Uganda: Using surveys for public sector reform

Data that can be used to inform policy decisions are typically scarce in low-income countries, where standard policy prescriptions are less likely to apply. Interventions based on inadequate information and thus misguided assumptions may not achieve expected results—despite the fact that substantial public or donor funds are being spent. For example, an adjustment operation that focuses on spending allocations may achieve its benchmarks but have no effect on actual service delivery.

Diagnostic surveys can provide vital information for decision-makers when institutional weaknesses inhibit a more regular flow of information. If strategically designed, a survey can help induce policy change by pointing directly to the main bottlenecks, making it easier for policymakers to find solutions. This note summarizes a case in Uganda where a diagnostic survey proved particularly useful in an effort to improve public spending on health and education.

Surveying service delivery

When assessing service delivery, most surveys examine the effects of policies or interventions on households and their demands for and perceptions of the quality of services. Inputs and outputs on the supply side—such as the flow of public funds and school enrollment rates—are left for official statistics or administrative records. Uganda shows that a survey can provide a useful check on the supply side of service delivery when institutions perform poorly and official statistics are lacking or of poor quality.

Expenditure tracking surveys began in Uganda once it was realized that, while public spending on basic services had increased substantially since the late 1980s (albeit from a small base), several officially reported outcome and output indicators remained stagnant. While World Bank structural adjustment programs specifically supported increased spending on basic services and contained provisions to protect budget allocations, they did not go beyond such allocations to
address deficiencies in actual spending or service delivery. The most obvious disparity in outcome indicators was seen in primary school enrollments. Budget allocations for primary education nearly tripled between 1991 and 1995—yet there was hardly any increase in officially reported enrollment.

The hypothesis was that actual service delivery (output) was much worse than budget allocations would imply because public funds (inputs) did not reach the intended facilities as expected. Reasons for facilities not receiving the allocated funds could range from competing priorities at various levels of government to corruption and misuse of public funds. To test this hypothesis, budget allocations and actual spending were compared in two decentralized sectors, primary education and health care.

Because local government accounts were not generally available, a field survey was carried out in 19 of Uganda’s 39 districts, covering a randomly selected sample of 250 government schools and 100 public health clinics, to collect spending and other data for 1991–95. The survey was designed and implemented in collaboration with the Ugandan government, a local research center (Economic Policy Research Centre) and an independent Ugandan consulting firm (MSE Consultants). Overall, local government (district) and health unit records turned out to be totally inadequate, while school records were relatively good.

**Findings on primary education**

The field survey confirmed the hypothesis that input flows suffer from serious problems that largely derive from weak governance and lack of accountability. On average, less than 30 percent of the funds intended for non-salary public spending actually reached schools in 1991–95 (Figure 1), because district authorities kept and used most of the nonsalary capitation (per student) grants meant for schools. Similarly, schools were allowed to keep, at best, only a third of mandatory tuition fees from parents. The rest went to district education offices. There were also large variations: at the median, school retention of both capitation grants and tuition fees was zero.

Relative to non-salary expenditures, tracking teacher salaries was complicated by the absence of disaggregated central government pay data. But salaries seem to have reached schools much better than non-wage allocations—though with a considerable delay. The only systematic way of misappropriating salary funds was through "ghost" teachers on the payroll. Previous efforts by the government to clean up the teachers’ payroll give some idea of the magnitude of the leakage in salaries: in 1993 nearly 20 percent of teachers on the payroll were removed as ghosts.

The survey also unearthed a host of other features of the service delivery system that were unexpected but crucial to the functioning of health and education services—and hence to any intervention in these sectors. First, in contrast to the stagnation in enrollments indicated by officially reported data, the school survey found that primary enrollment actually increased 60 percent in 1991–95. Such a stunning discrepancy indicates that official statistics cannot always be trusted.
Second, although the government’s share of spending on public primary education increased over time, most of the burden continued to be borne by parents, who accounted for as much as 70 percent of school spending in 1991 and 60 percent in 1995 (40 percent and 20 percent at the median school, respectively). Despite higher public spending, parents’ contributions continued to increase in real terms over the survey period.

Third, the survey showed that the performance of public facilities in different sectors can vary considerably even within one country, depending on the facilities’ institutional context and incentives. Schools, for example, keep systematic records of financial flows and enrollments. Health units, by contrast, do not keep good records.

**Findings on primary health care**

The health survey found that clinic records of resource flows were kept in kind—if at all—and that there were essentially no records for clinic in-patients or out-patients. Interviews at the clinics revealed that most medical supplies reached health facilities. This was because the supplies did not go through local governments but were distributed to health units directly from the center. For the most part, however, the survey instrument that had worked well in schools was unable to provide substantive quantitative information for health units.

From observations, discussions with focus groups, and other qualitative research methods, other researchers learned that many problems originated within clinics, where staff expropriated a large portion of drugs and medical supplies and sold them onward. This leakage was estimated to average nearly 70 percent. As a result, the poor, who cannot afford these misappropriated supplies, often do not receive even basic health services. These results indicate that the health system continues to suffer the legacy of the oppressive state in the 1970s and early 1980s and that past survival mechanisms of health staff (whose salaries were extremely low) have not changed.

**Policy changes**

Although many of the survey findings were troubling, there is a positive side to the story. After the survey results were released in 1996, the government responded actively to them. For example, to increase transparency and accountability, monthly transfers of public funds to districts are now reported in the main newspapers and broadcast on radio. Moreover, government policy requires that transfers to primary education be displayed on public notice boards in each school and district center, and the Ministry of Education monitors compliance.

School-based procurement has replaced the central supply of construction and other materials. Detailed data on spending on teacher salaries are now available at the central government level. The Ministry of Education replicated the school survey in 1998 and found major improvements in the flow of funds. Finally, an effort is being made—with support from the International Development Association—to institute basic public accounting systems that include districts. This experience demonstrates that data can be a powerful tool of change. In health care, where the survey could not provide clear-cut findings for policymakers to act on, improvements in
accountability have been less evident.

**Further reading**


Asiimwe, Delius, Francis Mwesigye, Barbara McPake, and Pieter Streefland. 1996. "Informal Health Markets and Formal Health Financing Policy in Uganda." Makerere Institute of Social Research, Ministry of Health (Uganda), London School of Hygiene and Tropical Medicine, and Royal Tropical Institute (Amsterdam).


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