RESULT REPORT 2014

INSTITUTIONAL SUPPORT FOR THE PRIVATE-NON-FOR-PROFIT (PNFP) HEALTH SUB-SECTOR TO PROMOTE UNIVERSAL HEALTH COVERAGE IN UGANDA (UGA 13 026 11)

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
BTC	Belgian Technical Cooperation, the Belgian development agency
DHMT	District Health Management Team
EoMC	Emergency Obstetric Care
GoU	Government of Uganda
HC	Health Centre
HIV	Human Immunodeficiency Virus
HQ	Headquarters
ICB	Institutional Capacity Building (Project)
M&E	Monitoring and Evaluation
MB	Medical Bureau
MoH	Ministry of Health
MTCT	Mother-To-Child-Transmission
NTA	National Technical Assistant
PHC	Primary Health Care
PNFP	Private-Non-For-Profit
PNFPCB	Private-Non-For-Profit Coordination Bodies
PNFPCB	Private-Non-For-Profit Coordination Bureau
PPPH	Public Private Partnership in Health
PS	Permanent Secretary (MoH)
PSC	Project Steering Committee
RBF	Result Based Financing
RRH	Regional Referral Hospital

SDHR	Skills Development for Human Resources (Project)
SRH	Sexual and Reproductive Health
ToRs	Term of References
TFF	Technical and Financial File
UCMB	Uganda Catholic Medical Bureau
UHC	Universal Health Coverage
UNMCHP	Uganda National Minimum Health Care Package
UPMB	Uganda Protestant Medical Bureau

1 Intervention at a glance

1.1 Intervention form

Intervention title	**Institutional Support for the Private-Non-For-Profit (PNFP) health sub-sector to promote universal health coverage in Uganda.**
Intervention code	**UGA1302611**
Location	**Uganda: Kampala, West Nile region and Rwenzori region.**
Total budget	**€ 8 000 000**
Partner Institution	**Ministry of Health**
Start date Specific Agreement	**13 May 2014**
Date intervention start /Opening steering committee	**27 June 2014**
Planned end date of execution period	**30 June 2018**
End date Specific Agreement	**13 May 2020**
Target groups	• **Ministry of Health and Medical Bureaux** • **PNFP health facilities and institutions in West Nile and Rwenzori region.** • **Rural population of West Nile and Rwenzori region, in particular the mothers and children.**
Impact	Contribute to strengthen service delivery capacity at district level to effectively implement PHC activities and deliver the UNMCHP to the target population.
Outcome	**PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.**

Outputs	**Result 1**	**MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies.**
	Result 2	**MB and PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions.**
	Result 3	**District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations.**
	Result 4	**MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities.**
	Result 5	**PNFP HC III and IV of the regions of West Nile and Rwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF.**
	Result 6	**PNFP hospital care of West Nile and Rwenzori is more accessible for the population without loss of quality of care through RBF.**
Year covered by the report		**2014**

1.2 Budget execution

	Budget	Expenditure		Balance	Disbursement rate at the end of year 2014
		Previous years	Year covered by report (2014)		
Total	€ 8 000 000	*N/A*	319 092	7 680 908	4%
Output 1	301.950		4 441	301 509	1%
Output 2	163.200		72	163 128	0%
Output 3	42.000		0	42 000	0%
Output 4	69.000		0	69 000	0%
Output 5	2.248.600		0	2 248 600	0%
Output 6	1954.600		0	1 954 600	0%
Common costs related to the activities	1.305.200		108.771	1.196.428	8%
General means	1.623.800		205.808	1.417.991	13%

1.3 Self-assessment performance

The project started in July 2014 and therefore it is too early to assess the outcomes, elaborate on level of achievement of the outputs and the level of management of activities

1.3.1 Relevance

	Performance
Relevance	A

The main target of the project are the PNFP health providers in two regions. Nationwide, they constitute 23% of all health facilities in Uganda: 606 in 2004 and 774 in 2010. The PNFP health facilities contribute to about 50% of health outputs and receive a subsidy from the Government, which amounts to 20% of the total expenditure of health facilities.

In the project's intervention area, there are 9 hospitals and 69 health centres under the PNFP's Medical Bureau umbrella. Many field missions were organized by the project staff and the BTC Representation in the two implementation regions to assess critically the level of partnership between the Government and the PNFP health sub-sector. One of the observations was that

many of these PNFP health facilities are indebted. All interactions with the in-charges pointed out a financial dire situation of the facility and the problem of financial accessibility of the rural population to health care. In addition, the project noted that there is considerable room for quality improvement of healthcare. Through providing direct financial support to PNFP health facilities through a Result-Based Financing mechanism, which will focus on the provision of quality healthcare, the project aims to tackle the above-mentioned problems.

Although the Public-Private Partnership in Health (PPPH) policy has been adopted in 2012, thep project observed that the partnership between GoU and PNFP health sub-sector at local governmental level – districts – is mainly limited to the government conditional grant and in some districts secondment of staff. There are no formal coordination structures and mechanisms, no initiatives to pool resources for supervision or support activities to the PNFP health facilities. In order to coordinate the various initiatives by different stakeholders to overcome these problems, the MoH has taken steps to set up a PPPH unit in the Directorate of Planning. The project will support the setting up of this unit and the implementation of the PPPH policy.

In summary, the project's intervention logic and the stipulated activities are aimed at addressing very relevant problems in Uganda's health sector. Therefore, the project rationale and strategy is fully endorsed by both the MoH as the PNFP health sub-sector. It’s well understood and endorsed by the partner institutions and the project indicators are fully aligned either with the Belgian Development Strategy, and the Health Sector Strategy and Investment Plan (HSSIP).

1.3.2 Effectiveness

	Performance
Effectiveness	A

By interacting with the partner institutions and observing the intervention areas, the project believes that full achievement is very likely in terms of quality and coverage.

Three National Technical Assistants (NTA) have been recruited. At national level, one will support the PPPH Unit's activities in the MoH and work on the monitoring and evaluation of the project. One NTA in each region will support the health districts in the design of their coverage plan and business plans, the cost study and the implementation of the Result-Based Financing mechanism. The high level of expertise of these NTAs will be an asset for the project, in terms of analysing the data collected during the project life, following up the evolution of the context and suggesting adaptation of the project strategies to the project management team if there is change in the external conditions.

To avoid delay in procurements, about 16% of the total budget is assigned to co-management. The remaining budget to implement activities falls under regie management. This will probably led to the soft organization of activities by reducing the logistic challenges and cash transfers from Uganda's National Bank.

1.3.3 Efficiency

	Performance

Efficiency	A

The first PSC decided to recruit a consultant to immediately start up the project. This facilitated the carrying out of the initial workload and paved the way for a fast and smooth preparation of the first project activities. The project staff was recruited on time and the project could rely on adequate resources to carry out the intervention. Because of the presence of a start-up consultant, the project coordinator and the national technical staff could dedicate more time on the preparation of project activities.

Although the delivery of the ordered IT material takes more time than expected, this has not jeopardized the project's activities.

1.3.4 Potential sustainability

	Performance
Potential sustainability	A

The RBF mechanism which is set up by the project will address the fund allocation to the supply side of the health sector. This fund allocation mechanism has been embedded in the financial strategy of the Ministry of Health.

Taking in account the best practices of RBF in other low- and middle-income countries, the RBF mechanism in the project will prepare the third party payment by financing the recurrent costs after conducting a comprehensive cost study. This cost study will inform the design in order to avoid underfunding of health facilities and hence production of poor quality of services, knowing that poor quality is always more expensive to the community than safe and unharmed health services. The subsides given to the health facilities will be in line with what the Government and other donors at national level can afford at mid-term level.

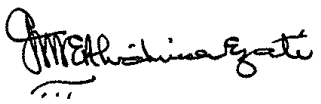
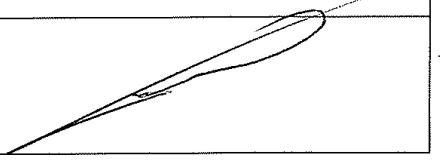
In addition, the project will support the defined UNMHCP and avoid neglected services and/or neglected populations by designing a comprehensive coverage plan in all districts of intervention.

The success of the project in the promotion of quality of services (effectiveness, efficiency, safety, access to health) can be taken up by the Belgian Development Cooperation in the health sector's policy dialogue to advocate for and convince other donors to accept the use of RBF mechanism and to build up with the GoU a trust fund to finance UHC in the country in the long term.

The project has taken the necessary steps – and will continue to do so – to ensure full ownership of the intervention by the partner institutions. It has been allocated office space in the MoH and the two RRHs of Arua and Fort Portal and is engaging on a daily basis with the partner institutions in designing, planning and implementing activities.

1.4 Conclusions

- Consultant facilitated start-up of project by handling setting project offices, recruitment of national staff and assisting the ITA in designing and planning the first project activities. This has contributed to the project's efficiency in the first six months.
- Project has taken the necessary steps to ensure full local ownership of the intervention.
- Project missions, meeting and discussions with partner institutions has learnt that the project's intervention (and its logic) is well understood, aligned with the national and Belgian policies and strategies, and very relevant.
- The project started up in July 2014 and therefore is too early to assess sustainability and effectiveness of the intervention.

Dr. Isaac Ezati Director Health Services (Planning and Development), Ministry of Health. Project Co-manager of MoH/BTC PNFP Project.	Dr. Thomas Galbert Fedjo Tefoyet ITA PNFP Project Project Manager of MoH/BTC PNFP Project
	

2 Results Monitoring

2.1 Evolution of the context

2.1.1 General context

The general context remained unchanged. No key evolution in sector policy, decentralization policy or general political and socio-economic environment. Neither was there an organizational change in one of the partner institutions.

2.1.2 Institutional context

The intervention is anchored at the Directorate of Planning and Development in the MoH. No major evolution has taken place in the MoH or the Planning and Development Department during the reporting period. The Director of Planning and Development is the project manager and he is very involved in the project. Thanks to his support the project has made adequate progress in a range of activities. It is also thanks to his support and that of the Permanent Secretary of the MoH that the project had no difficulties in setting up offices in the MoH and the two RRHs.

2.1.3 Management context: execution modalities

The project account at the Bank of Uganda is not yet open. This process is ongoing and it is too early to have any appreciation of the national execution modalities. However, budget modifications will be submitted to the steering committee, in order to transfer to BTC management the organization of workshops and other advocacy activities in order to avoid delay due to the local regulations on procurement and fund transfers.

2.1.4 Harmonisation context

The project has taken actions to harmonize with BTC's ICB and SDHR project. At a higher level, the BTC together with the Belgian Embassy has taking the lead in the policy dialogue with other bilateral donors to move towards a new joint financing mechanism that puts more emphasis on results and earmarks budget support and/or basket funds with well-defined outputs and M&E systems. Under the PNFP project a RBF system at district for the PNFP health sub-sector will be piloted and a RBF scheme to be rolled out at national level will be designed. To provide more scientific background and (technical) orientation to all stakeholders (MoH at central and district level, NGOs, PNFP and Development Partners) who might be involved in PBF initiatives, the PNFP project is organizing an International Orientation Workshop on PBF in Uganda, inviting PBF experts from abroad and PBF pilot projects implemented in Uganda by other development partners. This will promote harmonization within a sector wide approach.

The project is also harmonizing with other development partners with regards to supporting the MoH in implementing the PPPH policy. Both BTC and USAID support the setting up and functioning of a PPPH unit in the MoH. In order to avoid duplication and maximize efficient use of resources, BTC and USAID have coordinated their support.

2.2 Performance outcome

2.2.1 Progress of indicators

Baseline study is currently being carried out. As a result final values are not yet available. The indicators are in line with the Ministry of Health's Monitoring and Evaluation system.

The baseline study will not be limited to the collection of data to follow-up the project indicators:

1. A complete assessment of health facilities is scheduled in the first semester of 2015 to feed the elaboration Health District Coverage plan and identify the gaps in infrastructure, equipment and human resources in the existing facilities.
2. A cost study will inform the costing of RBF indicators, but also the elaboration of business plans and decisions on user fees in the facilities. The management of PNFP health facilities is largely decentralized, but there is a need of skills and information to build a comprehensive business plan, including strategies and interventions to go from the actual situation to an equilibrium between income and expenses without loss of quality. By increasing efficiency, the health facility will also be able to lower the user fees.

Outcome: PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
Total value of debt in PNFP health facilities enrolled into RBF					
Reported maternal death					
Reported under-five death					
% deliveries in health facilities					
Contraceptive Prevalence Rate					
Evolution of fee levels in PNFP health facilities					

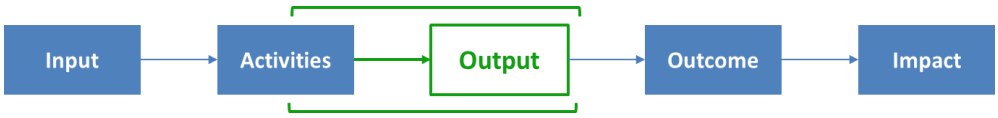
2.2.2 Analysis of progress made

The outcome indicators have been discussed and approved by the project stakeholders in the Project Technical Follow-up Committee meeting, but it's too early to make any progress analysis.

2.2.3 Potential Impact

The PNFP facilities contribute to about 50% of health outputs and receive from the Government only 20% of the total expenditure of the health facilities. Investing in their recurrent cost will then have an important added value in term of improvement of access to and quality of health in the intervention area.

2.3 Performance output 1



2.3.1 Progress of indicators

Output 1: MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of approved posts filled by trained health workers.					
% of PNFP health facilities implementing the national SRH/HIV policies.					
Amount of GoU budget (conditional grant) allocated to PNFP health sub-sector.					

2.3.2 Progress of main activities

Progress of main activities	**Progress:**			
	A	B	C	D
1 Support planning, management and administration of the PPP Unit in the Directorate of Planning and Development.				
2 Review PPPH related policies and guidelines.				
3 Disseminate policies and guidelines and do advocacy through communication activities.				
4 Perform field visits.				
5 Organize country study tours.				
6 Perform technical and scientific follow-up and evaluation to feed policy design.				

2.3.3 Analysis of progress made

It is prematurely to make any progress analysis of these outputs. Sub-activities to achieve the main activities have been planned and integrated in the project work plan, but have not yet been implemented. These actives are mainly from the 2015 work plan for the PPPH Unit which will elaborate a strategic plan the upcoming year.

With regard to supporting the PPPH unit, the MoH has allocated office space to the PPPH unit and assigned an officer as its head. The project recruited a technical assistant who will work alongside and support the PPPH unit in taking up its functions fully the upcoming years. The project received and assessed the needs of the PPPH unit (furniture, IT equipment, etc.) and will procure and install these in the first quarter of 2015.

A country study tour to Ghana is planned to share the experience on the implementation of a Universal Health Coverage strategy.

2.4 Performance output 2

2.4.1 Progress of indicators

Output 2: MB and PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of accredited health facilities					
% of certified health facilities	**0**				**50**

2.4.2 Progress of main activities

Progress of <u>main</u> activities	**Progress:**			
	A	B	C	D
1 Support installation and equipment of MBs				
2 Support exchange, coordination and cross-fertilizing activities between MB and with MoH.				
3 Support of MB to PNFPCB through supervision, workshops and meetings.				

2.4.3 Analysis of progress made

It is prematurely to make any progress analysis of these outputs. Sub-activities to achieve the main activities have been planned and integrated in the project 2015 work plan, but have not yet been implemented.

With regards to main activity 1 and 3, preliminary meetings have taken place to assess and discuss the installation and equipment's needs of MBs and PNFPCBs. An installation and equipment needs per MB matrix is being drafted. The procurement and installation of these needs at the MB offices will be done in the first quarter of 2015.

Two out of four MBs have been implementing accreditation in their facilities with different accreditation criteria. The UCMB's accreditation criteria are mostly licensing procedures to ensure that all facilities operate under one umbrella and work towards meeting the points stipulated in UCMB's mission. These are incremental criteria that were agreed upon as a management team and approved by UCMB's Health Commission. It is mandatory to all the health facilities under UCMB's umbrella to comply with the criteria. The UPMB approach is a quality assurance approach for improving the quality of health care structures by setting optimal but achievable standards.

The project will support the elaboration of joint accreditation procedures, accepted by all stakeholders and applicable in public health facilities in the future. Once the standards are define by the accreditation procedure, they will be included in the RBF quarterly evaluation.

2.5 Performance output 3

2.5.1 Progress of indicators

Output 3: District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of villages with trained VHTs per district.					
Number of health coverage plans completed.	**0**				**15**

2.5.2 Progress of main activities

Progress of <u>main</u> activities	**Progress:**			
	A	B	C	D
1 Perform supervision activities and joint meetings between DHO and PNFPCB.				
2 Organize exchange activities between districts at regional level.				

2.5.3 Analysis of progress made

It is prematurely to make any progress analysis of these outputs. Sub-activities to achieve the main activities have been planned and integrated in the project 2015 work plan.

District Health Teams will be train to design the coverage plan. They will assess their needs, elaborate a work plan and complete the coverage plan themselves, with the technical support of the project officers and, if needed, the support of consultants in Geographic Information System and Public Health.

The first drafts of the coverage plan will be elaborated in the first quarter of 2015 and be used to select a limited number of facilities to be included in the RBF scheme, which is to be started up in July 2015. This selection process will give an opportunity to test the accreditation criteria.

Non accredited health facilities will receive a top up of equipment according to the needs identified by the coverage plan. With the support of the project, they will elaborate and implement a business plan which can take them to being accredited 6 months later.

2.6 Performance output 4

2.6.1 Progress of indicators

Output 4: MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
RBF model, accepted by MoH and GoU as the national model, available.	**0**				**1**
Number of districts nation-wide joining the RBF scheme.					

2.6.2 Progress of main activities

Progress of <u>main</u> activities	**Progress:**			
	A	B	C	D
1 Review existing and past RBF related experiences and policies in Uganda and conduct complementary studies.				
2 Design a RBF scheme to fund PNFP health facilities.				
3 Train management and health professionals in RBF.				
4 Implement the RBF procedures and tools.				
5 Develop and conduct communication and advocacy activities.				

2.6.3 Analysis of progress made

It is prematurely to make any progress analysis of these outputs. Sub-activities to achieve the main activities have been planned and integrated in the project work plan.

The project team visited the two current implemented PBF pilot projects in Uganda and reviewed the applied tools and methodology.

An international workshop to orient the main stakeholders in Uganda's health sector on PBF is being prepared by the project. The outputs of this workshop are: a) a report highlighting the conclusions, positive and negative, of the local pilots so far and the opportunities and threats of implementing PBF in Uganda, b) a first policy note on the short- and long-term vision of a Ugandan national PBF strategy, c) operational recommendations on future pilot implementation, including the modalities for coordination and harmonisation of future initiatives, d) institutionalization of a technical secretariat to assist MoH and other stakeholders in institutionalising PBF in Uganda with a proposal of specific ToR for this secretariat.

A curriculum on RBF and procedures tools will be elaborated with the support of local universities, in order to build a strong Ugandan RBF model that can contribute on the way to the UHC.

2.7 Performance output 5

2.7.1 Progress of indicators

Output 5: PNFP HC II, III and IV of the regions of West Nile and Rwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of PNFP health centres delivering the full HIV package for maternal and child health and HIV/AIDS (including MTCT).					
% of PNFP health centres without any stock-outs of 6 tracer medicines.					
% of health centres IV with functioning theatre (providing EMOC).					
% of children under one year immunized with 3rd dose Pentavalent vaccine.					
% of pregnant women attending 4 ANC sessions.					
% of pregnant women who have completed IPT2.					
% of eligible person receiving HIV therapy.					

2.7.2 Progress of main activities

Progress of main activities	**Progress:**			
	A	B	C	D
1 Elaborate a complete health coverage plan per district, including HC II, III and IV and adapt it on a yearly basis according to evolutions in the district.				
2 Support yearly planning, taking into account the conclusions and projections of the coverage plans, and assist in elaborating business plans in the concerned facilities once RBF funding has started.				
3 Build the skills of PNFP HC staff for RBF to function in their facility.				
4 Finance PNFP health centres through RBF.				

2.7.3 Analysis of progress made

It is prematurely to make any progress analysis of these outputs. Sub-activities to achieve the main activities have been planned and integrated in the project work plan. However, no more than 8 PNFP HCs are expected to receive project RBF funds in 2015. Reason hereof is that in many of the PNFP health centres in the project intervention area are inadequately or poor medical equipped - only 40% of the available equipment is in good condition. As a result, many of them will then fail to be accredited.

The little number of health facilities receiving project RBF funds in 2015 will give enough time to capacity building in the health facilities, mastering the rationalization process by DHMT, and testing of RBF tools and procedures.

2.8 Performance output 6

2.8.1 Progress of indicators

Output 6: PNFP hospital care of West Nile and Rwenzori is more affordable for the population without loss of quality of care through RBF.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of referred patients among out-patient department (OPD) clients.					
Ratio number of referred deliveries / total deliveries within the hospital.					
% of post-surgery infections.					

2.8.2 Progress of main activities

Progress of <u>main</u> activities	**Progress:**			
	A	B	C	D
1 Perform and implement the conclusions of a hospital care coverage and care provision study.				
2 Conduct costing studies per hospital and comparative costing studies between the hospitals.				
3 Prepare the PNFP hospitals for initiating RBF.				
4 Finance PNFP hospitals through RBF.				
5 Experiment with urban primary care centres outside the hospital environment.				

2.8.3 Analysis of progress made

It is prematurely to make any progress analysis of these outputs. Sub-activities to achieve the main activities have been planned and integrated in the project work plan. Less than 5 General Hospitals are expected to receive the subsides in 2015. Some of the General Hospital may be downgrade to HC level while proceeding the coverage plans.

ToRs of costing study and comparative cost studies have been drafted. The cost study will be conduct by a local university witch will also train the hospital management to do the cost study themselves and use the result to refine their business plans.

2.9 Transversal Themes

It is prematurely to give an overview of achievements with regards to the transversal themes.

2.9.1 Gender

The project has taking full account of gender, in particular the health status of pregnant women, young mothers and children, in its start-up phase. Exemplary are the indicators of different project results, which highlight the focus on gender and sexual and reproductive health.

2.9.2 Environment

The hospital business plans will include the management of hospital wastage.

2.9.3 Other

2.10 Risk management

To see the full risk management matrix: double click on the table below.

in the MoH						*Insert a line here*
Output 2: Some Medical Bureaux do not have the required technical, structural and financial competences	September-14	DEV	Medium	Medium	Medium Risk	Capacity building activities Use scholarship program to increase competences Elaboration of guidelines an standardisation of tools *Insert a line here*
Output 3: Weak leadership and management skills of multiple actors at regional level	September-14	DEV	Low	Medium	Low Risk	Presence of NTAs Output based financing for Health Districts *Insert a line here*
Output 4: Shortage of sufficient national expertise at different levels.	September-14	OPS	Low	Medium	Low Risk	Expertise to be made available Capacity building activities through the project and scholarship programme

3 Steering and Learning

3.1 Strategic re-orientations

3.2 Recommendations

The strategy outlined in the project's TFF remains valid and relevant. This strategy is imbedded in the Health Sector Strategic plan.

The project's action plan takes up the strategic direction of the TFF, with little change of activities, but while maintaining the main strategic orientations.

Recommendations	**Actor**	**Deadline**
Propose to the steering committee the transfer of the workshops and procurement's budget under co-management to BTC management to avoid delay in the fund transfers and execution of activities.	*Project Co-Manager*	*June 2015*

3.3 Lessons Learned

It is prematurely to list any lessons learned since the project is still in the start-up phase and hence implementation of project's main activities have yet to take place.

Lessons learned	**Target audience**

4 Annexes

4.1 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				
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	**I**ntervention 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				
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 2014					
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).					
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.

4.2 Decisions taken by the steering committee and follow-up

Decision	Identification period (mmm.yy)	Source*	Actor	Action(s)	Resp.	Deadline	Progress	Status
SC 1: before arrival of project s	Jun-14			Recruitment of International Technical Assistants	BTC	end of July 2014	ITA took office first week of September 2014	CLOSED
				Recruitment of National Technical Assistants	BTC	end of August 2014	3 have been recruited	CLOSED
				Procurement of project vehicles	BTC	End of August 2014	4 project vehicles have been procured	CLOSED
				Identification of office space in MoH	MoH	End of August 2014	Office space in MoH was allocated and the project has occupied the office	CLOSED
				Launch project	MoH and BTC	Jan-15	Will be held at the end of february at Maracha Hospital	ONGOING
				Contract consultant for start-up project	BTC	Jul-14	Consultant was contracted on July 1st 2014.	CLOSED

4.3 Updated Logical framework

No up-date of logical framework. As a result the logical framework of the TFF is still valid.

4.4 MoRe Results at a glance

Logical framework's results or indicators modified in last 12 months?	No.
Baseline Report registered on PIT?	Not yet.
Planning MTR (registration of report)	mm/yyyy (estimate)
Planning ETR (registration of report)	mm/yyyy (estimate)
Backstopping missions since 01/01/2012	20/10/2014 – 25/10/2014.

4.5 “Budget versus curent (2014)” Report

Financial Planning of UGA1302611

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Fin Plan Version: **2015Q1**
Budget Version: **C01**
Donor: DGD
Currency: DGD

Amounts in 1000 EUR

	Status	Fin Mode	Budget	TtY-1	Balance	2015 Q1	2015 Q2	2015 Q3	2015 Q4	2015 Total	2016 to end	Est. end Proj. Bal.	Est. % exec
A SPECIFIC OBJECTIVE			4.783,35	4,51	4.778,84	78,16	205,25	134,52	259,20	677,12	0,00	4.101,72	14%
01 MoH is strengthened in its			305,95	4,44	301,51	28,40	41,00	48,72	13,47	131,58	0,00	169,93	44%
01 Support the planning,		REGIE	112,20	4,44	107,76	16,90	9,50	7,97	7,97	42,33	0,00	65,43	42%
02 Review PPPH related policies		COGEST	80,00	0,00	80,00	0,00	15,00	13,00	0,00	28,00	0,00	52,00	35%
03 Disseminate policies and		COGEST	25,00	0,00	25,00	8,00	13,00	8,00	0,00	29,00	0,00	-4,00	116%
04 Perform field visits		COGEST	16,00	0,00	16,00	1,50	1,50	1,50	1,50	6,00	0,00	10,00	38%
05 Organize country study tours		COGEST	48,75	0,00	48,75	0,00	0,00	16,25	0,00	16,25	0,00	32,50	33%
06 Perform technical and scientific		COGEST	24,00	0,00	24,00	2,00	2,00	2,00	4,00	10,00	0,00	14,00	42%
02 Medical Bureaus and the PNFP			163,20	0,07	163,13	18,68	20,68	2,30	2,30	43,96	0,00	119,17	27%
01 Support the installation and		REGIE	40,00	0,07	39,93	8,93	8,93	0,00	0,00	17,87	0,00	22,06	45%
02 Support exchange, coordination		COGEST	64,00	0,00	64,00	7,74	0,30	0,30	0,30	8,64	0,00	55,36	14%
03 Support of MB to PNFPCB		COGEST	59,20	0,00	59,20	2,00	11,45	2,00	2,00	17,45	0,00	41,76	29%
03 District and Subdistrict Health			42,00	0,00	42,00	16,08	0,00	6,00	6,00	28,08	0,00	13,92	67%
01 Perform supervision activities		COGEST	36,00	0,00	36,00	16,08	0,00	3,00	3,00	22,08	0,00	13,92	61%
02 Organize exchange activities		COGEST	6,00	0,00	6,00	0,00	0,00	3,00	3,00	6,00	0,00	0,00	100%
04 MoH has a model and a vision on			69,00	0,00	69,00	15,00	43,00	4,40	2,40	64,80	0,00	4,20	94%
01 Review existing and past RBF		COGEST	4,00	0,00	4,00	15,00	0,00	0,00	0,00	15,00	0,00	-11,00	375%
02 Design a RBF scheme to fund		COGEST	8,00	0,00	8,00	0,00	6,00	0,00	0,00	6,00	0,00	2,00	75%
03 Train management and health		COGEST	35,00	0,00	35,00	0,00	24,00	0,00	0,00	24,00	0,00	11,00	69%
04 Implement the RBF procedures		COGEST	15,00	0,00	15,00	0,00	13,00	0,00	0,00	13,00	0,00	2,00	87%
05 Develop and conduct		COGEST	7,00	0,00	7,00	0,00	0,00	4,40	2,40	6,80	0,00	0,20	97%
		REGIE	3.225,03	319,10	2.905,93	162,42	134,02	263,55	353,55	913,55	0,00	1.992,38	38%
		COGEST	4.774,98	0,00	4.774,98	52,32	186,81	126,55	251,23	616,92	0,00	4.158,06	13%
		TOTAL	8.000,01	319,10	7.680,91	214,75	320,83	390,10	604,79	1.530,47	0,00	6.150,44	23%

Financial Planning of UGA1302611

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Fin Plan Version: **2015Q1**
Budget Version: **C01**
Donor: DGD
Currency: DGD

Amounts in 1000 EUR

	Status	Fin Mode	Budget	TtY-1	Balance	2015 Q1	2015 Q2	2015 Q3	2015 Q4	2015 Total	2016 to end	Est. end Proj. Bal.	Est. % exec
05 PNFP HC II, III and IV of the			2.248,60	0,00	**2.248,60**	0,00	55,57	64,10	125,23	244,90	0,00	**2.003,70**	11%
01 Elaborate a complete health		COGEST	40,00	0,00	40,00	0,00	4,77	0,00	0,00	4,77	0,00	35,24	12%
02 Support yearly planning, taking		COGEST	60,00	0,00	60,00	0,00	16,00	7,23	12,23	35,47	0,00	24,53	59%
03 Build the skills of PNFP HC staff		COGEST	135,00	0,00	135,00	0,00	25,87	17,87	0,00	43,74	0,00	91,26	32%
04 Finance PNFP health centres		COGEST	2.013,60	0,00	2.013,60	0,00	8,93	39,00	113,00	160,93	0,00	1.852,67	8%
06 PNFP hospital care of West Nile			1.954,60	0,00	**1.954,60**	0,00	45,00	9,00	109,80	163,80	0,00	**1.790,80**	8%
01 Perform and implement the		COGEST	7,50	0,00	7,50	0,00	0,00	0,00	3,00	3,00	0,00	4,50	40%
02 Conduct costing studies per		COGEST	6,00	0,00	6,00	0,00	2,00	7,00	2,00	11,00	0,00	-5,00	183%
03 Prepare the PNFP hospitals for		COGEST	81,00	0,00	81,00	0,00	43,00	0,00	35,00	78,00	0,00	3,00	96%
04 Finance PNFP hospitals through		COGEST	1.640,10	0,00	1.640,10	0,00	0,00	2,00	54,80	56,80	0,00	1.583,30	3%
05 Experiment with urban primary		COGEST	220,00	0,00	220,00	0,00	0,00	0,00	15,00	15,00	0,00	205,00	7%
B COMMON COSTS DIRECTLY			1.305,20	108,78	**1.196,42**	39,30	40,30	176,30	249,30	505,18	0,00	**691,24**	47%
01 Results			1.305,20	108,78	**1.196,42**	39,30	40,30	176,30	249,30	505,18	0,00	**691,24**	47%
01 Scientific follow-up and		REGIE	120,00	0,00	120,00	0,00	0,00	0,00	0,00	0,00	0,00	120,00	0%
02 Short term international and		REGIE	152,00	16,25	135,75	20,00	21,00	7,00	30,00	78,00	0,00	57,75	62%
03 National technical Assistant		REGIE	105,60	9,54	96,06	6,00	6,00	6,00	6,00	24,00	0,00	72,06	32%
04 1 National Technical Assistant in		REGIE	211,20	2,47	208,73	12,00	12,00	12,00	12,00	48,00	0,00	160,73	24%
05 Basic equipment HC (on the		REGIE	234,00	0,00	234,00	0,00	0,00	75,00	100,00	175,00	0,00	59,00	75%
06 Basic equipment hospitals(on		REGIE	253,80	0,00	253,80	0,00	0,00	75,00	100,00	175,00	0,00	78,80	69%
07 Vehicles		REGIE	99,00	80,52	18,48	0,00	0,00	0,00	0,00	0,00	0,00	18,48	81%
08 Maintenance, fuel and insurance		REGIE	129,60	0,00	129,60	1,30	1,30	1,30	1,30	5,18	0,00	124,42	4%
		REGIE	3.225,03	319,10	2.905,93	162,42	134,02	263,55	353,55	913,55	0,00	1.992,38	38%
		COGEST	4.774,98	0,00	4.774,98	52,32	186,81	126,55	251,23	616,92	0,00	4.158,06	13%
		TOTAL	8.000,01	319,10	7.680,91	214,75	320,83	390,10	604,79	1.530,47	0,00	6.150,44	23%

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	Status	Fin Mode	Budget	TtY-1	Balance	2015 Q1	2015 Q2	2015 Q3	2015 Q4	2015 Total	2016 to end	Est. end Proj. Bal.	Est. % exec
X RESERVE BUDGET (MAX 5% OF			287,66	0,00	**287,66**	0,00	0,00	0,00	0,00	0,00	0,00	**287,66**	0%
01 Reserve budget			287,66	0,00	**287,66**	0,00	0,00	0,00	0,00	0,00	0,00	**287,66**	0%
01 Reserve budget co-management		COGEST	143,83	0,00	143,83	0,00	0,00	0,00	0,00	0,00	0,00	143,83	0%
02 Reserve budget BTC direct		REGIE	143,83	0,00	143,83	0,00	0,00	0,00	0,00	0,00	0,00	143,83	0%
Z GENERAL MEANS			1.623,80	205,81	**1.417,99**	97,29	75,29	79,29	96,29	348,16	0,00	**1.069,83**	34%
01 Staff costs			1.291,20	152,23	**1.138,97**	73,29	58,29	71,29	91,29	294,16	0,00	**844,81**	35%
01 International Technical assistant		REGIE	720,00	117,86	602,14	38,00	39,00	49,00	72,00	198,00	0,00	404,14	44%
02 International administrative and		REGIE	360,00	28,12	331,88	28,00	12,00	15,00	12,00	67,00	0,00	264,88	26%
03 Accountant		REGIE	48,00	2,50	45,50	3,69	3,69	3,69	3,69	14,76	0,00	30,74	36%
04 Secretary		REGIE	86,40	0,00	86,40	0,00	0,00	0,00	0,00	0,00	0,00	86,40	0%
05 Drivers (4)		REGIE	76,80	3,75	73,05	3,60	3,60	3,60	3,60	14,40	0,00	58,65	24%
02 Investments			52,00	42,90	**9,10**	4,00	0,00	0,00	0,00	4,00	0,00	**5,10**	90%
01 Vehicle		REGIE	33,00	29,72	3,28	0,00	0,00	0,00	0,00	0,00	0,00	3,28	90%
02 Office equipment		REGIE	4,00	3,88	0,12	4,00	0,00	0,00	0,00	4,00	0,00	-3,88	197%
03 IT Office equipment		REGIE	12,00	4,24	7,76	0,00	0,00	0,00	0,00	0,00	0,00	7,76	35%
04 Office refurbishment		REGIE	3,00	5,06	-2,06	0,00	0,00	0,00	0,00	0,00	0,00	-2,06	169%
03 Running costs			99,60	10,00	**89,60**	5,00	5,00	5,00	5,00	20,00	0,00	**69,60**	30%
01 Maintenance, fuel and insurance		REGIE	43,20	6,41	36,79	2,70	2,70	2,70	2,70	10,80	0,00	25,99	40%
02 Offices maintenance and supply		REGIE	28,80	2,87	25,93	1,80	1,80	1,80	1,80	7,20	0,00	18,73	35%
03 Télécommunications (5 Mobile		REGIE	21,60	0,45	21,15	0,50	0,50	0,50	0,50	2,00	0,00	19,15	11%
04 Representation and external		REGIE	5,00	0,00	5,00	0,00	0,00	0,00	0,00	0,00	0,00	5,00	0%
		REGIE	3.225,03	319,10	2.905,93	162,42	134,02	263,55	353,55	913,55	0,00	1.992,38	38%
		COGEST	4.774,98	0,00	4.774,98	52,32	186,81	126,55	251,23	616,92	0,00	4.158,06	13%
		TOTAL	8.000,01	319,10	7.680,91	214,75	320,83	390,10	604,79	1.530,47	0,00	6.150,44	23%

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05 Financial costs (ledger fees		REGIE	1,00	0,27	0,73	0,00	0,00	0,00	0,00	0,00	0,00	0,73	27%
04 Audit et Suivi et Evaluation			181,00	0,68	180,32	15,00	12,00	3,00	0,00	30,00	0,00	150,32	17%
01 Evaluation & Monitoring		REGIE	100,00	0,00	100,00	0,00	0,00	0,00	0,00	0,00	0,00	100,00	0%
02 Baseline		REGIE	30,00	0,00	30,00	15,00	12,00	0,00	0,00	27,00	0,00	3,00	90%
03 Audit		REGIE	30,00	0,00	30,00	0,00	0,00	0,00	0,00	0,00	0,00	30,00	0%
04 Backstopping		REGIE	21,00	0,68	20,32	0,00	0,00	3,00	0,00	3,00	0,00	17,32	18%
		REGIE	3.225,03	319,10	2.905,93	162,42	134,02	263,55	353,55	913,55	0,00	1.992,38	38%
		COGEST	4.774,98	0,00	4.774,98	52,32	186,81	126,55	251,23	616,92	0,00	4.158,06	13%
		TOTAL	8.000,01	319,10	7.680,91	214,75	320,83	390,10	604,79	1.530,47	0,00	6.150,44	23%

4.6 Communication resources

N/A.