TECHNICAL & FINANCIAL FILE

INSTITUTIONAL CAPACITY BUILDING PROJECT IN PLANNING LEADERSHIP AND MANAGEMENT IN THE UGANDA HEALTH SECTOR – ICB PHASE II

UGANDA

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THE BELGIAN DEVELOPMENT COOPERATION .be

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ABBREVIATIONS

ANC	Antenatal Care
BOG	Board Of Governors
BS	Budget Support
BTC	Belgian Development Agency
CBO	Community Based Organization
CC	Coordination Committee
CHD	Community Health Department
C-section	Caesarean Section
CSO	Civil Society Organization
DFID	Department for International Development
DGD	Directorate General for Development Cooperation and Humanitarian Aid
DHO	District Health Office
DHMT	District Health Management Team
EMHS	Essential Medicines and Health Supplies
EUR	Euro
FY	Fiscal Year
GIS	Geographical Information System
GoU	Government of Uganda
HC	Health Centre
HDI	Human Development Index
HDP	Health Development Partner
HIV	Human Immunodeficiency Virus
HMDC	Health Manpower Development Center
HMIS	Health Management Information System
HNP	Health National Plan

HPAC	Health Policy Advisory Committee
HPLM	Health Planning Leadership and Management
HRH	Human Resources for Health
HSD	Health Sub-District
HSSIP	Health Sector Strategy and Investment Plan
HTI	Health Training Institute
ICB	Institutional Capacity Building
IDCP	Indicative Development Cooperation Programme
IEC	Information Education Communication
IFMS	Integrated Financial Management System
IHP+	International Health Partnership and related initiatives
ITA	International Technical Assistant
JMS	Joint Medical Store
LG	Local Government
MB	Medical Bureau
MCH	Maternal and Child Health
MDG	Millennium Development Goal
M&E	Monitoring & Evaluation
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MoFED	Ministry of Finance, Planning and Economic Development
MoU	Memorandum of Understanding
MPS	Ministry of Public Service
MTCT	Mother-To-Child Transmission
NDP	National Development Plan
NGO	Non-Governmental Organization

NHP	National Health Plan
NMS	National Medical Store
NRH	National Referral Hospital
NTA	National Technical Assistant
OPD	Out-Patient Department
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PHP	Private Health Practitioners
PNFP	Private Non For Profit
PNFPCB	Private Non For Profit Coordinating Bodies
PPP	Public Private Partnership
R	Result
RBF	Results-Based Financing
RRH	Regional Referral Hospital
SDHR	Support to Beneficiary Institutes for the Skills Development of their Human Resources”
SDMT	Sub-District Management Team
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SURE	Securing Ugandan Rights to Essential Medicines
SWG	Sub-technical Working Group
SWOT	Strengths, Weaknesses, Opportunities and Threats
TA	Technical Assistant
TCMP	Traditional and Complementary Medicine Practitioners
TF	Trust Fund
TFF	Technical and Financial File
TFR	Total Fertility Rate

TWG	Technical Working Group
UAIS	Uganda AIDS Indicator Survey
UBOS	Uganda Bureau Of Statistics
UBTS	Uganda Blood Transfusion Service
UCMB	Ugandan Catholic Medical Bureau
UDHS	Uganda Demographic and Health Survey
UGA	Uganda
UGX	Ugandan Shilling
UMMB	Ugandan Muslim Medical Bureau
UNHCO	Uganda National Health Consumer Organization
UNHRO	Uganda National Health Research Organization
UNMHCP	Uganda National Minimal Health Care Package
UOMB	Ugandan Orthodox Medical Bureau
UPMB	Ugandan Protestant Medical Bureau
USAID	United States Agency for International Development
USD	United States Dollar
VHT	Village Health Team
WB	World Bank

EXECUTIVE SUMMARY

The Institutional capacity building project in planning leadership and management in the Uganda health sector phase 2 comes as a follow-up of a first phase and as a complement to the PNFP project.

It has a budget of € 5,000,000 and an expected duration of 36 months.

It is coming at a stage when Results-Based Financing (RBF) and national health insurance systems are high on the national agenda. The project will pave the way towards these goals.

It is strongly inspired by the actual National Health Programme (NHP-II) guiding principles with a particular attention on Primary Health Care (PHC); decentralization including reflection on coordination between networks of districts and MoH at regional level; Gender-sensitive and responsive health care; Pro-poor services and sustainability; Partnerships (with PNFP); Integrated health care delivery.

Strategic orientations

A project framework is structured through a series of strategic options presented hereafter.

1. Results–based financing as one of the building block in the perspective of a national social health insurance system.

Implementation of RBF in ICB-II will feed national policies for future health insurance system development in the country.

Firstly, ICB-II will define eligibility criteria for the (public) health facilities to enter in the RBF scheme. As for the PNFP facilities, public facilities will have to go through a certification and accreditation system to be eligible for RBF support. For health centres (II and III), this implies that they have to be part of a coverage plan, that they have the basic infrastructure, the minimal staff and the necessary equipment for them to function correctly. They must show that they have a sufficient initial stock of medicines and the management tools and forms in place to deliver quality services. The project has a limited fund to support the facilities in fulfilling these preconditions. HC IV and hospitals will need to develop a business plan for the facility, which includes a long-term vision for the facility, in congruence with the district coverage plans, a HR development plan stating the workload and division of labour within the different departments, a proper stock management system for the pharmacy and the laboratory needs and a performant accounting system for managing the received funds and expenses. Concerning drugs management, the project will support strategies for improvements at health facility and district level.

Secondly, ICB-II will progress towards proper implementation of the strategic purchasing function. This function will be differentiated for HC III (first level of care) and HC IV and general hospitals (second level of care). The differentiated approach will contribute to better health system integration.

For HC-IV and general hospitals, the RBF scheme will be very similar to the ones of the PNFP facilities of that level. RBF will not pay the HC IV and referral hospitals for their primary care activities. These activities should be oriented towards urban HCs which can deliver this care more efficiently. RBF will not pay for non-referred patients at the hospital (or HC IV) ((with the exception of road traffic accidents) either. Outpatient department patients and inpatients should normally be referred when consulting at hospital level.

As for the HC III (HC II would be excluded in this first phase, because of the logistical complications and the budgetary constraints, but they can be upgraded to HC III if they are retained in the health coverage plans), the results–based financing would not be organized at the individual facility level but at network level, within a district through the evaluation of the performance of all first line health facilities (HC III). The DHMT will receive the RBF funds and it is up to them, after consultation of the HC staff of the district, to identify the priority activities or investments in a selected number of HC III.

The support to the ambulance services that was introduced by the ICB I project will be discussed further. It might be that the viability of this life-saving activity will be covered through the RBF support to the districts, but these detailed calculations are not available at this moment and will depend on the decision and experiences of the district.

2. A health system perspective and systemic capacity building to improve quality of care and quality of management

This means that the intervention will aim at strengthening strategic organisations at different levels of the health sector. Although it is impossible to cover the whole country geographically and although not all organisations within the sector will benefit from the intervention's support, it is feasible to strengthen the entire health system by improving crucial structures (like the MoH) and through lessons learned that are taken up by health authorities for further dissemination over the territory.

As for the ICB I project, capacity, and therefore also capacity building, are defined from individual to system level in order to be effective. Capacity building is more than the development of personal skills. Skilled people need to work together in an harmonised manner and should be motivated to deliver a quality work. They also need a correct working environment to which the intervention will contribute. A proper working environment can include physical assets and equipment, but also a good leadership and a team spirit.

In order to reach this objective, the ICB II project will intervene at the 3 organisational-administrative levels of the health system (facility level, district and MoH) and will cover essentially the 3 major dimensions that each organisational level needs to cover (quality of care, quality of management and development of human resources).

In addition to the 3 organisational-administrative levels of the health system, ICB-II will strengthen work initiated in ICB-I at regional level. Indeed, regional coordination is one of the promising initiatives of the ICB I project. ICB I is completing a national study on behalf of the MoH to investigate the various possibilities or scenarios to de-concentrate the MoH at the regional level. Key questions that the study should answer is the exact mandates and roles of a regional health zone, the type of cadres and their level of competence needed to accomplish these tasks and the organisational costs. The ICB II project will continue accompanying the MoH in the development of the vision and its operationalisation.

3. A coherent approach

ICB II will build on the achievements and dynamics of the ICB I project. Several aspects of the ICB I intervention are explicitly taken into account in the new project. The regional coordination meetings, the emergency evacuation (ambulance) system, the leadership and management courses are but some of the promising results within ICB I that will be further supported by the ICB II project. These aspects are specifically dealt with further.

The ICB II project will have a life-time of 3 years of implementation and will end around the same time as the PNFP project in order to enable an overall planning of a single new global support programme strengthening the health system in the construction of a national health insurance system.

For the PNFP and ICB project to maximize their potential synergies and complementary functions, a strong technical coordination and the sharing of available technical competences is necessary.

4. Geographical focus

ICB-II will expand work started in 15 districts within the 2 regions of Rwenzori and Western Nile (learning from good practices and attempting to address challenges). It will intervene at the national level (MoH), at the intermediate coordination level, at district level and health facility level in complementarity with PNFP project, Health Budget Support and the SDHR project.

5. Capitalization of lessons learned to feed national policy: a realistic approach acknowledging the complexity of processes at stake

The type of support the Belgian cooperation is providing to the Ministry of Health is one of systemic strengthening, support to development processes. This implies the capacities of continuous analysis of a situation based on visions / models and policies. Those evolve and are adapted on the basis of lessons learned through their operationalization. Analysis will be based on a systematic documentation of a complex (and changing) situation, documentation of efforts, of initial working hypotheses based on the vision and strategy defined by MoH.

In the baseline study, the ICB II project will describe initial situations on various specific subjects – including the crosscutting issues - on which the projects will intervene and have an impact. This initial documentation can be completed later during the project lifespan when new information pops up. The project will write a short overview (summary) of the insights at that moment which needs to be shared with different stakeholders.

The overall purpose of the evaluations should be more on how decisions led to or contributed to change and why progress was made (or not). Understanding is more important than judging. Recommendations should deal with what has been learned and what new decisions might further improve given situations. New strategic points of attention or opportunities for further systemic improvements should be indicated.

Intervention framework

As described before, this project is a continuation of the ICB – I and comes as a complement to PNFP project. It will continue and expand the work initiated by ICB I in 15 districts within the 2 regions of Rwenzori and West Nile. It will intervene at the national level (MoH), at the regional level, at district level and health facility level in complementarity with the PNFP project.

Key strategic focus at operational level will include strengthening of quality of care at health facility level and strengthening the referral system at district level with regional inter-district coordination. This will be achieved through a combination of capacity building and new financing modalities. At policy level, emphasis will be on strengthening the capacity of capitalization from “field” experiences.

Quality of leadership, planning and management, as well as clinical care will be addressed by ICB-II activities.

Capacities in financial, monitoring and evaluation, clinical and managerial quality management, human resources planning and management will be strengthened at various levels of intervention of ICB-II. These strengthened capacities will contribute to the design and implementation of results-based financing (RBF) at facility level according to needs (with the perspective of a future health insurance system), to the improved planning and management at district level, to the possible design and implementation of regional structures in support to the districts, and to better functioning of MoH headquarters and HMDC.

The project will have as a **general objective** to further improve effective delivery of an integrated Uganda Minimum Health Care Package.

The **specific objective** is to strengthen the planning, leadership & management capacities of (public) health staff – particularly at local government level. This should enhance the provision of quality services within an integrated health system.

The results and corresponding budgets are the following:

- Result 1: The quality of care at hospital and HC IV is strengthened : **1.625.500 euros** budgeted
- Result 2: District health offices and management teams are strengthened in their capacity to

manage integrated district health systems and to strengthen quality of care: **1.375.500 euros** budgeted

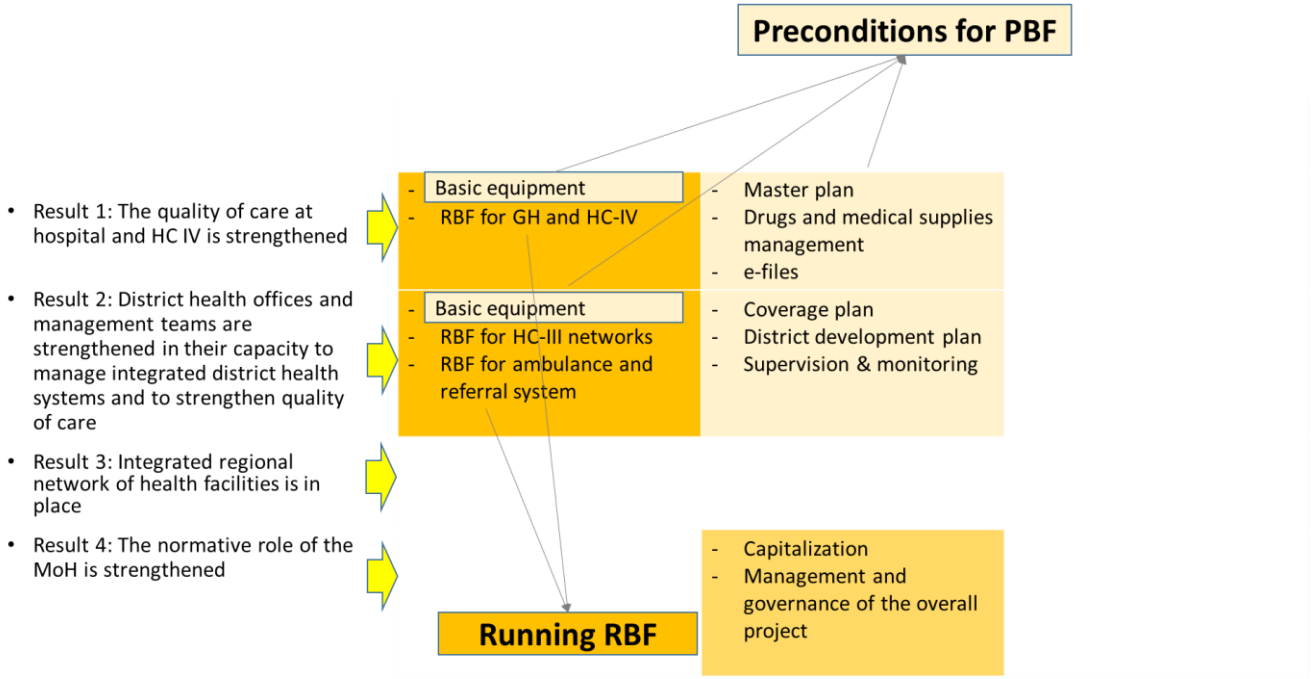
- Result 3: Integrated regional network of health facilities is in place: **397.600 euros** budgeted
- Result 4: The normative role of the MoH is strengthened: **870.150 euros** budgeted

Activities follow a double logic: (figure 1) A health system perspective and systemic capacity building to improve quality of care and quality of management (figure 1) and (2) Results–based financing as one of the building block in the perspective of a national social health insurance system (figure 2)

Figure 1

	Quality of care	Quality of administrative and financial management	Human resources development
• Result 1: The quality of care at hospital and HC IV is strengthened	- Basic equipment - RBF for GH and HC-IV	- Master plan - Drugs and medical supplies management - e-files	- Short courses
• Result 2: District health offices and management teams are strengthened in their capacity to manage integrated district health systems and to strengthen quality of care	- Basic equipment - RBF for HC-III networks - RBF for ambulance and referral system	- Coverage plan - District development plan - Supervision & monitoring	- mentorship
• Result 3: Integrated regional network of health facilities is in place		- Quarterly regional health forum	- Mentorship and e-conferences
• Result 4: The normative role of the MoH is strengthened		- Capitalization - Management and governance of the overall project	- Continuous training and e-learning (HMDC)

Figure 2



Implementation modalities

Institutionally the project will be anchored in the Ministry of Health (MoH) in the Planning and Development Directorate.

The project will continue to have field antennas in West Nile and Rwenzori regions.

The ICB II and PNFP projects will be considered as 1 intervention programme to support the health sector in Uganda.

The MoH, through the Director of Planning remains the overall technical responsible for the programme's content and orientations. The director of Planning, together with the team of ITA form the central decision making organ for the programme at which level planning and management are integrated (**programme management team**). The National Technical Assistants (2 NTA in the regions for ICB-II, 2 for PNFP) will technically contribute in the actual planning and execution of activities. They form together with the management team, the **programme technical team**.

Administrative support staff is needed due to the geographical spreading of the intervention and the important additional workload. This team is headed by an international administrative and financial officer and will work in an integrated way for the 2 interventions.

The international administrative and financial officer will contribute to capacity building in his field of competence and will technically contribute to the conception of hospital business plans and RBF (see chapter 2 for more details).

ANALYTICAL RECORD OF THE INTERVENTION

Title of the intervention	Institutional capacity building project in planning leadership and management in the Uganda health sector
Intervention number	NN 3016425
Navision Code BTC	UGA 1402811
Partner Institution	Ministry of Health
Duration of Specific agreement	48 months (4 years)
Duration execution	36 months (3 years)
Estimated start-up date	2015
Contribution of the Partner Country	In kind
Belgian Contribution	5,000,000 EUR
Sector (CAD codes)	12110 Health policy and administrative management
Global Objective	To further improve effective delivery of an integrated Uganda Minimum Health Care Package
Specific Objective	The planning, leadership & management capacities of (public) health staff – particularly at local government level is strengthened
Results	• Result 1: The quality of care at hospital and HC IV is strengthened • Result 2: District health offices and management teams are strengthened in their capacity to manage an integrated district health system and to strengthen quality of care • Result 3: Integrated regional network of health facilities is in place • Result 4: The normative role of the MoH is strengthened

1 SITUATION ANALYSIS

1.1 Demographic and Health Context

Uganda has an area of 241,000 km² and has seen extreme population growth from 9.5 million in 1969 to 34.9 million in 2014[1]. Eighty eight percent of the population lives in rural areas. With an annual growth rate of about 3.2 % translating into an annual increase of approximately 1 million people, the population is projected to reach 47 million inhabitants by 2025.² Rapid population growth is fuelled by a high fertility rate (6.2 live births per woman) and a low contraceptive prevalence rate (24%). Fertility levels are higher in the rural areas compared to the urban areas (6.8 and 3.8 respectively).

The rapid population growth puts severe strains on the Ugandan health system. In spite of an overall improvement in the national health indicators over the last ten years, they remain unsatisfactory and disparities continue to exist across the country[2] (UDHS 2011). Life expectancy increased from 45 years in 2003 to 52 years in 2008 and to 57 and 54 for females and males respectively in 2011 (WHO estimation). The prevalence of vaccine preventable diseases has declined sharply. Between 1995 and 2011, under-five mortality rate declined from 156 in 1995 to 90 deaths per 1,000 live births; infant mortality rate decreased from 85 to 54 deaths per 1,000 live births; and Maternal Mortality Rate (MMR) reduced from 527 to 438 per 100,000 live births. Teenage pregnancy estimated at 25% in 2006 and up to 30% in 2011 significantly contributes to the overall MMR in Uganda. The new-born mortality rate was 33 per 1000 live births in 2000 and decreased to 27 in 2011. In spite of earlier successes in the fight against HIV and AIDS - HIV prevalence has been reduced from 27% to 7% between 2000/01 and 2007/08 - the national HIV prevalence in the age group of 15-49 years is on the rise again and increased from 6.4% in 2004 to 7.3% in 2011. HIV prevalence among women aged 15-49 (8.3%) is higher than among men of the same age group (6.1%).

Malaria, malnutrition, respiratory tract infections, AIDS, tuberculosis and perinatal and neonatal conditions remain the leading causes of morbidity and mortality. Seventy percent of overall child mortality is due to malaria (32%), perinatal and neonatal conditions (18%), meningitis (10%), pneumonia (8%), HIV and AIDS (5.6%) and malnutrition (4.6%). Non-Communicable Diseases (NCD) are an emerging problem due to multiple factors such as adoption of unhealthy lifestyles, increasing life expectancy and metabolic side effects resulting from lifelong antiretroviral treatment. Gender inequalities including sexual and gender-based violence (UBOS, 2007) remain a major hindrance to improvement of health outcomes.

Seventy five percent of the disease burden in Uganda however is still preventable through health promotion and disease prevention. These problems call for intensive focused and well-coordinated collaboration between the health sector and other stakeholders.

The major determinants of health in Uganda include levels of income and education housing conditions, access to sanitation and safe water, cultural beliefs, social behaviours and access to quality health services. While the proportion of people living below the poverty line has significantly decreased from 52% in 1992 to 31% in 2005 and 24.4% in 2009 (World Bank), Uganda is still a low income developing country with income disparities spread across the country. A direct relationship exists between poverty and prevalence of diseases such as malaria, malnutrition and diarrhoea as they are more prevalent among the poor than the rich households (DHS 2011). Notwithstanding Uganda's high economic growth rate with an average of 7% per annum, the country is still classified amongst the countries with the lowest human development index (HDI value 0.422, rank 143/169 in 2010).

[1] Uganda Bureau of Statistics. 2014. Provisional Census Results, 18 November 2014.
[2] Uganda Demographic and Health Survey 2011.

1.2 Political and Administrative Factors

Administratively, Uganda is divided into districts which are sub-divided into lower administrative units namely counties, sub-counties and parishes. Overtime, the numbers of districts and lower level administrative units have increased in number with the aim of making administration and delivery of social services easier and closer to the people. This has however placed increased strain on delivery of health services, as numbers of management and administrative units and functions increase.

As a way of improving the efficiency and effectiveness of service delivery, the GoU decentralized delivery of services guided by the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997). Each level of the decentralized health delivery system has specific roles and responsibilities. With changing leadership and creation of new districts, the district leadership needs to be periodically oriented in the roles and responsibilities. Supervision both from central level to districts and districts to lower levels is inadequate; inadequate funding and weak logistics management constrain the delivery of quality health services. Over the period of the HSSIP, the sector shall continue reviewing the strategies and adopt the ones that will give optimum outcomes.

There is no intermediate, regional administration, neither is there a standard definition of what a region should be.

1.3 National Health Policies and Strategies

The 1995 Constitution of the Republic of Uganda provides for all people in Uganda to enjoy equal rights and opportunities, to have access to health services, clean and safe water and education, among many other things. Investing in the promotion of people's health and nutrition ensures that they remain productive and contribute to national development. The Government of Uganda (GoU) recognizes this obligation to provide basic health services to its people and to promote proper nutrition and healthy lifestyles. National Development Plan (NDP) for the period 2010/11-2014/15 places emphasis on these fundamental human rights. In the chapter on health and nutrition the NDP prioritises the implementation of the Uganda National Minimum Health Care Package (UNMHCP). According to the NDP the health service focus during the 5 year period should give priority to strengthening the health system and the implementation of programmes of national interest, i.e. reproductive health and child survival, HIV & AIDS, tuberculosis, malaria and nutrition. The ultimate aim is to ensure that Uganda achieves the health related MDG targets by 2015.

1.3.1 National Health Policy II (2011-2020)

The second National Health Policy 2011-2020 (NHP II) is based upon the 1995 Constitution of the Republic of Uganda, the National Development Plan 2010/2011-2014/2015 (NDP), and current global dynamics to achieve its vision of "A healthy and productive population that contributes to socio-economic growth and national development". The Uganda health policy emphasizes the achievement of the health related MDGs and more particularly MDG 4 (reduction of child mortality), MDG 5 (reduction of maternal mortality) and MDG 6 (fight against HIV & AIDS, tuberculosis and malaria).

The NHP mission is to provide the highest possible level of health services to all people in Uganda through delivery of promotional, preventive, curative, palliative and rehabilitative health services at all levels. The NPH is based on a series of social values, embedded in the Constitution and detailed in the Uganda's Patient Charter that will guide its implementation, i.e.: the right to the highest attainable standard of health; solidarity, equity, respect of cultures and traditions, professionalism and ethics, clients' responsibilities; and accountability.

The NHP II is inspired by ten guiding principles, nine of which are of importance for this new project:

- Primary Health Care (PHC): PHC shall remain the major strategy for the delivery of health services in Uganda, based on the district health system, and recognizing the role of hospitals as an essential part in a national health system.
- Decentralisation: Health services shall be delivered within the framework of decentralization and any future reforms therein.
- Evidence-based and forward looking strategy: taking into account emerging trends.
- Gender-sensitive and responsive health care: a gender-sensitive and responsive national health system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programmes.
- Pro-poor and sustainability: NHP II provides a framework to support sustainable development. In order to address the burden of disease in a cost effective way, GoU, Private Health Providers (PHP) and PNFP organizations shall provide services included in the Uganda National Minimal Health Care Package (UNMHCP) with special attention to under-served parts of the country. The GoU shall also explore alternative, equitable and sustainable options for health financing and health service organization targeting vulnerable groups.
- Partnerships: the private sector is seen as complementary to the public sector in terms of increasing geographical access to health services and the scope and scale of services provided.
- Ugandan National Minimum Health Care Package (UNMHCP): in order to address the burden of disease in a cost-effective way, public and private providers shall offer services that are included in the UNMHCP.
- Integrated health care delivery: curative, preventive and promotional services shall be provided in an integrated manner.
- Alignment with international development policies: The NHP follows the principles of the Sector wide Approach, the Paris Declaration and the Accra Agenda for Action through the IHP+ in the interaction and collaboration with national and international development partners.

1.3.2 Health Sector Strategic and Investment Plan (2010/11-2014/15)

The Health Sector Strategic and Investment Plan 2010/11-2014/15 (HSSIP) guided the participation of all stakeholders in health development in Uganda. To achieve its goal, the HSSIP is aimed at i) improving access of the population to the UNMHCP, with a special focus on increasing effective access for the poor and vulnerable groups of the population and at ii) improving the quality of the UNMHCP delivery of the package and of all health services. The HSSIP is based upon five strategic objectives:

1. To scale up critical interventions for health and health related services, with emphasis on vulnerable populations;
2. To improve levels and equity in access and demand;
3. To accelerate quality and safety improvements for health and health services;
4. To improve efficiency and effectiveness of resource management for service delivery;
5. To deepen sector stewardship of the health agenda by the MoH.

Because of the limited resources, all people in Uganda should have access to the UNMHCP, which consists of four clusters:

1. Health promotion, environmental health, disease prevention and community health initiatives, including epidemic and disaster preparedness and response;
2. Maternal and child health;
3. Prevention, management and control of communicable diseases;
4. Prevention, management and control of non-communicable diseases.

The HSSIP furthermore states that absolute priority should be given to sexual and reproductive health, child health, health education and control and prevention of HIV/AIDS, malaria and tuberculosis. Investments made during the HSSIP period should be geared at enabling the system to deliver, at a minimum, the services related to these priorities.

A new health sector strategic and investment plan is being designed.

1.4 Organisation and Management of the Health System

1.4.1 Organisational Structure of the Health System

The National Health System (NHS) is made up of the public and the private sector. The public sector includes all GoU health facilities under the MoH, health services of the Ministries of Defence (Army), Education, Internal Affairs (Police and Prisons) and Ministry of Local Government (MoLG). The private health delivery system consists of Private Not for Profit (PNFPs) providers, Private Health Practitioners (PHPs), and the Traditional and Complementary Medicine Practitioners (TCMPs). The provision of health services in Uganda is decentralised with districts and health sub-districts (HSDs) playing a key role in the delivery and management of health services at those levels.

The health services are structured into National Referral Hospitals (NRHs) and Regional Referral Hospitals (RRHs), General Hospitals, Health Centres (HCs) IV, HCs IIIs, HCs IIs and Village Health Teams (HCs I). Hospitals provide technical back up for referral and support functions to district health services. Hospital services are provided by the public, private health providers (PHPs) and private not for profit (PNFPs).

HCs IV are considered to be functional if it can carry out caesarean section surgical operations. In 2012, it was estimated that 24% of all HCs IV were functional. Overall, about 3% of health care facilities are hospitals, 4% Health Centre IV and 70% Health Centre II. Most facilities are owned by government (54%) while 29% are owned by private individuals as private for profit facilities. The government owns and operates a tiered structure of 2867 facilities of which 64 are hospitals (2 national referral hospitals, 10 regional referral hospitals, 47 district hospitals, and 4 military and police hospitals).

Over the past years the MoH has invested a lot in the expansion of the health infrastructure, including rehabilitation and upgrading of some existing facilities, in order to achieve greater coverage. According to the Health Facility Inventory 2011, there are a total of 5,073 health care facilities and it is estimated that 72% of the population are within 5km walking distance to a health care facility.

The government also provides non-facility based services through national programmes such as Community and Environmental Health and Communicable Diseases Control. Health services are provided by the public and private for profit and non-for profit with each subsector covering about 50% of the reported outputs.

HSSIP provides for the instauration of a regional health level, but so far intentions “to regionalise” or “to zonalise” the health sector has not come to materialize. This explains why many stakeholders (such as the Global Fund, UNICEF, Intrahealth but also the Belgian Cooperation) tend to set up programme specific regional structures and mechanisms in order to facilitate programme management as well as the coordination between the district and the central level.

A recent 'regional mapping study' exercise has been financed by Belgian Cooperation in order to document existing practices with strengths and weaknesses. This should be completed before end of April to be presented to the MOH and other stakeholders for consensus building. A 'feasibility study' on the chosen model will follow if needed / possible.

1.4.2 Roles and Responsibilities

1.4.2.1 At the central level: the Ministry of Health and National Institutions

The core functions of the Ministry of Health (MoH) at central level are as follows:

- Policy analysis, formulation and dialogue;
- Strategic planning;
- Setting standards and quality assurance;
- Resource mobilization;
- Advising other ministries, departments and agencies on health-related matters;
- Capacity development and technical support supervision;
- Provision of nationally coordinated services including health emergency preparedness and response and epidemic prevention and control;
- Coordination of health research;
- Monitoring and evaluation of the overall health sector performance.

Several functions have been delegated to national autonomous institutions including Uganda Cancer Institute, Uganda Heart Institute, Uganda Blood Transfusion Services, Uganda Virus Research Institute, National Medical Stores, Central Public Health Laboratories, Professional Councils, National Drug Authority (NDA) and research institutions. The Uganda National Health Research Organisation (UNHRO) coordinates the national health research agenda, whilst research is conducted by several institutions including the Uganda Natural Chemotherapeutic Research Laboratory. The Health Service Commission (HSC) is responsible for the recruitment, and deployment of HRH at Central and Regional Referral Hospital levels. In the districts, this function is carried out by the District Service Commissions. The Uganda AIDS Commission (UAC) coordinates the multisectoral response to the HIV/AIDS pandemic.

1.4.2.2 At the District Level

The Constitution (1995) and the Local Government Act (1997) mandate the Local Governments[3] (LGs) to plan, budget and implement health policies and health sector plans. The LGs have the responsibility for recruitment, deployment, development and management of human resources (HR) for district health services, HR development, the passing of health related by-laws and the monitoring of overall district health sector performance. LGs also manage public general hospitals and HCs and also supervise and monitor all health activities (including those in the private sector) in their respective areas of responsibility.

The District Health Management team (DHM) is headed by the District Health Officer (DHO) who is responsible for the planning, monitoring and coordination of both public and private health service provision in the sub-districts under their responsibility. However, the public private partnership at district level is still weak.

[3] Currently there are 137 Local governments -112 Districts and 25 Municipalities.

1.4.2.3 At the Sub-District Level

The Health Sub-Districts (HSDs) are mandated with planning, organization, budgeting and management of the health services at this and lower health centre levels. The HSDs carry an oversight function of overseeing all curative, preventive, promotive and rehabilitative health activities including those carried out by the PNFPs and PFP service providers in the health sub district. The headquarters of an HSD will remain a HC IV or a selected general hospital.

HCs IV provide preventive, promotive, curative, maternity, in-patient health services, emergency surgery, blood transfusion and basis laboratory services.

1.4.2.4 National, Regional and General Hospitals

Hospitals provide technical back up for referral and support functions to district health services. Hospital services are provided by public, private and private non-for profit (PNFPs) health providers. All hospitals are supposed to provide support supervision to lower levels and to maintain linkages with communities through Community Health Departments (CHDs). The Regional Referral Hospitals have been granted self-accounting status but remain under the MoH oversight. The two National Referral Hospitals, Mulago and Butabika, are semi-autonomous. All PNFP hospitals are autonomous.

National Referral Hospitals provide comprehensive specialist services and are involved in health research and teaching in addition to providing services offered by general hospitals and RRHs.

Regional Referral Hospitals offer specialist clinical services such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, higher level surgical and medical services, and clinical support services (laboratory, medical imaging and pathology). They are also involved in teaching and research. This is in addition to services provided by general hospitals.

General Hospitals provide preventive, promotive, curative, obstetric, in-patient health services, surgery, blood transfusion, laboratory and medical imaging services. They also provide in-service training, consultation and operational research in support of the community-based health care programmes.

1.4.2.5 Health Centres II-III and Village Health Teams (HC I)

HCs III, II and Village Health Teams (HCs I). HCs III provide basic preventive, promotive and curative care. They also provide support supervision of the community and HCs II are under their jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county. The HCs II provide the first level of interaction between the formal health sector and the communities. HCs II only provide out-patient care, community outreach services and linkages with the Village Health Teams (VHTs). The VHTs are supposed to play an important role in health care promotion and provision but their coverage is limited and their actual capacities are quite limited.

1.4.3 Health Financing.

1.4.3.1 Evolutions in Total Health Expenditure

The health sector in Uganda obtains varying levels of funding from public sources (central government, local governments and parastatals, private sources (households, firms and local NGO's) and external sources (donors, international NGOs and GHI). Total Health Expenditure (THE) in Uganda has increased substantially from financial year 2008/09 to financial year 2009/10 in absolute and per capita terms. Absolute amounts increased from UGX 2.81 trillion (US$1,455 Million) to UGX 3.23 trillion (US$1,594 Million) while THE per capita increased from UGX 94,916 (US$49) to UGX 105,506 (US$52). Nevertheless, total general health expenditure (TGHE) as a % of total government expenditure (TGE) was 9% and 7% in 2008/09 and 2009/10 respectively which still falls below the Abuja Target set at 15%.

Table 1: Financing sources – General health 2008/09 and 2009/10

	FY2008/09 Amount in Billions UGX	Percentage	FY 2009/10 Amount in Billions UGX	Percentage
Public Funds	449.98	16%	472.35	15%
Private Funds	1,392.08	50%	1,571.66	49%
ROW Funds	966.42	34%	1,190.68	36%
TOTAL	**2,808.49**		**3,234.68**	

Public Funds accounted for 16% of THE in financial year 2008/09 but decreased its relative contribution to 15% in financial year 2009/10. Private funds contributed 50% and 49% of the resources to the health sector in financial year 2008/09 and financial year 2009/10 respectively. The rest of the world (international NGO's and Donors) contributed 34% in FY2008/09 and 36% in financial year 2009/10.The public sector, which includes central government and district level, managed only 22% of total funds spent on health in 2009/10, and district health services 7%.Moreover, social security is little developed so that the ability of government is limited in determining priority areas in which funds should be allocated in order to improve the country's health indicators.

This trend has important implications for service delivery as it will imply the need for further priority setting based on the UNMHCP. The current population growth rate will have an escalating effect on the total resource envelope required. Not less than 9% of household expenditure is spent on health care (out-of-pocket health expenditure. The GoU will need to explore alternative financing mechanism to increase resources for health sector, to reduce dependency on donors, to improve resource allocation criteria to address inequities to build a better link with the private sector and better coordination of partners to attain policy goals and improvement of accounting systems.

Table 2: Government allocation to the health sector 2000/01 to 2011/12

Table 18: Government allocation to the Health Sector 2010/11 to 2013/14

Year	GoU Funding (Ushsbns)	Donor Projects and GHIs (Ushsbns)	Total (Ushsbns)	Per capita public health exp (UGX)	Per capita public health exp (US $)	GoU health expenditure as % of total government expenditure
2010/11	569.56	90.44	660	20,765	9.4	8.9
2011/12	593.02	206.10	799.11	25,142	10.29	8.3
2012/13	630.77	221.43	852.2	23,756	9	7.8
2013/14	710.82	416.67	1127.48	32,214	12	8.7

1.4.4 Health Information System, monitoring and evaluation

The GoU is investing heavily in the computerisation of its health information systems through the institution of several electronic systems, i.e.:

- a web-based District Health Information System (DHIS2), which has been rolled in 90% (100/112) of the districts

- the Human Resource Information System (HRIS), which has been rolled out in 66% (74/112) of the districts
- m-Trac[4] for monitoring service delivery and medicines availability, which has been rolled out in 24% (27/112) of the districts.

Both public and PNFP facilities report through the National HMIS.

However, a number of bottlenecks call for an adequate response in order to ensure optimal use of the system.

Recently, the MoH in Uganda has developed a M&E Plan to facilitate the establishment of a country led platform for the Health Sectors and is in the process to reform inspection, supervision and monitoring of health services delivery delegating such functions to a regional structure. However, this two plans remain virtually unimplemented and even their dissemination within the sector is limited

M&E coordination and oversight in the health sector is embedded within the Directorate of Health Services (Planning & Development). However, the M&E functions are divided be-tween the Quality Assurance Department, responsible for data analysis, validation, interpretation and preparation of reports, and the Resources Centre, under the Planning Department, which manage the HIMS. Due to this specific location its power is limited; coordination and oversight logically entail a location higher in the hierarchy.

The transition from the first (2000/10) to the second (2010/20) National Health Policy (NHP) has seen an increased number of districts, from 39 to 112 in less than two decades, a great increase in number of health facilities and the establishment of National and Regional Referral Hospitals (NRH and RRH) to provide specialized services for a fast growing population. This situation has overstretched the already limited capacity of the MoH to effectively supervise and monitor all districts bringing to virtual collapse of the support supervision. Although the core functions of the Health District remain unchanged, the establishment of RRH requires the revision of all M&E process, from the center to the district. There is an urgent need, to reorganize the services provided by the MoH through a regional approach to bridge the gap between Centre and Districts and optimize inspection, supervision and monitoring of health services delivery. The exercise is expected to decentralize important M&E functions from the Centre to the Regional Level, bringing those functions more close to the service delivery level.

1.4.5 Medical Equipment and Drug Supplies

Supply, procurement, and distribution of medicines and medical supplies for the public sector are carried out by the National Medical Stores (NMS), a public semi-autonomous body. The Joint Medical Store (JMS), a private not-for-profit entity co-owned by the Uganda Catholic Church and Church of Uganda, procures for the PNFP subsector. US$1.60 per capita is needed to provide Essential Medicines and Health Supplies (EMHS) in all government and PNFP facilities. The funding gap to provide the EMHS required for the delivery of the Uganda National Minimum Health Care Package is nearly 50 %.

The GoU and the Health Development Partners (HDP) have recently undertaken a number of initiatives to improve efficiency, cost-effectiveness, and access to medicines, including developing a classification system to strengthen the selection of medicines and medical products, updating the essential medicines list to include laboratory supplies and introducing a kit-based push system to district-level health centers, which has had a proven and positive impact on reducing stock-outs in the

[4] M-Tracis a SMS-based disease surveillance and medicine tracking system. It provides real-time data for response while monitoring health service delivery performance. The initiative also integrates governance and accountability through citizen feedback, an anonymous hotline and public dialogue sessions.

districts. In 2009/10, in a bid to improve efficiency, effectiveness, and compliance with expenditure guidelines, the MoH consolidated 50 % of the PHC budget for medicines with a credit line and created a new single pool for financing medical products. Money for this consolidated fund is channelled to NMS to procure and distribute medical products to the public sector providers.

However, stock-outs in public sector facilities, informal payments in the public sector, and high prices in the private sector continue to pose challenges to equity and access – about 65 % of households in the lowest socioeconomic bracket face monthly catastrophic expenditures on pharmaceuticals. A key challenge that exacerbates drug stock-outs and expiries is the lack of broad-based coordination between the public sector and development partners on procurement and distribution. Moreover the NMS makes use of different procedures for different lines of supplies (UNMHCP, ARV, family planning, etc.) depending on the criteria imposed by the respective donors.

1.4.6 Human Resources for Health.

The Health Service Commission (HSC) is responsible for the recruitment and deployment of public Human Resources for Health (HRH) at Central and Regional Referral Hospital levels. In the districts, this function is carried out by the District Service Commissions. Significant progress has been made in recent years in increasing the output of health professional and in producing a multi-purpose nursing cadre capable to perform both nursing and midwifery tasks. Availability of data on the public sector health workforce has also improved. A comprehensive HRH policy and strategy to address priority HRH constraints is in place, although its implementation needs to be improved. Another encouraging development is the recognition of the need for human resource management and leadership training. The wage bill limits the ability of the public sector to fill its vacant positions and to absorb the increasing numbers of health workers produced. New incentives have been created in 2012 to attract doctors to General Hospitals and HC IV.

In spite of the progress made, the health sector is still facing serious challenges in HRH. Uganda has an estimated health workforce of 45,598[5]. Although the percentage of filled public sector posts has increased from 38 % in 2006 to 56 % in 2010 and 63 % in 2011, the vacancy rates remain too high. The rapid increase in the number of districts has likely contributed to these high vacancy rates, as the number of health facilities in the districts has increased without an increase in Human Resources for Health (HRH). Ideally the health system should distribute health care workers to match geographic population and disease burden distributions. While 87% of the population lives in rural areas, HRH distribution, particularly among higher-level professional cadres, is skewed in the urban areas. This geographic mal-distribution is a result of the failure of the health system to attract health care workers to rural, remote, and hard-to-reach areas and to retain them once there. This poses major barriers for the rural population to have access to quality health care in these areas.

1.4.7 The Health Manpower Development Centre

The Health Manpower Development Centre (HMDC) was established in Mbale in 1982 as a national centre for continuing education of health workers, through the Uganda Health Training and Planning Project funded by the Canadian Development Agency (CIDA), and implemented by the MOH and the African Medical and Research Foundation (AMREF).

The Centre is located in the neighbourhood of Mbale Regional Referral Hospital. HMDC is responsible for providing In-Service Training (IST) / Continuing Professional Development (CPD) to various cadres of health workers in Uganda. The purpose of these programmes is to re-equip health workers with new knowledge and skills required to cope with the rapidly changing health sector environment. In recent years HMDC has started investing in modern training methodologies such as e-learning and

[5] Midterm Review Report Health Sector Strategic and Investment Plan (HSSIP) 2010/11 - 2014/15

has created several regional hubs (at the premises of the Regional Referral Hospitals) in order to facilitate access of the trainees. Training courses are not accredited by the Ministry of Education and Sports, which is responsible for all health and medical training in the country, but certificates are provided by the MoH. Official MoES accreditation is obtained through collaboration with accredited training institutions such as universities.

HMDC is highly donor dependent, however the MoH insists on keeping and strengthening HMDC as it is the only well-established in-service training institution under the MoH. In May 2013 a “Draft Strategic & Investment Plan for the Uganda Health Management Institute (Human Manpower Development Centre HMDC)” was developed (with support of the Belgian Cooperation) and in 2014 a memo about the “Principles of the Uganda Health Services Management Institute (UHSMI)” was submitted by the Cabinet of the MoH to the Prime Minister with the aim to pass a Bill that would turn the HMDC into an self-governing and autonomous institutions. The process, however, takes time and the bill has not yet been passed. The autonomous status appears to be key for the institute to become really viable, to be able to develop a quality and needs responsive training offer and to make the necessary agreements with the MoES for the accreditations. There also appears to be a growing consensus among other major health development partners about the added value that a well-managed training institute for continuous and in-service training can have for improving the quality of health service delivery in Uganda.

1.4.8 Supervision, Monitoring and Evaluation

The MoH and other central level departments/agencies have the mandate to supervise the health sector. In line with the decentralization framework, District Health Offices (DHOs) are responsible for the supervision of the district health system. Technical supervision is provided at all levels of care with each level supervising the implementation of the Second National Health Policy (2010). Monitoring relies on the Health Management Information System (HMIS) and compilation of quarterly and annual reports which are verified during quarterly monitoring visits and reviewed by Joint Review Missions, the National Health Assembly and the Uganda Parliament. Periodic evaluations of the sector’s performance such as the mid-term review of the HSSP are also carried out. Health professionals’ councils and the National Drug Authority are autonomous bodies charged with ensuring maintenance of professional standards and safety of pharmaceuticals, equipment and procedures.

Challenges exist in terms of inadequate human, logistical and financial resources for supervision, monitoring and evaluation. Other additional challenges are limited mechanisms that incorporate private sub-sector performance into overall sector performance and lack of coordination of community/civil society organizations (CSO) and monitoring with mainstream health sector.

1.5 Development Cooperation

1.5.1 The Indicative Development Cooperation Program (IDCP) 2012-2016

The Belgo-Ugandan Cooperation is present in the health sector since 2005 (IDCP I, 2005-2007) and since 2008 the health sector is one of the two priority sectors besides education. Geographically the activities are mainly located in the Western part of the country, more particularly in Rwenzori and West Nile. The new ICB-II Project will be supported under IDCP 2012-2016.

Since the Joint commission of 2008, Belgian health support in Uganda has opted for a “portfolio approach”, aiming at one strategic objective while working through a mix of modalities (projects and budget support). Currently there are four ongoing interventions: the Institutional Capacity Building Project (ICB-I), Budget Support (BS), the Private non-for Profit Project (PNFP) and the Skills for Human Resources Development Project (SHRD) which are designed to operate in a complementary and synergetic way.

- ICB-I/HPLM: the *"Institutional Capacity Building in Planning, Leadership and Management in the Uganda Health Sector"* (HPLM) project started in June 2010 with a budget of 7,850,000 EUR. Its execution will be extended till December 11, 2015. The aim is to improve the effective delivery of the integrated Uganda National Minimum Health Care Package. The specific objective is to strengthen the planning, leadership and management capacities of the health staff at national and Local Government levels. The project is anchored in the Department of Planning at the Ministry of Health. In order to facilitate its implementation the project decided to establish two Regional Project Implementation Committees based at the Regional Referral Hospitals in Fort Portal (Rwenzori) and Arua (West Nile), each of them covering 12 districts. In the meantime these committees have developed into dynamic Regional Health Fora to which other stakeholders in health are also invited. Other main achievements are the support to the national planning process and the regular performance reviews, extensive and demand driven training of the DHO in various aspects of health system management, the institution of performance based execution agreements as a way of financing the DHO and the establishment of a comprehensive ambulance system. ICB-I also included support to the HMDC in Mbale, which resulted, among others, in the development of its strategic plan, the adaptation of existing training modules in health system management, governance and leadership to the actual needs in the districts, the establishment of regional training hubs and the introduction of eLearning for health workers in remote areas.
- BS: In IDCP 2008-2012, 20 million EUR was allocated as budget support for the health sector. In IDCP 2012-2016 another 12 million EUR has been allocated to support the health sector with the implementation of HSSIP 2010/11-2014/15.
- PNFP: the implementation of the *"Institutional Support for the Private-Non-For-Profit (PNFP) health sub-sector to promote universal health coverage in Uganda"* started in June 2014 and will continue till 2020. The project aims to build stakeholders' capacities in order to strengthen and effectively implement the partnership with the PNFP sub-sector. It is embedded within the framework of the National Policy on Public Private Partnership in Health (PPPH) and will assist the Ministry of Health (MoH) in testing the "Specific implementation guidelines" that have been developed for the PNFP subsector. It has the ambition to strengthen the respective roles of the MoH, the District Health Offices (and Local Government), the Medical Bureaus (MB) and the PNFP health facilities. The project is anchored at the Directorate of the Planning and Development at the MoH and will also strengthen the Medical Bureaus, the Diocese Health Coordination (DHC) and other PNFP Coordination Bodies (PNFPCB) in their capacities of elaborating and maintaining partnerships with the MoH and the DHO. At regional level, the project will be implemented in synergy with ICB-I and strengthen the role of the DHO in planning, monitoring and supervision of the PNFP health units The project will use two complementary strategies to structure the strengthening of the PPPH between the Ugandan government (GoU) and PNFP, i.e.: the design and use of a health coverage plan and the financing of PNFP health units through a Results-Based Financing (RBF) mechanism.
- SHRD (2014-2019): The project *"Support to Beneficiary Institutes for the Skills Development of their Human Resources"* is a scholarship program aimed at strengthening the capacities of a selected number of institutions in the education, health and environment that play a key role in the development of their respective sector. As for the health component of the project, specific attention is paid to improving skills in the areas related to sexual and reproductive health and rights and child health. The project is implemented in synergy with the ICB-I and PNFP projects.

1.5.2 Health Development Partners

The Health Development Partners (HDP) in Uganda have a mandate to support the government and all public and private key stakeholders in health in their efforts to ensure universal access to a minimum package of health services, the equitable distribution of health services, the effective and efficient use of health resources and the promotion of sustainable health financing mechanisms through budget support and project mechanisms. This partnership is based on a Memorandum of Understanding with the MoH, within the frame of a sector wide approach (SWAp) to the health sector. The Uganda Health SWAp is a sustained partnership aimed at improvement of people's health through a collaborative program, with established structures and processes for negotiating policy, strategic and management issues, and reviewing sector performance against jointly agreed milestones and targets. Uganda is signatory to the International Health Partnership and related initiatives (IHP+). IHP+ seeks to ensure that all stakeholders rally around one result-focused country-led national health plan, one monitoring and evaluation framework, one review process focusing on results and mutual accountability in the joint effort towards the achievement of the health-related MDGs.

Currently, quite a number of HDP are involved in leadership and management, health financing and monitoring and evaluation.

DFID

DFID has been a budget support partner in Uganda but has been withdrawing from such support. DFID has since piloted a RBF initiative in Northern Uganda, on a limited scale and only at HC level. The piloting was very much inspired by an operations' research methodology and no complementary initiatives were taken. The official conclusions are not yet out, but they are mitigated. RBF by its own cannot regulate the entire care delivery system. RBF is potentially a strong corrective tool, but has to act in synergy with other measures in the system.

DFID is in principle interested in a national RBF approach and is supportive of the idea of creating a basket fund with other donors.

INTRAHEALTH

Intrahealth is the implementer of a multimillion USAID funded nationwide project (2014-2019) called "Strengthening Human Resources for Health". This project aims to bring the health sector's staffing levels up from 69% to 75% nationwide. The following results are expected: (1) Increase staffing and improve health care in all 112 districts in Uganda, focusing specifically on the 26 districts where less than 60% of health worker positions are filled; (2) design appropriate solutions for each district's unique HRH challenges; (3) provide districts with comprehensive packages of interventions, including human resource information systems, training, supervision support, and gender and management guidelines that make workplaces fairer and safer; (4) in partnership with Johnson & Johnson, establish a new e-recruitment system to enhance efficiency and transparency in hiring health workers (HRIS system).

Amongst activities, a support to the HMDC in Mbale is also planned. The "Strengthening Human Resources for Health" program is currently involved in a feasibility study on performance based financing (PBF) in the North (with PNFP) and in the East (with PNFP and public institutions), the results of which will hopefully be known by September 2015 when DFID will present its PBF evaluation report. In order to facilitate the program implementation Intrahealth has created eight regions that are supported by a regional team. The capacity building component focuses on pre-service training, leadership & management and performance management.

SIDA

The Swedish cooperation has decided to give priority to supporting private stakeholders in health

(PNFP, NGOs and civil society organizations) that align with national policies but to minimize its direct support to the public sector as much as possible. Its programs will particularly focus on mother and child health through a combination of service delivery and health promotion through community services. It will support NGOs and civil society organizations in areas that are underserved – or not served - by the public health sector, such as emergency contraception, abortion and services for the so-called LGBTI (Lesbian, Gay, Bisexual, Transsexual and Intersexual) populations. Priority will be given to supporting the health sector in fragile settings and districts with high rates of maternal mortality. The regions of intervention still need to be defined.

The World Bank

The World Bank is currently supporting a 220 million US$ program for Health System Strengthening. The programs runs till July 2015 but will be extended with another two years. The program focuses on strengthening Regional Referral Hospitals (mentorship of health workers), infrastructure (RRH, GH, HCs III and IV), leadership and HRH (training of health facility managers and health workers such as midwives, obstetric-gynaecologists, laboratory technicians). The program also supported to computerization of the HRIS system at the level of the DHOs.

UNICEF

UNICEF is currently rolling out a *"Reproductive Maternal Neonatal and Child Health"* program. For the implementation of the program three zonal offices were created: Gulu Zonal Office (North & West Nile), Moroto Zonal Office (Karamoja & East) and Fort Portal Zonal Office (based in Kampala though; West Central). The program focuses on capacity building, policy development, monitoring & evaluation and supplies. It also aims at strengthening the district's capacity in evidence based planning using HMIS data.

USAID

USAID is supporting the improvement of the National Medical Supply System through several programmes (SURE, Securing Ugandan Rights to Essential Medicines). SURE II runs from October 2014 till September 2018 and aims at eliminating barriers in drug supply. It also makes use of SPAR (Supervision, Performance Assessment and Recognition Strategy) for monitoring, mentoring and rewarding good performance in the supply chain. The program is being rolled out in all districts throughout the country and also includes a strong capacity building component

USAID is also supporting the *"Strengthening Uganda's System for Treating AIDS Nationally"* (SUSTAIN; 2010-2015). The program is based on a partnership with the MoH, research institutes and AIDS specific NGOs and focuses on prevention, treatment and care. It is being rolled out throughout the country.

Another major program of USAID is *"Saving Mothers, Giving Life"* (2012-2017) that is currently being implemented in a preselected number of districts in partnership with the MoH, CDC (Atlanta) and CSIC Global Health Policy Center (Washington). The programme also includes an ambulance component.

World Health Organization

The World health organization is supporting the MoH technically and is interested in supporting an RBF approach.

2 STRATEGIC ORIENTATIONS

2.1 A health system perspective and systemic capacity building to improve quality of care and quality of management

A health system strengthening approach means that the overall objective of the intervention(s) of the Belgian cooperation is to reinforce the performance of the entire system, not just to solve local problems. The Belgian interventions in the health sector aim for structural change in the system in such a way that health care facilities and support services like DHO and the MoH work more effectively together and each internal organisation is significantly improved.

This means that the intervention will aim at strengthening strategic organisations at different levels of the health sector. Although it is impossible to cover the whole country geographically (see further 1.5) and although not all organisation within the sector will benefit from the intervention's support, it is feasible to strengthen the entire health system by improving crucial structures (like the MoH) and through lessons learned that are taken up by health authorities for further dissemination over the territory (See further 1.7).

A functioning system implies that organisations within the system are performant internally and externally (see 1.4)

In order to reach this objective, the ICB II project will intervene at the 3 organisational-administrative levels of the health system and will cover essentially the 3 major dimensions that each organisational level needs to cover.

2.1.1 Three dimensions at each level

At each level of the health sector, specific attention should go to the different aspects of health performance.

For the **administrative and financial management aspects**, the organising bodies should be strengthened. Without a good management, support, supervision, control, appropriate monitoring and evaluation, planning and overall vision on the system at each organisational level, health facilities won't function properly. It encompasses financial support and control, but also HR and assets management, priority setting, norms application, interpretation and contextualization (when needed).

Quality of care is multidimensional and can be looked upon through the health services perspective (technical medical quality) or through the population-patients' perspective (perceived quality)[6]. Organisational aspects do influence quality of care, but also financial constraints, individual clinical capacity, drug procurement, the presence of a referral (evacuation) system, etc. Improving quality of care needs addressing problems at all 3 organisational levels. The promotion of patient centred care will be key for the promotion of gender equality and improving access of vulnerable populations to health services, and more particularly in the field of SRHR and HIV/AIDS

The **HR development** is another dimension if it comes to system capacity strengthening. This means more than just training individuals. It means also looking at the size of manpower (not too many, not too little number of personal according to the workload) and, looking at their (intrinsic and extrinsic) motivation determinants, including incentive structures (positive or negative). The gender aspects in HR management will also be addressed.

In reality of course, the 3 aspects are often inseparable. The ICB I project has been criticised that there was little or no attention for quality care and for the organisation of health care facilities because

[6] A technically correct prescription of drugs might be inacceptable for a patient because no injections are included. Another patient might be very satisfied with antibiotics whilst he might not need them.

of the restricted scope of the intervention. ICB II, together with PNFP project will be able to develop a more comprehensive look on the system.

2.1.2 Intervening at 3 organisational levels translated into 4 results

The project will intervene at the national level (MoH), the district level (DHMT and all the health facilities under their authority). It will also support de coordination between districts around the regional hospitals, through i.e. regional coordination meetings. Those are dealing with overarching health problems that need collaboration and joint decisions between different health districts (and the facilities that depend on them) and regional health facilities.

The MoH and the regional coordination activities each represent a result for the ICB II project. At the district level, 2 separate broad results will be expected, one concentrating on the health facilities under the DHO's jurisdiction including quality of care and one dealing with health management and leadership at the DHO level.

2.1.3 A broad definition of capacity building

Figure 3: Capacity building concept used by ICB I project

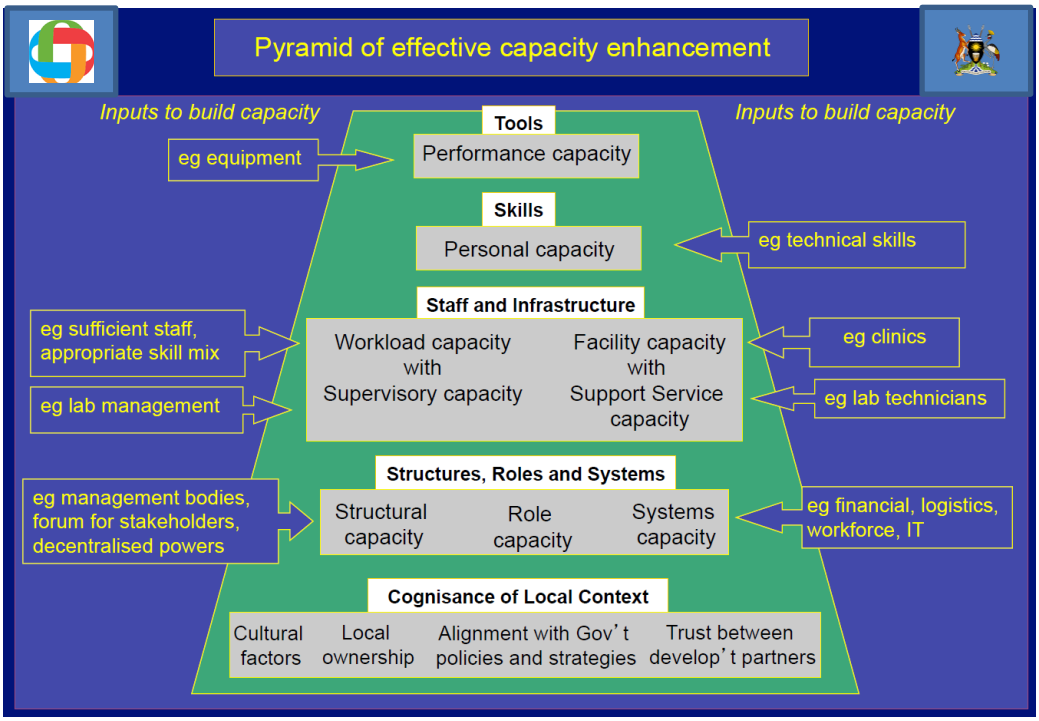


Figure 3 is extracted from Potter and Broughs[7]. It is a reference framework on which the MoH together with ICB I developed their view on capacity for the health system. ICB II will build further on this concept as is proposed by the identification file.

As for the ICB I project, capacity, and therefore also capacity building, are defined from individual to system level in order to be effective. Capacity building is more than the development of personal skills. Skilled people need to work together in an harmonised manner and should be motivated to deliver a quality work. They also need a correct working environment to which the intervention will contribute. A proper working environment can include physical assets and equipment, but also a good leadership and a team spirit. Clear instructions, mandates and division of labour can also contribute to it and will

[7] Potter, Christopher, and Richard Brough. 2004. —Systemic Capacity Building: A Hierarchy of needs.Health Policy and Planning 19(5),pp.336–45. doi:10.1093/heapol/czh038.

be part of the project's attention at various levels of the health organisation. This refers to the creation of structures with clear roles, (quality) norms and defined relations with other structures in the system. Each level of organisation and capacity gives feedback to other levels for adjustments when obstacles or structural problems need to be addressed.

In other words, skilled people might give raise to new structures and procedures to be negotiated and created. New structures might in turn demand newly skilled persons and hence call for training needs.

2.2 Guiding principles of the intervention

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

- The project will align entirely with long term strategic vision for the health sector as laid out in the National Development Plan and the National Health Policy, whereby particular attention will be given to gender and human rights.
- The project will support the implementation of the Health Sector Development Plan (HSDP) 2015/16 - 2019/20, hereby specific attention is given to the achievement of the health related MDGs.
- The project will be implemented according to the principles as laid down in the Memorandum of Understanding (MoU) signed by the GoU and development partners 2005.
- The project will be fully integrated into the planning procedures of the facilities or institutions that will be supported. No specific project activities will be planned for. The project will stimulate targeted facilities and institutions to integrate in their year plans activities eligible for project financing. Only under this condition, the project will intervene and support initiatives. The project's year plans will be extracted from the plans of the respective institutions that will be supported that year.
- The project will build synergies with other initiatives in the field of capacity building and strengthening health system initiatives in the country.
- The project will draw on existing capacities, initiatives and structures as much as possible, as well as learning from best practices elsewhere, regionally and internationally.
- The project will be implemented through a highly collaborative arrangement.
- Collaboration with universities and other training institutions will be developed.

2.3 A coherent approach

All interventions of the Belgian cooperation in the health sector work together in a complementary and synergetic manner and the forces are united around the common general objective of strengthening the national health system. Projects are not any longer regarded as independent interventions with independent and very specific objectives and results, but rather as different entry points in the same global national system that needs reinforcement. The same is true for the coordination and collaboration with other donor interventions, though in reality often a bit less evident.

The following aspects are crucial for a programmatic approach:

2.3.1 Building on the foregoing

ICB II will build on the achievements and dynamics of the ICB I project. Several aspects of the ICB I intervention are explicitly taken into account in the new project. The regional coordination meetings, the emergency evacuation (ambulance) system, the leadership and management courses are but some of the promising results within ICB I that will be further supported by the ICB II project. These aspects are specifically dealt with further.

2.3.2 Complementarity with PNFP Intervention (timing, approaches)

ICB II will be complementary to the PNFP intervention in several aspects:

2.3.2.1 Timing:

The ICB II project will have a life-time of 3 years of implementation and will end around the same time in order to enable an overall planning of a new global support programme in which PNFP support and ICB are fully integrated in 1 programme strengthening the health system towards the building of a national health insurance system

2.3.2.2 Synergies and complementary activities:

Potential synergies and complementary actions between PNFP and ICB II are obvious and are rendered explicit in table 4, page 39.

2.3.2.3 Geographical scope:

The ICB II will intervene in the same geographical settings as the PNFP project.

2.3.2.4 Coordination and sharing competences

For the PNFP and ICB project to maximise their potential synergies and complementary functions, a strong technical coordination and the sharing of available technical competences is necessary.

Therefore:

- The ITA responsible for the ICB II project will also be responsible for the technical coordination between the 2 projects (PNFP and ICB II). His profile is defined according to these particular duties. This implies that regular technical exchange meetings and joint planning meetings are organised. Strong coordination does not signify that individual interventions lose their autonomy of decision. The coordination does not imply a formal hierarchical relation between the 2 ITA.
- The PNFP ITA, who is a specialist in public health but with particular expertise in RBF, will be responsible for developing the RBF tools for both the PNFP and the public sector. Among other things, he will get support from the ICB project for developing coverage plans, business plans for hospitals, control visits with respect to RBF, etc.
- Steering committees will be organised as one for the 2 interventions.
- ICB II will engage 2 NTA. They will be pooled with the 2 NTA of the PNFP project. This implies that the 2 NTA in the regions of the PNFP project and the 2 NTA financed on the ICB II project will work as one team, irrespective of the individual projects that are financing them.
- The administrative officer working at regional level for PNFP will also work for ICB-II in the corresponding regions.

2.3.2.5 Joint evaluation

The evaluation of the 2 projects will be coordinated and integrated in one single exercise as much as possible. As programme team members are pooling their expertise and are working intensively together they will be responsible for overall achievements of the programme.

2.3.3 Complementarity with other Belgian development interventions

2.3.3.1 Sector budget support (Table 4, page 39)

The synergies and complementarity between ICB II and Sector budget support might seem less obvious or direct than with the PNFP project. Nevertheless, it is important that regular exchange meetings are held with the budget support technicians. Conclusions from technical working groups are

important to be taken into consideration in field interventions. Lessons learned from field experiences will inspire technical working groups and the policy dialogue with the MoH.

2.3.3.2 Support to Beneficiary Institutes for the Skills Development of their Human Resources (Table)

Individual capacity building needs should be addressed preferably by the SDHR project on demand or indication from the technical sector interventions. The SDHR project should be supported to identify opportunities, quality of existing courses and orientations on pertinence.

2.3.4 Complementarity and synergies with other Development Partners

The project staff will participate in technical working groups which concern their fields of interest and in other technical meetings in collaboration with other development partners. Opportunities to exchange information and to build active collaboration with other development partners will be actively looked for. Without being exhaustive, RBF, the PNFP approach and regionalisation are subjects that should be shared with other DP because their interest is already established.

Establishing a basket fund is another opportunity to contribute to a joint vision with other DP. As the Swedish Embassy, DFID and WB have expressed interest in both subjects of basket funds and RBF, these organisations can already be identified as interesting partners for collaboration and exchange to the mutual benefit of all.

2.4 Geographical limitations

The project will support various departments and institutions of the Ministry of Health and DHO offices and a selected number of public health facilities in Rwenzori and West Nile regions. These areas correspond with the geographical areas covered by the previous ICB I project and by the ongoing PNFP support programme.

2.5 Results–based financing as one of the building blocks in the perspective of a national social health insurance system

Annex 7.5 describes the general concept of RBF and the long-term vision of the RBF tool to evolve towards a National Trust Fund and a national social health insurance as was described and proposed in the PNFP project. It covers the rational of RBF, the possible perverse effects and the broad set-up of the piloting experience in the PNFP subsector in Uganda.

Particular aspects for the ICB II are:

2.5.1 Differences with PNFP subsector

In principle, the RBF approach and the management, monitoring and payment tools are the same for the PNFP and the public facilities. Because of the different conditions for PNFP and public facilities though, the rates that will be paid for the public facilities might differ. One example of important difference between the public and the PNFP sub-sectors is the organisation of the drug supply system. As public facilities are supported by the government for their drug supply, this becomes a running cost which does not need to be covered by the RBF funding. Salary differences are another aspect that will play in determining the exact amounts that will be paid to the public sector, different from the PNFP facilities. Finally, the actors who will play a role in controlling the health facilities will need a proper reflection. Project NTA will initially be part of the controlling entity. A more definitive system will be developed by PNFP project that can encompass control procedures in the PNFP or public health facilities.

2.5.2 Transparency and other preconditions

As for the PNFP facilities, public facilities will have to go through a certification and accreditation system to be eligible for RBF support. For health centres, this implies that they have to be part of a coverage plan, that they have the basic infrastructure, the minimal staff and the necessary equipment for them to function correctly. They must show that they have a sufficient initial stock of medicines and the management tools and forms in place to deliver good quality. The project has a limited fund to support the facilities in fulfilling these preconditions.

To fulfil the preconditions for funding, HC IV and hospitals will need to develop a business plan for the facility, which includes a long-term vision for the facility, in congruence with the district coverage plans, a HR development plan stating the workload and division of labour within the different departments, a proper stock management system for the pharmacy and the laboratory needs and a performant accounting system for the received funds and expenses. The hospitals should demonstrate to have the proper physical conditions, equipment skilled staff for the departments for which they might be financially supported through RBF. The project will technically support the individual facilities to develop these business plans and has a limited fund to support facilities in their initial needs for equipment and assets.

2.5.3 Scope of the RBF support to the districts

The RBF will concentrate on supporting individual HV IV and general hospitals. Preconditions for these facilities to enrol into the RBF scheme will be very similar to the ones of the PNFP facilities of that level.

As for the HC III (HC II would be excluded in this first phase, because of the logistical complications and the budgetary constraints), the results–based financing would not be organised at the individual facility level but at the district level through the evaluation of the performance of all first line health facilities (HC III). It will be up to the DHMT to decide, after consultation of the HC staff of the district, to identify the priority activities in a selected number of HC III. Other HC will benefit from the support on a subsequent occasion. The advantage of such approach is that the district has to act as a team, planning for investments jointly and encouraging peers to perform better if the group wants to increase the support. The details and the necessary execution agreements, based on previous experiences will have to be worked out by the project.

While focusing in the development of RBF in general hospitals, HC-IV and HC-III, the technical advisor of the project will participate in reflections for RBF in regional hospital as per request of the MoH.

2.5.4 Strengthening the referral system

The support to the ambulance services that was introduced by the ICB I project will be discussed further. It might be that the viability of this life-saving activity will be covered through the RBF support to the districts, but these detailed calculations are not available at this moment and will depend on the decision and experiences of the district.

RBF will not pay the HC IV and referral hospitals for their primary care activities. These activities should be oriented towards urban HCs which can deliver this care more efficiently. It would decongest overburdened hospitals and would rationalise referrals to much occupied doctors. The project can support the concerned hospitals to look into local solutions, for instance by separating the primary care wing from the hospital activities or by creating a close-by health centre. The latter is the preferred option but needs usually more initial investments.

RBF will not pay for non-referred patients at the hospital (or HC IV) either. Outpatient department patients and inpatients should normally be referred when consulting at hospital level. RTA (road traffic accidents) are the exception. Patients that consult directly the hospital should be paying. This rational

approach will need discussions at central level and good communication within the population before it can be introduced.

The preparatory phase will last 1 year. In the meanwhile, every hospital and HC IV can benefit from a fixed amount to invest in equipment and consumables in order to provide the correct conditions for RBF to be introduced.

The referral system as such will be a particular point of attention in the ICB II project and is discussed further in more general terms.

As for the health facilities, ambulances services results and procedures established at district level will feed reflection on the organisation of the referrals from general hospitals to regional or national hospitals. As much as possible technical advisors from the project will assist the MoH in this reflection.

2.5.5 National drug supply system

The drug supply system for public facilities is centralised and highly standardized in Uganda. The disadvantage of such a system is that the supplies do not always correspond to the needs (quantitatively or concerning the type of drugs). At this moment health facilities are not allowed to buy drugs even if they would be in need and would have the necessary resources to do so. This makes it difficult, especially for highly frequented facilities where deficits are greatest, to have adequate drug stocks and to increase their performance. An adequate and needs responsive drug supply system is also key for the improvement of the SRHR and HIV/AIDS indicators.

Consultations without delivering the care can hardly be accounted for as quality care to be accounted under RBF. The project will negotiate possible approaches to improve this situation.

2.5.6 The role of MoH in RBF tool designs

Various policies have been written on the area of monitoring and evaluation, including the running of supervision. It is very important that RBF evolve in a coherent way with policies and tools in these areas. For that reason, relevant department of the MoH (Q&A, Finance, etc.) will ensure the proper share of existing policies and the articulation of new tools with existing one.

2.6 Regional coordination

Regional coordination is one of the promising initiatives of the ICB I project. ICB I is completing a national study on behalf of the MoH to investigate the various possibilities or scenarios to de-concentrate the MoH at the regional level. In the actual situation with the multiplication of districts in the country, the MoH is not any longer in a position to supervise all of them from the centre. De-concentrated units of the MoH in regional health zones could solve this operational problem. Some other ministries already de-concentrated certain cadres at a regional level. There are no administrative-political regions defined so far in the country which might complicate the exercise slightly.

Key questions that the study should answer is the exact mandates and roles of a regional health zone, the type of cadres and their level of competence needed to accomplish these tasks and the organisational costs. A regionalised health sector approach such also lead to the development of context specific responses to specific health priorities such as maternal mortality, adolescent pregnancies, family planning, gender-based violence, HIV prevention, and NCD.

The ICB II project will continue accompanying the MoH in the development of the vision and its operationalisation.

2.7 Emergency and ‘cold case’ referral system

ICB I invested a lot in an emergency evacuation system. Ambulances were provided, communication

systems were established between HCs and HC IV and hospitals and several experiences with cost-containing are underway. Correctly so, MoH considers emergency evacuation as an important part of the health care system and showed a lot of interest in the ICB I experience.

ICB II will continue investing in and monitoring of the ambulance system but will have to concentrate on how to render the system sustainable. Local experiences are always fragile if a national policy is endorsing them. ICB II will invest in conceptualisation, organise broad consultation and workshops and finally will help the ministry to come up with a nation-wide policy. As ICB I is already investing in this process, it will be the continuation of it. The organisation of an operational and sustainable referral system is also key for the reduction of maternal mortality and morbidity.

The scope of the emergency evacuation system should probably be broadened up to emergencies not presenting at HC level. RTA and other disasters may occur in the villages. Obstetric and other medical emergency condition may occur in the village without the patients having time or opportunity to reach health centres. With the Red Cross volunteers network there might be an opportunity to liaise the community with the health facilities. Red Cross and Uganda-Belgium are ready to work hand in hand to study possible approaches.

The referral system does not only cover emergencies though. Cold referrals[8] need to be properly guided, non-referred patients should in principle not be treated at higher levels and fee-paying systems should financially discourage patients of doing so. Urban HC should give alternative opportunities for primary care patients to consult in urban environments, instead of organising the primary care within hospital premises.

Cold referrals are part of quality of care. Patients should be sent timely to higher levels of care, on the other hand false positive referrals (especially in urban areas under pressure of patients who 'want to see the doctor') also exist and should be avoided. Much of irrational allocation of funds (efficiency in the system) is due to a weakly performing referral system. The relation with the RBF (and future health insurance) is obvious. The referral system therefore will receive much attention from the ICB II project.

2.8 Coverage plans

Coverage plans are an important tool for health service planning and organisation. The PNFP project will have finished coverage plans for all the districts in the 2 regions of intervention. The ICB II project will make use of this result to organise a detailed integrated district planning for public and PNFP facilities alike. This will serve the execution agreements, already in place since the ICB I project, but also the micro-planning in the area of responsibility of each HC III. It will allow a more realistic information of coverage indicators, will facilitate home visits for the TB and/or HIV programme and most importantly will allow planning for outreach activities from the HC III to the more distant communities. This will increase coverages of child vaccination, antenatal consultations, etc. Specific attention will need to be paid to the role of (fait based) PNFP in service delivery in sensitive areas such as family planning or adolescent sexual and reproductive rights.

The coverage plan will be part of the policy dialogue with the MoH and all DP in order to rationalise the location of new health facilities, to objectivise the need for new health personnel or its reallocation, and to calculate the practical and theoretical workload of each centre and even individual cadre.

2.9 Hospital business plans and e-patient files

Hospital business plans are discussed already under RBF strategy. It is important though to highlight that business plans for hospitals and health centres IC are an important tool for creating efficiency in the health care system. It is a particular point of attention for the ICB II project. Experience from the

[8] Patients transferred from a lower to a higher level for advise, further investigation and/or treatment without this being an emergency

PNFP project will be taken forward.

Business plans include:

- Clear definition of mandate / role of the institution, including the scope of cure and care
- Calculation of workload and personnel affectation in different services and definition of a general HR management system
- Explicit articulation between services and division of labour (who does what). This seems obvious, in practice it is not (e.g. communication between lab services and wards, between admin and wards, organisation of doctors' rounds, etc.
- A transparent and analytical accounting system, allowing planning for recurrent costs and investments in short and longer time perspective.

E-patient files are an important tool to facilitate hospital planning and management and their introduction in general hospitals in Uganda would be an important step for improving general hospital performance and quality of care. The PNFP project is already accumulating experience in the matter and ICB II project will definitely benefit from it. MoH has internal capacity in the ICT unit to provide the necessary technical inputs and backup.

2.10 Revising the packages of health care

ICB II will work on quality of care and will revisit the respective roles of HC and general hospitals in order to come up with a more optimal division of labour between the facilities, regulated by a rational referral system.

But there exist also gaps in the health care system, e.g. important health care needs that are not addressed by either health facility close-enough to the population. They are important in several domains and the ICB project will think of piloting initiatives in:

- Integration of epilepsy and schizophrenia in the health care packages of HC II and III and in general hospitals. Complementarity between the 2 levels is key. International experiences in Africa show that at very low cost, such chronic patients can be dealt with close to the community. Interested district will be allowed to pilot.
- Integration of HIV care at HC II and III. Although this type of care is officially provided, many HC are under-performing in this matter. An effective integration into other activities is another important challenge.
- Integration of family planning services in the curative care, under-fives clinics and antenatal care sessions. Most HC do provide FP services, but have a rather passive approach to the matter and simply respond to explicit demand. It is known that soliciting women actively does provoke an otherwise unexpressed demand for such services.
- Basic ophthalmological care and specifically the provision of glasses is a highly neglected area in many health care settings. Nevertheless, WHO correctly indicates that the provision of glasses for instance for children is one of the most cost-effective health acts in the world. It is cheap, provides quality of life and simply the ability to function in society for another 50 to 70 years. One general hospital per region will be chosen to pilot such an ophthalmological workshop.

2.11 Continuous training for quality of care

ICB I project supported MoH Mbale training centre (HMDC) and some progress was made. Nevertheless performance so far remains below standards and its pertinence is still questioned by some stakeholders. All basic health care training courses fall under the responsibility of the Ministry of Education. Mbale training centre is the only centre remaining under MoH authority and MoH wrote 2 notes for official approval that would define the role and scope of the centre.

The MoH explicitly asked to continue support the centre. ICB II project will concentrate on the global policy of continuous training of MoH health personnel. Every medical doctor and nurse or midwife needs to receive continuous update and refreshment courses to maintain quality of care and to perform according to new scientific evidence. Although it is the medical council that is responsible for monitoring the system and to accredit individuals, it is the responsibility of the MoH to provide opportunities for continuous training and to assure their quality. The HR direction of the MoH, but also Mbale training centre probably, has a role to play.

The ICB II project will contribute to refining the national policy and to its operationalization. Continuous training can include distance learning (video courses, e-learning and formal short courses organised at national, regional or district level. Quality-of-training concerns should go hand in hand with the objective to keep the health personnel as much as possible in place and to provide refreshment courses to all health personnel as efficiently (cost-effectiveness) as possible. The role of Mbale training centre could be the one of coordinating efforts and financing, assuring quality and standardisation and timely updating of content and finally to organise some of the trainings. Specific attention needs to be paid to training on "soft" issues such as gender and the right to health. ICB-II will invest in the development of appropriate modules and methodologies.

2.12 Monitoring and evaluation

2.12.1 'Realistic evaluation' approach

The type of support the Belgian cooperation is providing to the Ministry of Health is one of systemic strengthening, support to development processes. This implies the capacities of continuous analysis of a situation based on visions / models and policies. Those evolve and are adapted on the base of lessons learned through their operationalization.

Figure 4 shows how a complex situation like a health system can evolve from an initial situation to a more favourable situation. The development pathway is in the first place influenced by a broader and more powerful context, that can act positively on change efforts, but also can show to be resistant to change.

For a ministry (MoH in ICB II context) to pass from an initial situation to a desired change, there is need to develop a vision in the first place. The vision, translated in a concrete model in which all elements or structures in the system get specific roles and conditions and translated in a change mechanism (e.g. RBF), will guide and orient the change pathway or process.

Figure 4: The Realistic Evaluation – Action Research approach for institutional capacity building

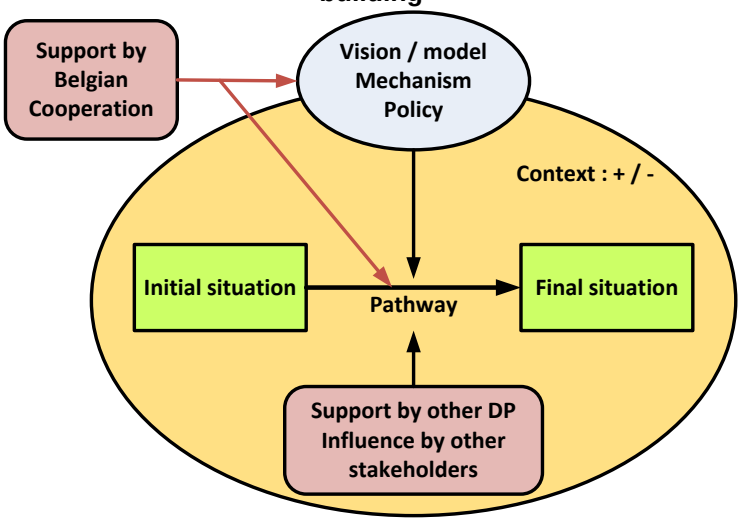


Figure 4 also shows the 2 levels of intervention for the Belgian cooperation and the ICB II project in particular. ICB II will support the MoH to develop its vision with several strategic aspects in the health system. Concrete examples are RBF, the emergency evacuation system, the regional coordination. For each of those strategic topics a vision needs to be developed and constantly refined as experience grows and new information emerges from the field experience.

A second level of support to the MoH is the implementation of new initiatives, often on a limited scale (piloting), in order for the Ministry to gain experience in the matter. Illustrated experience (see further link with M&E) will help the ministry to understand the mechanisms of progress or defeat and to subsequently adjust its policy where needed.

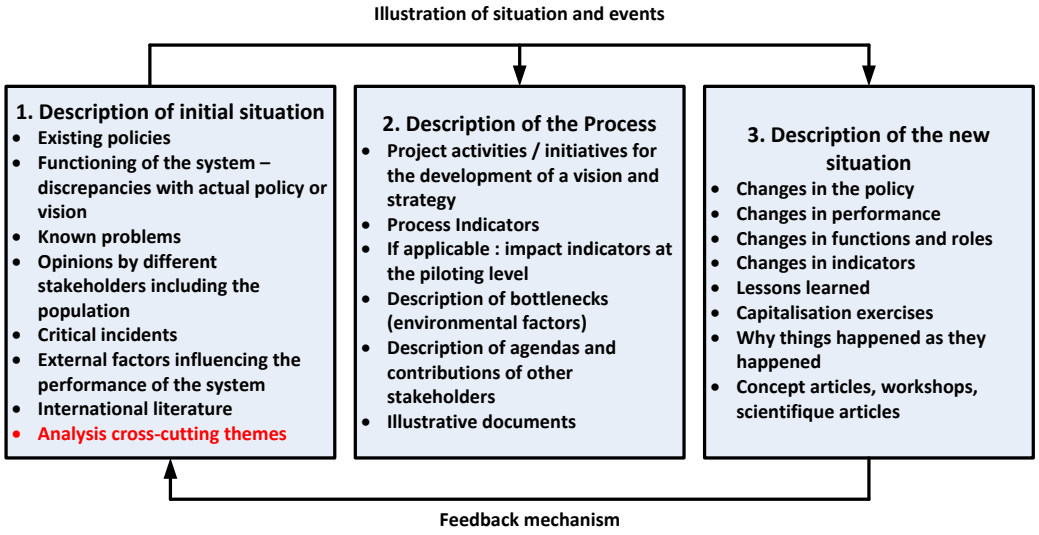
2.12.2 Monitoring

The monitoring of change in complex systems demands a systematic documentation of a complex (and changing) situation, documentation of efforts, of initial working hypotheses based on the vision and strategy defined by MoH. This is illustrated by Figure 5.

In the ***baseline study***, the ICB II project, will describe initial situations on various specific subjects – including the crosscutting issues - on which the projects will intervene and have an impact. This description can be constituted of specific (extractions of) official documents (policy papers) or plans of the MoH or other DP, indicators concerning the subject, (extractions of) year reports and all other written material available on the subject. The information will be organised in a way that a person (future evaluator) can understand the starting situation on a given subject that the project intents to tackle. This initial documentation can be completed later during the project lifespan when new information pops up. The project will write a short overview (summary) of the insights at that moment which needs to be shared with different stakeholders (Figure 5, ***1***).

The long term vision of the MoH on the strategic subjects needs to be illustrated as well. This can include models, policies (often there is need to extract the model from a policy paper that mixes vision, policies and practical guidelines for implementation or operational instructions. The long-term vision continuously inspires new decisions and should guarantee coherence in decision-making. Often the long-term vision allows to identify quantitative indicators and in exceptional cases even targets [9].

Figure 5: Systematic monitoring of changes in a complex system



[9] Targets are difficult to identify because most of the time it is simply impossible to predict in how far changes in the system will influence indicators. It is more important to follow indicators' evolution and to take correcting measures (new decisions) when evolution is not satisfactory.

All decisions, monitoring of indicators and observations (critical incidents) need to be illustrated systematically when events occur (Figure 5). This second data-base allows all stakeholders of the intervention to follow decisions, institutional and organisational evolutions on several strategic topics (points of interest) for the ICB II project. The description of the processes and efforts delivered by the project are at this stage more important than the hard results or impact that the project aims to support. Concrete results or highly unpredictable in the short period because they depend on many other factors than the isolated actions of a project (Figure 4).

Yearly internal evaluations (reflexion on efforts and intermediary results, qualitative and quantitative process indicators) and MTR / ETR allow to balance the project's efforts with its goals (objectives). This is represented in Figure 5. Such reflexions will allow feedback to previous stages of reflexion and action, creating an iterative process of action and reflexion (action research). Obviously, this approach also applies for giving more visibility and improving the impact of the crosscutting issues, which often tend to "disappear" as they are integrated in the various aspects of the project set-up.

2.12.3 Identification of Strategic Topics of ICB II

The present document already highlighted several strategic topics for ICB II, derived directly from the important achievements of ICB I that need continuation of efforts and from the specific objective and results of the project proposal. They are summarized in Table 3.

Other topics can pop-up during the lifespan of a project as opportunities or new MoH initiatives or policies that need project attention. These constitute new broad opportunities for the intervention. New topics need to go through the same process of describing a baseline, a vision (model), qualitative and quantitative process indicators, etc.

Obviously a priority will have to be decided in the documentation process so as to give feasible targets.

At this stage, PBF, creation of regional health zone, referral system with ambulance service, Coverage plans, human resource management and planning (Local, national) appear particularly important. However this may evolve and review by the project team.

Table 3: Topics of particular attention for the ICB II project[10]

Topics identified in this TFF	
• Performance based financing • Universal health insurance • Referral system general • Referral system – ambulance service • Coverage plans • Free health care • Human resource management and planning (Local, national) • Continuous training organisation • Role of DHO • Creation of regional health zones	• Role of HC IV • Role of HC II (?) • HIV care decentralisation and global performance • Chronic patient care (?) • Integration of mental health care • Reproductive health and family planning organisation and performance • Quality of care • Hospital business plans • Patient-centred care (?) • Improved understanding and application of a gender and human rights based approach to health

[10] (?) = not sure that the project will influence but may have insufficient opportunities to consider the theme as a topic of special attention with formal capitalisation.

Table 4: Synergies and domains of collaboration between Belgian development interventions in the health sector

Aspects in which ICB II project will be supported by other Belgian interventions		
Support and synergies provided by PNFP project	Support and synergies provided by SDHR project	Support and synergies provided by sector budget support programme
• Intervening at the operational level, complementary to ICB approach • Reinforcing DHMT • RBF rules for DHMT • RBF conception for government facilities • Support regional coordination • Capacity building at MoH level	• Provide trainings for health personnel in general and health managers, complementary to the capacity building in management and leadership • Organise trainings, also with none-state stakeholders	• Inform the project on general sector performance • Help the project in defining new / additional policies on specific subjects • Provide feedback on technical working group results
Support ICB II will provide to other Belgian interventions		
PNFP	SDHR project	Budget support
• Help formulate policies concerning PNFP facilities • Give feedback on global performance of PNFP facilities in the country • Inform about specific problems PNFP facilities encounter	• Identification of needs for training • Evaluation of proposals for training • Information on possible training institutes • Contacts with training institutes • Particular attention for the capacity building of human resources in the area of SRH and HIV (incl. complementary midwifery training for comprehensive nurses) • Help in selection of quality training courses • Provide network of useful contacts	• Provide feedback on field performance and bottlenecks • Report on discrepancies between policy and implementation • Provide information for interpretation of evolution of indicators • Participate in technical working groups • Provide information on RBF and other reform policy evolutions

2.13 Realistic evaluation[11]

The monitoring system of the project has been described before. The proposal is based on the realistic evaluation theory in complex environments. The difference with more traditional project evaluations is that the consequences of complexity are taken into account:

- Projects are part of the system. It may influence indirectly system's performance. System's effectiveness should be assessed mainly through its capacity of adaptation to achieve relevant outputs. Capacity to take relevant decision and adapt it after ongoing monitoring should be therefore at the centre of performance evaluation
- Targets are difficult to identify because there is much uncertainty on how far progress can be achieved.
- The coherence in decision-making and the process are more important than the concrete (temporary) results. Therefore illustration of processes, contributions and decisions are important to describe and understand.
- Quantitative indicators are important but qualitative descriptions have equal value (not everything can be measured, what is measured is not necessarily true or objective)

In this context, evaluations should concentrate more on how decisions led to or contributed to change and why progress was made (or not). Understanding is more important than judging. Recommendations should deal with what has been learned and what new decisions might further improve given situations. New strategic points of attention or opportunities for further systemic improvements should be indicated.

2.14 Sustainability

Sustainability is the final responsibility of the partner country, and in the ICB II project the MoH is responsible to maintain achievements, to make sure that dissemination of experiences in the field is realised and that financing remains accurate in a changing environment.

The ICB II project will nevertheless facilitate sustainability through certain approaches, attitudes and investments:

- The project provides institutional capacity through structural reforms of health facilities and administrative health institutions (hospitals, DHO, MoH departments, ..). The project will help reinforce organisational capacity by conceiving the necessary management tools and organisational capacity to effectively provide more decentralised rational decision power. The business plans for hospitals are one example.
- The project follows a long-term vision and enables structural improvements. Local solutions will only be achieved, and will only last, if structural systemic change is the underlying mechanism.
- The project explicitly pilots experiences, but will always provide feedback to all stakeholders including civil society and the donor community, invests in capitalisation exercises and dissemination of results (national discussion fora), and where opportune will contribute to a strategy to roll out successful initiatives. It provides the necessary conditions for Ugandan authorities to sustain achievements.

[11] Pawson and Tilley: "Realistic evaluation", 2003

3 INTERVENTION FRAMEWORK

As described in the strategy section (chapter 2), this project is a continuation of the ICB – I. It will continue and expand the work initiated by ICB I in 15 districts within the 2 regions of Rwenzori and West Nile. It will intervene at the national level (MoH), at the regional level, at district level and health facility level in complementarity with PNFP project.

Final evaluation of ICB-I will be done after the finalization of the formulation of ICB-II. The team of ICB-II project may therefore have to adapt some of the activities spelled out in this document to take into consideration recommendations of the final evaluation.

Key strategic focus at operational level will include strengthening of quality of care at health facility level and strengthening the referral system at district and "regional" level. This will be achieved through a combination of capacity building and new financing modalities (particularly RBF in the perspective of the implementation of a national health insurance system). At policy level, emphasis will be on strengthening the capacity of capitalization from "field" experiences.

Quality of leadership, planning and management, as well as clinical care will be addressed by ICB-II activities.

Capacities in financial management, monitoring and evaluation, quality management, human resources management and planning will be reinforced at various level of intervention of ICB-II. These improved capacities will contribute to the design and implementation of output-based financing at facility level, related to real performance. More accurate planning and management at district level, better regional coordination in support to the districts, and better functioning of MoH headquarters and HMDC are other strategic entry points of the ICB II project in order to strengthen the health system globally.

3.1 General objective

To further improve effective delivery of an integrated Uganda Minimum Health Care Package (or basic benefit package).

3.2 Specific objective

To strengthen the planning, leadership & management capacities of (public) health staff – particularly at local government level. This should include the provision of quality services within an integrated health system.

3.3 Expected results

There are 4 results foreseen that should contribute to the specific objective of this intervention. Result 1 and 2 will essentially pilot the RBF approach in respectively the hospitals and HC in the 2 regions. Direct support to health care facilities will be offered.

Results 3 and 4 cover important institutional support to the district and MoH authorities and provides an important input to organize the continuous training of health staff in the country.

- Result 1: The quality of care at general hospital and HC IV is strengthened
- Result 2: District health offices and management teams are strengthened in their capacity to manage integrated district health and to strengthen quality of care
- Result 3: Integrated regional network of health facilities in place
- Result 4: The normative role of the MoH is strengthened

3.3.1 Result 1: The quality of care at general hospital and HC IV is strengthened

Justification of this result:

Result 1 will facilitate the development of result-based financing for first level referral public health facilities (HC IV and general hospital that have been retained in the district coverage plans at an initial stage). The same pre-conditions for financing as defined by the PNFP project and specified further by the RBF procedures will apply to these public facilities. They need to be part of an officially recognised coverage plan, to have a business plan approved by DHO and ICB II according to pre-defined quality norms and a proven sufficient capacity for financial management. This capacity will be jointly assessed by the MoH and the project. Facilities not corresponding to the minimal norms will receive training and other inputs from the project in order to upgrade them to the required quality level. The project will support the less performant facilities until they qualify for financing through RBF, but as long as basic requirements are not fulfilled, the concerned facilities cannot obtain support through RBF. This support can consist of on-the-job-training, other types of training, purchase of medical equipment and other basic requirements, small construction works…

Indicators to measure performance will be equivalent to the ones already adopted by MoH (mediated by PNFP project). Controlling procedures and audits will be organised in the same way as for the PNFP project.

Quality of care, improve the package of care and the hospital management (financial, HR, assets,…) will be addressed as well. Hospitals starting the RBF will receive an initial support in equipment and consumables according to needs in order to provide them with optimal starting conditions.

As it is now,

- Financing, medical and drugs supplies are not necessarily corresponding to health facility's needs (See chapter 2)
- Conditions are being created to allow new financing mechanisms
    - USAID and World Bank projects have been working in building the capacity of health facility managers in performance appraisal, budgeting, planning guidelines, and other issues of management. Training is for 1 year, or it can be done through modular training.
    - The World Bank project has rehabilitated infrastructure for various health facilities (from regional hospitals to HC level)
    - Individuals have benefited from training on issues related to quality of care: ICB I organized training on the patient centred approach and provided training in leadership and management for all district health authorities.

Explanation of the result:

- Financing of health facilities should be according to the needs, i.e. according to quantity of activity.
- Similar initial conditions as for PNFP project should be sought: the possibility to use similar PNFP accreditation and certification process for public facility should be explored; health information system should be strengthened. The implementation of e-files at hospital level will be tested.
- In order not to fall into the vicious circle of "increased opportunistic behaviour of provider – increased control of purchaser", a simple fee paying system (flat fee per type of pathology at hospital and flat fee per episode of patient at HC level) should be implemented.
- Employees' incentives should remain independent from the paying system based on quantitative performance. The incentives should not become too important as to make the

basic salary obsolete, and should be based on quality measures rather than on quantitative indicators which are easily 'gamed'.

- Drugs and medical supply procedures (including family planning and ARV) should be improved in order to address the mal-distribution of drugs in health facilities.
- Training (when needed) and supervision will be continued (as in ICB I) and further refined.
- Money from the output financing may be leverage for customized purchasing of drugs, other recurrent costs and small investments.
- RBF for Regional Hospitals (RH) will not be effective in the ICB_II project for reasons of budget constraints but also because of the complexity of the matter. Exception might be made for maternal care (maternity units), as a piloting experience at this level. ICB-II will invest though in the conceptual preparatory work through studies and modelling of a future RBF model for regional hospitals.

3.3.2 Result 2: District health offices and management teams are strengthened in their capacity to manage integrated district health systems and to strengthen quality of care

Result 2 should strengthen the capacity of the DHO in the continuous improvement of an integrated district health system (insisting on the complementarity between health facilities, smooth circulation of information / patients between facilities, absence of functional gaps) offering quality of health care. In this result, the focus lies on first line health services e.g. HC III and HC II that are recognised as crucial in the health coverage plans and that therefore should be upgraded to HC III.

HC III that respond to minimal quality criteria will receive RBF financing through the DHO which are linked to the project by the execution agreements already put up and functioning under the ICB I project. These agreements are subject of regular revision. Selection criteria, besides those already in place for the execution agreements, are an evaluation of the weaknesses of the individual health centres and their needs for upgrading their specific quality. There will be particular attention for plans for decentralising HIV care and FP.

The HC will be further supported through training, equipment and piloting initiatives in order to provide a more complete quality package of care (increase quality and scope of care), as mentioned in chapter 2. A selected number of HC will experiment with taking care of epileptic and schizophrenic patients, complete the package of HIV care for that level of care and will experiment with a more integrated delivery of family planning services.

Health personnel will benefit from specific clinical training and broader training on patient-centred care, human rights, gender, etc. Part of this training will be provided by Mbale training centre.

Justification of this result:

The actual situation:

- ICB-I has strengthened DHO capacities in different ways:
  - Specific trainings focusing on leadership have been realised.
  - Execution agreements have been implemented under ICB-I. This has helped DHOs in developing skills to plan and manage according to objectives rather than to available budgets. It helped managers to follow the planning cycle (need assessment, strategy, work plan, budgeting, implementation, monitoring). In the execution agreement, the planning and budget structure is the same as the one of the Ugandan government. External auditors assess the spending.
  - Each district reviews their performance quarterly. The ICB-I project is member of the regional controling and supervising entity.

- Financing is directly allocated by government to health facilities; district authorities do not have the authority to re-allocate financing from one to another health facility (as a means to strengthen it). Although it speeds-up the availability of funds at health facility level, it removes a leverage for the DHO to solve issues in particular health facilities or at system level.
- Department of QA has recently introduced a quality aspect in the supervision. This supervision takes the form of a sort of accreditation system. Results are linked with “stars” attributed to health facilities (scoring from 0 to 5 stars) with publicity over the results for the “5 stars”.
- World Bank project has facilitated the acquisition of computers and software to manage HMIS and human resources at district level.

The explanation of the result:

- Strategies to improve quality of care are organized at district level.
- This will include, supervisions of health centres; promotion of staff meetings at the general hospital and implementation of “clinical leadership” tools.
- The new supervision process proposed by department of QA could be introduced in the districts of the 2 regions. Specifically, DHMT will be trained in this new approach. Besides further increasing management and leadership capacities, DHO will receive training on clinical issues like HIV, SRH and other clinical subjects that will be identified in the first year of the project. DHO have to support all types of piloting initiatives in their district, including the research and capitalisation aspects of it.
- Integration of health facilities within a district health system
- Initially, the integration of health facilities within a district implies a combination of strategic and operational planning at district level. The strategic planning combines a coverage plan for health facilities, a human resources development plan, planning of outreach activities and an integrated evacuation system.
- Coverage plan development should be an occasion to better define the functions of the health facilities. A possible scenario could be the development of a two tier system:
    - primary care ensured by health centre III (HC II to be progressively upgraded to III)
    - and first referral level to be ensured by general hospitals (HC IV to be progressively updated to general hospital, when needed)

Combination of DHMT meetings (for day-to-day management) and supervision of health facilities will be strengthened and will be part of a national strategy for continuous learning of clinical staff (see result 4).

Part of the output-based financing from the individual health facility might be “earmarked” for system integration activities (e.g. financing the strengthening of specific health facilities, strengthening referral system, etc.)

3.3.3 Result 3: Integrated regional network of health facilities in place

One of the strengths of ICB-I has been the creation of a dynamic regional coordination of DHO’s with meetings at the regional hospitals of Arua and Fort Portal. The ICB-II project will continue this support in order to feed policy making on the question of a regional level in the national health system of Uganda. It is estimated that with the continuous increase of the number of districts, the sub-districts concept will become gradually obsolete, but that the need for regional coordination will impose itself ever more.

Justification of this result:

As it is now,

- Concerning the leadership and management of the regional network of health services
  - The regional level is not an administratively recognised organisation level for the country.
  - At regional level, ICB I started with supporting Regional Project Implementation Committee (RPIC) meetings. These meetings are chaired by the Hospital Director of the Regional Referral Hospital, but they are hosted on a rotating basis by each district. The RPIC have now further developed in a Regional Health Forum (RHF). This takes place regularly (quarterly meeting with all the DHO's + director of the regional hospital – chairman + ICB technical officer + director of planning at MoH + sometimes from resource centres + other senior officers when needed). This meeting take place usually during 2 days. It discusses issues related to planning, budgeting, leadership, management. It is at the same time, a space for discussion and for training.
  - There is an expressed need among ICBI beneficiaries to also include civil society and political leaders in order to improve a common understanding of health sector challenges and to avoid the development of counterproductive initiatives.
  - There is a regional performance monitoring team based in each region, financed by Global Fund since one year. These teams are put in place to monitor the malaria, HIV/AIDS, TB, reproductive health and pharmacy focal points of the global fund program. These are teams with a "project" status and objectives. They focus on reporting data for global fund monitoring only.
  - Feasibility studies were conducted to implement "zoning" of the health sector in the same way as it has been done in Malawi. Zoning teams would be based at regional level, fill the gap between national and district level for leadership, planning and management. They would be supporting the districts.
- Concerning health system integration
  - An ambulance system is functional. Over the 2 regions, 32 ambulances with trained staff are managed by the district. Most districts have implemented community initiatives to cater for fuel. However, sustainability is at stake, particularly for maintenance and buying new vehicles when needed (4 of the 32 ambulance are presently out of order). This should be addressed in ICB-II.
  - By running the ambulance system, other system weaknesses become apparent. The complementary package of care (availability of blood transfusion services, permanence of functional operating theatres, etc.) is often deficient, which renders evacuation little effective. Furthermore, the closest or the most convenient place to refer a patient does not always correspond with the general hospital from the district (sometimes the closest general hospital is not the one of the concerned district).
  - There are functional regional hospitals with, sometimes superposition of functions with PNFP hospitals. For example, in Port Fortal, 3 hospitals (2 PNFP and 1 regional hospital) with a superposition of functions co-exist.

Explanation of the result:

Regional networks will be developed in order to better integrate the regional health system and improve quality of care at hospitals (and HC-IV).

- The referral system should be strengthened, taking as an entry point the critical incidents met with ambulance evacuations.
- Regional health fora have a consultative role only and will be consulted when coordination questions between hospitals or between districts arise. Such coordination between hospitals

should lead to a more cost-effective division of labour (between regional and PNFP hospitals for example). When the political and administrative regions will be installed officially their role might change significantly.

- Support to quality district care through regional exchanges between specialists and their district peers. Clinical case discussions, support ward rounds, development of clinical guidelines are but some of the opportunities for specialist medical doctors to support their colleagues at district level. Telemedicine will be tested.
- Improved accountability, coordination and interaction between various stakeholders in the health sector (public, private, civil society and other donor funded interventions). Civil society uses to play a key role in holding the authorities accountable for the fulfilment of the right to health, their HIV response and the SRHR. The district gender focal points should also be actively involved.

3.3.4 Result 4: The normative role of the MoH is strengthened

The MoH has in the first place a normative and regulating role. Too many policies are still defined top-down. The headquarters' role in defining and adapting policies according to lessons learned from the field should be strengthened, in order to make policies more realistic, adapted to the field conditions. The ICB II project will provide many opportunities for such learning. Many subjects were already highlighted under chapter 2.

To facilitate this learning modus, new initiatives should be approached with an action-research modality, allowing the systematic illustration of hypotheses, implementation, monitoring and adaptation of intermediary results and capitalisation. Moreover, MoH delegates should be visiting the field regularly. The project will provide many opportunities to do so.

At the same time, the various departments of the ministry of health should support the development of regional dynamics.

The specific issue of HMDC will have to be dealt with. Conditions for project involvement will be proposed. Meanwhile, execution agreements will be signed with HMDC in order to strengthen their activities in e-learning and in support of the two regions of the project.

Justification of this result:

As it is now,

- There are visits from MoH directly to the districts. Budget and finance division have mentioned the existence of "focal points" to the regions. QA department organises quarterly visits directly to the districts and the health facilities by an "area team" for each region. The Area team is made of 6-8 people with a team leader and a secretary (the chair is a commissioner and the secretary is a medical officer).
- Progressively, MoH has increased difficulties to visit all districts as their numbers are rising continuously.
- A project technical group is functional at MoH. Several technical groups are existing within MoH. Those covering M&E and QA may be strengthened.
- HMDC has received support from ICB-I but is meeting series of challenges to function adequately. Regional training hubs and an e-learning system have been implemented and a person has been recruited for that. (a module on governance leadership and management training has been put online). A policy paper and a strategy note concerning the future of the training centre have been written, awaiting political decision.
- HMIS is managed by resource centres (under department of planning)
- There is a project supporting the development of NMS (SURE project)

- The issue of national “top down” policies and programmes is particularly a problem for the approach to SRH and HIV issues, which use to be addressed through vertical programmes that show little sustainability and tend to neglect the local context.

Explanation of the result:

The main activities for this result will focus on strengthening the role of the MoH in capitalizing field experiences in order to improve policies – including SRHR and HIV policies and programmes - and in conceiving and monitoring continuous training for clinical and administrative staff.

Strategic topics for the ICB II project were identified earlier. They will all need an important input from the MoH to capitalize the experiences and to translate them into national policy proposals. This is the exact conceptual work a ministry should be doing to regulate the sector. Consultancy work might be mobilised to do the actual writing work. The particular monitoring approach highlighted in chapter 2 will enable this work. New policies will need communication through workshops and national seminars, roll-out strategies, and a proper monitoring system for close follow-up in the initial years of implementation.

Capacity of MoH personnel might need strengthening in this respect.

Continuous training of clinical staff is a legal requirement in the country and the MoH has an important regulating and facilitating role in this matter. For the moment it is not clear in how far this continuous training is responding to real needs, assures quality and is delivered in a cost-effective manner. Training sessions are too often donor-programme based, disruptive for the service and it is not clear if also nursing staff is sufficiently benefitting. For each type of health worker (nurses, clinical officers, generalists, specialist doctors) and health facility level, a strategy should be developed. The role of HMDC in this matter has to be clarified and rendered feasible.

3.4 Activities

3.4.1 Activities for Result 1: The quality of care at hospital and HC IV is strengthened

A.1.1. Develop regional coverage plans for general hospitals and HC IV

The PNFP project already deals with the development of health coverage plans. However, their completeness and adequacy to plan for coverage of HC-IV and general hospitals will have to be reviewed and discussed in detail with the MoH and district authorities. Prioritization of facilities to be strengthened will have to be made.

Possible sub-activities are to:

- compile regional coverage plans for general hospitals and HC-IV in both Rwenzori and West-Nile regions.
- perform regional meetings to agree on general hospitals and HC-IV to be strengthened and/or upgraded.

Resources needed include:

- the 2 regional local technical assistants
- financing 2 regional meetings
- finance a communication strategy for all stakeholders, beyond the health authorities
- capacity to conceive coverage plans

A.1.2. Support priority hospitals and HC-IV to realize a business plan:

Business plans will be realized / updated for each priority hospital and HC-IV. It will build on a proper

definition of the role of the hospital within the local health care system. Specifically, the primary care services function will have to be separated from the referral functions (through the creation of a separated health centre (type III) close by the general hospital – HC-IV. It will include an organizational analysis and a human resources development plan.

Possible sub-activities are:

- Initial training
- Communicate norms and formats
- Coaching for designing of business plans
- Evaluate the quality of business plans as one of the pre-conditions to be eligible for RBF

Resources needed include:

- the 2 regional local technical assistants

A.1.3. Complete basic requirements for quality of care

Once the health facility business plan has been updated, investment priorities will be defined. The project will finance the basic requirements for health facilities to provide minimum quality of care and for the facilities to start the RBF regime under optimal conditions.

Possible sub-activities will include:

- Making a list of basic material needed and purchase it with particular attention for drugs and equipment needed for ensuring adequate maternal and child health services (including PMTCT and EmOC), family planning services as well as improved HIV/AIDS care and treatment.
- Provide (clinical and managerial) training according to identified needs including clinical trainings for ensuring SRH and HIV/AIDS related services. For general management and clinical skills, activities will be implemented in liaison with the “skills for development in human resources project” and eventually the HMDC. For RBF implementation, training will be structured according to procedures established through the PNFP project.
- Providing support for the development of a policy on patient centred care.
- Select 2 hospitals to pilot ophthalmological workshops / clinics to provide reading glasses. Such workshops need 100 m², and an initial investment of 40,000 Euros per unit.

Resources needed include:

- Provision of basic material based on health facility business plan
- Financing training
- Financing policy development support
- Equipping and piloting of ophthalmological clinics

A.1.4. Improve drugs and medical supplies management

Because of the critical need for drugs and medical supplies, a special attention will be given to improving drugs and medical supplies management. The project will act in complement to other project interventions (“SURE” financed through US-AID, etc.). It will focus on the management at facility and district level.

Possible sub-activities will include:

- Making a diagnostic of the drugs and medical supply management in health facilities and

districts of the Rwenzori and West Niles regions

- Train staff according to needs
- Coach and supervise staff on the drugs and medical supplies management
- Give feedback to the MoH if problems with drug supply persist due to structural constraints (national procedures)
- Include drug availability is an important indicator in the RBF approach

Resources needed include:

- A consultancy for diagnostic of the drugs and medical supply management in health facilities and districts of the Rwenzori and West Niles regions
- Finance training

A.1.5. Introduce e-patient files

Relevant and valid clinical data are a pre-requisite for any results-based financing system (RBF). E-patient files, in which the clinical diagnosis, treatment and clinical management are recorded in individual electronic patient files, provide the potential to generate in an automated manner hospital statistics, invoices, stock management, etc. The PNFP project is actually identifying the most appropriated system for Uganda hospitals. MoH has much internal capacity in its ICT department, on which PNFP and now also ICB II can build. The PNFP project will set the requisite and procedures needed to implement e-patient files in general hospitals and HC-IV. ICB II project will be able to profit from the PNFP experience and the increased capacity of the ICT unit of the MoH to accelerate the installation of e-patient files in public hospitals.

Possible sub-activities will include:

- Liaise with PNFP project to define the approach and procedures to introduce e-patient files
- Training hospital personal
- Install hardware and network
- Monitor implementation

Resources needed include:

- Purchasing of hardware and network according to needs
- Finance training and monitoring visits

A.1.6. Implement RBF approach in general hospitals and HC-IV

General hospitals and HC-IV that have been identified as a priority through coverage plans, and that fulfil basic conditions, will benefit from RBF. They will use the same procedures and devices developed under PNFP project concerning quality preconditions, training, monitoring, controlling, payments and follow-up of expenses. ICB-II will profit from the progress in the PNFP project for swift introduction of the system in public hospitals. Free health care policy is an important interfering factor in the RBF approach in public facilities and will receive due attention.

Resources needed include:

- Finance RBF in the general hospitals and HC-IV
- Assure the monitoring and controlling.

3.4.2 Activities for Result 2: District health offices and management teams at sub-districts are strengthened in their capacity to integrate district health systems and to strengthen quality of care

A.2.1. Interpret coverage plan for HCIII and II

A coverage plan for each district will be realized under the PNFP project. These plans will be used to select eligible HC for future RBF support. Choices will have to be made for upgrading HC II to HC III level and geographical gaps for additional HC will be identified. A special attention will be paid to the health centres in an urban environment and /or close to hospitals or HC-IV. Hospitals should outsource primary care activities to urban HCs to reduce their workload and to rationalise scarce resources. The coverage plans in urban environments should be based on the principle that HC should provide primary care with a restricted, personalised team of health workers for a maximum population of 7,000. If the agglomeration contains more population, more HC should be strategically distributed in the city quarters, instead of increasing the size of the centre and the number of health workers per centre. This is necessary for primary care provision that is patient-centred and personalised.

Outreach and mobile clinics can be planned where there is poor access to health facilities in the district. HC should get the transport means and the organising capacity to plan and execute such outreach visits for preventive care (under-fives, vaccinations, antenatal and postnatal care and family planning.

Possible sub-activities will include:

- Organize a district workshop to interpret coverage plan. Community representatives and civil society should be implicated. Local politicians should understand the choices made for strategic implantation of new HC to avoid sub-optimal sites for new facilities. Training and tutorship to write proposals and bid local or international financing for strengthening health facilities.
- Making sure that in the discussions on the coverage plan due attention is paid to the MDG related health priorities as well as to the issue of access to modern contraceptive methods.
- Conceive specific coverage plans for urban areas

Resources needed include:

- Finance 1 district workshop in each district
- Training one person per district
- Motorcycles for outreaches (Included in the equipment budget)

A.2.2. Adjust district development plans according to coverage plan conclusions

District development plans will be updated before the introduction of RBF, particularly for human resources. Once coverage plans will have been interpreted, and HC to be strengthened identified, a plan for human resources allocation between health facilities will be updated. RBF-related financial incentives will not be given to plethoric staff. This is probably not so much the case in rural HC, but might have consequences for urban facilities.

Possible sub-activities will include:

- Organize a district workshop to update district development plans and to explain the principles and decisions, specifically regarding HR
- Organize a workshop for planning outreach activities organised by the HC and develop a communication (community participation) and implementation strategy.

Resources needed include:

- Finance minimal 2 district workshops in each district

A.2.3. Support basic requirements for quality of care

The project will finance the basic requirements for health facilities to provide minimum quality of care, with a particular focus on family planning, maternal and child health and HIV-related activities.

Possible sub-activities will include:

- Making a list of basic material needed and purchase it (including contraceptives)
- Provide (clinical and managerial) training according to identified needs. For general management and clinical skills, activities will be implemented in liaison with the "skills for development in human resources project" and eventually the HMDC. For RBF implementation, training will be structured according to procedures established through the PNFP project.
- Making sure that (all) staff is trained in patient-centred care including components of a gender and human rights approach to health.

Resources needed include:

- Provision of basic material based on health facility business plan
- Financing training

A.2.4. Install RBF financing through execution agreements

A fund will be allocated to the districts. Specific resource allocation mechanisms will be agreed through execution agreements. This will be based on a proper monitoring and evaluation system (results-based). Funds will be used to cover recurrent costs and to performance through small investments.

Possible sub-activities will include:

- Reinforce the HC monitoring and evaluation system through quarterly district meetings
- Strengthen capacities for M&E of gender and human rights based approaches to health;
- Training in HMIS has been done with ICB I. It will continue under the new ICB II. The training is given to biostatisticians and DHO by the resource centre.
- Define HC fund allocation mechanisms (RBF system)
- Finance HC-III (and II) according to agreed mechanisms

Resources needed include

- Finance quarterly meetings at district level
- Finance training
- Transfer a monthly fund for districts according RBF instructions
- Put up the RBF mechanisms and introduce the monitoring, controlling and financial support tools and procedures.

A.2.5. Assure Quality of care through support supervision and continuous training

Regular health centres supervision will be strengthened with specific focus on quality of care aspects. Supervision will be an occasion to identify needs for continuous training. Continuous training activities will be delivered by the DHO, coordinated and supported by the HMDC.

Regular meetings with representatives of all health facilities to discuss issues related to the integration of the district will be reinforced. Involvement of political representatives and eventually civil society organizations will be sought for.

Mentorship activities will be organised at general hospital and health centre IV level to work on patient-centered care with the HC staff.

Improved supervision and continuous training should also have an impact on improved performance of districts concerning gender and human rights aspects.

Possible sub-activities will include:

- Training in supportive supervision
- Mentorship activities
- Develop clinical guidelines and procedure manuals for preventive care activities in areas where they don't exist yet. Collect and disseminate existing ones. When the set of guidelines seems to cover the whole of the package of care foreseen for a HC, publishing the guidelines under booklet format might become an option.

Resources needed include:

- Training workshops
- Publishing
- Execution agreements at districts and sub-districts level

A.2.6. Improve ambulance services and referral system at district

Ambulance services will be strengthened further and used as an entry point to improve the first referral level. Sustainability and mainly financing mechanisms to cover recurrent costs will be tested.

Alliance with Red Cross will be established to link Red Cross volunteers networks with ambulance services in the management of emergencies in road traffic accidents. This may be tested in selected districts. A communication network between HC and the referral hospital is insufficient to effectively respond to RTA emergencies (occur seldomly close to a HC)

Possible sub-activities will include:

- Support districts through execution agreements in developing community based financing systems for ambulance services
- Implement in selected districts emergency systems for road traffic accidents and other domestic health disasters in collaboration with Red Cross (volunteer network).

Resources needed include

- Maintain ambulance vehicles
- Financing of the evacuations might be (partially) financed through RBF funds.

3.4.3 Activities for Result 3: Integrated regional network of health facilities in place

A.3.1. Organize quarterly regional health fora in the Rwenzori and West Nile regions

The existing quarterly regional health fora will be strengthened as an instance for coordination between districts and the regional hospital. It is expected that issues such as operational planning, budgeting, monitoring and evaluation, continuous training needs will be regularly discussed there. The coordination of an optimal emergency evacuation system is also a subject of discussion at this level.

Involvement of local politicians and civil society at regional level will be strengthened through the organization of a regional health assembly.

Important is the development of a national policy proposal, based on these experiences to formalise the approach country-wide.

Office material for a more official coordination organ might be delivered if progress in this respect is substantial. Offices space is already available at the 2 regional offices. Some upgrading might be considered.

Possible sub activities will include:

- Organisation of Quarterly regional health fora
- Compiling data at regional level
- 6 monthly regional health forum

Resources needed include:

- Financing meetings
- Office equipment (X2)
- Small rehabilitation work

A.3.2. install a coordination body for managing an integrated referral system

Ambulance systems make referrals possible between general hospitals and to regional hospitals. Coordination mechanisms will be developed from the regional hospital in order to improve efficiency of referrals (avoid referrals in places where services are not available). This will include setting duty rosters (between hospitals, or clinical specialists in various hospitals), optimize use of ambulances between districts, ensure an up-to-date information on available services in the various hospitals in the region. Referrals do not necessarily respect administrative borders and where hospitals are overlapping, night duties are not necessary in every hospital if well-coordinated.

Possible sub-activities will include:

- Set up a commission within the regional health forum to plan for this coordination body
- Organise regular meetings and a monitoring system to enable follow-up of the initiatives
- Organize at the emergency service of the regional hospital a coordinating body.

Resources needed include

- Meetings

A.3.3. Support continuous training by regional hospital specialists

Specialists from regional or PNFP's hospitals will help in training of clinical staff working in general hospitals and health centres IV for improving quality of health care. These training sessions will come up with clinical guidelines for GH level care.

Possible sub-activities will include:

- Outreaches of regional hospital specialists to general hospital to run joint consultations with general medical doctors.
- Formal training sessions in the context of a national plan for continuous learning for clinical staff
- Teleconferences of regional hospital specialists with groups of medical doctors from different general hospitals / health centres IV.

Ressources needed include

- Per-diem and transport for clinical specialists
- Equipment for organizing teleconferences
- organize teleconference and other continuous training initiatives

3.4.4 Activities for Result 4: The normative role of the MoH is strengthened

A.4.1 Ensure overall management and governance of the project within MoH

This activity covers the management and governance of the project within ministry of health. Much of it is explained under the chapter “implementation modalities”.

However, it is important to highlight the role to be played by various departments of the MoH (particularly Q&A and finance departments, but also resource centre) in the development of the tools for RBF and to support the development of quality. They will be supported in that work by the ITAs and the NTA working at MoH level.

Resources needed include

- International technical assistant
- National co-director
- Vehicle and functioning of it

A.4.2. Capitalize from field experiences developed in Rwenzori and West Nile regions

For each important strategic topic tackled by the ICB II project in the regions, the relevant department or directorate of the MoH will take stock of the progress made in these various fields, by interpreting the available data and will derive from these, adjusted policies and the tools and strategies for national dissemination. Action-research and realistic evaluation approaches adopted at the operational level in the ICB II supported regions will facilitate the MoH in this endeavour. An indicative list of topics was already identified in chapter 2. Other subjects or aspects will gain importance in the current of the project and will be added, whilst for some topics progress might be too erratic for influence on policy level.

Possible sub-activities will include:

- Research and development:
  - Monitoring and conceptualizing
  - Translate field experience in refined policies
- Communicate and roll out new policies through training (workshops at central and at decentralized level)
- Quarterly monitoring and evaluation visits to the Rwenzori and West Nile regions
- 6 monthly national workshops (supported by universities)

Due attention will be given to the capitalisation of experiences in gender, SRHR and HIV/AIDS.

Resources needed include

- Scientific guidance team
- 2 backstopping missions of 10 days every year
- National or international consultancies for writing up the necessary documents

A.4.2. strengthen continuous training policies and modalities

The HMDC is in a process of getting a new status (with more autonomy). Its role will be reviewed in relation with a coordination and a support function to continuous training for ministry of health and local government health personnel.

Activities from ICB-II in this domain will be coordinated with the “skills for development in human resources project”.

Possible sub-activities will include:

- Develop further resource centres at the Rwenzori and West Nile regions that will function under the coordinating authority of Mbale training centre (HMDC)
- Establish and maintain a “bank” of available e-learning and other tools for continuous training.
- Test a comprehensive continuous training policy in both intervention regions and support the training centre in its coordinating role. A national strategy for continuous training including the division of labour between HMDC, resource centres and District health authorities should leave no gaps and avoid overlap.
- Improve the training offer in the area of gender and human rights.

Resources needed include

- Through execution agreements
    - Financing for training sessions
    - Updating of data bank for e-learning
    - Reflexion workshop and work sessions with medical schools, local government, medical board and HR department in MoH

A.4.3. develop model and strategies for a social health insurance

The RBF mechanism is developed with the long-term vision of developing a global health insurance system, the RBF fund being transformed into a health insurance trust fund. The way the different pillars of a social health insurance gets conceived and operationalized will have to be reflected upon at the same pace as the RBF model is evolving. The MoH should develop a consistent dialogue with the donor community in this matter and will have to come up with a proposal for piloting in the 3 years to come. RBF will have to be experienced at a sufficient scale and for a sufficient period before actual transition might be considered. But the preparatory work and reflection on this matter has to start now.

Possible sub-activities will include:

- consultancies
- Study tours (Ghana, Belgium, Rwanda…)
- Create an inter-ministerial reflection forum on the matter
- Create communication opportunities with the donor community

Resources needed include

- Financing consultancies and study tours
- Financing inter-ministerial and international donor meetings

3.5 Indicators and means of verification

3.5.1 Indicators for General Objective

- Out of the scope of this intervention

3.5.2 Indicator for Specific Objective

- Nationally defined sector development indicators applied on the 2 intervention regions and compared with other regions
- The specific indicators that will be monitored are:
    - Business plans for hospitals are institutionalised at national level
    - District health plans, as developed by the ICB project are institutionalised at national level
    - The national supervision approach is adapted

3.5.3 Indicators for results

The indicators for the results are all part of the indicators that will be dealt with in the treatment of strategic topics and the context of a realistic approach as described in chapter 2. In dealing with topics and progress markers, the result indicators are not repeated although they all fit in one or another topic. It is in the context of these strategic topics of influence for the ICB II project that the indicators will be fully relevant.

- R1 :
    - Number of HC IV providing the full package of hospital care as defined by RBF
    - Number of HC IV and GH with approved business plans
    - % of essential drugs out-of-stock during > 1 week
    - % of personnel having followed sufficient continuous training according to national requirements
- R2 :
    - FP services, including access to modern contraceptives, are integrated and 75% of all HC III and supported HC II provide the service.
    - HIV care and treatment services, including PMTCT, are integrated and functioning at 95% of performance or more conform RBF norms
    - HC III based deliveries have increased and the average quality is > 75 % of performance according RBF norms
    - Number and % of HC III per district providing the complete national minimal health care package
    - Composed Quality of care indicator according RBF procedures for HC III performance is reached in > 75% of the HC III and supported HC II in both regions.
    - Degree of implementation of the integrated district plan (financial absorption capacity of the districts relative to the execution agreements)
- R3 :
    - National vision on Regional coordination developed
    - Regional coordination for ambulance services is functional

- R4:
    - RBF implemented in 70 % of HC IV and GH in the 3 regions
    - National RBF policy approved
    - At least 5 strategic topics of attention of the ICB II project have been subject of a national reflection exercise (workshop, reflection paper, policy note). They should include reflections on the gender, HIV and SRHR cross-cutting issues.

The way the baseline will be organized is described under chapter 2. The baseline is the description of an initial situation concerning interesting or strategic topics for sector development. It includes policy notes, quantitative indicators, strategic notes and operational instructions and organization. For big documents, a summary with the essential facts and actors should be produced. This exercise is more comprehensive than the classical approach of establishing quantitative values to predefined indicators related to results and activities.

Complex situations cannot be captured in a few quantitative indicators. The quantification of indicators for project's objectives and results can be derived from the NHMIS and does not need a special study.

Indicators (progress markers) are not organized by activity, because institutional capacity building is about processes and contribution rather than about attribution, outcome and impact. Several activities, even under different 'results' can contribute to processes and institutional strengthening of policies and policy implementation. The strategic topics of attention of the project should be regarded as the broad fields that the project would like to influence. The list is not exhaustive. New opportunities or necessities might pop up during the lifespan of the project. The same initial assessment and monitoring strategy can be initiated at that moment.

There is no specific budget to execute the baseline because of the peculiarity of the approach in baseline study as explained above but also because of the quantity of data that will be available as a result of ICB-I final evaluation and as a result of the PNFP project baseline.

In addition, a first backstopping mission will be organized to support the organization of the baseline.

Each pre-identified topic is attributed some progress markers. Only some of them are classical quantitative indicators. Others are (intermediate) deliverables or qualitative aspects to which the project intends to contribute.

These progress markers are broader than the indicators of the logical frame. They actually include all of them. The specificity of working around strategic topics of interest is the fact that the monitoring pays more attention for all other circumstances and the evolution of many less specific qualitative and quantitative indicators that contribute to the explanation why the principle indicators in the Log frame are moving in a specific direction.

Table 5 : List of strategic topics and their progress markers (QL = quality indicator)

TOPICS OF INTEREST	PROGRESS MARKERS
Performance based financing	• RBF: national policy defined • 70 % hospitals / HC IV in 2 regions benefit from RBF • 50 % of health districts benefit from RBF
Universal health insurance	• National Policy and vision written
Referral system general	• Number of hospitals that has dislocated the first line care • Policy on urban HC proposed • DHO training module on referral system available • % of new cases referred from HC to hospital (HC IV) level
Referral system –	• Number of evacuations + % of new cases evacuated from HC

TOPICS OF INTEREST	PROGRESS MARKERS
ambulance service	II and III. • Maternal evacuations per district
Coverage plans	• 100 % of coverage plans of districts in 2 regions available • National workshop on coverage plan principles held • Coverage plans integrated in national policy on the health district concept
Free health care	• Perverse effects of free health care demonstrated • Vision on alternative financing system written • National medical and drug supply system (including ARV and FP) for public facilities studied and under discussion
Human resource management and planning (Local, national)	• HC IV and GH have a HR development plan based on objective needs of staff (workload estimations) • The MoH has developed staffing norms for GH and HC III and IV based on workload estimates • Norms for HC staffing levels are made dependent from workload and for HC II depending on the upgrading intention according the coverage plan.
Continuous training organisation	• Health personnel in the intervention zones received at least 50% of continuous training hours according accreditation norms • National policy proposal available including functions, quality assurance, M&E and business plan (budgeting) • Clearer and shared vision (among DP) on the HMDC Training centre
Role of DHO	• Role of DHO, division of labour, norms defined and adjusted if needed
Creation of regional health zones	• Official vision developed
Redefined role of HC IV	• Role of HC IV redefined in terms of mandate, management tools, staffing norms and financing mechanisms
Redefined role of HC II	• Policy on long-term vision on HC II: transformation, staffing, mandate
HIV care decentralisation and global performance	• Number of HC III providing HIV care according to norms (RBF-based)
Integration of mental health care / Chronic patient care	• Number of patients (per type) under chronic treatment • Piloting reports
Reproductive health and family planning organisation and performance	• HMIS indicators on FP, C-sections, maternal mortality, blood transfusion, number of deliveries, neonatal reanimation
Quality of care	• Quality of care indicators to be developed by RBF • Hospital hygiene score (cleanliness, maintenance of toilets, needles and blood product treatment, etc.), • maternity care score (drugs and equipment for 0^2 treatment, blood transfusion, general hygiene, reanimation protocols for mother and newborn available as well as the necessary equipment (reanimation masks for adults and babies, emergency drugs, functional theatre for C-sections, etc.)
Hospital business plans	• 75 % of GH and HC IV have a business plan conform quality norms
Patient-centred care	• 75% of clinical and administrative staff at all levels is trained in patient-centred care including gender and human rights aspects

3.6 Description of beneficiaries

MoH is the first beneficiary of this project, not in financial terms but because this intervention will contribute to the realization of its public health mandate to assure that the population of Uganda has geographical and financial access to quality health care. It is the MoH that is in charge of the intervention.

MoH will very concretely be strengthened by:

- A coverage plan tool that will increase the coverage of most of the preventive services in the first place (outreach regulation) and a significantly higher efficiency of the system through a health care system with less overlap in services and a more optimal investment in infrastructures and HR. This tool will be of application for the whole country in the years to come.
- An alternative model of financing the services tested in the field that can be expanded nation-wide if proven positive in the Ugandan political context.
- An improved network of functioning health facilities liaised by a functional referral system

The most important beneficiary of the project in terms of financial resources and increased capacity are the public health facilities and institutions though. The financial and technical support will be invested at their level in the first place.

Special mention should be made for the personnel of the public facilities in the intervention regions, particularly those in rural areas. They will be motivated through the RBF mechanisms but more importantly by the fact that the project will contribute to lower their physical and intellectual isolation and by decentralizing means and decision power to their level.

The indirect beneficiaries of this intervention are the rural population and specifically the poorest and most vulnerable. Services will be organized close to their homes (rural health centres and hospitals) in a more affordable manner. Although public health care is free of charge in Uganda, out of pocket payment and other barriers for using the services remain important. Maternal and child care will be discriminated positively because they can be considered as generally most vulnerable in society, especially concerning health. The population of Western Nile and Rwenzori is estimated at roughly 5,250 million people.

3.7 Risk Analysis

3.7.1 Implementation risks

The project is complex and ambitious, especially regarding results 1 and 2 regarding the support of numerous hospitals and HC over a vast territory. The DHO responsible for these institutions have been strengthened significantly over the past years and many have reached the necessary quality to sign execution agreements with BTC. Other DHO will have to fulfil the minimal quality requirements before being eligible for BTC support. DHO that receive support will be monitored closely in order to avoid any fiduciary risk. As the execution agreements work with a maximum budget which can be replenished only if financial justification is accepted from previous expenses, the risk will always be low.

Because the project is executed over a vast territory of 2 regions, covering 5 million population, 15 Districts, about 35 sub-districts, and numerous health facilities scattered all over the territory, the project will work with NTA besides the ITA in order to absorb the workload. Two of the NTA will be based in the regions to create proximity.

The ministry and its staff are not familiar with the new RBF approach despite the efforts already undertaken by the PNFP project. As the RBF is an ambitious innovation on demand of the ministry, timely decision-making is crucial for the project to keep track. Therefore the project subscribes to the technical committee created by the PNFP project with members of the ministry and DP and the TA of the project to follow the process and to create leverage for decisions. It will at the same time stimulate coordination of the donors and will assure that individual interventions and initiatives are absorbed by 1 national approach and policy in the matter.

As the other results do not have such a large and innovative scope, and stakeholders are less complex, the implementation risk is far less.

Implementation risks	Risk Level	Alleviation measure
Objective Large scope, MoH understaffed with high competency profiles, vision on RBF underdeveloped	Medium	NTA, work with consultancies, organise capitalisation and technical workshops to increase awareness and competence. An international administrative and financial officer will facilitate the execution Field already partially prepared by PNFP project Regional concentration (2 regions)
Result 1: HC IV and GH do not develop or respect business plans	Low	Proximity of NTA Capacity building, tools and guidelines provided by project Execution agreements Quarterly control according RBF norms and procedures outside regular auditing
Result 2: Support to HC III through the DHO Vertical HIV and SRH programmes limit DHO capacity to develop a sustainable approach.	Low Medium	Idem as for result 1 Actions to be taken through the policy dialogue with the MoH, the Ugandan AIDS Commission and other HDP as well as with the AIDS Development Partners
Result 3: Political sensitivity to decentralise technical ministries before political consensus	Low	All decisions will be supported by MoH Coordination and information meetings foreseen with local politicians Regional support will remain restricted to technical aspects
Result 4: Shortage of sufficient national expertise Political instability within the ministry	Low medium	Support / create expertise Work ITA integrated in the MoH institutions Capacity building by the programme and in synergy with SDHR project Difficult to take specific measures. Good relations and regular exchange with high instances on the necessity to support the project

3.7.2 Management risks

Management risks in the project are situated at 2 levels. The execution is compromised by the limited capacity of the MoH. Secondly, the multitude of stakeholders does not facilitate management. The first risk will be addressed by the presence of an International administrative and financial officer and other programme support staff. The latter will be addressed among other things by making use of hired technical national and international expertise and capacity building initiatives by the programme and through synergies with the SDHR project.

Management risks	Risk Level	Alleviation measure
Objective: Low management capacity within MoH	Low	International administrative and financial officer
result 1 Subsidies from RBF cannot be absorbed or are used for other purposes	Low	Detailed and quarterly follow-up of use of funds by project staff Financing through execution modalities
result 2 Subsidies from RBF cannot be absorbed or are used for other purposes Restricted and basically theoretical understanding of gender and human rights based approach to health	Low Medium	Detailed and quarterly follow-up of use of funds by project staff Financing based on business plans Collaboration with national and international gender and right to health experts.

3.7.3 Effectiveness risks

The effectiveness risk for this intervention is considered in general as very low. The great majority of the budget will directly reach the public facilities that are obliged to reinvest the additional resources into the system. This will automatically render them more viable.

There are some system's challenges like the free health care and the national drug supply system that render the possible impact of the project on facility performance difficult. Free health care prevent communities' participation and increases hidden paying. The national drug supply system based on fixed amounts of drugs per quarter is not only ineffective because never optimal for a specific health facility, but it also takes away responsibility from health facility managers. They are passive victims of an irrational system. The autonomous status of the national drug stores prevents the MoH to easily take corrective measures. The donor community carries a high responsibility in this matter. These structural problems need careful efforts in the policy dialogue and a good donor coordination with technical inputs on alternatives. Time will be needed to overcome such performance barriers and sub-optimal impact on quality of care is never completely avoidable.

Effectiveness risks	Risk Level	Alleviation measure
result 1 Drug supply system and free health care makes health facilities dependent from others to improve their performance	Intermediate	Structure donor coordination and policy dialogue Use PNFP project to demonstrate alternatives in terms of drug supply and user fee policies Discuss the problems in national workshops to demonstrate the drawbacks in the system
result 2 Drug supply system and free health care makes health facilities dependent from others to improve their performance	Intermediate	Structure donor coordination and policy dialogue Use PNFP project to demonstrate alternatives in terms of drug supply and user fee policies Discuss the problems in national workshops to demonstrate the drawbacks in the system
result 4 The MoH has no clear vision on the HMDC	Low	The project will work on a global vision of continuous training

3.7.4 Sustainability risks

This programme intervenes with a long-term vision on social protection and an alternative financing system which it shares with the PNFP project. Some of the objectives can only find a sustainable solution in 5 to 10 years to come. The project is very much in line with MoH policy and the president's programme and therefore has the political commitment. There exist short and medium-term sustainability problems and long-terms sustainability problems. Short and medium-term, are the degree of engagement of the MoH in its political willingness to progress in the conception and financing of RBF and the Ministries' ability to unite the donor community around the ideas. The project definitely will support the ministry in developing this common vision in the technical aspects, but it is the MoH and MoFinance that will have to create the political credibility at national level, but also towards the donor community. MoH by itself will never be able to finance RBF or a universal health insurance system by its own in the short run. The piloting at a limited scale by the project will definitely help the ministry to find its way in the many technical and political aspects of these matters.

The donor community has shown interest and the Belgian embassy subscribes the joint efforts to coordinate the donor community and the MoH in these matters. This already guarantees to a certain level the financial sustainability over a period beyond the strict project's lifetime. Belgian Embassy and BTC are already making efforts to discuss with other DP the creation of a basket fund that would subscribe to RBF. Though without concrete results so far, this represents an important step to sustain the innovations in the longer run.

The gradual introduction of the programme, the efforts at the level of capacity building for all stakeholders should create a technically sound environment for sustaining the programme's initiatives beyond the programme's 3 years. But MoH will have to show signs of commitment with concrete financial engagements as well. This is not purely new funding. Many national budgets, now still oriented through input-based financing could be gradually reoriented to RBF efforts (output-based financing). It is for the moment too early to be sure how the MoH will be able to tackle these new orientations.

Sustainability risks	Risk Level	Alleviation measure
Objective: The national government does not fulfil its long-term engagements due to political or economic developments	Low	Donor coordination and policy dialogue
result 1: The MoH is not capable to organise an alternative financing mechanism and to reorient its actual budgeting efforts	Intermediate	Donor coordination and policy dialogue National workshops and participation in technical working groups organised by MoH Correct capitalisation of experiences Sufficiently long support to the health sector
result 2: Idem R1	Intermediate	Idem
result 3: No specific risk	/	/
result 4: No specific risk	/	/

3.7.5 Fiduciary risks

Fiduciary risks	Risk Level	Alleviation measure
• Multiple actors, outside MoH at a distance	Low	• Regional Technical Assistants and Financial Officers at Regional level • Paiments only after verification of achievement of activities
• Misuse of funds, wrong accounting information	Medium	• Strong follow-up by Finance and Technical team at project level => ITA & RAFI at national level; and regional antennes * Control mechanism to put in place
• High transaction costs	Low	• Cost sharing with PNFP • Use of PNFP systems in place

4 RESOURCES

4.1 Financial resources

4.1.1 Ugandan Contribution

The Ugandan contribution to the project will be “in kind” (See point 4.2 & 4.3). Among other things, the MoH will provide office space at the national level but also for the NTA in the regions (in the regional referral hospitals).

4.1.2 Belgian Contribution

The Belgian contribution amounts to 5,000,000 EUR.

The detail of the project budget is provided here below

BUDGET: UGA 14 028 11 - ICB 2				Exec. Mode	BUDGET TOTAL	%	Year 1	Year 2	Year 3
A			**Specific objective**		**4,268,750**	**85%**	**847,250**	**1,965,750**	**1,455,750**
A	*01*		*The quality of care at hospital and HC IV is strengthened*		*1,525,500*	*31%*	*365,500*	*710,000*	*450,000*
A	01	01	Develop regional coverage plan for general hospitals and HCIV	BTC management	35,500	-	35,500	-	-
			1 workshops per district for reviewing the data and completing the coverage plans		30,000		30,000		
			Printing the updated plans		1,500		1,500		
			2 regional workshops		4,000		4,000		
A	01	02	Support priority hospitals and HC-IV to realize a business plan and prepare for RBF	BTC management	62,000	-	62,000	-	-
			Short term international consultancy (1 international and 2 national consult)		54,000		54,000		
			Visits in the regions to perform the work		0				
			4 regional workshops		8,000		8,000		
A	01	03	Support basic requirements for quality of care	BTC management	270,000	-	40,000	230,000	-
			Basic equipment (on the basis of need assessment)		150,000		10,000	140,000	
			Short course according to managerial or clinical needs		120,000		30,000	90,000	
A	01	04	Improve drugs and medical supplies managements	BTC management	54,000	-	54,000	-	-
			Short term international consultancy (1 international and 2 national consult)		54,000		54,000		
			Visits in the regions to perform the work		0				
A	01	05	Introduce e-patient files	BTC management	204,000	-	174,000	30,000	-
			National consultancy work to set-up the system (2 national consultants)		24,000		24,000		
			Purchasing of hardware and network according to needs		150,000		150,000		
			Training		30,000			30,000	
A	01	06	Implement RBF approach in general hospitals and HC-IV	Co-management	900,000	-	-	450,000	450,000
			Financing general hospitals and HC-IV		900,000			450,000	450,000
A	*02*	02	*District health offices and management teams are strengthened in their capacity to manage an integrated district health system and to strengthen quality of care*		*1,475,500*	*30%*	*71,500*	*843,000*	*561,000*
A	02	01	Interpret coverage plan for HCIII and II	BTC management	31,500	-	31,500	-	-
			1 workshops per district for reviewing the data and completing the coverage plans		30,000		30,000		
			Printing the updated plans		1,500		1,500		
A	02	02	Adjust district development plan according to coverage plan conclusions	BTC management	30,000	-	20,000	10,000	-
			1 workshops per district for reviewing the data and completing the coverage plans		30,000		20,000	10,000	
A	02	03	Support basic requirements for quality of care	BTC management	150,000	-	20,000	130,000	-
			Basic equipment (on the base of need assessment)		150,000		20,000	130,000	
A	02	04	Implement RBF financing through execution agreements	Co-management	900,000	-	-	450,000	450,000
			Financing health centres		900,000			450,000	450,000
A	02	05	Assure Quality of care through support supervision and continuous training	BTC management	202,000	-	-	166,000	36,000
			Support supervisions and other activities for RBF through execution agreements		100,000		-	100,000	
			Training to supportive supervision (One workshop per district)		30,000			30,000	
			Mentorship (T&S - 15 exchanges a month)		72,000			36,000	36,000
A	02	06	Improve ambulance services and referral system at district	BTC management	162,000	-	-	87,000	75,000
			Operational costs for ambulance services		150,000			75,000	75,000
			National consultancy to plan districts emergency systems		12,000			12,000	

BUDGET: UGA 14 028 11 - ICB 2				Exec. Mode	BUDGET TOTAL	%	Year 1	Year 2	Year 3
A	*03*		*Integrated regional network of health facilities in place*		*397,600*	*8%*	*137,200*	*130,200*	*130,200*
A	03	01	Regional project team	BTC management	269,600	-	125,200	72,200	72,200
			1 National Technical Assistant in each of the 2 Regions		136,800		45,600	45,600	45,600
			Investment : 2 vehicles		68,000		68,000		
			Maintenance, fuel and insurance of vehicles (2)		64,800		11,600	26,600	26,600
A	03	02	Organize quarterly regional health forum in the Ruwenzori and West Nile regions	BTC management	36,000	-	12,000	12,000	12,000
			3 monthly meetings		36,000		12,000	12,000	12,000
A	03	03	Install a coordination body for integrated referral system	BTC management	0				
A	03	04	Support continuous training from regional hospital specialists	BTC management	92,000	-	-	46,000	46,000
			Mentorship of clinical specialists (T&S - 15 exchanges a month)		72,000			36,000	36,000
			Setting-up teleconference (material etc)		20,000			10,000	10,000
A	*04*		*The normative role of the MoH is strengthened*		*870,150*	*17%*	*273,050*	*282,550*	*314,550*
A	04	01	Ensure overall management and governance of the project within MoH	BTC management	633,400	-	212,800	210,300	210,300
			International Technical assistant (Co-manager)		540,000		180,000	180,000	180,000
			Vehicle		25,000		25,000		
			Maintenance, fuel and insurance of vehicles (1)		32,400		7,800	12,300	12,300
			Responsibility allowance for national project coordinator		36,000			18,000	18,000
A	04	02	Capitalize from field experiences developed in Ruwenzori and West Nile regions	BTC management	104,000	-	26,000	38,000	40,000
			Technical orientation and follow-up committee 3 monthly meeting		16,000		4,000	6,000	6,000
			Scientific follow-up and evaluation of the various strategies implemented		80,000		20,000	30,000	30,000
			Yearly capitalisation workshop at MoH level (1 day) and final (3 days)		8,000		2,000	2,000	4,000
A	04	03	Strengthen continuous training policies and modalities	BTC management	54,000	-	18,000	18,000	18,000
			Activities of e-learning, workshops, regional trainings through execution agreement with HMDC of MoH		54,000		18,000	18,000	18,000
A	04	04	Develop a model and strategies for a social health insurance	BTC management	78,750	-	16,250	16,250	46,250
			Short term international consultancy		30,000				30,000
			Transport (Flights, etc) for study tour		22,500		7,500	7,500	7,500
			Accommodation (5 people * 7 days * 3 trips) for study tour		15,750		5,250	5,250	5,250
			T&S allowances for study tour		10,500		3,500	3,500	3,500
X			**Budgetary reserve (max 5% of total activities)**		**137,850**	**3%**	**45,950**	**45,950**	**45,950**
X	*01*		*budgetary reserve*		*137,850*	*3%*	*45,950*	*45,950*	*45,950*
X	01	01	Budgetary reserve Co-management	Co-management	47,850		15,950	15,950	15,950
X	01	02	Budgetary reserve BTC management	BTC management	90,000		30,000	30,000	30,000

BUDGET: UGA 14 028 11 - ICB 2				Exec. Mode	BUDGET TOTAL	%	Year 1	Year 2	Year 3
Z			**General Means**		**593,400**	**12%**	**167,200**	**231,200**	**195,000**
Z	*01*		*Staff costs*		*406,800*	*8%*	*135,600*	*135,600*	*135,600*
Z	01	01	International administrative and finance Responsible (RAFI)	BTC management	270,000		90,000	90,000	90,000
Z	01	02	Support staff	BTC management	136,800		45,600	45,600	45,600
			Financial project controller (50%)		34,200		11,400	11,400	11,400
			Financial officer (50%)		25,200		8,400	8,400	8,400
			Administrative Assistant		28,800		9,600	9,600	9,600
			Drivers (3)		48,600		16,200	16,200	16,200
Z	*02*		*Investments*		*13,400*	*0%*	*7,200*	*6,200*	-
Z	02	01	Office and ICT equipment	BTC management	13,400		7,200	6,200	
			IT Office equipment		10,000		5,000	5,000	
			Office equipment		2,400		1,200	1,200	
			Office Fixing up		1,000		1,000		
Z	*03*		*Running costs*		*49,200*	*1%*	*16,400*	*16,400*	*16,400*
Z	03	01	Office recurrent costs	BTC management	20,400	-	6,800	6,800	6,800
			Offices maintenance and supply		5,400		1,800	1,800	1,800
			Telecommunications (5 Mobile phones)		9,000		3,000	3,000	3,000
			Representation and external costs		5,000		1,000	2,000	2,000
			Financial costs		1,000		1,000		
Z	03	02	Missions	BTC management	28,800		9,600	9,600	9,600
Z	*04*		*Audit and monitoring and evaluation*		*124,000*	*2%*	*8,000*	*73,000*	*43,000*
Z	04	01	Evaluation & Monitoring	BTC management	70,000			35,000	35,000
Z	04	02	Audit	BTC management	30,000			30,000	
Z	04	03	Backstopping	BTC management	24,000		8,000	8,000	8,000
TOTAL					**5,000,000**		**1,060,400**	**2,242,900**	**1,696,700**

BTC management	**3,152,150**		**1,044,450**	**1,326,950**	**780,750**
Co-management	**1,847,850**		**15,950**	**915,950**	**915,950**

4.2 Human Resources

This represents 22% of the total

Position	Number of months	Contracting Party	Type
Project Manager	36 Months	MOH	Management & technical expertise
Project Co-Manager (ITA) and coordinator	36 Months	BTC	
2 NTA in the Regions (Complementary to 2 NTA of PNFP)	2*36 months	BTC	Technical expertise
Administrative & Financial Responsible (RAFI)	36 months (50%)	BTC	Support staff
Financial project controller	36 months (50%)	BTC	
Financial officer at national level	36 Months (50%)	BTC	
Administrative assistant	36 months	BTC	
Drivers (3)	36 months	BTC	

A description of the main functions and profiles is to be found in Annex 7.

2 NTA will be recruited by ICB II project, additional to the 2 NTA already working in the regions. Their profile will be very similar as well as their tasks, because, among other things, they will introduce and implement the RBF initiative and be part of the controlling team. They will be based in the regions.

4.3 Other Resources

4.3.1 Services

This represents 21% of the total budget

Belgian contribution (project Budget)

- Consultancies represents 6% of the total
- Vehicle maintenance
- Communication costs
- Trainings

4.3.2 Investments

This represents 14% of the total budget

Belgian contribution (project Budget)

- Purchase of 3 vehicles
- Purchase of equipment needed for the project team at national and regional level
- Purchase of equipment to upgrade health facilities functioning

4.3.3 Others

This represents 36% of the total budget

Belgian contribution (project Budget)

- Support to RBF implementation for public health facilities, DHO and regional coordination development.

Ugandan contribution:

The MoH will provide the office space for the project team in the MoH building and in the Regional Referral Hospitals of Rwenzori and West Nile.

5 IMPLEMENTATION MODALITIES

5.1 Contractual Framework and Administrative Responsibilities

The legal Framework of the project is governed by:

- the General Agreement between the Belgian Government and the Ugandan Government that was signed on the 23rd of March 1995
- the Indicative Cooperation Program (2013 – 2016) between the Government of Uganda and the Government of Belgium that was signed on the 5th of April 2012
- the Specific Agreement – of which this TFF is part - signed between the Government of Uganda and the Government of Belgium.

There is a joint administrative responsibility for the execution of this project.

The Ugandan party designates the Ministry of Finance, Planning and Economic Development (MOFPED) as the administrative entity responsible for the project.

The MOFPED designates the Ministry of Health (MoH) as the responsible entity for the implementation of the project.

The Belgian party designates the Directorate-general for development (DGD) represented by the Head of Cooperation at the Embassy of Belgium in Kampala as the Belgian entity responsible for the Belgian contribution.

DGD delegates the fulfilment of its obligations to the Belgian Development Agency (BTC) represented by the BTC Resident Representative in Uganda as the Belgian entity responsible for the implementation and follow-up of the project. To that effect an “Implementation Agreement - CMO” is signed between BTC and the Belgian Government.

5.2 Institutional Anchorage

Institutionally the project is anchored in the Ministry of Health (MoH) in the Planning and Development Directorate.

The project will continue to have field antennas in West Nile and Rwenzori regions.

5.3 Technical and Financial responsibilities

There is a joint Belgian– Ugandan (MoH Directorate of Planning and Development) technical and operational responsibility for the execution and achievement of the results to reach the specific objective of the project both at the level of the steering committee (MoH Permanent Secretary & BTC Resident Representative) and the project management team (MoH Directorate of Planning and Development and the Technical Assistance assigned by BTC). (See point 5.5.1 and 5.5.2)

The financial responsibilities linked to the execution of the project are also joint to the two parties. The Permanent Secretary of the MOH is the Authorizing officer for the project and the Resident Representative of BTC is the project Co-Authorizing officer.

5.4 Project Life cycle

The Specific Agreement has a total duration of 48 months, as from the date of its signature.

The project execution period is planned for 36 months.

The project life Cycle entails the 3 phases.

5.4.1 Preparation phase

Activities to be carried out during the preparatory phase by the BTC representation Office and MoH:

- Launch of international and national HR recruitment processes
- Opening of main project account
- Start launching procurement of additional material & logistics needed
- Preparation of necessary procurements for outsourced parts of the baseline

At this stage, only expenses linked to the recruitment processes can be realised.

Estimated costs during the preparatory phase:

HR costs	
Recruitment costs for the staff to be financed by the intervention	€ 10,000

5.4.2 Execution phase

Project Effective Start-up phase

The incoming project team assumes start-up duties (HR, share understanding of TFF among the team members and stakeholders, Baseline, operational manuals, accounts opened and mandates defined, initial planning…), first cash call.

The start-up report comprises:

- Signed minutes of the PSC meeting
- Approval of the project team recruited
- Project operation manual (including the function of Regional Offices)
- Baseline work plan
- Operational and financial planning of the 1st year

Operational implementation phase

PSC 1 – PSC Closure programming (Operational closure planning is approved)

Both MTR and ETR happen during this phase.

At the end of this phase a planning of the operational closure is validated by the PSC.

Project Operational Closure

PSC Closing programming – PSC Final report validation (Discharge of project team)

The execution ends with an operational closure phase to ensure proper technical and administrative closing and hand-over. Project final report is produced after the end of the execution period.

This operational closure period starts at the latest 6 months before the end of the Specific Agreement.

Final report:

- Administrative information
- Financial information
- Operational information
- Information on Results

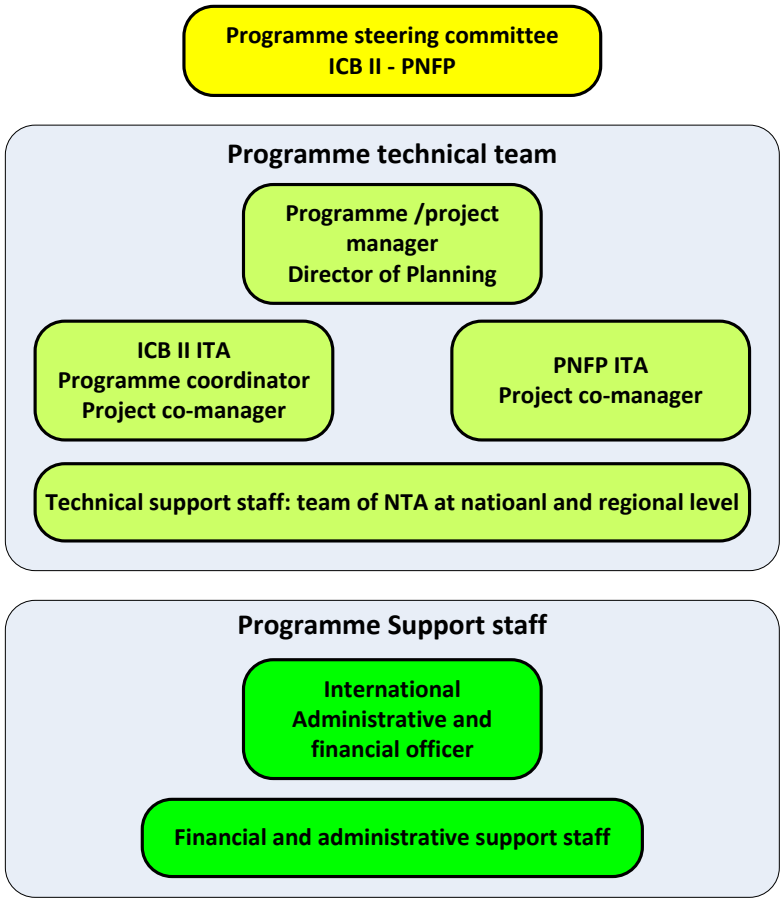
After Discharge of the project team the Representation and partner can still proceed to the liquidation of last commitments.

5.4.3 Administrative Closure phase

The final report is sent to DGD and the project is administratively closed.

5.5 Steering and implementation structures

Figure 6: Programme set-up



The ICB II and PNFP projects are considered as 1 intervention programme to support the health sector in Uganda. Technical coordination and collaboration were extensively discussed in chapter 2.

The MoH, through the Director of Planning remains the overall technical responsible for the programme's content and orientations. The director of Planning, together with the team of ITA form the central decision making organ for the programme at which level planning and management are integrated.

NTA will technically contribute in the actual planning and execution of activities. They all together form the programme technical team. The competences of the NTA at national level will be shared between PNFP and ICB-II and practicalities is the responsibility of the coordination of the project. Similarly, distribution of the tasks between NTA from PNFP and ICB-II at regional level will have to be organised in a team spirit. This will need support and specific attention from the coordination of the project.

Administrative support staff is needed due to the geographical spreading of the intervention and the important additional workload. This team is headed by an international administrative and financial officer.

The international administrative and financial officer will contribute to capacity building in his field of

competence and will technically contribute to the conception of hospital business plans and RBF (see chapter 2 for more details). In the logic of a program between ICB-II and PNFP project, the administrative assistants working at provincial level will assist equally for PNFP activities and ICB-II activities in both West-Nile and Ruwenzori regions.

5.5.1 Project Steering Committee (PSC)

The Joint Project Steering Committee (PSC) is the highest level of decision in the project and will strategically steer the project. Because of the high degree of coherence and synergy between ICB II and PNFP project, there will be one unique PSC for both interventions.

Composition:

The PSC will be composed of the representatives of the following institutions:

- MoH (Permanent Secretary), chair
- Ministry of Finance, Planning and Economic Development (MoFPED)
- Ministry of Local Government (MoLG)
- Medical Bureaus (PNFP)
- A representative of the Ministry of Gender, Labour and Social Affairs
- BTC (Resident Representative) co-chair.

The PSC may invite external experts or other stakeholders as resource persons on an ad hoc basis

Role and functions:

- Supervise the respect of the engagements of the parties
- Assess the development results obtained by the project (strategic quality assurance and control) and approve planning and recommendations from the project's annual results reports
- Validate Execution and Financing Agreements proposed by the team
- Approve eventual adjustments or modifications of results described in the TFF, while respecting the specific objective, project duration and total budget as described in the specific agreement while ensuring coherence and feasibility of the actions
- Resolve any problems that cannot be solved at the project management team level
- Approve and ensure the follow-up of recommendations formulated in the reviews (MTR and ETR) reports
- Based on the financial reporting and audit reports advice on corrective actions to ensure the achievement of the project's objectives
- Ensure approval of the final report and the final closure of the project.

Operating mode:

- This PSC will continue to hold its meetings jointly with the PSC meetings of the PNFP project (UGA1302611)
- The PSC establishes his rule of order during its first meeting
- The PSC meets upon invitation of its chair at least twice a year. Extraordinary meetings can be held upon request of one of its member. The invitation shall be received by the members at least 7 days before the meeting. The invitation shall include an agenda, suggested decisions and supporting documents
- The PSC meets for the first time (at the latest) three months after the signature of the Specific Agreement

- Decisions of the PSC shall be taken by consensus. Decisions of each meeting of the PSC shall be recorded in minutes signed by its present voting members
- A PSC is held at the latest three months before the end of the project activities in order to approve the final report and prepare the modalities of the project closure
- The project Team will act as the Secretariat for the Steering Committee and will provide the necessary information to its members in advance of each meeting

5.5.2 Project Management Team (PMT)

The PMT is the operational level in the project.

The MoH designates the director of the Directorate of Planning and Development as the **Project Manager** and BTC contracts – after non objection from the MoH – an international technical assistant as the project **Co-manager**.

Manager and Co-manager work in close collaboration and take operational decisions and actions on a day to day basis in order to ensure that the project strategy is fully implemented, in time, within budget and as approved by the PSC. They are jointly responsible for the achievement of results and specific objective of the project.

The Management of the project's responsibilities comprise:

- Develop and implement the project strategy and operational plans
- Overall project coordination management
- Overall project monitoring : operational and financial planning, adjustments and reporting of the project on a quarterly and annual basis (See 5.6.5)
- Ensure proper management and apply stringent accountability arrangements for the management of the financial resources allocated to the project
- Ensure that procurement processes and procedures used by the project is conform to the applicable procurement guidelines
- Ensure proper human resources (technical and support teams) management practices conforming to the applicable guidelines
- Compilation of the project final report at the end of the project.

The Management team is assisted by an **international administrative and financial expert (iAFE - RAFi)** who will be shared with the PNFP project (UGA1302611) and any future Belgian/Ugandan bilateral project in the health sector.

The management team will at least meet shortly on a weekly basis and have a more detailed planning meeting monthly in an informal way and upon request. A more formal planning meeting is required every quarter. The latter should be at least partly jointly with the PNFP project as to assure proper coordination and synergies and an optimal use of the available expertise.

5.5.3 Project Technical Team

The technical team headed by the project management is responsible for the operational implementation of the project activities. It will be anchored in the MoH Directorate of Planning and Development, with antennas in the Rwenzori and West Nile Region. It will be composed of:

- The national project manager and the international technical advisor Co-manager at national level. At this level, intense coordination will take place with the PNFP national and international experts.
- 2 national technical assistants responsible for supporting the implementation of RBF and

capacity building in the public facilities in the districts. They will be based in the intervention regions. They form one integrated team with the PNFP NTA.

The technical team will meet on a regular basis, and at least quarterly. Field visits of the management team will permit sufficient coordination and follow-up.

A mechanism will be set to have a regional coordination team in collaboration with the PNFP project so that resources can be shared (vehicles, supporting personnel, offices, etc.)

The management and technical teams will be supported by the following staff:

Within the MoH Directorate of Planning and Development:

- 1 financial project controller (co-shared with PNFP)
- 1 financial officer (co-shared with PNFP)
- 1 administrative assistant
- 1 driver

Within the regions:

- 2 administration and finance officers in collaboration (co-financing) with the PNFP project (UGA1302611)
- 2 drivers

5.6 Operational management

A Project Operation Procedures Manual (in conformity with BTC procedures and manuals) will be adopted at the start of the project that will further detail all the areas of the operational management in close collaboration of the UGA1302611 – PNFP project.

5.6.1 Human Resources Management

	Manager	Co-Manager	RAFI	NTA's	Support Staff
FUNDED BY	MOH/Project	Project funds	Project funds	Project funds	Project funds
	Responsibilities				
ToR	Joint (in the TFF)	Joint (in the TFF)	Joint (in the TFF)	Joint (in the TFF)	Joint
Publication	NA	BTC	BTC	JOINT	JOINT
Candidates pre selection	NA	BTC	BTC	JOINT	JOINT
Selection of candidates	NA	BTC	BTC	JOINT	JOINT
ANO	NA	MOH	MOH	NA	NA
Signature of the contract	MOH	BTC	BTC	BTC	BTC
Individual evaluations	MOH	BTC	BTC	BTC	BTC

Publication:

- Positions are open for men and women. Female candidates will be encouraged to apply.

Contract Legislations

- Human resources recruited in Belgium will have a contract governed by Belgian law.
- Human Resources recruited in Uganda will have contracts governed by Ugandan law.

Missions:

- Every mission of the team members must be approved by the manager and co-manager.
- Every mission abroad (outside Uganda) of the international advisor or National TA will have to be approved also by BTC Resident Representative.
- Perdiem rates to be applied are the one to be found in the project operation manual and directives from the BTC Representation in Uganda.

Additional remarks:

- If the ToR defined in this TFF must be revised before advertisement, the revised ToR need to be approved by the PSC.

5.6.2 Financial management

The management of the Belgian contribution is done according to both co-management and BTC-management. The general means remain under BTC-management and the funds will be made available according to the appropriate system.

In accordance with the partnership principles between the Belgian and Ugandan parties, the planning and execution of the financial commitments will be done, for both co-management and BTC-management, with mutual agreement.

Bank Accounts

Co-management

From the signature of the Specific Agreement a main bank account in co-management will be opened at a commercial bank in Uganda or at the Bank of Uganda named “BTC project – co-management – ICB II “ in EURO. Other bank accounts in co-management (operational accounts) can be opened when needed.

In terms of signature, the double BTC-signature is compulsory with the following specifications:

Mandate Partner	Mandate BTC	Ceiling	Account
Authorizing Officer or his substitute	Co-Authorizing officer or his substitute	According to the rules of his organisation	Main and operational account
Manager of the project or his substitute	Co-Manager or his substitute	< 25,000 EUR	Operational account
Authorizing Officer or his substitute) or delegate	Co-Authorizing officer or his substitute/ RAFI	< 200,000 EUR	Operational account

The Authorizing and Co-Authorizing Officer are together responsible for the opening of the accounts. They are responsible for adding and removing signatory rights on the mandatories of the accounts, in accordance with the internal rules of their respective organization. In case of modification, the party

concerned shall communicate it to the bank and formally inform the other party.

All payments made under the co-management budget line must be paid from funds on the co-management bank or cash accounts.

BTC -management

For payments made under BTC -management budget lines, BTC opens specific bank account with only BTC personnel signatory rights.

Funds transfer

First Transfer

From the notification of implementation agreement between the Belgian State and BTC and after the opening of the main accounts, a cash call can be submitted by the Project Management to BTC Representation. The requested amount must be in line with the financial needs of the first three months and will follow the BTC internal procedures.

Subsequent transfers

To receive subsequent transfers, the project PCT must request a cash call to the RR following BTC procedures.

Subsequent requests for transfers must be based on action and financial plans approved by the PSC.

Each transfer should equate to the estimated funding requirements of the project as prepared by the PCT for the succeeding three months, plus a small margin for contingency, possibly paid in several tranches. The transfer of funds by BTC to the bank accounts will be made provided that:

- The financial accounts for the project are up to date and have been submitted to the BTC Representative
- All required reports have been submitted to the local representation of BTC
- Any recommendations proposed by external audits and/or MTE have been followed up or implemented and reported to the BTC representation

In addition, intermittent urgent cash transfers may be requested; but such urgent cash calls are only acceptable if they are fully justified in relation to extraordinary events.

The final payment of the project will follow the same conditions as described above.

The cash management procedures and rules of BTC (transfer to operational accounts, cash management) apply.

Preparation of annual and multiannual budgets

Each year, the project team must develop a budget planning proposal for the next year following BTC procedures. In this budget proposal, an indicative budget for the following years should also be included. This budget proposal must be approved by the SC.

The annual budget is part of the annual plan and provides the basis for the monitoring of budget execution of the next year. (Cf. 5.6.8)

Monitoring and budgetary commitments

Each quarter, the project must report on the budget execution and the forecast of expenditure, compared to the total budget and annual budget approved. The reporting is done according to the format provided by BTC and is part of the quarterly reporting.

The project must ensure proper control and regular budget monitoring of commitments (Cf. 5.6.8).

Accounting

Accounting is done on a monthly basis according to BTC rules and regulations and its own financial system and tool.

The accounting documents must be signed for approval by the Project Co-Manager and RAFi sent to the Co-Authorizing Officer (BTC Resident Representative).

The accounting documents must be up to date, accurate, and reliable and conform accounting standards and rules in place.

Eligible costs are actuals costs which meet the following criteria:

- They are identifiable and verifiable, in particular being recorded in the accounting records of the project according to the applicable accounting standards
- They relate to activities and criteria as specified in the TFF and necessary for achieving the results
- They are indicated in the budget and registered under the correct budget line
- They comply with the requirements of sound financial management.

Budget Management

Budget constraints:

The total budget and the budget per execution mode may not be exceeded. The budget of the project sets out the budgetary limits within which the project must be executed.

Budget changes:

- Overshooting of a general means section or a result less than 20% of the amount budgeted for on this section or result in the latest version of the budget is authorized.
- At budget line level, budget overshooting is allowed if the overshooting is less than 10% of the amount of the latest approved budget for this line or if it is less than 50,000 EUR.
- At the level of the annual budget, there are no constraints, except for the general means section for which the annual budget overshooting can be no more than 5%.
- In case a global budget increase is needed, a written request for the increase must be submitted by the national party to the Belgian state after agreement of the steering committee. If Belgium accepts the request an exchange of letters is signed by both parties.
- For all other budget changes, a written agreement of the Authorizing Officer and Co-Authorizing officer is sufficient.
- For each request for budget change, the project team must elaborate a budget change proposition according to BTC's procedures.
- The contingencies budget can only be used for project activities and after approval of the PSC.

5.6.3 Public Procurement Management

Procurement for items under co-management budget lines will be done according to the Ugandan procurement rules and regulations and the technical support of the procurement team at the Representation.

The procurement of goods and services for the budget under co-management lines will be carried out in conformity with the Public Procurement and Disposal of Assets (PPDA) Act 2014, which provides the legal framework for procurement activities by all public institutions.

Tenders under co-management above 25,000 EUR must have the approval ('no-objection') of the BTC Resident Representative in relation to the tender plan (including bid document), and on the tender evaluation report, with the positive evaluation of a legal advisor.

The opening and analysis of the offers will be organized according to the national procedures. BTC must participate in the analysis of the offers if the value is greater than 5,000 EUR. The award proposal has to be approved by MoH according to their normal internal procedures.

Procurement for items under BTC-management budget lines will be done according to Belgian procurement rules and regulations.

The following activities will be managed according to Belgian Law and BTC system (BTC-management)[12] with a support of team of experts on procurement based at the Representation:

- Staff contracting
- All Investments (Except operational/running costs)
- All the Consultancies
- Audits
- Mid-term and End-term reviews

5.6.4 Financing Public health facilities through the Results-Based Financing (RBF) Mechanism

This project will introduce RBF at the level of the Public health care facilities: at HC II, III and IV level and at district (general) hospital level.

In order to increase ownership the project will use the Ugandan system. The Ugandan government has the mandate to issue grants to run particular projects. As the responsible Ministry for this project (cf. 5.1), the MoH[13] is the entity responsible for the RBF mechanism.

Setting up the RBF conditions:

The project (MoH and BTC in co-management) will sign Execution Agreements[14] with the Districts[15] in the Rwenzori and West Nile regions to define:

- The Public facilities beneficiary as selected by the MoH
- The conditions and modalities of the RBF mechanism
- The budget available, the finance and payment modalities
    - the role that the District (DHO) will play in the RBF mechanism (contract Public facilities beneficiaries through MoUs, verify of RBF results through DHO supervisions, evaluate RBF reports, ….)
    - the support that the project will give for the implementation of the RBF mechanism at district health care organization level.

[12] Not exclusive list, cf. to management mode defined in the project budget

[13] MOPFED in the Specific agreement delegates the responsibility to the MoH

[14] Execution Agreements can be concluded with public third parties to enable the project to delegate execution of part of the activities or the implementation of sub-objectives defined in the TFF. Those agreements should increase third parties' ownership and an increase in their technical, financial and administrative competencies. Cf. BTC Execution Agreements guidelines. The concerned districts have already undergone an organizational assessment in the framework of the ICB I project (UGA 0901701) in November /December 2013.

[15] Not any more relevant

Reporting and channelling RBF funds:

The public facilities will report quarterly to the DHO and issue the corresponding invoice according to the conditions set in the MoU. RBF procedures foresee quarterly evaluation of the performance on which payments are done and quarterly audits of the use of previously received funds. DHO as well as project TA are members of the controlling committee.

Cf. chapters 2 and 3 for technical details on the RBF mechanism.

5.6.5 Monitoring & Evaluations

Monitoring and Evaluation (M&E) contribute to achieving more and better results while strengthening accountability, continuous learning and strategic steering.

5.6.6 Monitoring

	Report Title	Responsibility	System	Frequency	Users
Baseline	Baseline Report	Project Team	BTC	Unique	Project, PSC, BTC
Operational Monitoring	MONOP	Project Team	BTC	Quarterly	Project, BTC Rep office
Results Monitoring	Progress report	Project Team	BTC	Annually	Project team, partner, PSC, BTC rep office, BE embassy
Final Monitoring	Final Report	Project Team	BTC	Unique	PSC, Partner, BTC rep office, BE embassy, donor

Baseline

A comprehensive Baseline Report will be established by the Project Team at the beginning of the project (ideally within the 6 months after the first project steering committee). The logical frame mentions the baseline values for the specific objective and the results of the project. Some of the figures will need an update at the start of the project. As mentioned earlier (chapter 2) the activities and the themes of interest will need also their indicators and follow-up. These will be addressed in the Comprehensive Baseline Report.

The baseline report comprises:

- A monitoring plan, constituted of the description of the initial situations of specific subjects of attention considered strategic for the sector. These subjects were identified in chapter 2. During the lifespan of the project, new subjects might be added and subsequently will be described according the proposed procedures. Quantitative indicators will be part of each described topic. For each topic, process and impact indicators will have to be defined.
- A risks management plan
- An updated operational work plan

The PSC takes note of the Baseline Report and validates the way the project will be monitored.

Operational Monitoring

Operational monitoring refers to both planning and follow-up of the project's management information (inputs, activities, outputs) and its purpose is to ensure good project management. It is an internal management process of the project team. Every quarter the Operational Monitoring update is sent to and discussed with BTC representation.

Results Monitoring

Results Monitoring refers to an annual participatory reflection process in which project team reflects about the achievements, challenges, etc. of the past year, and looks for ways forward in the year(s) to come. The progress for each specific topic of attention will be judged. The PSC approves or disapproves recommendations made by the project team in the annual result Report.

Final Monitoring

The purpose of final monitoring is to ensure that the key elements on the project's performance and on the development process are transferred to the partner organization, the donor and BTC and captured in their "institutional memory". This enables the closure of the project (legal obligation for back-donor of BTC), the hand-over to the partner organization and the capitalization of lessons learned. It can be considered as a summary of what different stakeholders might want to know at closure or some years after closure of the project.

5.6.7 Reviews (Evaluations) and Audits

	Responsibility	System	Frequency	Users
Mid-term Review	BTC HQ	BTC	Unique at mid term	PSC, partner, project, BTC, donor
End-term review	BTC HQ	BTC	Unique at end term (6 months before operational closure)	PSC, partner, project, BTC, donor
Audits	BTC	BTC	At least once	PCS, partners, project, BTC, donor

Mid-Term and End-term Reviews

Reviews are organized twice in a lifetime of a project: at mid and end of term. BTC-HQ is responsible for organizing the reviews. The ToR of the reviews and their implementation are managed by BTC Brussels, with strong involvement of all stakeholders. The role of the PSC is to approve or disapprove the recommendations made in the reviews. The evaluations will follow a realistic evaluation methodology, in which the accent is put on the way the project contributed to the sector and local changes and on the explanation of changes in the indicators. The evaluation concentrates on the why and how questions rather than on the attributable impact.

Audits

The project must be audited at least once during the implementation (two audits are budgeted) following BTC procedures. BTC will deploy an independent qualified audit firm (International Accounting Standards) to audit the dedicated project accounts annually. BTC will write the terms of references of the audits. Theses audits will be carried out by the auditors according to the BTC framework contract in force.

BTC and the Steering Committee may request additional audits if necessary.

The auditor's reports must be presented to the SC.

The audit reports will include recommendations and proposal of corrective actions.

The PMT will prepare an action plan to improve the procedures and justify that corrective measures were taken.

Additionally to project audits, the College of Commissioners will yearly audit BTC accounts. They also audit the projects at that moment. BTC Audit Committee can also request that BTC internal auditors audit a project.

5.7 TFF modifications

The formal agreement of the Belgian State and the Ugandan Government is needed for the following changes:

- Modification of the duration of the Specific Agreement
- Modification of the total Belgian financial contribution
- Modification of the Overall and Specific Objective of the project.

The request of the above modifications has to be motivated by the PCT and approved by the Steering Committee. The exchange of letters requesting these modifications shall be initiated by the Ugandan Government and shall be addressed to the Belgian Embassy in Uganda.

The following changes to the TFF will have to be approved by the Steering Committee:

- The project results and activities and their respective budgets
- The execution modalities
- Competences, attributions, composition and tasks of the SC
- The indicators at the level of the specific objective and the results
- The mechanism to change the TFF.
- The financial modalities to implement the contribution of the Parties.

All other changes to the TFF should be approved by the chairman of the PSC and the BTC resident representative. The adapted version of the TFF shall be communicated to the BTC headquarters and to the Head of Cooperation (DGD) in Kampala.

6 CROSS CUTTING ISSUES

ICB-II will particularly focus on gender, sexual and reproductive health and rights (SRHR) and HIV/AIDS as crosscutting issues conform the priorities set forward in the National Health Policy II.

6.1 Gender, SRHR and HIV/AIDS

ICB-II will particularly focus on gender, sexual and reproductive health and rights (SRHR) and HIV/AIDS as crosscutting themes conform the priorities set forward in the National Health Policy II (NHP II). In NHP II the Ministry of Health points at gender inequalities as one of the main hindrances to the improvement of the national health outcomes. NHP II calls for a gender-sensitive and responsive health care system that should be achieved through the mainstreaming of gender in the planning and implementation of all health programmes. The use of the Health Impact Assessment (HIA) is promoted as a tool for measuring the potential impact of new health policies in other sectors, on the population in general, and on various population categories in terms of gender, age, socio-economic status (including the more vulnerable, disadvantaged and marginalised strata of the population).

6.1.1 Strong link with the Health Related MDGs

Gender is an important determinant in health seeking behaviour and decision making. The Uganda Demographic and Health Survey 2011 (UDHS, 2011) reveals that husbands are still the most important decision makers on women's health and that only 23 per cent of married women independently decide on their own health care. This may result in a delay or even denial of the woman's need for seeking appropriate health care. Poor health seeking behaviour at personal/family/women/community level – including the lack of partner support – has been identified as the second commonest avoidable cause of maternal mortality.

Gender is particularly significant for the achievement of the health related Millennium Development Goals on (child health, maternal health and HIV/AIDS). In spite of the fact that HSSIP III insists that absolute priority should be given to reducing maternal mortality, improving child health and fighting HIV/AIDS, the latest report of the Uganda Bureau of Statistics (UBOS, 2014) reveals a stagnating trend in the number of deliveries in public and PNFP facilities (39%), a high – and even increasing - maternal mortality ratio (438/100.000)[16], a low proportion of births attended by skilled health staff (58%), a low contraceptive prevalence rate (30%)[17], a high adolescent birth rate (134,5/1000)[18] and poor comprehensive knowledge among young people about HIV/AIDS (38%). The under-five mortality rate (90/1000) and infant mortality rate are still far from the MDG target (of respectively 56/1000 and 31/1000).

In Uganda the commitment to give priority to the achievement of the MDGs has been channelled through a number of top-down, vertical and parallel programmes that did not result in a sustainable strengthening of the health system and even reduced the capacity of the health sector to develop a more appropriate response. There is a need to strengthen the role of the DHO in the areas of gender, SRHR and HIV/AIDS and to invest in their leadership and stewardship regarding the adaptation of national policies to the local needs and priorities.

According to the Annual Health Sector Performance Report 2011/2012 (AHSPR 2011/2012) almost

[16] The MDG target for Uganda is to reduce maternal mortality by 75% to 131 maternal deaths per 100.000 live births in 2015.
[17] The contraceptive prevalence rate increased from 24% in 2006 to 30% in 2011, but is still far below the HSSIP III target of 40%.
[18] Twenty-four per cent (24%) of women aged 15-19 are already mothers or pregnant with their first child. In the conflict affected areas of Northern-Uganda and in parts of Eastern-Uganda, incidences of early pregnancies are very high at 43.1 per cent and 31.1 per cent respectively. The culture of early marriage is partly responsible for the country's high maternal mortality ratio and high fertility rate.

none of the health facilities in the country dispose of the full package of 19 tracer items needed for the provision of basic obstetric care. Only three in ten hospitals provide the full package of comprehensive obstetric care. Only 17% of all health facilities provide the full package of basic emergency obstetric care (EmOC).

Currently 81% of the health facilities provide modern contraceptives, of which male condoms (78%) and injectables (78%) are the commonest. Particularly among the catholic PNFP resistance against the promotion of modern contraceptives remains high. They rather focus on the promotion of natural contraceptive methods for married couples. In order to boost the use of modern contraceptives the MoH has recently issued the Uganda Family Planning Cost Implementation Plan 2015-2020. (AHSPR 2011/2012)

In spite of the fact that Uganda has one of the highest adolescent pregnancy rates in the world and the highest in Sub-Saharan Africa, only 47% of the health facilities provide adolescent friendly health services. (AHSPR 2011/2012)

National HIV prevalence in the age group of 15-49 years is on the rise again and increased from 6.4% in 2004 to 7.3% in 2011. In some districts, such as Kabarole district, the prevalence rate is even as high as 12.9%. The percentage of health facilities offering HIV counselling and testing services has only slightly increased from 37% in 2009/2010 to 38% in 2011/2012. According to the National HIV Prevention Strategy 2010-2015 every health facility providing antenatal care services is expected to test pregnant women for HIV and to ensure that at least 95 percent of HIV-exposed infants receive combination ARV therapy. The number of health facilities offering PMTCT services increased from 23% in 2009/2010 to 32% in 2010/2011 and to 36% in 2011/2012. 84% of hospitals, 95% of HC IV and 93% of HC III and 12% of HC II offer PMTCT services. The PMTCT service provision is still very low in HC II which make up the majority (70%) of health facilities in the country.

6.1.2 Approach

The mainstreaming of the crosscutting themes will align with the national strategies, policies and guidelines as well as with the priorities set forward by the districts. Since the project aims at improving the quality of health care through strengthening planning, leadership and management capacities, SRH and HIV will inevitably be covered by most activities such as improved drugs and medical supply, quality of care, supervision and continuous training, ambulances and referral systems, the introduction of RBF, the organisation of regional health fora, etc.

In order to ensure that real progress will be made in the mainstreaming of gender, SRHR and HIV/AIDS, the project has identified a limited number of activities and indicators (for three out of the four results). This should also allow for proper monitoring and evaluation as well as for proper capitalization of the approach taken.

In the comprehensive baseline study that will be conducted at the start of the project implementation due attention will be paid to the crosscutting issues with the aim to create a sound basis for the further process of action research/reflective action and realistic evaluation in these areas. Moreover, a series of progress markers in the field of gender, SRHR and HIV/AIDS has been identified that should enable the project team to mentor the progress made and to underpin the reflection process on how to best to address the challenges that may arise. This integrated mainstreaming approach should ensure that the crosscutting themes receive the necessary attention throughout the project implementation process.

Overview of gender, SRHR and HIV/AIDS specific activities and indicators

Result Area	Proposed activities	Proposed indicators
R.1 The quality of care at hospital and HC IV is strengthened	A.1.3 Providing support for the development of a policy on patient centred care.	% of HC IV and GH with a operational patient centered care policy
R.2 DHOs and DHMTs are strengthened in their capacity to integrate district health systems and to strengthen quality of care	A.2.1 Interpret coverage plan for HC III and II: due attention is paid to the MDG related health priorities as well as to the issue of access to modern contraceptive methods.	• FP services, including access to modern contraceptives, are integrated and 75% of all HC III and HC II provide the services • HIV care and treatment services, including PMTCT, are integrated and functioning at 95% of performance or more, conform RBF norms • HC III based deliveries have increased and the average quality is >75% of performance according to RBF norms • Number and % of HC III per district providing the complete national minimal health care package
R.4 The normative role of the MoH is strengthened	A.4.1 Capitalize from field experiences developed in Rwenzori and West Nile regions	• The capitalisation exercises include reflections on the crosscutting issues (gender, SRHR and HIV/AIDS)

Overview gender, SRHR and HIV/AIDS specific progress markers

TOPICS OF INTEREST	PROGRESS MARKERS
Referral system – ambulance service	• Number of evacuations + % of new cases evacuated from HC II and III. • Maternal evacuations per district
Free health care	• Perverse effects of free health care demonstrated • National medical and drug supply system (including ARV and FP) for public facilities studied and under discussion
HIV care decentralisation and global performance	• Number of HC III providing HIV care according to norms (RBF-based)
Reproductive health and	• HMIS indicators on FP, C-sections, maternal mortality, blood

family planning organisation and performance	transfusion, number of deliveries, neonatal reanimation
Quality of care	• Hospital hygiene score (cleanliness, maintenance of toilets, needles and blood product treatment, etc.), • maternity care score (drugs and equipment for 0² treatment, blood transfusion, general hygiene, reanimation protocols for mother and new-born available as well as the necessary equipment (reanimation masks for adults and babies, emergency drugs, functional theatre for C-sections, etc.)
Patient-centred care	• 75% of clinical staff at all levels is trained in patient centred care including gender and human rights aspects

6.2 Environment

There are no important environmental measures to be taken within the framework of this project as the project activities will not particularly affect the environment negatively. On occasion, investments in the facilities might include creating an ambient environment such as tree-planting in hospital premises or in (human and medical) waste disposal.

7 ANNEXES

7.1 Logical framework

	Logical of the intervention	Indicators	Baseline	Sources of verification	Hypotheses
GO	Global objective To further improve effective delivery of an integrated Uganda Minimum Health Care Package				
SO	Specific objective The planning, leadership and management capacities of (public) health staff – particularly at local government level, are strengthened	• Business plans for hospitals are institutionalised at national level • District health plans, as developed by the ICB project are institutionalised at national level • The national supervision approach is adapted	0 (Target: 1 policy adapted) 0 (Target: 1 policy adapted) 0 (Target: 1 policy adapted)	Minutes of workshops on the matter Ministerial decisions and recommendations Procedure manuals	International donor agencies are willing to follow in the RBF approach as proposed by the MoH/Belgian cooperation International donors are willing to step into a basket fund like aid mechanism to co-finance RBF and to work in the long term towards universal public health insurance.

R 1	Result 1 The quality of care at hospital and HC IV is strengthened	• Number of HC IV providing the full package of hospital care as defined by RBF • Number of HC IV and GH with approved business plans • % of essential drugs out-of-stock during > 1 week • % of personnel having followed sufficient continuous training according to national requirements.	37% Target 75% 0 Target : 75% 53% Target 75% 10% Target 50%	• Hospital business plans and yearly plans • RBF control reports • National health information system	The MoH and districts alike understand the need for rationalisation of the health pyramid and the way forward through district coverage plans The MoH has sufficient technical authority on local governments to convince them on district health coverage plan approach The MoH has sufficient political power and organised technical arguments to reform essential drug distribution policies and re-orientation of free health care subsidies (evolution from input-based to output-based national financing
R 2	Result 2: District health offices and management teams are strengthened in their capacity to manage an integrated district health system and to strengthen quality of care	• Access to FP services, including access to modern contraceptives, are integrated and 75% of all HC III and supported HC II provide the service. • HIV care and treatment services, including PMTCT, are integrated and functioning at 95% of performance or more conform RBF norms • HC III based deliveries have increased and the average quality is > 75 % of performance according RBF norms	30 % contraceptive prevalence rate (Target : 35 %) 36% Target : 60% Baseline not available at this stage		The MoH has sufficient technical authority on local governments to convince them on district health coverage plan approach The MoH has sufficient political power and organised technical arguments to reform essential drug distribution policies and re-orientation of free health care subsidies (evolution from input-based to output-based national financing International donor agencies recognise the opportunity created by RBF approach to integrate successfully HIV care.

		• Number and % of HC III per district providing the complete minimal package of care • Composed Quality of care indicator according RBF procedures for HC III performance is reached in > 75% of the HC III and supported HC II in both regions. • Degree of implementation of the integrated district plan (financial absorption capacity of the districts relative to the execution agreements)	Baseline not available at this stage Baseline cannot be determined before introduction of RBF procedures Baseline cannot be determined before introduction of RBF procedures		
R 3	Result 3: Integrated regional network of health facilities is in place	• National vision on Regional coordination developed • Regional coordination for ambulance services is functional	0 0 Target : 2	• Concept notes and minutes of meetings on the matter • Minutes of the regional coordination meetings • District statistics on emergency evacuations	
R 4	Result 4: The normative role of the MoH is strengthened	• RBF implemented in 70 % of HC IV and GH in the 3 regions • National RBF policy approved • At least 6 strategic topics of attention of the ICB II project have been subject of a national reflection	0 0 0 Target : 6	• Minutes of national workshops on the matter • Manuals and procedures defined on RBF • Minutes of meetings between donor agencies on the matter • Illustration of strategic topics (see chapter 2)	

		exercise (workshop, reflection paper, policy note). The capitalisation includes reflections on the crosscutting issues (gender, SRHR and HIV/AIDS).			

	Activities to reach Result 1	Means	Belgian Contribution
R 1	Result 1 The quality of care at hospital and HC IV is strengthened		Costs in Euros
A 1.1	A.1.1 Develop regional coverage plan for general hospitals and HCIV	• 1 workshops per district for reviewing the data and completing the coverage plans • Printing the updated plans • 2 regional workshops	35.500
A 1.2	A.1.2 Support priority hospitals and HC-IV to realize a business plan	• Short term international consultancy (1 international and 2 national consult) • Visits in the regions to perform the work • 2 regional workshops	58.000
A.1.3	A.1.3 Support basic requirements for quality of care	• Basic equipment (on the base of need assessment) • Basic ophthalmological equipment 2 hospitals • short course according to managerial or clinical needs	370.000
A 1.4.	A.1.4 Improve drugs and medical supplies managements	• Short term international consultancy (1 international and 2 national consult) • Visits in the regions to perform the work	54.000
A 1.5	A.1.5 Introduce e-patient files	• National consultancy work to set-up the system (2 national consultants) • Purchasing of hardware and network according to needs • training	204.000
A.1.6	A.1.6 Implement RBF approach in general hospitals and HC-IV	• Financing general hospitals and HC-IV	900.000

	Activities to reach Result 2	Means	Belgian Contribution
R 2	Result 2 District health offices and management teams are strengthened in their capacity to man age an integrated district health system		Costs in Euros

	and to strengthen quality of care		
A 2.1	A.2.1 Interpret coverage plan for HCIII and II	• 1 workshops per district for reviewing the data and completing the coverage plans • Printing the updated plans	31.500
A 2.2	A.2.2 Adjust district development plan according to coverage plan conclusions	• 1 workshops per district for reviewing the data and completing the coverage plans	30.000
A.2.3	A.2.3 Support basic requirements for quality of care	• Basic equipment (on the base of need assessment)	150.000
A 2.4.	A.2.4 Implement RBF financing through execution agreements	• Financing health centres	900.000
A 2.5	A.2.5 Assure Quality of care through support supervision and continuous training	• Training to supportive supervision (One workshop per district) • mentorship (T&S - 15 exchanges a month)	102.000
A.2.6	A.1.6 Improve ambulance services and referral system at district	• subsidies for ambulance services • National consultancy to plan districts emergency systems	162.000

	Activities to reach Result 3	Means	Belgian Contribution
R 3	Result 3 Integrated regional network of health facilities in place		Costs in Euros
A 3.1	A.3.1 regional project team	• 1 National Technical Assistant in each of the 2 Regions • Investment : 2 vehicles • Maintenance, fuel and insurance of vehicles (3)	269.600
A 3.2	A.3.2 Organize quarterly regional health forum in the Rwenzori and West Nile regions	• 3 monthly meetings	36.000
A.3.3	A.3.3 Install a coordination body for integrated referral system	•	
A 3.4.	A.3.4 Support continuous training from regional hospital specialists	• mentorship of clinical specialists (T&S - 15 exchanges a month) • setting-up teleconference (material etc)	92.000

	Activities to reach Result 4	Means	Belgian Contribution
R 4	Result 4 The normative role of the MoH is strengthened		Costs in Euros
A 4.1	A.4.1. Capitalize from field experiences developed in Rwenzori and West Nile regions	• Topping-up for national co-director • Technical orientation and follow-up comitee 3 monthly meeting • Scientific follow-up and evaluation of the various strategies implemented • Yearly capitalisation workshop at MoH level (1 day) and final (3 days)	141.500

A 4.2	A.4.2 strengthen continuous training policies and modalities	• Short term national consultancy	24.000
A.4.3	A.4.3 develop model and strategies for a social health insurance	• Short term international consultancy • Transport (Flights, etc) for study tour • Accomodation (5 people * 7 days * 3 trips) for study tour • T&S allowances for study tour	78.750

7.2 Implementation calendar (Chronogram)

				year 1												year 2												year 3											
A	*01*		*The quality of care at hospital and HCIV health facilities level is strengthened through output financing according to needs*	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
A	01	01	Develop regional coverage plan for general hospitals and HCIV																																				
			1 workshops per district for reviewing the data and completing the coverage plans																																				
			Printing the updated plans																																				
			2 regional workshops																																				
A	01	02	Support priority hospitals and HC-IV to realize a business plan																																				
			Short term international consultancy (1 international and 2 national consult)																																				
			Visits in the regions to perform the work																																				
			2 regional workshops																																				
A	01	03	Support basic requirements for quality of care																																				
			Basic equipment (on the basis of need assessment)																																				
			short course according to managerial or clinical needs																																				
A	01	04	Improve drugs and medical supplies managements																																				
			Short term international consultancy (1 international and 2 national consult)																																				
			Visits in the regions to perform the work																																				
A	01	05	Introduce e-patient files																																				
			National consultancy work to set-up the system (2 national consultants)																																				
			Purchasing of hardware and network according to needs																																				
			training																																				
A	01	06	Implement RBF approach in general hospitals and HC-IV																																				
			Financing hospitals and HC-IV																																				
A	*02*	02	*District health offices and management teams are strengthened in their capacity to manage an integrated district health system and to strengthen quality of care*																																				
A	02	01	Interpret coverage plan for HCIII and II																																				
			1 workshops per district for reviewing the data and completing the coverage plans																																				
			Printing the updated plans																																				
A	02	02	Adjust district development plan according to coverage plan conclusions																																				
			1 workshops per district for reviewing the data and completing the coverage plans																																				
A	02	03	Support basic requirements for quality of care																																				
			Basic equipment (on the base of need assessment)																																				
A	02	04	implement RBF financing through execution agreements																																				
			Financing health centres																																				
A	02	05	Assure Quality of care through support supervision and continuous training																																				
			support supervisions and other activities for RBF through execution agreements																																				
			Training to supportive supervision (One workshop per district)																																				
			mentorship (T&S - 15 exchanges a month)																																				
A	02	06	Improve ambulance services and referral system at district																																				
			Operational costs for ambulance services																																				
			National consultancy to plan districts emergency systems																																				

				year 1												year 2												year 3											
A	*03*		*Integrated regional network of health facilities in place*																																				
A	03	01	regional project team																																				
			1 National Technical Assistant in each of the 2 Regions																																				
			Investment : 2 vehicles																																				
			Maintenance, fuel and insurance of vehicles (2)																																				
A	03	02	Organize quarterly regional health forum in the Ruwenzori and West Nile regions																																				
			3 monthly meetings																																				
A	03	03	Install a coordination body for integrated referral system																																				
A	03	04	Support continuous training from regional hospital specialists																																				
			mentorship of clinican specialists (T&S - 15 exchanges a month)																																				
			setting-up teleconference (material etc)																																				
A	*04*		*The normative role of the MoH is strengthened*																																				
A	04	01	Ensure overall management and governance of the project within MoH																																				
			International Technical assistant (Co-manager)																																				
			Vehicle																																				
			Maintenance, fuel and insurance of vehicles (1)																																				
			Responsibility allowance for national project coordinator																																				
A	04	02	Capitalize from field experiences developed in Ruwenzori and West Nile regions																																				
			Technical orientation and follow-up comitee 3 monthly meeting																																				
			Scientific follow-up and evaluation of the various strategies implemented																																				
			Yearly capitalisation workshop at MoH level (1 day) and final (3 days)																																				
A	04	03	strengthen continuous training policies and modalities																																				
			short term national consultancy																																				
A	04	04	develop a model and strategies for a social health insurance																																				
			short term international consultancy																																				
			Transport (Flights, etc) for study tour																																				
			Accomodation (5 people * 7 days * 3 trips) for study tour																																				
			T&S allowances for study tour																																				

7.3 ToR international long-term personnel

7.3.1 General description of the project

The Institutional capacity building project in planning leadership and management in the Uganda health sector comes as a follow-up of a first phase and as a complement to PNFP project.

It will expand work started in 15 districts within the 2 regions of Rwenzori and Western Nile (learning from good practices and attempting to address challenges). It will intervene at the national level (MoH), at the intermediate coordination level, at district level and health facility level in complementarity with PNFP project, Health Budget Support and the SDHR project.

Quality of leadership, planning and management, as well as clinical care will be expected to improve as a consequence of ICB-II activities.

Capacities in financial, monitoring and evaluation, clinical and managerial quality management, human resources planning and management will be strengthened at various level of intervention of ICB-II. These strengthened capacities will contribute to the design and implementation of results-based financing (RBF) at facility level according to needs (with the perspective of a health insurance system in the long run), the improved planning and management at district level, the possible design and implementation of regional structures in support to the districts, and better functioning of MoH headquarters and HMDC.

As a consequence of the above strategic options, the project will have as a general objective to further improve effective delivery of an integrated Uganda Minimum Health Care Package.

The specific objective is to strengthen the planning, leadership & management capacities of (public) health staff – particularly at local government level. This should enhance the provision of quality services within an integrated health system.

The results are the following:

- Result 1: The quality of care at hospital and HC IV is strengthened
- Result 2: District health offices and management teams are strengthened in their capacity to manage integrated district health systems and to strengthen quality of care
- Result 3: Integrated regional network of health facilities is in place
- Result 4: The normative role of the MoH is strengthened

7.3.2 International Technical Assistance public health (ITA PH)

The International Technical Adviser will assure the general management of the above project at the Belgian side of the partnership with Uganda. As a programme coordinator he will assure the coherence and complementary role of the PNFP project with the ICB II project. As a programme coordinator he will also coach the international Administrative and Financial Expert.

Functions – tasks

- Responsible for the functional coordination between PNFP and ICB II project
- Support coordination with all stakeholders inside and outside the MoH
- Steer the international Administrative and Financial Expert
- Coordinate the work between all NTA working in PNFP and ICB-II
- Participate to joint planning
- Support the MoH in its efforts to coordinate capitalisation of experiences and policy recommendation exercises

- Responsible for the co-management procedures in the ICB II project
- Co-responsible for the planning and budgeting of activities
- Co-responsible for the guiding of NTA
- Actively assist in capacity building of project and national MoH staff
- Conceive and organise action-research initiatives
- Co-responsible in the development of a M & E system, based on the establishment of a baseline for each explicit topic of interest of the project
- Support the MoH in capitalising experiences generated at the operational level and translate them in a national policy
- Organise activities to improve the quality of care and the organisational quality
- Organise formal evaluation conversations with the ITA of the PNFP project and the iAFE

Profile:

- Qualifications
  - Degree in Medicine
  - Master Degree in Public Health or equivalent diploma (candidate will have to provide course content)
- Experience
  - At least 8 years in the field of public health and health service organisation of which at least 3 years in development countries.
  - Experience in institutional support and work at a ministry's level.
  - Experience in effective management of health care facilities (Health district management).
  - Previous experience of coordination and leadership in a similar context
  - Experience in dealing with crosscutting issues (gender, SRHR, HIV)
  - Experience in action-research and capitalisation exercises are advantages
  - Knowledge on complexity concepts and management in complex environments are advantages
  - Knowledge on RBF and health insurance are advantages
- Other
  - Leadership and coaching skills (listening, consensus building, take difficult decisions)
  - Good knowledge of computer tools.
  - Able to initiate new ideas, discuss and question them.
  - Willingness to learn new concepts and a scientific curiosity
  - Combine analytical skills with good interpersonal skills.
  - Good communication skills (negotiation, moderation, representation, presentation of results).
  - Excellent in oral and writing skills in English.

Location

The candidate will reside in Kampala and its main field of activity will be within the MoH (70%) and field visits at DHO level, in hospitals and HSDs (30%) in the regions of intervention. Ten days field presence every 2 months.

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

Selection procedure

BTC Brussels will recruit the ITA by launching an international tender. The selected candidate will be proposed to MoH Uganda for approval. In case more than 1 valid candidate is identified, more candidates can be proposed to MoH for final selection.

7.3.2.1 Management of the contract

The contract is managed by the BTC under Belgian law. The person will report to the BTC resident representation.

7.3.2.2 Development circles

Development circles will be conducted by the country representation in Kampala with consultation of the BTC Health Department in Brussels for the technical part.

7.3.3 International Administrative and Financial Responsible (iAFE - RAFI)

7.3.3.1 Responsibilities and tasks

The RAFI will be a member of the technical team in the program. He will be the team leader of the project support staff. He will be reporting to the International technical advisor of the programme and work in close collaboration with the ITA of the PNFP project. Because of his profile of financial manager, he will be asked to contribute on punctual occasions in technical debates of the project. He will work in close collaboration with MoH administrative and financial staff and therefore contribute to the Ministry's capacity in these fields of competence. In more detail his tasks will be:

Financial management of the program

- Monitor budget execution
- Draft budget proposals and financial planning
- Monitor efficient use of funds
- Control and validate financial reports
- Supervise and validate accounting
- Monitor cash position and manage cash requests
- Execute payments or provide no-objection approval for commitments and payments
- Manage audit actions plans
- Monitor execution agreements (financial reports, audits, ….)

Procurement management

- Draft procurement plan
- Supervise the procurement process
- Ensure compliance with the Belgian and Ugandan procurement rules
- Supervise the management of the vehicles, infrastructure and materials
- Ensure management and follow-up of contracts

HR management

- Ensure administrative management of the local personnel with the help of the project officer (contracts, payroll, days-off)

- Help with the recruitment and the personnel selection

Technical assistance

- Assist in capacity building of MOH, regional hospitals and districts in financial management and procurement
- Provide advice to the MOH, regional hospitals and districts in order to improve their financial management and procurement
- Provide assistance in the development of new procedures and tools

7.3.3.2 Profile

- University degree in (applied) economics; or equivalent through experience
- Minimum 5 year experience in financial management
- Experience in international organization or NGO is an advantage
- Experience in team management
- Experience in human resource management and public procurement is an advantage
- Very good hands-on knowledge of IT tools;
- Proficient in English. Working knowledge of French
- Strong written and analytical skills
- Good communicator and team player;
- Solution/result-oriented
- Organisation skills
- Accurate
- Pro-active

7.3.3.3 Place of work

Kampala, Uganda, with frequent travelling in the two regions of the project. The person will report to the ITA coordinator of the programme.

7.3.3.4 Duration

Three years in this project

7.3.3.5 Selection process

This person is already selected and in place

7.3.3.6 Management of the contract

The contract will be managed by BTC, under Belgian law. It will be a HQ contract

7.3.3.7 Development circles

Development circles will be conducted by the ITA, coordinator of the programme.

7.3.1 Project Coordinator

The MoH assigned the Director of Planning as the project coordinator of this project. Besides his routine work as a MoH Director of Planning, he will execute some specific tasks in the context of the ICB II project. These tasks will be reported to the Project Steering Committee (PSC).

The PC will refer to the PSC and ensure that the members are well informed of project progress and are adequately supplied with sufficient information to carry out their decision-making responsibilities. The PC will feed back to the MoH any changes in policy or direction that the PSC may wish to carry out within the Project framework.

The project coordinator is head of the project management team (PMT) of both PNFP and ICB II project as well as head of the programme technical team (PTT), as described under chapter 5. The following specific tasks are related to these 2 functions:

The PC's specific tasks include:

- Providing overall leadership of the PMT and coordinate its activities with the ones of MoH
- Organising, coordinating and supervising the implementation of project activities in accordance with the approved project work plans;
- Technical guidance on project methodology and strategy;
- Supervise financial management, accounting and timely compilation of quarterly progress reports and budgeted work plans for the following period for consideration by the PSC;
- Contribution to compilation of the project final report at the end of the project;
- Coordination and networking with other national and international partners;
- Analyse and consolidate monitoring reports and prepare recommendations to the PSC;
- Organise bi-annual PSC meetings;
- Prepare the contents and agenda of the PSC meetings;
- Be responsible for regular communication with BTC on the management and supervision of Project implementation;
- Act on behalf of the Chairman of the PSC when authorised, and report back to the Chairperson on actions taken;
- Ensure the capturing and integration of lessons learnt and experience drawn in the implementation of project activities;
- Ensure coordination and exchange of experiences between the project and other related experiences;
- Be authorised account-holders for the accounts.

Reporting

The PC shall discuss and agree with the Chairperson of the PSC on the form and frequency of reporting. Besides periodic progress and financial reports the PC shall provide the following reports:

- Prepare consolidated and coordinated quarterly and annual progress reports, including recommendations;
- Coordinate the establishment of financial reports in accordance with the requirements of BTC and the MoH;

- Coordinate the final report, summarising the results of the Project including lessons learnt, conclusions and recommendation on how the achievements of the Project can be sustained;
- Any other reports as requested by the Chairperson of the PSC.

Remuneration

The PC will receive a responsibility allowance, which is not cumulative with other allowances related to development interventions. The amount is fixed in agreement with MoH and acted in the steering committee.

7.4 ToR National Technical Assistant (NTA)

7.4.1 Two National public health Technical Assistants (Rwenzori Region, Fort Portal and West Nile Region, Arua)

7.4.1.1 Responsibilities and tasks:

Two national technical assistants will be recruited to work at regional level (one in West Nile region and one at Rwenzori region). They will assist the project manager and the ITA in performing particular duties, specifically the design and implementation of ICB project activities and complementary activities of the ongoing PNFP support project.

They will work hand in hand with the National Technical Assistant at MoH level (NTA central) and the regional NTA of the PNFP project. NTA of PNFP and ICB in the regions will function under a common plan to assure optimal coordination and division of labor within the team.

The main tasks of the ICB NTA will be:

- Guide all ICB II project activities assigned according to the joint planning
- Support DHMT and DHO office in their work related to quality assurance, coverage plans and support supervision
- Support HC IV and general public hospitals in the development of business plans and e-patient files.
- Support the regional health coordination meetings
- Support the emergency evacuation system and contribute to the reflection on its financing mechanisms
- Organise the M&E system and assure the quantitative data collection
- Contribute to the baseline knowledge and to the description of decisions and processes.

7.4.1.2 Qualifications

- Medical doctor
- Master's Degree in Public Health or related subspecialty

7.4.1.3 Requirements

- At least 5 years in the broad field of Public Health.
- Experience in working within the public health system at the implementation level.
- Experience in national M&E system
- Experience in dealing with crosscutting issues (gender, SRHR, HIV)
- Capacity to work in a multidisciplinary and multicultural environment

- Strong interpersonal skills, including team management
- Good capacity to reflect and conceptualize from practice (including capacity to perform action research and theory-driven enquiry)
- Strong capacity to manage usual software (Word, Excel, PowerPoint, Database software…).

7.4.2 A project Accountant to be based at MoH (Ministry Headquarters)

7.4.2.1 Responsibilities and tasks:

The Project Accountant working at MoH level will assist the national project manager and the ITA on a variety of administrative and finance-related tasks. The main tasks will be:

- Implementing all project financial and accounting/reporting procedures.
- Monitoring of the project budget and managing the financial planning.
- Processing and monitoring of project accounts to guarantee their accuracy.
- Financial management of the project and providing follow-up at a regional level.
- Monitoring cash flow
- Ensuring consolidation, control, reporting and analysis of financial and accounting data for the project
- Manage the project procurement and all logistics matters.

7.4.2.2 Qualifications

- University degree in fields related to financial management and accounting
- Extra professional training (ACCA, CPA, CIMA or similar certification) will be an advantage

7.4.2.3 Requirements

- Minimum 5 years' experience in accounting and project administration;
- Knowledge of accounting programs, excel and word will be considered a strong advantage;
- Mature, good communicator and team player;
- Able to work under stressful conditions, overtime working and undertaking field missions

7.5 Financing Health Facilities through Results-Based Financing, as a first step towards Universal Health Coverage

7.5.1 General Principles

The potential of Results-Based Financing (RBF) or output-based financing has not to be proven anymore. The Belgian Cooperation has large experience, not only in the conception but also in the execution and monitoring of such systems. Good examples are Rwanda, Burundi and Benin.

The advantages are numerous and one of the most important ones is to render local actors responsible for their performance with real decentralization of decision-making combined with a financial motivational aspect. It generally goes together with a substantial increase of the recurrent budget at the operational level, which of course adds to realizing the potential created.

Possible side-effects are by now well-known as well and should be taken into consideration when introducing the system.

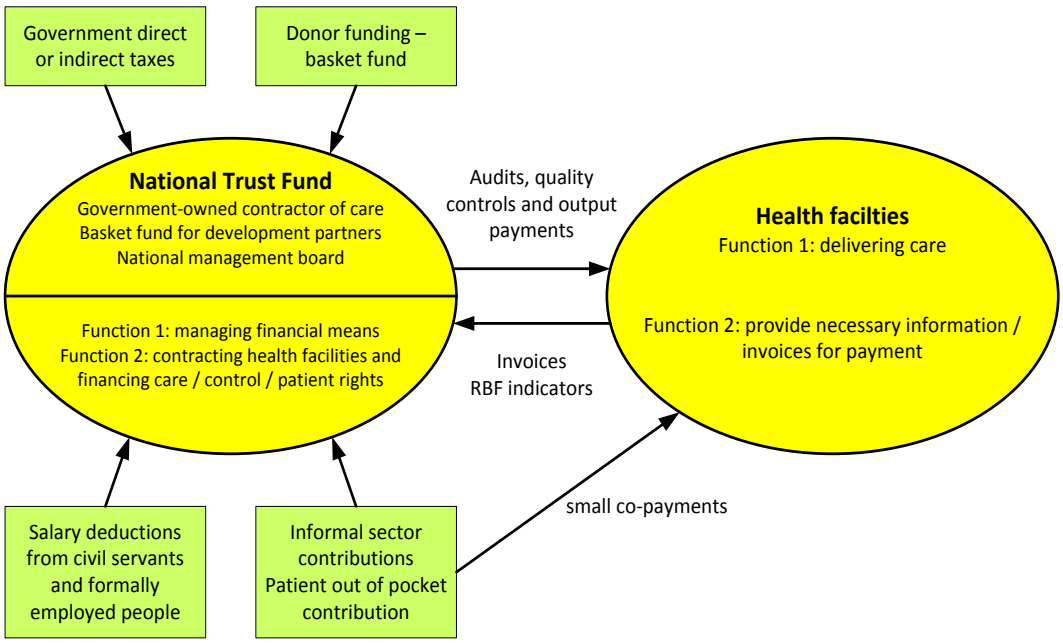
The most important dangers are:

- Lack of strong leadership and engagement from both Government (MoH) and the donor community. RBF is not possible without serious increases in the global budget for health, although some existing funding mechanisms and fund allocations can be switched to RBF eventually.
- Falsification of indicators. This is the most obvious side-effect if financing depends on indicator values. It has been observed everywhere where RBF has been introduced. There is need for rigorous control mechanisms and for quality indicators that are more difficult to falsify. It is important that impunity is not allowed to settle in. Clear rules for allocation of funds with restrictions on salary allocations are necessary. Basic salaries should remain decent and the financial motivation factor should not become the leading principle for RBF. A strong salary policy for civil servants remains a cornerstone of the system and RBF should not try to replace such policy.
- Neglect of activities that are not included in the RBF indicators. This is a natural tendency in any RBF funding mechanism. The widely heard criticism is that when projects target very specific activities and provide particular staff salary increase, the overall service gets disrupted. The indicators should therefore cover the majority of activities that are foreseen in the health care package for a specific level of care. The measured activities should not be exclusively clinical and comprehensive “global” indicators that try to look at quality of care of complete packages (e.g. antenatal care of under-fives’ clinics) should be included.
- Costly control exercises and biased evaluations. Control exercises should be at least partly independent from the health care services and authorities. Otherwise falsifications might not be corrected or quality estimates exaggerated. However, the costs of control can be extremely high if the most “independent” and “complete” form of control is chosen (i.e. through special contracting of NGO for example). The costs of the control exercises should therefore not outweigh the cost of the opportunistic behaviour of providers in a situation of no control.
- Using the funds for savings. This is a rather particular perverse effect that HC do not inject the received funds back into the system but save them for more precarious periods. Rules should be put in place that oppose this tendency e.g. savings should not represent more than a certain percentage of total funding except when major investments are planned for necessitating more than one quarter savings to cover the purchase.

- Irrational organization of services when specific services are remunerated. This is one of the least-known side-effects. There is more and more evidence for instance that when C-sections are specifically remunerated, the indications for this surgical intervention change and the C-sections rate increases. If hospitalization is financed at HC level, this might cause serious delay in referral to hospital. Lastly, if outreach activities are encouraged to be conducted by the hospitals, while HC provided by the necessary means could conduct them even at a much lower cost, irrational allocation of funds will be institutionalized.
- Too powerful controlling mechanisms. A last side effect worth mentioning here, is the creation of a huge and diverse controlling mechanism (plenty of NGO solicited) that become the real authority in the districts (they decide on the money) and with different standards. This project proposes that the long-term vision should be the creation of a government-owned National Trust Fund that becomes the contractor of health services. The Trust would receive the funds from government (tax money), from development partners (basket funding in the Trust) and from contributions from the population (small health insurance). In the national management board all contributors could be represented including civil society organization such as the UNHCO mentioned earlier. (see figure 1 below)

To avoid to a maximum these side-effects, RBF should be introduced only after thorough preparation and initially at a manageable scale, without necessarily returning into micro-pilots, to ensure enough time to install the system, including the control procedures, and to offer sufficient training to all stakeholders.

Figure 1: Model of financing mechanism that insures affordable and quality care for a large population

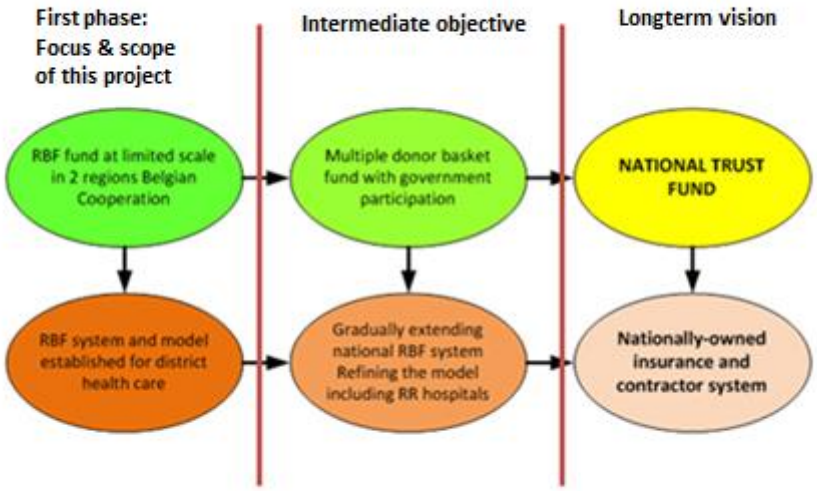


This project proposes to introduce RBF at the PNFP health care organization: at HC III and IV level and at general hospital level (district level). HC IV will be regarded as hospitals if they are the only hospital facility in the sub-district (coverage plans – see further), but as urban HC III if a hospital is in the vicinity. HC II will be particularly judged in relation with the coverage plan, minimal quality standards and the opportunity for their upgrading to HC III before including them in a support scheme. The initial design of RBF will provide the necessary criteria.

The preparation will take a year. During that period, initial investments will be done in the PNFP health facilities that are selected according to the coverage plans and capacity building activities can start from the beginning. Some of the necessary conditions that need to be created before starting RBF are mentioned under 2.3.2.

The above model (Figure 1) cannot be realized in one step or with a simple political decision. It should be introduced gradually and the covered health care packages by the system should increase according to the expected increasing financial leverage the Trust Fund would build up. In its actual phase, this project will contribute to attaining the first step out of many, as presented in figure 2. The other two situations represent respectively a mid-term and long-term vision on how the financing of the health care system can evolve gradually to a universal health insurance system, covering the whole population. These are beyond the scope of the actual project.

Figure 2: Phasing the introduction of a national health insurance and financing system



7.5.2 Initial Conditions – Creating an Enabling Environment

Initial Investments

Before starting the RBF, which will take time anyway to put in place, some basic investments in terms of basic equipment and logistics, particularly at the HC levels are needed to render them operational. In later stages, minor equipment replacement and maintenance should be covered by the RBF resources.

Health Coverage Plans

Ugandan districts and sub-districts do not have explicit and elaborated coverage plans that can be used as a management tool to orient important public health decisions. Decisions on implantation of new facilities have been taken by a variety of stakeholders (health authorities, Local Government (LG), politicians, PNFP organizations, etc.) through a relatively uncoordinated process. This has caused a sub-optimal implantation of health facilities on Uganda territory with multiple structural inefficiencies as a consequence. Coverage plans can give more insight and permit better technical decisions and coordination for future decisions in these matters.

Good coverage plans should:

- Identify the actual implantation of existing health facilities, and particularly the HC II and III, with their respective catchment areas and distribution of villages. The catchment areas should not be according to theoretical administrative boundaries but according real utilization. Patients do not respect administrative boundaries.
- Identify underserved (far-away) populations in the catchment areas who might benefit from outreach activities for preventive services organized by the HC of this catchment area. This map must be communicated and discussed with LG officials and be used in dialogue with development partners, PNFP organizations for them to subscribe to this plan. It should allow a more optimal implantation of new health facilities.
- Identify underserved populations with virtually no reasonable access to any HC facility and identify villages where a new HC should be implanted preferentially.
- Identify the most optimal way of organizing support supervision at the HC level and determine supervision circuits that permit individual supervisors or small supervision teams to share a supervision vehicle the same day.

A good health coverage plan is regarded as a pre-condition for the DHMT and the HC in the area to benefit from a RBF. Without this coverage plan, planning activities and rationalizing the service is very difficult.

A more detailed conceptual frame of a health coverage plan is annexed in §. 7.7.

7.5.3 Support to PNFP Health Centres: From Initial Investment to RBF

This project document proposes a different approach for the direct support to PNFP HC than for the hospitals. This has to do with the different care packages, self-management capacities and type of efforts needed at the two types of facilities.

HC III in the rural areas are crucial for providing basic health care close to the population. The system has been relatively neglecting them, compared with hospital care. Many of these rural HC are dysfunctional even though individual HC have low running costs in general and in most cases only need basic investments to (re-)start functioning again.

In the first year of the project, these basic investment needs in terms of necessary basic medical equipment and logistics should be addressed. If coverage plans exist at that level and if outreach activities can be organized with the existing staff to increase coverage of preventive care in their catchment area, these HC should also be equipped with a motorbike.

To start the Results-Based Financing mechanism at this level it will probably take a year of preparation work. Performance indicators should permit to subsidize the health facilities accordingly. These support budgets should be able to cover:

- The recurrent costs of the HC, which will make them financially autonomous. Existing subsidies such as the government conditional grants should remain the same or should even increase. This condition will be monitored at central level. In the long run all government support to public services, including PNFP should be integrated in a pooled fund for contracting services (trust fund, see further).
- Basic maintenance and replacement costs for basic equipment, including the maintenance of a motorcycle if present.
- Motivation fees to increase the rewarding of the personnel. Such fees should not be higher than a certain percentage of the total salary, but should contribute to bridging the

gap between PNFP and government wages. In the wage analysis, payment in kind such as providing housing, which seems a more frequent practice in PNFP facilities, should be taken into account as well as special compensations like rural allowances (more frequent in government-owned services).

- Lastly, the subsidies should permit to lower the fees for patients, without necessarily abolishing them. This measure will not significantly lower their income because it will be at least partially compensated by increased use of the services.
- Efforts aimed at improving mother and child health as well as the fight against HIV/AIDS - including prevention and health promotion as well as the establishment of a functional health infrastructure (ambulances, equipment, etc.) - will be specifically targeted in this respect.

Providing capacity building for the personnel might also be considered by the project. In general it will be organized through training sessions by the DHMT. For other subjects, synergies will be looked for with the ICB and the SDHR project.

Only fully accredited facilities will be taken into account.

7.5.4 Support to PNFP Hospitals: From Initial investment to RBF

PNFP hospitals are largely functional despite the huge challenges they are facing, especially regarding financial resources and maintaining appropriate staffing levels because of salary discrepancies with the public sector.

They have the important operational advantage though, compared with the government-owned hospital facilities, that they are very flexible in decision-making (organizational, but also financially e.g. adjusting fee-paying systems, deciding on budget allocations) and personnel management (engaging and licensing, rewarding systems).

For the hospitals that will be supported by the project a Results-Based Financing mechanism, based on monitoring of a set of indicators will be put in place. These additional funds should in the first place enable:

- **To increase the financial accessibility for patients to hospital care**. Therefore the additional funds should be strictly directed towards care of patients referred from lower levels and to typical hospital services. This way the funds will contribute significantly to the complementary service between primary care level (HC III, eventually IV) and the hospital care, and will create a shift of first line health services actually delivered by the hospital towards lower-level (and cheaper) health care facilities. Actual primary care outpatient departments should be operationally separated from the hospital care and regarded as a HC III facility, though without hospitalization facilities. The fee-paying system should be adjusted to such situation.
- **To bridge the gap between government and PNFP health workers' salaries**. Part of the additional funds can be directed towards salary subvention. It will not only create a more equitable global health care system, but also stabilize personnel movements. It will permit in future a more integrated (PNFP-Government) personnel management and support system. If salaries become equitable, shifts between the subsectors can be realized without much difficulty.
- **To increase the financial means for small maintenance and other recurrent costs.** PNFP hospitals already cover these costs in their annual budgets. This should continue of course, but they will have more financial means to cover the real needs.

PNFP hospitals will be equipped with an electronic patient file system. Some of them seem to use already this very useful and powerful management tool. All clinical and support units of the hospital are linked to the same database in which the hospitalization of every patient is individually recorded. The system permits to generate statistics, to manage laboratory and pharmacy supply systems, to automatize the administrative management of the patient and the invoices for an insurance system. Although the initial investment (financial but also capacity building) is important, it saves several salaries for the next 20 years, which means that it is a very cost-effective investment that reduces operation costs considerably. Moreover the generated data become more accurate and transparent.

The continuation and increase of the government conditional grant is also at this level a condition for the project before supporting the PNFP hospitals.

Only fully accredited facilities will be taken into account.

7.5.5 Designing a National RBF System

RBF systems are getting relatively widespread in the world. Results are promising on the one hand, whilst it becomes more and more obvious that :

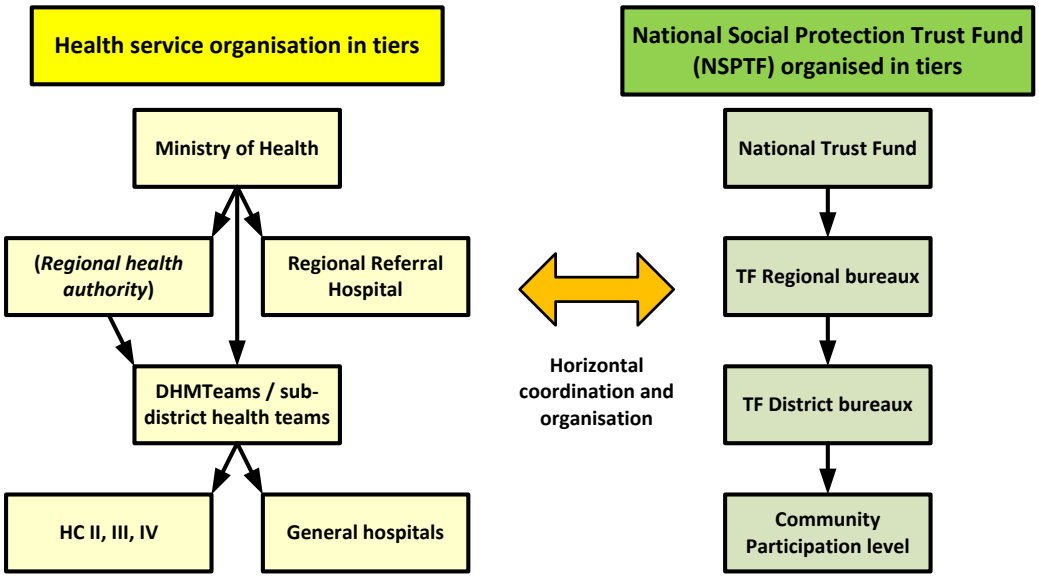
- RBF does not bring the necessary changes in the system when taken in isolation and if other regulating mechanisms for dealing with quality service organization are not developed in parallel.
- Important negative side-effects are inherent to RBF. They actually become predictable as the knowledge on the dynamics of RBF is increasing.
- Output-based financing has its advantages, but input-based financing for basic salaries and important investment and maintenance works should remain a prerogative of the MoH and Public Service.

Therefore, Uganda should consider every known side-effect when designing its own national RBF system. The one-bullet-fits-all approach cannot work. Further in this text, the perverse effects will be considered and mitigating measures in the design will be proposed.

Lack of strong leadership and long-term engagement from both Government (MoH) and the donor community

A strong coordination body should be established at national level where government and development partners are represented. The Belgian Embassy has already pronounced its interest in such an organization of the dialogue between partners. It is important that this coordination deals with RBF, but that the long-term vision on creating a national public social protection mechanism should be at the centre of the discussions. The TFF already referred to the concepts, Figure 3 represents a possible operational organisation of a NSPTF.

Figure 3: Possible operational organisation of a National Social Protection Trust Fund in the context of Uganda



Falsification of indicators

This is the most obvious side-effect if financing depends on essentially quantitative indicator values. From experience it appears to be difficult to fight falsification mainly because salaries (topping-ups) are to a significant level influenced by the qualitative performance and controlling agencies “play the game”. As a consequence often controlling mechanisms tend to become more and more important and more expensive.

Falsification of performance figures can be avoided (at least to a certain extend) when salary topping-ups are not directly or in a linear way related to performance indicators. Salaries should not go up with a fixed amount for every ANC consultation or curative care consultation. This approach does not only invite people of falsifying performance figures, it also punishes people working in more remote and less populated areas, where the number of clients by definition is less.

Not linking salaries in a linear way to quantitative performance indicators can be avoided by:

- Working with lump sum increases : Up to 25 % of coverage is corresponding with a given sum, up to 50 with another, and so on.
- Working with qualitative or more comprehensive indicators: for example, is the maternity unit functional, according to a number of criteria?
- Salary topping-ups should be limited to a reasonable percentage of the basic salary. Basic salaries should be decent, topping-ups might boost motivation to do better than usual.

Neglect of activities that are not included in the RBF indicators

This is a natural tendency in any RBF funding mechanism. The widely heard criticism is that when projects target very specific activities and provide particular staff salary increase, the overall service gets disrupted. To mitigate this effect, RBF should be inclusive, meaning that all the aspects of the foreseen packages should be included in the performance. The HC minimal package and the general hospital complementary package should be completely covered. Specific other services of hospitals might be added to the system if recognised by the coverage plans for hospitals.

Such an approach will motivate HC to complete the minimal health care package if not yet done. HC often do not yet implement HIV preventive care for instance.

Costly control exercises and biased evaluations

Controls and audits (for the re-investments) are necessary to reduce the overall risk of the system. Control has its price though as well, and in many experiences is more costly than the misuse that is avoided.

Controls have no added value in an environment of impunity. Clear rules for rectification of false situations should be installed and correctly applied if the RBF wants to succeed.

The system should avoid though that it has to verify at the level of precision of a single consultation or other medical act. If the salary topping-ups are limited and also linked to global performance indicators as suggested by the above table. In such case, fraud will be avoided and a little exaggeration of figures of performance will not affect the salary level but will give extra financing for the running of the facility. The latter is less catastrophic.

Using the funds for savings

This is a rather particular perverse effect that HC do not inject the received funds back into the system but save them for more precarious periods. Rules should be put in place that oppose this tendency e.g. savings should not represent more than a certain percentage of total funding except when major investments are planned for necessitating more than one quarter savings to cover the purchase.

Institutionalise inefficiencies through RBF funding

When funds are allocated to inefficient services, such inefficiencies will continue to exist thanks to the injected resources.

This can be avoided through critical coverage plans, respecting policies on basic and complementary packages of care, correct personnel affectation to services according to objectivised workload and by creating urban health centres (remove primary care services from hospitals).

Though it is agreed that corrective measures are not easily introduced (especially for the latter problem), RBF should not fund irrational activity. It could mean that outpatient departments are financed only at the level of a HC although the real costs are higher. It is up to the hospital to look for cheaper solutions.

Creation of parallel authorities

Experience has shown that the risk of creating strong controlling entities that exert power over health facilities and indirectly paralyse existing authorities is real. Auditing should be separated from taking corrective measures for defiant activities. The latter should be corrected by the health authorities. They should also remain in control of the business plans.

	Purchaser responsibility (Fund responsibility)	Care organiser responsibility (MoH, DHMT, hospital directing board)
Control of invoices and performance indicators	**XX**	
Payments	**XX**	
Business plans and salary topping-up authorisation		**XX**
Declaring fraud or anomalies or quality problems	**XX**	
Corrective measures for quality assurance		**XX**
Disciplining measures		**XX**

7.5.6 The auditing and business plans

The amounts facilities receive through the RBF funds should cover recurrent costs, small investments, lowering user fees and salary topping-ups. Rules should be established and applied as described partly in above paragraphs. Investments should be audited and the facilities will get external help to assist in establishing business plans (analytical book keeping and re-investment plans). At HC level the necessary support will be delivered by the DHMT, for the general and referral hospitals the project will provide for the necessary expertise in a first stage.

The auditing and support for the business plans of the health facilities constitutes an additional occasion not only to reduce the risk of fraud, but will also increase the efficiency of the system through an optimal use of the available funds.

7.6 Health Coverage Plans: Content, Use and Importance

7.6.1 Coverage Plans as Indispensable Tools for Public Health Planning

- Coverage plans allow for a spatial repartition of health facilities in a given territory. It therefore becomes an important tool for:
- Planning tool for MoH for future investments in infrastructure with prioritization, whether it is about new infrastructure or upgrading (even down-scaling) of existing ones.
- Negotiation of implantation of new infrastructures and of upgrading (even down-scaling) of existing structures with possible partners: PNFP organizations, politicians, donor agencies and community-based local initiatives.
- Coverage plans allow for HR planning based on real (or projected) workload which is an important way of optimizing scarce resources, like qualified and specialized personnel.
- Coverage plans allow to organize health services:
- Coverage plans rationalize services such as ambulance services, supervision plans, community participation and initiatives.
- Coverage plans allow at the local level to optimize outreach activities for an increased coverage of preventive services in rural populations.

7.6.2 General Considerations

Further practical considerations to take into account, when reflecting on developing concrete health coverage plans, are:

- Norms are needed but interpretation and adaptation to the given context are very important. Especially for international norms which are not always applicable in a given context.
- Patients cannot and do not respect administrative boundaries.
- Decisions on staffing levels should be according to real and projected workload, and not be uniform for every type of health facility according to fixed norms. The staffing norms should be based on an ‘average facility of its kind’. The workload estimate per unit of production is most important in this context. For example: how much time is needed for an ANC consultation, how many can be done by one person a day, how much time for a consultation at HC level, how much workload for a delivery, etc.

- Coverage plans should be based on complementary services. Services should be organized more ”centralized” if they are highly technical and if it concerns rare events, and this for advantage of scale (high technical means and ‘rare event’ often mean higher equipment investment costs but also possible HR competences). More “decentralized” organized services for services that are frequent and repetitive because they are often cheap and can be delegated to lower level staff – nurses).
- The referral system is the link between the different and complementary levels. No rational referral system is possible if services are not complementary. Too many referral levels are operationally impossible to manage or to organize. Too many referral levels inevitably cause overlapping services and patients cannot and will not respect this anyway.
- Hospital coverage plans need a regional analysis because they have huge catchment areas
- General Hospital coverage plans are based on number of beds / 1,000 population served. In rural areas the norm of 4 beds for every 10.000 population is being used but these “sick” beds exclude beds of the maternity ward. The number of maternity beds for normal deliveries is based on the number of expected deliveries in a surrounding of maximum 5 km. For urban populations, the number of “sick” beds is estimated at 1 per 1,000 inhabitants. Although maternity care for first-line uncomplicated deliveries is a typical PHC activity, in urban areas with a general hospital, one maternity at the level of the hospital catering for all the normal deliveries of the local town is more cost-effective because the 24 hour service 7 days per week only needs to be organized once and not in every urban HC. Urban HC could therefore be organized without maternity wing, only providing ambulant care for pregnant women (e.g. ANC, PoNC).
- HC coverage plans are based on the areas of responsibility and the size of the population served, the so called catchment area. They should be planned for at (sub) district level. A rural HC (hospitalization excluded) can serve a (rural) population of 5,000 to 10,000 population. When population density is too high for the existing structure, it is better to create new (relatively small and manageable units) health centers than to try to concentrate more care in the same facility by making it bigger. ”Bigger” means more personnel and more operational and organizational costs.
- Hospitalization at HC level is an activity which consumes too much time and personnel because it needs 24 hours coverage, 7 days a week. Guarantying such continuity of care for very few patients is very inefficient. In addition the quality of this care is probably questionable because of the low capacity of the personnel in this matter. It might cause unnecessary service delay[19] for hospitalizing patients at the appropriate level of care. Prompt referral or referral after a short observation period at the HC level (maximum 24 hours, most of the time much shorter) is far more cost-effective.

7.6.3 Practical Organization of Health Coverage Plan Development

The planners should have maps of the concerned regions (for hospital coverage) or (sub-) districts (for health center coverage) indicating the localization of all the health facilities, the main road network, the

[19] Service delay : delay in appropriate treatment for the patient due to factors caused by the health service. This is contrary to patient delay, when it is the patient (or his family) who causes the delay.

villages and their populations.

HC and hospitals should do a three months' data collection of the origin of their users, and this per service. If records are kept very correctly, the data collection can be done retrospectively based on the registers, but from experience we know that often the residence of patients / clients is neglected or filled in rather arbitrarily. For the hospitals a difference between referred and non-referred patients should be made.

Subsequently the patients' origins are plotted on the map and the utilization rates and coverage for preventive care are calculated per HC. Areas of attraction can then be drawn from this situation, including all the villages that effectively use the services.

Thereafter, non-covered populations can be identified. If they are distant but not too far away from an HC, this area might be planned for as outreach location for preventive care offered by this HC. If the distance is too big for any HC, outreach activities should be organized by the hospital / district level for at least some health services such as immunization for children. This can be considered as a solution awaiting new HC facilities to be built in this area. Outreaches organized by district of hospital are by definition less cost-effective than starting from HC (bigger distances, use of cars instead of motorbikes, more personnel involved).

HC that are planning for outreaches for distant populations will be equipped with a motorcycle if needed. Outreach activities will be highly valuated in RBF evaluation, because they are highly effective in increasing coverage for preventive services.

Figure 11 illustrates an existing coverage situation for HC in a given sub-district. Figure 12 represents a completed coverage plan to be implemented over time.

Figure 11: Example of a sub-district territory coverage with health centres: actual situation

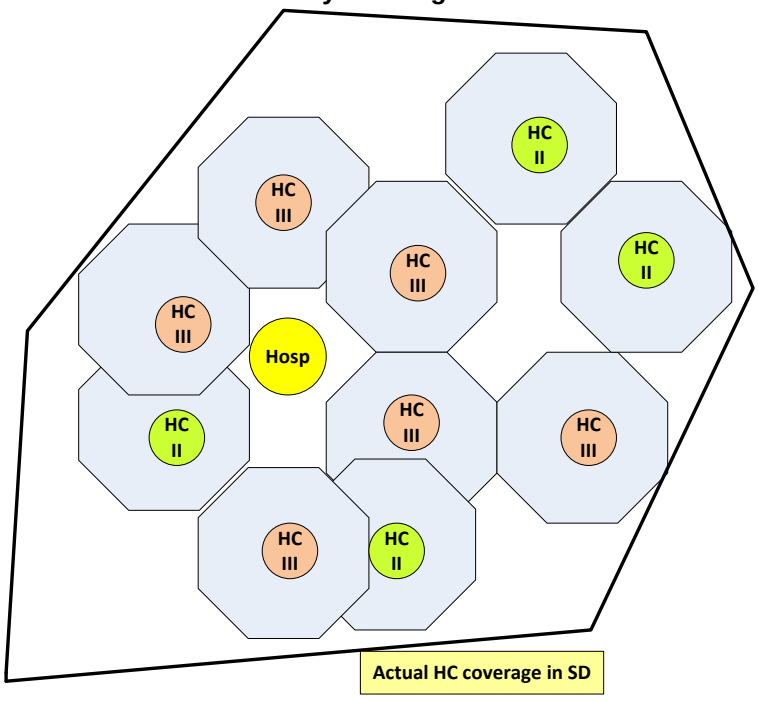
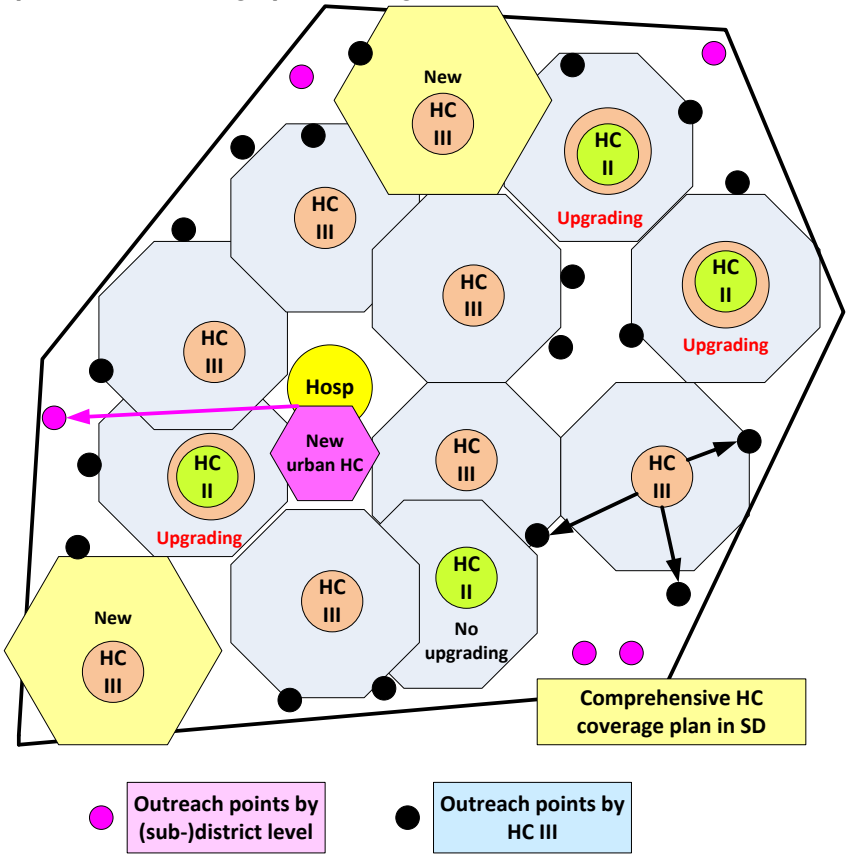


Figure 12: Completed HC coverage plan for a given sub-district



The above physical coverage plan for health facilities should be completed with the staffing needs according to workload. This will depend on the population covered, including outreach activities.

7.6.4 Estimates of Personnel Needs

When health facilities are planned for, the workload can be estimated based on the populations they will serve and the identified outreach visits. Depending on the workload, the norms for staffing can be applied to the individual facilities in order to optimise the staffing levels. This will clearly influence the need for staff nation-wide because the actual norms are rather maximalist and do not take into account real workload.

Eventually, a new repartition of staff in the territory can be envisaged.

7.6.5 Participation in and Communication on Health Coverage Plans

Health coverage plans are technical, public health issues. Several criteria of efficiency, accessibility and patient preferences are combined to come to a technically sound plan. But coverage plans need to be adhered to by all stakeholders, as there are the health authorities at central but also at LG level, the population at large, the local politicians, civil society and the PNFP stakeholders. All these stakeholders need to understand the rationale behind the coverage plans.

Coverage plans cannot be considered “completed” as long as all these parties have not been communicated to and have understood the dynamic of the proposal. This negotiation might actually still alter the plan.

PNFP authorities (DHC, MB) should be included in the technical planning process for them to understand their responsibility in contributing to an optimal plan.

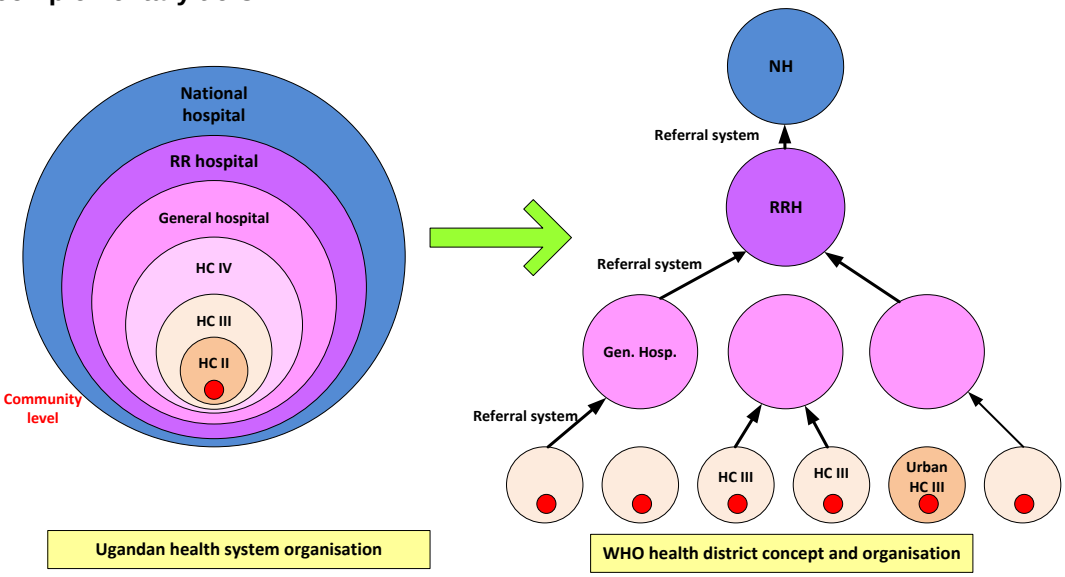
7.6.6 WHO versus Uganda

Despite many efforts, the health coverage in Uganda remains insufficient. Rapid population growth and system restrictions (financially but also in terms of HRH) are the main challenges for Ugandan authorities to address the health coverage problem in the country. Some policy issues are equally at stake: The national health policy foresees that “every superior level in the health pyramid organizes the same services as the lower tiers plus an additional package of care”.

Contrarily, WHO foresees that the different tiers in the health system should be complementary, meaning that those services that are better realized at decentralized level should be done at that level and should not be duplicated at a higher level. Every additional tier causes new delays and operational problems.

The Ugandan health pyramid and the WHO model applied for the different types of Ugandan health facilities are illustrated in Figure 13.

Figure 13: Ugandan health care organisation versus WHO health district concept of complementary tiers



Complementary services are not compatible with the policy of ‘the superior level doing all what lower levels of care offer plus other services’. They should only cover the additional package. In practical terms, this means that the system needs to replace PHC outpatients replaced by urban HC, preferably outside the hospital premises. HC II and HC III notion should be abolished. HC IV becomes either HC III or a general hospital, but its actual ‘in-between’ position is inefficient.