities, an unsuitable Chief of Party (COP), and administrative problems that prevented delivery of consistent TA. Most important, there was confusion about the project's main purpose, stemming from tension between the project's identity as a health project and the very strong governance focus of its programmatic objectives.

In its *second year,* after settling on a clear capacity-building focus, SDS executed a massive turnaround and gained the confidence of most districts and of USAID. Three regional offices were staffed up, allowing clustered training, mentoring, and oversight to be conducted with a high degree of visibility to district personnel. To address the challenges faced by SDS in coordinating other DBTA partners, USAID introduced a new formal coordination mechanism in 16 of the SDS districts ("Mission-focused districts"): the District Operational Plans (DOPs). These were MOUs signed between districts, USAID, and all DBTA's in those districts. DOPs were to drive the institutional strengthening plans (the aforementioned DMIPs). SDS also developed its methodology for the so-called 'A' Grants, whereby, districts would obtain a grant and apply for renewal of the funding based on performance—meeting quarterly programmatic and financial targets. Failure to meet the targets would result in a graduated loss of funding for the next quarter's disbursement. Meanwhile, the project organized an inter-ministerial steering group (the "Inter-Sectoral Committee") to ensure that the project progress was regularly communicated to central authorities.

The *third year* was the project's high water mark in terms of congruence with its core capacity-building objectives and support from district officials. Based on experience with the DOP in Year 2, that mechanism was extended at USAID's request to all 35 SDS districts. In the grants area, higher expectations led to a change in A Grants: disbursements were now to be based predominantly on *outcome* targets—key action items—being implemented, rather than simply *outputs* (such as meeting reports and support supervision). After initially struggling, by the end of the year most districts had registered outcome improvements and many expressed pride in meeting a higher standard of accountability. The 'Grant B' program—intended to provide resources for enhanced management systems and strengthened capacity—also got underway. B Grants, meanwhile, served as an open-ended complement to the DMIP process that would allow districts freedom to address critical capacity issues. Finally, the competitive 'Grant C' program also moved forward, soliciting innovative approaches to social service delivery challenges. In the last quarter, however, with SDS running smoothly, the Mission suddenly expanded the project's scope by having it undertake activities in three new areas: recruitment of health workers to address shortages in a number of districts (the Human Resources for Health initiative, or HRH), integration of water, sanitation, and hygiene (WASH) activities in three districts over the course of a year, and a new two-year education sector support initiative encompassing early grade reading activities in four SDS districts. While generally consistent with the overall SDS goals, these add-ons ultimately reshaped the project in Years 4 and 5 and diverted significant attention away from capacity-building.

The project's *fourth year* saw significant funding cuts, necessitating a redesign to accommodate priority activities, including the new sector support activities (above), the DOP mechanism, and the Grant A program. These developments led to closure of the project's three regional offices and further curtailment of TA and mentoring. Grants B and C were brought to an early end. Although these two grant programs were viewed as flawed and lacking focus, this step weakened the project's local credibility. USAID/Uganda and SDS appeared to be trading continuity, trust, and ownership at the local level for expanded DBTA delivery, utilizing SDS as a handy 'platform.'

In *years 4 and 5*, there was a push to make good on the Mission's CLA imperative. SDS commissioned an impact study of TA and the Grant A program in a sample of SDS vs. non-SDS districts. It showed little impact. However, the project then conducted an exhaustive TA Uptake and Application Self-Assessment Study that, in contrast, showed at least a few TA modules contributing to improved local governance functions in several districts.

In the *sixth year*, with the project's identity shifting and the transition to all Ugandan key personnel underway, SDS at USAID's request undertook a major expansion of HRH work in 15 additional districts in Northern Uganda, as well as direct service delivery work in several areas. This new activity included (1) voluntary medical male circumcision (VMMC), family planning, and malaria prevention/control activities; (2) health facility lab renovations; and (3) a behavioral change initiative for adolescent girls and young women. Corresponding Grant A and DOP mechanisms adjustments supporting these activities followed (although direct grants were halted by USAID in the final months of the project). This expanded scope, as along with the urgency of demands in the North, brought wrenching change to a project already stretched thin. But once again, USAID saw SDS' superior performance, versatility, and well- regarded district-based 'platform' as a convenient solution to urgent health-related problems.

1.3. Analysis, conclusions, lessons

The remainder of the case study analyzes the innovative features of the project in greater depth, particularly in light of USAID Forward and other efforts to improve the effectiveness of donor-funded development programs. The study identifies several lessons learned as a result of the SDS project implementation experience, some of which h a v e proven instructive for later USAID governance projects supporting decentralized service delivery.

1.3.1. Integration

Although ostensibly a health project, SDS had an unusual focus on decentralized capacity-building. Efforts of this kind are now frequently anchored in local government support projects managed by a DRG team (though they have increasingly been *financed* through USAID health and other sectoral teams with larger funding streams). For a health team to champion local institutional strengthening was itself innovative, but there were several individual capacity-strengthening interventions that broke new ground as well. First, SDS provided *direct performance-based financial support* to local governments, relying on local systems and accounts (although the A Grants were ultimately halted at the end of Year 6 due to overall skittishness in USAID about such mechanisms). Second, the project directed TA to local governments *based on individualized organizational capacity assessments,* which were new at the time. Third, it assisted those governments to *coordinate and monitor* the health and social services initiatives being carried out by donor-funded IPs. All of these pillars were designed to enhance district ownership and autonomy that could help sustain service delivery improvements. In this sense, it was one of a handful of early projects that advanced USAID's efforts to integrate governance work into sectoral service delivery initiatives.

But SDS was never entirely clear about the causal pathways by which district capacity-building would translate into better health service delivery—or about how the former would be balanced with the latter in terms of effort and funding. And the design team failed to ground its work in any rigorous political economy analysis (PEA) of Uganda's overall local government context or particular power dynamics in the core 35 districts. There was, moreover, little coordination at the design stage, or thereafter, between the health and DRG teams—something that is now becoming more routine due to the efforts of USAID's DRG Center and its 2016 dissemination of cross-sectoral integration case studies. Better coordination might have resulted in a more realistic scope, more sustained capacity-building, and a more robust set of demand-side activities (SDS was unable to engage meaningfully with local political figures (local councils) or CSOs/CBOs, which made it more difficult to empower on the demand side some of the mechanisms of accountability it was pledged to strengthen on the supply side).

In the end, the Grant A performance-based financing system greatly enhanced reporting and delivery of health outputs by the districts. And SDS coordination efforts allowed districts to exert somewhat better control and coordination of IPs operating in their jurisdiction. There is anecdotal evidence that the SDS model of capacity enhancement (A Grants, TA, and coordination) resulted in better short-term results than would have been the case simply with DBTAs and *indirect* grant funding (i.e., with inputs purchased by the IP's). Certainly SDS benefited

greatly from synergies resulting from its capacity-building work being carried out in the focused contexts of health and child protection services delivery—and later, in the contexts of the WASH, education, and HRH interventions. This lent the local institutional strengthening work an applied, problem- solving orientation, whether the subject was planning, grants management, or support supervision. But the relatively short duration of the core capacity-building work (and its subsequent curtailment) made a more rigorous evaluation of potential impact impossible.

1.3.2. Local solutions and partnerships

A key feature of SDS was a commitment to district partnership and working through local systems and processes. The linchpin here operationally was the direct cash grant mechanism under Grant A, accompanied by TA and coordination   activities designed to work with existing local government processes. These two features were mutually reinforcing. The districts' management of the grants instilled a performance-based orientation that opened up opportunities for both immediate and longer-term capacity-building TA, while the TA itself—whether supplied by DBTA implementers or SDS—for the most part reinforced districts' motivation to improve grant performance. Districts were expected to be active partners in service delivery, not passive recipients, as was often the case with earlier health and social services projects.

Some observers, however, felt the grant incentives could have been better calibrated to reward districts for *improved* performance over time, not simply sanction sub-standard performance (particularly for districts with poor baseline indicators; poorer performing districts were thus penalized, and their neediest health facilities and citizens were, in effect, punished). Other criticisms reflected concerns that Grant A priorities were set primarily by the DBTA implementers rather than in genuine dialogue with local governments (and in closer accord with existing DDPs). More fundamentally, the sustainability of improved district financial management practices under Grant A were somewhat suspect, given their dependence on USAID project funding and associated objectives and oversight; without continued funding and deeper institutionalization of such practices (however consistent they were with basic Ugandan Government conditional district grant protocols), more durable incentives may have been lacking.

Meanwhile, it is not clear that the project provided adequate technical assistance to districts with severe capacity-building needs, a problem that grew when budget cuts forced closure of the regional offices. But even then, SDS was resourceful, consolidating its training and TA through a 'surge' approach and utilizing peer-to-peer learning where feasible. The ultimate capacity building impacts of these dedicated TA and training efforts are difficult to assess, and the evidence is mixed. Still, a number of indicators showed positive movement during the project's later years (reflecting the expected time lag for any TA-related outcomes). For example, in SDS districts, there was a steep decline in unspent balances returned to central authorities between FY 2012-13 and FY 2014-15, suggesting real improvements in planning and procurement. There was also a large jump in the number of district procurement plans submitted on time during this period. In the public financial management area, progress was uneven, but all SDS districts received unqualified reports (i.e., 'no issues') from the Auditor General for FY 2014-15 (the previous year, seven such districts had received qualified reports) and none had unspent account balances.

One test of sustainability—notably part of the SDS Project's name itself—is whether the Ugandan Government was convinced to adopt any policies that deepened these practices. To a very limited extent, this occurred; SDS staff made progress with the project's Inter-Sectoral Committee in modifying the methodology by which the DDPs were developed. Yet, establishing this collaboration sooner, devoting more resources to it, and expanding it, might have secured more successful policy uptake.

SDS generally succeeded in engaging with districts because it harnessed proper Ugandan local governance knowledge after a faltering start. Even though the grants program and the DMIPs introduced new and sometimes burdensome   requirements, they were nevertheless *generally consistent with existing Ugandan performance-based conditional grant financing mechanisms and the DDPs.* Other TA, from improving procurement procedures to

enhancing planning functions, also respected existing local rules. Beyond this, perhaps the most important factor promoting SDS' capacity-building progress,   such as it was, was the critical mass of resources the project was able to deploy toward this work. Many local government projects suffer from insufficiently sustained partnership with local officials – and most projects – at least now -- cannot make direct grants to localities, incentivizing action and follow up. SDS (at least for its first three years) had the means to achieve these goals.

1.3.3. Selectivity, Co-Location, Coordination

SDS was one of the earliest USAID projects deliberately designed to help coordinate different Agency assistance streams at the local level. The idea was, first, to have SDS serve as a capacity-building interface with Ugandan local governments   receiving USAID assistance—helping render such assistance more transparent, providing local authorities greater voice in assistance delivery, and ultimately helping districts expand their role in planning and budgeting. This would put the districts more 'in the driver's seat' with regard to overall health service delivery. Second, SDS was to help streamline assistance consistent with the CDCS. This coordination and 'selectivity' (in USAID Forward parlance) grew out of a concern in USAID and the State Department – via the Presidential Policy Directive on Global Development – that foreign assistance was insufficiently focused and strategic at the global, country, and even sub-national level.

But was SDS sufficiently empowered, politically and practically, to coordinate in the manner envisioned in the project's scope of work? Were districts genuinely in a position to 'drive,' even with (or perhaps in spite of) substantial help from SDS? Each IP cooperating with SDS functioned within its own contract or agreement and had its own budget and work plan to execute. Many IPs had district responsibilities that generally aligned with those of SDS, but most did not have the necessary human resources to attend district coordination meetings regularly or to 'ride circuit' among district clusters. No matter how much SDS might empower districts to request adjustments in DBTA programming, there was often little latitude to alter highly directive scopes of work. Many coordination efforts were further hobbled by the lack of well-trained and empowered political leaders in the local councils, and by central authorities' weak interest in genuinely empowering local governments.

To highlight the importance of both transparency and coordination – particularly in the Mission Focus Districts that had lots of other DBTA activity – USAID/Uganda worked closely with SDS to develop the DOP process. The DOP was intended, among other things, to eliminate duplication and improve complementarities among USAID   IP's,   while   improving   collaboration and communication with local governments and various other stakeholders working at the district level. But this multi-stakeholder participation entailed a degree of formality and reporting that may have drawn valuable time and effort away from more substantive problem-solving and coordination by SDS and its district counterparts. Ultimately, some streamlining was introduced, but USAID's formal participation in the DOP process hindered efficiency. In subsequent USAID integrated local government projects, coordination was often intensified, but without formal USAID participation.

1.3.4. CLA and adaptive programming

An emphasis on CLA arose from USAID/Uganda Program Office efforts to create a partnership between project officers and IP staff—to use monitoring and evaluation tools to continuously reappraise activities in ways not usually emphasized by top-down, prescriptive scopes of work. As designed, prior to the advent of CLA, the SDS Project in fact lacked this kind of learning agenda, as well as any real overarching theory of change that could anchor such an initiative. And only in Year 4 was the Mission in a position to actively encourage CLA as a 'whole-of-project cycle' discipline, and to hold regular lessons-learned sessions among IPs (and across sectoral silos). It was in that year that SDS undertook its CLA study on the project's TA and Grant A work. A more robust learning effort came in Year 5 when, with active Mission support, SDS undertook a dedicated monitoring, evaluation, and learning (MEL) initiative to study and improve the operation of the DOP. This analyzed what

was working with the DOP and what was not. The experience provided support for the idea that small process changes and rapid feedback from stakeholders could yield better results and greater trust and teamwork.

The SDS project's ability to pivot to address new circumstances and challenges has frequently been cited as evidence of its adaptive management abilities. But flexibility in responding to Mission programming requests should not be confused with adaptive management, which entails listening to the *local* political environment and adjusting work plans, partnering arrangements, and training/mentoring modalities. By its own admission, SDS could not create the learning culture that USAID/Uganda sought among its IPs, or engage with local leaders as effectively as originally envisioned. But even setting aside the enormous demands placed on SDS by the Mission, there are limits to the amount of data analysis and learning time that can be accommodated on the average mid- to large- sized project, particularly where large numbers of individual interventions complicate both evaluation and learning. Until the Agency gets more concrete about core CLA guidance--something it has done in the past couple of years— project learning may remain hostage to more immediate work requirements and traditional (narrow) M&E methods.

1.3.5. SDS: a promising model only partly applied

The synergistic project components discussed here comprise what might be termed an 'SDS Model' of local government capacity-building. This approach demonstrated significant promise in working toward an improved culture of accountability and commitment to results in several discrete health and social services arenas. This incremental progress represented a significant accomplishment in a Ugandan political environment of partial decentralization that severely constrains district resources and freedom of maneuver. But full application of the SDS model in practice proved impossible. First, the model did not have sufficient time to generate more robust results; start-up difficulties and later mid-stream programming changes and budget cuts effectively limited the project's core capacity-building work to no more than 2 ½-3 years.

Second, the project's trajectory reflected difficulties typically encountered by large, ambitious local institutional strengthening and service delivery support programs that operate in challenging environments but may not be anchored in a governance design that closely meshes with existing political realities. To this day, USAID often pursues such interventions as a matter of bureaucratic convenience – addressing multiple CDCS priorities and signaling serious engagement – even when a proper PEA would highlight unrealistic assumptions about local capacity and the speed of local TA uptake. These projects frequently allow insufficient time for work plan development and baseline data collection for M&E activities, and do not adequately 'go with the grain' in cultivating central and local political leaders, CSOs and CBOs). This was true of SDS, where a health team's otherwise strong grasp of basic local governance problems in the country ran up against a lack of governance programming experience--and inadequate early consultations or coordination with the Mission's DRG Team, which designed its own local government program, albeit largely in complementary districts (That program—the Governance, Accountability, Participation and Performance (GAPP) Activity—has also sought to strengthen local government capacity to support improved service delivery, but with a stronger emphasis on central government oversight and community monitoring of services; while the GAPP approach has shown promise in incrementally improving accountability, it too has tended to spread its capacity-building work too thinly across dozens of districts and has notably lacked SDS' urgent, applied focus on specific sectoral service delivery priorities).

Finally, SDS fell victim to its own success. As it innovated, achieved, and demonstrated its flexibility as a successful platform, it attracted higher-level interest in the Mission. This resulted in the project's assuming the DOP work, as well as the later HRH, primary reading, and WASH activities. Such disparate, high-visibility demands discouraged reflection and learning, which might otherwise have led to stronger, more sustainable results consistent with the original capacity-building focus.

2 INTRODUCTION

This case study seeks to extract lessons learned from the Strengthening Decentralization for Sustainability (SDS) Project, a hybrid health, HIV/AIDS and governance project funded by USAID. SDS was one of the very earliest projects to attempt large-scale integration of local governance capacity-building work into a sectoral service delivery initiative (in this case, principally an initiative to strengthen delivery of social services managed under USAID/Uganda's health team). Further, SDS demonstrated USAID's concern for the coordination of different streams of US development assistance at the local level, and its interest in working directly through local systems by means of direct grants to sub-national governments. (A brief overview of SDS is given in Box 1.)

Box 1 SDS Overview

SDS was designed to improve social services delivery through improvements in local government budgeting, planning, and program oversight. The cooperative agreement, awarded in the spring of 2010, as amended, has reached a current value of nearly $70 million. Starting in 45 districts, the project supported capacity-building through technical assistance (TA) and grants. The latter are principally performance-based implementation grants intended to complement existing (generally quite meager) resources provided by central government conditional transfers or by the districts' own-source revenues. The project also established District Operational Plans (DOPs), designed to align USAID resources and project implementation streams in various social service areas with local priorities – all while improving collaboration and communication among government and other stakeholders in each of the districts. Once these foundational components gained traction, SDS undertook at USAID's request a number of specialized capacity-building pilot initiatives focused on education, water and sanitation, and human resources development. Finally, the SDS Project was tasked with directly delivering health- and other social services-related assistance to selected districts in the North. This included HIV/AIDS, TB, Malaria, maternal and child health/family planning, and safe sex/prevention of gender-based violence. It also involved renovation of 5 health facility laboratory hubs.

This last category of work greatly expanded during the last two years of the project, dissipating some of its capacity-building focus. And following the granting of the first of two project extensions in 2015, the direct service delivery role has expanded even further in ten districts of Northern Uganda, where a predecessor health project had been abruptly phased out.

SDS served as a laboratory for innovation even before some of these development modalities were sought to be mainstreamed under the USAID Forward initiative. And more broadly, as the USAID Mission in Uganda gained a reputation for innovation, SDS and other projects in the Mission's portfolio became important testing grounds, consciously or not, for many key USAID Forward concepts. In many ways, SDS was a forerunner of several later large-scale sectoral service delivery projects in Africa and Asia funded by USAID that sought to provide significant institutional strengthening assistance at the local government level, along with coordination anchorage. However, unlike most of these later projects, SDS was designed and managed by a health team at USAID, not a democracy and governance team—which had important implications for the project's evolution, focus, and achievements.

Yet all of this experience and learning has yet to be analyzed or shared systematically. This is to some extent expected for an ongoing project; when the study was commissioned by Cardno, with the blessing of its AOR and the Mission's CLA team, the project still had nearly two years to go, and the project was experiencing wrenching, almost continuous change. Also, the Uganda Mission was – and still is – an extraordinarily busy one, with massive development investments and daunting health and other programming challenges. Thus, over the past several years, it has proven difficult for the Mission to ensure that projects are self-reflective – this despite its being the birthplace of the Agency's CLA initiative. Finally, because SDS was designed and managed as a health project, and thus subject to heavy demand for direct service delivery in recent years, many of its original 'hybrid' governance features (and the accompanying learning) have been obscured. When the study was ultimately delivered in February 2017, the project was winding up its work and it was intended to document carefully the

full scope and history of the project (something all too rarely done, even in ordinary final technical reports) and to sum up the major lessons learned from the project over its nearly seven years of operation.

2.1. Purpose

The case study seeks to encapsulate a wide range of learning from the project. The knowledge base is particularly rich, given the substantial ambitions of the project and its longevity (a $69 million USAID project running nearly seven years with diverse activities in local governance capacity-building, local USAID implementing partner coordination, and direct delivery of certain kinds of health and other social services); the significant political, organizational, and management challenges it faced; and the overall learning environment that USAID/Uganda sought to create. Indeed, this report was very much animated by USAID/Uganda's emphasis on learning and its encouragement (in partnership with USAID's Learning Lab in Washington) of reflective and adaptive management of USAID programs. In examining what can be learned from the SDS Project, the case study not only recounts the specific trajectory of the project, but also illustrates broader issues and tensions in USAID development management.

The SDS Project is an instance of the Uganda Mission's early embrace of several innovations later adopted by the Agency as a whole during the project's lifespan, including the following:			
an emphasis on greater program selectivity (more attention paid to both country-specific strategies and coordination and co-located assistance *within* countries);	reliance on local solutions/local systems, and a heightened concern for sustainability;	a move toward more adaptive management approaches and more flexible contracting vehicles; and	above all, the importance of integrating DRG concerns and capacity-building into sectoral service delivery initiatives.

In Uganda as elsewhere, DRG integration as pursued under USAID Forward not only offered more sustainable, politically attuned sectoral engagements in service delivery, but access to larger funding streams (some of them earmarked Presidential initiatives) able to support otherwise resource-starved governance work. The SDS Project's strong management record and willingness to adapt to meet evolving Mission needs won considerable praise from the USAID Mission and from other stakeholders. However, as discussed in detail below, the time and resources necessary to sustain the original capacity-building work were significantly diverted to direct health services support after the midpoint of the project, and while that work also was commended for its high quality and responsiveness, there were questions raised in some quarters about the extent to which the original focus of the project was lost, and along with it, an opportunity for more sustainable and politically engaged impact.

2.2. Key questions

This case study seeks to capture the learning that occurred in the project, but particularly during the project's innovative early years, when programming was aligned with the original scope and intent. The study also examines a number of questions arising from the project's hybrid identity, which are very much at the heart of broader debates concerning DRG integration, as well as USAID Forward.

The present case study was accordingly deliberately designed with a learning purpose in mind, not as an evaluation. It was also designed to highlight, in the microcosm of a single project, both the advances and the challenges encountered in the USAID Forward experience, in which it was arguably at the forefront. Among the key questions this study addresses are the following:

Urgent service delivery implementation pressures	How much emphasis can be placed on the strengthening and utilization of 'local systems' when the necessary capacity-building may require a decade or more to show results, and delivery of donor-supported health care services, (e.g. for HIV/AIDS and malaria) is an urgent priority, largely carried out by other international implementers on the basis of loose coordination?
Scale of local capacity building work	How much genuine technical assistance and mentoring is feasible for a project whose work is spread across many dozens of individual districts? Should USAID or other donors concentrate efforts of this kind in a smaller number of jurisdictions to ensure better capacity-building and sustainability?
Deeper political economy constraints	More broadly, how successful can a project like SDS be from a sustainability perspective when district governments in Uganda (like many others around the world) lack significant administrative and financial agency as a legal and policy matter? In an environment of this kind of 'partial decentralization,' to what extent should projects like SDS place more emphasis on policy advocacy and engagement with central authorities to create a more favorable enabling environment for local governance?
Costs and benefits of local assistance coordination	What is the cost-benefit of a project like SDS that prioritizes significant co-location and coordination of different USAID projects/assistance streams at the district level? To what degree does such an approach genuinely respond to local preferences and not simply U.S. bureaucratic convenience and post hoc rationalization?
DRG integration	How much DRG integration is possible when Mission DRG budgets and staff are dramatically smaller than those of their sectoral counterparts; and when cross-sectoral or 'hybrid' projects are principally driven by sectoral service delivery objectives, funding mechanisms (often earmarked Presidential initiatives), and time horizons that are significantly more inflexible?
How is CLA understood and used	To what degree are project staff encouraged to 'collaborate' and 'learn' from their local counterparts? Does project 'adaptation' respond more to the local environment or to program teams in the Mission or in Washington? These kinds of questions surface in most development projects. This case study will examine the extent to which they were identified and addressed, and how USAID might face them in the future.

2.3. Case study design

The case study was deliberately designed with a learning purpose in mind, not as an evaluation (a summative evaluation of the project, scheduled at a time when the project was slated to close after approximately five years, was conducted by a local evaluation firm in November 2015-January 2016).[1] The CLA case study employed mostly qualitative methods of data collection, and included 76 in-depth interviews[2] with a wide variety of stakeholders, including current and former USAID/Uganda Mission staff, managers and staff of the SDS Project, implementing partners, political and technical leaders in District-level government, and relevant staff from the Ugandan Ministry of Local Government (MoLG). Substantial numbers of documents—well over 70 reports, manuals, and information sheets/brochures—were reviewed. In addition, an After-Action Review (AAR) on the project as a whole, employing an appreciative inquiry approach and involving the participation of 20 staff members, was

---

[1] See Kibombo, R., et al., 2016. *Evaluation of the USAID/Uganda Strengthening Decentralization for Sustainability (SDS) Project.* Washington: USAID.

[2] Sixty-eight individuals were interviewed, but in the case of eight individuals on the SDS staff, two interviews each were conducted.

conducted on October 18, 2016; this served as both a CLA event for the entire SDS team, and as a means of adding perspective to the main conclusions of the case study.

The case study is organized into four main parts. First, it examines some key contextual aspects of the SDS project, starting with the state of Ugandan decentralization and local government functioning, and then reviewing the USAID/Uganda Mission context in which the project was designed. Next, the study looks at the evolution of the project from start-up to final year of the project, identifying its main objectives and components and tracing changes in programming and management approaches. The following section (Section 4) is the heart of the case study. It analyzes some of the most innovative features of the project in greater depth, particularly in light of USAID Forward and other efforts to improve the effectiveness of donor-funded development programs. That section delves into several areas in which SDS has generated significant learning. These include the project's 'hybrid' cross-sectoral design, its role in helping coordinate co-located USAID programs at the local level, and its emphasis on local solutions and partnerships. Throughout, as a cross-cutting matter, we are interested in exploring the degree of experimentation and risk-taking that took place on the project – with or without the explicit blessing of USAID – as well as the extent to which Cardno staff had the opportunity and/or discipline to engage seriously with local government stakeholders and employ meaningful adaptive management methods. The study concludes with an assessment of SDS from a learning perspective, especially its significance for possible future governance projects in support of decentralized service delivery improvement efforts.

3 Background and Context

SDS has operated in two important contexts—the Ugandan political environment with its decentralized governance framework; and the foreign assistance environment in Uganda shaped by the USAID Mission in Kampala. Each of these is discussed in turn.

3.1. Ugandan Decentralization and Service Delivery

The SDS Project takes Uganda's decentralized governance structure as both a backdrop and an experimental subject. Local government in Uganda suffers deficits in capacity, autonomy, and funding, making it difficult for districts to assume the roles legally defined for them. At the same time, international donor assistance, comprising up to 25% of the total Ugandan government budget,[3] has created a range of complications and distortions in local administration, even as it provides essential support for social services.

Original 35 USAID/SDS Core Program Districts
Additional Northern USAID/SDS Core Program Districts
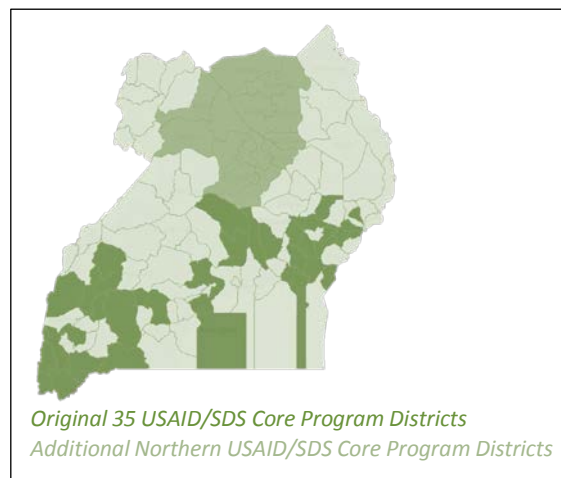
Initially lauded by Ugandans and the international community alike in the 1990s, the country's decentralization reforms have failed for the most part to bring delivery of public services up to an acceptable standard. One fundamental problem is the system's asymmetry. While formally progressive, it imposes unrealistic coordination and implementation responsibilities (and costs) on the lower levels of government. Meanwhile, the system in effect enhances state authority and legitimacy at the center. Uganda's decentralization essentially concedes a degree of participatory democracy at the district council level in exchange for continued central control of the political system.

The administrative system has seen steady de facto re-centralization over the past decade or more, in tandem   with a partial move toward multi-party democracy. This expansion of central control has taken several forms:

> more limited and conditional transfers to the districts;

> curtailment of permissible own-source revenue-raising by districts;[4]

> loss of local government control over recruitment of district chief administrative officers (CAOs), deputy CAOs, and municipal town clerks;

> proliferation of new districts with pliant appointees and patronage jobs (including in opposition areas)[5];

---

[3] Matthew Andrews, 2013. "Overcoming the Limits of Institutional Reform in Uganda*," Effective States and Inclusive Development (ESID) Working Paper   No. 27*, p. 15 (*citing Uganda Government Annual Performance Report, FY 2011/2012* , vol. 1, p. 38).

[4] A major blow to districts was the repeal of the graduated tax, the major source of local revenue for the local governments, in 2005. Districts still have the ability to raise property taxes, but few are able to use it effectively, as is often the case with various local fees, licenses, and other revenues   such as hotel taxes. Local revenue now constitutes no more than 3% of district budgets. *Local Finance Commission Annual Report, 2014*. In most cases,   administrative and political constraints (namely, political sensitivity surrounding landholding and use) undermine collections. And generally, the   shrinking amount of unconditional grant allocations has meant that such funds are used for nondiscretionary recurrent costs, including salaries.

[5] The number of districts has increased from 56 in 2002 to a current total of 112. Meanwhile, in September 2015, Parliament approved an additional   23 districts, so that in four years, 135 districts will exist. This has regrettably entailed associated administrative costs for service delivery, as well as   increased lower level government demands for health facilities to meet Ministry of Health Service Standards—even when

Patronage and corruption indeed continue to take their toll on politics in Uganda, including at the local level.[7] While patronage from the center affects CAO appointments (which can sometimes have a ripple effect in district administration), local councilors at both the district and sub-county level can use their powers of oversight as some leverage over spending decisions.[8]

The problems of decentralization are, meanwhile, nested within larger problems of governmental dysfunction generally. Poor central government performance on compliance with civil service, management, procurement, and financial management legal requirements has accelerated in the past decade, creating a culture of cynicism and distrust. And despite– or perhaps because of – the wave of 'best practice' public financial management, procurement, and other public administration reforms set in motion over the past decade and a half, practical implementation of such reforms has deteriorated. Quite simply, on-the-ground realities (whether due to corruption, political pressures, or low capacities) have allowed the adoption of reforms in name, but the contributed to the persistence of behaviors and operational systems that are fundamentally unchanged.[9] This has resulted in as few as one out of sixteen 'national core projects' being achieved—a category that includes many important health and social service delivery programs.[10]

All of these developments – but particularly the disordered policy landscape, unaccompanied by adequate training and mentoring[11] – have tended to undermine the incentives and ability of local governments to improve service to the public. Shrinking intergovernmental transfers to the districts (from more than 25% of annual national revenues in FY 2004 to about 15% in FY 2014) and the suspension of parish and village elections since 2001, has progressively undercut policy initiative at the grass roots. This is reflected most poignantly in the virtual disappearance in many districts of parish development committees– forums for engaging communities in decentralized planning processes – due to inadequate resources. One result is an erosion of trust in government, and in turn diminishing tax compliance.[12]

Meanwhile, cooperation struggles to emerge. Donor coordination at the macro level has improved as a result of the Decentralisation Management Technical Working Group. But the focus remains on *ministerial* coordination rather than local government information sharing, capacity-building, coordination, or cross-sectoral problem-solving. In light of this, little attention has been paid by either donors or local governments to civic engagement

---

there is no human resource or procurement capacity.

[6] Several of these trends were apparent within the first few years after the introduction of multi-party democracy and persuaded the World Bank to curtail its previously substantial capacity-building assistance to local governments. *See* World Bank, 2014. *Project Performance Assessment Report for the Republic of Uganda Second Local Government Development Project*, Report No. 87597.

[7] Transparency International's East African Bribery Index rated Uganda as having the highest likelihood of bribery among East African countries over the past several years.

[8] Some observers would argue that the decision in 2015 to raise district government councilors' allowances by 150% was less about incentivizing their commitment to representation and oversight duties and more about the government seeking to buy the loyalty of these cohorts.

[9] Andrews and Bategeka, p.25.

[10] Id, p.15.

[11] There are well documented problems with the lack of coordination and training regarding changing reporting mechanisms, policies, reviews, and inspections. *See* Smoke, P. Muhumuza, W., and E. Ssewankambo, 2010, *Comparative Assessment of Decentralization in Africa: Uganda Desk Study* (Washington: USAID).

[12] See Tususbira, F, and Nkote, N., 2013, "social Norms, Taxpayers' Morale and Tax Compliance: The Case of Small Business Enterprises in Uganda.", Journal of Accounting, Taxation, and Performance Accountability, v. 2(1):1-10.

or feedback to the public on budgeting and local decision-making. These difficulties are compounded by competing government and donor priorities. At the same time, donors continue to look for opportunities to 'work with the grain' locally by cultivating progressive district and sub-county leadership, expanding channels for citizen voice in service delivery, injecting performance management approaches into programs and financing streams, and filling gaps in training and mentoring left by overburdened and frequently underfunded central ministry personnel.[13]

3.2. USAID/Uganda Mission Context

Over the past two decades USAID/Uganda's budget has reflected the country's high priority in U.S. foreign policy. This stems from a variety of factors, including Uganda's large population and strategic location, the relative openness of the society, and the demographic stresses experienced over the past two decades (including population control challenges, a devastating incidence of HIV/AIDS, and vast youth unemployment). Also important is the generally pro-U.S. orientation of President Yoweri Museveni. The President has supported efforts at regional stabilization in South Sudan, Somalia, and the Central African Republic, enlisted support of the US against the Lord's Resistance Army in Northern Uganda, accepted larger numbers of regional refugees, and curried favor with American political conservatives and evangelical church groups. The US, like other donors, has stayed engaged in Uganda despite the many challenges, seeking to frame a democracy and governance strategy that would that would more closely support (but also benefit from) the large investments made in the health, education, agriculture, and water/sanitation sectors.

Following two successive USAID-funded decentralization support projects between 2001 and 2007 -- Support for Decentralization in Uganda I and II (SDU I and II) – USAID/Uganda saw a need to move in a new direction This was a response to several concerns. First, the earlier work had produced few tangible results and was seen as excessively supply-side oriented (focused significantly on training around new procurement and budgeting rules). Second, those projects appeared insufficiently attuned to the needs of particular districts and civic organizations (particularly in light of district proliferation, which often drained resources away from surrounding districts). Third, enormous local reconstruction and development needs had arisen in Northern Uganda, and were being substantially neglected by central authorities, in the wake of the Lord's Resistance Army insurgency.

USAID mounted two innovative projects in response. One, called NUDIEL (Northern Uganda Development of Enhanced Local Governance, Infrastructure, and Livelihoods), aimed to address critical reconstruction needs. Under the authority of a separate USAID office in Gulu, cash transfers were arranged to channel GoU funds into capacity-building efforts targeted at local services, infrastructure rehabilitation, and associated job creation activities – all with significant contributions from USAID's Office of Transition Initiatives, the Food for Peace Initiative, and Official Development Assistance from various countries. Another project, Support for Democratic Linkages, sought to strengthen CSO and local government demand-side policy advocacy to address common priorities ranging from local government budget support to youth unemployment.

NUDIEL pioneered the transfer of Government-to-Government (G2G) assistance to severely under-resourced districts in the North, implementing a multi-disciplinary, cross-sectoral project that broke away from existing earmarked USG assistance channels. The idea was to boost the visibility and the capacity of district governments. The project would enable these entities to plan, manage, oversee, and maintain infrastructure, thereby also

---

[13] Within the significant constraints imposed on local governments by the center, it is difficult to know to what extent external assistance can have a demonstrable impact on local government functioning and particular kinds of service delivery. One study suggests that the key factor determining district government capacity and funding is popular electoral support for the dominant party, the National Resistance Movement (NRM), which translates into more favorable inter-governmental transfers and enhanced policy input via informal channels. *See* Lambright, G., 2011, *Decentralization in Uganda: Explaining Successes and Failures in Local Government* (Boulder: Lynne Rienner).

increasing the credibility of local governments with their respective constituencies.[14] An innovative funding and governance mechanism was introduced, consistent with local procurement rules.[15] The project was led by a cohesive cross-sectoral team in the USAID field office in Gulu that itself embodied the breakdown of traditional programming silos.

When a new USAID Mission Director, Dave Eckerson, arrived in 2008, he embraced both projects. The new leadership sought to deepen the Mission's problem-solving orientation and to break with established program modalities. The USAID/Uganda Front Office and Program Office endorsed efforts already underway by the health team, , to tackle long- standing capacity gaps at the local level. These gaps had not been addressed by prior health projects– even as many health statistics deteriorated. These capacity problems seemed intractable, even in the face of huge donor investments in health, education, and agriculture around the country. Capacity-building assistance did not reach large numbers of districts, especially in the southern two-thirds of the country. Linkages featured intensive work in only 10 districts, and NUDIEL dealt with only a dozen Northern districts.[16] The Mission's health team believed that local governments needed not only to receive appropriate TA, but to be incentivized to improve their own capacity. Moreover, basic funding gaps at the local level needed plugging in order for USAID health and social service partners to do their job on other projects.

A number of important strategic discussions took place within the Mission in 2008-2009, reflecting policy trends in the agency as a whole. These concerned, among other things, the agency's initiatives under new Administrator Rajiv Shah that new country programming reflect greater selectivity and strategic focus; rely more on local government systems and solutions; seek out cross-sectoral synergies and opportunities for assistance coordination; conduct more rigorous evaluations and other learning activities; and utilize such learning along with more flexible contracting mechanisms to make programs more adaptable in mid-stream.[17]

Meanwhile, the momentum for innovation within the Mission accelerated. The Mission Director energized the work of the Program Office and made it the nerve center of innovation within the Mission. The focus was in particular on expanding the reach and ambitions of evaluation and learning, developing a more focused, selective, and contextually informed country strategy, and exploring stronger partnerships with local organizations.[18]

In a relatively short period of time, USAID/Uganda became known as a pioneer within the agency.[19] It was the first to develop a new Country Development Cooperation Strategy,[20] shrinking the number of development objectives, highlighting and promoting synergies between them, and encouraging more coordinated and co-located

---

[14] Engagement of local communities in the program was conceived as a critical principle for bridging the gap between the government and citizens in development. Community engagement was encouraged through the identification of projects, monitoring and oversight of project implementation through community management committees, and maintenance of facilities and services.

[15] Interviews with former USAID/Uganda officers, June 22, 2016, August 22, 2016. The project operated through a Sector Program Assistance (SPA) modality, which allowed for the transfer of USAID assistance resources to the GOU through a separate deposit of local currency resources at the Central Bank (i.e. Bank of Uganda) and in turn into a District Government-owned project account (local Barclays Bank). Districts could then directly access funds to assist with the procurement and delivery of services (i.e. infrastructure rehabilitation) to the population, rather than through the traditional modality of funding a development partner or contractor to deliver these services. Meanwhile, from a governance standpoint, NUDIEL funds were managed, and activities implemented, by district authorities in accordance with local government regulatory procedures. A program management committee, referred to as *the Joint Results Management Committee (JRMC)* was established at the national level with membership from the Ministry of Finance, Planning and Economic Development, Bank of Uganda, Ministry of Local Government and USAID.

[16] A sizable Local Government Development Project continued to be funded by the World Bank, but it also had a significant central government focus and insufficient training and mentoring for local officials.

[17] These policy priorities were themselves influenced by the Presidential Policy Directive on U.S. Global Development that had as three of its major themes greater programmatic selectivity, country ownership, and greater rigor applied to the evaluation of development work.

[18] Interviews with former USAID/Uganda officers, September 28, 2016, October 26, 2016.

[19] A measure of the Mission's influence within the Agency is reflected by the relatively large number of individuals who have been asked to join the Policy, Planning, and Learning Bureau in Washington after their service in Uganda. These include several learning officers and Program Office and Contracts Office staff. Moreover, the influence of Mission Director Eckerson within the Agency was indirectly confirmed by his appointment to the position of Counselor to the Administrator in 2012.

[20] Although the CDCS was not formally approved until April, 2011, work on it began as early as late 2009.

assistance within Uganda (particularly through so-called "Mission-focused" districts). It also included CLA as a formal policy component of the CDCS. This was meant to ensure that the CDCS functioned as a "living strategy," providing implementation and course correction guidance as needed. To carry out these reforms, the new Mission leadership expanded Program Office staff (US direct hire Mission staff grew by a third under his tenure) and hired the first full-time learning officer in 2010.[21]

3.3. Designing SDS

It was within this fertile and open-minded USAID Mission environment that the SDS Project was conceived. In response to the gaps in capacity, funding, and incentives mentioned above, the health team, impelled by veteran USAID officer Elise Ayers, developed a scope of work that evolved into SDS. The core idea was to take some of the World Health Organization's basic health systems strengthening 'building blocks'[22] and leverage PEPFAR funding to assist governance capacity-building at the local level in Uganda.[23] The Mission would seek to provide intensive help in planning, budget, and oversight to 45 districts across the country (later reduced to 35 by excluding 10 Northern districts). USAID would specifically provide direct financial inducements to local governments – a performance-based grants program focused on specific health and other social service needs – so as to provide a degree of financial agency and control lacking in Uganda's highly constrained system of conditional transfers from the center. Instead of NUDIEL's multi-stakeholder financial oversight mechanism anchored at the central government level, SDS would create more direct performance accountability between the districts and the project implementer. This was consistent with both the higher capacity of many of the non-Northern districts and the desire to empower them in a more flexible manner without the involvement of central authorities.

In addition to the signature grants program, SDS was to have three other distinctive features. First, the program would provide direct TA to districts and establish a separate performance-based grants program to furnish funds for additional TA, equipment, and supplies. Second, the implementer would develop yet another grants stream to focus on innovative leadership development and ways of sustaining progress made under the basic health/social services grants. Finally, the project would seek to coordinate and align all USAID assistance with local priorities in the target districts. This would avoid program inconsistencies and make US assistance more transparent and responsive to local needs—a core tenet of evolving USAID thinking and the Paris Declaration.

In this innovation climate, it is perhaps unsurprising that SDS contained a number of novel features, and was transformed over time. Indeed, given the adjustments and policy mandates to which it was subjected over its almost seven-year lifespan, SDS provides an interesting lens through which to view an eventful period in the evolution of U.S. foreign assistance. Certainly the NUDIEL project provided a precedent within the Mission to think boldly about project implementation approaches and cross-sectoral thinking. But while NUDIEL was radical in its core G2G design and breaking down of sectoral and funding silos, SDS hewed to a somewhat more traditional implementation model. This meant relying on a large implementer to run the project, situating the project within a single sector (the health, with relatively little input from Mission's DRG staff), and channeling significant funding through a grants mechanism (albeit a performance-based one). Ultimately, a health team-driven model has proven less influential than one might have imagined (see Box 2).

---

[21] In this respect, USAID/Uganda was also out in front when it came to the Agency's overall efforts to increase the ranks of its full-time officers and bolster in-house expertise, which had become attenuated over the past decade. *See* Eckerson, D., 2013. "How a New USAID Was Born," March 20, 2013, https://blog.usaid.gov/2013/03/how-a-new-usaid-was-born/ ("...[H]ave enough staff to do the job ourselves, and not rely on hired guns").

[22] The WHO building blocks include 'service delivery,' 'health workforce,' and 'leadership/governance,' as well as health financing, information, and medical products, vaccines, and technologies. *See Everybody's Business: Strengthening Health Systems to Improve Health Outcomes* (Geneva, 2007), p. 3.

[23] Interviews with former USAID/Uganda officers, September 28, 2016; October 26, 2016.

Before delving into an analysis of the SDS model, we consider the SDS Project's structure and objectives, its evolution in response to a wide range of external and internal factors, and some of the learning gained by its staff, sometimes fitfully, over the past seven years.

4 THE EVOLUTION OF THE SDS PROJECT

This section provides a big-picture overview of the project from its origins to the present, highlighting important program developments and turning points, as well as project-wide learning. A more detailed analysis of lessons in key thematic areas and components appears in Section 4.

The SDS Project was put out for bid in the late summer of 2009. Valued at just over $40 million, SDS had a five-year duration. With a local government capacity-building and grant-making focus, the project was designed to assist efforts to address service delivery challenges in such areas as HIV/AIDS, tuberculosis, malaria, maternal and child health, and family planning and reproductive health. It would do so by helping districts and sub-counties plan, budget, coordinate, monitor, and evaluate decentralized service provision. This would depend on more efficiently utilizing the Government of Uganda's existing administrative and fiscal decentralization framework. SDS would also give the districts performance-based grants to help support district- and implementing partner (IP)-identified service delivery priorities. (See Box 3 for a description of SDS components.)

Box 3 **SDS components**

The SDS Project has four basic objectives

1	effective coordination of all USAID-supported technical assistance provided by district-based implementing partners (DBTAs);
2	technical assistance to districts in such areas as planning, procurement, and oversight to help them better manage their limited resources and achieve better social service delivery program results (all of this occurring within the framework of USAID-assisted District Management Improvement Plans and in conformity with established Ugandan local government guidelines);
3	issuance of performance-based grants to districts to address targeted non-recurrent financial needs (i.e., non-wage expenditures such as supplies, materials, vehicle operational costs, and staff per diems for travel) in key health and other social service delivery areas (so-called A Grants), as well as particular capacity-building priorities (so-called B Grants); and
4	introduction of innovative organizational and leadership strategies and approaches to mobilize resources and sustain improvements in social sector service delivery (to be effected through both special TA and competitively-procured "C Grants").

USAID/Uganda intended to put the project's financial resources as close to the project's district-based beneficiaries as possible, while helping improve resource management and accountability at district and sub-district levels. The assumption here was that direct technical and financial capacity strengthening assistance would enhance local ownership and autonomy of decentralized government systems. In particular, SDS financial assistance was targeted at providing technical support to health sub-districts, to lower-level facilities, and to overall improvement of the monitoring of district health service delivery. By helping fill capacity and funding gaps (e.g. inadequate numbers of qualified health staff), SDS could help reverse a number of worrying health trends in the country.

4.1. A Difficult First Year (May 2010-June 2011)

The project was awarded to Cardno Emerging Markets USA, Ltd. in early 2010, and work began in late April of that year. It was procured as a cooperative agreement, as is common for large health projects with complex

implementation demands and requiring relatively frequent program adjustments. But this structure, perhaps counterintuitively, remains unusual for major USAID governance projects, ostensibly because they often involve potentially sensitive interactions with host government authorities, over which USAID and the State Department would like to retain more control or oversight.

The project's first year was by all accounts, surpassingly difficult. Several factors contributed here, including (i) disagreement and confusion about objectives within the project and the USAID Mission, as well as among DBTA partners; poor communication about the project to central and local authorities in Uganda (which in turn led to unrealistic expectations from districts about what assistance SDS was able to provide); (iii) a Chief of Party (a doctor) largely unversed in governance work); and (iv) problems in management and staffing that prevented consistent technical assistance from being delivered to many districts. Most important was the confusion about the project's main purpose by the USAID health team and the Cardno COP. While the USAID solicitation clearly focused on district-based capacity building, the SDS start-up was delayed by discussions about central-level health systems strengthening.[24]

The Mission's unrealistic milestones added to the difficulties. It was anticipated that MoUs would be signed with all participating districts, and that Grant A disbursements would be made, within six months, and further that all Grant B disbursements would be made within eight months. Insufficient time was allocated to political outreach and relationship- building with both central government and district officials. Also, there appeared to be little understanding that technical assistance needs required careful attention, in each district, to assessment, consultation, and buy-in. Finally, inadequate time had been allocated to Cardno to hire its full complement of staff and build them up as a team. Despite the innovative SDS project design, the Mission's initial approach to implementation reflected the traditional top-down, highly directive practice, in which the districts were largely passive aid recipients. The tensions inherent in the design of SDS added to the complexity (see Box 4).

Box 4 Two projects in one

The first-year experience sharpened the tension between the project's primary identity as a *health* project—based on its bureaucratic home—and the *governance* focus of its programmatic objectives. USAID health projects typically work in dozens of local districts in a relatively rapid, self-contained implementation mode, interacting primarily with the Ministry of Health and local health officers (as in PEPFAR initiatives). By contrast, the design of SDS called for much more intensive engagement -- not only with the Ministry of Local Government and district executive and technical staff, but with elected officials (district councilors) as well. This required much greater attention to the details of institutional capacity in each district, and sharing information with local governments and civil society. Indeed, *process considerations* involving consultation, transparency, and local ownership and sustainability were far from being adequately appreciated by donor health staff or many Cardno personnel at the time.

Faced with these challenges, Cardno in 2011 hired a new CoP (Ella Hoxha) with a deep local governance background. At the same time, there was a general restructuring of the staff—many left, or were let go—consistent with a renewed focus on the project's original capacity-building scope. USAID/Uganda accompanied SDS personnel to a series of regional meetings with district officials to jump-start district interest in the grants program and technical assistance delivery. And, the Mission formally relieved SDS of its obligations to serve 10 districts in the North, reducing the program's coverage to 35 districts.[25]

Around the same time, Cardno and its subcontractor, the Urban Institute, collaborated to provide intensive short-term technical assistance to complete the 35-district baseline management self-assessments, begun nearly a year earlier. These were intended to establish the level of service delivery capacity in terms of quality, coverage,

---

[24] Quite amazingly, the project scope of work was not shared for months with senior local project managers by the COP, adding to confusion about the actual capacity-building thrust of the project. Interviews with SDS staff, May 23, 2016.

[25] This was done in part to simplify SDS' responsibilities, but it was also understood that the dual streams of social services and governance-related assistance would soon be delivered by the NU-HITES and GAPP projects, respectively.

and accessibility while pinpointing management and service delivery gaps. The baseline assessments found that there were few mechanisms to bring community stakeholders together to address issues of common concern affecting service delivery. They also found poor performance in planning, budgeting, procurement, and financial management, along with inadequate use of M&E and management information systems to support decision-making.[26]

A complement of SDS local staff with institutional development expertise was also brought on board to assist the drafting of District Management Improvement Plans (DMIPs) based on the results of the baseline assessment reports. The DMIPs in turn were to help SDS shape its prioritized technical assistance plans for the districts, while enabling the latter to apply for the capacity-building 'B' grants in an extended time frame. Work on the grants manual and grants procedures went into high gear in the final quarter, and USAID determined that Category 'A' grants could be used not only to help finance a range of health service delivery needs, but social services needs of orphans and vulnerable children (OVC) as well.

Year One 2010 – 2012: Major Program Milestones and Events
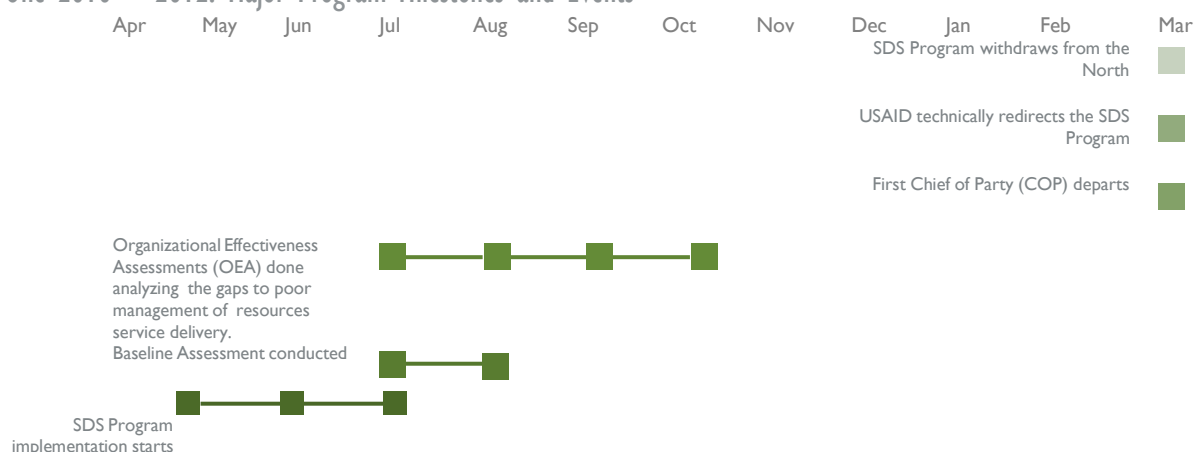
Meanwhile, in accordance with Objective One, SDS took on the daunting task of coordinating and harmonizing service delivery support by all DBTA partners in every target district. Not only did this require an enormous time commitment on SDS' part, but it was unclear how this coordination could work in practice. DBTA partners were governed by discrete contracts and cooperative agreements that did not envision the particular resource commitments and activities demanded by intensive district-level, cross-sectoral synchronization. SDS was given only minimal guidance by USAID in managing this effort (as will be analyzed in more detail below in Section 4). In fact, the issuance of Grant A's made coordination significantly easier. Since Grant A's explicitly involved input from the DBTA's and incorporated quarterly action plans, SDS was able to hold coordination meetings around a tangible product and expected outputs.[27]

4.2. Year Two: Turnaround (July 2011-June 2012)

In its second year, SDS reached a number of high-profile milestones in consolidating progress on all four Objectives. In the process, SDS created the foundational district mechanisms and training modalities that would serve the project for several years into the future. Three regional offices were staffed up, allowing training, mentoring, and oversight to be conducted with a high degree of visibility to district personnel. The regional structure grouped participating districts together in 'clusters' of (three or four each) to permit efficient project interaction, and later on, peer learning and technical assistance (TA) on issues of budgeting and planning.

---

[26] SDS Annual Report, April 2010-June 2011.

[27] Id.; Interviews with SDS staff, May 19, 20, 24, 25, 2016.

Year Two 2011 – 2012: Major Program Milestones and Events

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |

SURGE roster of local consultants established (Spring board for Technical Assistance) — Jan – Mar

Growing visibility of SDS Program as the COP at the time showed the flexibility of SDS — Jan – Mar

Funding by DANIDA, and USAID — Jan – Mar

LOGIC 1: Local councilors and technical leaders are trained on their responsibilities and responding effectively to citizen demands — Jan – Mar

Jan – May 2012 : demands Outcome Grants — Jan – Mar

Performance Based Grants commence — Jun – Aug

First Grant A is signed — Aug

Introduction of Performance Based Financing — Apr – Jul

New Chief of Party joins the SDS Program — Apr

Portfolio Review — Apr

Regional meeting in Jinja, Mbale and Kumi, under direction of USAID — Apr

USAID collaboration with the SDS Program grows. Substantial involvement and action plan developed to enhance performance — Apr

SDS Program is restructured — Apr

On Objective One specifically, more intensive regional IP meetings were held with the DBTA partners to ensure that all IP activities (especially training plans) and budgets were included in each district's work plan.[28] More important, to address the challenges faced by SDS in coordinating DBTA partners, USAID introduced a new formal coordination mechanism into the project in sixteen of the SDS districts (the "Mission-focused districts"): *District Operational Plans* (DOPs).

DOPs had their origin in discussions within USAID/Uganda in late 2010 (in conjunction with development of the CDCS). The idea grew from the hypothesis that development results from health, economic growth, and democracy and governance investments would improve where they all concentrated in a smaller number of districts. Yet the Mission also realized that greater numbers of programs in the same locations would produce some negative results, e.g., duplicative or conflicting interventions, confusing signals from Mission project officers, and excessive time and information demands placed on district officials. Accordingly, DOPs—memoranda of

---

[28] Each DBTA partner was also required to designate a focal person in each district to coordinate with district leadership. The main USAID-supported DBTA partners operating in the SDS districts at the onset of the project were the Strengthening TB and HIV &AIDS Responses-Eastern and East Central (STAR-E and STAR-EC) projects, the Strides for Family Health project (STRIDES) Supporting Public Sector Workplaces to Expand Action and Responses against HIV/AIDS (SPEAR), The AIDS Support Organization (TASO), Livelihoods and Enterprises for Agricultural Development (LEAD), AFFORD Health Marketing Initiative (AFFORD), Uganda Health Marketing Group (UMHG), Sustainable Responses for Improving the Lives of Vulnerable Children and their Households (SCORE), and Securing Uganda's Right to Essential Medicines (SURE).

understanding between districts, USAID and all DBTA partners located in a limited number of districts—were to be adopted. This would ensure that USAID programs were aligned with existing district development plans (DDPs), promote complementarity and efficiency among DBTA partners and their provision of assistance, and improve communication and M&E channels among all three parties.

Thus USAID acknowledged the need to treat districts as genuine partners in development – and doing so would deepen the *Objective One* work on SDS. To that end, each of the DOP MoUs in the SDS Mission-focused districts established a District Management Committee (DMC). The DMC would be chaired by the District CAO and composed of sectoral staff of the district (in USAID-relevant sectors), representatives of each of the USAID DBTA partners, and a designated USAID official. The USAID Mission Director and the District Council Chairperson were designated as ex-officio members. DMCs were designed to meet quarterly to resolve coordination issues and align IP activities with existing district development plans (DDPs).[29]

Meanwhile, on *Objective Two* (training and capacity-building), DMIPs were completed by several of the higher-capacity districts (eleven partner districts in total).[30] Also, conferences and workshops were held to acquaint district staff with gap and root cause analysis and improve their use of Organizational Effectiveness Analysis (OEA) tools (eventually, an OEA was developed for each of the 35 districts). And given the huge capacity-building needs of the 35 individual districts, a decision was made to hold more cross-district training events. These had the added benefit of allowing districts to compare data and organizational approaches, and to identify reform opportunities. (Particularly useful were comparisons about own-source revenue mobilization approaches, as well as methods to pre-allocate late fiscal year conditional and unconditional transfers).[31]

To complement ongoing mentoring activities and more effectively help lagging districts with their planning, oversight, and evaluation objectives, SDS created a so-called "Surge Team" of consultants. This team would address remaining assistance needs without overwhelming district officials. The method was a rolling series of regional training and TA events that would help the clustered districts to complete their DMIPs and later provide training on key budgeting, planning, revenue enhancement and other topics. This approach also enabled follow-up mentoring and reinforcement through both technical TA staff and regionally-based program coordinators.[32]

Under *Objective Three*, covering the grants program, SDS successfully disbursed four consecutive quarters of Grant A payments to all but two of the 35 districts, using the project's recently adopted performance-based financing methodology (see Box 5). During the year, grantee performance consistently improved and intensive 'validation' (i.e., audit) activities conducted by SDS grants staff led to an abundance of Grant A program and policy adjustments (including fine-tuning of

the rewards system for meeting various performance targets—utilizing a more outcomes-oriented approach). Permissible Grant B funding targets were also preliminarily identified based on a systematic review of the districts' DMIPs.

---

[29] Eventually, virtually, all districts chose to hold a DMC meeting quarterly. Interview with former USAID/Uganda officer, September 28, 2016.

[30] These DMIPs were assisted by SDS staff. Later, all 35 districts completed their DMIPs, assisted by the SDS 'Surge' Team.

[31] SDS Annual Report, July 2012-June 2013; Interviews with SDS staff, May 22, 24, 25, 2016.

[32] In Year 2, specific TA Surges were conducted relative to DMIP completion and Development of Grant B and C applications.

Box 5 Grant Methodologies

Grant A

Under this methodology, meeting quarterly programmatic and financial targets would secure renewal of the funding. Failure to meet the targets would result in a graduated loss of funding for the next quarter's grant disbursement. For example, one target involved adequate use of local revenue to pay for certain activities in support of orphans and vulnerable children. Another addressed cost-sharing by the districts—often in-kind—to complement DBTA activities in the district.

Grant B

Grant Bs provide resources for enhanced management systems and strengthened capacity at district and sub-county administration levels. Grant Bs will lead to improvements in the selected focus areas, resulting in better health and other social sector service outcomes. Based directly off of gaps identified in DMIPs, Grant Bs fund activities that address the SDS program areas as they apply to health and other social sector service areas.

Successful performance on Grant As was a prerequisite to be considered for Grant Bs. Districts which applied for Grant Bs were also required to meet certain performance standards in the focus areas of planning, coordination, budgeting, financial management, procurement, monitoring and evaluation, and implementation. Grant B implementation has been slowed across recipient districts due to other commitments by Technical Assistance Partners. Given the nature of agreed performance based indicators, performance will be measured at annual bases.

Grant C

Grant C, competitive grants, support the piloting or scaling of approaches to sustain and improve social service delivery at the district and sub-county levels. Grant Cs fund improvements to public and private not-for-private health facility structures and equipment and improvements to referral (transportation) systems to these facilities. Additionally, piloting new innovations with regard to community outreach for health and OVC may be addressed.

Grant C eligibility was limited to 20 of the 35 SDS-partner districts, which were identified as high-performing districts based on performance criteria from SDS grants and program team evaluations as well as GoU assessments. The 20 districts submitted concepts and 13 will be requested to complete full grant applications. Grant C continues to build off structures development in Grant A and B, supporting stronger institutions and improved coordination with partners.

As for *Objective Four*, the DMIP process uncovered some potential for genuine innovation in certain districts (although very severe constraints on district management flexibility foreshadowed a need to scale back expectations for extensive Grant C activities).Further, SDS was tapped by USAID to provide induction training to a massive cohort of 23,264 recently- elected local councilors, helping them understand and oversee the workings of district- and sub-county level service delivery activities and respond more effectively to citizen demands (some 4,868 department heads participated in the 325 training sessions held across the country over a period of several months in the spring of 2012).

Meanwhile, the project had organized a special inter-ministerial steering committee to ensure that the project was communicating learning to central government authorities. The so-called Inter-sectoral Committee included representatives from the Ministry of Health, Ministry of Local Government, the Uganda Local Government Association (ULGA) and the Uganda Local Authorities Association. The group met quarterly.[33]

---

[33] Id.

By the end of Year 2, the project had executed a massive turnaround and gained the confidence of most districts and of USAID. Both saw the project as well-led, hugely energetic, and willing to engage with districts in a new way – as more serious political partners, and as more serious financial managers subject to stringent performance expectations and auditing/validation actions. (The performance criteria are analyzed in Section 4). During this period, the project's identity became clearer—as a governance-oriented project operating in a health context (albeit with many of the tensions inherent in this hybrid identity).

Yet the project had an enormously ambitious capacity-building and coordination agenda that afforded less attention to any particular activity or district than was originally envisioned by Cardno via the DMIP process. By Year 2, it became abundantly clear that the original vision in the RFA of providing significant capacity-building assistance to a limited number of sub-counties within each district was not feasible. Breadth, not depth, seemed to be necessary for a project at this scale, particularly as SDS staff struggled to meet the capacity-building needs of individual districts that had so carefully been identified through the DMIPs. But even in districts starved for such attention (and funds), SDS' support was genuinely appreciated. Grants provided an incentive for these districts to play a greater leadership role in monitoring and coordinating DBTA assistance as originally envisioned by the SDS project scope.

4.3. Year Three: High-Water Mark (July 2012-June 2013)

The project's third year represented a high water mark in terms of congruence with the core capacity-building objectives of the project and support and enthusiasm from district officials. The grants program was in full swing, as were the technical assistance activities designed to complement it. And based on the experience with the DOP in Year 2, it was extended at USAID's request to all 35 SDS districts. All of this work solidified the project's reputation with the Mission as a competent and trusted platform able to influence all 35 SDS districts. While challenges inevitably arose, there was a palpable sense that new skills were being learned and responsibilities assumed by local officials –in many ways beyond what had been achieved previously by either the Ugandan Government or international donors. There was general agreement that many district officials for the first time had a clear picture of the activities and resources directed to their jurisdictions (although many DBTAs and district officials questioned the formalities and transactions costs involved in using the DOP procedures).

In the area of TA, nine categories of assistance were developed for all of the districts, complementing both the service delivery-enhancing funds provided under the Grant A program and the focused capacity-building funds to be released under the Grant B program.[34] A companion 'Flagship TA' program was developed for seven discrete areas where SDS experts saw the need for additional and deeper capacity-building help, drawing on the expertise of several SDS consortium partners, including Urban Institute and the Infectious Disease Institute.[35] Intensive TA clinics were delivered by Cardno and Urban Institute on revenue enhancement and procurement. These identified strategies to improve revenue collection and procurement systems. Possible new revenue sources were also identified, such as assessments on private schools and health facilities, and a produce tax. Year 3 also saw a fourth surge, devoted to Integrated Planning and Budgeting, which sought to integrate donor support (including direct monetary grants and off-budget support) into the districts' respective Budget Framework Papers using an output budgeting tool (OBT)—allowing districts to track, forecast and plan for resources from implementing partners.[36]

---

[34] These included (1) district HIV/AIDS strategies, (2) drafting of social sector ordinances, (3) revenue enhancement, (4) district supervision of private health services providers, (5) health sector human resource management, (6) enhancement of community-based orphans and vulnerable children (OVC) services, (7) health information management systems and M&E, (8) enhancement of communications on social sector service delivery, and (9) learning from model districts via exchange visits. SDS Annual Report, June 2013-July 2014.

[35] The seven areas included (1) revenue enhancement, (2) procurement, (3) grants management, (4) MIS/M&E, (5) communications strategies, (6) integrated budgeting and planning (IPB), and (7) audit and accounting.

[36] Id. Other surge activities conducted subsequently included those for recruitment of human resources, revenue enhancement and procurement management, the conduct of mid-term reviews of District Development Plans, and public financial management and audit.

Year Three 2012 – 2013: Major Program Milestones and Events

| Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |

Technical assistance for Innovations — Feb

First cohort of Grants B disbursed, all districts receive their respective grants, selection process includes MOLG — Jan

Integrated Planning and Budgeting (IPB) Technical Assistance commences — Dec

Grant Bs awarded — Dec

A list of activities to be funded under Grant A and B schemes is prepared — Jul

District Management Improvement Plans (DMIPs) planning commences — Jul

Institutionalization of the SURGE roster approach — Jun

Orphans and Vulnerable Children (OVC) services action plans are changed from output to outcome grants — May

Round Two of district grants awarded — May

SDS Program Learning Moment — May

In the grants area, higher expectations placed on the districts under the performance-based regime at the end of Year 2 led to a change. Disbursements were now to be based on outcome targets—action items—being implemented, rather than simply on outputs (such as reports on meetings and support supervision).[37] The first two quarters under the new approach were a struggle for many districts, especially given the high volume of TA and training needing to be absorbed. But, by the end of the year most districts had registered improvements and many expressed pride in meeting a higher standard of accountability.[38]

The Grant B program—intended to provide resources for enhanced management systems and strengthened capacity— got underway, though not entirely as envisioned in the original project design. The original idea was an open-ended complement to the DMIP process that would allow the districts freedom to address particularly critical capacity issues. In the event, the program was rolled out as a more standardized, even partially 'earmarked' program in the view of some observers. This was not only for administrative efficiency, but also to address needs that USAID/Uganda and many DBTAs felt deserved deeper attention. These included better integration of social sector development partners into district planning and budgets, more rigorous assessment of district health workers, and better coverage of services for the eligible OVC population.

---

[37] Id. The PBF indicators substantively focused on the functionality of District Orphans and Vulnerable Children Committees established by the project, the use of data in planning OVC interventions, and the proportion of OVC receiving child care and protection services, but also addressed the implementation of agreed upon action points by an integrated health support supervision staff and financial management (the percentage of allowable costs as a proportion of the total quarterly grant disbursement).

[38] Id. Interviews with SDS staff, July 13, 14, 2016.

The Grant C program, meanwhile, gathered steam as SDS worked with the Ministry of Local Government, Ministry of Health, Ministry of gender labor and social development, Ministry of Education, district leaders, NGOs, universities, businesses, and donors to collect over 70 innovative approaches to delivery of social services that could inform the districts' Grant C applications.[39] On the basis of their Grant A performance and various qualitative and quantitative criteria, 20 high-performing districts were made eligible to receive C Grants— then pegged at $250,000 per grant. As Year 3 drew to a close, additional TA was provided to help the districts submit worthy proposals.

In the last quarter of Year 3, with SDS running smoothly, the Mission (through Modification No. 4) expanded the scope of the project by having it undertake activities in three new areas: recruitment of health workers to address shortages in a number of districts (Human Resources for Health, or HRH), the integration of water, sanitation, and hygiene (WASH) activities in three districts over the course of a year (Kabale, Kisoro, and Kunungu), and a priority technical assistance activity in the nutrition field designed to ensure that each district established a multi-sectoral District Nutrition Committee and associated integrated nutrition action plan. While they were consistent with the overall SDS goals, these social service add-ons ultimately led to a major reshaping of the project in Years 4 and 5.

4.4. Years 4 & 5: Big Changes (July 2013-June 2015)

Four significant developments punctuated the Project's fourth year. One was the addition of the three social service components to the project's district-based portfolio—the aforementioned WASH and nutrition activities. Second was the addition of the HRH activities, but on a larger scale than originally anticipated—ultimately embracing 29 additional districts beyond the 35 existing SDS districts. Third, an early grade reading activity was added in the spring of 2014, encompassing support to basic education in the four districts of Budaka, Kumi, Mbale and Sironko.[40] Finally, there were significant funding cuts to the overall SDS program, based on both an overall reduction in PEPFAR funding that represented the bulk of the SDS budget and a cautionary slowdown in overall Washington funding support for Uganda after the country passed the controversial Anti-Homosexuality Act.[41]

As a result of these cuts, USAID/Uganda informed the SDS leadership that the project needed to be redesigned to accommodate priority activities, which encompassed the new sector support activities above, the DOP mechanism, and the Grant A program. In the second half of Year 4, these developments led to closure of the project's three regional offices and a substantial curtailment of the project's TA and mentoring work. This seemed to undercut the project's long- term commitment to district capacity building and continuing support to improved district financial management, procurement, data management/M&E, and revenue collection in particular.

This change in identity took a toll on the Grant B and Grant C programs. In the case of Grant B, which were now being utilized in part to add the education activities in the four districts of Budaka, Kumi, Mbale, and Sironko, the activity's progress had been very uneven, due in part to the delay or failure of certain DBTAs to deliver necessary TA associated with grant-supported activities. District implementation also lagged as a result of a poor incentive structure. Grants were validated only annually, not quarterly. This led not only to a relatively high level of ultimately questioned costs, but also to the blunting of district personnel motivation to meet their performance targets. Equally problematic, these looser strictures had a knock-on effect on Grant A, causing performance to

---

[39] Many concepts revolved around innovations in the use of mobile phone technologies, MIS, public-private partnerships, and innovative human resource management.

[40] The focus of the initiative was using SDS' work with community development officers and high level support from CAOs to leverage already existing activities in those districts by USAID programs like the School Health and Reading Program (SHRP) for early grade reading activities, the Education Management Information System (EMIS) II Program for data collection activities, and the SUNRISE project focused on OVC work.

[41] SDS Annual Report, July 2014 – June 2015; Interviews with SDS staff, May 23, July 13, 2016.

flag due to the relatively 'easier money' obtainable under Grant B.[42] In the end, against the backdrop of the new financial pressures, SDS determined to end the program, seeking to strengthen and augment the more successful Grant A mechanism.

Year Four 2013 – 2014: Major Program Milestones and Events

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

HRH, Education and water and sanitation components commence — Jan

Grants Rounds continue — Jan

USAID sends technical direction memo on allowable and disallowable costs — Oct

First round of public sector HRH recruitment takes place — Aug

On boarding ACCLAIM as a sub-a wardee to support seconded public health workers — Aug

USAID sends technical direction memo to commence laboratory works — Aug

Extension of SDS Program to include: Water Sanitation and Hygiene, Early Grade Education, and Human Resources for Health (HRH) — Jun

The Grant C program fared only marginally better. Of the 20 eligible districts, only 13 districts were selected for funding, and many of those grants were viewed as "cookie-cutter" projects.[43] Due to the project's financial constraints, no Grant C's were made in Year 4, and only in Year 5 were such grants finally awarded—and then only to the six selected districts of Mbale, Sironko, Kaliro, Bugiri, Kiruhura and Ibanda, and in the greatly scaled-down amount of $50,000 per district.

For grants programs that had once held so much promise, Grant B and Grant C seemed to district officials to have evolved into mechanisms lacking consistency in purpose and execution—and to have placed USAID programming priorities ahead of their own. Still, in ending the respective grant programs prematurely, USAID/Uganda and SDS appeared to be trading continuity, trust, and ownership at the local level for an expansive project scope predicated on the superior performance of the SDS project as a handy vehicle or 'platform.' At the same time, it could be argued that the new education, WASH, and HRH activities were building on a relatively strong district foundation and relationships that SDS had been instrumental in putting in place. These interventions could be seen as yet another dimension of capacity-building (see Box 6[44]).

---

[42] SDS grants officers surmised that some districts focused on implementing mostly those activities that would maximize performance scores, rather than the full complement of planned activities, although in some cases, the latter were particularly time and money intensive. *See, e.g.,* SDS, 2014. *Grant B Consolidated Desk Review Performance Report (January-December 2013).* March 2014, p. 12.

[43] SDS had been highly accommodating in facilitating contacts between districts and individual point persons to share information on a peer-to-peer basis—although perhaps expectedly, this also generated considerable mimicking and copy-and-pasting of proposals without adequate reflection or adaptation. Interviews with SDS staff, May 24, 2016.

[44] SDS Annual Report, July 2014 – June 2015. In addition to the education and WASH areas, one other subject matter addition to the SDS portfolio was a mandate (per both the Government of Uganda and USAID/Uganda) to help form nutrition coordination committees at the district and sub-district level in all SDS districts, so as to help implement the GoU's Five-Year Nutrition Action Plan (2011-2016).

Implementation of SDS add-ons

The new education and *WASH* activities ramped up quickly toward the end of Year 4. The education initiative, now denominated the Education Support Program for Improved *Early Grade Reading (eGRIP)*, focused on empowering community structures and systems in the four districts. This included, e.g., capacity-building in planning, budgeting, and MIS related to education; intensive training of School Management Committees; and the holding of town hall meetings (*Barazas*). These structures could be mobilized for stronger community engagement in primary school reading, while improving stakeholder involvement in education at the district level and expanding outreach to the wider public through organized radio talk shows. A limited number of grants were also made to youth groups to lead innovative interventions to encourage early interest in reading and writing, while a new, modified Grant B mechanism was utilized (with new tailored PBFs) to support and augment the district-led activities. Meanwhile, in the three WASH districts, a similarly tailored Grant B tool was utilized to complement TA and training by funding a range of infrastructure (e.g. roof rain water systems, latrines, and handwashing basins), sanitation, and community and school hygiene activities, as well as the revitalization of Water Users Committees.

The *HRH* initiative dominated the new Objective 2 capacity-building activities. HRH's objective was to recruit skilled human resources in the health care field –midwives, doctors, nutritionists, laboratory staff, and pharmacists—and second them to public and private not-for-profit facilities to address the needs of Uganda's most vulnerable citizens, especially women and children in underserved rural areas. The aim was to help meet a Ministry of Health target figure of 75% health service coverage and reverse the high HIV prevalence in the country (which increased from 6.3% in 2006 to 7.3% in 2011 despite massive domestic and donor investments in HIV/AIDS assistance). In partnership with USAID, SDS developed the idea of recruiting and paying the new workers while working closely with private health bureaus throughout the country (Uganda Moslem Medical Bureau, the Uganda Protestant Medical Bureau, and the Uganda Catholic Medical Bureau) and District Service Commissions to utilize, supervise, train, and eventually absorb such workers into the government payroll over time. SDS also pioneered the use of specially designed timesheets to ensure worker accountability and productivity monitoring. Modified Grant B's were designed and issued to support the work of the three medical bureaus.

Despite significant challenges, over 650 workers were employed in 67 districts by the end of Year 5, about two thirds of them in public positions and the remainder in the private medical bureaus. Altogether, about 43% of the public facility staff had been absorbed into the local government service. Massive and labor-intensive support supervision activities were undertaken by SDS staff and local officials, not only to promote absorption efforts but also to validate the level of effort by HRH workers and ensure that performance appraisals were routinely conducted. SDS staff also worked with facilities to implement quality improvement plans and facilitate rewards and promotions for their best-performing staff.

With all these new activities in the foreground, the project's core TA work continued, but at a less intense pace due to other priorities and the closing of the regional offices.[45] But SDS managed to keep advancing its work on two other core fronts—the DOP and Grant A. The DOP work continued in all of the SDS districts through the DMC mechanism. There were lingering questions about the uneven quality of the meetings resulting from excessive formality due to the USAID presence, weak or under-informed CAOs, absenteeism by many IPs, and ineffective management of the process. Partly for this reason, USAID and SDS pushed to have the DMC integrated into the districts' regular district technical planning committee (DTPC) meetings, but this was resisted by several districts as unnecessarily intruding upon their internal work and over-burdening their staff.[46] Further efforts were

---

[45] In Year 4, the project still managed to conduct some core TA and training activities, including those in areas like accounting and auditing, communications, enactment of district ordinances, and M&E and MIS training for purposes of using sector data for planning, change actions, and development of district based PMPs for health and other areas of social sector activity. The project also undertook a comprehensive review of District Development Plans (DDPs) and provided leadership TA and training for CAOs and other senior district executives.

[46] Blending the DMC with the DTPC in many cases had the awkward effect of creating an agenda loaded with issues of little direct relevance to many IPs, thereby creating a disincentive for some of them to attend. So too did the inclusion of more IPs and other stakeholders complicate the streamlining and sequencing of agenda items.

made to hold key sectoral/departmental meetings with IPs before the DMC so that only strategic issues already synthesized and prioritized were referred to the DMC. Ultimately, a DOP Monitoring, Evaluation and Learning Plan (MEL) was adopted with the help of the Mission's Learning Contract implementer to adopt DOP best practices from around the country and standardize DOP reporting templates for the 19 Mission-focus districts.

Year Five 2014 – 2015: Major Program Milestones and Events

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Critical Services concept is implemented. Change of Program focus				■								
Concept idea of Critical Service Support is developed	■											
HRH Supplementary recruitment commences	■											
SDS Program undergoes second programmatic restructuring	■											
Funding reductions: SDS Regional Offices are closed	■											

The Grant A component, meanwhile, went through Round 3 and Round 4, learning and adapting as its experience with the districts deepened (and as new subject matter – including a new Health Waste Management pilot— was added and closed out).[47] For example, as the districts became more accustomed to being held to a higher level of accountability, the Grants Team added more service delivery output indicators to the performance-based evaluation standards. Other indicators were also tweaked to produce better incentives, e.g., the percentage of OVC MIS data that was up to date, and timely disbursement of grants by districts to sub-counties. While these changes could be burdensome to weakly staffed district governments, the overall emphasis on results seemed to most knowledgeable observers to have a positive effect.[48] Still, the overall shrinkage of Grant A amounts (especially with the closure of the STRIDES Project in 15 districts) was demoralizing. And overall performance progress was halting, with many district quarterly performance scores still hovering in in the 50-65% compliance range (meaning that they only received 80% of the funds available to them).

One notable cross-cutting development on the project during Years 4 and 5 was a serious push to make good on the Mission's CLA imperative. SDS commissioned a CLA impact study of the results of technical assistance and the Grant A program in a sample of SDS vs. non-SDS districts. The study showed little SDS project impact. The project also took it upon itself to conduct an exhaustive CLA TA Uptake and Application Self-Assessment Study that showed several TA modules contributing to improved local governance in SDS districts.[49]

---

[47] SDS Annual Report, July 2014 – Jun 2015. The Health Care Waste Management component was added to Grant A in 2 districts to help districts engage health waste management disposal providers to deal with the medical waste generated by some of the health IPs.

[48] Id. The project did not hesitate to use a 'tough love' approach to financial irregularities or insufficient documentation, suspending some grants entirely until questioned costs were satisfactorily resolved or for a failure to meet more than 40% of the performance-based targets for two consecutive quarters.

[49] Id. The project found that district compliance with new procurement planning guidelines had improved significantly, from 20 out of 30 sampled districts in FY 2013 to 28 out of 30 in FY 2015. Meanwhile, the 35 partner districts registered a 119% in increase in revenue collection between FY2012 and FY2014 (although more than 20% of that total was represented by enhanced revenue mobilization in one district, Kasese).

An annual citizen survey on service delivery was conducted, yielding predictably mixed results, but providing important insights in substantive areas where district staff were also surveyed and where SDS involvement was strong. Some synthesis and application of learning also occurred through the Inter-sectoral Committee, which became much more active during this period and which relayed important policy recommendations to both district governments as a whole, and relevant central government ministries.

4.5. Year Six: Pivot to the North (July 2015—December 2016)

Even before the end of Year 5, with the project's identity shifting, and the transition to all Ugandan key personnel underway,[50] SDS was approached by USAID/Uganda about a major expansion of HRH work in 15 additional districts in Northern Uganda. Due to the early phasing out of the Northern Uganda Health Integration for Enhanced Services project (NU-HITES), these districts required bridge funding and vital health services support through the end of 2015. Once again,   USAID saw SDS' superior performance, versatility, and district-based 'platform' as a convenient solution to an urgent problem. SDS Agreement Modification No. 11 initially focused on HRH program expansion in the North. By the end of 2015, however, SDS found itself being asked not only to continue the overall SDS program (first through June 30, and then to September 30 of 2016), but to take on direct health service delivery and support in the Northern districts. (A summary of these activities appears in Box 7.[51])

Box 7 **Direct service provision in the North**

The service activities added in Year 6 included:

- Renovation, maintenance, and operational strengthening of health facility laboratories in five districts (including medical   sample and results transportation by motorcycle);
- Expansion of risk avoidance and harm reduction strategies into various communities, including expansion of voluntary   medical male circumcision (VMMC), family planning, and malaria prevention and control activities; and
- Introduction in three districts (Gulu, Oyam and Lira) of the DREAMS (Determined, Resilient, Empowered, AIDS-free,   Mentored and Safe) behavioral change initiative for adolescent girls and young women.

At the same time, SDS extended its DOP and Grant A work to the North, which involved (for the DOP) taking over coordination performed until then by USAID personnel. New Grant A's were made to the 15 districts and 50 high-volume   health facilities in the North to ensure uninterrupted delivery of HIV/AIDS care and treatment services, and continuation of other critical health services in areas like maternal and child health, TB, and malaria.[52] These grants also supported capacity-building for overall DBTA/IP coordination under the DOP, and training on oversight of medicine and supply distribution. Technical assistance priorities, meanwhile, revolved around coordinated work with the ASSIST project (Applying Science to Strengthen and Improve Systems) to ensure that health facilities used their grants effectively.[53]

---

[50] SDS Annual Report, July 2015-June 2016. The management restructuring was formally recognized effected on June 12, 2015, and featured a handover from COP Ella Hoxha to new COP Denis Okwar.

[51] Using the so-called Stepping Stones methodology, the DREAMS program works on multiple fronts to create and sustain behavioral change, including the use of community dialogue meetings with parents/guardians, and political, cultural, and religious leaders, and reliance on community-based facilitators, peer educators, and health workers—all designed to foster strong group cohesion and peer role models among target girls and women.

[52] Id. SDS also made special new grants to a number of key CSOs in the Northern districts that could assist with various health services support, particularly regarding HIV/AIDS and malaria prevention activities. Grant A's, meanwhile, continued to be made in the original   SDS districts, but now only to the 24 such districts that were being provided health services by the STAR-E, STAR-EC, and RHITES- SW (Regional Health Integration to Enhance Services in Southwest Uganda) projects.

[53] Id. In addition to the specially tailored Grant A program in the North, SDS also developed a separate grants program for CSOs in the 15 Northern Districts, mostly focused on CSOs helping to support social and behavioral change for better health results in critical   service areas.

The new scope, and the urgency of the demands in the North, brought wrenching change to a project that was already stretched thin. Its original capacity-building work across 35 districts had been expanded into several new subject areas (education, WASH, HRH), some of them in new districts. Further, after having its regional offices closed and its funding cut, SDS was now being asked to take on an entirely new direct health services delivery role in 15 new districts weakened by years of war, mismanagement, and central government neglect. Addressing this massive reorientation required SDS to hire over 20 new technical and administrative staff, adapt its grants to entirely new conditions, and adjust even more of its programming modalities to more top-down orientation of PEPFAR objectives and their execution. SDS found itself furiously multitasking in a wide range of health-related areas.

The SDS team continued to adapt and work successfully in the face of these challenges. HRH managed to recruit 86% of its mandated hiring target of 401 new health workers across 26 districts (although absorption into public and private facilities remained a substantial challenge).[54] It also carried out training, monitoring, and support supervision.

In an effort to bring scale efficiencies to its TA delivery, SDS created a peer-to-peer resource pool of over 70 district experts in critical disciplines, while conducting training-of-trainers to create more skilled instructors in those disciplines. The subject areas included local revenue enhancement, integrated planning and budgeting, public financial management (PFM), accounting and audit, and procurement planning and management. The project also created a registered company, the Surge Consulting Group, to supply consultants to work for districts and donors in the years ahead. Finally, SDS worked with local stakeholders to assemble an online Local Government Knowledge Resource Center (http://uganda-sds.org/krc/) that would make accessible to central and local authorities all of the learning and documentation from the project.

Image of Online Knowledge Resource Center
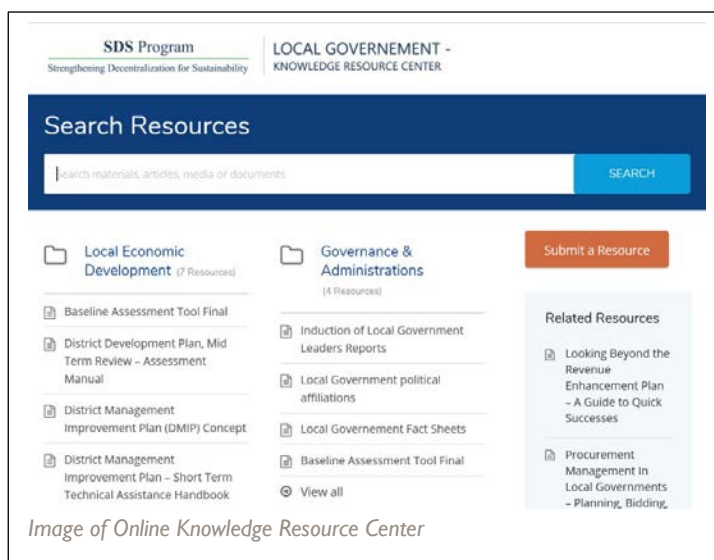
Meanwhile, aware that the project had lacked the means to deliver meaningful TA to the sub-county level, as originally envisioned, SDS' TA team mounted a large companion ToT program using a peer-to-peer approach. It created a cadre of district experts with the capacity to train sub-county personnel in four lower level governments (LLGs) following the end of the project. These exercises were perhaps too little, too late. But they heightened awareness of the capacity challenges facing both district governments and lower local governments (LLGs).

Year 6 concluded with the expectation that SDS would be extended through September, 2017, and then hand over to a successor project. Progress on this front stalled, however. With the end of the project less than a month away, SDS made contingency plans to terminate staff and wrap up grants. Finally, in October, SDS was extended through March, 2017.

---

[54] Reasons for slow absorption varied across districts: for many, the wage bill was simply too high; in other cases, there was lack of local planning and leadership; in still other cases, some job categories were not included in local staffing structures (e.g. lab technicians).

Year Six 2015 – 2016: Major Program Milestones and Events

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |

Expansion on Health Care Waste Management (from 6 districts to 16 then finally to 61 districts)

SDS Program has a renewed focus on communications and Collaborating Learning and adapting (CLA)

Evaluation of the SDS Program takes place

SDS Program receives a new scope of work to include, DREAMS, Laboratory renovation, Malaria (ACT distribution and work with VHT)

SDS leadership transitions to new local Ugandan COP

SDS assumes responsibility for inspection, verification and recommendation for payment covering construction done as part of Northern Uganda Development of Enhaced Local Governance, Infrastructure, and Livelihoods

Grants are awarded to Northern Districts, expanding the number of districts from 35 to 50

USAID conceptualizes around an integrated health programming approach

Evaluation of District Operational Plans (DOP) approach takes place

SDS Program receives a major extension covering bridge activities in northern Uganda including VMMC

Meanwhile, in August 2016, USAID issued technical direction to SDS to cease disbursement of performance-based cash grants to district accounts. Instead, the project would only employ 'in-kind' grants, whereby equivalent amounts would be paid either to direct service providers already working with the districts, or to vendors and beneficiaries through mobile money. This switch was seen as a setback for the project's aspiration to improve financial management in the districts and inculcate a new culture of autonomy and accountability.[55]

---

[55] SDS Quarterly Progress Report, July 2016 – September 2016.

5   LEARNING FROM SDS

The SDS story is one of innovation, but also one of coping with significant programmatic and operational demands at virtually every step. The demands of USAID and other agencies dramatically reshaped the identity of the project – from a health and governance capacity-building project, to a local governance strengthening project supporting health and social services delivery, and finally to a (mostly) a direct service delivery project. These developments were shaped by evolving policy and operational changes embodied in the USAID Forward initiative (in turn reflecting influential research pioneered by the U.K.'s Overseas Development Institute's Politics and Governance Centre,[56] among others, and calls by many in the development community to "Do Development Differently").[57]

5.1. Integrating Governance and Sectoral Service Delivery

Although ostensibly a health project, SDS was unusual for being a capacity-building project *in support of other health and social services interventions—and even other service delivery projects.* First, it provided direct performance-based financial support to local governments, relying on local systems and accounts. Second, it directed technical assistance and capacity strengthening to local governments. Third, it assisted those governments in coordinating and monitoring the health and social services initiatives being carried out by donor-funded implementing partners. All three of these pillars – grants, TA, and program coordination – were designed to enhance district ownership and autonomy in a way that secures sustained improvement in service delivery.

The resulting project was never entirely clear about the causal pathways by which local government capacity-building would translate into better health service delivery. The USAID scope of work referenced no evidence base to support its hypothesis. And perhaps most critically, the scope of work did not explain how the mix of TA and grants support allocated to the capacity-building mission could affect real change in health service delivery across 35 different districts— particularly against the backdrop of significant dysfunction and disincentives in the Ugandan local government space.

This analysis raises questions that continue to resonate in the development community. How clearly should a theory of change be articulated, particularly for a project of this size and duration, and what kind of assumptions must be surfaced? What level of political economy analysis should precede the development of a scope of work like this, and to what extent should a candid appraisal of risks inform course corrections? What should the blending of capacity-building 'governance' work with health service delivery support look like – and where, institutionally, should the capacity-building work be based? If such 'cross-sectoral integration' is seriously pursued, what kind of cooperation is needed at the implementer and donor levels? How ambitious and prescriptive can a project like SDS be when long-term capacity-building work is involved – and when the enabling environment may be poorly aligned? What kinds of sustainability plans and policy commitments need to be built into such projects to ensure that capacity gains are not lost at project end or due to programming shifts?

Many of these questions have been partially answered by USAID's subsequent push – through the DRG Center – to encourage cross-sectoral integration generally and DRG cross-sectoral integration in particular. These efforts, which have gained traction in a number of USAID Missions around the world, have been aided by strong Mission leadership, more flexible contracting mechanisms, and increasingly useful cross-agency information sharing.[58] Still, despite significant consciousness raising across the Agency, significant management, planning, budgeting,

---

[56] See ODI's publications on Doing Development Differently: https://www.odi.org/projects/2857-doing-development-differently

[57] See the Doing Development Differently Manifesto Community: https://www.odi.org/projects/2857-doing-development-differently

[58] An important milestone was the publication, in March 2016, of synthesized information from a DRG Center-supported set of case studies on DRG cross-sectoral integration. *See* USAID, 2016. *DRG Cross-Sectoral Programming Support Project: DRG Integration Case Study Synthesis* (Washington: USAID).

coordination, and reporting barriers   remain, as do differences in world view, terminology, and indicators of success/incentives among technical specialists and teams.

5.1.1. Coping with Project Design Flaws and Later Mission Requests

Quite apart from the project's approach to issues of cross-sectoral integration, its scope of work raised fundamental questions about program realism and attention to detail. Certainly it demonstrated a common-sense understanding that USAID's substantial health service delivery assistance streams were not sustainable without more intensive investment in human and material resources at the local level. And, such assistance was not possible without stronger ownership,   leadership, and mentoring in local government as a whole—not just with local health officials. This thinking fit with Ugandan national priorities as defined in the National Development Plan II. By seeking to make health and social services investments   by USAID more transparent, accountable, and coordinated at the local level, the project helped operationalize the broad   promises of the Paris and Accra Declarations.   The SDS design was farsighted in providing for direct grant funding to local   governments as an incentive for improvement, and as a learning mechanism —well before USAID Forward adopted this approach as a model.

At the same time, the project design suffered from a number of limitations. Most notably, the design team failed to adequately ground its work in any recent assessments of Uganda's local government dynamics or capacity. The SDS scope of work gave little evidence in advance that the Mission understood how truly enfeebled districts governments were due to re-centralization of political control, loss of local government own-source revenues, and dispersal of administrative resources owing to district proliferation. No political economy analysis (PEA) informed the scope or the start-up of the project – and regular use of PEA at the agency still lay in the future as an aspiration.[59] No real theory of change or other causal chain analysis underpinned the scope of work, so that a wide range of assumptions – particularly about TA uptake in Ugandan districts – went unexamined. And there was no sustainability strategy, no vision of how capacity innovations could be handed off and scaled up, or the funding gap bridged by central authorities.

These omissions perhaps reflect insufficient input from the DRG Team in the Mission. The DRG team was in fact consulted on the project's design, but reservations about what could realistically be achieved through short-term grants and TA, in the absence of strong central government support and a more intensive focus on a smaller number of districts, went mostly unheeded.[60] If a stronger DRG Team perspective had been brought to bear on the SDS design, the heavy supply- side orientation of the project might have been tempered a bit. At the same time, the DRG Team personnel might have otherwise had more success in communicating to their colleagues that strong patronage and other political pressures exerted from Ugandan central authorities make it unlikely that local bureaucrats and even elected councilors would have strong incentives to respond to many specific service delivery concerns of local voters.[61] Certainly there were missed opportunities to absorb lessons learned from prior USAID governance projects in the country, including a host of technical   details about Ugandan experience with planning, budgeting, and procurement reforms and their poor implementation. While USAID/Uganda was out in front with an innovative cross-sectoral project of this nature, the institutional leadership to spur active team collaboration in strategy and design was still a few years away.[62] This exacted a price later on,

---

[59] Many saw the efforts of DfID to mainstream PEA in their own projects as both pioneering and long overdue, but it was only with the publication   of *Development Aid Confronts Politics: The Almost Revolution,* by Thomas Carothers and Diane de Gramont (Carnegie Endowment, 2013) that discussions   of PEA and working in a 'politically smart' manner went mainstream at USAID.

[60] Interviews with multiple USAID/Uganda and SDS staff, May and July, 2016.

[61] Thanks to USAID-funded and –synthesized research, some of this understanding and learning, generated over the past decade or so, is better   disseminated within the agency, at least within the Center of Excellence on Democracy, Human Rights and Governance. See, e.g. Rodden, J. and E.   Wibbels, 2013, *Responsiveness and Accountability in Local Governance and Service Delivery: An Agenda for USAID Program Design and Evaluation*, An Evidence   Review Paper, (Washington, DC, USAID)

[62] Getting Mission teams and individuals to collaborate across sectors remains a huge challenge for the Mission, even as several Missions have

as a stronger initial stake in the project by the DRG Team might have led to more information-sharing collaboration across the SDS and GAPP projects. It might also have tempered the Health Team's willingness to push the SDS project's expansion into diverse social services interventions in a way that dissipated its original focus (something discussed in greater depth in Section 4.d. below).[63]

While the project design went 'with the grain' insofar as it sought to align SDS with local systems and priorities, it took a supply-side approach and was not able to accord a role for local councilors or civil society in promoting budget or service delivery accountability. There was also a lack of realism in seeking to tackle capacity-building not only across 35 districts – a huge number of jurisdictions in which to build trust and provide grant funding and technical assistance – but to extend such assistance downward to the sub-county level, where most local health institutions were located and governed. Outputs and results were more specified and standardized than would be optimal for a capacity-building project. Important horizontal relationship- and coordination-based activities at the district level were mixed in with strong vertical (i.e., top-down) service delivery priorities generated by PEPFAR.[64]

In the end, the ambitions of the project were trimmed in some areas but not others. The sub-county work was largely dropped with the assent of the Mission as simply beyond the human and financial capacity of the project (although some modest cascading of TA work downwards from the district level was attempted later; this issue of adequate TA coverage has also affected the ultimate effectiveness of the GAPP Activity). The district-level work was not circumscribed, however, even though one sensible approach would have been to sequence assistance in such a way as to provide more intensive assistance initially to some districts than to others on a pilot basis to uncover learning and adaptation opportunities. USAID was committed to building capacity in all of the Mission-prioritized districts that had significant PEPFAR-funded health investments via the DBTAs. And for its part, the Ugandan Government has traditionally been reluctant to prioritize certain districts over others on a programmatic basis—there by preempting many competitive performance-based options. As a result, SDS did not allow for the optimal tailoring of TA, and ultimately required the 'surge' approach to cope with the heavy demands of core TA delivery.

After a difficult first year, the SDS team adapted, capitalizing on the cross-sectoral strengths of the project and especially the capacity-building mandate at its core. It navigated local politics and relationships adeptly, more closely aligned DMIPs with existing local DDPs, and used performance-based cash grants to great effect. Under tremendous time pressures, it managed to adapt its approaches to both TA and grants based on rapid learning in in the field. But with little formal mandate or funding to do so beyond the one-off LOGIC training exercise and limited DBTA-driven coordination, the project was unable to engage in any significant way with local political figures or CSOs/CBOs. This made it more difficult to empower on the demand side some of the mechanisms of accountability it was pledged to strengthen on the supply side (this was noticeable as to possible participatory budgeting processes and social accountability re: oversight of program execution—although to be sure, such efforts did come into play on the WASH and education pilots).[65] In the end, the bigger problems with sustainability arose elsewhere.

---

exhibited strong leadership in creating a potentially durable cross-sectoral collaborative culture. *See* USAID, 2016. *DRG Cross-Sectoral Programming Support Project: DRG Integration Case Study Synthesis.*

[63] At the same time, given the lack of strong collaboration between the two teams, and the DRG Team's subsequent management of the GAPP Project, this advocacy might not have really emerged; competitive incentives soon came into play for each of the teams to focus on 'their' projects and champion 'their' approach to local government capacity strengthening. Interviews with current and former USAID/Uganda and SDS staff, May, July, and September, 2016.

[64] These included scaling up core HIV prevention, treatment and care interventions; focusing on women and girls to increase gender equality in HIV services; and setting benchmarks for outcomes and programming efficiencies through regularly assessed planning and report processes to ensure goals are met. PEPFAR Country Regional Operational Plan (COPROP). Feb. 2015 Guidance.

[65] It should also be noted that local councilors were in fact utilized to help conduct Grant A validation activities. And it should be conceded that concerted work with local politicians and CSOs/CBOs would have required substantially more time and project funding—something SDS simply did not have (some might also argue that as a matter of conflicts of interest, it might not be feasible or appropriate for a project to be principally engaged with local executive authorities and simultaneously be expected to help empower and advocate on behalf of

5.1.2. Cross-Sectoral Approach: What Value Added?

Without a reasonably detailed theory of change, it is difficult to know precisely how the project's novel cross-sectoral design was intended to generate intermediate and longer-term results, particularly in a complex multi intervention environment. Certainly the combination of TA and direct grants were expected to strengthen short-term capacity in particular health institutions and delivery streams, alongside the DBTA health interventions. Once the project began, SDS adopted a clear emphasis on the provision of technical support and backstopping assistance to health Sub-Districts and lower level health facilities. At the same time, district governments were supposed to devote increased attention to the monitoring and supervision of district health service delivery. And overall, there was to be improved coordination between various district health sector stakeholders. But the linkages and synergies between these more immediate priorities (driven largely by the DBTA implementers) and the longer-term capacity building embodied in the Objective 2 technical assistance program were not clearly articulated.

The parameters of short-term capacity-enhancement activities were not fully well explicated, nor was the division of labor between SDS and DBTA health implementers. This was due in part to the original transitioning of health grants (and some TA) from the STAR-E and STAR-EC Programs to SDS at the beginning of the project (see Box 8).

Box 8 **SDS takeover of health activities**

SDS found itself taking over a large number of activities such as coordination of the Extended District Health Management Team (EDHMT) meetings in each district, assisting sub-county health workers to support TB patients through the CBDOTS program, supporting integrated support supervision from the district level to health sub-district facilities, supporting health management information system (HMIS) review meetings on a quarterly basis, and facilitating lab sample transportation from health facilities to lab hubs. While some TA work was reabsorbed by the STAR and other implementers, most of the above work was supported by Grant A (and later some Grant B) funding.

In the end, the grants program's performance-based financing system greatly enhanced reporting and delivery of health outputs by the districts. Meanwhile, SDS coordination efforts via the EDHMT allowed districts to exert better control and coordination of IPs, and SDS empowered districts to generate their own work plans. However, it was always clear that districts had very little flexibility in setting priorities for health service delivery or for most A Grants -- these were invariably established by the DBTA health implementers.[66]

The combination of direct and TA/supervision support provided under the Grant A mechanism would be expected to improve planning, human resource management, financial management, and monitoring by district health officials. But how much of an impact did these capacity-enhancing activities in fact have on district operations? To what extent was this support harmonized and sequenced with the general TA provided by SDS? At present, there is insufficient information to determine whether and how these potential synergies were exploited. It is also difficult to assess to what degree lessons learned from the Grant A coordination work consciously informed the district-wide coordination efforts under the DOP. **But there are positive signs that an improved culture of accountability was established in a number of districts for a period of time based on overall work of the project, particularly where CAOs were supportive and engaged – and not frequently transferred to other districts.[67]**

---

local representative officials and civic groups.

[66] Many of these priorities were in turn set by donors and IPs in reasonably close consultation with Ugandan Ministry of Health officials. In any case, a sense of relative district subservience and lack of discretion remained a concern of those seeking to enhance local ownership of district health services priority-setting and delivery.

[67] SDS Project Evaluation, pp.34-46.

Simply by engaging intensively with districts and DBTA health implementers on a range of management, supervision, and coordination responsibilities, **SDS doubtless raised the quality of service delivery in some cases.[68]** The resources allocated to the project for M&E, however, did not permit extensive research along these lines (especially given the empirical complexities). But there is anecdotal evidence that the SDS model of channeling significant resources into capacity enhancement (via both the direct grant mechanism and independent TA and coordination) resulted in better short-term results than would have been the case simply with DBTAs and indirect grant funding (where inputs were purchased by the IP). Improvements were noted in terms of efficiency enhancements, reduction of redundancies, and especially the extension of services to hard-to-reach communities (see Box 9[69]).

Box 9 Suggestive evidence of health sector improvements due to SDS

A number of interviewees in the project endline evaluation and this case study pointed to improvements in this area. They cited the project's catalyzing role in mobilizing integrated outreach efforts for TB treatment, ante-natal care (ANC), mother-to-child HIV transmission prevention work, and antiretroviral treatment. National district-level data on TB treatment success examined by the endline evaluation showed that 58% of a sample of SDS-supported districts registered an improvement in this indicator during the period 2010 to 2015 – above the national average – while 17% maintained high success rates through the entire period. The two non-SDS districts, by contrast, performed below the national average during the same period. Since the CB DOTS initiative supported by SDS operated for much of this period in all of the SDS districts, the superior success scores might be attributable to the SDS approach (SDS Project Evaluation, p. 28). Similar evidence of shorter-term results exists for the HRH initiative, where rapid recruitment of health workers was facilitated not only by a massive hiring push and expenditure of grant funds, but by improved district planning and coordination efforts facilitated by the project.
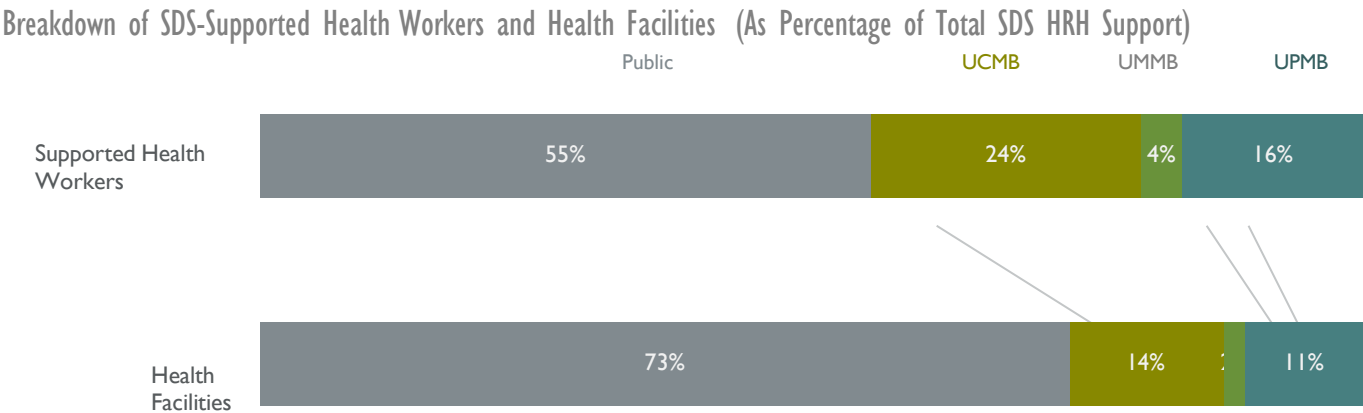
Attribution of this kind in the health arena is problematic. Evidence of deeper, more sustainable capacity changes is still harder to come by. For example, on the District League Table Indicators maintained by the Ministry of Health – comprising 11 measures of performance, from timely submission of medicine orders to HIV testing in exposed infants – the SDS endline evaluation showed no real evidence of the impact of SDS support in SDS (as against non-SDS) districts, with only 17% of the sampled districts showing consistent improvement between 2010 and 2015 (and several districts showing overall deterioration in scores. SDS Project Evaluation, p. 27). The HRH-related data are similarly opaque as to possible attribution to SDS work. Not only were there problems in getting new health workers absorbed by public and private health payrolls under the HRH initiative – something almost wholly outside SDS control—but there were many instances reported of SDS practices with timesheets and discipline/accountability not being incorporated into district office management processes despite SDS efforts (SDS Project Evaluation, p. 23).

There may be a more pronounced causal effect of the project's cross-sectoral synergies in the child protection arena. There was both a single chain of management and delivery down to the sub-county level through a district's CBS Department and coordinated teamwork by SDS and its two DBTA implementers (SCORE OR SUNRISE, depending on the district). CBS support had been so neglected by the Ugandan Government and donors alike that the kind of focused support provided by SDS had an immediate tangible impact. The project's Grant A funding, when paired with the program support furnished by SUNRISE and SCORE, enabled districts to carry

---

[68] Interviews with SDS staff and DBTA partners, Kampala, July 23, 24, 2016.

[69] A more rigorous evaluation would need to compare a larger sample of SDS and non-SDS districts while additionally addressing overall service delivery modalities, including inclusion of the direct grant support and TA. Regarding the lack of sustainability, an additional possible reason for this, even within the duration of the Grant A program, was the perverse effect that the performance based financing (PBF) system had on subsequent funding; PBF sanctions (reduced funding) threatened the achievement of strict PEPFAR targets being reached, and therefore frequently triggered substitute funding by the DBTA IPs—rather than encouraging better district performance and eventual ownership/budgeting of certain health activities. Regarding absorption, this may be affected by location in the country, health care infrastructure, availability of staff accommodation, job security, and perceived working conditions, and overall district management and leadership. Some of the private not-for-profit medical bureau facilities have attempted to retain the system of timesheets. Interviews with SDS staff in Gulu, May 19, 2019 and Kampala, July 13, 2016.

out a range of basic activities. These included comprehensive mapping of OVCs, using advanced MIS and planning skills to allocate services (particularly successful in the districts of Namutumba and Mbale), training community development officers and other stakeholders (e.g. police, health workers, para-socials) in child protection issues, and otherwise activating dormant District Orphans and Vulnerable Children Committees (DOVCCs) as well as counterpart Sub-country committees (SOVCCs).

Breakdown of SDS-Supported Health Workers and Health Facilities (As Percentage of Total SDS HRH Support)

	Public	UCMB	UMMB	UPMB
Supported Health Workers	55%	24%	4%	16%
Health Facilities	73%	14%		11%

The result was a significant increase in both the supply of, and demand for, child protection services during Years 3 and 4 of the project, when funding and TA were readily available. Perhaps more important from the standpoint of sustainability, many district governments formulated ordinances and bylaws to strengthen protections for OVCs and linked them to a wider range of relevant service providers. In some districts, CBS departments also received more funding from internally generated revenues—something reinforced by the Grant A requirements for a certain level of co-funding. Skills acquired in child protection issues were used by community development officers in all of the SDS districts. Still, as noted by the end-line evaluation, the rapid decline of project financial support in Year 5 raised genuine concerns about sustainability. Without continued funding, most indicators dropped sharply thereafter, including the regularity of OVC monitoring visits, reports of OVC cases, the updating of OVC databases, and the frequency of DOVCC and SOVCC meetings.[70]

Several factors, aside from simply the availability of funding, seem to confirm the wisdom of the Mission's original cross- sectoral vision in OVC arena. First, the project devoted a significant amount of time to planning, budgeting, and MIS technical assistance for both central district units and some of the CBS Departments with responsibility for OVCs. There is some evidence of spillover effects in both directions that proved helpful in targeting services to the most pressing needs. Second, relationships at both the district and sub-county levels were easier to nurture in this area, and there was greater latitude for local ownership and goal-setting, as compared to the health sector with the rigidities stemming from PEPFAR and the DBTAs. Moreover, coordination in OVC was simpler, involving a single IP that had discrete objectives and more implementation latitude.

5.2. Harnessing Local Solutions and Partnerships

A key feature of the SDS Project was its commitment to partnership with its beneficiary districts and to working through local systems and processes. The linchpin here operationally was the direct cash grant mechanism, inspired by the USAID experience in Northern Uganda, which placed ownership and accountability with district governments. In SDS, this was accompanied by technical assistance and coordination activities designed to work with existing local government processes. These two features were mutually reinforcing. **The districts' management of the grants instilled a performance- based orientation that opened up opportunities**

---

[70] SDS Project Evaluation, p. 27

for both immediate and longer-term capacity-building TA, while the TA—whether supplied by DBTA implementers or SDS—for the most part reinforced the motivation to improve grant performance. "What we liked," said one district official from Kaliro, "was that [SDS] trained the people in the districts and funded them to carry out the activities rather than do direct implementation [by the project]. This is good for capacity building."[71]

It is noteworthy that the partnership ethos and commitment to 'local solutions' modalities were incorporated into a large and highly structured project several years before these thematic precepts were mainstreamed at USAID. This is a tribute to health officers who had sufficient freedom to think creatively about departures from the norm; to SDS senior leadership, who had a real desire to implement and improve upon the Mission's original vision; and to the rank-and-file SDS staff, most of whom thrived on the highly challenging and innovative work of the project.

The ongoing challenges of meeting the local solutions imperative are best captured by the learning and adaptation that occurred under the project's grants work (Objective 3) and TA (Objective 2).) Such learning might have been able to gain more sustainability and been more effectively scaled up had the project's work with the Inter-sectoral Committee been more strongly supported by Cardno and USAID/Uganda. Each of these three subjects is discussed in turn below.

5.2.1. Grants: The Power of Incentives

The grants programs (particularly Grant A) departed from the normal practice of IPs indirectly granting funds to local governments and then using their own procurement systems and accounts to purchase goods and services on behalf of the beneficiary government. Inspired by the NUDIEL experience (but with stricter risk assessment and accountability standards), the SDS grants program aimed to deepen local ownership and create an active learning platform for planning and financial management. The districts were expected to be active partners in service delivery, not passive recipients, as is often the case with large health and social services projects. Over the life of the project, grant funds represented between 22 and 25% of the total SDS budget.

How Grant A Performance Sanctions Worked
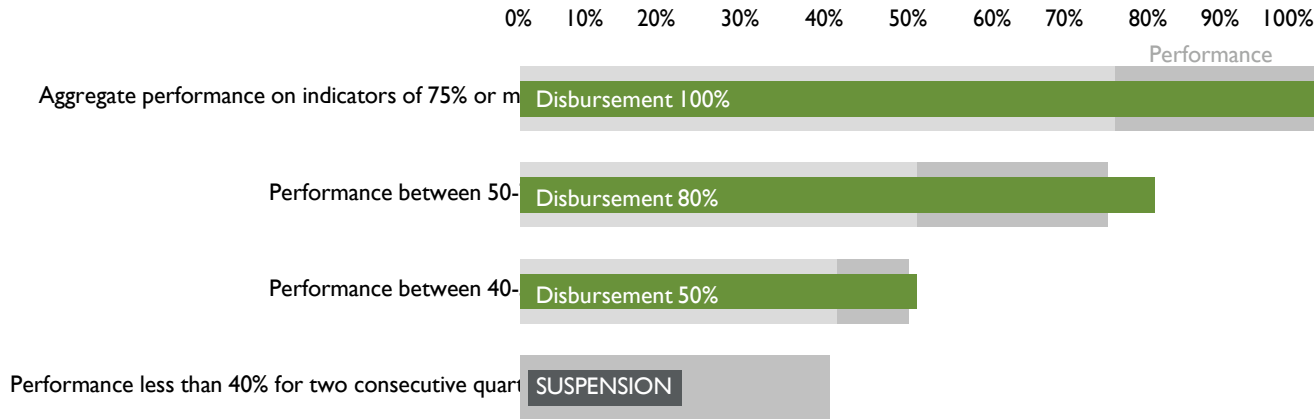
The performance-based financing mechanism tracked process, output, and outcome indicators on a quarterly basis, with results determining eligibility for subsequent disbursements as shown in the chart. The indicators evolved over the first year of the project through interactive learning and improvement, ultimately becoming more

---

[71] SDS Project Evaluation, p. 27

outcome-oriented. [72]Validation was conducted in a participatory manner with DBTA implementers, district administrators, and local councilors (introduced to the subject via the LOGIC activity). While SDS had its own rules and procedures, the performance-based mechanism and conditional grant modality were generally consonant with the GoU standards utilized by the districts in the Local Government Management and Service Delivery Program (LGMSDP).

Grants to Districts, 2011-2016 (Millions of Dollars)
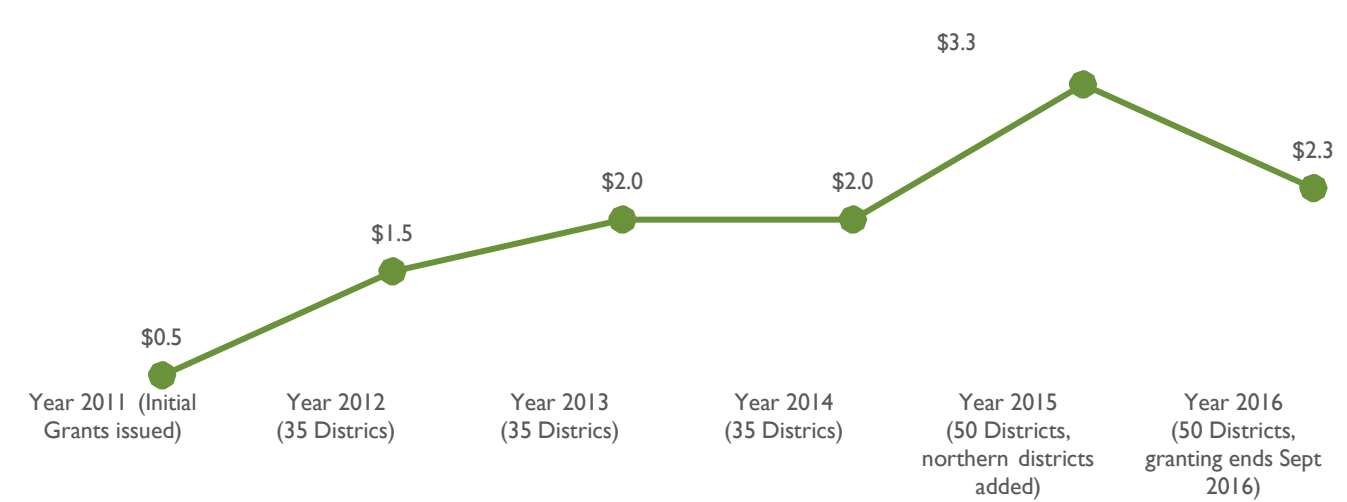
A great deal of learning accompanied the grants programs, some that resulted in changes during the life of those programs and some that inspired thinking about possible future mechanisms of this kind. For example, in the former category, some   of the districts were inadequately prepared for the rigorous validation process; SDS was able to retool its education efforts to provide adequate training and mentoring. District co-funding, a core PBF indicator, was initially set at 10% but later lowered to 7% in deference to the challenges faced by districts in enhancing local revenue collection.

Looking to the future, other issues raised were more fundamental in nature. **Some observers felt that the grant incentives could have been calibrated to reward districts for *improvement*, not simply sanction them for sub-standard performance – particularly those with poor baseline indicators.** Otherwise, under Grant A's absolute performance criteria, poorer performing districts are penalized and find it even more difficult to erase their   deficiencies (and their neediest health facilities and citizens are in effect punished). Grant suspensions were a real problem. Many district officials were especially upset that *aggregate* district indicators held sway, and that funds couldn't be channeled in a more differentiated manner to well-performing sub-county health facilities. Short of reconfiguring the entire program, SDS did what it could to address these concerns through enhanced TA and mentoring in the poorer-performing districts and sub-counties, and worked with CAOs to resolve suspensions quickly—or waive them when appropriate.

Other criticisms reflected concerns that Grant A priorities were being set solely or predominantly by the DBTA   implementers rather than in dialogue with the local governments and in close accord with the DDPs (although many PBF indicators were fully consistent with DDP objectives). To some extent this simply reflected

---

[72] The core outcome-oriented PBF indicators for Grant A were as follows: (1) the percentage of action points resulting from the District Health   Management Team meeting; (2) the percentage of action points resolved during the reporting period as reported in the DOVCC meeting; (3) the   percentage of key action points implemented during the reporting period that were identified during the integrated health supervision activities; (4)   the percentage of eligible children (OVCs) provided services in one or more core CBS program areas; (5) the percentage of action points resulting   from extended District Technical Planning Committee (DTPC) Secretariat meetings resolved during the reporting period; and (6) the percentage of   non-SDS revenue expended on the social services sector as a proportion of the budgeted amount of Grant A funds planned to be released.

the fact that SDS was a health project financed with PEPFAR funds,[73] and this was simply the price to be paid for using such funds, which had to specify project targets and expend a certain level of funding in each district. Others were upset that grants were strictly tied to the DBTAs, so that they invariably ended when the latter projects expired (e.g., when the SUNRISE or STRIDES projects came to an end).

Various Grant Uses as Share of Overall Grants Program Dollar Totals
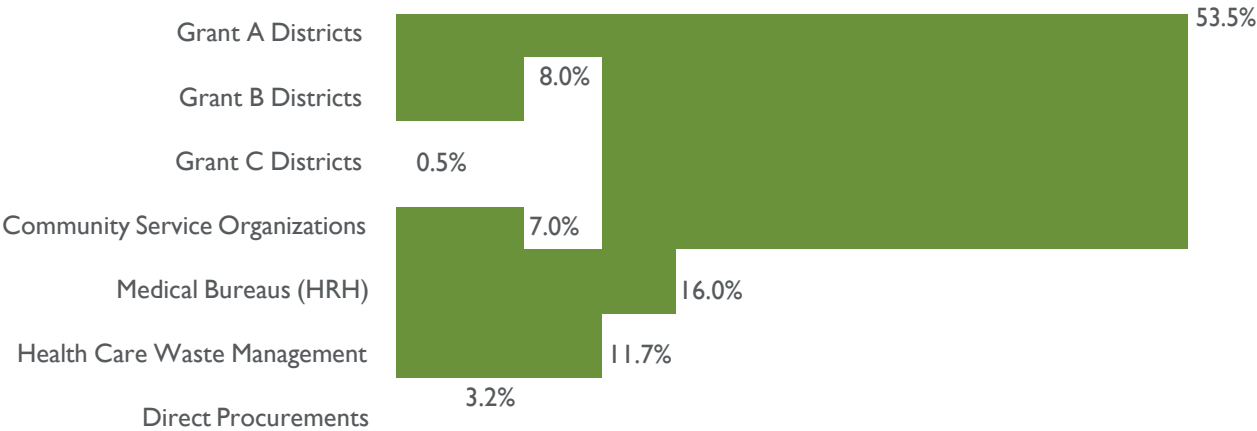
These criticisms raise important questions about what the real content of 'local solutions' should or could be. Certainly there are local systems and processes that could constitute a foundation for direct grant-making for improved learning and accountability. Yet there are additional incentives that donors and implementers can explore that may stimulate still better behavioral responses, regardless of their consonance with existing local processes. The experience with all three grant modalities suggests that basic administrative and accounting processes should be harmonized as much as possible with local systems for reasons of both sustainability and transactions costs. But it also suggests that **incentive frameworks should be designed with great care—in a way that properly balances accountability with learning and ownership.** With enough time and funding, a future performance-based program might fruitfully combine elements of both Grant A and Grant B, balancing conditional and unconditional elements and creating rewards and sanctions that acknowledge existing constraints.

5.2.2. The Challenge of Delivering TA on a Large Scale

The TA component of SDS was focused principally on the basic financial management of the A grants, but also on the planning and coordination work on which SDS and the DBTA implementers collaborated. In connection with Grant B, TA originally had a broader focus on capacity strengthening needs identified in each district's DMIP. As the program developed further and the similar deficits became apparent across virtually all of the districts in Year 2, the project's TA ambitions grew larger. With a new and stronger cadre of governance staff and consultants at work (including the COP), the project also perceived ways in which expanded TA could benefit not only the broader health objectives of the DBTA health implementers (beyond the basic HIV/AIDS work emphasized in the first two years of the project), but also the IPs working on OVC matters in the SDS districts. This adaptation posed the risk of capacity overstretch, even with the addition of surge training and TA modalities. But it was also a reflection of the SDS project's unique depth of involvement in the districts and the trust and goodwill it had already engendered.

---

[73] In fact, in the aggregate, USAID's Uganda portfolio has consisted of nearly 80% PEPFAR funding for the past several years, so the SDS experience is not unusual in this regard.

How does a project of the size of SDS provide meaningful and effective technical assistance to districts with severe capacity-building needs? The project faced this puzzle from the start, and never quite solved it due to the cutbacks in funding and the closure of the regional offices. This problem was compounded by a number of factors. First, **USAID's Health Team did not appear particularly invested in the project's TA work and didn't appreciate its longer- term importance in relation to immediate competing service delivery imperatives**. Second, with the constant changes to the project, this part of the project usually suffered the most when cutbacks were needed to accommodate new technical areas. Third, the cooperative agreement required many different kinds of TA, which were challenging to develop and then implement in a sustained way over the life of the project.

In Years 2 and 3, the project simply operated in overdrive, utilizing technical specialists and regional coordinators in creative ways through completion of the DMIP process and then smaller-scale cluster-based trainings that privileged peer- to-peer discussion and learning. And substantial mentoring and monitoring was feasible through frequent regional coordinator visits to the various districts. But the project was forced through sheer logistical necessity to undertake its surge approach, organized on a larger scale and with less frequency. Even on the less personalized basis, **districts were grateful for the practical training that the SDS 'surge' assistance provided, which often exceeded that provided by Ugandan authorities in thoroughness and quality.[74]** Lo officials were often especially enthusiastic to receive training and mentoring that covered existing requirements and duties prescribed by Uganda law and regulations.

"We used to work with donor agencies haphazardly. We never asked for their specific activities and budgets. We never thought of harmonizing our work plans and budget with theirs. Integrated planning and budgeting sorts out all of this……it improves decision-making, enhances accountability, and gives us an opportunity to monitor and reflect on the progress achieved toward meeting our priorities."

Senior Official, Ntungamo District.[75]

The TA efforts benefitted from a number of SDS delivery modalities – particularly peer learning and self- assessment/benchmarking – that distinguished them from those of many other donor-funded programs. First, the project's complementary grants and DBTA coordination in the districts created a foundation of trust, as well as synergies with the TA programs. Second, trainings for line staff were often accompanied by parallel cross-cutting sessions that included the CAOs and district chairpersons, chief financial officers, chief finance committee and district internal auditors, and contract committee and procurement heads. Third, the project emphasized the use of M&E and visual tools to enhance TA efforts and self-assessment/benchmarking by district officials (see Figure immediately below).[76] And finally, the project promoted informal peer-to-peer learning, some of which fostered dialogue and relationships across districts, and generated new 'local solutions.'[77]

---

[74] Interviews with local officials in Amuru and Gulu districts, May 19 and 20, 2016; SDS staff, May 19, 2016.

[75] USAID/Uganda DOP Activity Description (handout).

[76] Beginning with early TA clinics, and extending even into some of the later surge cluster trainings, each district would be encouraged to review a revenue collection performance report, based on its own selected revenue enhancement strategies. Armed with charts and tables, the districts could compare their trends and per capita performance for specific revenue sources with the SDS 35 district average as well as the higher performers in each category of local revenue. This would in turn spark meaningful peer discussion and learning about strategy considerations and execution.

[77] Based on its size and reputation, the project was also able to attract and retain some of the most dedicated and talented technical specialists in Uganda to work on training and mentoring.

Example of Graphic Self-Assessment Tool Depicting Per Capita Local revenue Collection Sources: Mityana District Compared to SDS Districts as a Whole: 2011-2102
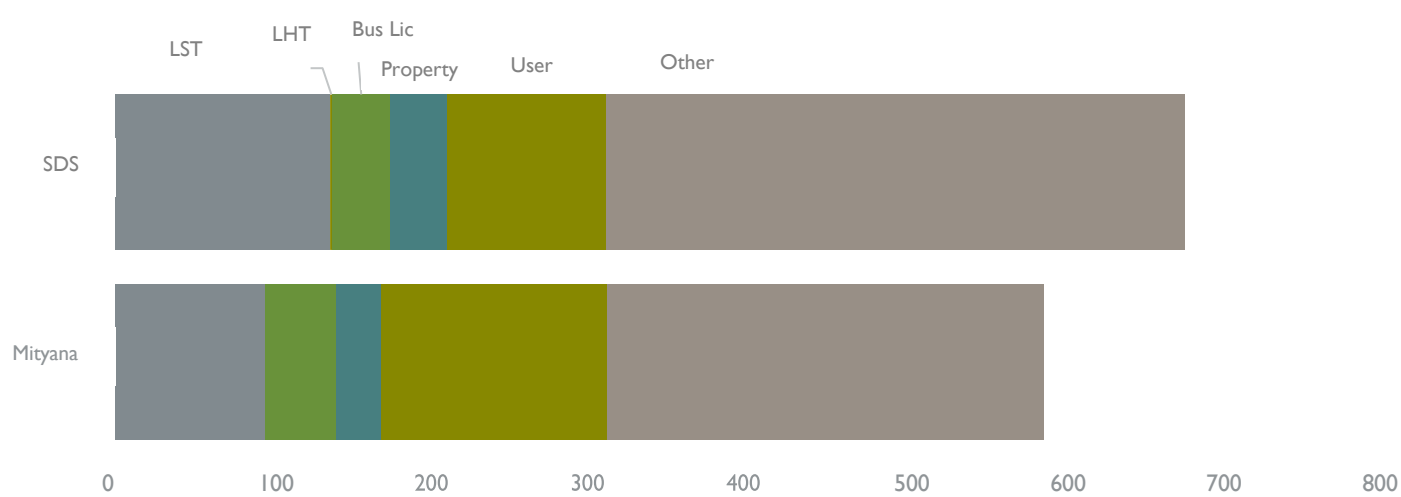

Figure 1 Example of SDS benchmarking: Aggregate District Performance/Per Capita Revenue Collection   Source: SDS TA Materials in possession of Juliana Pigey, SDS Consultant

The capacity-building impacts of these dedicated TA, training, training, and mentoring efforts are difficult to evaluate, and the overall evidence is mixed. Still, a number of indicators showed positive movement during the latter years of the project (reflecting expected time lags for certain TA outcomes). In the area of planning, for example, in SDS districts, there was a steep decline in the unspent balances returned to the central government between FY 2012-13 and FY 2014-15, suggesting real improvements in planning and procurement.[78] There was also a large jump in the number of district procurement plans submitted on time during this period.[79] In the public financial management area, progress was uneven, but all SDS districts received unqualified reports from the Auditor General for FY 2014-15 (in the previous fiscal year, seven such districts received qualified reports) and none had unspent account balances due to a failure to absorb funds (see Table 1 below).[80] This suggests that the tight audit procedures of the SDS grants programs may have had a spillover effect on overall district   financial management.

---

[78] This was likely linked to general procurement planning training rather than specific training on the handling of unspent balances, since training on   the latter only occurred at the end of FY 2014-15—too late to have been reflected in the data.

[79] TA Uptake and Application Self-Assessment Study, p. 30. Ultimately, 93% of the districts had their procurement plans approved in time in FY   2014/15. *Id.,* p. 39.

[80] Typically more sobering statistics include the fact that there remain significant problems in getting District Public Accounts Committees to sit as   least quarterly as required by law, and getting districts to provide feedback on Auditor General Reports (i.e., clearing backlogs on audit queries). See   TA Uptake & Application Study, p. 34.

Auditor General's Opinion re: Financial Statements of Sampled SDS Districts

District	FY2011/12	FY2012/13	FY 2013/14	FY2014/15
Budaka	Qualified	Qualified	Qualified	Unqualified[81]
Busia	Unqualified	Qualified	Qualified	Unqualified
Kaliro	Unqualified	Disclaimer	Unqualified	Unqualified
Kamuli	Qualified	Unqualified	Qualified	Unqualified
Kamwenge	Qualified	Qualified	Qualified	Unqualified
Kanungu	Qualified	Unqualified	Qualified	Unqualified
Kayunga	Qualified	Unqualified	Unqualified	Unqualified
Kiruhura	Qualified	Unqualified	Unqualified	Unqualified
Mbale	Unqualified	Unqualified	Unqualified	Unqualified
Namutumba	Unqualified	Unqualified	Qualified	Unqualified
Ntungamo	Qualified	Qualified	Unqualified	Unqualified
Sembabule	Unqualified	Unqualified	Qualified	Unqualified

Table 1
Source: R. Kibombo et al., 2016. Evaluation of the USAID/Uganda Strengthening Decentralization for Sustainability (SDS) Project, p. 16.

Yet, there were significant district staff coverage and absorption issues, especially in the latter years, as funding shrank, the regional offices closed, and the surge approach became the channel for training and TA. This was especially true for certain kinds of financial management training, e.g. the project's Output Budgeting Tool was challenging for district cadres to use, and senior district officials were wary of mandating its application across multiple departments. And absorption issues were even evident at times with the DMIP process, which was sometimes viewed as belabored and perhaps ill-suited to use by local officials in a hierarchical work environment with insufficient autonomy. Ultimately, the project confronted a breadth versus depth dilemma that only a longer and more amply-funded TA component could have alleviated – and perhaps even then only by more rigorous priority-setting.

Political economy factors created additional complications. TA initiatives were carried out for the most part in full accord with local government policies and practices, and with the consultation of the Ministry of Local Government and other relevant central authorities. But some initiatives, like the promotion of new revenue sources and improved revenue collection, ran afoul of both central and local government politics. Initiatives in this area were perceived as threats to overall government authority and integrity -- new taxes were seen as susceptible to capture by untrustworthy local political leaders or likely to provoke opposition by business interests.

5.2.3. Impact, Sustainability, and the Inter-sectoral Committee

Advancing local solutions isn't simply about building a degree of sustainable capacity in local institutions and processes during the life of a project. Ideally, projects should also seek to expand or scale up successful local policies and practices and entrench them through broader reforms. SDS has pursued sustainability through training and mentoring at the district level and through the documentation posted by the project to the Knowledge Resource Center (http://uganda- sds.org/krc/), which currently resides on the project's website and is slated to be turned over to local capacity building entity near project end. Still other resources and skills will be available through the peer-to-peer learning networks created   by the project, as well as through the expert consultants associated with the nascent Surge Consulting Group. But to what extent will this knowledge be used, whether by

---

[81] An unqualified audit report is an audit report with nothing outstanding or out of the ordinary (no issues.)

individual districts, donors, or other implementers? There is evidence of backsliding in the application of new practices in some districts as a result of the withdrawal of Grant A funding and associated TA.[82]

Indeed, more fundamentally, the sustainability of improved district financial management practices under Grant A were always somewhat suspect given their dependence on USAID project funding and associated objectives and oversight; without continued funding and deeper institutionalization of such practices (however consistent they were with basic Ugandan Government conditional district grant protocols), more durable incentives may have been lacking. There is no easy answer about how to ensure that incentive structures and even intrinsic motivation are maintained after withdrawal of direct program funding. However, it is arguable not only that Grant A modalities should have been given a longer time to affect local government behavior and been more routinized (perhaps with more *rewards* for grantee good performance, rather than punishments for substandard performance, a modality that the GAPP project has experimented with in its small grant program), but that stronger efforts should have been made to inculcate SDS project management and mentoring practices in central government authorities as part of the their work overseeing the use of conditional district grant transfers. But this would have entailed both a much more concerted advisory and educational effort with central institutions – perhaps a project in and of itself – as well as much closer work with the Inter-sectoral Committee.

Accordingly, the real test of sustainability is not simply whether a successor project picks up where SDS left off – which is by no means certain – but whether the Ugandan Government adopts reforms that incorporate these practices. And the project's Inter- sectoral Committee was perhaps the most obvious formal link to GoU policy levers. When it was set up, the Committee was seen as critical for mutual accountability between the project and its central and local stakeholders. The Committee would ensure higher-level buy-in and political cover for project activities– ensuring at least some degree of harmonization with local solutions and a degree of leverage vis-à-vis certain district CAOs. The Committee would also permit the project to "take the temperature" of government at local and national levels on a regular basis. For example, when SDS knew that central authorities might have interests inimical to certain aspects of the project (e.g., efforts to promote certain kinds of local revenue enhancement), the Committee helped surface those concerns. Ultimately, SDS gained the trust of the Committee by virtue of the depth of its understanding of local governance and the no-nonsense approach it took to the grants and TA. The MoLG and others were impressed with the inroads made in gaining local compliance with PFM and procurement standards, as well as integrated budgeting that incorporated donor financial commitments at the district level.

In a number of cases, the Committee also served as a problem-solving forum to address systemic issues in real time. For example, SDS was able to bring to the Committee recurrent problems in such areas as rules changes required of the districts under the grants program, and potential disallowance of funds. The Committee would intercede as necessary with LGs to clarify the issues or otherwise apply pressure on particular districts to put their house in order. With players like the Ministry of Health at the table, the Committee was able to serve as a clearinghouse for information-sharing and higher-level policy and implementation coordination on the project's health and OVC work. Both the GoU members and SDS could compare notes on the progress of information-sharing and coordination at the individual district level through the DOP.

The real value of the Committee in terms of its potential 'scaling up' role is illustrated by the cooperation between SDS and the Committee in modifying the methodology of the District Development Plans (DDPs). Early on, SDS experts noted that the plans tended to be vague and generic (as well as long). While the DMIP process was criticized in some quarters as a time-consuming overlay on the DDPs, in fact most districts and central authorities appreciated the greater specificity and issue focus of the former. When it came time for SDS to assist with a mid-term review of the then-extant DDPs, the project took the opportunity to engage with the Inter-sectoral Committee about modifications to the latter. Eventually, the Committee ratified substantive and format changes

---

[82] This is evident in several health service delivery areas, but even in the case of the more focused TA and funding lavished on the OVC work.

that not only helped SDS with the remaining TA work it was trying to accomplish, but mapped a new approach to district strategic planning going forward.[83]

The misfortune is that SDS was unable to work more consistently with the Inter-sectoral Committee to secure successful policy uptake and heightened sustainability. By Years 4 and 5 of the project, there were multiple examples of project innovations that had demonstrated their value across multiple districts and might have been subject to fruitful study and deliberation under Committee auspices. These included the use of some version of the Output Budgeting Tool, certain community engagement and oversight mechanisms utilized with the pilot education (primary reading) support activity, and the successful introduction of timesheets in some districts to foster better health worker accountability. The problem was not only that SDS did not have the time and resources to more carefully test such approaches and adapt them through more iterative learning. The project also lacked the capacity to document successes and present them to the Committee as part of a concerted policy advocacy effort.[84] (Another lost opportunity is discussed in Box 11).

Box 11 Why so little investment in SDS policy reform advocacy?

The absence of a more robust policy change dimension to SDS is notable, particularly on a project of this size and importance. This absence is all the more striking in light of the fact that the Mission's GAPP Project, a somewhat smaller initiative, had policy advocacy, and work with both central oversight institutions and local community organizations, as central elements of its scope of work. For the most part, this was a major design oversight; USAID's significant investment in local government capacity building in SDS led to a number of interesting work modalities and policy applications otherwise of great interest to central authorities, including revisions to the District Development Plan process (and now GAPP has sought to make the DDPs more participatory). The most convincing explanation for this blind spot was the project's provenance in the Health Team. As health teams do, they may have steered clear of policy work, believing it was not an area of expertise and that getting more involved with politics, however defined, was both potentially risky and distracting from the project's main service delivery objectives.

Whatever the missed opportunities, it is clear that future capacity-building building projects of this kind – particularly those spread across many individual local governments (as are several USAID projects) – should consider including a policy analysis and advocacy dimension. This is especially important if a project aspires – as most should – to ensure broader uptake of project of innovations and see them potentially transformed into policy. Certain projects, particularly those working in certain illiberal democracies or patronage democracies, may not in fact, find particularly favorable central government interlocutors. But so long as local government projects of this kind are undertaken, it is critical to have clear communication with central authorities and the ability to translate modest innovations at the local level into more enduring country-level policies.

5.3. Selectivity, Co-Location, Coordination

SDS was one of the earliest USAID projects deliberately designed to help coordinate different Agency assistance streams at the local level. The idea was, first, to have SDS serve as a capacity-building interface with Ugandan local governments receiving USAID assistance, helping render such assistance more transparent, providing local authorities greater voice in the delivery of such assistance, and ultimately helping districts assume a larger role in planning and budgeting for their own activities in conjunction with the donor-funded work. This would put the districts more 'in the driver's seat' with regard to health service delivery. Second, SDS was to help streamline assistance. The project would create a platform whereby inefficiencies and redundancies could be identified and

---

[83] Notably, this new approach was specifically requested by GoU authorities to be used on the GAPP project.

[84] There was discussion within SDS about launching a kind of 'Policy Brief' series that would simultaneously disseminate cutting-edge findings and innovation based on project learning while serving as an adjunct to serious policy advocacy work. But it was concluded that the project had too few resources and skilled staff writers to launch such an effort.

eliminated, and where local officials would be less burdened by overlapping and competing demands for meetings and information.

This coordination emphasis grew out of a concern in USAID and the State Department that foreign assistance was insufficiently focused and strategic at the global, country, and even sub-national level. Missions saw this move toward program selectivity as requiring them to direct their resources in a more concentrated way to a smaller number of priority localities. The emerging thinking was that these more concentrated packages of assistance, potentially across multiple subject areas, could have synergistic effects, particularly if properly coordinated. Missions were encouraged to map their programs and assets more systematically and think seriously about co-located projects as a way to promote synergies. Well before USAID Forward and the CDCS process were mainstreamed throughout the Agency, USAID/Uganda championed this idea and found that SDS could play a critical connective role in many districts—not just in the health arena, but also with regard to other USAID assistance projects.

The coordination function contained in Component One was a notable innovation for USAID at the time, particularly for a health project. It called upon Cardno, the implementer, to work with local authorities to establish a coordination platform that would simultaneously serve as an information clearinghouse, an accountability and problem-solving forum, and a means of spurring particular capacity-building activities in relevant local government departments. This would prove difficult, particularly in the absence of any political economy analysis of district governments or the putative synergies and incentives of particular co-located USAID projects. In time, many would question whether the later decision to designate priority districts as 'Mission Focus' Districts was driven by an informed understanding that latent synergies existed and could be exploited, or by a more expedient desire simply to rationalize existing project investments.

Several questions arise about the nature and practicability of the SDS coordination function. There is a first set of questions about whether coordination could actually be achieved as a political and managerial matter. Was SDS sufficiently empowered, politically and practically, to coordinate in the manner envisioned in the project's scope of work? Were districts in a position to 'sit in the driver's seat,' even with substantial help from SDS, as a matter of capacity and influence? And even if such capacity and influence were exercised, how much difference would that make in terms of the priorities, content and modalities of USAID assistance delivered to a district? A second group of questions concerns the District Operational Plan process—which was superimposed on Component One in 2011. What value did the DOP add? Were the additional protocol and reporting burdens placed on SDS and the districts commensurate with the benefits to local governments – and USAID? Did the DOP in some ways detract from the project's otherwise strong commitment to a 'local solutions' orientation in much of its work? These questions are addressed in turn below.

5.3.1. SDS Coordination: political realities

A major challenge that USAID/Uganda largely sidestepped in promoting coordination was SDS' limited leverage over the DBTA implementers. How would SDS, working with and for the districts, ensure that the other implementers actually cooperated with the project—whether such cooperation involved the provision of information, attendance at district meetings, following up on action points, or adjustment of workplans? Each IP functioned within the terms of its own contract or agreement and had its own budget and workplan to execute. Coordination, even at a relatively modest level, takes time and money that many IPs – and even other USAID program officers – would not usually divert from their existing priorities. As SDS itself had no ability to force action from DBTAs, it was up to USAID to prod the parties to work together. And it was not clear that the USAID Health Team had sufficient backing from Mission leadership—at least initially—to follow through.

As related by a number of different SDS and USAID personnel interviewed for this case study, the Health Team over time did enlist support for SDS coordination from the Program Office—a task eased by the growing

reputation of SDS and eventually of the DOP itself. USAID/Uganda eventually inserted SDS coordination guidance into several DBTA contract and cooperative agreement modifications. But at the DBTA level, district geographic coverage presented a problem. Many implementers had district responsibilities that aligned with those of SDS, but most did not have the necessary human resources (mid- to senior-level personnel with cross-cutting knowledge) to attend district coordination meetings regularly or to 'ride circuit' among district clusters as did SDS personnel.

Thus, many opportunities may have been lost for closer information-sharing and problem-solving among IPs.[85] On occasion, this had a detrimental effect on district grantee performance under Grant A (when certain action steps were unable to be properly executed). At the same time, the inability or disinclination of certain DBTAs to attend DOP meetings had a corrosive impact on the perceived effectiveness of that mechanism.

Beyond the differences among its various projects, USAID had to acknowledge a further disparity between the DBTAs and the districts. **No matter how much SDS might empower districts and their CAOs to request adjustments in DBTA programming, there was often little latitude for DBTAs to alter highly directive scopes of work.** (Analogously, the thrust of Grant A plans were almost completely determined in advance by USAID project officers and DBTAs, allowing little or no adjustment by the districts.) This did not prevent productive problem- solving with DBTA participation. EDHMT work and complementary Grant A validation activities helped fine-tune delivery assistance mid-stream. But a forward-looking coordination agenda was harder for the districts to shape.

Districts also varied in their capacity to take advantage of the coordination benefits of SDS. A critical determinant was CAO talent and commitment. Where there was a capable and engaged CAO in office, a culture of cooperation and problem-solving carried over from the TA and grant activities to the coordination work of the EDHMT and (to a lesser extent) the District Technical Planning Committee. Even then, however, some CAOs and senior district officials saw coordination as largely an exercise in re-labeling existing priorities and arrangements agreed upon at higher levels. Moreover, any efforts to put districts 'in the driver's seat' as a political matter were hobbled by the lack of well-trained and empowered political leaders in the local councils. They had been largely sidelined and asserted little influence in the work of the EDHMT and the EDTPC. The local communities at the sub-county level in practice had little say over the terms of DBTA assistance streams.

This inherently problematic power dynamic – reflecting the larger political economy in Uganda – was only slightly mitigated by involvement of the MoLG. While the Ministry and the Inter-sectoral Committee were both supportive of enhanced coordination, their concern lay more with enhancing overall transparency of donor assistance, asserting national priorities, and tailoring conditional transfers accordingly. Predictably, central authorities were less enamored of 'putting districts in the driver's seat' and had little inherent interest in advancing this goal.

Despite these constraints, SDS in fact carried out its coordination functions capably, and earned the respect of district officials and DBTA implementers alike. Moreover, district-led performance reviews, facilitated by SDS, often helped to identify discrete coverage and service gaps to tackle such problems as they arose in real time. In many instances, working with Ugandan MoH representatives, district health management teams, district councils and individual health facilities, SDS and DBTA partners were able to increase accessibility and utilization of particular health services.

In this way, **whether larger-scale coordination was effective or not, SDS personnel came to play an important facilitative or liaison role between the districts and the IPs** due to their familiarity with the work of the EDHMT and DTPC. According to several SDS staff and district personnel, **SDS helped**

---

[85] At least some SDS staff related that there were occasions when DBTAs in given districts were slow to comply with certain process steps that the district grantees had to fulfill under their Grant A's, thereby inadvertently penalizing the latter. Interviews with SDS staff, May and October, 2016.

smooth out problems, expedite cooperation and information-sharing, identify corruption risks and capacity gaps at the sub- county level, flag priorities for capacity-building, and nudge DBTAs to modify assistance packages and eliminate redundancies.[86] SDS also pioneered an output budgeting tool (OBT) that met GoU requirements for incorporating external assistance into the district budgeting process. And SDS helped inculcate a set of meeting and agenda-setting skills among senior district personnel, whose improvement could be measured over time.[87] Perhaps most important, SDS helped change the symbolic dynamics of district-DBTA interaction. CAOs and senior district officials appreciated the newfound respected accorded them by SDS and DBTA personnel, and gained a much better understanding of the work being done around the districts by USAID-funded IPs.[88]

The SDS facilitation and coordination role, in tandem with targeted TA provision, is an important and effective one, particularly when problems are addressed through the normal workings of the EDHMT or DTPC. But its utility as a longer-range planning and coordination tool in the hands of district leaders is constrained in practice by the Ugandan power structure. This is especially true where USAID seeks to carry out capacity-building activities simultaneously across dozens of districts. **Future coordination activity – and capacity-building TA – might be more effectively continued in a tiered manner, with districts that have demonstrated better leadership and uptake given proportionately greater and more intensive assistance.**

5.3.2. DOP: Cost-Benefit

SDS faced particular challenges in overseeing the development of the DOP process. The DOP came into play with the Mission's adoption of the CDCS, and its recognition that the SDS coordination function could play a more expansive role vis-à-vis all of the USAID-funded implementers in certain districts. The DOP did not fundamentally change the coordination function as outlined in the SDS scope of work. But coordination gained greater prominence in the 13 SDS 'Mission Focus Districts' and 22 SDS non-Mission Focus Districts where formal District Operational Plans were to be formulated and signed by USAID and the districts governments. The DOP was heralded by USAID as a way to advance both the Paris Declaration Principles of Aid Effectiveness and the Government of Uganda's Partnership Policy. The DOP was to provide the institutional mechanism for DMIP implementation and formalize multilateral coordination of USAID assistance with the districts. (Key features of the DOP are given in Box 12.[88])

---

[86] This role should not be exaggerated, however; it is also true that DBTA health implementer personnel often provided significant TA to district health teams and District Health Officers themselves, and also could serve as important facilitators and problem-solvers regarding specific health service delivery needs.

[87] Interviews with SDS staff, May 17, 2016, local authorities, Gulu, May 19, 2016, SDS staff, July 23, 2016.

[88] Other building blocks of effective coordination need to receive attention and demonstrate improvement before coordination could play the more expansive and forward-looking role envisioned in the SDS scope of work. These improvements necessarily include better expectation-setting among USAID project officers and USAID-funded IPs by USAID Program Office and other senior Mission personnel; more explicit guidance on coordination (contractual and otherwise) for IP's; provision of additional resources for USAID projects to support adequate coordination activity; more project transparency and information-sharing and reduced reliance on physical coordination meetings; and finally, overall capacity-building progress within district governments to make better use of the information made available through DBTA implementers (particularly among key planning staff and those responsible for MIS and M&E functions).

> **Box 12 District Operational Plans**
>
> The DOP was intended to (1) ensure that USAID programs are aligned with district development plans; (2) eliminate duplication and improve complementarities among USAID implementing partners; (3) improve collaboration and communication with Local Governments and other stakeholders working at the district level; (4) strengthen partner districts while jointly coordinating, implementation, monitoring and evaluation of activities within the district; and (5) make it easier for district governments to understand USAID's portfolio and provide feedback to USAID on project performance. In each of the districts, with SDS help, USAID and the LG formed a District Management Committee chaired by the CAO and staffed by selected district staff relevant to USAID-supported sectors (e.g. District Health Officer and District Production Officer), one representative from each of the USAID implementing partners, and USAID. The District Chairperson and the USAID Mission Director (or his designee) were designated as *ex officio* members of the committee. The meetings were held quarterly to discuss and resolve coordination, alignment, and operational issues, but also to work on a "joint management results framework," in which a limited number of indicators were selected to measure improvement in the sectors in which USAID and the district are collaborating.

From its inception, the DOP process forced a precarious balancing act on SDS and the districts. On the one hand, it brought symbolic and diplomatic benefits to SDS' work by bringing USAID personnel directly into the picture and better acquainting them with district-level capacity-building and service delivery challenges. But that same participation entailed a degree of formality – through the DMC meetings and the drafting and approval of the DOP agreement itself – that drew valuable time and effort away from more substantive problem-solving and coordination work anchored by SDS on a continuous basis (involving district EDHMT and DTCP counterparts). DMC meetings invariably struggled to avoid[89] how- and-tell" sessions and the inevitable diplomatic *politesse* that prevented substantive discussion– or that masked deeper tensions among district staff, DBTA implementers, and USAID. Political leaders were not quite integrated into the meetings and often relegated to a ceremonial role. In addition, USAID personnel attending the meetings were widely seen as generalists unprepared to address technical issues that districts and their CAOs were eager to talk about.[90] USAID officers also had difficulties attending all of the DMC meetings, given other work commitments and the expectation of USAID representation at four such meetings per year in each district.

Over time, these burdens and disadvantages became more apparent, as reported by several different current and former USAID staff and SDS personnel. SDS and the districts struggled to streamline DMC meeting agendas and keep them from running over the partial day allocated to them.[91] Most CAOs had difficulty running meetings and keeping participants on task. Agendas were process-heavy, with introductions and updates allowing little time for longer-range thinking or immediate problem-solving. Information-sharing and DBTA transparency proved more limited than envisioned, since insufficient time was set aside for DBTA implementers to present visually accessible materials (and some DBTA representatives did not or could not attend). Even when task forces or working groups were delegated to work on issues between meetings, substantive DMC discussion time was severely constrained and often recapitulated work that had already been done by the EDHMT or DTPC. And predictably, the parties struggled to fulfill their joint indicator reporting responsibilities.

Eventually, as already noted, SDS and USAID agreed to undertake a CLA exercise (MEL Plan) to learn from the DOP experience and improve it. Many different types of modifications and improvements were to be tested and evaluated. These included everything from better coaching and preparation of CAOs, to the designation of higher-ranking DBTA partner focal persons, to the holding of preparatory meetings. But many of these innovations

---

[89] Regarding DOP results management: in each DOP district, USAID chose 13 "common indicators" from the three sectors in which USAID works: Health, HIV/AIDS, and Education; Economic Growth (principally agriculture); and Democracy and Governance. Each district was asked to provide a small number of indicators it would like to track as part of the agreement as well. USAID's common indicators are high-level outcome and impact indicators and an important part of the DOP mechanism.

[90] Interviews with SDS staff and district officials, May 2016.

[91] Meetings were limited to a half day or slightly longer at the maximum due to constraints on participant travel but especially the inability of the districts or SDS to provide meals.

shared the problem of adding more time and formality to the existing arrangements. There was a consensus that the information-sharing aspects of the DMC were the most valuable, but that such transparency could, and ultimately did, occur on a rolling basis throughout the year.

Under the circumstances, one of the most effective modifications to the DOP process was the decision to merge the DMC with one of the district's monthly DTPC meetings. Many districts had complained that the DMC duplicated much of the work of the latter body and yet required the district to accommodate four extra meetings per year. The resulting Extended District Technical Planning Committee meeting combined the functions of the DMC with some of the regular DTPC agenda on a harmonized calendar. Yet some districts were still unhappy; the less substantive nature of the DMC detracted from regular DTPC work and also made it harder for local officials to hold candid discussions.

> "The DOP has enabled us to eliminate duplication even beyond USAID Projects. For example we learned that the Malaria Consortium and SPEAR (a USAID project helping public sector workplaces expand responses against HIV/AIDS) were both training village health teams. The District Management Committee asked our district health officer to harmonize VHT training activities so that resources are effectively used."
>
> Mbale District Official

Even as these *contretemps* continued and the MEL exercise was determining what other modifications might achieve a better cost-benefit balance, the core SDS Grant A and TA components were substantially wrapped up in the 35 districts, severely diminishing the practical importance of the DOP process. And yet USAID and SDS continued the process, committed to sustaining the partnership ethos it signified, the transparency it enabled, and the relationships it nurtured.

In the final analysis, **the DOP process was generally burdensome for all participants – principally due to the formality involved in having one or more USAID representatives attend meetings and recapping decisions already made – but it fundamentally served valuable purposes.** According to the SDS Project Evaluation, it provided a context in which IPs could harmonize workplans and occasionally identify redundancies.[92] It continued to empower districts politically and bind the partners in accountability relationships, however loosely. For the most part, it elicited positive reactions from most districts. It strengthened information-sharing, even as its process dictates occasionally suggested an ironic counterpoint to the 'local solutions' mantra. And even though most 'real' coordination occurred through other district structures, the DOP process still made a platform available for longer-range planning and larger-scale coordination. The challenge of coordination is making sure that it genuinely serves the needs of all participants, and especially local stakeholders. If it can continue to evolve in a more cost-effective direction,[93] the DOP can serve a valuable purpose in Uganda in the future—and be a source of learning for other USAID Missions.[94]

5.4. Adaptation to the Local Environment or Responsiveness to the Donor?

The SDS Project has won praise from the USAID Mission, development partners, and a number of local government beneficiaries for its ability to adapt to changing donor requests, local conditions, and management

---

[92] SDS Project Evaluation, p. 13. The Evaluation also cited observers who found that DMC/EDTPC meetings were conducted in a much more businesslike fashion than was previously the case, and that if action points are not followed up later, individuals are held accountable.

[93] For the most part, the partners might genuinely benefit from a radically restructured DOP—one that acknowledged the more representational nature of the agreement, and that would ask the parties to hold their DMC annually or semi-annually for 2 days, so as to chart a longer-term general strategy.

[94] For example a new Malawi local government strengthening program envisions a similar coordination mechanism to exist, which will be facilitated by the main implementer. SDS DOP experience could prove very valuable.

challenges. The project went through a series of transformations over the years -- clarification of project objectives and staffing needs, re- assessment of the scope of capacity-building assistance it could provide, major changes to the three grant programs, the addition of other capacity-building initiatives, and ultimately, execution of substantial direct service delivery work in the North. SDS repaid the trust placed in it by continuing to perform effectively and responsively despite the breakneck pace and managerial demands. Even while the scaling back assistance in Years 4 and 5, the project managed to maintain a sense of continuity in last two years.

Much of the credit for this adaptability stems from the high technical standards and proactive work culture established by the Chief of Party early in the project's second year. By aligning the project's core work with the original capacity-building vision of its authors, creating a new management structure, attracting staff with the right skills, and later demonstrating an openness to new technical challenges and learning opportunities, the SDS COP established a highly effective team. With this new posture, along with the emphasis on grants and relationship-building, the team created the SDS 'Platform' that came to be admired by the Mission, the Government of Uganda, and many others in the implementing partner community.

The Chief of Party and SDS senior staff also cultivated a strong collaborative working relationship with the USAID Mission—not only with the AOR and Health Team, but with the Mission leadership and the Program Office. This strong partnership ethos enabled the project to gain a high degree of autonomy in carrying out the capacity-building work on a week-to-week, month-to-month basis –unusual for a project of this size and importance. As the project met with success in tackling challenges like the LOGIC intervention and the DBTA coordinating responsibilities, it attracted higher-level interest and scrutiny in the Mission. This resulted in the project's assuming the highly visible (and demanding) DOP work, as well as the later HRH, primary reading, and WASH activities. Still greater scrutiny and less flexibility came in the later years as PEPFAR strictures tightened and pressures to meet key health indicators increased.

The project's adaptability is also attributed to its operation under a cooperative agreement rather than a contract. In fact, as a health project, SDS' procurement as a cooperative agreement was far from unusual; most of the large USAID health projects in the past decade have used this contracting modality to allow for short-term course corrections and responses to health emergencies. Moreover, this flexibility was constrained by USAID's many different substantive and budgetary amendments to the project, requiring no fewer than 16 contractual modifications.[95] A more persuasive explanation for the project's innovative work at the local level is this: the original project scope was relatively open-ended, and the health team trusted the SDS Team's governance expertise and patient relationship-building. In encouraging this hands-off approach, the cooperative agreement may have been quite helpful.[96]

We should distinguish between, on the one hand, the project's undeniable ability to adapt to the new programming demands thrown its way by USAID, and on the other hand, the iterative management adaptation occasioned by reflective learning on the ground and changing understandings of local conditions. The latter embodies the 'adaptive management' thinking behind USAID's "Collaborating, Learning, and Adapting (CLA)" emphasis (to be considered in more depth in the next section). **Despite the project's strong engagement with most district and central government stakeholders, its reputation for adaptation had less to do with systematic, iterative problem-solving and learning in a CLA vein, and more to do with its nimbleness in absorbing modifications imposed on the project by USAID.**

---

[95] The most significant substantive modifications included No. 1 (LOGIC Training); No. 2 (the DOP work and IP mapping); No. 4 (WASH, HRH, and nutrition work); No. 5 (extending the project to 6 years, instead of 5); and No. 11 (launching the work in the North).

[96] In this indirect sense, the cooperative agreement was perhaps influential; most larger-scale governance projects have traditionally – and counter- productively – been procured as contracts, seemingly due to the political sensitivities involved. Most development specialists would agree, however, that governance projects require substantial flexibility precisely due to the need to build trust over time, and due to political changes, including changes in political leadership. This dovetails with recent thinking about so-called "development entrepreneurship." See Faustino, J. and D. Booth, 2014. *Development Entrepreneurship: How Donors and Leaders Can Foster Institutional Change*. Overseas Development Institute, *Working Politically in Practice: Case Study No. 2*.

Is the SDS 'can do' management approach – operating under relentless technical demands and contractual changes – sustainable or replicable? Most projects would find it difficult to maintain the pace of the SDS Project over three or four years, never mind five or more. Even with a strong and resilient work culture that attracted talented and highly motivated staff, projects like SDS suffer staff burnout. The heavy demands can discourage reflection and learning, which might otherwise lead to improved technical approaches and results. SDS staff commented on learning and reflection being casualties of the demands placed on the project. In this case, responsiveness appears to be the enemy of adaptation.

A further question for USAID is whether the SDS Project's responsiveness may have come at the expense of more durable capacity development and systemic change in the original 35 districts. Did the effort to meet USG demands shift the SDS focus away from the deeper, lasting changes in local and national practices that were the original aim? The answer appears to be yes. The core work of the project only had 2-2 ½ years to demonstrate measurable results, i.e. outcomes that usually emerge only with longer engagement and time lapses. In contrast, many of the larger health interventions, especially those funded by CDC, use relatively rigid, linear, best practice-oriented approaches that meet urgent targets rather than strengthening health service delivery institutions over the long run.[97]

In the end, the scaling up of ostensibly successful approaches was hampered by staffing, funding, and management demands elsewhere in the project that made it difficult to adopt a sustained policy advocacy effort involving, for example, the production of evidence-based policy briefs. Thus, short-term responses appear to have diminished the focus on long-term systemic change, although a definitive finding would require more rigorous assessment than SDS has received.[98] Can a typical USAID hybrid project tasked with both short-term service delivery and longer-term capacity-building responsibilities capably manage *both*? Certainly the management and quality control functions would be extremely challenging. In an aid environment that values learning and sustainability, a modular, experimental design would be optimal.   The path forward for USAID would thus be to include some smaller and more focused projects in overall Mission team portfolios. This has implications for both project design and modification.[99]

5.5. Collaborating, Learning, and Adapting

Collaborating, Learning, and Adapting (CLA) arose as a conscious decision of the Program Office at USAID/Uganda under then-Mission Director Dave Eckerson as a way of encouraging Mission staff and implementers to think more creatively about their work and adopt a stronger learning orientation. The idea was to create a partnership between project officers   and IP staff to use monitoring and evaluation tools to continuously reappraise their activities in ways not usually emphasized   by top-down, prescriptive scopes of work. Progress toward development objectives was to be guided by continuous learning that questions received wisdom or routine and encourages adjustments as causal pathways to desired outcomes are better understood. While SDS, designed in 2009, was

---

[97] To be sure, the direct health service delivery interventions in the North under SDS were avowedly short-term in nature, in order to address   pressing needs. At the same time, in addition to the opportunity costs of pulling attention and resources away from longer-term systemic needs in   the original 35 districts, these shorter-term interventions have tended not to allow for any significant systems thinking or flexibility and adaptation.   So while general quality improvement work in the international health arena may exhibit characteristics of adaptive management, the frequent lack of connection to political institutions and mechanisms for 'scaling up' means that project-level gains may be unsustainable. *See* Tulloch, O., 2015. *What   Does 'Adaptive Programming' Mean in the Health Sector?* Overseas Development Institute Briefing (December 2015).

[98] Although the project's generally solid end-line evaluation was undertaken by a local evaluation firm rather hastily before the project was extended   for another six months (to September 30, 2016), no effort was made to provide more time for a systematic evaluation of capacity-building indicators   such as those initially compiled in the Project's TA Uptake and Assessment Study. Additional and more in-depth interviews in sampled districts would   also have provided more perspective on the possibility for sustained capacity growth over time.

[99] In addition to embracing the possibility of a certain number of projects with 'rolling design' features – or at least the opportunity for certain   projects to flesh out their detailed designs after award -- USAID and other donors should explicitly incorporate opportunities for significant design   changes to occur with modest contractual modification formalities and review. On longer projects, this could include a purposeful mid-term pause   by both donor and implementer for considered reflection and learning.

imbued with this spirit, it preceded CLA's incorporation into the Mission's CDCS by over a year. For projects like SDS awarded before the CDCS, there was little practical guidance about what CLA really meant, and even CLA boilerplate was not incorporated into SDS' cooperative agreement, it later was with dozens of projects in Uganda and elsewhere. While CLA has become a very significant part of USAID's program support efforts over the past three years via Learning Lab within the Policy, Planning and Learning Bureau (PPL), SDS truly started on the ground floor when it came to trying to integrate a learning agenda into its work.

5.5.1. CLA: from brainstorm to mandate

CLA took on a life of its own in Washington with the advent of USAID Forward's strong support for rigorous evaluation (2011), thus forcing the Uganda Mission to demonstrate its own seriousness about the subject.[100] This effort took time, especially given questions about definition and rigor. Many USAID officers and implementers asked whether CLA simply attached new jargon to enhanced M&E efforts and common sense adaptation of project features to meet new realities on the ground. However, against the backdrop of the Doing Development Differently movement, most donor M&E was more clearly seen as privileging narrow definitions of 'success' and upward accountability to donors rather than encouraging the use of monitoring data to directly *influence* program success and learning for adaptation. In this context, CLA sought to tie learning more directly to M&E, rather than having it stand apart.

As the SDS Project struggled through its first few years simply to define its approach and reorganize its staffing, there was little time for project leadership or its M&E team to pursue an active learning agenda or think in a highly intentional adaptive manner. To begin with, the project itself lacked any real overarching theory of change that could anchor such a learning initiative (and the common use of theories of change within USAID did not emerge until the project was well into its third year). Targeted project objectives were largely unclear until the project's capacity-building purpose had been clarified in Year 2, and learning objectives of any kind were not really articulated until Year 4. At the same time, until 2013, when the Mission ended up hiring a full-time Learning Advisor working out of the Program Office, the Mission itself did not develop clear definitions and an analytical framework to help its staff and partners better understand what CLA might entail.[101]

Only toward the beginning of Year 4 did the Mission actively encourage CLA as a 'whole-of-project cycle' discipline and seek to hold regular CLA lessons-learned sessions (usually quarterly) among implementers and across sectoral silos. The Mission also encouraged projects to convene 'learning moments' with staff and encourage the holding of periodic retreats to take stock of knowledge gained, fill other knowledge gaps, and build in time for adaptive management adjustments. In these endeavors, SDS was a willing and able partner with USAID, sharing information frequently with other IPs about different aspects of its successful 'platform,' particularly its DBTA coordination work.

Ultimately, SDS, like many other implementers juggling multiple urgent demands, was unable to set aside regular time for reflection and brainstorming in the normal course of its work.[102] Course corrections were of course still made—witness the many changes to the TA and grants programs over the life of the project. But in hindsight, SDS staff concede that many of these adaptations could have been more thoughtful and systematic, and perhaps not as fraught with serial adjustments, had time been set aside on a regular (e.g. monthly) basis for such exploration and discussion.[103] Many also said that more systematic use of such meetings would have strengthened

---

[100] The more rigorous evaluation championed under USAID Forward differed significantly from the broader and more process oriented CLA.

[101] It did not help that up until this time, the Mission was serviced by an M&E contractor that was not sufficiently equipped to make the leap to a more ambitious learning support role (a successor vehicle, specifically denominated a "Learning Contract," was awarded to a new contractor in mid- 2013).

[102] Interviews with SDS staff, May 17, 19, 24, 26, 2016 and July 19, 2016.

[103] Today, USAID's Learning Lab specifically suggests that projects set aside time for a monthly Friday learning and reflection meeting that

trust and teamwork, reminding staff of the higher, longer-range objectives of their work and providing a welcome and rejuvenating 'learning respite' from the taxing work of the program. But some of the positive momentum in CLA generated in Years 4 and 5 was dissipated at the end of Year 5 when the Project's M&E Director left the project, leaving the MEL agenda adrift until a replacement was found many months later.

The project's existing M&E systems and performance management plan were, however, strong throughout the project, yielding useful information about the progress of the project, especially the core grants and TA activities. The information was displayed in visually compelling and easily accessible formats. In addition, the project took it upon itself to launch a labor-intensive annual survey of service delivery satisfaction, but this suffered from issues of bias and attribution (due to larger funding and administrative-political influences).[104] Government staff responses revealed an increase in positive perceptions over time, perhaps reflecting the better understanding of the activities and causal pathways involved in, say, getting medical supplies and personnel to various communities. Citizen responses, by contrast, were mostly negative over the life of the project (although they registered some improvement regarding the quality of health and education services between 2012 and 2014.)[105] There were intriguingly large differences in citizen satisfaction between districts, but no indication that SDS had the time or willingness to follow up on this information and try to tease out more micro-lessons from them.

In Year 4, SDS undertook a CLA study aimed at more rigorously gauging the effectiveness of the project's signature TA and Grant A work. SDS gathered data from 12 SDS districts and compared it to data from 12 roughly comparable non- SDS districts (based on the 2 ½ years' worth of results then available). There were some methodological weaknesses that the study could not avoid. It relied on the self-reporting of local officials in the two sets of districts, introducing issues of potential bias and differing understandings of concepts that may have skewed the results. In the end, the TA and grants did not demonstrate any clear advantage for the SDS districts relative to the non-SDS districts. SDS did, however, go back and complement the CLA study with its own TA Uptake and Application Self- Assessment Study. In this latter study, SDS utilized rich documentary evidence in its own possession, and that of the Ugandan Government, to show in greater detail the progress in local systems strengthening made by the SDS districts.[106] **The Project's later self-assessment efforts not only demonstrated a genuine commitment to learning, but better contextualized the project's work in the limited time allotted to it and within the much larger local government administrative framework in which it operated.**

5.5.2. The MEL initiative

A more robust learning effort came in Year 5 when, with active Mission support, SDS undertook the dedicated monitoring, evaluation, and learning (MEL) initiative to study and improve the operation of the DOP. This analyzed what was working with the DOP and what was not -- iteratively introducing new process elements in response to participant feedback to ascertain improvements in efficiency, effectiveness, and user satisfaction. It also operated in real time, as a quasi- experimental initiative incorporating aspects of developmental evaluation and so called 'outcome mapping.' Both of the elements focus on complex, non-linear programming contexts and emphasize actor-centered development and behavior as much as ultimate 'external' outcomes. This was important in a situation where a new coordination mechanism had been introduced without significant consultation and where participants' evolving views on the value of the exercise had to be taken into account.

---

would habituate staff to such a purpose.

[104] Bias was a significant potential problem with the staff responses to the survey, while the citizen responses were problematic due to the convenience sampling used, rather than a more rigorous household-type survey, which would have been much more probative, but also much more expensive.

[105] SDS Citizen Reports, 2012, 2013, 2014, 2015.

[106] See more of the selected results of this exercise in Section 5.2.2 above.

In retrospect, the DOP MEL experience provides some support for the idea that CLA and adaptive learning methods can be integrated into even the most complex and nuanced governance contexts. Small process changes and rapid feedback from stakeholders can yield better results and greater trust and teamwork. These kinds of highly process-oriented learning efforts (documented through interviews and focus groups) could potentially have been used for many different training, mentoring, and grant-making/grant validation modalities. These CLA initiatives may be easier to introduce and serve more practical, incremental learning needs than more ambitious experiments seeking to assess the effectiveness of the 'surge' activities or the overall HRH recruitment effort.

No matter how adaptive donors may want their projects to be, there are powerful forces limiting the extent to which genuine adaptive programming can be mainstreamed on most projects. These forces are not simply bureaucratic inertia or rigid management patterns. They include donors, beneficiaries, and even implementers, who may all be resistant to drawing funds away from direct assistance to MEL activities, no matter how potentially valuable. Each may have its own short-term reasons for viewing such learning as potentially 'slowing things down' and thwarting accomplishment of certain benchmarks and goals. And these parties may also raise practical, political, or ethical objections to withholding particular approaches ('treatments') from certain groups or geographic areas as part of a quasi-experimental evaluation design or other learning activity.

There are equally serious concerns about what can be accomplished on projects (and there many) that have a core mandate (sometimes with powerful political constituencies) to deliver a certain quantum of assistance. Better M&E and more frequent and active monitoring and reflection can certainly result in more nimble project adaptations, but there are limits to the amount of data analysis and learning time that can be accommodated on the average mid- to large-sized project. **It is costly to undertake, even on a modest scale, the kind of rapid trial and analysis of different approaches that some observers have seen as facilitating the search for 'better fit' project pathways.[107] Unless and until donors and advisors can thoughtfully determine which kinds of projects may be best suited to these more ambitious learning activities, some reasonable minimum standards should be set for CLA imperatives and expectations.** (See Box 13 below.[108])

---

[107] Truly more innovative and demanding MEL designs might incorporate 'structured experiential learning' whereby 'multiple bets' are deliberately launched by a project in parallel fashion to permit rapid feedback and learning to narrow down complex social change approaches (giving way later on perhaps to more focused sequential methods). See e.g. Pritchett L., Sanjii, S., and J. Hammer, 2013. "It's All About M&E: Using Structured Experiential Learning ('e') to Crawl the Design Space." Center for Global Development Working Paper, No. 322 (April 2013).

[108] Expectations about cross-sectoral integration, for example, no matter how loosely articulated to encourage maximum flexibility and creativity in implementation, needed to be inserted into USAID contract language and made the subject of Mission-driven IP meetings in order for implementers to take the subject seriously. *See*, e.g., the experience of the Malawi Mission. USAID, 2016. *DRG Cross-Sectoral Programming Support Project: DRG Integration Case Study Synthesis.* Regarding output mapping: This typically defines outcomes as changes in behavior and it particularly helpful in measuring contributions to complex change processes (rather than being focused on attribution). Outcome mapping focuses less on the project's actual progress as defined by what may be inappropriate or overly narrow indicators but according to the project's influence (both intentional and unintentional) during the project's progression.

> **Box 13 CLA standards**
>
> CLA standards should properly be included in contracts and grants to incentivize real behavioral change. They could include several elements. First, they should rest on reasonably specified theories of change, along with realistic assumptions about activity linkages and constraints that could inform project development but also evolve in response to new information and learning. They should include an explicit budget allocation for MEL, as well as for a project learning officer on projects of a given magnitude. They should also enshrine the importance of building learning into all phases of the project cycle, and encourage more 'rapid cycling' on project components or activities that lend themselves to rapid experimentation/ iteration. They should also mandate quarterly and/or semi-annual reports that explicitly focus on lessons learned and problems confronted (whether or not overcome) rather than simply activities conducted and successes achieved. Finally, they should include guidance on the desirability of implementers not simply focusing on deliverables or more rigorous evaluation activities, but on more demanding *learning* activities. The latter could feature developmental evaluation or outcome mapping tools that track, among other things, behavioral changes in beneficiaries and other parties affected by the project's work.

SDS' own experience with MEL activities during the life of the project illustrates the difficulties that implementers face in an environment where many projects still are not designed with reasonably rigorous evaluation in mind (often due to the proliferation of many different and thinly spread interventions) and where the understanding of CLA is rapidly evolving (and explicit donor guidance is often lacking). SDS did the best it could with a scope of work that matched a hazy set of objectives (without the benefit of any real PEA) with fairly prescriptive methods for reaching them. MEL expectations were also unclear, making it difficult to budget for those activities or engage learning experts. As is the case with far too many projects, the pace of work was unrealistically ambitious for project staff and partners alike, making it hard to plan thoughtfully or collect critical baseline data. Project pacing only became more demanding as the project progressed and additional disparate project activities were added, further marginalizing the centrality of MEL activities. **And yet, more contractually explicit attention to CLA concerns on SDS might have at least served as a marker to remind** USAID and SDS staff of the importance of the project's core capacity-building work and the learning that accompanied it.

5.5.3. Getting CLA right

It is possible to imagine what more systematic attention to learning and adapting (beyond the important efforts already being made) might have produced on the SDS project. Certainly it might have helped the project spend more time on policy-oriented work with the Inter-sectoral Committee. It also might have led to a better consolidation of learning around the well-regarded OVC work that took place in the districts. And it might well have accelerated self-initiated learning and adaptation regarding the DOP. As it turned out, of course, the issue of improving the functioning of the DOP process eventually led to a fairly rigorous MEL Plan on the subject. But with more time and MEL staff, SDS might have undertaken a faster, less demanding process of eliciting and analyzing suggestions for DOP improvement.

Like many reform priorities in the development community, **entrenching CLA thinking in USAID Missions and projects means setting aside time and money for the specific purpose involved—and creating an appropriate reward structure.** Where project design and implementation agendas are already overcrowded and coordination of various kinds (and 'matrix management') has swamped project officers and implementers alike, privileging space for CLA will require sensitivity to the work demands of these audiences. It will need to take account of organizational culture and leadership, team skills and composition, appropriate tools and systems (including, above all, space for reflection and experimentation), and an enabling environment (good project designs and contractual and other guidance) established by USAID/Washington and individual Missions.

6 CONCLUSION

The SDS Project represents a remarkable achievement on several levels. Its design as one of the earliest hybrid governance/social service delivery support projects reflected a serious Mission commitment to local government capacity- building – both as a means of improving the short-term effectiveness of health and other community-based service delivery and as a longer-term investment to help sustain many of those accomplishments. It also contained a number of innovative core features, including consensually-developed District Management Improvement Plans, direct performance-based grants to local governments to support social services delivery, coordination activity that sought to align work by USAID-funded projects operating in a particular district with that locality's development plans, and intensive capacity-building and peer learning in planning, budgeting, and program oversight that built on the districts' own ongoing service delivery support activities. Much of this work was anchored by well-staffed regional offices that permitted substantial technical engagement and 'face time' with district counterparts.

These synergistic project components generated what might be termed an 'SDS Model' of local government capacity- building. This approach demonstrated significant promise in building an improved culture of accountability and evolving district commitment to achieving results in several discrete health and social services provision arenas, particularly regarding assistance to orphans and vulnerable children. This incremental progress represented a significant accomplishment in a Ugandan political environment of partial decentralization that severely constrains district resources and freedom of maneuver. As district structures grew stronger through direct grants management, joint problem-solving and support supervision, and transparent sharing of information for planning purposes, SDS also created a serious partnership ethos grounded in strong personal relationships with district officials.

The critical part of the SDS story, however, is the fact that this SDS model did not have sufficient time to develop and generate more robust results. Start-up difficulties and later programming changes related to HRH and health service delivery essentially limited the project's concerted core capacity-building work in 35 districts to less than three years. A victim of its own evolving success, the later-year programming shifts further dissipated the project's focus and tilted its unique hybrid identity decidedly in the direction of a more conventional health services provider. Nevertheless, the project generated substantial lessons—and questions--for future learning, which is the purpose of this case study. A number of the most pertinent questions are summarized below.

6.1. Cross-sectoral integration: scope and details matter

SDS benefited tremendously from synergies generated from the serious capacity-building work of the project (TA, grants, and district-led coordination) *carried out in the focused contexts of* discrete health and child protection services delivery— and later, in the contexts of the WASH, education, and HRH work. The lent the local institutional strengthening work a critical *applied, problem-solving orientation,* whether the subject was planning, grants management, or various kinds of support supervision. This tangible, practical anchoring is paid lip service on many 'hybrid' projects, but in many cases, one or the other dimension is scanted: DRG teams often commission local government projects that privilege policy and public management work without sufficiently – and directly – engaging with pressing service delivery needs, while sectoral projects neglect to put sufficient resources and expertise into meaningful capacity-building activities. Arguably – and surprisingly for a health project – SDS got the balance just about right (although even here, the TA was spread far too thin).

The SDS cross-sectoral experience raises deeper questions about USAID integration efforts. One is a matter of terminology: what, ultimately constitutes DRG integration? At one end of the spectrum, it can refer to any integration of discrete DRG mechanisms or processes (particularly those enhancing participation, accountability, and transparency) into otherwise highly technocratic sectoral reform projects. At the other end, it can involve the

more thoroughgoing blending of activities, perspectives, and expertise characteristic of a project like SDS. Both have their place, but project implementation modalities and result expectations differ tremendously and development actors must be clear about their intentions. A related issue has to do with project labeling and identity. No matter how much certain members of the USAID/Uganda health team saw SDS as a 'health project,' both the original design and Cardno's eventual vision for the project necessitated its grounding in local institutional strengthening. Ultimately, the development community may have to invent a new vocabulary for 'hybrid' projects as traditional sectoral silos are broken down. In the meantime, existing terminology must be employed with precision.

Other cross-sectoral issues raised by the project concern donor management and expertise. SDS was lucky to have had health team designers of the project who were bold and knowledgeable enough to support and 'own' a serious capacity strengthening project. Still, their apparent unfamiliarity with political economy analysis and the true state of district capacity led them to underestimate the challenges of gaining traction with much of the TA and grants work with district officials. That in turn reflected a Mission inability to ensure better cross-team collaboration on both project design and implementation. And arguably, better cross-sectoral ownership of the project might have not only helped shape a longer- term sustainability orientation and less ambitious geographic scope (perhaps 20 districts instead of 35), but pushed back on the more direct service delivery functions that the project was asked to undertake at the expense of the core capacity- strengthening work. As the recent USAID study of DRG cross-sectoral integration noted, DRG integration works best when DRG teams not only have a seat at the table, but have sufficient DRG funding to advance their views and materially influence the design of hybrid projects.[109]

6.2. Local solutions: what makes it effective—and sustainable?

SDS succeeded as well as it did in engaging with the districts because it harnessed proper Ugandan local governance expertise after a faltering start. That expertise was keenly aware of the need to align project TA and the grants program with local systems. Even though the grants program and the DMIPs introduced new and sometimes burdensome requirements on district audiences, they were nevertheless fundamentally in harmony with existing performance-based conditional grant financing mechanisms and District Development Plan objectives, respectively. Other TA and training, from improving procurement procedures to enhancing planning functions, consummately respected existing local government rules and regulations. Beyond this, perhaps the most important factor promoting SDS' capacity-building progress was the critical mass of resources the project was able to deploy toward this work. Many local government projects suffer from insufficiently sustained partnership with local officials; SDS had reasonable coverage of its districts through the circuit-riding work of its local coordinators operating out of regional offices (at least while these existed). And most projects typically do not have the funds or the mandate to make direct grants to localities, incentivizing action and follow up that provide a tangible sense of accomplishment and learning. SDS did.

The harder challenge for USAID or other donors seeking to promote better long-term ownership of locally-embedded reforms under USAID Forward is a reasonable sustainability strategy. Most projects profess to encourage a sustainable handoff to local authorities – or perhaps a successor project or implementer – but few have well thought-out plans or a reasonable time frame for doing so. SDS in this regard was no exception. Despite a strong respect for capacity-building and funding through the use of host government systems under the grants program, the USAID health team's main priority in the end was using SDS to support the short-term needs of its key health and community-based social services delivery providers. That the USAID Mission would risk allowing its partner districts to backslide on the progress made during the life of the project was generally problematic, but the fact that this was discernible shortly after the Grant A program ended in the 35 districts meant that even a successor project might have trouble making up ground. A commitment to local solutions ultimately means a

---

[109] See USAID, 2016. *DRG Cross-Sectoral Programming Support Project: DRG Integration Case Study Synthesis.*

commitment to long-term, sustained engagement, with significant follow-up with central government authorities on both TA and some improved performance grant mechanism. The situation might have been mitigated somewhat if the project had been designed to include a more robust policy advocacy role to scale up reforms and secure more central government support; this could have been done through the mechanism of the Inter-sectoral Committee. But without this mandate and resources, the project's ability to generate evidence-based reports and the like was stunted.

6.3. Selectivity and local solutions: limits to formal district-implementer coordination

Partnership with local governments and commitment to the principles of the Paris Declaration found their embodiment in USAID's support for enhanced aid transparency and better coordination of assistance flowing to the districts. This happened more or less informally and organically to a degree on the SDS project through work with DBTA partners and local authorities on DTPC's and EDHMT's—not to mention occasional meetings with CAOs. But to highlight the importance of both transparency and coordination – particularly in Mission Focus Districts with lots of other DBTA activity ('selectivity' under USAID Forward parlance) – USAID/Uganda worked hard with SDS to develop the DOP process. Concededly well-intentioned and symbolically powerful, the DOP process nevertheless ran somewhat afoul of both practical cost-benefit considerations and, ironically, local solutions (it was often cumbersome and conflicted at times with some of the regular monthly DPTC meetings). In the end, despite a dedicated learning effort to help render the DOP process more conducive to practical problem-solving (including the merging of the DMC with a new EDTPC), it ultimately withered somewhat due to the shrinkage of the SDS footprint in the original 35 districts (although it was also continued by USAID in some of the GAPP districts).

No matter how locally specific the DOP saga is, it illustrates broader cost-benefit dilemmas that USAID coordination imperatives confront. How much coordination is enough to alleviate burdens on local or central government offices caused by repetitive and/or duplicative interactions? Can such macro coordination largely occur outside of local government forums through understandings reached by IPs, leaving the more action-oriented coordination work to take place as needed through informal liaisons, task forces, or the occasional DTPC meeting? Can more ceremonial meetings be more streamlined and infrequent? Can transparency—both among IPs and vis-à-vis local governments—take place more efficiently through simple written information-sharing? In the end, mechanisms like the DOP process – at least insofar as it continues to serve as a more formal affair – may come to look more like a tool benefitting and flattering the USAID Mission than a practical help to the districts.

6.4. 'Adaptive management': more attention to the local environment?

The SDS project's ability to pivot to new circumstances and respond capably to new challenges thrown its way has frequently been cited as evidence of its adaptive management capabilities. And undeniably, the project's strong management team and willingness to venture into new subject areas was both impressive and admirable. But this flexibility is not necessarily unusual or innovative, nor is the cooperative agreement mechanism that allegedly facilitated it; good IPs do what they are asked, and significant programming departures still require an agreement modification. In short, management flexibility in responding to the USAID/Mission's requests should not be confused with adaptive management as it is usually construed in management circles and in the context of CLA: the latter concerns the ability to listen carefully to the local environment and make necessary adjustments to workplans, technical activities, partnership arrangements, and training/mentoring modalities.

SDS did a good job with the latter; as noted, the project made many small adjustments as required in order to render its grants and TA programs more effective and responsive to district needs and capacities--. It also made more significant adjustments to ramp up the surge process or work with USAID to try to improve a flawed

DOP mechanism. But this kind of adaptation was frequently offset by the project's responsiveness to new requests by USAID/Uganda. IPs need to be alert to situations where donors' own perception of themselves as responsive to new conditions on the ground run into conflict with a deeper implementer understanding of local dynamics – as well as the costs that may be incurred where existing commitments and longer-term adaptive management methods are compromised by new—and sometimes unrelated—programming demands.

6.5. Collaborating, learning, and adapting: staying intentional

SDS did a good job of handling M&E tasks on a truly ever-changing project but by its own admission was not able to create the learning culture that USAID/Uganda sought to foster among its implementing partners. CLA generally took a back seat to regular M&E work that was itself regularly playing catch-up with the breakneck pace of implementation on all major components of the project. And during the first half of the project, the Mission was also trying to define what it meant by CLA and how to operationalize it. By Year 4, SDS had not managed to hold periodic reflection meetings or retreats – which SDS staff later said it would have tremendously appreciated – but it had undertaken a number of learning studies, including the ambitious effort to compare certain measurable indicators of district strengthening in SDS versus non-SDS districts.

As the USAID Learning Lab now emphasizes regularly, learning must be intentional, and many different conditions must exist for this intentionality to take root, including resources and supportive leadership. And learning must be incorporated into all aspects of the project cycle. At the same time, however, USAID itself is still struggling to determine the conditions that it must help create for IPs to have a reasonable chance of being – and staying – intentional. These include contractual mandates to undertake learning activities (including developmental evaluations and outcome mapping exercises, as well as case studies and roundtables), budgets that are adequate to support meaningful learning activities, forums in which learning can be shared and good practices analyzed, and special project components and modalities that will permit parallel and/or sequential trialing of alternative work methods/technical treatments to be undertaken – to assess what works well and what doesn't. Deeper learning may also rest on USAID demanding more nuance and detail about project theories of change. Without this foundation – and better articulated connective assumptions – learning exercises will simply not be as rich. And until USAID itself gets more concrete generally about core CLA guidance as well as experimentation, project learning will remain hostage to more immediate work requirements and traditional (narrow) M&E methods. It is encouraging that this concreteness is now becoming visible in several USAID Missions around the world, which are providing more explicit written Monitoring, Evaluation and Learning (MEL) guidance to implementing partners and requiring the submission of comprehensive MEL plans that place a much greater emphasis on learning and adaptation.

7 APPENDICES

7.1. Sources consulted

Andrews, M. and L. Bategeka, 2013. "Overcoming the Limits of Institutional Reform in Uganda," Effective States and Inclusive Development (ESID) Working Paper No. 27. Manchester: University of Manchester.

Boex, J., Kimble, D., and J. Pigey, 2010. "Decentralized Local Governments as a Modality for Post-Conflict Recovery and Development: An Emerging Natural Experiment in Northern Uganda," Urban Institute International Development Group Working Paper No. 2010-01.

Brinkerhoff, D., Wetterberg, A., and E. Wibbels, 2016. Distance, Services, and the Decoupling of Citizen Perceptions of the State in Rural Africa. Research Triangle Institute International Development Working Paper No. 2106-01 (Research Triangle Park, May 2016.

Carothers, T. and de Gramont, D., 2013. Development Aid Confronts Politics: The Almost Revolution. Carnegie Endowment. Washington, DC.

Eckerson, D., 2013. "How a New USAID Was Born," March 20, 2013, https://blog.usaid.gov/2013/03/how-a-new-usaid- was-born/.

Faustino, J. and D. Booth, 2014. Development Entrepreneurship: How Donors and Leaders Can Foster Institutional Change. Overseas Development Institute, Working Politically in Practice: Case Study No. 2. London: ODI.

Government of Uganda, 2014. Local Finance Commission Annual Report, 2014 –Government of Uganda, 2013. Uganda Government Annual Performance Report, FY 2011/12 , vol. 1, p. 38.

Kibombo, R., et al., 2016. Evaluation of the USAID/Uganda Strengthening Decentralization for Sustainability (SDS) Project. Washington: USAID.

Lambright, G., 2011, Decentralization in Uganda: Explaining Successes and Failures in Local Government. Boulder: Lynne Rienner. Manyak, T, and Katono, I., 2010. "Decentralization and Conflict in Uganda: Governance Adrift," African Studies Quarterly, v. 11:4.

Muhumuza, W., 2008. "Pitfalls of Decentralization Reforms in Transitional Societies: The Case of Uganda," Africa Development, v. 33(4), pp. 59-81.

Pritchett, L., Sanjii, S., and J. Hammer, 2013. "It's All About MeE: Using Structured Experiential Learning ("e") to Crawl the Design Space," Center for Global Development Working Paper, No. 322 (April, 2013).

Rodden, J. and Wibbels, E., 2013. Responsiveness and Accountability in Local Governance and Service Delivery: An Agenda for USAID Program Design and Evaluation (Washington, DC: USAID).

Smoke, P., Muhumuza, W., and E. Ssewankambo, 2010. Comparative Assessment of Decentralization in Africa: Uganda Desk Study. Washington: USAID.

Tusubira, F. and Nkote, N., 2013, "Social Norms, Taxpayers' Morale and Tax Compliance: The Case of Small Business Enterprises in Uganda," Journal of Accounting, Taxation, and Performance Accountability, v. 2(1): 1-10.

Tulloch, O., 2015. What Does 'Adaptive Programming' Mean in the Health Sector?' Overseas Development Institute Briefing.

USAID, 2016. DRG Cross-Sectoral Programming Support Project: DRG Integration Case Study Synthesis. Washington, DC: USAID.

USAID, 2015. Evaluation of USAID/Uganda's District-Based Technical Assistance (DBTA) Model as Applied under the Strengthening Tuberculosis and HIV/AIDS Responses (STAR) Projects.

World Bank, 2014. Project Performance Assessment Report for the Republic of Uganda Second Local Government Development Project, Report No. 87597. Washington, DC: World Bank.

World Health Organization, 2007. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. Geneva.

SDS Reports and Other Program Documents

SDS Programme, 2016. SDS Quarterly Progress Report, July 2016-September 2016.

SDS Programme, 2015. SDS Technical Assistance Uptake and Application (Self-Assessment) Study. . SDS Programme, 2015. Year 6 Program Extension.

SDS Programme, 2014. Support to Basic Education: Early Grade Reading Improvement Programme (eGRIP); Synthesis Report.

SDS Programme, 2014. Collaborating, Learning, and Adapting Impact Study: Grant A and Direct Technical Assistance (Kampala, August 2014).

SDS Programme, 2014. Year 5 Workplan.

SDS Programme, 2013. Year 4 Workplan.

SDS Programme, 2013. Thinking Differently: Innovations in Local Government Social Service Delivery.

SDS Programme, 2013. Technical Assistance Surge 3: Cascading Innovations to Generate and Meet Demands for Social Services.

SDS Programme, 2013. Revenue Enhancement and Procurement Management Clinics Synthesis Report.

SDS Programme, 2013. Innovative Concepts for Improving Local Government Social Service Delivery: A Compendium. SDS Programme, 2013. Integrated Planning and Budgeting Technical Assistance Synthesis Report.

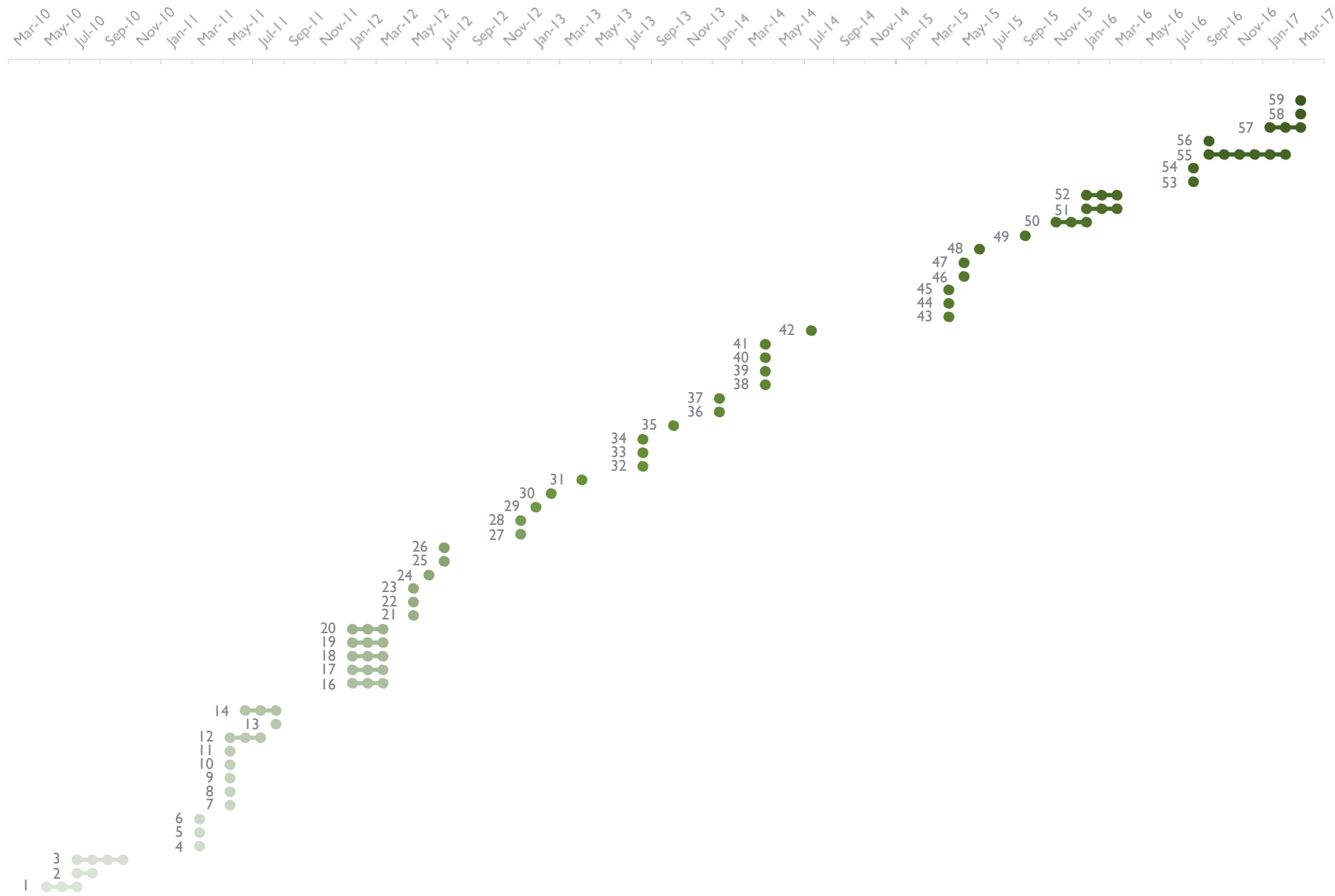SDS Programme, 2013. District Development Plan Mid-term Review: TA Process Report for SDS Partner Districts. SDS Programme, 2013. Technical Assistance Implementation Tracker, FY 2013/2014.

SDS Programme, 2012. DMIP Surge Support Synthesis Report. SDS Programme, 2012. Year 3 Workplan.

SDS Programme, 2011. SDS Annual Report, April 2010-June 2011. SDS Programme, 2012. SDS Annual Report, July 2011- June 2012. SDS Programme, 2013. SDS Annual Report, July 2012-June 2013. SDS Programme, 2014. SDS Annual Report, July 2013-June 2014. SDS Programme, 2015. SDS Annual Report, July 2014-Juune 2015.

SDS Programme, 2011. Year 2 Workplan.

7.2. Project Timeline

7.3. Project Timeline Key

1 SDS Program implementation starts

2 Baseline Assessment conducted

3 Organizational Effectiveness Assessments (OEA) done analyzing the gaps to poor management of resources service delivery.

4 First Chief of Party (COP) departs

5 USAID technically redirects the SDS Program

6 SDS Program withdraws from the North

7 SDS Program is restructured

8 USAID collaboration with the SDS Program grows. Substantial involvement and action plan developed to enhance performance

9 Regional meeting in Jinja, Mbale and Kumi, under direction of USAID

10 Portfolio Review

11 New Chief of Party joins the SDS Program

12 Introduction of Performance Based Financing

13 First Grant A is signed

14 Performance Based Grants commence

15 Collaborating Learning and Adapting (District Based Technical Assistance, USAID and SDS)

16 Jan – May 2012 : Output to Outcome Grants

17 LOGIC 1: Local councilors and technical leaders are trained on their responsibilities and responding effectively to citizen demands

18 Funding by DANIDA, and USAID

19 Growing visibility of SDS Program as the COP at the time showed the flexibility of SDS

20 SURGE roster of local consultants established (Spring board for Technical Assistance)

21 SDS Program Learning Moment

22 Round Two of district grants awarded

23 Orphans and Vulnerable Children (OVC) services action plans are changed from output to outcome grants

24 Institutionalization of the SURGE roster approach

25 District Management Improvement Plans (DMIPs) planning commences

26 A list of activities to be funded under Grant A and B schemes is prepared

27 Grant Bs awarded

28 Integrated Planning and Budgeting (IPB) Technical Assistance commences

29 First cohort of Grants B disbursed, all districts receive their respective grants, selection process includes MOLG

30 Technical assistance for Innovations

31 Extension of SDS Program to include: Water Sanitation and Hygiene, Early Grade Education, and Human Resources for Health (HRH)

32 USAID sends technical direction memo to commence laboratory works

33 On boarding ACCLAIM as a sub-awardee to support seconded public health workers

34 First round of public sector HRH recruitment takes place

35 USAID sends technical direction memo on allowable and disallowable costs

36 Grants Rounds continue

37 HRH, Education and water and sanitation components commence

38 Funding reductions: SDS Regional Offices are closed

39 SDS Program undergoes second programmatic restructuring

40 HRH Supplementary recruitment commences

41 Concept idea of Critical Service Support is developed

42 Critical Services concept is implemented. Change of Program focus

43 SDS Program receives a major extension covering bridge activities in northern Uganda including VMMC

44 Evaluation of District Operational Plans (DOP) approach takes place

45 USAID conceptualizes around an integrated health programming approach

46 Grants are awarded to Northern Districts expanding number of districts from 35 to 50

47 SDS assumes responsibility for inspection, verification and recommendation for payment covering construction done as part of Northern Uganda Development of Enhanced Local Governance, Infrastructure, and Livelihoods (NUDEIL) initiative

48 SDS leadership transitions to new local Ugandan COP

49 SDS Program receives a new scope of work to include, DREAMS, Laboratory renovation, Malaria (ACT distribution and work with VHT)

50 Evaluation of the SDS Program takes place

51 SDS Program has a renewed focus on communications and Collaborating Learning and Adapting (CLA)

52 Expansion on Health Care Waste Management (from 6 districts to 16 then finally to 61 districts)

53 USAID guides SDS to no longer disburse new funds to the district local government accounts

54 SDS Conducts Regional workshops with districts to notify them of change in the modality of financial support

55 SDS Interim Financing Plan commences. SDS covers direct payments for provision of services

56 SDS is directed to include interim support to East-Central Districts as part of ending STAR EC project

57 All of the SDS activities end

58 SDS Regional closeout events take place

59 SDS Central closeout event takes place