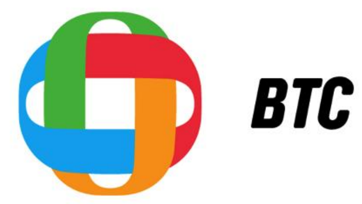

# RESULTS REPORT 2014

## UGA 0901711 - INSTITUTIONAL CAPACITY BUILDING IN PLANNING, LEADERSHIP & MANAGEMENT IN THE HEALTH SECTOR IN UGANDA

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# Acronyms

| | |
|---|---|
| AHSPR | Annual Health Sector Performance Report |
| BTC | Belgian Technical Cooperation – Belgian Development Agency |
| DHO | District Health Officer / Office |
| DHS(P&D) | Director Health Services (Planning & Development) |
| DLG | District Local Government |
| DMT | District Management Team |
| EA | Execution Agreement |
| GH | General Hospital |
| G&HHR | Gender & Health Human Rights |
| GFATM | Global Fund for AIDS, Tuberculosis and Malaria |
| GLM | Governance, Leadership and Management |
| HC IV | Health Centre level IV |
| HDP | Health Development Partner |
| HPAC | Health Policy Advisory Committee |
| HPD | Health Planning Department |
| HSD | Health Sub-District |
| HSS | Health Systems Strengthening |
| HSSIP | Health Sector Strategic & Investment Plan |
| HW | Health Worker(s) |
| ICB | Institutional Capacity Building |
| JLCB | Joint Local Consultative Body (Steering Committee) |
| JRM | Joint Review Mission / Meeting |
| M&E | Monitoring & Evaluation |
| MOH | Ministry of Health |
| MOFPED | Ministry of Finance, Planning and Economic Development |
| MOLG | Ministry of Local Government |
| NDP | National Development Plan |
| NRH | National Referral Hospital |
| PC | Project Coordinator |
| PLM | Planning, Leadership & Management |
| PNFP | Private – Not – For - Profit |
| PS | Permanent Secretary |
| QAD | Quality Assurance Department |
| R-PIC | Regional Project Implementation Committee |
| RRH | Regional Referral Hospital |
| SBS | Sector Budget Support |
| SC | Steering Committee |
| SIP | Strategic & Investment Plan |
| SIDA | Swedish International Development Agency |
| TSMC | Top Senior Management Committee (MOH) |
| TWG | Technical Working Groups (MOH) |
| UHSSP | Uganda Health Systems Strengthening Programme |

# 1 Intervention at a glance (max. 2 pages)

## 1.1 Intervention Form

| | |
|---|---|
| **Intervention title** | **"Institutional Capacity Building in Planning, Leadership & Management in the health sector in Uganda"** |
| **Intervention code** | **UGA 0901711** |
| **Location** | **Uganda – Ministry of Health** |
| **Total budget** | **EUR 8,008,350=00** |
| **Partner Institution** | **Ministry of Health Uganda** |
| **Start date Specific Agreement** | **19/12/2009** |
| **Date intervention start /Opening steering committee** | **16/06/2010** |
| **Planned end date of execution period** | **30/11/2015** |
| **End date Specific Agreement** | **10/12/2015** |
| **Target groups** | MOH HQ, RRH & GHs, DMT & HSD MTs, HWs |
| **Impact**[1] | To improve effective delivery of an integrated Uganda National Minimum Health Care Package. |
| **Outcome** | Improved organizational and institutional performance of the Ministry of Health HQ and the health institutions in the two selected regions |
| **Outputs** | 1. The Ministry of Health is strengthened in its organizational and institutional capacity. |
| | 2. Institutional capacity is developed in the health sector in Rwenzori and West Nile regions at all levels (i.e. regional coordination, RRH's, Districts, General Hospitals and Health Sub-Districts). |
| | 3. The training needs in L&M of the health sector are strengthened through transformation of the Health Manpower Development Centre (HMDC) and the establishment of two regional training satellite centres. |
| | 4. Capitalization and Scientific Support accompanies the capacity building process in the Ugandan health sector |
| | |
| **Year covered by the report** | January – December 2014 |

[1] Impact refers to global objective, Outcome refers to specific objective, output refers to expected result

## 1.2 Budget execution

| Outputs | Budget line | Budget | Cumulative Expenditure | | | Balance | |
|---|---|---|---|---|---|---|---|
| | | | Start to end 2013 | Start to end 2014 | Exp 2014 | | Cumulative Execution rate 2014 |
| **Total** | | | | | | | |
| **Output 1** | A-01 (Q1-3 2013) | 491,518 | 491,518 | 491,518 | - | - | 100.0% |
| | B-01 (Q4 2013) | 498,500 | 23,186 | 271,019 | 247,833 | 227,481 | 54.4% |
| | | | | | | | |
| **Output 2** | A-02 (Q1-3 2013) | 529,833 | 529,833 | 529,833 | - | - | 100.0% |
| | A-03 (Q1-3 2013) | 461,432 | 461,432 | 461,432 | - | - | 100.0% |
| | A-04 (Q1-3 2013) | 178,973 | 178,973 | 178,973 | - | - | 100.0% |
| | A-05 (Q1-3 2013) | 343,088 | 343,088 | 343,088 | - | - | 100.0% |
| | B-02 (Q4 2013) | 3,319,955 | 249,081 | 1,663,459 | 1,414,378 | 1,656,496 | 50.1% |
| | | | | | | | |
| **Output 3** | A-06 (Q1-3 2013) | 36,735 | 36,735 | 36,735 | - | - | 100.0% |
| | B-03 (Q4 2013) | 385,000 | 11,794 | 105,315 | 93,521 | 279,685 | 27.4% |
| | | | | | | | |
| **Output 4** | A-07 (Q1-3 2013) | - | - | - | | | |
| | B-04 (Q4 2013) | 25,000 | - | - | | 25,000 | 0.0% |
| | | | | | | | |
| **Management Revenue** | W_01_01 | 137,123 | - | - | - | 137,123 | 0.0% |
| **General means** | Z-01 | 1,210,725 | 608,322 | 917,634 | 309,312 | 293,091 | 75.8% |
| | Z-02 | 71,776 | 65,927 | 72,880 | 6,953 | -1,104 | 101.5% |
| | Z-03 | 148,909 | 83,064 | 112,261 | 29,197 | 36,648 | 75.4% |
| | Z-04 | 169,667 | 87,522 | 97,546 | 10,024 | 72,121 | 57.5% |
| **VAT** | Z_10 | - | - | 20,188 | 20,188 | -20,188 | |
| **Conversion rate adj.** | | 116 | 109 | 109 | - | 7 | |
| **Total** | | **8,008,350** | **3,170,584** | **5,301,990** | **2,131,406** | **2,706,360** | **66.2%** |

## 1.3 Self-assessment performance

The Mid Term Review (May 2013) recommended a number of changes to improve the project performance as scored on the quality criteria. A project reformulation took place in July 2013 to address the recommendations made, which was approved by the project Steering Committee in September 2013.

The scoring on the four criteria in the 2014 Results Report, is the conclusion of a joined critical review of the project performance[2]:

### 1.2.1 Relevance

| | Performance |
|---|---|
| **Relevance** | B |

Conclusion Mid Term Review Report (May 2013): *"Strengthening and building of institutional capacities and leadership is very **relevant**. It meets a genuine need and corresponds to the stewardship objective of the HSSIP».* Score Results Report 2013: A.

The relevance of the project over 2014 is assessed positive as its logic and implementation are embedded within existing structures.

- Positive feedback from beneficiaries at central and regional level
- Execution Agreements aligned to HSSIP and DLG workplans
- Positive impact of ambulance system on district and regional referral system
- Flexible, adaptive project logic
- Indicators logical framework not optimal for measuring relevance
- Insufficient central level commitment to some ICB supported activities (e.g. regional health level development, health financing strategy, restructuring process).

### 1.2.2 Efficiency

| | Performance |
|---|---|
| **Efficiency** | B |

Conclusion MTR (May 2013): *« The project **efficiency** is low, though improving. The project started off slowly in the first year until the entire MoH top management was replaced. Though financial disbursements were low during this period, the project consistent engagement with the MoH contributed to its organizational change process. The technical review mission held in April 2011 provided a much needed reorientation in implementation modalities, especially with the creation of a central and two regional implementation committees which meet quarterly, the appointment of a new project coordinator at the rank of Director (Planning & Development), and the geographic expansion to two full regions, where service delivery is supposedly integrated».* A number of factors effecting efficiency have been addressed during the reformulation, which resulted in a higher score for 2013. Score Results Report 2013: B.

The efficiency of the project over 2014 is assessed positive, with the introduction of execution agreements and a high implementation and execution rate. The following issues are noted:

Management of inputs:

- The project demonstrates a focus on efficiency and value-for-money, as noted by district

[2] Result Report workshop with regional stakeholders on 5 & 6 January 2015

leaders during formulation of Execution Agreements and development of workplans.
- Execution rate over 2014 (on Financial Planning Q1 2014) is at 94 % (Co-Management 76 %; BTC Management 112%)
- Good and adequate use of project assets (e.g. vehicle assessment report, theatre tables)
- Project execution not optimal due to delayed accountability at all levels
- Project funding delays through BOU (eBanking) and IFMIS (district level)

Management of activities:
- Execution delays have reduced over time
- Mostly efficient implementation at district level of activities under Execution Agreements
- Delays in status change HMDC could compromise achievement of objectives
- Central level delays due to capacity constraints as well as complicated structures and procedures could compromise achievement of project results (e.g. regional health level development.

Outputs achieved:
- Regional Project Officers recruited and available at regional level.
- Two cohorts of Governance, Leadership and Management Course completed (>300 managers) with very positive feedback from beneficiaries
- Regional Project Implementation Committee meetings in both regions organized as scheduled and well attended
- Execution Agreements with 15 districts and 2 Regional Referral Hospitals signed in 2014
- Procurement plan implemented and assets delivered to MOH, HMDC, hospitals and DHOs.
- Capitalization of project experiences (Output 4) did not yet take place.

### 1.2.1 Effectiveness

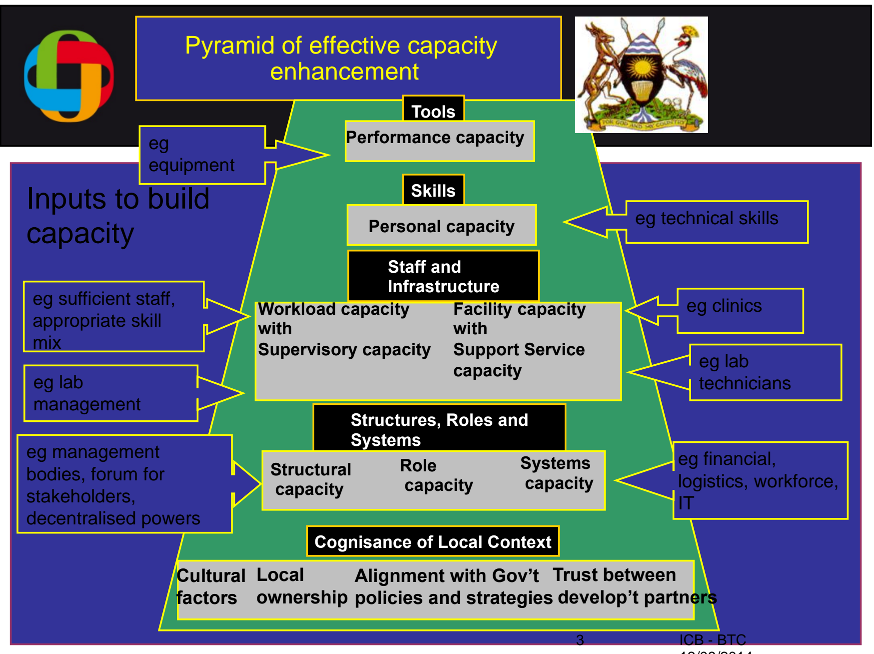
| | Performance |
|---|---|
| **Effectiveness** | A |

Conclusion MTR (May 2013): *«The project **effectiveness** is low, as few outputs have been achieved to date».* Score Results Report 2013: A.

The effectiveness at the end of 2014 is scored high, as many planned activities and procurements were completed during the year.

Likelihood of outcome being achieved:
- Leadership and Management capacities have increased at district and regional level (>300 managers trained in GLM)
- Use of 'capacity building pyramid' established and useful tool with attention to all levels[3].
- All execution Agreements signed and operational, with system of output and outcome monitoring
- Referral system in project regions with increase in services
- No negative effects noted from project intervention (but stakeholder alignment not optimal)
- Limited progress at central level on project supported interventions (e.g. regional health level development, status change HMDC, nursing policy draft).

[3] From "Systemic capacity building: a hierarchy of needs", Potter & Brough; HPP 2006




Adaptations to achieve outcome:

- Project reformulation (July 2013) covered most issues raised during MTR and is fully implemented
- Adjustments to project team with positive impact (i.e. Regional Project Officers, Contracting & Finance TA)
- Capacity building of financial staff at district level (Execution Agreements monitoring) with involvement of District Local Government
- Procurement support and active use of public procurement system (Belgian Law)
- Active financial management with recovery of funds where needed

### 1.2.2 Potential sustainability

| | Performance |
|---|---|
| **Potential sustainability** | B |

Conclusion MTR (May 2013): *« The potential **sustainability** is relatively good in economic and financial terms, but poor in technical and institutional terms, as an ad hoc approach has been used so far ».* Score Results Report 2013: B.

The ICB project is well embedded within MOH structures and therefore does not support interventions that are unable to be continued after the project period, although this is also dependent on the environment in which the sector operates in future.

Financial / economic sustainability:

- Activities started under Execution Agreements included under DLG workplans (e.g. district health assemblies)
- Established regional health forum, with multiple stakeholder involvement
- Community mobilisation for ambulance service management and resource mobilisation in most districts (ambulance committees)
- Transfer of Uganda National Ambulance Service (UNAS) to Department of Clinical Services within MOH (alignment)
- Limited perspective for resource mobilisation at HMDC Mbale, without change to self-accounting status (Cabinet approval)

Ownership:

- Activities implemented within existing structures (DLG, MOH)
- Execution Agreements fully integrated into district health workplans
- Regional health forum organized and led by local stakeholders; increased input to agenda from local level
- No active central project committee, but interaction through various departments / divisions (coordinated by office of DHS(P&D)).

Policy support / interaction:

- Important experiences at regional and central level insufficiently documented for dissemination and policy input (capitalisation needs)
- Support for selected health sector reforms at central level not fully available (e.g. regional health level development, transformation of HMDC)
- Gender & Health Human Rights desk at MOH weak and unproductive; no visible prioritisation by MOH TSMC.

Capacity Building:

- Strong contributions at regional level through GLM training and regular regional coordination and interaction
- Limited contribution to institutional strengthening at central level (multiple stakeholders interactions, political context), but several contributions to policies and systems strengthening (e.g. Nursing policy, Supervision Strategic Plan)
- Institutional strengthening of HMDC with increased visibility and presence in health sector; Strategic plan developed, skills enhancement of teaching staff, infrastructure improvements
- The new "Institutional support to the Private-Not-For-Profit sector to promote Universal Health Coverage" (PNFP project) started towards the end of 2014 and will intervene in both ICB supported regions.

## 1.3 Conclusions

- The project reformulation after the Mid Term Review (2013) resulted in increased project efficiency and effectiveness.
- Execution Agreements have increased ownership at district level, with increased efficiency (reduction of delays). This resulted in improved project execution rate.
- ICB project is relevant at all interventions levels (MOH, regional district and HMDC).
- ICB project is considered to generate sustainable changes and capacity enhancement, especially at district and regional levels.
- Regional coordination and development has continued to increase during 2014 in both Rwenzori and West Nile regions.
- There is need to intensify capitalisation on project experiences (i.e. documentation, studies, result dissemination) in order to improve sustainability of efforts
- The formulation process of a second phase ICB project has started, after approval of identification (October 2014).

| National execution official[4] | BTC execution official[5] |
|---|---|
| **Dr. Isaac Ezati, DHS (P&D) - MOH** | **Dr. Hans Beks, Technical Advisor ICB** |

[4] *Name and Signature*
[5] *Name and Signature*

# 2 Results Monitoring[4]

## 2.1 Evolution of the context

### 2.1.1 General context

The Belgian support to the health sector in Uganda faced a 3-year long interruption of the disbursement of budget support. It was only resumed during the second half of 2013. SBS funds were only disbursed once in 2013, without further disbursements in 2014.
The ICB project was formulated as an intervention complementary to the Sector Budget Support. As the only (Belgian supported) intervention in the sector for some time, the ICB project was made to operate outside its original mandate at times, with increasing workload for the project staff.

Towards the end of 2014, the president of Uganda changed the political leadership at the Ministry of Health. The Minister of Health was appointed as Prime Minister. He however maintained his position as MOH, which led to a leadership vacuum at the ministry HQ which affect sector coordination. The ministry is awaiting the appointment of a new or acting minister in 2015.

Presidential and parliamentarian elections will take place in 2016 and the campaigning process will have an effect on sector operations over 2015, both at national and at district level.

### 2.1.2 Institutional context

The Mid Term Review in 2013 highlighted the successes, but also the challenges the project was facing. The MTR was a catalyst to make necessary adjustments to the project design, to expected and achievable outputs, as well as to the project execution (staffing).
The project staffing was revised with the introduction of two regional Project Officers and a Finance & Contracting coordinator in January 2014. A third Project Officer for HMDC joined in September 2014. The accountant recruited in 2013 left in April 2014 and a new accountant joined in August 2014. The contract of the MOH Project Officer ended in July 2014 and was not renewed. An Administrative Project Officer replaced her in September 2014. These various staff changes resulted in increased efficiency and effectiveness of project implementation.

The Bank of Uganda introduced eBanking for all its accounts udner the Minisry of Health. Although this can be an efficient system once established, the introduction period created delays and errors in project transactions under co-management. With approval of PS MOH, the project was given authority to upload transactions directly, which did reduce the earlier delays. Technical challenges, as well as availability of PS for approval  are still affecting efficiency of the system.

During the year, the regional coordination and collaboration has increased and the regional meetings developed into multi-stakeholder regional health forums. The concept of Institutional Capacity Building has increasingly been better understood at various levels with the introduction of Execution Agreements and involvement of the local district leadership.

The development of a regional ambulance / referral system is a successful and visible example of the project support, which is raising interest beyond the two implementation regions. The system continued to evolve and is an important component of improved service delivery at district and regional level (see also under 2.3.2 output 2).

The project support towards the revitalization of the Health Manpower Development Centre (HMDC) raised questions related to its sustainability. As the centre can be an important sector contributor to continuous professional development for the health workers, MOH stewardship is needed to

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[4] Impact refers to global objective, Outcome refers to specific objective, output refers to expected result

determine its future status. A concept note in its future status and ICB support was presented to and approved by the Steering Committee in June 2014 (see also under 2.3.3.).

### 2.1.3 Management context: execution modalities

The project has been formulated under co-management modality, with MOH responsible for project implementation. In 2012 the Steering Committee approved transferring funds for procurements under the project to the BTC-management modality. Although many procurement tenders were started it has been challenging to complete them, due to inadequate capacity at the project team (both quantity and quality) to manage the various procurement processes. In June 2014, the SC recommended the support of a procurement specialist and progress has been made since than.

The MTR emphasized the need for decentralised implementation at district level. Execution Agreements have been developed and were signed with all 15 District Local Governments. Its implementation is under co-management modality, at the insistence of the Ministry of Health.

### 2.1.4 Harmo context

The Mid Term Review Report included a section on the assessment of the HARMO criteria under the ICB project, which is included here in italics:

***Harmonisation:*** *The ICB project is embedded in the MoH and harmonized with other donor supported actions. However, it has, like any other project, a separate budget line in the MoH annual work-plan. While facilitating attribution and enhancing its visibility, this approach may increase fragmented planning. The project is perceived as a potential ad hoc service provider for any MoH office, rather than an authoritative partner.*
*Discussions with the World Bank and USAID have led to the geographic concentration of the ICB project in two regions, where limited technical and educational activities from other stakeholders are currently being implemented. The project has virtually taken over former DANIDA regions*
*The project team seems to have little dialogue with UN agencies, especially WHO, whose technical role may be obscured by the relative plethora of donors delivering substantial financial and technical resources (including, recently, the GFATM and GAVI, after its reactivation). The MTR team was told that donor coordination has weakened over the years. Several donors have been reported having different channels to provide support and TA and still different implementation modalities. One specific objective for the ICB project may well have been the reorganization of the MoH capacity to lead the sector and drive donors.*

After the MTR, the ICB project has made active attempts to increase its interaction with especially the UHSSP and GFATM. Also the development of the Execution Agreements led to an increased collaboration with partners that are active in the same two regions. In 2014, the project collaborated with the newly established Regional Performance Monitoring Teams (GF ATM funded) in both regions. Coordination a partner support takes place through the office of the Director Health Services (Planning & Development). The BTC health sector advisor represents the Belgian Cooperation at both HPAC and HDP meetings.

***Alignment:*** *The project formulation was fully aligned to the health sector strategic plan and the national health policy. Both documents have been updated after the initial formulation. However, the accompanying project logframe was not updated accordingly. Not surprisingly, this management tool is little used, and the project attempts to align its activities to the annual work-plans. However, these (consolidated) annual work-plans are at times only published in the last quarter of the Financial Year, thus defeating their usefulness.*
*The project does for the most part no longer use the national procurement system. The procurement*

*using the Belgian law has drastically increased the project short-term efficiency, but fails to build the capacity of the PDU, thus defeating the project purpose of capacity building. The lack of criteria-based district and RRH funding further weakens the national budgetary and planning capacity.*

During the reformulation in July 2013, the project logframe has been reviewed and updated. It has not been adapted since as the project period was coming its end. The indicators and activities as reflected in the logframe are used in the quarterly (MONOP) and annual reporting.

The strengthening of local capacity of the institutional procurement systems has not been intensively pursued during 2014. The head of unit was dismissed on corruption charges and only replaced in December 2014. Project procurement continued to be executed under BTC management.

***Result-based management:*** *So far, there seems to be mainly activity-based management, rather than results-based management. For example, the log frame indicators are not used and no targets have been set for the various output and process indicators. The opportunity offered by the newly established performance agreement of the various levels of governance is equally not yet used to link financing to performance.*

Over 2014, the focus has been on results and both efficiency and effectiveness increased. The quarterly regional meetings developed into a regional health forum with multiple stakeholder involvement. Also the involvement of the local leadership in health improved. Emphasis of project interventions in the areas of quality of care and gender and Health Human Rights increased over the year. The execution rate jumped from 40% to 66% and it is foreseen that end-of-project expenditure will be close to 100%. The increased expenditure is mostly contributed to the introduction of district Execution Agreements and the successful completion of a number of procurements.
The impact in institutional strengthening is visible at regional and district level, however not at central level, where support is mostly output oriented.

***Mutual responsibility*** *is not well established, as the project is mainly perceived as a funding agency, and less as a collaborative venture towards the achievement of common objectives and shared, mutual responsibilities.*

***Ownership****. The project enjoys a high visibility, especially since the delivery of the ambulances and at first sight, has a high ownership. Unfortunately, this ownership can by and large be attributed to its funding of ad hoc, more or less pressing needs. There is little ownership of transformational capacity building and leadership goals. In the project sites, the ownership is negatively affected by the poor communication on the progress of planned interventions, and by the sometimes perceived lack of involvement in funding decisions, which are once again made ad hoc, without objective criteria and a long term vision.*

Regular briefings on project activities were introduced in 2013 and continued over 2014. These improved information sharing between the project secretariat and the implementation areas. The introduction of the Execution Agreements has increased the sense of ownership and responsibility at the level of the District local Government.

At the central level, ownership of the project is ensured as it is governed under the office of the Director Health Services (Planning & Development). Ownership of project objectives is affected by changes in the leadership positions and requires continuous sensitization of MOH officials.

## 2.2 Performance outcome

### 2.2.1 Progress of indicators[5]

| Outcome[6]: **Improved organizational and institutional performance of the Ministry of Health HQ and the health institutions in the two selected regions** | | | | |
|---|---|---|---|---|
| **Indicators** | **Baseline value 2009** | **Value 2013** | **Value 2014** | **End Target 2015** |
| Central: MOH restructuring / reform plan in execution | **Draft restructuring plan MOH** | **MOH Health Reforms task-force established** | **MoPS submitted draft MOH restructuring proposal** | **Restructuring to be included in HSSDP 2015/16-2019/20** |
| Central: Meeting frequency of SWAP coordinating structures | **As scheduled** | **No data available** | **HPAC 83% (10/12) SMC 67% (8/12) No data available on TWG** | **100%** |
| Regional: District annual league tables (position and score) | **AHSPR** | **See table (2.2.2)** | **See table (2.2.2)** | **Improved** |
| Regional: Regional consolidated HMIS (HSSIP indicators progression) | **HSSP II** | **No consolidated data available** | **Quarterly (2) consolidated regional reports produced in WN and Rwenzori** | **Improved** |

[5] *You can use the table provided, or you can replace it by your own monitoring matrix format. Add/delete columns according to the context (some interventions will need to add columns for previous years while other – new - interventions will not have a value for the previous year).*

[6] *Use the formulation of the outcome as mentioned in the logical framework (TFF)*

### 2.2.2 Analysis of progress made

**League table Rwenzori region: 2010 - 2014**

| District | Ranking 2010 / 2011 | Ranking 2011 / 2012 | Ranking 2012 / 2013 | Ranking 2013 / 2014 |
|---|---|---|---|---|
| Kamwenge | 28 | **30** | **15** | **6** |
| | (61.2 / 100) | (63.5 / 100) | (71,9 / 100) | (83,8 / 100) |
| Kyegegwa | 48 | **18** | **5** | **7** |
| | (56.2 / 100) | (66.7 / 100) | (76,0 / 100) | (83,3 / 100) |
| Kabarole | 3 | **1** | **2** | **32** |
| | (73.1 / 100) | (83.3 / 100) | (81,8 / 100) | (77,0 / 100) |
| Kyenjojo | 63 | **32** | **10** | **37** |
| | (53.2 / 100) | (63.2 / 100) | (73,6 / 100) | (76,0 / 100) |
| National Average | | | | |
| | (58.4 / 100) | (58.8 / 100) | (63,0 / 100) | (74.9 / 100) |
| Bundibunyo | 67 | **21** | **65** | **50** |
| | (52.7 / 100) | (65.9 / 100) | (60,3 / 100) | (74,5 / 100) |
| Kasese | 43 | **60** | **69** | **71** |
| | (57.2 / 100) | (57.1 / 100) | (59,2 / 100) | (70,2 / 100) |
| Ntoroko | 109 | **103** | **108** | **110** |
| | (22.9 / 100) | (41.5 / 100) | (44,7 / 100) | (56,1 / 100) |

**League table West Nile region - 2010 - 2014**

| District | Ranking 2010 / 2011 | Ranking 2011 / 2012 | Ranking 2012 / 2013 | Ranking 2013 / 2014 |
|---|---|---|---|---|
| Nebbi | 23 | 28 | **27** | **23** |
| | (62.6 / 100) | (64 / 100) | (66.3 / 100) | (77,7 / 100) |
| Zombo | 55 | 73 | **47** | **26** |
| | (54.8 / 100) | (53.6 / 100) | (63,2 / 100) | (77,5 / 100) |
| *National Average* | *(58.4 / 100)* | *(56.8 / 100)* | *(63,0 / 100)* | *(74.9 / 100)* |
| Maracha | 69 | 42 | **59** | **65** |
| | (52.8 / 100) | (61.2 / 100) | (61.4 / 100) | (71,8 / 100) |
| Arua | 66 | 90 | **76** | **69** |
| | (52.7 / 100) | (48.6 / 100) | (57.8 / 100) | (71,4 / 100) |
| Koboko | 81 | 44 | **85** | **70** |
| | (49.4 / 100) | (60.8 / 100) | (56.1 / 100) | (71,3 / 100) |
| Adjumani | 97 | 93 | **103** | **98** |
| | (42.7 / 100) | (47.2 / 100) | (49.4 / 100) | (65,0 / 100) |
| Yumbe | 86 | 87 | **104** | **101** |
| | (47.9 / 100) | (50 / 100) | (47,3 / 100) | 63,8 / 100) |
| Moyo | 102 | 72 | **109** | **109** |
| | (40.7 / 100) | (53.7 / 100) | (43.9 / 100) | (57,6 / 100) |

The league table is based on a selected number of HMIS indicators with a different weight factor and maximum score of 100. The ranking is renewed annually and included in the AHSPR. Both the actual score as well as the position in the table need to be considered together.

All 15 districts in the two project regions, with the exception of Kabarole, improved their league table score. However, as others also improved the actual score, some districts lost some positions in the national table.

A detailed analysis of the Kabarole district performance was made in order to assess the reasons behind the loss in league table score and position (from 2 to 32). Most of the loss was related to 'administrative' issues (i.e. wrong data on latrine coverage and non-payment of staff salaries for several months) and corrective measures were introduced at district level.

The use of the league table is only one way to review district performance and is based largely on service indicators. However, there appears to be a link between league table score and 'leadership & management' aspects in the districts (e.g. timeliness of reporting, staffing levels, involvement of the local political leadership in health, cohort indicators, etc.)

In 2014 the (provisional) results of the population census were published. All districts in the two project regions which scored below the national average, had ***over-estimated populations***. This means that the denominator for a number of population-based indicators was too high and the league table score should be higher.
At the same time, the population of the high-performing districts were ***underestimated*** and their league table score should be lower.
Once the revised population figures are entered into the HMIS database, the league table will be very different. For the districts within the two project regions, we include the old and new population figures for information purposes.
The low performing districts (Ntoroko and Bundibugyo in Rwenzori and Moyo, Adjumani and Yumbe) will certainly be at higher positions in the next (population adjusted) league table. However, this will also negatively affect their PHC funding allocation and this will need to be considered during the next planning cycle.

**League table Rwenzori region: 2010 - 2014**

| District | Ranking | Ranking | Ranking | Ranking | Population HMIS 2014 | Population Census 2014 | Over / Under estimates | Revised league |
|---|---|---|---|---|---|---|---|---|
| | **2010 / 2011** | **2011 / 2012** | **2012 /2013** | **2013 / 2014** | | | | |
| Kamwenge | 28 | **30** | **15** | **6** | 347,350 | 421,470 | -74,120 | |
| | (61.2 / 100) | (63.5 / 100) | (71,9 / 100) | (83,8 / 100) | | | -17.6% | - |
| Kyegegwa | 48 | **18** | **5** | **7** | 172,000 | 277,379 | -105,379 | |
| | (56.2 / 100) | (66.7 / 100) | (76,0 / 100) | (83,3 / 100) | | | **-38.0%** | -- |
| Kabarole | 3 | **1** | **2** | **32** | 428,050 | 474,216 | -46,166 | |
| | (73.1 / 100) | (83.3 / 100) | (81,8 / 100) | (77,0 / 100) | | | -9.7% | - |
| Kyenjojo | 63 | **32** | **10** | **37** | 412,580 | 423,991 | -11,411 | |
| | (53.2 / 100) | (63.2 / 100) | (73,6 / 100) | (76,0 / 100) | | | -2.7% | - |
| National Average | | | | | | | | |
| | (58.4 / 100) | (58.8 / 100) | (63,0 / 100) | (74.9 / 100) | | | | |
| Bundibunyo | 67 | **21** | **65** | **50** | 289,320 | 224,145 | 65,175 | |
| | (52.7 / 100) | (65.9 / 100) | (60,3 / 100) | (74,5 / 100) | | | **29.1%** | ++ |
| Kasese | 43 | **60** | **69** | **71** | 803,200 | 702,029 | 101,171 | |
| | (57.2 / 100) | (57.1 / 100) | (59,2 / 100) | (70,2 / 100) | | | 14.4% | + |
| Ntoroko | 109 | **103** | **108** | **110** | 92,970 | 66,422 | 26,548 | |
| | (22.9 / 100) | (41.5 / 100) | (44,7 / 100) | (56,1 / 100) | | | **40.0%** | ++ |

**League table West Nile region - 2010 - 2014**

| District | Ranking | Ranking | Ranking | Ranking | Population HMIS 2014 | Population Census 2014 | Over / Under estimates | Revised league |
|---|---|---|---|---|---|---|---|---|
| | **2010 / 2011** | **2011 / 2012** | **2012 / 2013** | **2013 / 2014** | | | | |
| Nebbi | 23 | 28 | **27** | **23** | 364,400 | 385,220 | -20,820 | |
| | (62.6 / 100) | (64 / 100) | (66.3 / 100) | (77,7 / 100) | | | -5.4% | - |
| Zombo | 55 | 73 | **47** | **26** | 231,160 | 240,368 | -9,208 | |
| | (54.8 / 100) | (53.6 / 100) | (63,2 / 100) | (77,5 / 100) | | | -3.8% | - |
| *National Average* | | | | | | | | |
| | *(58.4 / 100)* | *(56.8 / 100)* | *(63,0 / 100)* | *(74.9 / 100)* | | | | |
| Maracha | 69 | 42 | **59** | **65** | 212,090 | 186,176 | 25,914 | |
| | (52.8 / 100) | (61.2 / 100) | (61.4 / 100) | (71,8 / 100) | | | 13.9% | + |
| Arua | 66 | 90 | **76** | **69** | 827,820 | 785,189 | 42,631 | |
| | (52.7 / 100) | (48.6 / 100) | (57.8 / 100) | (71,4 / 100) | | | 5.4% | + |
| Koboko | 81 | 44 | **85** | **70** | 267,670 | 208,163 | 59,507 | |
| | (49.4 / 100) | (60.8 / 100) | (56.1 / 100) | (71,3 / 100) | | | 28.6% | ++ |
| Adjumani | 97 | 93 | **103** | **98** | 425,380 | 232,813 | 192,567 | |
| | (42.7 / 100) | (47.2 / 100) | (49.4 / 100) | (65,0 / 100) | | | **82.7%** | +++ |
| Yumbe | 86 | 87 | **104** | **101** | 637,370 | 485,582 | 151,788 | |
| | (47.9 / 100) | (50 / 100) | (47,3 / 100) | 63,8 / 100) | | | **31.3%** | + |
| Moyo | 102 | 72 | **109** | **109** | 479,700 | 137,489 | 342,211 | |
| | (40.7 / 100) | (53.7 / 100) | (43.9 / 100) | (57,6 / 100) | | | **248.9%** | +++ |

### 2.2.3 Potential Impact – HMIS indicators

<table>
<tr><th rowspan="2">Indicator</th><th rowspan="2">Source</th><th rowspan="2">2010/11</th><th rowspan="2">2011/12</th><th rowspan="2">2012/13</th><th colspan="4">2013/14</th></tr>
<tr><th>HSSIP Target</th><th colspan="2">Achievement</th><th>Performance Trend</th></tr>
<tr><td>% pregnant women attending 4 ANC sessions</td><td>HMIS</td><td>32%</td><td>34%</td><td>31%</td><td>55%</td><td colspan="2">32.4%</td><td>Negative and far below the HSSIP target by 24%</td></tr>
<tr><td>% deliveries in health facilities</td><td>HMIS</td><td>39%</td><td>38%</td><td>41%</td><td>65%</td><td colspan="2">44.4%</td><td>Positive trend but below HSSIP target</td></tr>
<tr><td rowspan="3">% children < 1 year immunized with 3rd dose Pentavalent vaccine (M/F)</td><td rowspan="3">HMIS</td><td rowspan="3">90%</td><td rowspan="3">85%</td><td rowspan="3">91%</td><td rowspan="3">83%</td><td colspan="2">93.0%</td><td rowspan="3">On track and above HSSIP target</td></tr>
<tr><td>90.9%</td><td>95.1%</td></tr>
<tr><td>Male</td><td>Female</td></tr>
<tr><td rowspan="3">% one year old children immunized against measles (M/F)</td><td rowspan="3">HMIS</td><td rowspan="3">85%</td><td rowspan="3">89%</td><td rowspan="3">91%</td><td rowspan="3">85%</td><td colspan="2">86.5%</td><td></td></tr>
<tr><td>84.7%</td><td>88.3%</td><td>On track and above HSSIP target</td></tr>
<tr><td>Male</td><td>Female</td><td></td></tr>
<tr><td>% pregnant women who have completed $IPT_2$</td><td>HMIS</td><td>43%</td><td>44%</td><td>47%</td><td>60%</td><td colspan="2">48.6%</td><td>Positive trend but still below HSSIP target</td></tr>
</table>

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| % of children exposed to HIV from their mothers accessing HIV testing within 12 months | EID database | 30% | 32% | 46% | 55% | 53.8% | Steep positive trend and nearly reaching HSSIP target |
| % U5s with fever receiving malaria treatment within 24 hours from VHT | HMIS | No data | No data | No data | 60% | No data | iCCM implemented in only 9 districts, VHTs not reporting |
| % eligible persons receiving ARV therapy (M/F) | ACP | 53% | 59% | 83% | 65% | | Positive trend and above HSSIP target (WHO 2010 guidelines) |
| | | | | 46% | 75% | 48.0% | Positive trend but below HSSIP target (WHO 2013 guidelines |

*Source: MOH Annual Health Sector Performance Report 2013 – 2014 (October 2014).*

Measurement or assessment of the likely impact of the ICB project to its general objective is rather difficult. The main internationally agreed health indicators are influenced by a variety of factors both within and outside the health sector and are not within the ‘sphere of control or influence’ of the project . It is assumed that ‘leadership & management’ in the health sector are important contributions to “the effective delivery of the Ugandan Minimum Health Care Package”, as measured by the set of indicators above.

At regional and district level it has been noted that districts with strong leadership and management practices, perform better on management and cohort indicators (e.g. reporting, TB and HIV indicators).

## 2.3 Performance output 1

### 2.3.1 Progress of indicators

| Output 1: The Ministry of Health is strengthened in its organizational and institutional capacity | | | | | |
|---|---|---|---|---|---|
| **Indicators** | **Baseline value** | **Value 2012** | **Value 2013** | **Value 2014** | **End Target 2015** |
| Number of TSMC retreats | **2008** | **Nil** | **Nil** | **Nil** | **2** |
| Number of trainings supported (disaggregated by number of people, gender and type) | **No data available** | **No data available** | **No data available** | **No data available** | **NA** |
| Number of annual Regional Planning meetings | **All regions** | **Nil** | **2** | **2** | **2** |
| Number of ICB Steering Committee meetings. | **N/A** | **SC: 3** | **SC: 3** | **SC: 2** | **SC: 2** |
| | | | | | |

### 2.3.2 Progress of main activities

| **Progress of main activities [7]** | **Progress:** | | | |
|---|---|---|---|---|
| | A | B | C | D |
| 1 Capacity assessments & planning support MOH HQ | | | x | |
| 2 Institutional and individual capacity building at MOH | | | x | |
| 3 Investment support to capacity building at MOH HQ | | x | | |

### 2.3.3 Analysis of progress made

Continued ***support*** under ICB was provided to the **MOH HQ** in 2014 (i.e. biannual performance reviews, Annual Health Sector Performance Report, budget conference planning, Ministerial Policy Statement, etc.). The support also included IT and furniture procurements for various departments.

The roll-out of the revised HMIS systems was supported at national (TOT) and regional level (WN and Rwenzori). In both regions, HMIS capacity has been strengthened and,

[7] A: The activities are ahead of schedule
B The activities are on schedule
C The activities are delayed, corrective measures are required.
D The activities are seriously delayed (more than 6 months). Substantial corrective measures are required.

with support of MOH Resource Centre, ***consolidated regional HMIS reports*** were produced for two quarters for the first time in Rwenzori and West Nile regions

The development of a national ***Supervision, Monitoring and Inspection Strategic Plan (SMI SP)*** was finally completed with regional and national consultations. The draft SP was accepted through the SMER TWG and needs to be presented to TSMC.

A number of planned institutional development activities could not take place due to ***organizational problems at MOH HQ***.
The development of a MOH procurement manual was derailed as the head of unit was removed on corruption charges. He was only replaced in December 2014.
The development of a Regional Health Level has been delayed, as TSMC had not yet formulated a common vision on this. The appointment of the Minister of Health as Prime Minister, affected the coordination at MOH HQ and the topic has not yet been discussed.
Regular meetings of the HRH TWG did not take place due to coordination issues at MOH HQ (HRM versus HRD). This negatively affecting progress on various documents, such as the draft Nursing Policy, the SIP for HMDC and the health sector Training and Development plan. A study under Uganda Capacity Programme did not result in revitalising this important TWG.

*MOH HQ from the air, Kampala*

The process of development of a new ***Health Sector Strategic Development Plan*** (HSSDP) for 2015/16 to 2019/20 has started. A new National Development Plan (NDP II) has been produced and MOH contributed to the health sector chapter.
The process needs to be accelerated and ICB will support this at request of MOH (e.g. through procurement of consultancies on G&HHR).

## 2.4 Performance output 2

### 2.4.1 Progress of indicators

| **Output 2:** Institutional capacity is developed in the health sector in Rwenzori and West Nile regions at all levels (i.e. regional coordination, RRH's, Districts, General Hospitals and Health Sub-Districts). | | | | | |
|---|---|---|---|---|---|
| **Indicators** | **Baseline value** | **Value 2012** | **Value 2013** | **Value 2014** | **End Target 2015** |
| Feasibility study report available | **Included in HSSIP** | **No** | **TOR developed** | **No** | **Yes** |
| Number of Regional project Implementation Committee meetings | **Nil** | **8** | **6** | **8** | **8 / year** |
| Number of Execution Agreements signed | **N/A** | **N/A** | **NIL** | **17** | **17** |
| Number of Governance. Leadership & Management (GLM) trainings | **N/A** | **N/A** | **1** | **4** | **15 (included in district EA plans)** |

### 2.4.2 Progress of main activities

| **Progress of main activities** [8] | **Progress:** | | | |
|---|---|---|---|---|
| | A | B | C | D |
| 1 Support implementation of district workplans – execution agreements | | x | | |
| 2 Support implementation of district workplans – non-execution agreements | | x | | |
| 3 Support implementation of RRH workplans – execution agreements | | | x | |
| 4 Support implementation of RRH workplans – non-execution agreements | | x | | |
| 5 Support to executing investment plans of districts, RRHs and Regional coordination | | x | | |
| 6 Support to regional health level coordination | | | x | |

### 2.4.3 Analysis of progress made

***Exection Agreements with all 15 District Local Goverments*** in the two regions have been signed in 2014. Seven districts EA's included an addendum to reduce risks for the project (i.e. disbursement of 10% rather than 20% of EA amount). All distrocts have received funds and implemented activities as included in the approved workplans for

[8] A: The activities are ahead of schedule
B The activities are on schedule
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D The activities are seriously delayed (more than 6 months). Substantial corrective measures are required.

2014-2015. Regular financial meetings are organized at regional level to verify accountability and build capacity in financial management.
An “EA implementation manual” has been developed for follow-up of EA implementation through regular progess reports (at the time of requests for re-payment), standard quarterly reports for financial, output and outcome monitoring. The first quarter reports were received for the period (July – September 2014).

*Signing ceremony first Execution Agreements, MOH January 2014*

*Closing of 1st District Health Assembly, Kyegewa November 2014*

The organizational (specifically financial) management capacity of the two ***Regional Referral Hospitals*** was assessed and considered rather weak. Submission of accountability by the RRHs of funds received under the project, showed frequent delays, errors and incomplete documentation.
The Steering Committee approved (June 2014) to reduce the amounts per hospital for capacity building under ***Execution Agreements***, and re-allocate the balances to direct project support on hospital equipment. Workplan for 2014-2015 were developed and approved and EAs were signed on 12 December 2014. Initially funding will be activity

rather than lumpsum based. Depending on the experiences under the EA, the modality will be changed in 2015. Identification of equipment for the two (training) hospitals has been identiifed and procurement tenders are under preparation.

The concept of ***Patient-Centered-Care*** has been introduced at the RRH's. After a capacity buidling workshop, both hospitals conducted self-asessment and developed PCC action plans (supported by MOH Quality Assurance Department). Activities have been included in the EA workplans. A Client Satisfaction study at Fort Portal and Masaka RRHs was conducted and disseminated.

The roll-out of ***Governance, Leadership and Management (GLM) training*** continued in 2014 with a second cohort completed, including 170 senior (health) managers (from helath sector and local governments). Over 300 officers successfully completed the GLM trainings and obtained an MOH certificate. Further roll-out at distric level (for health Sub-District and facility managers) has been included in the district EA workplans.
An impact evaluation will be conducted in Quarter 1 2015 as part of the project capitalization activities.

A structural ***assessment*** was made of ***Adjumani Hospital*** (Health Infrastructure Division MOH with external consultants), which resulted in a plan for urgent rehabilitation. MOH allocated nearly EUR 300,000 for FY 2014-2015 and works have already started.

The development and introduction of a ***regional level within the health sector*** is reflected in the HSSIP and experience building in the two ICB supported regions has continued. The quarterly regional project meetings have evolved into a Regional Health Forum, with increasing experience sharing within the regions. The introduction of the Regional Performance Monitoring Teams (RPMTs) stengthened the regional approach and the teams are now permanent stakeholders in the regional meetings. Officers at MOH HQ also have ackowledged the benefits of the regional fora in West Nile and Rwenzori and increasingly show interest to paricipate. Documenting and studying the regional experiences will be an important area under the project capitalization efforts in 2015.
A feasibility study on the potential scenario's for the establishment of a Regional Health Level has not yet been conducted, due to coordination challenges at the level of MOH.

The introduction and development of the ***regional ambulance and referral systems***, has become a case study for the country, as other initiatives are faced with extensive delays (i.e. development of the Uganda national Ambulance System (UNAS), ambulance service provision under the UHSSP/WB). A second vehicle assessment report, at the request of the Minister of Health, showed good use and management of both the ambulances and the utility vehicles in both regions. The number of referrals is increasing, vehicles are serviced on schedule and logbooks are kept. Ambulance committees have been established within most of the districts and are instrumental in mobilizing community contributions to support sustainable ambulance services.
Additionally to the 13 procured ambulances fro the two regions, another nine ambulance vehicles have been fully equipped with all necessary items. Another 20 ambulance teams (100 staff members) were trained in accident & emrgency care. The total number of functional ambulances (equipped and staffed by trained officers) has increased to 32 for both regions. A study on the experiences with the regional ambulance services is under preparation, as part of the capitalization efforts for 2015.

*Ambulances hand-over at Arua RRH 2013.*

Unfortunately four ambulances were involved in serious Road Traffic Accidents in 2014. All vehicles were comprehensively insured. Road safety issues have been reviewed during the regional meetings and in the assessment consultancy. GOU guidelines on vehicle use have been re-emphasized and a Defensive Driving Course for 80 drivers has been prepared.

***A number of Procurements/ tenders*** started in 2013 were completed in 2014. These included 39 theatre tables for hospitals and HCs IV, IT equipment and additional library books. However, as progress was too slow, the Steering Committee recommended in June 2014, to recruit a procurement specialist to support and accellerate the implementation of project procurements.
A number of stalled procurement processes were re-started and successfully completed (i.e. PA systems, staff house rehabilitation at HMDC, MOH and RRH websites development), or nearly completed (i.e. ambulance uniforms, motorcycles and X-ray Kilembe). An extensive solar needs assessment was also completed for both regions.
An updated 2015 procurement plan has been completed and additional tenders are under preparation (e.g. solar equipment, medical equipment, Master Plans for RRH, etc.).

*Kabarole district receiving and testing the PA system, December 2014*

## Performance output 3

### 2.4.4 Progress of indicators

| **Output 3:** The training needs in L&M of the health sector are strengthened through transformation of the Health Manpower Development Centre (HMDC) and the establishment of two regional training satellite centres. | | | | | |
|---|---|---|---|---|---|
| **Indicators** | **Baseline value** | **Value 2012** | **Value 2013** | **Value 2014** | **End Target 2015** |
| Number of regional training centres established | **N/A** | **Nil** | **Nil** | **2** | **2** |
| Number of eLearning courses conducted (by number, gender and type) | **N/A** | **Nil** | **1** | **1** | **5** |
| Number of GLM trainings | **N/A** | **Nil** | **1** | **4** | **15 (included in district EA plans)** |

### 2.4.5 Progress of main activities

| **Progress of main activities** [9] | **Progress:** | | | |
|---|---|---|---|---|
| | A | B | C | D |
| 1 Support the transformation of HMDC into a national centre for L&M development in the health sector | | | x | |
| 2 Support the development of 2 regional satellite training centres in Rwenzori and West Nile regions | | | x | |
| 3 Infrastructure development for regional training centres in Rwenzori and West Nile regions | | | | x |
| 4 Infrastructure development HMDC Mbale | | x | | |

### 2.4.6 Analysis of progress made

The **Strategic Investment Plan for HMDC** was presented to and approved by the HRH TWG and Senior Management Committee at MOH. The transformation of HMDC into a semi-autonomous institution is essential for its future development and long-term sustainability. Guiding principles and a cabinet memo have been prepared and were presented to a group of stakeholders.
'Benchmarking' visits were made to a number of national training institutions to assess their organizational structures and modes of opration. The findings from there visits are used to strengthen the proposal for a status change. The MOS(GD) visited HMDC and

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D The activities are seriously delayed (more than 6 months). Substantial corrective measures are required.

expressed his support for the proposed transformation.

***eLearning*** has become an established modality for training. The L&M training concluded a successful pilot in Moyo district and has been rolled-out to student in both Rwenzori and Wets Nile regions. Capacity of staff at HMDC has increased through various trainings. A group of 15 HMDC, MOH and regional officers was supported to participate in the international "eLearning Africa" conference in May 2014. HMDC was invited to present their experiences with setting-up a new eLearning system.

***Regional Training Centres*** in Fort Portal and Arua have been established. As there is no regional health level yet or regional training infrastructure, the (virtual) centres are hosted by the Regional Referral Hospitals. A regional coordinator was appointed in both regions. The on-line L&M training has been rolled-out within both regions and student are able to use the resource centres of the RRHs. Follow-up was made on the development of district Training Needs Assessments in order for HMDC to respond to the training needs in the regions. Courses on HIV& AIDS, SRH and IMCI have been revised and new course in G&HHR and anti-corruption have been developed. They will be made available to students in the regions in 2015.
Without the establishment of a Regional Health Level, ***infrastructure development for the regional training centres*** could not proceed. The project is assisting the RRHs with their equipment needs (e.g. furniture and IT) for hosting the virtual centre. A Local Area Network (LAN) was installed at Arua RRH to improve on IT infrastructure and internet access.

***Infrastructure development at HMDC Mbale*** continued with the completion and inauguration of the wallfence in March 2014. The staff houses were re-roofed and an assessment for re-designing the student hostels was completed. A tender for classroom and sanitation rehabilitation is under preparation.

*Inauguration of HMDC wallfence by Attache Belgian Embassy, March 2014*

## 2.5 Performance output 4

### 2.5.1 Progress of indicators

| **Output 4:** Capitalization and Scientific Support accompanies the capacity building process in the Ugandan health sector | | | | | |
|---|---|---|---|---|---|
| **Indicators** | **Baseline value** | **Value 2012** | **Value 2013** | **Target 2014** | **End Target 2015** |
| Areas / themes for scientific support identified and agreed | **N/A** | **Nil** | **Nil** | **Nil** | **3** |
| Number of scientific support team missions | **N/A** | **Nil** | **Nil** | **Nil** | **3** |
| Products of capitalization available | **N/A** | **Nil** | **Nil** | **Nil** | **3** |

### 2.5.2 Progress of main activities

| **Progress of main activities** [10] | **Progress:** | | | |
|---|---|---|---|---|
| | A | B | C | D |
| 1 Inception phase on capitalization of project experiences and identification of health sector needs for scientific support | | | | x |
| 2 Continuous capitalization and scientific support during project implementation | | | | x |

### 2.5.3 Analysis of progress made

During the project period several unsuccessful attempt have been made to procure Scientific Support. Under project support, several innovations and developments took place, which will require studies into their process and impact. The results will also require a roadmap for possible dissemination.

Some ***areas identified for capitalization studies*** are:
Impact evaluation of GLM training course (TOR under preparation), experiences with the development of a regional health coordination mechanism in Rwenzori and West Nile regions, the introduction and management of a regional ambulance system (TOR discussed during backstopping mission), and the development, introduction and impact of Execution Agreements.

The focus during the Health Sector Days 2014 (BTC HQ) was on ‘action research’. The BTC – KIT Amsterdam framework contract, as well as local consultancies, will be used for organizing capitalisation studies in 2015. Experiences with institutional support in health in Rwanda have been shared during a second exchange visit in September 2014. In Q1 2015, capitalization and use of KIT framework in both Rwanda and Burundi will be shared during a regional exchange.

[10] A: The activities are ahead of schedule
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D The activities are seriously delayed (more than 6 months). Substantial corrective measures are required.

## 2.6 Transversal Themes

### 2.6.1 Gender

Results Report 2013: *No activities in this area took place during 2013 and the G&HHR desk is considered non-functional. The desk is located within the Health Planning Department, which is already understaffed. Capacity on gender and human rights issues of the respective desk officers is rather limited.*

***Gender & Health Human Rights*** was re-emphased as an areas for project interventions at the Steering Committee meeting in February 2014. Due to the weakness of the MOH G&HHR desk, no progress was made and attention for capacity building was shifted to the two regions. A concept note was developed and approved by the SC in June 2014. Stakeholder workshops were conducted in both regions and G&HHR capacity buidling has been included in most district EA workplans. A training package has been prepared in collaboration with HMDC and will be made available on-line (eLearning course). Collaboration with district gender focal persons has been established and will be intensified in 2015.
Unfortunately, a relocation and reassignment of the 'gender desk' has not yet taken place at MOH HQ.

### 2.6.2 Environment

Environmental aspects are taken into consideration in construction and rehabilitation activities at health facilities.
An extensive solar needs assessment has been conducted in 2014, in order to provide health facilities with (renewable) energy for service delivery.
A water harvesting system has been designed and is being constructed at Viroqua Hospital in Fort Portal. The design will provide a standard for other hospitals.

### 2.6.3 Other

HIV & AIDS, children's rights or social economy do not have any direct relevance for the project implementation.

# 3 Risk management

| Identification of risk or issue | | Analysis of risk or issue | | | Deal with risk or issue | | | Follow-up of risk or issue | |
|---|---|---|---|---|---|---|---|---|---|
| Risk description | Period of identification | Likelihood / Probability | Potential impact | Total | Action(s) | Resp. | Deadline | Progress | Status |
| Resignation of Project Coordinator (ICB and PNFP project) due to unrewarded responsibilities | October 2014 | Medium | High | High Risk | Introduction of Project Coordinator payment | RR / Ops Mgr. BTC | 15/01/2015 | Discussed and agreed during Ops Mgr. country visit and technical backstopping (Oct 2014); approved by PS MOH. Awaiting approval BTC HQ for presentation to Steering Committee | In progress |
| Time for implementation of procurement plan too short | January 2015 | Medium | Medium | Medium Risk | Timely initiation of procurements; Active management of procurement planning; | TA; REPUGA | | Phased procurement management and support BTC HQ | |
| Emergencies (outbreaks and / or refugees) disturb project implementation | January 2015 | Low | Low | Low Risk | Support emergency preparedness plans; Health worker training | DHS(P&D) | | | |
| Potential overlap of activities with introduction of PNFP project in WN and Rwenzori regions | Q4 2014 | Low | Medium | Low Risk | Joined Planning; Joined coordination | DHS(P&D) | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Unrecoverable VAT claims on procured assets (VAT reimbursements have been introduced to URA since June 2012). | 01/10/2013 | Medium | Medium | Medium Risk | BTC representation has taken action towards URA in the form of a letter from RR | RR | | Discussion BTC – URA on recuperation of VAT on assets procured for MOH. Follow-up has been discussed during BTC Finance meeting and with BTC HQ | In progress |
| Non-sustainability of project interventions, due to inadequate facility staffing levels | 17/12/2013 | Medium | Medium | Medium Risk | Support HRH planning at district level | TA ICB | Ongoing | Sustainability should remain on radar. Review (and modification) of budget foreseen December 2014 | In progress |
| High turn-over of staff at MOH and local government levels | 17/12/2013 | Medium | High | High Risk | Training and development policy development | DHS(P&D) | Ongoing | Rotation of personnel is a good control mechanism but might have consequences on building and anchoring capacity, particularly in outreach areas. | In progress |
| Interference on project implementation during period of political campaigning (national elections 2016) | 17/12/2013 | Low | Medium | Low Risk | Priority setting; avoid periods of high political activity | ICB secr | Ongoing | | In progress |
| | | | | | Induction of political leadership to understand project concept | DHS(P&D) | Ongoing | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Risk of inappropriate use of funds | 17/12/2013 | Medium | High | High Risk | Regular project audits | TA(F&A) | Ongoing | Fine-tuning and implementation of internal control system and its application. Needs further attention and deepening of I/C mechanisms | In progress |
| | | | | | Release of funds in phases, after approved accountability | TA(F&A) | Ongoing | foreseen in EA's + creation of procedures and guidelines for EA | |
| Risk of non-sustainability of interventions at HMDC due to indecisiveness at MOH HQ on future status | 17/12/2013 | Medium | High | High Risk | Lobby for progress on legal status HMDC | MOH | Q1-Q2 2014 | Increased support from MOH – minister visiting centre in August 2014; principles of status change developed for submission to cabinet. Newly recruited RPO on board as per 15/9/2044 | In progress |
| | | | | | Concept for TSMC decision (consultancy) | DHS(P&D) | Q1 2014 | Continuous follow up on progress. Depending on ministerial agenda. | |
| Risk of limited impact of training courses | 17/12/2013 | Medium | Medium | Medium Risk | Evaluate training processes = evaluation tool GLM | ICB secr / MOH | Ongoing | Trainings have taken place within regions and districts. Evaluation was done. | In progress |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Adequate supervision and follow-up | ICB secr / MOH | Ongoing | Keep following up | |
| Impact of change to e-banking by BoU and timing of signature activation | 08/04/204 | Medium | High | High Risk | Risk on timely and efficient execution of co-management payments | T&A (F&A) | Q3 | eBanking experienced several technical breakdowns. Today the system is operational, albeit still with room for improvement | In progress |

# 4 Steering and Learning

## 4.1 Strategic re-orientations:

After the project reformulation in July 2013, strategic re-orientations were introduced:

- developing execution agreements with District Local Governments and Regional Referral Hospitals,
- introduction of regional Project Officers and Contracting & Finance TA,
- transformation of HMDC into a Health Management Institute.

These re-orientations resulted in increased efficiency and effectiveness.

For 2015 the following re-orientations are anticipated:

- Formulation of "ICB phase II" as a continued support to the sector in general and the two implementation regions specifically, building on experiences under ICB Phase I, and aligned with the content and duration of the new PNFP project.
- As a result, the ICB phase I project will continue its implementation period into FY 2015-2016 (up to end of Specific Agreement December 10, 2015), including district support through Execution Agreements
- Joint planning and implementation of project activities at regional level by ICB and PNFP project; joined Steering Committee meetings.

## 4.2 Recommendations

| Recommendations | Actor | Deadline |
|---|---|---|
| Audit ICB project, including Execution Agreements | BTC HQ / RR | Q1 2015 |
| Start of project formulation of ICB Phase II | RR BTC Uganda | Q1 2015 |
| Intensive financial and operational follow-up of Execution Agreements implementation with 15 District Local Governments and two Regional Referral Hospitals | PS MOH / RR BTC Uganda | Q1-Q4 2015 |
| Launch and manage planned procurements | Project | Q3 2015 |
| Joint planning and implementation of ICB and PNFP activities in West Nile and Rwenzori regions. | RR BTC Uganda | Q1 – Q4 2015 |
| Support MOH with development of Health Sector Strategic Development Plan (HSSDP) 2015/16 – 2019/20 | DGHS / DHS(P&D) | Q1 – Q2 2015 |
| Focus on Gender & Health Human Rights aspects at regional and district level, as well as during formulation of next HSSDP. | MOH / SC | Q1 – Q4 2015 |

## 4.3 Lessons Learned

| Lessons learned | Target audience |
|---|---|
| Increase of ownership at district / Local Government level is essential in order to mobilise support for project objectives (decentralization). | DLG / DHO |
| Execution Agreements are a good instrument for increasing ownership at district / Local Government level and is a step towards Results Based Financing | MOH / HDP / BTC Uganda |
| Improved coordination between ICB and other HDP interventions on Leadership & Management strengthening in the health sector | MOH / HDP / BTC Uganda |
| Focus on 'portfolio approach' within Belgian health sector support modalities (SBS, ICB and PNFP projects, skills development) | BTC Uganda |
| Public procurement management requires specialised skills and support at country (representation level) to avoid errors and work overload at project level | BTC / REPUGA |
| "Institutional Capacity Building" is a (long-term) process of organizational and institutional developments. As there are no clear immediate results, the indicator set needs to assess the process, rather than the actual outputs. | BTC / REPUGA / MOH |
| BTC (annual) Results Report needs to follow logically from quarterly reports (MONOP) | BTC HQ / REPUGA / MOH |

# 5 Annexes

## 5.1 Quality criteria

| **1. RELEVANCE: The degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries** | | | | |
|---|---|---|---|---|
| *In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D* | | | | |
| **Assessment RELEVANCE: total score** | **A** | **B** | **C** | **D** |
| | |  | | |

| | | |
|---|---|---|
| **1.1 What is the present level of relevance of the intervention?** | | |
| | **A** | Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group. |
|  | **B** | Still fits well in national policies and Belgian strategy (without always being explicit), reasonably compatible with aid effectiveness commitments, relevant to target group's needs. |
| | **C** | Some issues regarding consistency with national policies and Belgian strategy, aid effectiveness or relevance. |
| | **D** | Contradictions with national policies and Belgian strategy, aid efficiency commitments; relevance to needs is questionable. Major adaptations needed. |
| **1.2 As presently designed, is the intervention logic still holding true?** | | |
| | **A** | Clear and well-structured intervention logic; feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable). |
|  | **B** | Adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions. |
| | **C** | Problems with intervention logic may affect performance of intervention and capacity to monitor and evaluate progress; improvements necessary. |
| | **D** | Intervention logic is faulty and requires major revision for the intervention to have a chance of success. |

| **2. EFFICIENCY OF IMPLEMENTATION TO DATE: Degree to which the resources of the intervention (funds, expertise, time, etc.) have been converted into results in an economical way** | | | | |
|---|---|---|---|---|
| *In order to calculate the total score for this quality criterion, proceed as follows: 'At least two 'A', no 'C' or 'D' = A; Two times 'B', no 'C' or 'D' = B; at least one 'C', no 'D'= C; at least one 'D' = D* | | | | |
| **Assessment EFFICIENCY : total score** | **A** | **B** | **C** | **D** |
| | |  | | |

| | | |
|---|---|---|
| **2.1 How well are inputs (financial, HR, goods & equipment) managed?** | | |
| | **A** | All inputs are available on time and within budget. |
|  | **B** | Most inputs are available in reasonable time and do not require substantial budget adjustments. However there is room for improvement. |
| | **C** | Availability and usage of inputs face problems, which need to be addressed; otherwise results may be at risk. |

| | | |
|---|---|---|
| | D | Availability and management of inputs have serious deficiencies, which threaten the achievement of results. Substantial change is needed. |
| **2.2 How well is the implementation of activities managed?** | | |
| | A | Activities implemented on schedule |
| ▯ | B | Most activities are on schedule. Delays exist, but do not harm the delivery of outputs |
| | C | Activities are delayed. Corrections are necessary to deliver without too much delay. |
| | D | Serious delay. Outputs will not be delivered unless major changes in planning. |
| **2.3 How well are outputs achieved?** | | |
| | A | All outputs have been and most likely will be delivered as scheduled with good quality contributing to outcomes as planned. |
| ▯ | B | Output delivery is and will most likely be according to plan, but there is room for improvement in terms of quality, coverage and timing. |
| | C | Some output are/will be not delivered on time or with good quality. Adjustments are necessary. |
| | D | Quality and delivery of outputs has and most likely will have serious deficiencies. Major adjustments are needed to ensure that at least the key outputs are delivered on time. |

| **3. EFFECTIVENESS TO DATE: Degree to which the outcome (Specific Objective) is achieved as planned at the end of year N** | | | | |
|---|---|---|---|---|
| *In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D* | | | | |
| **Assessment EFFECTIVENESS : total score** | **A** | **B** | **C** | **D** |
| | ▯ | | | |

| | | |
|---|---|---|
| **3.1 As presently implemented what is the likelihood of the outcome to be achieved?** | | |
| | A | Full achievement of the outcome is likely in terms of quality and coverage. Negative effects (if any) have been mitigated. |
| ▯ | B | Outcome will be achieved with minor limitations; negative effects (if any) have not caused much harm. |
| | C | Outcome will be achieved only partially among others because of negative effects to which management was not able to fully adapt. Corrective measures have to be taken to improve ability to achieve outcome. |
| | D | The intervention will not achieve its outcome unless major, fundamental measures are taken. |
| **3.2 Are activities and outputs adapted (when needed), in order to achieve the outcome?** | | |
| ▯ | A | The intervention is successful in adapting its strategies / activities and outputs to changing external conditions in order to achieve the outcome. Risks and assumptions are managed in a proactive manner. |
| | B | The intervention is relatively successful in adapting its strategies to changing external conditions in order to achieve its outcome. Risks management is rather passive. |
| | C | The intervention has not entirely succeeded in adapting its strategies to changing external conditions in a timely or adequate manner. Risk management has been rather static. An important change in strategies is necessary in order to ensure the intervention can achieve its outcome. |
| | D | The intervention has failed to respond to changing external conditions, risks were insufficiently managed. Major changes are needed to attain the outcome. |

| **4. POTENTIAL SUSTAINABILITY: The degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention).** | | | | |
|---|---|---|---|---|
| *In order to calculate the total score for this quality criterion, proceed as follows: At least 3 ‘A’s, no ‘C’ or ‘D’ = A ; Maximum two ‘C’s, no ‘D’ = B; At least three ‘C’s, no ‘D’ = C ; At least one ‘D’ = D* | | | | |
| **Assessment POTENTIAL SUSTAINABILITY : total score** | **A** | **B** | **C** | **D** |
| | | □ | | |

| | | |
|---|---|---|
| **4.1 Financial/economic viability?** | | |
| | **A** | Financial/economic sustainability is potentially very good: costs for services and maintenance are covered or affordable; external factors will not change that. |
| □ | **B** | Financial/economic sustainability is likely to be good, but problems might arise namely from changing external economic factors. |
| | **C** | Problems need to be addressed regarding financial sustainability either in terms of institutional or target groups costs or changing economic context. |
| | **D** | Financial/economic sustainability is very questionable unless major changes are made. |
| **4.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support?** | | |
| | **A** | The steering committee and other relevant local structures are strongly involved in all stages of implementation and are committed to continue producing and using results. |
| □ | **B** | Implementation is based in a good part on the steering committee and other relevant local structures, which are also somewhat involved in decision-making. Likeliness of sustainability is good, but there is room for improvement. |
| | **C** | The intervention uses mainly ad-hoc arrangements and the steering committee and other relevant local structures to ensure sustainability. Continued results are not guaranteed. Corrective measures are needed. |
| | **D** | The intervention depends completely on ad-hoc structures with no prospect of sustainability. Fundamental changes are needed to enable sustainability. |
| **4.3 What is the level of policy support provided and the degree of interaction between intervention and policy level?** | | |
| | **A** | Policy and institutions have been highly supportive of intervention and will continue to be so. |
| | **B** | Policy and policy enforcing institutions have been generally supportive, or at least have not hindered the intervention, and are likely to continue to be so. |
| □ | **C** | Intervention sustainability is limited due to lack of policy support. Corrective measures are needed. |
| | **D** | Policies have been and likely will be in contradiction with the intervention. Fundamental changes needed to make intervention sustainable. |
| **4.4 How well is the intervention contributing to institutional and management capacity?** | | |
| | **A** | Intervention is embedded in institutional structures and has contributed to improve the institutional and management capacity (even if this is not an explicit goal). |
| □ | **B** | Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible. |
| | **C** | Intervention relies too much on ad-hoc structures instead of institutions; capacity building has not been sufficient to fully ensure sustainability. Corrective measures are needed. |
| | **D** | Intervention is relying on ad hoc and capacity transfer to existing institutions, which could guarantee sustainability, is unlikely unless fundamental changes are undertaken. |

## 5.2 Decisions taken by the steering committee and follow-up

| Major decision from steering committee | | | Action | | | Follow-up |
|---|---|---|---|---|---|---|
| **Decision** | **Period** | **Source*** | **Action(s)** | **Resp.** | **Deadline** | **Progress** |
| **19-Mar-13** | | | | | | |
| Monitor Ambulance Management in districts | Mar-13 | Minutes | Comprehensive assessment done with no management issues noted that required action. | RR | 31/07/2013 | Completed |
| Outstanding advances ICB project to be reviewed | Before Dec 2013 | Minutes | Advances reviewed during audit May 2013. Active management by project secretariat. | BTC HQ | 31/12/2013 | Ongoing |
| **02-Jul-13** | | | | | | |
| Approval MTR report | Jul-13 | Minutes | | RR | 31/07/2013 | Completed |
| Extend project implementation period to June 2015 | Jul-13 | Minutes | Included in reformulation and workplan during mission in July 2013 | RR | 31/07/2013 | Completed |
| Recruit International TA (Finance & Contracting) | Before Dec 2013 | Minutes | included in reformulation and workplan | BTC HQ | 31/12/2013 | Completed (January 2014) |
| Develop Execution Agreements with district LG and RRHs | Before Dec 2013 | Minutes | Included in reformulation and workplan | Project | 31/12/2013 | Completed (December 2014) |
| Recruit Regional project Officers | | Minutes | Included in reformulation and workplan | Project | 31/12/2013 | Completed; started Jan 2014 |
| **29-Sep-13** | | | | | | |
| Approval reformulation proposal | | Minutes | Reformulation approved, including workplans 2013-2014 and 2014-2015 | Project | | Completed |

| | | | | | | |
|---|---|---|---|---|---|---|
| Approval Budget modification | | Minutes | Budget modification approved | Project | | Completed |
| HMDC wall fence construction | Before Nov 2013 | Minutes | Agreement with contractor reviewed and restarted | Project | 31/01/2014 | Completed |
| Follow-up recommendations MTR | | Minutes | Action matrix | Project | | On going |
| **20-Feb-14** | | | | | | |
| Approval Results Report 2013 | | | Approved with adjustments noted to be included | Project | 01/03/2014 | Completed |
| HMDC workplan and budget | Before end Q2 | Minutes | To be presented to SC | Project | 30/06/2014 | Completed |
| Follow-up recommendations MTR | | Minutes | Action matrix | Project | | On going |
| Follow-up recommendations Audit 2013 | | Minutes | Action matrix | Project | | On going |
| **18-Jun-14** | | | | | | |
| Approval concept note ICB support HMDC | | Minutes | Support HMDC and regional CPD; Project Officer support | Project | | Completed |
| Approval concept note ICB support G&HHR - G&HHR workplan | | Minutes | Workplan prioritization: Support regional Gender mainstreaming in health and gender screening HSSDP 2015-2020. | Project | | Completed |
| Approval workplan 2014-2015 | | Minutes | Adjustments noted (G&HHR; EA's RRH); Procurement consultant for implementation procurement plan. | Project | 10/07/2014 | Completed |
| Approval principles for budget modification | Jul-14 | Minutes | Budget modification to be prepared on approved workplan for validation by BTC HQ | Project | 10/07/2014 | Completed |
| Establish MOH - BTC team for identification ICB phase II project | Q3 2014 | Minutes | Concept note on principles for ICB Phase II, for presentation Joint Commission Oct 2014 | REPUGA | 30/09/2014 Partner Committee 14/10/2014 | Completed |

## 5.3 Updated Logical framework

| Result Areas | Expected results / activities | Indicators | Source of verification | Assumptions |
| --- | --- | --- | --- | --- |
| **General objective Impact:** "To improve effective delivery of an integrated Uganda National Minimum Health Care Package" | | | | |
| | | • HSSIP indicators<br>• JAF indicators | • MOH Annual report<br>• GOU JAF report | |
| **Specific objective / Outcome: "**The strengthening of the Planning, Leadership & Management capacities of health staff at national and local government levels**"** | | | | |
| **Improved organizational and institutional performance of the Ministry of Health HQ and the health institutions in the two selected regions** | | Central level:<br>• MOH restructuring / reform plan in execution<br>• Meeting frequency of SWAP coordinating structures (HPAC, SMC, TWGs)<br>Regional level:<br>• District annual league tables (position & score)<br>• Regional consolidated HMIS (HSSIP) indicators progression | • Restructuring report<br>• MOH Annual report<br>• HMIS<br>• Meeting minutes<br>• District league table | • Strengthening of organization at national level will strengthen the regional levels performance<br>• District league table is sensitive in assessing district performance |
| **Results area 1 / Output 1[11]:**<br>**The Ministry of Health is strengthened in its organisational and institutional capacity** | **1. Capacity assessments & planning support MOH HQ**<br>**2. Institutional and individual Capacity building at MOH**<br>**3. Investment support to capacity building at MoH HQ** | • TSMC retreats<br>• Number of trainings supported (disaggregate by number of people, gender and type)<br>• Number of annual Regional | • Project quarterly progress reports<br>• Planning process guidelines<br>• Annual work plans for MoH | • MOH TSMC adopts programme for sector reforms<br>• TA needs assessment and plan should be available<br>• MOH HQ annual training |

[11] Output definition = set of services and products delivered by the intervention

| | | | | |
|---|---|---|---|---|
| | | Planning meetings<br>• Number of Steering Committee and Implementation Committee meetings | • Framework for support supervision<br>• Evaluation reports (HSSIP MTR)<br>• Meeting minutes<br>• Interviews | plan should be available<br>• Sanction/approval by MOH management to conduct activities required.<br>• Availability, interest and willingness of MoH senior managers to participate and cooperate<br>• Project Admin & Finance TA available |
| **Key result are 2 / Output 2: Institutional Capacity is developed in the health sector in Rwenzori and West-Nile region al all levels (regional coordination, RRHs, Districts, General Hospitals and Health Sub-district)** | **1 Support implementation of district workplans – execution agreements**<br>**2 Support implementation of district workplans – non-EA**<br>**3 Support implementation of RRH workplans – execution agreements**<br>**4 Support implementation of RRH workplans – non-EA5**<br>**5 Support to executing investment plans of districts, RRHs and Regional coordination**<br>**6 Supporting regional health level coordination** | • Feasibility study report available<br>• Number of Regional Project Implementation Committee meetings (R-PIC)<br>• Number of execution agreements signed<br>• Number of Governance, Leadership & Management (GLM) trainings (disaggregate by number of people, gender and type) | • Feasibility study report<br>• Project quarterly progress reports<br>• Annual work plans<br>• Meeting minutes<br>• Execution agreements<br>• District and regional HMIS reports | • Progress on GOU introduction of Regional Administration (MoPS)<br>• Sanction/approval by MOH management to conduct activities required.<br>• Availability, interest and willingness of MoH senior managers to participate and cooperate<br>• Revision of Hospital Policy to reflect complementary role of Health Facilities (HFs) rather than additional roles)<br>• Project Admin & Finance TA available |
| **Result area 3 / Output 3: The training needs in L&M of the health sector are** | **1. Support the transformation of HMDC into a national centre for L&M development in the** | • Number of regional training centres established<br>• Number of eLearning courses conducted (by | • Training session reports<br>• Project quarterly progress reports | • MOH appointments of required staff<br>• Training Needs Assessments conducted at |

| | | | | |
|---|---|---|---|---|
| **strengthened through transformation of the HMDC (Mbale) and the establishment of 2 regional satellite training centres** | **health sector**<br>**2. Support the development of regional satellite training centres**<br>**3. Infrastructure development for regional training centres in Rwenzori and West Nile regions**<br>**4. Infrastructure development at HMDC (Mbale).** | number, gender and type)<br>• Number of GLM trainings | • Field visits and observation<br>• Interviews<br>• HMDC Strategic & Investment Plan (SIP) | national, regional and district level<br>• Sanction/approval by MOH management to conduct activities required.<br>• Availability, interest and willingness of MoH senior managers to participate and cooperate<br>• Project Admin & Finance TA available |
| **Result Area 4 / Output 4:**<br>**Capitalisation and Scientific support accompanies the capacity building process in the Ugandan health sector** | **1. Inception phase on capitalisation of project experiences and identification of health sector needs for scientific support**<br>**2. Continuous capitalisation and scientific support during project implementation** | • Areas / themes for scientific support identified and agreed<br>• Number of Scientific Support team missions<br>• Products of the capitalisation available | • Capitalization mission reports<br>• Minutes from meetings/seminars<br>• Project quarterly progress reports<br>• Reports and publications | • Scientific Support team engaged in project through BTC-KIT framework contract<br>• Sanction/approval by MOH management to conduct activities required.<br>• Availability, interest and willingness of MoH senior managers to participate and cooperate<br>• Project Admin & Finance TA available |

| N° | Activities | Means | Cost (Euro) |
|---|---|---|---|
| **Result 1**<br>**The ministry of health is strengthened in its organisational and institutional capacity** | **1. Capacity assessments & planning support MOH HQ**<br>**2. Institutional and individual Capacity building at MOH**<br>**3. Investment support to capacity building at MoH HQ** | International and national consultants<br>MoH staff<br>Transport<br>Stationeries | 518,500 |
| **Result 2**<br>**Institutional Capacity is developed in the health sector in Rwenzori and West-Nile region at all levels (regional coordination, RRHs, Districts, General Hospitals and Health Sub-district)**. | **1. Support implementation of district workplans – execution agreements**<br>**2. Support implementation of district workplans – non-EA**<br>**3. Support implementation of RRH workplans – execution agreements**<br>**4. Support implementation of RRH workplans – non-EA5**<br>**5. Support to executing investment plans of districts, RRHs and Regional coordination**<br>**6. Supporting regional health level coordination** | International and National consultants<br>MoH staff members<br>Transport<br>Stationary | 2,571,000 |
| **Output 3:**<br>**HMDC and two regional training centres for capacity building of (health sub-district) management teams are functional.** | **1. Support the transformation of HMDC into a national centre for L&M development in the health sector**<br>**2. Support the development of regional satellite training centres**<br>**3. Infrastructure development for regional training centres in Rwenzori and West Nile regions**<br>**4. Infrastructure development at HMDC (Mbale).** | Architect expertise<br>Construction materials<br>Transport | 785,000 |
| **Output 4.**<br>**A scientific support team accompanies the capacity building process in the Ugandan health sector** | **1. Inception phase on capitalisation of project experiences and identification of health sector needs for scientific support**<br>**2. Continuous capitalisation and scientific support during project implementation.** | International and national consultants;<br>Transport | 210,000 |

## 5.4 MoRe Results at a glance

| Logical framework's results or indicators modified in last 12 months? | No (Last modification July 2013) |
|---|---|
| Baseline Report registered on PIT? | No |
| Planning MTR (registration of report) | June 2013 |
| Planning ETR (registration of report) | Q3 2015 |
| Backstopping missions since 01/01/2014 | January 2014; November 2014 |

## 5.5 "Budget versus current (y – m)" Report

See annex (December 31, 2014).

## 5.6 Communication resources

High media coverage at national and regional level took place in February 2013 related to the hand-over of  project vehicles and the set-up of a Regional Ambulance system, by the honorable Minister of Health, Dr Christine Ondoa.

During the MTR, the inadequate communication between the project secretariate and the implementation areas was noted. The project has introduced a monthly "brief" to inform the stakeholders on the progress of planned activities and other developments under the ICB project.