TECHNICAL & FINANCIAL FILE

Institutional Capacity Building in Planning, Leadership and Management in the Ugandan Health Sector Project

Uganda

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ABBREVIATIONS

AMREF	African Medical and Research Foundation
BFP	Budget Framework Paper
BTC	Belgian Technical Cooperation
CB	Capacity Building
CHDs	Community Health Departments
CYP	Couple Year Protection
DANIDA	Danish International Development Agency
DDP	District Development Plan
DGDC	Directorate General of Development Cooperation
DMT	District Management Team
DP	Development Partner
EMOC	Emergency Obstretic Care
FDS	Fiscal Decentralisation Strategy
FY	Financial Year
GAVI	The Global Alliance for Vaccines and Immunisation
GH	General Hospital
GoU	Government of Uganda
HC	Health Centre
HDP	Health Development Partner
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HR	Human Resource
HRH	Human Resource for Health
HRM	Human Resource Management
HSD	Health Sub District
HSDMT	HSD Management Team
HSSP	Health Sector Strategic Plan
IC	Institutional Capacity
ITM	Institute of Tropical Medicine, Antwerp
JBSO	Joint Budget Support Operation
JICA	Japan International Cooperation Agency
JRM	Joint Review Mission
LG	Local Government
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MUST	Mbarara University of Science and Technology
NDP	National Development Plan
NHA	National Health Assembly
NHP	National Health Policy
NHS	National Health System
NMS	National Medical Store
PHCCG.	Primary Health Care Conditional Grant
PEAP	Poverty Eradication Action Plan
PEPFAR	The US President's Emergency Plan for AIDS Relief
PHP	Private care health practitioner
PNFP	Private-not-for-profit organization

PPDAA	Public Procurement and Disposal of Assets Act
RRHs	Regional referral hospitals
Sida	Swedish International Development Cooperation Agency
SURE	Securing Uganda's Right to Essential medicine
SWAp	Sector-wide approach
TA	Technical Assistance/Technical Adviser
TFF	Technical & Financial File
ToR	Terms of Reference
UHSSP	Uganda Health Systems Strengthening Project
UMU	Uganda Martyrs University
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

EXECUTIVE SUMMARY

The Institutional Capacity Building Project in planning, leadership and management in the health sector project has been designed to support the Ministry of Health (MoH) in Uganda in its endeavour to strengthen the capacity in the health system in the area of leadership, planning and management, areas which have been identified to be very weak at all levels of the health system. This has also been recognized in the newly developed second National Health Policy (NHP), which has a focus on health system strengthening.

The project was designed in close collaboration with the MoH to secure that it is in line with the ministry's priorities and will tally entirely with the strategic vision as laid out in the NHP. The project will also support the implementation of the Health Sector Strategic Plan (HSSP).

The project is based on the concept of institutional capacity building meaning that the project aims at improving performance of institutions and organisations rather than concentrating exclusively at the individual capacities of staff members. Starting from the institutional needs for capacity building ensures that initiatives at the individual level are indeed meaningful for the institution and the system in general.

The project will examine the different aspects of capacity building in the areas of leadership, management and planning at the individual or the team level through the capacity assessment exercises and will look into several possibilities for remediation of the situation.

The project will be touching on the various levels of the health pyramid. It proposes to intervene at the **ministry's level** itself, but also to introduce and support the institutional capacity building process at two **regional referral hospitals (RRHs)**, a few **general hospitals (GH), districts** and **Health Sub Districts (HSDs)**.

For operational but also for synergistic potentials, it has been important that the project is concentrating its efforts as much as possible in the same geographic areas. This implies that in the same regions where regional referral hospitals are introduced in a capacity assessment and capacity building process, that the same regions will be used for identifying the general hospitals and HSDs the project will support.

HSD management team (HSDMT) are probably the weakest link in the management chain. The project engages in creating two formal training centres/demonstration sites for hands-on training of HSDMT in the respective regions. Therefore the centres will be located at Health Centre (HC) IV level where praxis training is directly possible. Creating these training centres/demonstration sites are a result on its own in the project.

Many development projects are active in capacity building in the areas of leadership, management and planning. The risk is real that different initiatives become unintentionally contradictory and destabilise the system. The project proposes to help the MoH to improve on the coordination of these capacity building efforts and to formulate a policy and strategy per organisational level to streamline the efforts of the ministry and the donor community in the field of capacity building.

During the project formulation, other development partners were extensively consulted to examine how synergies in the area of leadership, management and planning could be achieved and overlap be avoided. Close collaboration will take place with the Belgian Scholarships programme and with the Institute of Tropical Medicine, Antwerp (ITM)-School of Public Health, Makerere University initiative. Synergies and coordination will be developed with World Bank (WB), United States Agency for International Development (USAID) and Japan International Cooperation Agency (JICA) on other initiatives in the field of leadership, management and planning.

Collaboration with universities and other training institutions will be developed in order to influence basic training, but also for developing other training opportunities.

ANALYTICAL RECORD OF THE INTERVENTION

DGDC intervention number	3008322
BTC code	UGA 09 017 011
Partner institution	MoH (Department of Planning)
Duration of Specific Agreement	5 years
Duration of the intervention	4 years
Estimated starting date of intervention	Beginning 2010
Partner's contribution	In kind
Belgian contribution	6 500 000 EUR
Intervention sectors	Health (DAC 12110)
Overall Objective	To improve effective delivery of an integrated Uganda National Minimum Health Care Package.
Specific Objective	The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels.
Results	1. The MoH is strengthened in its organisational and institutional capacity. 2. One selected Regional Referral Hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity. 3. One further Regional Referral Hospital (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity. 4. District management teams are strengthened in their managerial capacity, leadership and planning functions. 5. A comprehensive approach on capacity building of HSD management teams is operational. 6. Two training centres/demonstration sites for capacity building of HSD management teams are functional 7. A scientific support team accompanies the capacity building process in the Ugandan health sector.

Overall and specific objective were accepted as specified in the identification file.

1. SITUATION ANALYSIS

1.1 POLICY CONTEXT

The overriding priority for national socio-economic development in Uganda is poverty eradication.

In 1997, the government along with other stakeholders evolved an over-arching national framework for poverty eradication - the Poverty Eradication Action Plan (PEAP). The PEAP ended Financial Year (FY) 2008/09 and will be replaced with a National Development Plan (NDP) for the period 2010/11-2014/15.

The Government has also reaffirmed its commitment to achieving the Millennium Development Goals (MDGs) which were streamlined within the PEAP/NDP.

The NDP will be operationalized through the implementation of sector-wide plans and in the case of the health sector; the National Health Policy and the Health Sector Strategic Plan (HSSP) are the major implementation frameworks. The first NHP adopted 1999 has been guiding the health sector between 1999 and 2009.

The Health Sector Strategic Plan I (2000/01-2004/05) and II (2005/06-2009/10) have guided the implementation of the NHP. A Mid Term Review of the implementation HSSP II was done between 2007 and May 2008. Although some appreciable improvements were reported in some indicators were was a general slow down of sector performance. This decline was explained by an inadequate budget, insufficient or irregular availability of essential medicines and health supplies and not least challenges in management at the various levels of the sector.

The second National Health Policy II has been developed awaiting approval by the Cabinet. The policy has been informed by the NDP, the 1995 Constitution of the Republic of Uganda and the new global dynamics. The NDP places emphasis on investing in the promotion of people's health and nutrition, which constitute fundamental human rights for all people. The Constitution of the Republic of Uganda provides for all people in Uganda to enjoy equal rights and opportunities, have access to health services, clean and safe water, and education among others.

The focus on the NHP is defined to be on health promotion, disease prevention and early diagnosis and treatment of disease with emphasis on vulnerable populations. Cost-effective and affordable primary, secondary and tertiary preventive services constitute the core health interventions. In addition the NHP focuses on health systems strengthening specifically:

- Strengthening health systems in line with decentralisation through training, mentoring, technical assistance and financial support.

- Re-conceptualising and organising supervision and monitoring of the health systems at all levels in both public and private health sector and improving the collection and utilization of data for evidence-based decision making at all levels.

- Establishing a functional integration within the public and between the public and private sectors in health care delivery, training and research.

- Addressing the human resource crisis and redefining the institutional framework for training health workers, including the mandate of actors, leadership and coordination mechanisms, with the aim of improving the quantity and quality of health workers production.

Health Sector Strategic Plan III will guide the implementation of the NHP II for the years 2009/10-2014/15. This plan is currently being prepared.

1.2 Demographic and health status

Uganda has an area of 241 000 km2 and a projected population of 32,2 million in 2010. With a total fertility rate of 6.7 and an average annual growth rate of 3,2% Uganda's population is expected to increase to 44 million by 2020 raising the population density from 120 to 164 km2. Such a population increase puts high demand on the health sector.

Uganda has made progress in improving the health of its population and the life expectation has increased from 45 years in 2003 to 52 years in 2008. Malaria, malnutrition, respiratory tract infections, AIDS, tuberculosis and peri-natal and neonatal conditions are the leading causes of morbidity and mortality.

1.3 The Uganda National Minimum Health Care Package

The focus of the NHP continues to be the delivery of an integrated package of basic services to all Ugandans, referred to as the Uganda National Minimum Health Care Package (UNMHCP). The UNMHCP is composed of a combination of proven cost-effective interventions appropriate for the Ugandan disease burden. Unfortunately however, this package is not affordable within current sector resources.

According to the report "Development of the Minimum Service Standards in Uganda's Health Sector ", the revised per capita cost of the UNMHCP calculates to be $41.2 for 2008/09, rising to $47.9 in 2011/12. This translates to a total amount of about 2,134 billion shillings required in 2008/9 to deliver the package to the whole population in line with current norms and standards. This is far above the current available resource envelope for the sector. According to the same report the resource envelope for 2009/09, including Government of Uganda (GoU) and donor funding, is estimated at Ugshs 627.64bn which equates to $12.5 per capita. This represents about 29.4% of the necessary funding to provide the full UNMHCP to the full population.

1.4 The organisation of the health system

The National Health System (NHS) comprises all the institutions, structures and actors whose actions have the primary purpose of achieving and sustaining good health. The

boundaries of Uganda's National Health System encompass the public sector including the health services of the army, police and prisons; the private health delivery system comprising of the private-not-for-profit organizations (PNFP), private care health practitioners (PHP), the traditional and complementary medicine practitioners and the communities.

The Governance structure of the health sector is complex and involves a multitude of stakeholder organizations, both at national and local government level.

1.4.1 National Level

The National level includes the MoH, National referral hospitals (Mulago and Butabika), Regional referral hospitals and institutions affiliated with the MoH. These include some specialised clinical support functions; National Medical Stores (NMS), Uganda Blood Transfusion Services and National Public Health Laboratories and regulatory bodies; the professional Councils and the National Drug Authority. Uganda National Health Research Organisation coordinates research activities.

1.4.1.1 Ministry of Health

The functions of the MoH include:

- Policy formulation, standard setting and quality assurance
- Resource mobilisation, Coordination and liaisons
- Capacity development and logistical support;
- National support supervision;
- Provision of nationally coordinated services e.g. epidemic and disasters
- Coordination, promotion and dissemination of health research
- Provision of guidance on management of referral hospitals
- Health advocacy and public relations

The MoH is structured in line with its mandate and core functions. Currently there are two directorates; clinical and community health, and planning and development. Under the directorates there are departments and divisions. There are also some units reporting directly to the Permanent Secretary.

A reorganisation of the MoH is ongoing which emphasised the need for clarifying the distinction between the MoH's policy and its management functions and for streamlining the decision making process. The restructuring process includes besides the MoH, the two national referral hospitals and the regional referral hospitals.

To inform the restructuring process a number of activities have been carried out and among these a SWOT analysis of the MoH identifying the strengths and weaknesses of the MoH. The capacity by the MoH to fulfil its responsibilities has also been defined. Based on the outcomes a reorganisation of the MoH has been proposed which so far has been presented to the senior management. The next step is to present it to the Top Management for endorsement and submission to the Ministry of Public Service (MoPS) for approval.

The finalization and subsequent approval of a new structure for the MoH might however be delayed because of an announced restructuring of the whole public sector.

a) **Technical assistance (TA) to the MoH**

To strengthen the capacity of the MoH a need for technical assistance funded by the development partners has been identified in the foreseeable future. This has been noted in the restructuring report of the MoH. The modalities for this support have been elaborated in a report "Consolidate Technical Assistant needs of the MoH in Uganda".

The report recommends that a medium-term comprehensive plan shall be developed indicating the needs for technical assistance. The objectives of the plan are proposed to read:

- Reflect identified capacity gaps at the MoH for which long-term technical assistants are needed.
- Serve as a tool for discussions and agreement between the government and development partners in the area of technical assistance.
- Give a comprehensive picture of the support of long-term technical assistants to the ministry.

The plan will be restricted to long-term technical assistants (i.e. longer than six months) providing technical assistance to the MoH. For short-term consultancies a lump sum can be included in the plan but be detailed in the annual work plan for the ministry. The funding of the technical assistance would be from different sources including a pooled funding mechanism, which is still to be established.

1.4.1.2 National and Regional Referral Hospitals

Currently there are two national referral hospitals (Mulago and Butabika) and thirteen regional referral hospitals in Uganda two of them; Moroto and Mubende, just being upgraded to regional referral hospitals. Most of these RRHs were built in the early 30's.

The roles and responsibilities by the referral hospitals are defined in the NHP and further detailed in a National Hospital Policy from 2006. The National Hospital Policy defines new services to be provided by the RRHs resulting into the need to remodel existing structures and provision of new ones. To assist in this process the RRHs have been encouraged by the MoH to develop master plans.

1.4.2 Local Government levels

The National Health Policy I provided for decentralisation of health services to Local Government (LG) level through creation of the District Health System with HSDs as operational zones within the districts.

The district health system is comprised of the following:

- District Health Management Team led by the District Health Officer, which provides the overall leadership in the delivery of health services at district level.
- HSD level is charged with the operational responsibility of delivering the UNMHCP within its area of jurisdiction, which is comprised of a number of sub-counties. It provides leadership in planning and management of health services within the HSD. It also carries out supervision, quality assurance, procurement of medicines and other medical

supplies and capacity development support to lower health units and communities.

- General hospitals provide general and referral services. In addition they offer technical support to lower level units.
- Health Centre IV offering preventive, promotive, curative and inpatient services and Emergency Obstetric Care and Blood transfusion. In addition they offer technical support to lower level units.
- HC III offering preventive, promotive, curative and inpatient services and technical supervision to HC II level.
- HC II is the first level of interface between the formal health sector and the communities. It offers preventive, promotive, curative services. In addition it provides ambulatory services and emergency delivery.

With the establishment of the HSD the planning, management and organisation of delivery of health services was decentralised from the district to HSD level. The district level remained with the responsibility of providing overall leadership and planning, monitoring and evaluation, resource mobilisation and coordination.

Currently there are 82 districts and 214 HSDs in the country. The government envisages creating more districts in the coming years. 165 HSDs are based at HC IV and the remaining at a hospital.

1.4.3 Restructuring of the Public Sector

The Government of Uganda is envisaging restructuring the entire public sector. In addition it intends to create regional tiers in the next financial year. This might have implications on the structure of the health sector.

If this reform takes place, this might change certain aspects in the project conception.

1.5 The Capacity in Leadership and Management

The leadership and management capacity to provide direction, mobilize and align system resources, mobilize resources and plan is currently weak at all levels of the health system in Uganda. This capacity gap has been well articulated in a number of documents. The mid-term review of the HSSP II identified the capacity gap as one of the key sector challenges. The National Human Resources for Health Strategic Plan 2005-2020 calls for leadership and management capacity building at all levels of the health system. The Ministerial Policy statements of 2008/2009 and 2009/10 put particular focus on leadership and management improvement at different levels of the health service as key to improving sector performance. Leadership and management capacity building is also a key focus of the new Draft National Health Policy II.

Adding more resources to the sector without addressing the leadership and management deficiencies that plague the health sector has been defined to have little impact on system performance, principally in the areas of quality and coverage of health services.

1.5.1 National level

There is no agreed structure for capacity building in management and leadership for the sector. The capacity at the MoH to coordinate and spearhead the capacity building in leadership and management is weak and not well defined.

The RRHs have been granted self-accounting status by the Ministry of Finance, Planning and Economic Development (MoFPED). In future these hospitals will be prepared for autonomy on a case-by-case basis. Some of the hospitals have Management Boards appointed by the Minister responsible for Health. According to the National Hospital Policy there are minimal skills in planning and management among members of the Management committees/boards.

1.5.2 Local Government's level

As mentioned above several new districts were created during the HSSP II. This has significant resource (financial, infrastructural, human) implications but also implication on the leadership and management capacity to run these new districts.

The HC IV (as part of the HSD policy) was a major focus of both the HSSP I and HSSP II. However, performance on operationalising this key strategy is poor. There are many contributing factors and among these are:

- The managers at HSD and health facility levels
  - have no formalized training in leadership and management training before being thrust into leadership and managerial positions;
  - are not exposed to any introduction (induction) before taking up the position.
- High attrition among HSD managers

1.5.3 Initiatives to address the capacity in leadership and management

Although the capacity gaps in leadership, management and planning has been identified as a major challenge for the sector some initiatives have been taken aiming at strengthening these areas since the adoption of the NHP I. These initiatives have been initiated by the MoH, Health Development Partners (HDPs), the Medical Bureaus, academic institutions and others.

Some of these initiatives can be defined as having been more or less on an ad hoc basis but some of them have been well planned for and sustained for a longer period of time. Some examples are given below.

When establishing the district health system all district health teams by that time were trained in planning and management. This training took place at Mbale Manpower Training Centre. After all District Health Management Teams were trained a programme for training of HSD managers was embarked upon. This was a tailor made training

developed by MoH in collaboration with World Health Organisation/Country Office Uganda. The main objective of the training was to equip the HSD teams with comprehensive and standardized understanding of their roles and responsibilities and enhance skills for planning, organization and management. From 2003-2006 the training covered 102 HSD teams from 33 districts.

In 2007 before committing more resources to extending the programme it was found necessary that the course would be evaluated. This evaluation took place in 2007- 2008 and resulted in a report given a number of recommendations for improvement of the programme. Although the recommendations were found to carry a lot of weight they have not yet been adhered to. During 2007-2009 more HSDs have been covered by the programme.

Other initiatives have also taken place in order to strengthen the capacity of the HSDs teams. WHO conducted an action based research intended to provide evidence to the MoH on how the HSD strategy could best be implemented. The process resulted in an operational manual for HSD teams. This manual however seems not to be well recognised among key stakeholders.

1.5.4 Course in health service management at Academic Institutions

Academic and training institutions provide courses in management of health services. Among these are the Uganda Martyrs University (UMU), Makerere University School of Public Health, Makerere University Faculty of Economics and Management, the Uganda Christian University in Mukono and International Health Services University. Uganda Management Institute also provides courses in public service management.

Uganda Martyrs University has a 12-month diploma in Health Services Management targeted at mid-level managers, and a 12-month MSc in Health Services Management aimed at developing managerial competencies linked with analytical and critical skills.

The School of Public Health at Makerere University offers a full-time Masters in Public Health taken as a 2-year full time course or through distance learning. Students are attached to districts as part of its problem-based approach though this is more on the public health aspects and not management. This course's focus is on clinical and epidemiological skills with less focus on management.

The Institute of Tropical Medicine from Antwerp, in collaboration with the School of Public Health of Makerere University, are working on a new programme to support capacity at the HSD level, effectively starting beginning 2010. See more under chapter 2.5

Mbarara University of Science and Technology (MUST) offers MSc and diploma courses in leadership and management and also from time to time short practical courses (3 weeks) in leadership and management.

The Uganda Christian University in Mukono offers a diploma and a degree course in Health Administration.

1.6 The Capacity in Support Supervision

The MoH and other central level departments/agencies have the mandate to supervise the health sector. In line with the decentralisation framework district health offices have the responsibility of supervising the district health system. Technical supervision is provided at all levels of care with each level supervising the level below. Monitoring relies on the Health Management Information System (HMIS) and quarterly and annual reports.

The NHP II has identified support supervision as an area facing a number of challenges which need to be addressed.

1.6.1 National level

The support supervision within the national level (National Referral Hospitals and the Central Level Institutions i.e. the Autonomous and Semi-Autonomous bodies) hardly exists.

1.6.2 Supervision from national to local government levels

The significant increase in number of districts has placed more responsibilities for supervision and monitoring on the MoH. The increase in number of districts requires a re-examination of the supervision and support mechanisms used today.

The current mechanisms of support supervision and monitoring from national level to the levels of local governments and hospitals are mainly through the Area Team activities and the Specialist Outreach Programmes.

The Area Teams support Health Teams at districts, general hospitals and HSD. Relevant supervision tools, checklists and guidelines are used each quarter depending on the programme focus. Individual district supervision reports are prepared and a database compiled by the area teams secretariat. However follow up of issues in the Area Team reports at the MoH has not been consistent.

A program for consultants' outreach supervision and on-job training was reactivated during HSSP II. Consultants from RRHs are supposed to visit general hospitals and health centre IV twice a year. During these visits the consultants are supposed to supervise the staff at the centre but also to attend to some patients.

The support by the area team includes support in management and planning while the consultant outreach programme mainly is focusing on clinical support.

Besides these mechanisms Community Health Departments (CHDs) exist at RRHs and GHs with a responsibility to support the districts, but these have not been fully operationalised.

1.6.3 Internal supervision of Districts, HSDs and health facilities

A system for supervision is elaborated through the HSSP II and relevant MoH guidelines. However because of inadequate supervision skills, lack of staffing and inadequate funding for transport this area is weak in most districts and needs to be reinforced.

1.6.4 Policy strategies in the NHP II

The NHP recognises that effective supervision and monitoring are essential aspects of the health system and critical in improving the quality of health services and care.

Among the policy strategies to achieve that are:

- To build capacity at all levels of the MoH, local governments, the private sector, facilities and communities to carry out support supervision, monitoring and evaluation of health interventions and diseases surveillance.

- To support the functionality of HSDs which will be responsible for management of routine health service delivery, planning and management of health service delivery at lower levels, planning and management of health services and fostering community involvement in the planning, management and delivery of health care.

- Reconceptualise and re-organise the managerial and clinical support mechanisms and structure to districts and RRH, including redefining the role of Area teams, Office of the Medical Superintendent, Community Health Departments at RRH and others at district and HSD levels.

The NHP I also defines the Regional referral hospitals to be strengthened to effectively supervise and support health systems.

1.7 The Capacity in Planning

A well-defined planning system covering all levels of the health system is in place. The guiding principles for the sector planning and budgeting process and resource allocation are contained in the annual health sector Budget Framework Paper (BFP). The BFP takes into account the NHP and the HSSP and the annual health sector priorities as agreed by stakeholders at the National Health Assembly (NHA) and Joint Review Mission (JRM). The BFP is aligned to the Government of Uganda Medium Term Expenditure Framework (MTEF) which is the overall mechanism by which resources, expected from Government, including donor budget support are allocated to and within sectors. It sets sector and local government spending ceilings within a three-year rolling framework.

1.7.1 National level

According to the National Hospital Policy the RRHs are supposed to develop strategic and operational plans (annual work plans), however the capacity to develop these plans is weak.

The capacity to develop annual work plan at the MoH is weak.

1.7.2 Local Government levels

The GoU has adopted a Fiscal Decentralization Strategy (FDS) with the purpose to decentralize decision-making in respect to planning and budget allocation. All Local Governments activity, whether funded from the centre, district level donors, local revenue or any other source must be included in a District Development Plan (DDP) (3-year plan). Besides this annual Budget Framework papers are being developed as well as annual work plans. All budgeting and work plans must relate directly to the activities identified in the DDP.

Besides the overall district plans, annual work plans are to be developed for the different levels of district health system; district, HSD, general hospitals and health centres. To assist in this process guidelines have been developed by the MoH as a supplement to the sector guidelines. These guidelines do underscore sector priorities arrived at JRM.

The planning system requires good skills in planning as well as knowledge of nationally defined health sector priorities at all levels of the health system. Efforts have been made in order to achieve this but still there a capacity gaps in these areas specifically at LG's levels but also at the national level. The skills are specifically lacking in the newly created districts and at HSD levels and below. The high attrition rate of HSD managers also requires a continuous ongoing capacity building effort in this area, apart from measures that should address this attrition rate.

1.8 OTHER RELEVANT DONOR INTERVENTIONS

A number of donor interventions in the health sector include activities aiming at strengthening the capacity in leadership, management and planning. Below are the most important ones.

Danish International Development Agency (DANIDA) is through its Danida Health Sector Programme Support Phase III programme (July 2005 - June 2010) supporting the implementation of the HSSP II. One component in the programme is strengthening MoH's capacity to support, supervise and monitor the districts through the Area Teams, including support to the health management information system and integrated disease surveillance and reporting.

DANIDA will with effect from July 2010 pull out from the health sector.

Swedish International Development Cooperation Agency (Sida) has been supporting a programme "Health Economics Capacity building". This programme included components aiming at strengthening health service managers in financial management and their capacity to make decisions.

Sida has also expressed its interest to continue to support capacity building initiatives and to support a pooled funding mechanism for technical assistance to the MoH.

During 2002-2006 a Strategic Leadership Project was piloted in 5 districts by support from the Melinda and Bill Gates Foundation. Based on the experiences of the piloting a

proposal for capacity building programme in strategic leadership and management of primary health care in Uganda has been developed by African Medical and Research Foundation (AMREF). This is a 10-year programme. Funding for the programme is still being sourced.

USAID is funding a project: "Capacity Project Planning, developing and supporting the health work force" which has been running for 5 years with the overall, goal "to provide support for strengthening strategic, data-based Human Resource for Health (HRH) management, leadership and decision-making at the MoH's central and LG levels". A number of activities in the area of human resource management and planning have been initiated by the project. The first phase of the project came to an end September 2009 but has been prolonged for an additional 5 years.

USAID is also funding a programme "Securing Uganda's Right to Essential medicine (SURE)". The SURE programme has just started and is targeting the management of National Medical Store and it will work to strengthen the supply chain for medicines in the country. SURE is working closely with the division of pharmacy at the MoH and the NMS and will focus on 45 districts across the country, although the districts are not yet determined. SURE is implemented by Management Sciences for Health.

USAID is also working on a new programme that would provide leadership and management training, along with coaching to mid-level and district-based staff

Italian cooperation will during the FY 2009/10 support some planning activities in ten pilot districts related to the implementation of the Public Private Partnership policy.

A WB funded project "Uganda Health System Strengthening project" is just being formalized with the general objective to improve functionality of existing infrastructure, strengthen planning and management of Human Resources and to strengthen management of Health Facilities in order to deliver the UMHCP. Among the specific objectives is "To strengthen the leadership and management systems for health care delivery with focus on logistics and procurement, health facilities management and health infrastructure maintenance".

JICA has expressed it interest in supporting the MoH in introducing the concept on Total Quality Management (TQM) in RRHs. Piloting of the concept has taken place in Tororo RRH.

Both the Global Alliance for Vaccines and Immunisation (GAVI) and the US President's Emergency Plan for AIDS Relief (PEPFAR) have funds for health system strengthening.

Off all development partners, Belgian Cooperation is the first to have finished its project proposal on 'Institutional capacity building'. It is therefore at this stage difficult to specifically identify and describe the synergies that will be built with other interventions in the same area of interest. It will be the challenge of the project itself to actively look into this matter and to create a continuous dialogue with other development partners intervening in institutional capacity building.

Paragraph 2.5 defines how the Belgian Technical Cooperation (BTC) project will collaborate with the above initiatives in order to achieve synergies and avoid duplications.

2. STRATEGIC ORIENTATIONS

2.1 GUIDING PRINCIPLES

The following guiding principles will be respected for the implementation of the project:

- The project will tally entirely with long term strategic vision for the health sector as laid out in the National Development Plan and the National Health Policy.

- The project will support the implementation of the Health Sector Strategic Plan III.

- The project will be implemented according to the principles as laid down in the Memorandum of Understanding (MoU) signed by the GoU and development partners 2005.

- The project will be fully integrated into the planning procedures of the facilities or institutions that will be supported. No specific project activities will be planned for. The project will stimulate targeted facilities and institutions to integrate in their year plans activities eligible for project financing. Only under this condition, the project will intervene and support initiatives. The project's year plans will be extracted from the plans of the respective institutions that will be supported that year.

- The project will develop a system's approach, meaning that the overall objective is to strengthen the health system globally and that working with a selected number of health institutions at different levels of the health pyramid is but the entry point to strengthen the entire health system.

- The project will build synergies with other initiatives in the field of capacity building in leadership, management and planning.

- The project will draw on existing capacities, initiatives and structures as much as possible, as well as learning from best practices elsewhere, regionally and internationally.

- The project will be implemented through a highly collaborative arrangement.

- Collaboration with universities and other training institutions will be developed in order to influence basic training, but also for developing other training opportunities.

2.2 INTERVENTION STRATEGY- THE CAPACITY BUILDING CONCEPT APPLIED IN THE HEALTH SECTOR

2.2.1 Introduction

Capacity building (CB) is high in contemporary discussions on development aid and is an important issue in the Paris declaration. At the same time, capacity building as an intake point for a project is not evident. In literature, "Capacity building" is being described as a 'risky, murky business with unpredictable and unquantifiable outcomes, uncertain methodologies, and contested objectives, many unintended consequences, little credit to its champions and long time lags'. Others say: "As things stand, it is (capacity building) as diagnostically useful to say 'there is a need for capacity building' as to say 'this patient is unwell'." Or still: "At worst, the expression (capacity building) has become an over-pompous synonym for training, even worse than the expressions staff/human resource development".

To clarify issues, it is necessary to look into capacity building in a broad sense, starting from the need to strengthen systems, -health systems-, and to gradually descent to more detailed levels of analysis. The following paragraphs describe how this project proposal understands the concept of capacity building as a tool in developing or strengthening health systems. Departing from this strategy, the results and activities of the present proposal will be deduced as described in chapter 3.

2.2.2 Capacity Building: a hierarchy of concepts and needs

Departing from complex systems, capacity building and CB needs can be defined at different levels. Without being exhaustive CB can be looked into at the level of:

- System's capacity building
- Institutional capacity building
- Individual capacity building
- Development of tools for management

No matter how many levels are identified, with ever more attention for detail, it is clear that the different levels are interlinked. Although system's CB has its own approach and specificities, it depends at the same time on all other levels. In other words, the different levels are interdependent and should never be regarded separately or in isolation. Yet in other words, it is for example not worthwhile to invest into individual CB (providing skills at the individual level) if other levels are not addressed ***simultaneously***. CB is an ***iterative process*** seeking for ***continuous incremental performance improvements*** in the health system.

2.2.3 System's Capacity and Capacity Building

Looking at the entire system is the broadest way of looking at the CB problem in the health sector. While the system's performance depends on the lower levels' performance, the latter are depending on the specific guidelines provided from the system's level. In other words, one level shapes the other.

System's capacity therefore looks specifically into how the system defines the roles and responsibilities of its lower levels. System's capacity is nothing else than the quality of the policies, strategies and norms handled by an organisation. The more these are consistent, effective and efficient, complete, unambiguous and realistic (among other things, realistic in function of the needed resources) at the same time, the more the system's capacity will enable the other levels in the hierarchy of capacity and CB.

The project will therefore support the MoH in its endeavour to refine or complete its strategies and definitions of norms and regulations in those areas that weak capacity has been identified due to imprecise instructions or incomplete policies.

In order to strengthen the system and not just particular institutions, the project proposes to respect certain principles:

- MoH will systematically participate in all activities at the different health facilities in the country. This will be particularly the case for all institutional capacity assessments, the planning of capacity building activities (institutional or individual), the conception of master plans and coverage plans. Staaf of MoH accompanying the project's activities should be considered as a major contribution to capacity building efforts of the project for MoH central staff.

- A capitalisation process is foreseen in every result in order to refine the national health policy, in the various aspects of institutional capacity building. Each local experience will systematically serve to strengthen the health system globally.

- The project will concentrate its efforts in 2 provinces and will be involved at every level of the health pyramid within these areas. This should allow the MoH to gain valuable experiences throughout the health system, with respect of the structural relation between the different levels. Therefore the activities also include the referral system, supervision and supply system. Master plans and coverage plans will start from the logic of complementary roles between the health facilities.

Figure 1 defines the MoH in its system's context. The institutional and organisational capacity assessment and capacity building will involve and have consequences for all levels of the ministry's mandate.

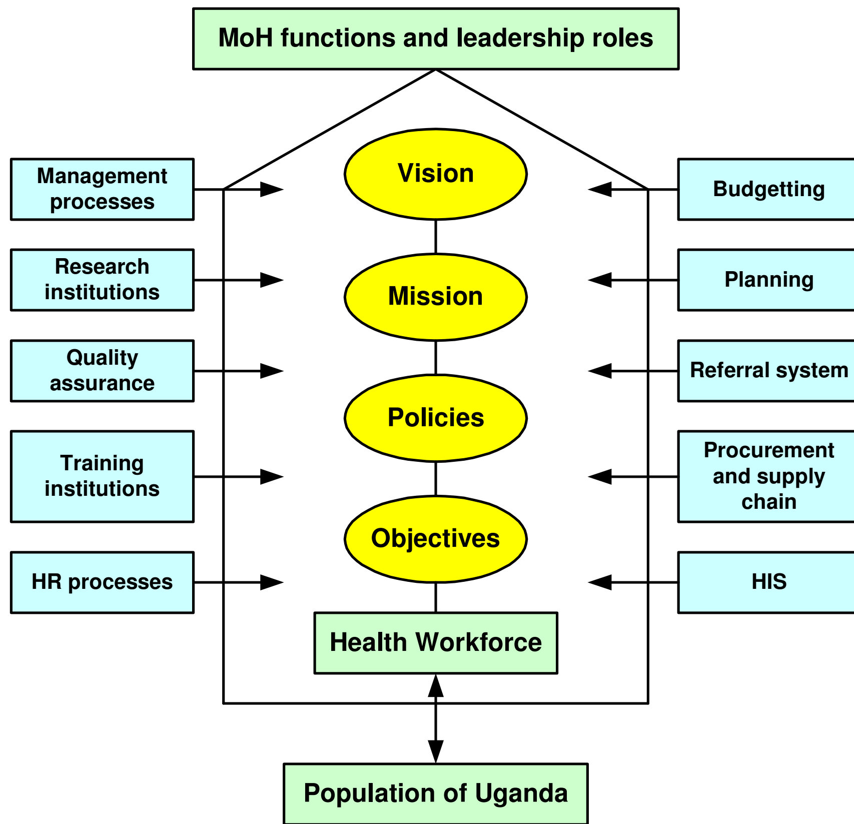

Figure 1: MoH functions defined in a system's approach

In blue are represented crosscutting aspects of the health system. They are relevant for every level of the health pyramid organisation and should be coordinated at the ministry's level. Capacity assessment and building at the various levels of the health pyramid will inevitably have to deal with these aspects of the health system functioning. The MoH will have to provide the synthesis of these findings and change processes, strengthening in this way its legitimate leadership role in the system.

The different results will inevitably have a special attention for these aspects. Capitalisation processes will certainly influence the levels of objectives and policies of the MoH. In combination with other interventions in the health sector, this will contribute to improve the ministry in its definition of the mission and vision of the global health system.

2.2.4 Institutional Capacity and Capacity Building

Institutional capacity can be defined as the level of performance, hence the level of outputs an institution can provide in accordance with its mandate.

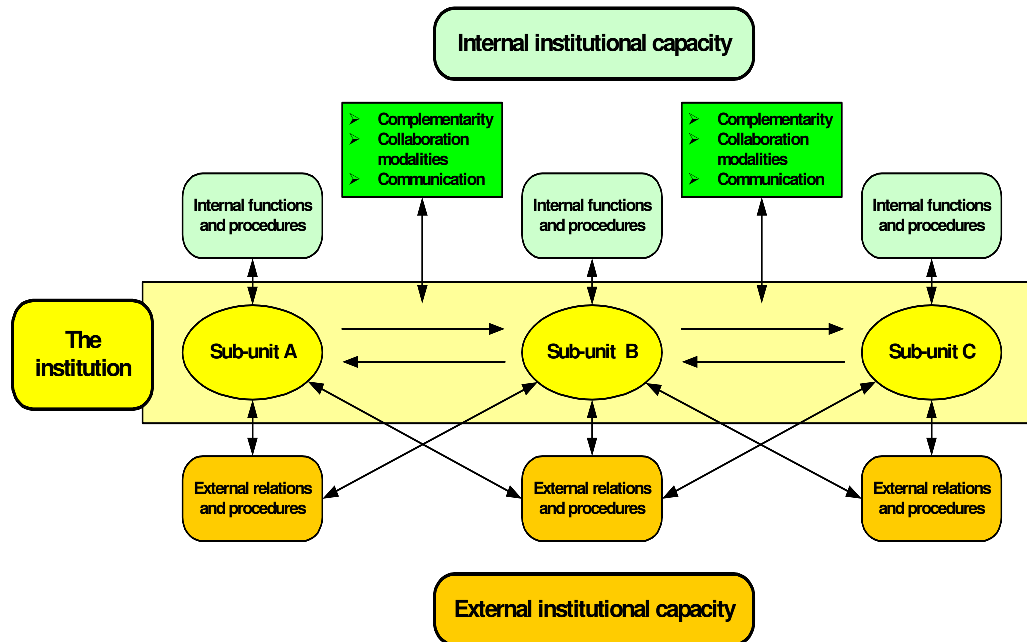

Figure 2: Schematic representation of institutional capacity

Figure 2 represents in a simplified way, how institutional capacity could be defined. Institutions are complex organisations, often with different (operational) sub-units that not only each have a mandate to fulfil, but also have to collaborate with each other in order to come to effective outputs of the organisation as a whole. This implies that the capacity of an institution is not the simple sum of the capacity of its sub-units but depends also on the quality of the relations (collaboration) between these units. Investments in capacity should therefore be oriented to the sub-units and their interdependent relations at the same time.

The scheme also highlights that institutional capacity should take into account both internal and external relations with other institutions. Institutions cannot be defined in isolation of their (immediate) environment and their performance depends largely from the way the institution (or its sub-units) interacts with other institutions.

Examples of external relations to be taken into account for IC analysis	
At the level of MoH	**At Hospital level**
• The population • Ministry of Finance, Planning and Economic Development • Ministry of Public Service • Universities and other training institutions • Universities and other research institutions • Donor community • Operational levels of health care • Other administrative levels in the health care organisation • etc.….	• The population • MoH • Local government • Higher operational level (referral for example) • Lower operational level (supervision, referral and counter-referral, supply services, etc) • Administrative authorities • Medical stores • Etc…

Table 1 : Examples of external relations for the MoH and a hospital

Table 1 illustrates through some examples what is meant by external relations of an institution. These relations have to be made explicit and the way an organisation is handling them has to be structured in detail in order to arrive at uniform and unambiguous rules of functioning and responsibilities.

2.2.4.1 The process

Institutional capacity building is a complex process. Figure 3 represents the different steps in a schematic way. Although reality is more complex than this, it highlights that institutional capacity building evolves in 3 more or less separate stages:

- Diagnostic phase
- Planning phase
- Implementation and monitoring phase

The initial ***diagnostic phase*** or ***capacity assessment process*** can be defined as a phase of thorough analysis of every sub-unit in the organisation, with attention on the internal functioning, its inter-relation with other units and its external relations, as described earlier. Each time sub-units look at their internal relations with others, the diagnosis shifts to a higher level of hierarchy in the organisation (uniting sub-units). This bottom-up approach of analysing the organisation is very participative and reinforces the appropriation of the assessment at all levels, necessary to make eventually changes acceptable and understood by all staff members. For complex institutions such as MoH, this phase can take up to 6 months among other reasons because people have to do this on top of their daily routine work.

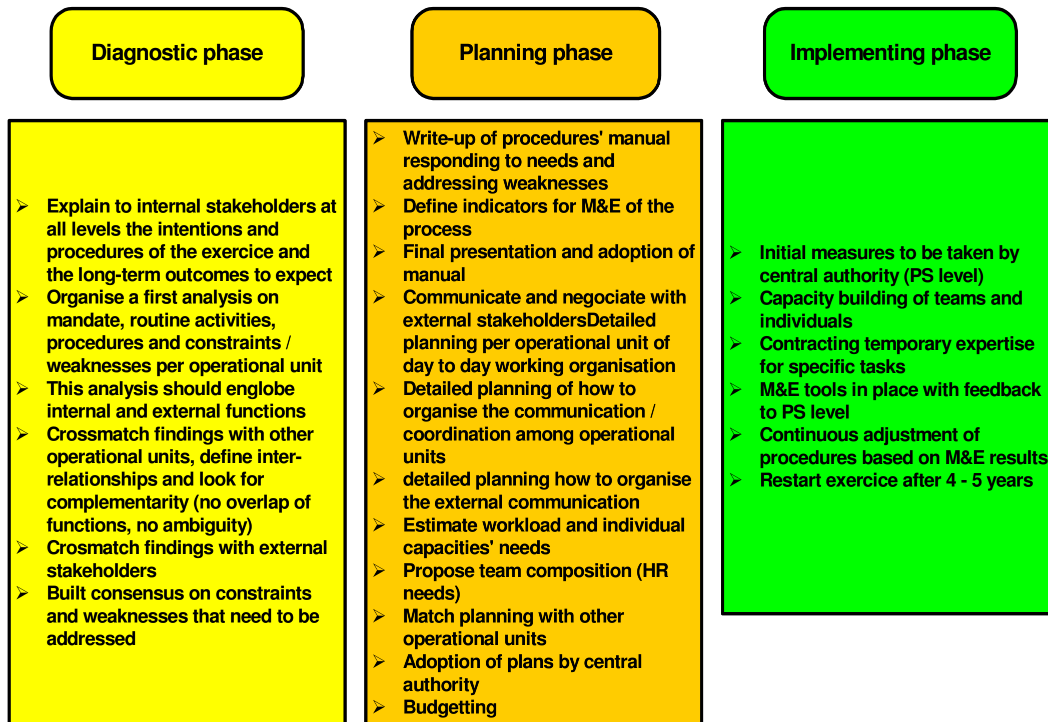

Figure 3: The institutional capacity building *process*

The separation between the diagnostic and the ***planning phase*** is partially artificial. They are part of one process. Important outputs of the planning phase are the writing of a procedures' manual for the organisation, in which norms, responsibilities, and procedures are described in detail. This consensual document becomes an important tool that not only orients workers in the organisation and increases their understanding of the goals of the organisation and the way it wants to achieve them, but it automatically becomes also an important tool for supervision. Without such an explicit manual, the risk of ambiguous instructions and responsibilities at all levels is real which in turn creates an environment in which supervision becomes impossible due to the difficulty of the supervisor to take uniform and acceptable corrective measures. During this phase, ***performance indicators*** must be identified in order to enable monitoring of progress afterwards and should also include budgeting for keeping an eye on the feasibility of the proposed procedures. They should as much as possible consider first the indicators identified for the sector.

An ***implementation phase*** should complete the management cycle. With the procedures' manual as guideline, the institution introduces gradually the new initiatives and sometimes the new organisational structures. Monitoring tools should be in place for the institution to be able to monitor performance in accordance with the procedures' manual. This might also lead to correction / adjustment of the guidelines. After a certain number of years, an organisation has to restart the whole management cycle of institutional CB because of the ever-changing environment in which it has to evolve and to adapt.

2.2.5 Individual or team capacity and capacity building: institutional capacity assessment as departing point

As discussed earlier, institutional capacity depends on individual capacity but the latter is not a sufficient condition for the first. This is because the sum of individual capacity is not equal to the capacity of an institution.

It is often observed that the individual capacities are not matching the needs of the institution in which they are employed. The principal underlying reason for this situation is the incomplete and/or ambiguous definitions of roles, objectives and responsibilities of sub-units and of the institution as a whole.

Therefore it is important that the individual capacity needs are identified through the process of institutional capacity assessment (see Figure 4). Only in that way, one can identify the pertinent capacity gaps at individual level that will reinforce institutional capacity.

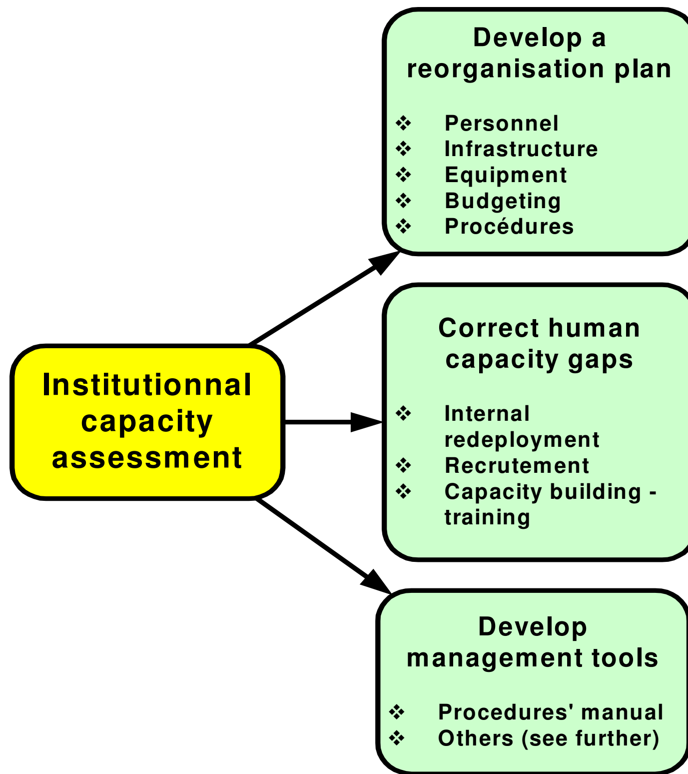

Figure 4: Minimal outcomes from an institutional capacity assessment

Individual capacity and capacity building should not be confounded with training, although often there is need for it. Creating the proper working environment is at least as important as creating additional knowledge and skills because a favourable and stimulating environment permits people to stay motivated. Institutional capacity assessment should result in identifying measures that need to be taken simultaneously for the working environment and the training needs for the existing personnel.

Individual capacity gaps can be situated at various levels:

- Poor basic training
- Poor practical skills to put theoretical knowledge into practice
- Poor management skills in compliment with the technical skills
- Poor attitudes
- Poor working environment

2.3 INTERVENTIONS INCLUDED IN THE PROJECT

2.3.1 Institutional Capacity building

Based on the concepts above the present project wants to support the MoH in its endeavours to strengthen the institutions in the health system. The project will be touching on the various levels of the health pyramid and it proposes to intervene at the **ministry's level** itself, but also to introduce and support the institutional capacity building process at two **regional referral hospitals**, a few **general hospitals, districts** and **HSDs**.

The project will examine the different aspects of capacity building in the areas of leadership, management and planning at the individual or the team level through the capacity assessment exercises and will look into several possibilities for remediation of the situation.

The flow of authority and support supervision in the health system remains an area of concern and part of the process will be to examine how this can be addressed.

The project will also as part of that process support the MoH in refining its policies, strategies and definitions of norms and regulations.

2.3.2 Management tool development

Institutions need management tools that enable decision-making and follow-up (e.g. monitoring and evaluation). Looking into existing management tools and their utilization is part of the institutional capacity assessment. The project will support the utilization of existing management tool and if it is found that some management tools are lacking assist in filling in these gaps.

The management tools on which the project will put a specific focus on:

- Procedures/operational manual
- Strategic plan
- Master plan
- Coverage plan
- Annual work plan
- Health Management Information System.

Procedures manual/ Operational manual

Procedures manuals describe in detail how an organisation and the people working in the organisation should function together. Outside detailed job descriptions, it is important that the mandate and functions of every sub-unit are determined. Special attention should be given to avoid too much overlap and of course on how to prevent gaps in functioning. The sequence of logic could be:

- Mandate per sub-unit
- Detailed profile and job description for each member of the unit (also of those that are needed but maybe do not exist at that moment), including tasks and responsibilities.
- Description of how individuals relate to each other, to whom they report and how they will interact with other units (internal or external).
- Responsibilities of personnel and their direct supervisor (rights and duties)

This document constitutes a contract between supervisors and their personnel. It guides the discussions on why things did not happen, as it should. A procedures manual remains a guideline though. It should be adapted at regular intervals and it is possible, especially in the beginning, that insufficiencies in the document are detected. Therefore it should be seen as a dynamic management tool with continuous updates if needed.

Strategic plans. According to the National Health Policy the hospitals are expected to develop strategic plans to guide their performance. Hospitals are expected to contribute to overall sector goals and targets as expressed in the NHP and HSSP and the plan shall define how this will be done. It shall prioritise activities to be undertaken and provide a platform for coordinated and harmonized resource mobilization strategies.

Besides this if social health insurance is being implemented in country it will have implications on the setting and organisation and financial management for which the hospitals need to be prepared and a well-prepared strategic plan can assist in this process.

Master plan includes an architectural plan of existing health facilities (essentially hospitals) and an architectural plan that projects the development of the facility in future, respecting the norms defined by the MoH. Such plans allow hospitals to plan for capital investments and to negotiate them with the MoH, local governments and the donor community in order to develop the facility in a rational and systematic way and not on the basis of uncoordinated ad hoc opportunities. It helps the institutions to project their material and personnel needs over time.

The MoH foresees master plans for the hospitals in its policy and could realise a few already. The project will support the MoH to develop master plans for targeted regional referral hospitals, general hospitals and for HC IV facilities.

Coverage plans can be defined as a map with the location of all health structures (public and Private not for Profit (PNFP), including the coverage populations and the staffing levels. The plan should be completed with a second map projecting the implementation of new and the evolution of existing health facilities. The maps should include the covered populations in the areas of responsibility. The maps should go together with a plan for estimation of human resources needs per facility and stocktaking of available equipment and needs according to the existing norms. Use of these plans should be integrated in yearly planning procedures for the district and HSD.

The concepts of master and coverage plans are further defined in annex 7.5.

2.3.2.1 Expected minimal outputs

Minimal outputs at the various levels of the health system are described in Table 2. For details on the development of management tools, see specific paragraphs on management tools.

Minimal outputs to be expected from institutional capacity building at the MoH
• Procedures' manual with detailed descriptions of responsibilities and mandates of sub-units • Procedures' manual with clear division of labour, communication channels, and internal organisation • Procedures' manual with clear description of how internal and external relations will be managed (communication channels, meetings organisation, etc.) • Monitoring and evaluation tools in place • Need for individual capacity building identified • Personnel needs, redeployment needs, needs for long and short term technical assistance • Planning guidelines manual • Global strategy and framework for support supervision
Minimal outputs to be expected from institutional capacity building at referral or general hospital level
• See outputs at ministry's level But also more specifically • Strategic plans (which shall address strengthening of the referral system, support supervision of lower level units and other issues of strategic importance). • Master plan of the existing infrastructures and a definition of a 10-year development plan, corresponding to the norms of the ministry and taking into account the population size and the local terrain (see further management tools development) • Supervision roles, responsibilities and organisation based on realistic options and respecting the hierarchy in the health service organisation (no by-passing) • Annual work plan up to standard
Minimal outputs to be expected from institutional capacity building at the district and HSD level
• The outputs concern the HSD management team, the HC IV and HC II and III, regarded together as one institution. The district management team could be included in the same exercise. • A coverage plan for the district and HSD territory (see further under

management tools for HSDs) • A master plan should be developed for the HC IV level taking into account the results from the HSD coverage plan in order not to create overlap with general or referral hospitals in the same area (see further management tools development).

Table 2: Minimal outputs to be expected after institutional capacity assessment and planning

2.3.3 Coordination of capacity building initiatives

Many development projects are active in capacity building in the areas of leadership, management and planning. See Chapter 1.8. The risk is real that different initiatives become unintentionally contradictory and destabilise the system. The project proposes to help the MoH to improve on the coordination of these capacity building efforts and to formulate a policy and strategy per organisational level to streamline the efforts of the ministry and the donor community in the field of capacity building. (See Activity 7 under result 1).

2.3.4 Reinforcing district and HSD management teams

Districts are the decentralised technical health authority in the country. District Health Departments perform similar functions as the MoH headquarters at the district level. They are responsible for the harmonious development of general hospitals and HSDs in their area of jurisdiction. They also directly respond to the local government and develop and negotiate the district plans with them. They in addition perform a stewardship role and coordinate other government departments and other players that contribute to the improvement of population health in their jurisdiction.

The HSDs being often still weak and sometimes largely understaffed, the districts are often also obliged to take on functions that would normally fall under the HSDMT's responsibility. Districts are too large to expect a district health team to supervise and regulate more than 30 health facilities (and often much more). It is therefore crucial that HSDMT are put in place and that a normal division of labour can take place.

The project will touch also upon this level of the health care organisation.

HSD management teams are key for the operational level of the health services. MoH, WHO and the donor community in the health sector at large identified the HSDs and its capacity as crucial for the system.

The HSDs are meant to organise and provide essential care as close to the population as possible. At the same time, they often seem the weakest link in terms of human capacity. Different factors contribute to this situation:

- The human resources at this level are often young and inexperienced, not prepared for the specific complex tasks that the system expects them to do.
- It includes different health units spread over sometimes a huge territory, causing operational problems for organising, supervision, provision and distribution of drugs and other consumables, etc.

- This level is probably the poorest in terms of financing.

Capacity building at the individual or team level can and should be addressed in various ways. In many cases though, the needed additional skills are practical and are specific for the environment in which one works. For example, young medical doctors at HSD level know how to treat patients, but have no idea on how to run a HSD in all its aspects. The same young doctor employed at a general hospital needs different management skills again. In both cases, this doctor is familiar with how to behave in a university hospital setting, but has less practical knowledge of the organisation of the institution in which he/she has to work. Doctors or other cadres who have to work in difficult environments and who on top feel insecure because they do not know very well how to organise their work have a high risk for demotivation and burnout.

For all these raisons, it is important to reinforce capacities at the HSD team level. In the first place, the project would like to continue financing the existing HSD team capacity building course. But at the same time it would like to build further on these experiences to improve the project.

The project would like also to look into the problem of a practical and hands-on training. Much of the incapacity of the HSD team is due to the fact that the basic training has been incomplete, not covering the variety of subjects needed for such a mandate, but also because they are not sufficiently familiar with the environment in which they will have to perform and the practical side of the work.

Questions like how to supervise, how to organise meetings, how to follow up decisions over time or to organise a pharmacy and a drug supply service can be learned through theoretical modules but will always prove to be incomplete. There is need for much more hands-on and other practical training in places similar or equivalent to the circumstances in which one will have to work afterwards. HSD team members should be familiar with how a health centre should function, how a rural hospital can and should be organised, how a drug supply service is organised in a HSD or how the national TB programme looks like and should be run in practice.

Although some practical work in rural areas is sometimes included in the basic curriculum of for instance medical training, the question is how far this is comprehensive to really prepare them for their practical tasks and whether they saw the best possible example. Universities or other basic training institutions have generally little say in how services are run and organised where their students follow their practical exposure to services. Too often they actually have to learn from poor examples.

The project proposes to create **training/demonstration sites** that are imbedded in well-functioning HSD. Demonstration sites are well-functioning institutions (in this case HSDs) that have the capacity to receive peer-trainees who remain in these institutions in order to apprehend the “good example” of the level of care in which they will have to work. This does not mean that the demonstration sites are ideal places in all aspects, but they are institutions that try in a conscious and systematic way to achieve the norms and standards defined by the MoH and they are very conscious on their own strengths and weaknesses as to be able to demonstrate them to their peers. They can also show how they themselves are organised to work in a problem-solving and decision-making team.

Specifically for complex organisations such as HSDs, combining different health facilities, each with their specificities and different organisation requirements, supply and support services, supervision and guidance in both clinical and managerial skills and need for negotiating skills at the local political level, demonstration sites have been proven to be very useful.

The demonstration sites in HSDs will be areas for on-the-job and hands-on training for HSD (and district) management teams in parallel with more traditional modular training sessions. They should have the facilities to receive teams from other HSDs for several weeks and trainers from outside the local HSD team. Minimal training areas to be covered are listed in Table 3. Experience has demonstrated that once functional, one such centre can train 10 to 15 HSD management teams per year.

The number of HSDs in mind and the relatively high turnover of key staff, which can not be addressed in the short run and will hence continue for a while, imposes several training centres/demonstration centres for the country. The project can construct, equip and render two of such centres operational. The centres shall be regarded as a prolonged arm to the regional training centre the MoH will be establishing.

Creating demonstration sites takes time and calls for specific investment in capacity building of the local team and to set up a conducive environment for such trainings. It demands a close collaboration between the local staff, and high-level trainers from the MoH and universities or other training institutions.

The local HSD team probably will need one extra cadre (medical doctor with public health experience) and some auxiliary staff to absorb the extra work within the HSD. The local HSD team should be implied in the formal training sessions together with the trainers from regional, national level or from training institutions.

Training aspects in HSD demonstration sites (not exhaustive)
HSD management team functioning:
• Functioning as a team • Problem-solving cycle in practice • How to organise continuous capacity development for staff in the HSD • How to use in practice supervision for continuous capacity improvement • How to use specialised hospital staff for continuous capacity building • Peoples' management in the HSD • How to organise the dialogue between districts • Planning for the HSD • Monitoring and evaluation in practice • Working with coverage plans and master plans • Organisation of pharmacy and medicine management • Health Information Management System management and utilization • Patient records and record keeping • Medical audits and quality of care improvement • Organisation of referral system • Receiving emergency patients • Follow-up of chronic patients

HC level
• Role and mandate of HC • HC administration • Support and supply services • HC calendar • Community participation and community dialogue • Outreach organisation • Quality of care • Integration of vertical programmes

Table 3: Examples of possible training subjects for HSD management team members (this list is only indicative)

The initial financing of these regional training centres should be supported by the project, maybe in collaboration with other development partners. At the longer term, the centres should be auto-sufficient through the tuition fees paid for the participants. The first few years will serve to create a good and transparent costing system and to show the real costs for maintaining such centres.

2.3.5 Creating in-service introductory trainings for newcomers

Newcomers in an institution are far too often just dropped into their working place without them being prepared. Health facilities or institutions should think of how new recruits could be better prepared for their work though.

Newcomers in the system should get to know their institution in a systematic way and get a global view on the organisation in which they will work. This implies that newcomers should get the time and training tools (guidelines) to make systematic observations on their institution and how it functions. The project will concentrate on the "newcomers" for management positions (HSD managers, HC IV directors, hospital management staff, responsible staff for HCs, etc. In principle, the HSDs should provide introductory trainings for all types of staff, but this will be only demonstrated in the demonstration HSDs (see result 6 – creation of training centres).

A HSD is regarded here as one health institution on its own. New doctors, nurses or other staff, whether they will be serving in one of the peripheral HC or in the HC IV or general hospital, should be introduced in the whole of the organisation. New staff should get to know the HSD management team, should be introduced in how the HSD manages supplies and supervision, how demands can be formulated, how drugs can be ordered, where and how to refer patients, should get familiar with what the lab could offer them etc.

By doing so, not only new staff will be better prepared technically, but they will also feel that the organisation is concerned with them boosting their motivation.

Special modules should be developed for this purpose and the HSD should be organised to accompany these people during this hands-on trainings and observations. General and

referral hospitals should organise in the same way. But this will be probably out of the scope of this project.

The project will help the HSDs with a training centre to develop the guidelines and accompany the first practical trials for different types of staff.

2.4 Conscious geographical concentration of the project

The project will involve all types of health institutions from regional referral hospital to general hospitals, districts and HSDs with the HC IV, III and II. These institutions, especially the lower levels, show difficulties in functioning in isolation. They depend from higher levels among others things for support supervision and referral possibilities.

The relation between the different levels is part of the management needs (and failures) in the system. For operational but also for synergistic potentials, it is important that the project is concentrating its efforts as much as possible in the same areas. This was also the explicit demand of the MoH.

For these reasons, the project will be operating in the catchments areas of 2 regional referral hospitals. The general hospitals and HSDs included in the project activities are selected within the catchments areas of the two regional referral hospitals. In the same logic, 5 HSDs will be selected for capacity assessment and capacity building in each of the 2 regions. One in each region will be subsequently selected to become a training and demonstration area for HSD managers. This approach is visualised in Figure 5.

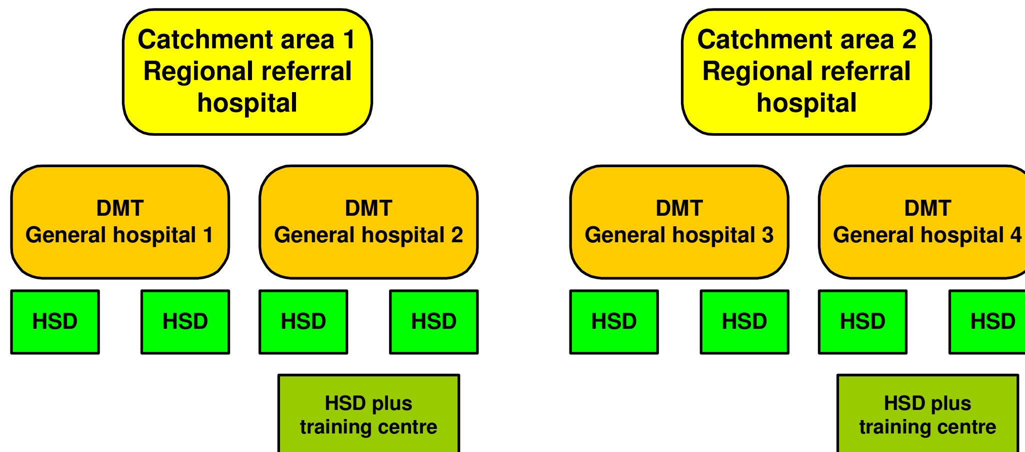

Figure 5 : Geographical concentration of the project intervention areas

2.4.1 Criteria used for selecting regional referral hospitals, districts and HSDs

Several factors were considered in selecting regional referral hospitals, districts and HSD to be targeted by the project. These factors include:

- Achieving synergies but avoiding overlap with other ongoing or proposed interventions. The World Bank project for example includes elements of leadership, planning and management. Geographical areas that form the catchments population of hospitals targeted by the World Bank project were excluded to avoid overlap. However, geographical areas that are targeted by other interventions from which the project would achieve synergies were highly favoured. At least one of the regional referral hospitals targeted by the project shall be located in the same area in which the ITM-School of Public Health is planning to intervene
- There should be reasonable infrastructure in place upon which to hinge the intervention. The argument was that leadership, planning and management would be more beneficial when there is something to build upon. Fort Portal regional referral hospital was recently renovated and is defined as a model RRH when it comes to infrastructure.
  BTC has also supported infrastructure uplift in Kasese and Kabarole districts. This creates synergies with the proposed project on leadership, planning and management.
- There should be established functioning management boards or committees to facilitate the implementation of the intervention.
- The geographic spread should be taken into account. Given that Mbale Manpower Development Centre exists and is also being targeted by the World Bank project, which excludes its catchments area.

2.5 Synergies/collaborations with other interventions

The project will as much as possible draw on and collaborate with existing or planned interventions. Below are the identified most important ones with a description about how the project will intervene with them.

The project will also during its implementation support the MoH in its effort to coordinate the different interventions targeting leadership, management and planning capacity building in order to minimize the risk that different initiatives become unintentionally contradictory and destabilise the system. See Activity 5 under result 1.

This can be done for example by supporting the MoH and the concerned organisations to organise broader forums for reflection to disseminate experiences and to contribute to refining a sector policy on capacity building relevant and uniform for the whole sector. Organising seminars and workshops on the subject are also possible ways of streamlining the discussions

2.5.1 BTC funded interventions

2.5.1.1 DGCD/BTC Scholarship programme

The DGCD/BTC Scholarship programme is providing scholarship for studies at national and international level. The programme has three components:

- Local scholarship (Bachelors degrees, Masters and PhD courses and local short training)
- Master and PhD studies in Europe
- Short courses in Europe.

The beneficiary sectors of the programme are mainly health and education. The beneficiary sector through the line ministries identifies priority areas for capacity building. The Belgian Embassy, BTC and the line ministries agree on these and allot scholarships for each category.

Possible synergies between this project and the scholarship programme are obvious. The project provides the MoH at all levels, through the capacity assessments, the opportunity to identify pertinent capacity building needs. The requests that the MoH will address to the scholarship programme will therefore be by definition real and priority.

The budget for the project will not include budget for long-term international trainings and will rely on the scholarship programme for financing such needs. The capacity assessments surely will also come forward with individual capacity building needs outside the scope of leadership, management and planning. The scholarship programme could cover these in a very complementary way as to strengthen the health institutions in all its aspects, also outside the management field (for example clinical aspects).

The international technical adviser of the project will liaise with the scholarship programme to use its procedures and to get all the information on the existing training opportunities in Uganda and in the sub-region.

Concerning financing of training courses the project will as much as possible align with financial norms of the scholarship programme.

2.5.1.2 Capacity strengthening for health systems research and health policy development in Uganda

The Institute of Tropical Medicine from Antwerp, in collaboration with the School of Public Health of Makerere University, are working on a new programme to support capacity at the HSD level, effectively starting beginning 2010. The training would be praxis-oriented and as much as possible would take place at the HSD level. This goes in the same direction as 2 of the major results of this project.

Collaboration between the project and this training initiative is key. The project and the initiatives have overlapping objectives and will be run during the same time period. They also both will need health facilities that can receive trainees for hands-on training at the HSD level, will need to identify the curriculum and how to scale-up the training for the whole country. The project will seek contact from its very start in order not to miss out on this coordination / collaboration potential. To assist in this collaboration at least one of the regional referral hospitals targeted by the project shall be located in the same area in which the ITM-School of Public Health is planning to intervene; Arua and Masindi districts.

2.5.2 Other programme/projects in progress

2.5.2.1 World Bank (WB) funded project "Uganda Health System Strengthening project"

A World Bank (WB) funded project "Uganda Health System Strengthening project" is just being formalized with the general objective to improve functionality of existing infrastructure, strengthen planning and management of Human Resources and to strengthen management of Health Facilities in order to deliver the Ugandan Minimum Health Care Package. Among the specific objectives is "To strengthen the leadership and management systems for health care delivery with focus on logistics and procurement, health facilities management and health infrastructure maintenance". The project is a 5-year programme with an initial phase of 2 years starting towards the end of 2010.

The WB project will consist of four components among these are one component on Human Resource Development and Management and one on Leadership and management systems. Activities to be included in the programme have been defined and one of the activities under the Leadership and Management component is to develop a leadership and management capacity building strategy and plan for the health sector. This activity will include defining the role and responsibilities for the different levels in the health system and to design and develop leadership and management course and modules.

The WB project has also identified a number of hospitals and HC IV to be targeted for health infrastructure up lift and the same hospitals will also be targeted for leadership and management capacity building.

This means that the BTC and the WB projects are aiming at strengthening the capacity in leadership and management and it is therefore very important that the projects work in close collaboration and support and draw on each others' experiences. To achieve synergies and avoid duplication the hospitals to be targeted by the present project will not be the same as those targeted by the WB project but the project will assure approaches will be harmonised.

2.5.2.2 USAID funded interventions

The project will collaborate with the Capacity project in the area of Human resource management and with the SURE project in the area of supply chain management. The SURE programme will work to strengthen the supply chain for medicines in 45 districts across the country, although the districts are not yet determined. It has been agreed that this project will not target the same districts as SURE will be targeting, but the same model be used in capacity building efforts within this area.

It is also envisaged that a close collaboration will have to be established between the BTC project and the announced new programme in leadership and management funded by USAID. This programme is still being developed and it has not been possible to get a clear picture on it. It will be up to the BTC project secretariat to liaise with this future project and to define collaboration and synergy opportunities.

2.5.2.3 Italian cooperation

Italian cooperation will during the FY 2009/10 support some planning activities in ten pilot districts related to the implementation of the Public Private Partnership policy. The districts will be located in the northern and the western part of the country. The districts have not yet been finally identified, but the BTC project shall avoid intervening in these districts.

2.5.2.4 JICA –TQM

If JICA will come to support implementation of the TQM concept in the RRHs it will be up to the BTC project secretariat to liaise with this future project and to define collaboration and synergy opportunities.

2.5.3 Collaboration with Sida

In the identification report it was envisaged that Sweden/Sida would be contributing to this project. The collaboration would specifically aim at supporting the implementation of harmonized TA plan for the MoH. However it is not yet clarified how and with what amount Sida will be able to contribute to the project. Sida and MoH will have a meeting to discuss this. During the formulation process however Sida has expressed its interest to be participating in the project. The project will follow this up.

2.6 Capitalisation of field experiences through an organised policy dialogue

The project will not cover the whole health sector with capacity building efforts. As described under part 2.4 the project identifies organisations at different levels of the health pyramid to introduce institutional capacity building initiatives and to accompany the process. The local improvement of these organisations is but one partial objective of the project. Different stakeholders should familiarise with the approach in order to incorporate it in a national and systematic strategy of capacity building for the entire sector.

This implies that the initiatives supported and financed by the project will serve as an example for the MoH that has to capitalise the experience and translate it into national sector policies. This is an active process (see Figure 5) in which the project will invest in different ways:

- Active participation
- Monitoring and evaluation of the procedures
- Seminars on capacity building strategies
- Continuous scientific external support by public health institutions

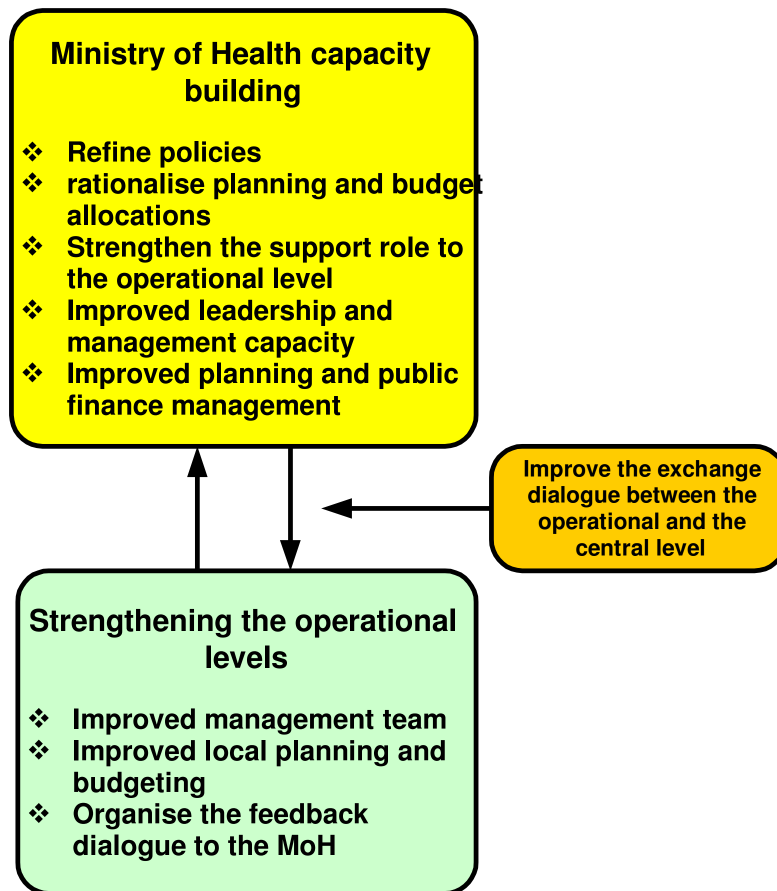

Figure 5: Capitalisation process enabling the MoH to learn from local experiences

The project will strengthen this dialogue between the operational and central level in different ways:

- The institutional assessment exercises will examine also this relation and will have to come up with proposals to strengthen it
- The MoH should accompany the institutional assessment processes enabling them to better understand the local realities in detail and to bring forward this information on various occasions at the central level
- The results also contain activities on capitalisation of experiences directly supporting the dialogue between the operational and central level
- One of the major objectives of the scientific support team (result 7) is to strengthen the capitalisation process by stimulating the reflections at the Ministry's level, based on the various field experiences. See more under 2.6.3.

2.6.1 Continuous active participation of MoH staff members

MoH selected staff members should accompany hospitals and HSDs in their institutional capacity building process, starting from the assessments. This will enable the MoH their proper practical understanding of the process and will increase their capacity to continue apply the approaches in other organisations or institutions outside the project. A selected

group of MoH staff and partners should also be identified and trained to support the training in the training centres/demonstration sites for HSD management teams.

2.6.2 Monitoring and evaluation of the procedures

All institutional capacity building initiatives have to define indicators that will be followed by the organisation in question but also by other stakeholders like the MoH. This will contribute to understanding the process and valuing the possible impact for the performance of the institutions concerned. Also the follow-up of the costing of the initiatives is important in order to budget for them in future independently from the project.

2.6.3 Continuous scientific external support by public health institutions

Universities and public health institutions are important stakeholders in capacity building in the health sector. They are useful and inevitable partners of the MoH in this matter.

Moreover, they have the capacity and skills to engage in action-research and are professional in organising and interpreting data systematically. The project proposes to engage a scientific support team composed of national and international public health experts in order to organise and support the capitalisation process, translating field experiences in evidence-based policy proposals. The main objective of this team is to stimulate a reflection between the stakeholders interested in capacity building in the health sector and to help them formulating health policies on the matter.

2.7 INTERVENTIONS NOT SPECIFICALLY INCLUDED IN THE PROJECT

HMIS and drug management were identified in the identification report as important bottlenecks in the health system. The project did not formulate specific results to address these problems. It has opted to keep these aspects as part of overall management and planning problems institutions are facing. In the institution or health facility where the capacity assessment takes place and HMIS and drug management will come up as crucial issues. In that sense, in any of the results, management of the HMIS and drug distribution and supply will be addressed.

HMIS will be strengthened also because the capacity building process demands M&E tools to be put in place. They probably won't be different from the existent, but maybe under-utilised tools already in place. The same counts for the coverage and master plans that will be developed. They will be based on indicators like population covered, bed occupancy and utilisation and referral rates: important indicators to be followed by health institutions.

2.8 SUSTAINABILITY

Sustainability is an important aspect when designing and managing a project. This project has taken sustainability concerns into account in various ways at different levels of the intervention.

- ***Capitalisation and strengthening the health policies*** are discussed elsewhere. The project gives much attention to these aspects because it should reinforce the sustainability of the project. The impact of the project is lasting if the experiences are integrated into policies and guidelines for the sector, even if maybe the local successes won't be fully maintained after the project.

- The project does not engage in activities that imply much ***additional recurrent costs*** to be covered by the system afterwards.

- The project aims at a ***fully integrated planning***. There should not exist any specific and parallel project planning. All project activities are fully integrated in the strategic and action plans of the concerned institutions. This increases ownership and obliges these institutions to take their responsibility. No activities will be developed if the health facilities do not take the forefront in defining them.

- MoH and district authorities should at any time ***accompany the capacity assessment initiatives*** and subsequent planning at the operational levels. It is not only a means for capacity building for MoH and districts, but it allows them as well to integrate the specific approach into their daily routine.

- The project ***works with a cluster*** within the chain of the health care organisation: MOH, RRH, DHMT, GH, HSDMT and HCs. It tries as much as possible to intervene in the same geographical area. The various facilities touched upon will be able to better maintain their capacity and performance in the field of management and planning, if the hierarchy is functioning within the same approach and indeed has increased its institutional capacity simultaneously.

- Concerning the 'capacity building centres' at the HSD level for HSDMT capacity building, the project will fully finance them (besides salaries) during the 4-year period. It gives the time to the ministry to ***define the legal and financial status*** of the centre. The project through its monitoring also of financial and administrative needs will provide the ministry with the necessary information to make choices possible. This should allow the centres to continue functioning independent from the project.

- The Belgian cooperation in principle ***will remain supporting the health*** sector for a longer period than the project's 4 years in Uganda. Therefore it will normally be possible to complete unfinished tasks, also in the area of sustaining results after the 4-years period of the project, if the ministry identifies this as a priority.

3. INTERVENTION FRAMEWORK

As described in the strategy in the previous chapter, this project is concerned with the capacity building problem in the areas of leadership, management and planning at all levels of the health pyramid. To assist in closing these gaps the project will intervene at the national level (MoH) itself, at the hospital level (referral and general hospital) and at the HSD level. At each level the starting point is an institutional capacity assessment from which all other activities will be depending.

3.1 GENERAL OBJECTIVE

"To improve effective delivery of an integrated Uganda National Minimum Health Care Package"

This objective is retained as such and accepted by the partner country

3.2 SPECIFIC OBJECTIVE

"The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels.

The specific objective is accepted with a minor modification in its phrasing. The Ugandan health authorities as well as the development partners that were interviewed were unanimously welcoming the project's objectives as very pertinent and timely.

3.3 RESULTS

1. **The MoH is strengthened in its organisational and institutional capacity.**

2. **One selected regional referral hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity.**

3. **One further regional referral (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity.**

4. **District management teams are strengthened in their managerial capacity, leadership and planning functions.**

5. **A comprehensive approach on capacity building of HSD management teams is operational.**

6. **Two training centres/demonstration sites for capacity building of HSD management teams are functional.**

7. **A scientific support team accompanies the capacity building process in the Ugandan health sector.**

The results are clearly linked with the different levels that should be touched by the project. Result 1 concerns the MoH, result 2 and 3 is looking at improving institutional capacity of a limited number of hospitals. The MoH, based on several criteria selected the 2 regional hospitals that would benefit from these interventions. See chapter 2.4.1. The criteria included minimal infrastructure and equipment in place, geographical spreading, and possible synergies with other interventions but avoiding overlap with others that would cover similar activities. The regional referral hospitals identified are Fort Portal and Arua. The general hospitals in the first catchments area are Bundibugyo and Bwere and in the second Adjumani and Yumbe. Result 4 is dealing with the district level and 5 and 6 with HSD level. The selection of the HSDs will be decided upon at the early start of the project together with MoH and LG authorities.

When hospitals and HSDs are going through the capacity assessment and start planning and working on their strategic and master plans and/or coverage plans (see result 2, 3 and 5) they will be confronted with the problem of complementary roles and planning for the referral system. The MoH will accompany them in this endeavour and will work around these themes together with these operational levels based on their concrete experiences and problems in the matter. A synergy between the policy and operational level will be actively looked for. It is therefore hoped that the national level and the operational level will find mutual benefits through these efforts and that indeed the project will be able to contribute to clarifying certain weaknesses in the national policies and guidelines.

The project will strengthen the dialogue between the operational and national level in different ways:

- The institutional assessment exercises will examine the relation between the different levels and to come up with proposals to strengthen it.
- The MoH will accompany the institutional assessment processes enabling them to better understand the local realities in detail and to bring forward this information on various occasions at the central level.
- The Results contain activities on capitalisation of experiences directly supporting the dialogue between the operational and central level.
- One of the major objectives of the scientific support team (result 7) is to strengthen the capitalisation process by stimulating the reflections at the Ministry's level, based on the various field experiences.

The attitudinal problem of health personnel, be it in a clinical or a managerial context is important. Among other things, leadership attitudes are at stake.

The project will try to work on attitudes in two different ways:

- By creating more capacity at the individual and the institutional level, the working environment should improve and encourage health personnel to change for a more client- and performance-oriented attitude.
- The different training modules and the capacity assessments should mention and discuss also attitudinal problems. Many people are but partially conscious that they have an attitude problem and that it causes dysfunctions in the institution.

Finally result 7 covers a crosscutting issue of capitalising experiences. This will strengthen the national health policy and will institutionalise the positive experiences and hence increase sustainability of the results obtained.

Result 1: The MoH is strengthened in its organisational and institutional capacity

The MoH is the first level where the project will intervene. At this level it is useful to distinguish institutional and organisational capacity[1].

As described already in the project situation analysis, the MoH represents capacity weaknesses both at individual and institutional and organisational level. Getting involved in a process of institutional assessment and institutional CB at this level will not only strengthen the MoH as an organisation by itself, but will have a repercussion on the performance of the whole sector. The MoH is key in creating a favourable working environment at the operational and service delivery level by:

- Defining a realistic health policy and strategy.
- Providing the means to operationalise the policy and strategy at the service level.
- To create procedures for and streamline individual capacity building at the operational level.

The different activities retained for obtaining this result cover all aspects of institutional capacity building as described earlier in this document, but also key policy issues have been identified. The project will support the MoH and hence contribute addressing certain key policy issues in a comprehensive way. Some areas that will be touched upon could be:

- The Support Supervision framework including reviewing the possibility of deconcentration.
- The MoH coordination of all efforts in the field of capacity building in the areas of management, leadership and planning.
- The implementation of a comprehensive TA plan and pooled funding mechanism for technical assistance.
- The definition of introductory trainings for new recruits in the health system at least for all management positions.

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Activities 1 to 2 describe the process of capacity building, starting from an institutional and organisational capacity assessment and linking up individual capacity with the creation of a positive working environment.

Activity 3 concerns the development of a procedures manual for the MoH.

Activity 4 concerns revision of the support supervision framework, specifically from national to local government level taking into account the increasing number of district.

[1] At the other levels, the TFF considers institutional and organisational capacity as synonyms, but at the MoH level some activities can be directly linked to specific institutional capacity building. The MoH should develop policies that will increase (facilitate) capacities at the operational level of the health pyramid.

Activity 5 concerns the coordination of capacity building initiatives in the sector within the domains of management, leadership and planning. Plenty of projects in the sector have a capacity building component and plenty of training institutions provide a variety of training courses probably with various degrees in quality but also in the subjects that are covered. The MoH is in an urgent need to streamline the training courses, standardise the content and to coordinate the individual capacity building initiatives. The project will help the ministry to realise this by determining the needed skills per personnel category, making an inventory of existing courses and to come up with a global plan for the personnel at stake.

Activity 6 concentrates on the use of national and international technical assistance by the MoH and is aiming at supporting the implementation of the recommendations made in the report Technical Assistance to the MoH by establishing a pooled fund for technical assistance.

Activity 7 is an activity that will not strengthen directly the output of the ministry itself but should enable the operational levels to perform better. Important aspects of the national health policy are among others the supervision system, improving and maintaining capacity in management, leadership and planning, de-concentration and devolution strategies for the ministry, etc. Some of the aspects will be covered by other result of the project like the referral system and the complementary organisation between the different levels of health care provision.

The activities planned under result 1:

1. Taking into account the recent initiatives already taken in this field, the MoH engages in a capacity assessment and capacity building exercise with a specific focus on leadership, management and planning.

2. Based on the conclusions of the capacity assessment exercise, the MoH provides individual in-service trainings for several of its staff members and creates the material environment needed to support capacity.

3. Develop a procedures manual for the MoH.

4. The MoH reviews and updated its support supervision framework.

5. The MoH coordinates all efforts in the field of capacity building in the areas of management, leadership and planning.

6. The MoH implements its policy on the use of technical assistance in the sector including the modalities for creating a pooled funding mechanism.

7. The MoH designs a policy and provides modules specific for each type of health facility enabling the organisation of introduction periods for newcomers in management positions in the system.

8. The MoH organises the monitoring and two-yearly evaluation of the progress.

Budget estimate for this result is 627 855 Euro.

Result 2: One selected regional referral hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity

The local improvement of the capacity of these institutions is but the occasion for the MoH and hospital managers to become familiar with the handled concepts and procedures of institutional capacity assessment, capacity building and developing important management tools like hospital strategic plans and master plans.

Therefore an international expertise team and a significant number of national experts and cadres from the MoH have to accompany these first experiences. The first three hospitals will serve as a capacity building exercise so that for the other hospitals (see result 3), this team will master the different steps in the process.

As for the previous result, the project starts from a global institutional analysis (activity 1) before engaging into individual capacity building programmes and some support will be given to create a proper working environment (activity 2). Activity 3 is aiming at assisting the hospitals in the development of a procedures manual.

Activity 4 and 5 is aiming at supporting the planning capacity and to ensure that the findings capacity assessment are also resulting in concrete action and that they will be evaluated in due time (activity 6). With activity 4 the project also supports the implementation of the National Hospital Policy, which defines strategic plans to be developed for each hospital. Part of that process is to carefully examine the complementary roles between the different health facilities and to achieve a comprehensive organisation of the referral system and a well functioning support supervision system.

Activity 4 also foresees the writing of guidelines for strategic planning of hospitals. Such guidelines do not exist for the country. They should be based on the specific mandate and functions of the hospital according norms of the MoH and on the services and functions in place. The writing of these guidelines should also be inspired by the first experiences from the institutional capacity assessment exercise and the subsequent reform plan and process. These guidelines should be proposed by the hospital management teams in collaboration with MoH and officially proposed to the MoH to integrate them among their planning guidelines.

The importance of master plans for hospitals was explained in chapter 3 on the project strategy. With activity 6, the project supports the MoH who has already encouraged the development of such plans. The project will make sure that the plans are not just limited to an architectural overview of buildings but that an active reflection on the existing infrastructure takes place including an argumentation on future development of the structures. The development of the plans will contribute the reflections and the sector policy of the MoH regarding the creation of complementary health facilities each with a specific mandate.

The capitalisation of the experiences for the MoH and hospital managers is foreseen through activity 8.

The activities planned under result 2:

1. The three hospitals engage in a capacity assessment exercise.
2. The three hospitals go through an organisational reform process based on the capacity assessment results.
3. Assist the hospitals in the development of a procedures manual.
4. Assist the hospitals in the development of a strategic plan taking into account the results of the institutional capacity assessment.
5. Assist the hospitals in their yearly planning exercise taking into account the strategic plan and the result of the institutional capacity assessment.
6. Develop a master plan for each hospital.
7. The hospitals organise the monitoring and two-yearly evaluation of the progress.
8. Presenting experiences and results in a training workshop for hospital management teams and MoH.

Budget estimate for this result is 761 695 Euro.

Result 3: One further regional referral hospital (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity.

Result 3 is a logical continuation of the experiences built with the previous result. It is a useful further capacity building opportunity for hospital managers and MoH staff in the matter and at the same time provides a critical mass of hospitals that went through the process for it to be institutionalised.

The activities planned under result 3:

1. The three hospitals engage in a capacity assessment exercise.
2. The three hospitals go through an organisational reform process based on the capacity assessment results.
3. Assist the hospitals in the development of a procedures manual.
4. Assist the hospitals in the development of a strategic plan taking into account the results of the institutional capacity assessment.
5. Assist the hospitals in their yearly planning exercise taking into account the strategic plan and the result of the institutional capacity assessment.

6. The hospitals organise a monitoring and evaluation workshop.

7. Develop a master plan for each hospital.

Budget estimate for this result is 511 350 Euro.

Result 4: District management teams are strengthened in their managerial capacity, leadership and planning functions.

Like for any other health institution the project is addressing, the district management teams will have to go through a systematic and detailed analysis of their functions and actual performance to identify capacity gaps. These will result in an action plan for reorganisation, individual training needs identification and identification of material needs (creating a motivating working environment). The project will support this initiative under activity 1. International and national consultants will facilitate the first three districts in close collaboration with MoH. The national consultants and MoH staff will animate the remaining three.

District management teams are closely related to the organisation and functioning of general hospitals and HSDs. Therefore, they should really take part in the capacity assessment exercises that these institutions engage in. It is not only a learning experience for the district, it is part of their capacity building and provides them the necessary insights into the problems they are actually sharing with these institutions. By doing so, they will assure that these different operational levels of care develop complementary strategies. As the districts are directly in contact with the LG authorities, they are responsible to communicate and negotiate these integrated plans at that level (activity 4).

The activities planned under result 4:

1. Districts are engaging in an institutional capacity assessment.

2. Districts accompany general hospitals in their capacity assessment and building process.

3. Districts accompany HSD management team in their capacity assessment and building process.

4. District develop and negotiate with the LG authorities a strategic plan taking based on the results of the HSD and GH capacity building plans including the coverage and master plans developed at that level.

Budget estimate for this result is 220 200 Euro

Result 5: A comprehensive approach on capacity building of HSD management teams is operational.

Narrowing the capacity gap at the level of (sub-) districts was identified by MoH as well as by the donor community at large as the most important support for the health sector

in Uganda. At the same time that it is a very important level in health care because of its volume and its proximity with the rural poor, it is also the level with the highest turnover of staff and the least experienced.

The first activity in result 4 is to continue the already existing efforts of the MoH, supported by WHO in the field of capacity building of HSD management teams. This initiative does not get at the desired output level so far.

Parallel with this support to a capacity building programme, the project will support the MoH in the same process of institutional capacity assessment and building as for the previous results, reflected in the activities 2, 3, 4 and 5. The ten HSDs will be chosen at the start of the project.

As for the previous results, an external team of national and international experts together with the MoH will support the first 2 HSDs concerned. After the national teams and MoH cadres are familiar with the process, they will continue to cover the other 8 HSDs.

In every HSD exercise, the district management team will be fully involved. Already the collaboration between district and HSD is very close and with the increase of the number of districts, districts and HSDs will merge even further.

Activity 6 and 7 are covering the need for specific management tools to be developed for HSDs: coverage plans for the HSDs and master plans for the HV IC level. These concepts are briefly explained in the previous chapter.

Finally, activity 8 allows the MoH to capitalise the local experiences. It streamlines the information flow from the operational to the policy level. As for previous results, facilitating this information flow and subsequent discussions is regarded as very essential because it will permit to transcend the local successes to come to a more complete health sector policy and an institutionalisation of so far 'project' activities.

The activities planned under result 5:

1. Support the ongoing capacity building for HSD management teams based on the modules developed by MoH/WHO.

2. 10 HSDs (+ related district) engage in a capacity assessment exercise (Five HSDs per catchments area of the RRHs under result 2 and 3).

3. The HSDs engage in an organisational reform process based on the capacity assessment results.

4. The HSDs are supported by the MoH in the first year plan following the assessment.

5. The HSDs organise the monitoring and an evaluation workshop after 2 years of implementation.

6. Develop a coverage plan for 10 HSDs.

7. Develop a master plan for each HC IV.

8. MoH capitalises the experiences and translates them into the sector policy.

Budget estimate for this result is 1 916 675 Euro.

Result 6: Two training centres/demonstration sites for capacity building of HSD management teams are functional.

The MoH in its policy foresees 5 regional centres for continuous training. For practical reasons, the ministry foresaw to locate these centres uniquely in RRH because they have already the necessary infrastructure. The Belgian cooperation is willing to support this initiative in 2 areas but the scope and priority has been slightly modified though and therefore the centres would be constructed in rural settings. The advantages are discussed below. The only disadvantage is the fact that there is no existing infrastructures in those areas and that therefore extra construction efforts are needed.

Practical, hands-on training was felt as an important aspect to solve capacity gaps among the health personnel at different levels but especially at this operational HSD level. Young staff often got the necessary basic training inputs needed, but often lacks any exposure to the practical aspects of their needed competences.

Supervision is one of these typical subjects that cannot be learned in a classroom only. Knowing what to do can be quite different from knowing how to do. Moreover the training institutions often do not have the means, the time nor the authority to organise practical trainings in the curriculum. Result 5 addresses the need for more practice-oriented training with more emphasis on hands-on training and knowing how to do things in practical terms.

There is still also some confusion on the fact that "teaching" hospitals are not always the best place to learn these practical aspects of health care and health care organisation. People should learn their practical management skills under equivalent circumstances as their proper working environment.

Therefore the project proposes to create regional training centres for HSD management teams, but clearly located in 'typical' or representative HSD environment: in HSDs with a HC IV or HSD hospital and a network of HC II and III in rural areas. The HSD management team should be complete with at least two medical doctors in function. Because of the additional workload (extra supervision, field visits with course participants, quality assurance and training sessions), the MoH should consider affecting additional staff for the HSD (see further staffing for the training centre).

The centres will host the trainings for HSD management team members, and will organise practical training sessions in the health facilities in the HSD. These facilities should work up to the standards foreseen in the policy of the MoH so that they can serve as a good practical example on how things should be done at that level. One could speak of demonstration sites, places where people have the facility and possibility to see services organised up to the standards determined by the MoH.

In order to create such areas, special efforts need to be deployed. HC and HSD hospitals should be intensively supported for them to reach the necessary quality of organisation and for them to know how to receive and guide course participants in their practical training. The location of the training centres should be within the catchments areas of the RRHs under result 2 and 3 and based at one of the ten HSDs that have gone through the capacity assessment exercise.

They should however probably not be located in the capital area of the region because it would not be an atypical HSD with a nearby referral, which has its repercussions on for instance the referral system and the development and activities of the HC IV.

The training centres/demonstration sites need to be built and equipped. This is foreseen in activity 1. The centre should contain simple sleeping facilities and a dining room where participants and outside trainers can remain in the evenings and where they can take their meals. A capacity of 15 to maximum 20 persons should be sufficient because for practical trainings (contrary to classroom teaching) the HSD cannot absorb more people. The centre itself should have one teaching room for maximum 15 participants, a storeroom, a small library room with photocopy facilities, 2 or 3 offices. Specific decisions need to be taken regarding constructing staffing houses. Care should be taken not to create disparities between key HSD staff and specific personnel affected to the training centre, as they will have to work closely together, even in an integrated way.

As essential equipment one should include computers, 2 beamers, a performing photocopier, flipcharts, projection screen, and a car for transporting materials and participants. The HSD itself should have an extra supervision vehicle for more intensive supervision to the HC and to organise joint visits with the course participants.

The training curriculum should be carefully established (activity 2 - 3). For every competence needed, practical skills should be identified to include them in the training package. Practical skills can be obtained through direct observation or by doing one-selves. Often a combination of the two is needed, hence the importance of having performing HSDs. The capacity building assessments at the HSDs combined with detailed job descriptions and health care and administrative packages the HSD should fulfil, can help a lot to identify the full range of competences and skills that a HSD management team needs.

Many training modules already exist and are very valid (especially when it comes to the theoretical content). After having established an inventory of the existing material, gaps should be identified and probably for most of the practical skills modules and guidelines need to be developed (activity 3).

Activity 4 is probably the most important and at the same times most difficult activity under this result. It will need a high degree of time-consuming commitment of the HSD management team, but also of the district team and the rest of the staff and even the MoH to create this quality environment. Therefore the ministry should allocate an extra senior staff member (public health physician with 10 years experience in district management) to the HSD for it to be able to absorb the extra workload of organising the field and to organise and accompany the practical exercises in the field supervision of health centres, in-service training for the staff, etc. An alternative would be to allocate this staff member to the training centre but it has to be clear that he has to work intensively in the HSD. The HSD management team should also be very actively

involved in the theoretical and practical training sessions. If they were able to create quality centres, they will be good teachers in the matter as well.

The preparation phase (curriculum, creation of demonstration sites), parallel to the building phase, will take at least 2 years. Therefore, actual training sessions will probably only start in the third year of the project.(activity 5)

The MoH has an important responsibility to take in this matter. The MoH should take important decisions regarding:

- The legal status of the training centre
- The future financing modalities: central MoH budget, regional or HSD budget, inscription fees, donor community
- Collaboration with universities or other training institutions
- Collaboration with MoH
- Other training opportunities outside HSD management teams
- Staffing: norms, profile, quantity, articulation and integration with local HSD management teams. The local teams should get extra workforce as well (as explained earlier). The minimal staff for the training centre should consist of a public health physician as director, one senior nurse, an administrator – financial officer and a driver.
- Quantity of centres needed: The project proposes to start with two centres. Rough calculations taking into account absorption capacities in the HSDs, staff turnover and number of HSDs in the country, show that the country might need 3 to 4 of these centres, which could be further optimised by allowing other types of training to be organised in these centres. But more accurate data will be needed (e.g. what is the real absorption capacity of a HSD, can neighbouring HSDs be used for organising practical training, can one maintain sufficient quality in those HSDs?) and the centres to be evaluated before taking definite decisions.

The project will cover all costs of the centres during the first 4 years, probably combined with tuition fees to be paid by donor agencies supporting participating HSD team members. The MoH thus has the time to study the various questions and to define a definite policy, including financing modalities, towards the end of this project. A thorough evaluation of the courses, the organisation but also of the impact of the courses on the actual management of the HSD concerned will be carried out. The opinion of the HSDMT members that benefited from the training will be actively looked for. This is reflected in activity 6. Some aspects like affecting personnel should be decided already in the beginning of the start up of the centres. The experiences later will permit the MoH to finalise its decisions and to institutionalise it in a policy document.

***The activities planned under result 6*:**

1. Build training facilities and equip for receiving a maximum of 15 participants and 2 outside trainers at a time.

2. Based on previous activities formulate a comprehensive approach for further capacity building activities for HSD and district management teams.

3. Establish training modules and programmes.

4. The HC and hospital(s) that will receive course participants for their practical training are prepared and work up to standards.

5. Organise 3 training sessions with each 12 participants in a first year in the two centres.

6. The MoH defines a long-term status and a sustainable financing mechanism for the centres, based on the findings of an in-depth evaluation of the impact of the courses on the management performance of the SDHMT.

Budget estimate for this result is 1 113 200 Euro

Result 7: A scientific support team accompanies the capacity building process in the Ugandan health sector

The MoH (and hence the project) that has to cover broad problems and that has the ambition to cover both planning and implementing "field" activities as well as reflecting around policy issues (linking up practical experiences with policy development) can benefit a lot from an external expertise team. This multidisciplinary team, composed of external national and international experts in the matter, should serve as a think-tank for the MoH (and the project) to facilitate the dialogue between the operational level and the central policy level. By involving national and international training institutions in the matter, the link between the MoH and the academic world will be strengthened simultaneously with the structuring of the policy dialogue between operational and policy level in the health sector.

All previous results foresee that experiences are capitalised and in the long-term are reflected in the national health policy and procedures. The principle mandate of the scientific support team is to facilitate this process.

Capitalisation of experiences is only possible if:

- Experiences should be managed in a systematic way with explicit decision-making and formulation of working hypotheses
- Experiences should be monitored systematically to allow arguing afterwards whether hypotheses can be confirmed and under which conditions they would be replicable and sustainable. Therefore any decision and working hypotheses should be monitored utilising measurable indicators
- Follow-up decisions adjusting or completing initial initiatives should be immediately integrated in the monitoring and reflection process
- Interpretation of data and subsequent scientific report writing should reflect a critical evaluation of the initiatives, combining qualitative data (eventually with specific data collections) with conclusions derived from monitoring quantitative indicators.
- These reports should contribute to the policy dialogue between the operational level and the MoH central policy level through for instance national seminars or other communication and reflection forums.

The activities planned under result 7:

1. An external expert team composed of national and international experts supports the MoH in organising the capitalisation process between the operational and policy level of the MoH.

2. Facilitate the policy dialogue between the operational and policy level of the MoH.

Budget estimate for this result is 256 800 Euro.

3.4 INDICATORS AND MEANS OF VERIFICATION

Specific indicators concerning gender will be proposed to and approved by the first steering committee at the moment first detailed plans are presented, including specific activities in this area of interest.

The project will follow 2 sets of indicators.

At the level of the specific objective, the project will follow indicators that are directly extracted from the national Joint Budget Support Operation (JBSO) indicators list and from the HSSP II. Those that were not applicable at the project's level were excluded from the list. By doing so, the project clearly wants to align with the national monitoring system already in place and used in the policy dialogue between the MoH and the development partners.

On the other hand, some indicators of local health system's outcome were added. Indeed if management has to lead to better overall performance of the health institutions / facilities, also the output should increase.

The selected indicators are all routine indicators for the district and HSD or for the general hospital or HC IV. They can be grouped by type of health facility:

- HC II and III and outpatient facilities HC IV are grouped

- HC IV hospitalisation together with general hospital for inpatient care

- RRH have their own set of indicators.

By the start of the project, and whenever a new health facility or region is taken on board, clear definitions of the indicators will be given to the stakeholders so that data collection and calculation of the indicators will be uniform throughout the project. As the indicators all belong to the HMIS system, this will only improve the quality of the data provided without real additional work for the services.

No specific baseline study is foreseen, as all indicators are already collected routinely by the facilities involved. The project will though constitute a baseline together with the concerned health facilities each time they start activities at that level.

At the level of the project results and activities, a more classical set of indicators to monitor project results is given.

3.4.1 Indicators for the specific objective

Table 4 lists the indicators under HSSP II and JBSO that were judged useful for the present intervention. The baseline values given are specific for the country. It is up to the project to identify the local baseline and target values.

N°	Category	Indicator	Baseline value 03/04	2006/07 target	2009/10 target	Data source
1.	Input	% of PHCCGs released on time to the sector	97%	100%	100%	MoH/MoFPED reports
2	Process	Proportion of districts, submitting quarterly assessment reports	5%	40%	90%	HMIS reports
3.	Process	% of facilities without any stock out of first line anti-malarial drugs, measles vaccine, Depo-Provera, ORS and cotrimoxazole	40%	55%	80%	HMIS/reports records review
4.	Process	% of population residing within 5kms of a health facility (public or PNFP)	72%	80%	85%	1. Mapping of health facilities 2. Population based surveys
5.	Process	% of the health units by level providing all components of the UNMHCP	N/A	N/A	N/A	To be determined locally
6	Process	% of health units providing EMOC	14%	30%	60%	HMIS en surveys
7.	Output*	% of children <1 yr receiving 3 doses of DPT/Pentavalent vaccines	84%	87%	90%	HMIS
8.	Output*	Proportion of approved posts that are filled by health professionals	68%	85%	90%	Annual HU/district reports
9.	Output	Couple Year Protection (CYP)	223,686	325,407	494,908	HMIS
10.	Output	Urban /rural specific HIV sero-prevalence rates	6.2%		4.4%	ANC reports ACP reports
11.	Output*	% of deliveries taking place in a health facility (GoU and NGO). Deliveries supervised by a health worker	24.4%	35%	50%	HMIS UDHS
12.	Output*	Total GoU and NGO/Capita OPD utilization per year	0.72	0.90	1.0	HMIS/record review
13.	Output	Caesarean section per expected pregnancies (Hospital)	1.5%	7%	10% consult RH	HMIS reports & records review
14.	Output	Proportion of TB cases notified compared to expected	49%	60%	70%	NTLP reports
15.	Output	Proportion of TB cases that are cured	62%	80%	85%	NTLP records

16.	Output	Proportion of pregnant women receiving a complete dose of IPT2	24%	50%	75%	HMIS

Table 4 : Selected indicators from HSSP II and JBSO the project will follow in the cadre of this intervention.

The following routine indicators from the districts and hospitals complete this list(see Table 5). They are also related to the specific objective because they indicate how the system as a whole is functioning. They cannot be related to specific activities or results.

As mentioned before, as they are all routine indicators collected in the HMIS system, this does not constitute any additional work for the national staff. For the project secretariat, some calculations need to be done, and they are responsible for the raw data arriving at their level for some specific calculations and analysis.

These indicators are related to the various MDG related to health.

Description of indicator	Source of verification
Maternal health	
Expected number of deliveries / HSD	HMIS
Assisted deliveries at HC II, II, IV level **+ rate (%)**	HMIS
Number of C-Sections in the district + **rate (%)**	HMIS
Number of ruptured uterus and institution-based maternal mortality / Number of C-sections in the district	HMIS
Child care	
Number of children receiving DPT before first birthday + **rate (%) + compared with national level**	HMIS
% children covered with measles vaccine before first birthday + compared with national level	HMIS
% children vaccinated at HC II and III compared with total number of children vaccinated in the district	HMIS – specific calculations needed
Number of severely malnourished children diagnosed	
Health facility performance	
Referral rate (new cases) HC II and III to HC IV or GH	HMIS – specific calculations needed
Utilization rate curative care HC II and III related to catchment area population	HMIS
Number of outpatients in HC IV, GH, RRH	HMIS
Number of new outpatients in HC IV, GH, RRH	HMIS
Number of return visits in Outpatients in HC IV, GH, RRH	HMIS
Number of hospitalised patients / time (excluding maternity normal deliveries) in HC IV, GH, RRH	HMIS
Bed occupancy rate (excluding maternity normal deliveries) in HC IV, GH, RRH	HMIS
Average length of stay (excluding maternity normal deliveries) in HC IV, GH, RRH	HMIS

Drugs out of stock (see HSSP data collection)	HMIS
Number of management meetings and % according to norms	HMIS – specific calculations needed
Supervision DMT to HSDMT (% realized according to norms)	HMIS – specific calculations needed
Supervision HSDMT to HC II and III (% realized according to norms)	HMIS – specific calculations needed

Table 5 : Additional indicators to monitor overall performance and outcome of concerned health facilities.

The next 2 pages list the indicators directly related to the results and activities of the project (Table 6).

Result 1:The Ministry of Health is strengthened in its organisational and institutional capacity	• Reform plan in execution • Number of people trained by the project • Number of field visits for ➢ Coverage plan development ➢ Master plan designing ➢ Procedures manual identification • MoH Procedures manual in place • Support supervision policy paper renewed • Established procedures for training coordination
Result 2: One selected regional referral hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity	• Strategic plans incorporating master plans in place • Hospital mandate reflects efforts for complementary role definition • Number of support supervisions realised respecting new policy in the matter • Number of people trained
Result 3: One further regional referral hospital (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional capacity	• Strategic plans incorporating master plans in place • Hospital mandate reflects efforts for complementary role definition • Number of support supervisions realised respecting new policy in the matter • Number of people trained
Result 4: District management teams are strengthened in their managerial capacity, leadership and planning functions	• Number of people trained • Number of support supervisions to GH realised • Number of support supervisions to HSDMT realised • Strategic plan developed, followed and discussed with LG • Level of understanding of coverage and master plans for strategic planning
Result 5: A comprehensive approach on capacity building of sub-district management teams is operational.	• Number of HSDMT members trained • Coverage plans, master plans and procedures manual reflected in strategic and yearly plans • Coverage plans discussed with LG authorities • Number of HSDMT meetings held • Number of HC II and III supervised by HSDMT

Result 6: Two training centres/demonstration sites for capacity building of health sub-district management teams are functional	• Number of HSDMT members trained in training centres • Number of training sessions held • Number of HC II and II up to quality standard for receiving trainees • Evaluation report after 2 years of functioning available. • Status training centres clarified
Result 7: A scientific support team accompanies the capacity building process in the Ugandan health sector	• Policy paper on support supervision refined and approved • Policy paper on referral system refined and approved • Complementary roles of health facilities better defined and approved in policy paper • Continuous training policy for health personnel refined

Table 6: Log frame indicators per result

3.5 DESCRIPTION OF BENEFICIARIES

The principles beneficiaries will be the managers at different levels of the health system in Uganda, this includes managers at the MoH and at operational levels, hospitals and (sub)-districts.

Less directly, but also universities and health training institutions are beneficiaries of this intervention. The intense relations they will develop with international expertise teams are meant to build their capacity and the intense involvement in certain project activities will equally increase their capacity. The link with the basic training for medical students and other health cadres is clear.

By strengthening the leadership, management and planning capacity in the health sector the project will allow for adhering to nationally agreed priorities and better utilization of the resources available for health services in the country. In this way, the ultimate beneficiary is expected to be the people of Uganda, specifically the poor and disadvantaged groups.

4. RESOURCES

4.1 FINANCIAL RESOURCES

The Government of Belgium will fund the project with co-funding from the Government of Sweden/Sida. The Belgian contribution amounts euro 6,500,500 for the four years.

The Government of Uganda will contribute in kind to the project. This contribution will be by guaranteeing that key personal will be participating in the implementation of the project. In addition, it will provide the international Technical Adviser with sufficient office space.

The MoH will also affect staff to the training centres.

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BUDGET TOTAL				Mode d'exéc.	BUDGET TOTAL	%	CHRONOGRAMME ANNEE 1	ANNEE 2	ANNEE 3	ANNEE 4
A			**The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels**		**5.397.705**	**83%**	**251.775**	**3.079.100**	**1.501.900**	**564.930**
A	*1*		*MoH strenghtend in its organisational and institutional capacity*		*627.855*	*10%*	*92.075,00*	*393.200,00*	*133.000,00*	*9.580,00*
A	01	01	Capacity assessment and capacity building exercise	Co-management	193.200		50.000,00	143.200,00		
A	01	02	Capacity building at individual level	Co-management	275.000			150.000,00	125.000,00	
A	01	03	Development of procedures mannual	Co-management	27.000			27.000,00		
A	01	04	Ministry of Health reviews and updates support supervision framework	Co-management	92.575		22.575,00	70.000,00		
A	01	05	Ministry of Health coordinates all efforts in the field of capacity building	Co-management	12.180		3.000,00	3.000,00	3.000,00	3.180,00
A	01	07	MOH develops policy and modules for newcomers in management positions	Co-management	16.500		16.500,00			
A	01	08	Monitoring and two-yearly evauation of the progress	Co-management	11.400				5.000,00	6.400,00
A	*02*		*One selected RRH and two GH are strengthened in their institutional and organisational capacity*		*761.625*	*12%*	*0,00*	*743.500,00*	*18.125,00*	*0,00*
A	02	01	The three hospitals engage in capacity assessment exercise	Co-management	204.800			204.800,00		
A	02	02	The three hospitals go through an organizational reform process based c	Co-management	255.000			255.000,00		
A	02	03	Development of procedures mannual	Co-management	18.500			18.500,00		
A	02	04	Assist the hospitals in the development of a strategic plan	Co-management	35.700			35.700,00		
A	02	05	Assist the hospitals in their yearly planning exercise	Co-management	2.250			2.250,00		
A	02	06	Develop a master plan for each hospital	Co-management	227.250			227.250,00		
A	02	07	Monitoring and two-year evaluation of progress	Co-management	11.100				11.100,00	
A	02	08	Presenting experiences and results in training workshop	Co-management	7.025				7.025,00	
A	*03*		*One further RRH (Arua) and two additional general hospitals strengthen in its institutional and organisational capacity*		*511.350*	*8%*	*0,00*	*0,00*	*386.250,00*	*125.100,00*
A	03	01	The three hospitals engage in capacity assessment exercise	Co-management	76.800				76.800,00	
A	03	02	The three hospitals go through an organizational reform process based c	Co-management	255.000				155.000,00	100.000,00
A	03	03	Development of procedures mannual	Co-management	18.500				18.500,00	
A	03	04	Assist the hospitals in the development of a strategic plan	Co-management	35.700				35.700,00	
A	03	05	Assist the hospitals in their yearly planning exercise	Co-management	2.250				2.250,00	
A	03	06	Monitoring and two-year evaluation of progress	Co-management	11.100					11.100,00
A	03	07	Develop a master plan for each hospital	Co-management	112.000				98.000,00	14.000,00
A	*04 A*		*District management teams are strengthened in their managerial capacity, leadership and planning*		*220.200*	*3%*	*0,00*	*111.500,00*	*108.700,00*	*0,00*
A	04	01	6 districts are engaged in an institutional capacity assessment	Co-management	136.800			70.000,00	66.800,00	
A	04	02	District accompany GH in their capacity assessment and building	Co-management	4.500			2.500,00	2.000,00	
A	04	03	Districts acompany HSD MT in their capacity assessment and building pı	Co-management	7.500			4.000,00	3.500,00	
A	04	04	Development of a strategic plan etc	Co-management	71.400			35.000,00	36.400,00	
A	*05*		*A comprehensive approach on capacity building of sub-district management teams is operational*		*1.916.675*	*29%*	*50.000,00*	*825.000,00*	*757.125,00*	*284.550,00*
A	05	01	Support to ongoing HSD team capacity building programme	Co-management	150.000		50.000,00	100.000,00		
A	05	02	10 Health sub-districts are engaged in an institutional capacity assessme	Co-management	456.200			200.000,00	200.000,00	56.200,00
A	05	03	10 sub-districts go through an organizational reform process based on ca	Co-management	950.000			400.000,00	400.000,00	150.000,00
A	05	04	Assist the sub districts in their yearly planning exercise	Co-management	137.500			50.000,00	50.000,00	37.500,00
A	05	05	Monitoring and two-year evaluation of progress	Co-management	3.700				3.700,00	
A	05	06	Develop a coverage plan for 10 HSDs	Co-management	69.850			25.000,00	30.000,00	14.850,00
A	03	07	Develop a master plan for each HSD HC IV	Co-management	146.000			50.000,00	70.000,00	26.000,00
A	05	08	Presenting experiences and results in training workshop	Co-management	3.425				3.425,00	

				Mode d'exéc.	BUDGET TOTAL	%	ANNEE 1	ANNEE 2	ANNEE 3	ANNEE 4
A	*06*		*2 training and demonstration sites forHSD management team functional*		*1.103.200*	*17%*	*70.000,00*	*936.200,00*	*29.000,00*	*68.000,00*
A	06	01	Build training facilities and equip for receiving participants	Co-management	880.000		40.000,00	840.000,00		
A	06	02	develop training strategy	Co-management	55.500		20.000,00	35.500,00		
A	06	03	Establishing training modules and programmes	Co-management	40.000			40.000,00		
A	06	04	prepare the field	Co-management	38.700		10.000,00	20.700,00	4.000,00	4.000,00
A	06	05	Organise 3 training sessions with 12 participants	Co-management	66.000				22.000,00	44.000,00
A	06	06	longterm strategy after evaluation	Co-management	23.000				3.000,00	20.000,00
A	*07*		*A Scientific support team accompanies the capacity building process*		*256.800*	*4%*	*39.700,00*	*69.700,00*	*69.700,00*	*77.700,00*
A	07	01	An external expert team organising the capitalisation process	Co-management	158.800		39.700,00	39.700,00	39.700,00	39.700,00
A	07	02	Organise the policy dialogue	Co-management	98.000			30.000,00	30.000,00	38.000,00
X			**Budget Reserve (max 5% * total activites)**		**144.375**	**2%**	**0,00**	**30.000,00**	**80.000,00**	**34.375,00**
X	*01*		*Budget reserve*		*144.375*	*2%*	*0,00*	*30.000,00*	*80.000,00*	*34.375,00*
X	01	01	Budget reserve COMANAGEMENT	Co-management	144.375		0,00	30.000,00	80.000,00	34.375,00
X	01	02	Budget reserve REGIE	Regie	-		0,00	0,00	0,00	0,00
Z			**General means**		**957.920**	*15%*	**242.040,00**	**243.600,00**	**213.600,00**	**258.680,00**
Z	*01*		*Personnel cost*		*674.400*		*168.600,00*	*168.600,00*	*168.600,00*	*168.600,00*
Z	01	01	International technical advisor	Regie	624.000		156.000,00	156.000,00	156.000,00	156.000,00
Z	01	02	Project officer	Regie	38.400		9.600,00	9.600,00	9.600,00	9.600,00
Z	01	03	Project driver	Regie	12.000		3.000,00	3.000,00	3.000,00	3.000,00
Z	*02*		*Investissements*		*53.440*		*53.440,00*	*0,00*	*0,00*	*0,00*
Z	02	01	vehicles	Regie	35.500		35.500,00	0,00	0,00	0,00
Z	02	02	Office equipment	Regie	4.700		4.700,00	0,00	0,00	0,00
Z	02	03	Equipement IT	Regie	12.240		12.240,00	0,00	0,00	0,00
Z	02	04	Office fixing-up	Regie	1.000		1.000,00	0,00	0,00	0,00
Z	*03*		*Recurrent costs*	*Regie*	*110.080*	*2%*	*20.000,00*	*20.000,00*	*35.000,00*	*35.080,00*
Z	03	01	Maintenance and insurance of vehicle	Regie	11.520					
Z	03	02	Maintenance and fuel of motorcycles	Regie	7.200					
Z	03	03	Fuel vehicle	Regie	5.760					
Z	03	04	Office maintenance (2)	Regie	4.800					
Z	03	05	Telecommunications 3 mobiles	Regie	2.880					
Z	03	06	Missions	Regie	70.000					
Z	03	07	Representation costs and external communication	Regie	1.920					
Z	03	08	recruiting (1 ticket + stay in Belgium)	Regie	6.000					
Z	*04*		*Audit et Suivi et Evaluation*	*Regie*	*120.000*	*2%*	*0,00*	*55.000,00*	*10.000,00*	*55.000,00*
Z	04	01	Frais de suivi et évaluation	Regie	50.000			25.000,00		25.000,00
Z	04	02	Audit	Regie	40.000			20.000,00		20.000,00
Z	04	03	Backstopping	Regie	30.000			10.000,00	10.000,00	10.000,00
TOTAL					**6.500.000**		**493.815**	**3.352.700**	**1.795.500**	**857.985**

Regie	**957.920**
Co-management	**5.542.080**

15%	**242.040**	**243.600**	**213.600**	**258.680**
85%	**251.775**	**3.109.100**	**1.581.900**	**599.305**

4.2 HUMAN RESOURCES

The project will have an international Technical Advisor, a Project Officer and a driver.

BTC Brussels will recruit the international Technical Adviser by launching an international tender. The candidate will be selected on the basis of a joint interview between the BTC selection committee and a representative of the MoH. According to circumstances and possibilities this will either happen through a videoconference or the person of the ministry will come to BTC Brussels. The Technical Adviser should have a background in organizational development and institutional capacity building combined with a very good understanding of the health sector organisation.

BTC will additionally recruit a driver who will be paid on the project's budget.

The MoH jointly with BTC will recruit the Project Officer in Uganda. He/she will be contracted by MoH but paid on the project budget. (See chapter 6 execution modalities).

The MoH should affect sufficient staff to the training HSDs. This probably does not signify additional staff for the ministry but rather re-allocation of existing staff. The quality of this staff will be crucial for the outcome of the project.

4.3 MATERIAL RESOURCES

4.3.1 Material for the Technical Adviser and Project Officer

Equipment needed for the Technical Adviser and the Project Officer will be allocated by the project. The MoH will provide the office space for both cadres in the MoH building.

4.3.2 Material for the institutions target by the interventions (institutional capacity building)

Capacity assessment and capacity building processes in resource-poor countries are inevitably confronted with lack of certain equipments that disable the introduction of change. On the other hand, the MoH receives an important budget support and hence disposes of a national budget that should enable procurement of the necessary equipments.

The project would like to respect this organisation lines but should not be blind of the important delays that can occur when solely relying on the national health budgets to finance ad hoc needs.

Therefore the project proposes that an amount should be fixed per institution supported for investments directly related to the future performance of the institution. This excludes heavy investment such as important infrastructure works or purchasing expensive medical equipment, which should be financed through the national accounts. Small infrastructure works related to increasing management capacities could include for example construction – rehabilitation of meeting rooms and its furniture, equipment like laptops, teaching equipment like LCDs, printing materials like patient files, etc.

5. IMPLEMENTATION MODALITIES

The overarching policy and strategic framework governing the health sector in Uganda consists of the National Health Policy (NHP) and the Health Sector Strategic Plan. The implementation of these is supported by a sector-wide approach (SWAp), which addresses the health sector as a whole in planning and management, and in resource mobilization and allocation.

The SWAp is formalised in the Memorandum of Understanding signed by the Government of Uganda and key development partners (donors), including the Kingdom of Belgium. The MOU describes the obligations of the GoU and the health development partners, as well as their co-operation in the areas of planning, monitoring and review, sector reporting, financial systems, procurement and technical assistance. The project has been designed within the above framework.

5.1 MANAGEMENT MODALITIES

The project will be implemented in **co-management** i.e. the Permanent Secretary of the MoH will be the project director while the BTC Resident Representative in Uganda will be the co-director of the project, together they will be responsible for the management of the EURO account. The Director Planning will be the project manager and an international Technical Adviser appointed by BTC will be project co-manager. To support the day-to-day management of the project a Project Officer reporting to the project secretariat will be recruited.

5.2 TECHNICAL RESPONSIBILITIES

The project manager together with the Technical Adviser as co-manager will be responsible for execution of the project as described in the Specific Agreement. They will form the project secretariat and will jointly be responsible for technical, administrative, budgetary and accounting management of the project. It shall however be noted that the co-management modality differs from the classical jointly managed intervention in that the co-manager/Technical Adviser plays a more supervising role rather than a strictly implementing role with regard to release of funds and reporting on accountability. He/She still has reporting and accountability responsibilities in the co-management arrangement but his/her main functions should be to provide capacity building and giving support for achieving the projects results.

A scientific support team will support the project secretariat in its technical reflections and decisions, but has no authority on the project secretariat. Project execution and results are not their responsibilities.

ToR for the Technical Adviser and Project Officer see annex 7.3

The Steering Committee (detailed role and functions discussed below) will be required to follow annual work plans and budget. The primary function of these review meetings will be to ensure that agreed policies and principles have been followed in the planning and budgeting process.

The project secretariat will report to the Steering Committee.

5.3 LEGAL FRAMEWORK

BTC Brussels will recruit the international Technical Adviser by launching an international tender. The candidate will be selected on the basis of a joint interview between the BTC selection committee and a representative of the MoH. According to circumstances and possibilities this will either happen through a videoconference or the person of the ministry will come to BTC Brussels. The Technical Adviser should have a background in organizational development and institutional capacity building combined with a very good understanding of the health sector organisation. MoH and BTC Representation will recruit the programme officer and the driver jointly under Ugandan law. These personnel will be paid on the project's budget.

Public tendering follows Ugandan laws and regulations for goods, services (including national technical expertise) or works within the "co-management" budget lines. Items within the "BTC management" will be procured according to Belgian laws and regulations.

5.4 IMPLEMENTATION AND FOLLOW-UP STRUCTURES

5.4.1 Implementation

The project will be fully integrated into the procedures of the MoH and the annual planning and budgeting for the activities of the project will be part of the annual planning process of the MoH. The activities eligible for funding by the project shall be reflected in the relevant Departmental annual work plans and budgets. Activities targeting institutions outside the MoH will be reflected in their annual and 3-monthly work plans.

The project's year plans will be extracted from the annual work plan of the MoH and the other institutions that will be supported that year in order not to create parallel planning procedures or authority. The project secretariat will be involved in the planning exercises and negotiations for financing at the different beneficiary institutions to facilitate the full integration of project activities into the concerned health plans.

The implementation mechanism should support and reinforce the participatory planning modalities of the MoH. Open dialogue and exchange during the planning process and a pro-active communications strategy is essential and all the relevant departments/units at the MoH should be participating in the planning process to avoid monopolized and biased prioritisation.

The program will be implemented through a highly collaborative arrangement involving all relevant staff members at the targeted institutions/units. The targeted units/institutions will also be kept informed regarding resource allocation, approval of plans and the overall progress of implementation.

The implementation process will be "owned" by the MoH and targeted institution/units and assisted by technical assistance (international and national). MoH selected staff members will also assist in the implementation process.

The project manager, assisted by the Technical Adviser, will organize regular coordination meetings with heads of departments/institutions responsible for implementing of components/activities in the project.

Throughout the planning process the Technical Adviser will actively participate to the dialogue, advice on policy and capacity building issues relevant to the project's specific objective and expected results.

The project can engage in a few procurements before arrival of the technical advisor (General Means budget) in order to prepare the project.

5.4.2 Follow up structure

The MoH and the SWAP structures as defined in the Memorandum of Understanding will be used for follow up on the project. The SWAP structure includes working groups with specific technical functions take forward specific issues as need arise. They work under the overall guidance of Health Policy Advisory Committee (HPAC). Each result of the project will clearly relate to at least one of these working groups.

5.4.3 The Steering Committee

Besides the SWAP structure a steering committee will be established to guide the project.

The principal role of the Steering Committee is to ensure that the project follows the procedures and principles contained in the technical and financial file, to get aware of internal and external bottlenecks that might jeopardize the project from achieving its results and take decisions accordingly. The Steering Committee should not appear to involve itself in operational decisions within the project because this goes against national planning procedures and reduces beneficiary control over resource management. It also makes it more difficult to generalize lessons learnt to other local authorities in Uganda where no such Steering Committee exists. The detailed functions of the Steering Committee will therefore be:

- To examine and approve the project document with the Technical and Financial File (TFF) before its approval by both parties.
- To endorse the annual work plan in order to be able to foresee the necessary budgets for project financing. The content of the plans remains the responsibility of the project secretariat and eventually MoH and LG authorities that are the owners of the plans.
- To review and approve proposals for important changes in the budget like important budget shifts between results (> 15 %), or to shift budgets between co-management and Belgian management budget lines.
- To approve proposals for change in project design, policies and procedures described in the TFF to improve effectiveness of implementation. This does not include changes in activities, which will be remaining the responsibility of the project secretariat, MoH and LG and eventually the SWAp structure.
- To approve the changes in implementation modalities
- To appraise progress based on six monthly progress reports.
- To get aware of important bottlenecks jeopardizing the achievements of the project and take decisions accordingly (example: important internal or external conflicts)
- To call for audits and appraise internal and external audit reports and other monitoring reports.

- To call for mid-term and end evaluation of the project
- To approve the final report and close the project.

The Steering Committee will meet at least twice a year, preferably during June/July and December/January, corresponding to the six-monthly reporting.

It is proposed that the Steering Committee membership should include:

- A representative from the MoH (Permanent Secretary; Project Director and chair);
- A representative of the Ministry of Finance, Planning and Economic Development;
- A representative of the Ministry of Local Government
- The BTC resident representative (Co-director)

Other people can be invited. The attaché of the Belgian Embassy is member of the first steering committee meeting for approving the Technical & Financial File (TFF).

The Steering Committee will decide by consensus. The Project Management will act as the Secretariat for the Steering Committee and will provide the necessary information to its members. Each Steering Committee meeting shall be minuted and its minutes duly signed by the authorized members.

5.5 FINANCIAL RESPONSIBILITIES

5.5.1 Bank accounts and signing authorities

From the moment that the implementation agreement is signed between the Belgian State and BTC , a project EURO account will be opened at the Bank of Uganda for the co-managed funds. The Director and co-Director will jointly sign on this account.
Subsequently, BTC together with MoH will open an operational UGX account for the co-management funds. This account will be named "BTC project – co-management - Capacity building in the health sector" and shall operate by double signature:

Signature 1	Signature 2	Ceiling
Project Manager	Co-manager	12.500€
Director (Authorising officer)	Co-director (Co-authorising officer)	The ceiling depends on the internal procedures within the institutions

With regards to the direct administered funds, BTC will open a specific account entitled "BTC project – regie - Capacity building in the health sector" in EURO at a commercial bank.

5.5.2 Funds transfer

5.5.2.1 First transfer

After signing of the implementation convention between the Belgian State and BTC, a first request for funds can be done and introduced to the BTC local representative based on the action plans and the financial needs (financial planning). The requested amount should correspond to the financial needs of the first three months and will follow the BTC internal procedures.

5.5.2.2 Subsequent transfers:

To receive the following requests, the Project must introduce a cash call (by financial mode) to the BTC Representative at the beginning of the month before the next quarter. This cash call must be signed by the Project Management and approved by the Authorising Officers

The amount of the cash call is equal to the needs estimated in treasury for the following quarter with a cash buffer.

The transfer of funds by the BTC is done at the beginning of the quarter.

The subsequent transfer of the funds is done only if:

- The accounting for the previous period has been closed and has been transmitted to BTC Representative.
- An updated financial planning of the current quarter has been transmitted to BTC Representative.
- The amount of the request do not exceed the budget balance.

It is possible to submit an urgent cash call with a written explanation of the unforeseen circumstances.

The amount of the transfer equals the estimated needs of funds for the following 3 months with a reserve. The amount of the cash-call cannot exceed the budget balance.

5.5.3 Financial reporting

5.5.3.1 Accounting

The accounting of the project must be elaborated and approved following the BTC internal procedures. The accounting must be signed by the Project Manager and Co-manager and sent to the Authorising (PS) and Co-authorising Officer. (BTC representative)

The following must be forwarded by the project to the BTC Resident Representative:

- Electronic account files.
- Bank statements and signed cash statements.
- All supporting documents

5.5.3.2 Financial Planning

Every quarter, the project Management will prepare a financial planning for the current quarter and upcoming quarters of the current year and the future years.
The financial planning must be done in accordance with the BTC internal procedures and must be sent to the BTC Representation.

5.5.3.3 Reporting to the Steering Committee

At the Project Steering Committee meeting, the Project Management will present the following financial information:

- Budget monitoring reports
- Updated financial planning
- List of the main commitments
- Bank accounts statements
- List of received funds
- Budget change proposal if needed
- Action plan related to audit recommendations

5.5.4 Budget management

The total budget amount cannot be exceeded. If a budgetary increase is necessary, a justified request for increase must be introduced at the Belgian State after having received the agreement of the Steering Committee. If Belgium accepts the request, an exchange of letters between the two parties must follow.

The budget of the project gives the budgetary constraints in which the project must be carried out. The Steering Committee, on the basis of proposals worked out by the project management, must approve each change of budget. The possible budgetary changes are:

- Change of the budget structure
- Transfer of resources between existing budget lines
- Use of the reserve allocation. The budgetary reserve can only be used for project activities and after approval of the SC. Its use must always be accompanied by a change of the budget.

The management of a budget change must be made according to BTC procedures.

5.5.5 Auditing

The project and its accounts are subject to an annual external audit. The external audit has to evaluate:

- whether the accounts of the project reflect reality

- the existence and respect of procedures
- the economic and efficient use of funds

BTC and the Office of the Auditor General jointly elaborate the TOR and selection of the auditors. The external auditor has to be a certified independent company either national or international.

The audit report has to be presented to the Steering Committee. The project management has to draft an action plan related to the recommendations of the audit.

The Steering Committee can require additional audits if necessary.

5.5.6 Execution agreements

In case decentralized funds administration is considered, execution agreements will be signed at the decentralised level for the execution of certain activities.

The execution agreements will take into account following aspects :

- description of activities and related budget
- quarterly transfer of funds to a specific account based on justification and financial planning
- quarterly progress reports
- quarterly financial planning and budget follow-up
- monthly justification of financial transactions (bank statements, supporting documents)
- annual audit (financial and internal control system)
- commitments and payments above 5.500 EUR are done centrally (double signature BTC and Uganda).
- stipulations about eligibility of funds

These conditions may be reviewed after an assessment of the maturity of the management.

5.6 PROCUREMENT

The procurement will be carried out using the institutional set up at the MoH. All procurement will be done in conformity with the Public Procurement and Disposal of Assets (PPDA) Act in 2003, which provides the legal framework for procurement activities by all public institutions.
The project shall manage procurement.

A non-objection on the following procurement steps is required:

- ✓ Before publication of tenders (contribution to technical specifications/terms of reference)
- ✓ At tender awarding
- ✓ At the provisional and final appraisal/acceptance of the completion of works, services or deliveries.

5.7 Modification of the TFF

The project management can decide on minor changes in the TFF and the project budget. However changes which would affect the specific objective, the total budget or the duration of the specific agreement can be proposed by the steering committee and would have to be followed by an exchange of letters.

Changes in budget line from co-management to management under Belgian laws and regulations or vice versa shall be approved by the steering committee.

5.8 Reporting and monitoring and evaluation

Reporting and monitoring will be an integral component of implementing the project. It will be carried out at different levels: MoH, hospital and (sub-) district level.

Key Performance Indicators described in chapter 3.4.1 will be used to measure progress during annual progress reporting and mid-term and final evaluation.

The steering committee will hold bi-annual and annual project reviews based on half-year and annual progress and financial reports compiled by the project manager and the Technical Adviser.

A mid-term project review will be held after two years of project implementation. This independent exercise, led by an external evaluator, will aim at drawing lessons from the progress made and at refocusing project strategies to the objectives for the remaining years. The mid-term review will be executed following the procedures developed by BTC.

5.9 End-of-project preparation

The project will have a lifespan of four years. The Steering Committee decides on the closure process six months before the end of the project. The project management in consultation with the Technical Adviser will submit a final narrative, technical and financial report to the Steering Committee. The Steering Committee will meet not later than one month before the end of the project in order to examine and approve the final draft report of the project according to BTC regulations.

An external end evaluation will be carried out to evaluate the achievements of the project. The Steering Committee will ensure that an end evaluation will be carried out through which it can draw lessons for others and/or future projects.

5.10 Closure of the project

After having fulfilled the requirements to end the project, the signatories to the account will officially close the account.

Equipment purchased within the ‘co-management’ budget lines will be property of the relevant institution throughout the project and beyond. However, equipment under ‘BTC management’ remains BTC property during the project’s lifespan and will be handed over to the MoH at the end of the project.

6. CROSS CUTTING THEMES

6.1 ENVIRONMENT

The activities in the project will have limited impact on the environment.

6.2 GENDER

Uganda adopted in 1997 a National Gender Strategy followed by a National Action Plan on Women. This action plan was updated in 2007. The overall goal is to achieve gender equality and women's empowerment as an integral part of Uganda's socio-economic development. The strategy makes explicit reference to human rights treaties and relevant international consensus documents, as well as regional charters and consensus documents. Linkages are made between the high maternal mortality and the rights of women. There is also mention of the problems of the young people, especially pregnancy among girls and livelihood issues. The strategy also explicitly covers gender and rights, gender and governance issues, and gender and macro-economic management.

Gender is an important social determinant of health and development as it shapes the social norms that regulate the behaviour of men and women and value placed on them by society. Gender roles and relations directly and indirectly influence the level and quality of the utilisation of health services. This has been recognised in the National Health Policy and gender mainstreaming is premised on one of the guiding principals reading that "a gender-sensitive and responsive national health system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programmes."

To inform the mid term review of the HSSP II a study on human rights and gender equality was commissioned by the MoH. The main focus of the study was to describe and assess: the status of human rights and gender equality within the context of HSSP II planning and reporting at the national and local government levels; the processes and mechanisms for strengthening human rights and gender structures within the health sector; HSSP II indicators and targets; and making recommendations regarding strengthening the operations of health and human rights and gender equality.

One part of the study was to assess the planning processes at national and local government levels to establish how human rights & gender equality aspects were addressed and recognized. Overall the MoH planning process is mainly guided by two sets of planning guidelines; by the Ministry of Local Government (MoLG) (2006/07) and supplementary guidelines from MoH (June 2007). These guidelines clearly spell out gender based planning and budgeting, which is also a prerequisite for receiving funds from Ministry of Finance Planning and Economic Development. Although gender issues were reported to have taken a centre stage in planning and budgeting at all levels, the concept was still found to be difficult to comprehend and put into practice. It was found evident that the districts could not conceptualise gender and human rights concepts and lacked entry points for human rights and gender based planning and budgeting for health.

There are several opportunities in the project to assist in the conceptualisation of the gender and human rights concepts both at national and LGs levels. Among these are:

1. to impart skills by health service managers to identify gender issues and how to plan to address them;
2. to develop knowledge and understanding by health service managers on gender issues to

be considered in the daily running of health services.

During the implementation of the project consideration will also be taken to other relevant guiding documents on gender mainstreaming.

The project proposes specific maternal health indicators

6.3 SOCIAL ECONOMY

In 2008/09 Uganda has a projected population of 32.2 million persons and with a population growth rate of 3.2% the population is estimated to rise to 44 million by 2020.

88 % of the population lives in rural areas.

The percentage of the population living below the poverty line was 31 % in 2005. Poverty continues to be a rural phenomenon with 96% of the poor living in rural areas in 2004/05. Regional disparities still exist with the north lagging behind most of the country, followed by the Eastern region.

A direct relationship exists between poverty and prevalence of diseases such as malaria, malnutrition and diarrhoea as they are more prevalent among the poor compared to the rich households (Uganda bureaus of Statistics, 2007).

The vision of the NHP is "A healthy and productive population that contributes to socio-economic growth and national development" and the goal "to attain a good standard of health for all people in Uganda in order to promote a healthy and productive life".

The project is expected to contribute to this goal in an indirect way by strengthening planning and management capacity among leaders and managers to adhere to these national priorities. Without decreasing child mortality in a country, demographic transition is not possible. The project is concentrating on strengthening peripheral health services, through capacity building at the HSD level (results 4 and 5). This is the best way to fight against child mortality in the health sector.

6.4 CHILDREN'S RIGHTS

The Government of Uganda has ratified the convention on the Rights of the Child in 1990. In 2003 a report was submitted to the Committee on the Rights of the Child in 2003. Some of the recommendations from the Committee in 2005 are health related, including:

- to take all necessary measures to strengthen programmes for improving health care by, inter alia, supporting these programmes with adequate resources and paying particular and urgent attention to mortality rates, vaccination uptakes, nutrition status, and management of communicable diseases and malaria;
- to provide children with disabilities with access to adequate social and health services;
- to ensure that professionals working with and for children with disabilities, including medical and paramedical personnel, are adequately trained;
- to prevent discrimination against children infected with and affected by HIV/AIDS
- to undertake comprehensive study to assess nature and extent of adolescent health problems and, with participation of adolescents, use it as basis to formulate adolescent health policies and programmes with particular focus on prevention of early pregnancies and sexually transmitted infections, especially through reproductive health education

- to provide street-children with adequate health-care services

As already mentioned under 'social economy', the project will contribute to the fight against child mortality and childhood disease, by concentrating efforts on the peripheral health facilities where the bulk of sick children consult. Investing in the support supervision and in the referral system are other means (the latter in a direct way) to fight child mortality. A weak referral system has in the first place an impact on children because evacuation of children is the least socially accepted.

The project will also insist that the MoH, like they did previously, always is evaluating its national plans against the children's rights, just like for gender issues.

6.5 HIV / AIDS

Uganda has been badly hit by the AIDS epidemic. Thanks to relatively early action in the field of information and prevention, the AIDS prevalence has come down. In the meanwhile, therapy for AIDS-affected people has become increasingly accessible in the country and is contributing to the decrease of the disease burden.

The project will not get directly involved into the AIDS problematic of the country. But beyond any doubt, strengthening the HSDs and the hospitals in their management and planning skills, will have an impact on the way the national AIDS programme will be run and planned for. It will further help to decentralize effectively the therapy opportunity in favour of the poor.

By strengthening the routine services, the integration of this heavily subsidised programme will be made possible. This is the only way the fight against AIDS can be sustained in the long run. In the demonstration HSDs, the question on how to better integrate the fight against AIDS will get the necessary attention.

7. ANNEXES

7.1. Logical Framework
7.2. Chronogram
7.3. Terms of Reference for personnel engaged in the context of the project:
7.4. ToR for missions at the start of the project
7.5. Management tools, Master and Coverage plan

7.1 LOGICAL FRAMEWORK

	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
General objective: "To improve effective delivery of an integrated Uganda National Minimum Health Care Package"			
Specific objective: The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels			
Result 1:The Ministry of Health is strengthened in its organisational and institutional capacity	• Reform plan in execution • Number of people trained by the project • Number of field visits for ➢ Coverage plan development ➢ Master plan designing ➢ Procedures manual identification • MoH Procedures manual in place • Support supervision policy paper renewed • Established procedures for training coordination	• Project Progress reports • Procedures manual • Planning manual • Annual work plan for the MoH • Framework for support supervision • Evaluation reports • Meeting minutes • Interviews	• Sanction/approval by the top and senior management at the MoH to conduct the activities required. • Availability and interest and willingness by MoH top managers and senior managers to participate and cooperate
Result 2: One selected regional referral hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity	• Strategic plans incorporating master plans in place • Hospital mandate reflects efforts for complementary role definition • Number of support supervisions realised respecting new policy in the matter • Number of people trained	• Project Progress reports • Strategic plans • Master plans • Annual work plans • Evaluation reports • Meeting minutes	• Sanction/approval by the MoH and district authorities to conduct the activities required. • Availability and interest and willingness by hospital managers to participate and cooperate
Result 3: One further regional referral hospital (Arua) and two additional	• Strategic plans incorporating master plans in place • Hospital mandate reflects efforts for complementary role definition	• Project Progress reports • Strategic plans • Master plans	• Sanction/approval by the MoH and district authorities to conduct

	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity	• Number of support supervisions realised respecting new policy in the matter • Number of people trained	• Annual work plans • Evaluation reports • Meeting minutes	the activities required. • Availability and interest and willingness by hospital managers to participate and cooperate
Result 4: District management teams are strengthened in their managerial capacity, leadership and planning functions	• Number of people trained • Number of support supervisions to GH realised • Number of support supervisions to HSDMT realised • Strategic plan developed, followed and discussed with LG • Level of understanding of coverage and master plans for strategic planning	• Project Progress reports • Minutes from meetings • Annual work plans. • Evaluation reports • Interviews	• Sanction/approval by the District authorities to conduct the activities required. • Key stakeholders willing to cooperate
Result 5: A comprehensive approach on capacity building of sub-district management teams is operational.	• Number of HSDMT members trained • Coverage plans, master plans and procedures manual reflected in strategic and yearly plans • Coverage plans discussed with LG authorities • Number of HSDMT meetings held • Number of HC II and III supervised by HSDMT	• Project Progress reports • Minutes from meetings • Annual work plans and reports • Coverage plans • Master plans • Evaluation reports	• Sanction/approval by the MoH to conduct the activities required. • Key stakeholders willing to cooperate
Result 6: Two training centres/demonstration sites for capacity building of health sub-district management teams are functional	• Number of HSDMT members trained in training centres • Number of training sessions held • Number of HC II and II up to quality standard for receiving trainees • Evaluation of the first 2 years of functioning • Status training centres clarified	• Training sessions evaluation reports • Project Progress reports • Field visits and observation • Evaluation report • Interviews • Policy note	• Sanction/approval by the MoH and district authorities to conduct the activities required. • Identified HSDs/ key stakeholders willing to cooperate
Result 7: A scientific support team accompanies the capacity building process in the Ugandan health sector	• Policy paper on support supervision refined and approved • Policy paper on referral system refined and approved • Complementary roles of health facilities better defined and approved in policy paper • Continuous training policy for health personnel refined	• Evaluation reports • Minutes from meetings/seminars • Policy documents • Interviews	

N°	ACTIVITIES	MEANS	COST (Euro)
Result 1 **The ministry of health is strengthened in its organisational and institutional capacity**	1. Taking into account the recent initiatives already taken in this field, the MoH engages in a capacity assessment and capacity building exercise with a specific focus on leadership, management and planning. 2. Based on the conclusions of the capacity assessment exercise, the MoH provides individual in-service trainings for several of its staff members and creates the material environment needed to support capacity. 3. Develop a procedures manual for the MoH 4. The MoH reviews and updated its support supervision framework. 5. The MoH coordinates all efforts in the field of capacity building in the areas of management, leadership and planning 6. The MoH implements its policy on the use of technical assistance in the sector including the modalities for creating a pooled funding mechanism. 7. The MoH designs a policy and provides modules specific for each type of health facility enabling the organisation of introduction periods for newcomers in management positions in the system. 8. The MoH organises the monitoring and two-yearly evaluation of the progress.	International and national consultants MoH staff Transport Stationeries	627 855
Result 2 **One selected regional referral hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity**	1. The three hospitals engage in a capacity assessment exercise 2. The three hospitals go through an organisational reform process based on the capacity assessment results 3. Assist the hospitals in the development of a procedures manual 4. Assist the hospitals in the development of a strategic plan taking into account the results of the institutional capacity assessment 5. Assist the hospitals in their yearly planning exercise taking into account the strategic plan and the result of the institutional capacity assessment. 6. Develop a master plan for each hospital 7. The hospitals organise the monitoring and two-yearly evaluation of the progress 8. Presenting experiences and results in a training workshop for hospital management teams and MoH	International and National consultants MoH staff members Transport Stationary	761 625
Result 3: One further regional referral hospital (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional capacity	1. The three hospitals engage in a capacity assessment exercise. 2. The 3 hospitals go through an organisational reform process based on the capacity assessment results. 3. Assist the hospitals in the development of a procedures manual. 4. Assist the hospitals in the development of a strategic plan taking into account the results of the institutional capacity assessment. 5. Assist the hospitals in their yearly planning exercise taking into account the strategic plan and the result of the institutional capacity assessment. 6. The hospitals organise a monitoring and evaluation workshop. 7. Develop a master plan for each hospital.	National consultants MoH staff members Transport Stationary	511 350

Result 4: District management teams are strengthened in their managerial capacity, leadership and planning functions	1. Districts are engaging in an institutional capacity assessment. 2. Districts accompany general hospitals in their capacity assessment and building process. 3. Districts accompany HSD management team in their capacity assessment and building process. 4. District develop and negotiate with the LG authorities a strategic plan taking based on the results of the HSD and GH capacity building plans including the coverage and master plans developed at that level.	International and national consultants Transport Stationary	220 200
Result 5: A comprehensive approach on capacity building of sub-district management teams is operational.	1. Support the ongoing capacity building for HSD management teams based on the modules developed by MoH/WHO. 2. 10 HSDs (+ related district) engage in a capacity assessment exercise (Five HSDs per catchments area of the RRHs under result 2 and 3). 3. The HSDs engage in an organisational reform process based on the capacity assessment results. 4. The HSDs are supported by the MoH in the first year plan following the assessment. 5. The HSDs organise the monitoring and an evaluation workshop after 2 years of implementation. 6. Develop a coverage plan for 10 HSDs. 7. Develop a master plan for each HC IV. 8. MoH capitalises the experiences and translates them into the sector policy.	National Consultants Trainers	1 916 675
Result 6: Two regional training centres for capacity building of health sub-district management teams are functional	1. Build training facilities and equip for receiving a maximum of 15 participants and 2 outside trainers at a time 2. Based on previous activities formulate a comprehensive approach for further capacity building activities for HSD and district management teams 3. Establish training modules and programmes 4. The HC and hospital(s) that will receive course participants for their practical training are prepared and work up to standards 5. Organise 3 training sessions with each 12 participants in a first year in the two centres 6. The MoH defines a long-term status and a sustainable financing mechanism for the centres starting from a thorough evaluation of the impact of the course on HSDMT"s management performance	National consultants Architect expertise Construction materials transport	1 113 200
Result 7. A scientific support team accompanies the capacity building process in the Ugandan health sector	1. An external expert team composed of national and international experts supports the MoH in organising the capitalisation process between the operational and policy level of the MoH. 2. Organise the policy dialogue between the operational and policy level of the MoH.	International and national consultants transport	256 800

7.2 CHRONOGRAM

UGA0901711 **Institutional capacity building in planning, Leadership and management in the Ugandan health sector project**

Budget Code	Results/activities	Year 1 Q1	Year 1 Q2	Year 1 Q3	Year 1 Q4	Year 2	Year 3	Year 4
A 01 The Ministry of Health is strengthened in its organisational and institutional capacity								
A_01_01	Taking into account the recent initiatives already taken in this field, the MoH engages in a capacity assessment and capacity building exercise with a specific focus on leadership, management and planning.			■	■	■		
A_01_02	Based on the conclusions of the capacity assessment exercise, the MoH provides individual in-service trainings for several of its staff members and creates the material environment needed to support capacity.					■	■	
A_01_03	Develop a procedures manual for the MoH					■		
A_01_04	The MoH reviews and updated its support supervision framework.				■	■		
A_01_05	The MoH coordinates all efforts in the field of capacity building in the areas of management, leadership and planning		■	■	■	■	■	■
A_01_06	The MoH implements its policy on the use of technical assistance in the sector including the modalities for creating a pooled funding mechanism.			■	■			
A_01_07	The MoH designs a policy and provides modules specific for each type of health facility enabling the organisation of introduction periods for new-comers in management positions in the system.				■	■		
A_01_08	The MoH organises the monitoring and two-yearly evaluation of the progress.						■	■
A 02 One selected regional referral hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity								
A_02_01	The three hospitals engage in a capacity assessment exercise					■		
A_02_02	The three hospitals go through an organisational reform process based on the capacity assessment results					■		
A_02_03	Assist the hospitals in the development of a procedures manual					■		
A_02_04	Assist the hospitals in the development of a strategic plan taking into account the results of the institutional capacity assessment					■		
A_02_05	Assist the hospitals in their yearly planning exercise taking into account the strategic plan and the result of the institutional capacity assessment.					■		
A_02_06	Develop a master plan for each hospital					■		
A_02_07	The hospitals organise the monitoring and two-yearly evaluation of the progress						■	
A_02_08	Presenting experiences and results in a training workshop for hospital management teams and MoH						■	
A 03 One further regional referral hospital (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity								
A_03_01	The three hospitals engage in a capacity assessment exercise.						■	
A_03_02	The three hospitals go through an organisational reform process based on the capacity assessment results.						■	■
A_03_03	Assist the hospitals in the development of a procedures manual.						■	
A_03_04	Assist the hospitals in the development of a strategic plan taking into account the results of the institutional capacity assessment.						■	
A_03_05	Assist the hospitals in their yearly planning exercise taking into account the strategic plan and the result of the institutional capacity assessment.						■	
A_03_06	The hospitals organise a monitoring and evaluation workshop.							■
A_03_07	Develop a master plan for each hospital.						■	

A 04 District management teams are strengthened in their managerial capacity, leadership and planning functions								
A_04_01	Districts are engaging in an institutional capacity assessment.							
A_04_02	Districts accompany general hospitals in their capacity assessment and building process							
A_04_03	Districts accompany HSD management team in their capacity assessment and building process.							
A_04_04	District develop and negotiate with the LG authorities a strategic plan taking based on the results of the HSD and GH capacity building plans including the coverage and master plans developed at that level.							
A 05 A comprehensive approach on capacity building of HSD management teams is operational.								
A_05_01	Support the ongoing capacity building for HSD management teams based on the modules developed by MoH/WHO.							
A_05_02	10 HSDs (+ related district) engage in a capacity assessment exercise (Five HSDs per catchments area of the RRHs under result 2 and 3).							
A_05_03	The HSDs engage in an organisational reform process based on the capacity assessment results.							
A_05_04	The HSDs are supported by the MoH in the first year plan following the assessment.							
A_05_05	The HSDs organise the monitoring and an evaluation workshop after 2 years of implementation.							
A_05_06	Develop a coverage plan for 10 HSDs.							
A_05_07	Develop a master plan for each HC IV							
A_05_08	MoH capitalises the experiences and translates them into the sector policy.							
A 06 Two training centres/demonstration sites for capacity building of HSD management teams are functional								
A_06_01	Build training facilities and equip for receiving a maximum of 15 participants and 2 outside trainers at a time							
A_06_02	Based on previous activities formulate a comprehensive approach for further capacity building activities for HSD and district management teams							
A_06_03	Establish training modules and programmes							
A_06_04	The HC and hospital(s) that will receive course participants for their practical training are prepared and work up to standards							
A_06_05	Organise 3 training sessions with each 12 participants in a first year in the two centres							
A_06_06	The MoH defines a long-term status and a sustainable financing mechanism for the centres, based on the findings of an in-depth evaluation of the impact of the courses on the management performance of the SDHMT							
A 07 A scientific support team accompanies the capacity building process in the Ugandan health sector								
A_07_01	An external expert team composed of national and international experts supports the MoH in organising the capitalisation process between the operational and policy level of the MoH.							
A_07_02	Facilitate the policy dialogue between the operational and policy level of the MoH.							

7.3 TERMS OF REFERENCE FOR PERSONNEL ENGAGED IN THE CONTEXT OF THE PROJECT:

7.3.1 Justification

The project will support the MoH in a vast capacity building effort in order to strengthen the health system globally. Therefore the project will engage an international expert with the profile of a senior public health physician with a vast experience in institutional capacity building, health system's strengthening and who has been working at the level of a MoH. He will occupy the function of co-manager in cadre of the execution modalities in this project.
Besides this expert, the project will pay a project officer to support the financial and administrative procedures.

7.3.2 An international Technical Adviser in capacity building.

Functions – tasks

- Work closely and continuously with the assistant project coordinator with regard to all technical and financial issues of the project. He will work through consensus building, principally with the assistant project coordinator
- Responsible for the co-management procedures in the project
- actively assist in the planning and budgeting of activities
- support coordination with all stakeholders
- support the MoH in its efforts to coordinate all capacity building activities in the field of management, leadership and planning
- actively assist in capacity building
- participate in the development of a M & E system
- Support the MoH in capitalising experiences generated at the operational level and translate them in a national policy
  participate in activities to improve the quality

Profile

- Qualifications
  - Degree in Medicine
  - Degree in Public Health

Other degrees can be considered if long-term experiences prove equivalence in competence.

- Experience
  - At least 10 years in the field of public health and health service organisation of which at least 5 years in development countries.
  - Experience in institutional support and work at a ministry's level.

- Experience in effective management of health care facilities (HSD management).

- Other

  - Good knowledge of computer tools.
  - Familiar with Action Research.
  - Able to initiate new ideas, discuss and question them.
  - Combine analytical skills with good interpersonal skills.
  - Good communication skills (negotiation, moderation, representation, presentation of results).
  - Excellent in oral and writing skills in English.

Location

The candidate will reside in Kampala and its main field of activity will be within the MoH (70%) and field visits in hospitals and HSDs (30%).

Duration

The position is open for the period of funding: four years.

Selection procedure

BTC Brussels will recruit the ITA by launching an international tender. The candidate will be selected on the basis of a joint interview between the BTC selection committee and a representative of the MoH. According to circumstances and possibilities this will either happen through a videoconference or the person of the ministry will travel to BTC Brussels. The test will also contain questions to be answered in writing.

Contract specification

The contract is managed by the BTC under Belgian law.

In order to assist the International technical adviser, the project will also pay for a project officer. This cadre will be recruited by the MoH with non-objection from BTC and contracted by MoH (under Ugandan law), but paid by the project budget.

7.3.3 Project Officer

The Project Officer will cooperate closely with the Technical Adviser, will assist with all issues related to the management of the project and will refer to the Technical Adviser.

Tasks:

- Support the assistant project manager and technical adviser in planning and executing the project budget;
- Support the planning and budgeting process;

- Check the respect of budgeting norms in all activity proposals;
- Support the procurement process in the following ways:
    - Advise on and assist in preparing tender dossiers by the project
    - Monitor implementation of contracts
    - Liaise with the BTC representation administrative staff
- Support strengthening of the MoH financial management system by using the national procedures and working in close collaboration with MoH administrative and financial staff;
- Support the cash call process and financial reporting of the project for BTC;

Profile

- Qualifications
    - Degree public administration and financial management
- Experience
    - At least 5 years experience in financial and administrative management. Specific project management in these areas is a plus.
- Other
    - Good knowledge of computer tools
    - Able to initiate new ideas, discuss and question them
    - Good communication and interpersonal skills (negotiation, moderation, representation, presentation of results)
    - Excellent in oral and writing skills in English

Location

The candidate will reside in Kampala and will work in the MoH.

Duration

The position is open for the period of funding: four years.

Selection procedure

Recruited by a national tender by HR department in the MoH. The candidate will be selected jointly by MoH and BTC through written and oral tests.

Contract specification

The MoH manages the contract under Ugandan legislation. The salary will be paid for by the project's budget.

7.4 ToR for missions at the start of the project

No missions at the start of the project have been found necessary to take place.

7.5 Management tools, Master and Coverage plan

7.5.1 Master Plan

Master plans include an architectural plan of existing health facilities (essentially hospitals) and an architectural plan that projects the development of the facility in future, respecting the norms defined by the MoH. Such plans allow hospitals to plan for capital investments and to negotiate them with the MoH, local governments and the donor community in order to develop the facility in a rational and systematic way and not on the basis of uncoordinated ad hoc opportunities. It helps the institutions to project their material and personnel needs over time.

These plans should look into the patient flow and the (re-) interpretation of the designation of existing buildings, needs for rehabilitation or environmental aspects and electricity and water supply.

Master plans are developed through the close collaboration of hospital managers, public health specialists and architects. The plans take into account the populations to be covered (link with coverage plans), the referral system and the norms defined by the MoH.

The MoH foresees master plans for the hospitals in its policy and could realise a few already. The project will support the MoH to develop several more master plans for referral hospitals, general hospitals and for HC IV facilities that are meant to evolve towards a HSD hospital.

Norms and standard plans exist for HC IV. The master plans should allow the standard plans to be adapted to the local circumstances (for instance population to be covered, proximity of other hospitals or existing buildings and equipment).

For the lower health facilities (HC II and III), standard plans at the Ministry's level exist which take into account the minimal care package these centres should provide with explicit norms of 'useful surfaces' that should not be exceeded. In the coverage plan for the HSDs, existing HC facilities should be compared with these norms to allow for proper adjustments where needed.

7.5.2 Coverage plans

Coverage plan***s*** can be defined as a map with the location of all health structures (government and Private not for Profit (PNFP), including the coverage populations and the staffing levels. The plan should be completed with a second map projecting the implementation of new and the evolution of existing health facilities. The maps should include the covered populations in the areas of responsibility. The maps should go together with a plan for HR needs estimations per facility and stocktaking of available equipment and needs according to the existing norms. Use of these plans should be integrated in yearly planning procedures of for instance sub-districts. It will be part of the capitalisation process in the project to conceptualise this process and to describe how coverage plans can be incorporated routinely in planning of health districts.

Such plans should be available at the ministry's level, but should exist at every HSD level. It is a tool for programming infrastructure and equipment investments, Human Resource (HR) planning in short and long-term and a negotiation tool with the donor community and (local) politicians. They avoid at hoc investments. They also permit in particular to contribute to the dilemma in many HSDs whether the HC IV should be further developed into a full HSD hospital or should be rather downgraded towards a HC III facility for an urban area.

At the HC level, the maps should identify which HC II facilities should be developed further to HC III facilities depending on the coverage of maternity services in the area.

The project will support several HSDs to develop such plans. At least in the training HSDs, the coverage plans should be fully utilised for the year planning, for the planning of supervision visits, for the planning of investments and HR needs.