TECHNICAL & FINANCIAL FILE

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

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THE BELGIAN DEVELOPMENT COOPERATION .be

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANO	After No Objection
ASRH	Adolescent Sexual and Reproductive Health
BOG	Board Of Governors
BS	Budget Support
BTC	Belgian Development Agency
CBO	Community Based Organization
CC	Coordination Committee
CHD	Community Health Department
CMO	Implementation Agreement
C-section	Caesarean Section
CSO	Civil Society Organization
DFID	Department for International Development
DGD	Directorate General for Development Cooperation and Humanitarian Aid
DHC	Diocese Health Coordination
DHO	District Health Office
DHMT	District Health Management Team
EMHS	Essential Medicines and Health Supplies
EmOC	Emergency Obstetric Care
ETR	End Term Review
EUR	Euro
FB-PNFP	Facility Based Private Non For Profit
FY	Fiscal Year
FP	Family Planning
GIS	Geographical Information System

GoU	Government of Uganda
HC	Health Centre
HDI	Human Development Index
HDP	Health Development Partner
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HPLM	Health Planning Leadership and Management
HQ	Head Quarters
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
MTCT	Mother-To-Child Transmission
MTR	Mid Term Review
NA	Not Applicable
NDP	National Development Plan
NGO	Non-Governmental Organization
NHP	National Health Plan
NFB-PNFP	Non-Facility Based Private Non For Profit
NMS	National Medical Store
NRH	National Referral Hospital
NTA	National Technical Assistant
OPD	Out-Patient Department
OVC	Orphans and Vulnerable Children
PCT	Project Coordination Team
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PHP	Private Health Practitioners
PM	Project Management Team
PNFP	Private Non For Profit
PNFPCB	Private Non For Profit Coordinating Bodies
PoNC	Postnatal Care
PPP	Public Private Partnership
PPPH	Public Private Partnership in Health
PS	Permanent Secretary
PSC	Project Steering Committee
PTFC	Project Technical orientation and Follow up Committee

R	Result
RBF	Results-Based Financing
RRH	Regional Referral Hospital
SDMT	Sub-District Management Team
SRH	Sexual and Reproductive Health
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
ToR	Terms of Reference
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 project "Institutional Support for the Private-Non-For-Profit (PNFP) health sub-sector to promote universal health coverage in Uganda" is designed to build the stakeholders' capacities in order to strengthen and effectively implement the partnership with the PNFP sub-sector.

It is inscribed in the frame of the National Policy on Public Private Partnership in Health (PPPH) that has been finalized by the Technical Working Group (TWG) on PPP and approved since March 2012. It will assist the Ministry of Health (MoH) and other partners in testing the "Specific implementation guidelines", that have been developed for the PNFP subsector.

This project adopts a holistic approach with a "public oriented" perspective. It has the ambition to strengthen the respective roles of the MoH, the District Health Offices (DHO) and Local Government, the Medical Bureaus (MB) and the PNFP health facilities. It should not be perceived as a sole support to PNFP health facilities.

The project will act at two levels, namely at National and at regional/district level:

A) At national level, it will strengthen policies and implementation guidelines, in their design and update. In that process, it will promote a combined evidence based and concerted approach.

    a. It will support the stewardship role of the MoH through its Directorate of Planning and Development and more specifically the PPP unit. The project will be anchored at the Directorate of the Planning and Development.

    b. It will 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 District Health Offices.

B) At regional and district level, it will pilot innovative approaches in planning, monitoring and financing of PNFP health units within the district health systems. Strategies will be defined at central level and implemented at regional and district level. These local pilot experiences will feed back into the refining of national strategies (loop):

    a. It will strengthen the role of the District Health Offices in planning, monitoring and supervision of the PNFP health units with the aim to reach a more functionally integrated health system and to improve equity in the accessibility of the population to health care services of good quality.

    b. The project will use two complementary strategies to structure the strengthening of the PPPH between the Ugandan government (GoU) and PNFP: the design and use of a health coverage plan and the financing of PNFP health units through a Results-Based Financing (RBF) mechanism.

A health coverage plan is a planning and monitoring tool that will help in building an integrated health system with a mix of government and PNFP providers. Through the allocation of specific responsibilities to each health care provider, this plan will formalize the complementarity between health facilities. It makes also clearer the specific need of resources from each facility.

The RBF mechanism is a "fashionable" financing mechanism. It will have to be "customized" to the reality of the PNFPs in Uganda, such as to ensure (1) an equitable distribution of resources between PNFP and government facilities and (2) an efficient provision of health services.

As a consequence of the above strategic options, the project will have as a general objective to contribute to strengthen service delivery capacity at district level to effectively implement PHC activities and deliver the UNMHCP to the target population.

The specific objective is : PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.

The results are the following:

Result 1: MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies

Result 2: MB and PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions

Result 3: District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations

Result 4: MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities

Result 5: PNFP HC III and IV of the regions of West Nile and Ruwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF

Result 6: PNFP hospital care of West Nile and Ruwenzori is more accessible for the population without loss of quality of care through RBF

Throughout the project implementation attention will be given to the mainstreaming of crosscutting issues such as environment, gender and sexual and reproductive health (SRH) (including adolescent sexual and reproductive health and HIV/AIDS). This focus on SRH – and more particularly on maternal and child health and the fight against HIV/AIDS - is in line with the priorities set out in the Health Sector Strategic Investment Plan 2010/11-2014/15 and are directly related to the achievement of MDG 4, 5 and 6.

The Ugandan contribution to the project will be "in kind" and the Belgian contribution amounts to 8,000,000 EUR.

Since the Joint commission of 2008 the cornerstone of the Belgian program in Uganda has been a well-considered "portfolio approach", aiming at one strategic objective while working through a mix of modalities (projects and budget support). There are two interventions currently ongoing in the health sector: the Institutional Capacity Building (ICB) project and the Budget Support (BS), which are designed to operate in a complementary and synergetic way.

- ICB: the Institutional Capacity Building in planning, leadership and management in the Ugandan health sector (HPLM) project is being executed from June 2010 till June 2014 with a budget of 7,850,000 EUR to improve the effective delivery of an 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.
- BS: In the IDCP 2008-2012, 20 million EUR has been allocated as budget support to the health sector of which 15 million EUR has been disbursed. In the new IDCP 2012-2016 another 12 million EUR has been allocated to health sector budget.

Analytical record of the intervention

Title of the intervention	Institutional Support for the private-non-for-profit (PNFP) health sub-sector to promote universal health coverage in Uganda
Intervention number	NN 3014036
Navision Code BTC	UGA 13 02611
Partner Institution	Ministry of Health
Length of the intervention	72 months (48+24)
Estimated start of the intervention	2014
Contribution of the Partner Country	In kind
Belgian Contribution	8,000,000 EUR
Sector (CAD codes)	12110 Health, general Health policy and administrative management
Global Objective	Contribute to strengthen service delivery capacity at district level to effectively implement PHC activities and deliver the UNMHCP to the target population.
Specific Objective	PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.
Results	Result 1: MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies Result 2: MB and PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions Result 3: District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations Result 4: MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities Result 5: PNFP HC III and IV of the regions of West Nile and Ruwenzori are fully implementing the health care package as foreseen in the national health policy and this

	in an affordable manner for the catchment population through RBF Result 6: PNFP hospital care of West Nile and Ruwenzori is more accessible for the population without loss of quality of care through RBF

1 SITUATION ANALYSIS

1.1 General Context

Uganda has an area of 241,000 km² and a projected population of 35,356,900[1]. With an average annual growth rate of 3.2% Uganda's population is expected to increase to 44 million by 2020 raising the population density from 120 to 164km². A Total Fertility Rate (TFR) of 6.2 birth/woman and a contraceptive prevalence rate of only 24% both contribute significantly to the increase in Uganda's population. Such a population growth strains the demands on the health sector every year again. Eighty eight percent of the population lives in rural areas. While Uganda's economic growth has been rather high in recent years with an average of 7% per annum and improvements have been made in reducing the percentage of the population living in poverty, Uganda is still classified amongst the countries with the lowest human development index (HDI value 0.422, rank 143/169 in 2010).

Uganda has made progress in improving the health of its population as shown by improved health indicators over the last ten years, but they remain unsatisfactory and disparities continue to exist across the country[2] (UDHS 2011): life expectancy increased from 45 years in 2003 to 57 and 54 for females and males respectively in 2011 (WHO estimation); HIV prevalence reduced from 27% to 7% between 2000/01 and 2007/08, but the overall HIV prevalence among women and men aged between 15-49 years has increased from 6.4% in the 2004-05 (UHSBS) to 7.3% (UAIS 2011); and 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 neonatal mortality rate was 33 per 1,000 live births in 2000 and decreased to 27 in 2011.

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 mal nutrition (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 22% in 2013 (National Household Survey 2013), Uganda is still a low income developing country with income disparities spread

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[1] State of Uganda Population Report 2012, Uganda Bureau of Statistics (UBOS), 2012 Midyear Projection

[2] Uganda Demographic and Health Survey 2011 (UDHS)

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).

1.2 Health Sector

1.2.1 Policies and Strategies

The 1995 Constitution of the Republic of Uganda provides for all people in Uganda to enjoy equal rights and opportunities, have access to health services, clean and safe water and education, among 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.

1.2.1.1 National Health Policy II

The second National Health Policy (NHP II) is based upon the National Development Plan (NDP), the 1995 Constitution of the Republic of Uganda and current global dynamics to achieve its vision of "A healthy and productive population that contributes to socio-economic growth and national development".

Its 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 NHP II has seven guiding principles 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.
- 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.

One of the seven policy objectives of the NHP II defines partnerships in health with and between ministries, private health sector, development partner, Civil Society Organizations (CSO) and communities. It promotes the implementation of the national policy on Public Private Partnership in Health (PPPH). In order to achieve a functional PPPH, the following strategies are proposed:

- Assure continued participation of the private sector in the process of policy development, planning, effective implementation and quality assurance, with the aim of building consensus and sharing ownership of policies and plans.
- Establish appropriate legislative frameworks and guidelines to facilitate and regulate the private sector in line with existing laws and regulations.
- Establish specified structures of the partnership, at all Local Government levels to facilitate consultation and coordination among partners and promote active participation of the private sector in district health planning and services delivery.
- Work with the private sector to reform incentive mechanisms (e.g. fiscal) that would attract legally accepted private health practitioners to the under-served and difficult-to-reach areas.
- Formalize commitments with the PNFP sub-sector through memoranda of understanding and service level agreements with the view of ensuring that the level of subsidies is linked to agreed outputs with the objective of improving access for vulnerable populations.
- Support the adoption of the Health Management Information System (HMIS) by the private health providers to improve completeness of national data, planning and health financing.
- Facilitate access of the private sector to development capital, essential medicines and supplies for healthcare developments vital to service expansion to the population.
- Develop and establish collaboration mechanisms with Traditional and Complementary Medicine Practitioners (TCMP) in the broad service delivery.

1.2.1.2 Health Sector Strategic and Investment Plan (HSSIP)

The HSSIP guides the participation of all stakeholders in health development in Uganda. To achieve its goal, the HSSIP aims to i) improve access of the population to the UNMHCP, with special attention on increasing effective access for the poor and vulnerable groups of the population and ii) improve the quality of delivery of the package and of all health services. The HSSIP recommends a scale up in sector coordination and partnership to ensure more sustained and accelerated improvement in health. Therefore it proposes the following interventions regarding Public Private Partnerships:

- Finalization and approval of the National Policy on PPPH (policy has been approved in 2012).
- Disseminate the PPPH Policy and test the Implementation Guidelines to operationalize the public private partnership in health
- Establish PPPH structures at district and lower levels necessary to facilitate coordination and consultation among stakeholders

- Develop and implement in consultation with the PNFP, a MoU which would link level of subsidies to agreed service outputs with the objective of increasing access to health services for most vulnerable population.

1.2.1.3 Public Private Partnership in Health (PPPH) Policy

A partnership with the private health sector is seen as one of the means to reduce morbidity, mortality and disparities in access to health care.

To formalize, implement and monitor partnerships with the private health providers a National Policy on Public Private Partnership in Health (PPPH) has been finalized by the Technical Working Group on PPPH (TWG) and approved in March 2012. Specific implementation guidelines, for each subsector, have also been developed. The policy aims to promote recognition and value of the role and contribution of the private sector in health development and to provide an enabling environment for effective coordination of efforts among all partners, to increase efficiency in resource allocation, achieve equity in the distribution of available resources for health and effective access by all Ugandans to the UNMHCP. The policy is based upon the Ugandan Constitution, the NDP, the NHP II and the HSSIP.

The PPP unit is the central coordination structure to execute the countrywide implementation of PPPH interventions (see 1.2.11.1). Implementing the partnership has proved to be a remarkable challenge because of the plurality of actors with different identities, administrative set up, views and interests. Disparities and inequities between government and PNFP facilities exist, mainly due to underfunding and lack of capacity of both.

The PPPH has **three general objectives**, which are:

- To establish a clear institutional and legal framework to effectively build and utilize the full potential of the public private partnership in Uganda’s national health development.
- To establish a functional integration and to support the sustained operation of a pluralistic health care delivery system by optimizing the equitable use of available resources.
- To invest in comparative advantages of the partners in order to sustain scope, quality, and volume of services to the population.

The priority areas for partnership between the public and private sectors as highlighted within the PPPH policy are policy development, HSSIP monitoring and evaluation, co-ordination and planning, financial resource mobilization and allocation, capacity building/management and service delivery. It describes the central government’s regulatory and coordination role towards all health care providers, as well as the roles assigned to the individual structures at central and local level.

Implementation of the PPPH policy

MoH lacks adequate resources (Human Resource, financial, Infrastructure) and adequate governance capacity (at both central & district levels) to execute effective coordination of all players in the health sector and implementation of partnership interventions.

At the national level, implementation of the PPPH policy has taken root with the institutionalization of coordination structures that include the PPPH Technical Working Group (TWG) and the PPP Unit that currently functions as the focal point for partnership activities. With respect to partnership interventions, the PNFP subsector, through its representative Umbrella Organizations (including the Medical Bureaus), engages with the MoH and the Health Development Partners (HDP) at the PPPH TWG level and the higher Health Policy Advisory Committee (HPAC) level. Currently, the MoH is finalizing the PPPH implementation guidelines

which will guide the operationalization of the policy (a draft is circulating in October 2013).

The level of awareness and knowledge of the PPPH policy[3] at Local Government (district) level is markedly much weaker than at central level than and this for both sectors, public and private. The District Health Offices (DHO) and the PNFP health facilities do not have a clear understanding of how the PPPH policy implementation has to take root at district level and they lack knowledge about the formal coordination structures essential for both partners to collaborate and actively engage in partnership interventions such as joint public-private support supervision. That is why there is no evidence of institutionalization of decentralized partnership coordination structures (PPPH Desk Officers & Private Sector Coordination Committees) nor of tangible initiation of joint Public-Private planning activities which proof the implementation of PPPH interventions.

1.2.1.4 Coherence between the policies

The NHP 2010/20 and the HSSIP 2010/15 assign a relevant role to the PNFP sub-sector in the achievement of the national health objectives. The NHP II acknowledges the role of the private sector in health and the need for the PPPH policy to provide a legal framework for linkage of the public and private sectors. Strong coherence exists as well between the PPPH policy and the HSSIP. The establishment of a functional integration[4] between the public and private sectors, in health care delivery, training, and research, is considered as an important strategy for strengthening health systems in the HSSIP.

The PPPH policy has been developed guided by the 1995 Constitution of the Republic of Uganda and the government's liberalization policy, which gives strong incentive for government to collaborate with and support private initiatives in health care delivery. The PPPH policy is also consistent with the National Poverty Eradication Action Plan (PEAP), recognizing that for development to be sustainable, health and economic growth must be mutually reinforcing. As such all government and private sector partners in health should be working towards the goal of poverty eradication and economic growth. The policy takes into account the roles and responsibilities of Local Government structures for service delivery under decentralization. In addition, the level of awareness and initiation of implementation of the PPPH policy is relatively stronger at central level but still very weak at Local Government level (districts) given that government is yet to finalize the implementation guidelines[5].

1.2.2 Health Service Delivery

The number of health facilities in the public sector and of the PNFP has grown from 2,585 in 2004 to 3,396 in 2010 of which PNFP constitutes 23% (606 in 2004 and 774 in 2010).

[3] Preliminary Study Report, BTC, July 2013: A National Assessment of the PNFP Health Subsector.

[4] The organisation and management of the public and private subsector as parts of one operational well-functioning health care system without separation between both subsectors. WHO's definition: Integration can also refer to integrated policy-making and management which is organized to bring together decisions and support functions across different parts of the health service. For example a management team in an integrated system may have overall responsibility for the health status of a given population and may be able to simultaneously contract services from the public, voluntary and private sectors. An integrated district service would conduct integrated supervision – supervisory visits to health centres, for example, would look at all aspects of the centre's work, ideally using a standardized checklist. http://www.who.int/healthsystems/service_delivery_techbrief1.pdf

[5] Preliminary Study Report, BTC, July 2013: A National Assessment of the PNFP Health Subsector.

Health services are provided by the public and private subsector with each subsector covering about 50% of the reported outputs. The UNMHCP has been developed for all levels of the health system for both public and private sectors and service delivery is based on this package.

The Ugandan health system consists of the district health system comprising Health Centers (HC) type I (corresponding with the community level and Village Health Team – VHT), II, III and IV and general hospitals. Regional Referral Hospitals (RRH) and National Referral Hospitals (NRH) complete the tiered system. The RRH and NRH are semi-autonomous institutions. District health services are managed by Local Governments. The district health system is further divided into Health Sub-Districts (HSD). Each HSD is supposed to have a referral facility being either a HC IV or a general hospital. In 2008 only 28% of the existing 154 HC IV were fully operational (MoH, 2008).

Table 1: Overview of health facilities by level and ownership[6]

Year 2010	Ownership						
Level	GOU		PNFP		TOTAL GOU + PNFP	PRIVATE	TOTAL
Hospitals	69	53%	56	47%	125	9	129
Health centre IV	164	93%	12	7%	176	1	177
Health centre III	832	79%	226	21%	1058	24	1082
Health centre II	1562	76%	480	24%	2042	964	3066
Total	2622 2867*	77%	774	23%	3396	998	4394 5073*
Health Training Institutions	8	30%	19	70%	27	-	27

*2011 MoH Health Facility Inventory

In general, district management capacity is still being built. Leadership skills, health services management and specialist skills are inadequate at all levels. High levels of attrition tend to curtail capacity development initiatives. While Community Health Departments (CHD) exists at RRH to support districts, systems to carry out this function are not yet fully operational. The increase in number of districts has placed more supervisory and monitoring responsibilities on MoH.

The increase in number of districts necessitates a re-examination of the standard service delivery model in the districts and supervision and support mechanisms.

1.2.3 The Public Sector

The public health care system has undergone transformation over the last several years as a result of proactive policies instituted by government. Health infrastructure has been expanded to achieve greater coverage including rehabilitation and upgrading of some existing facilities, in-service training of staff has been implemented to improve clinical competences, extensive capacity development has been instituted to improve system management and efficiency at

[6] Uganda HSSIP 2010-2015, annex 3 identification file

both central and district level, and improved capacity has been built in the MoH for policy formulation, planning, budgeting and monitoring of the sector.

According to the more recent Health Facility Inventory of 2011, the increase of the total of health care facilities to 5,073 shows the efforts of the GoU to improve the geographic accessibility (see table 1*). But although 72% of households in Uganda live within five kilometers from a health facility (public or PNFP) utilization is limited due to poor infrastructure, inadequate medicines and other health supplies, the shortage and low motivation of human resources. 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 69 are hospitals (2 national referral hospitals, 14 regional referral hospitals, 49 general hospitals, and 4 military and police hospitals). Overall, about 3% of health care facilities are hospitals, 4% HC IV and 70% HC II. An HC IV is considered functional if it can carry out caesarean sections. In 2012, it was estimated that 24% of all HC IV were functional. The government also provides non-facility based services through national programmes such as Community and Environmental Health and Communicable Diseases Control.

However, despite considerable achievements over the last 15 years there are still significant gaps in access to services and quality of care, particularly in rural areas. Although government funding to the sector is increasing annually, there are still many under-funded and un-funded priorities, and many challenges remain to be addressed to achieve the objectives set out in the HSSIP.

The functions of the Ministry of Health (MoH) include resource mobilization and budgeting; policy formulation and policy dialogue with HDPs, strategic planning, regulation, advising other ministries on health matters, setting standards and quality assurance, capacity development and technical support, provision of nationally coordinated services such as epidemic control, co-ordination of health research and monitoring and evaluation of the overall sector performance.

The MoH has devolved responsibilities to the districts for them to manage the delivery of health services by both the public and private sectors. The supervision of the NRH and the RRH remains under the MoH headquarters.

Several functions have been delegated to national autonomous institutions, including some specialized clinical support functions (Uganda Blood Transfusion Service (UBTS), National Medical Stores and National Public Health Laboratories) and regulatory functions (the professional councils, the National medicines and medical supplies Authority and other regulatory bodies). Research activities are conducted by several research institutions and coordinated by the autonomous Uganda National Health Research Organization (UNHRO).

1.2.4 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 have the responsibility of supervising the district health system.

Technical supervision is provided at all levels of care with each level supervising the Promoting People's Health to Enhance Socio-economic Development. 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 medicines and medical supplies 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 and monitoring of community/Civil Society Organizations (CSO).

1.2.5 Human Resources for Health

Uganda has an estimated health workforce of 45,598[7]. Although the percentage of filled public sector posts has increased due increased government recruitments, namely from 38% in 2006 to 56% in 2010, 71% at district level and 63% nationwide 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). In an ideal case, a health system would distribute health care workers to match geographic population and disease burden distributions but unfortunately this logic has not been followed in Uganda. 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.

1.2.6 Medicines and Medical 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. About 1.60 USD 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 to deliver the Uganda National Minimum Health Care Package is nearly 50 %.The government and development partners 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 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 medicines and medical supplies stock-outs and expiries is the lack of broad-based coordination between the public sector and development partners on procurement and distribution.

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

1.2.7 Health Financing and Sustainability

The health sector is financed through government revenue and development assistance under the Sector-Wide Approach (SWAp). Internal budget allocations are based on an agreed formula. In the past eight years, health expenditure as a proportion of government's discretionary expenditure has been relatively stable at around 9.6%, thus remaining below the Abuja Declaration target of 15% (MoH 2008b). This does not compare favourably with the per capita requirement for provision of UNMHCP in all facilities which was estimated at 41.2 USD per capita in 2008/2009 rising to 47.9 USD in FY2011/2012[8]. 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, see table…).

The PNFP health providers receive a subsidy from the consolidated funds but this has stagnated at 20% of the total expenditure of the health facilities over the last few years. The private wings of public hospitals, PNFP and Private Health Providers (PHP) receive additional resources through a user fee system to cover their recurrent costs. The dependency on user fees as the main mechanism of financing for the private sector has created equity gaps with the poor unlikely to afford the services.

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

Year	GoU Funding (U Shs bns)	Donor Projects and GHIs (U Shs bns)	Total (U Shs bns)	Per capita public health exp (UGX)	Per capita public health exp (US $))	GoU health expenditure as % of total government expenditure
2000/01	124.23	114.77	239.00	10,349	5.9	7.5
2001/02	169.79	144.07	313.86	13,128	7.5	8.9
2002/03	195.96	141.96	337.92	13,654	7.3	9.4
2003/04	207.80	175.27	383.07	14,969	7.7	9.6
2004/05	219.56	146.74	366.30	13,843	8.0	9.7
2005/06	229.86	268.38	498.24	26,935	14.8	8.9
2006/07	242.63	139.23	381.86	13,518	7.8	9.3
2007/08	277.36	141.12	418.48	14,275	8.4	9.0
2008/09	375.46	253.00	628.46	20,810	10.4	8.3
2009/10	435.8	301.8	737.6	24,423	11.1	9.6
2010/11	569.56	90.44	660	20,765	9.4	8.9
2011/12	593.02	206.10	799.11	25142	10.29	8.3
2012/13	630.77	221.43	852.2	23,756	9	7.4

Source: Approved Budget Estimates of Revenue and Expenditure - MoFPED

1.2.8 The National Health Management Information System

The government has instituted a web-based electronic system (DHIS2) for its national Health Management Information System (HMIS). Data is transmitted from district level to the national Resource Centre in MoH. Currently the DHIS2 has covered more than 90% of districts countrywide, however access to the system is highly restrictive and requires formally obtaining access rights.

Public and PNFP facilities report through the National HMIS with health data collated at district level and transmitted to the Resource Centre.

[8] HSLP Africa Limited, 2008

The information flow of the PNFP subsector goes from the PNFP facilities to its respective Medical Bureau (MB). The MB collate, analyse and provide feedback to member facilities (particularly Hospitals & HC IV) during their Annual General assemblies, national/district level training sessions and during technical support supervision visits. Data is also direct transferred to hospitals and HC IV. Data to lower level facilities is transmitted by the respective regional health coordination structures.

A number of HMIS bottlenecks and challenges exist, which have an impact on the collaboration between the public and private (PNFP) health sector, in particular for the players at policy level, namely:

- The production of disaggregate data resulting in failure to appreciate the respective contributions of reporting facilities to the national indices
- The training of PNFP facilities on the use of DHIS2. The MB do not have sufficient resources to train their member facilities.
- The submission of accurate data reflecting true outputs and performance. Data validation exercises are very critical but often too expensive for MoH and the MB to execute.
- The use of data for evidence based decision making
- The capacity, especially in terms of personnel and equipment to manage data and effectively report through the HMIS for most lower level facilities (public and PNFP).
- Access for the MB to freely connect to the DHIS2 system. This erodes ownership and handicaps their ability to monitor compliance and performance of member facilities.
- Multiple reporting requirements from different donors which strain the capacity of the PNFP facilities and negatively impacts on the quality of HMIS reports.

1.2.9 Achievement of Health Related MDG

The Uganda health policies are driven by a concern to increase the efforts of the health system in view of the achievement of the health related MDG targets by 2015, and more particularly MDG 4 on the reduction of child mortality, MDG 5 on the improvement of maternal health and MDG 6 on the fight against HIV/AIDS, malaria and other diseases (such as tuberculosis). HSSIP 2010/11-2014/15 explicitly states that sexual and reproductive health (SRH), child health, health education and control and prevention of communicable diseases (HIV/AIDS, tuberculosis and malaria) are to be given absolute priority by both the government and the donor community. Maternal and child health as well as the prevention, management and control of communicable diseases are two of the four main clusters in the Uganda Minimum Health Care Package (UMHCP). The UMHCP consists of promotional, preventive, curative and rehabilitative and palliative services for all prioritized diseases and conditions, to all people in Uganda, with emphasis on vulnerable populations.

1.2.10 The Private Health Sector

1.2.10.1 Structure and Organization

The government of Uganda recognizes the crucial role the Private Health Sector plays in the equitable access to quality health services of communities, attributing up to 50% of the national health outputs. The private health sector comprises three broad categories of service providers:

- The **Private-Not-for-Profit organizations** (PNFP), subdivided in
    - Facility based PNFP (FB-PNFP)

    - Non-facility based PNFP (NFB-PNFP)

- The **Private Health Practitioners** (PHP)

  This subsector encompasses all cadres of health professionals in the Clinical, Dental, Diagnostics, Medical, Midwifery, Nursing, Pharmacy and Public Health categories who provide private health services outside the PNFP establishment. The PHP have a large urban and peri-urban presence and provide a wide range of services, mainly in primary and secondary care. Curative services are widely offered while preventive services are more limited, with the exception of family planning offered by three-quarters of PHP facilities.

- The **Traditional and Complementary Medicine Practitioners** (TCMP)

  They include all types of traditional healers including herbalists, traditional bone-setters, traditional birth attendants, hydro therapists and traditional dentists. There are several associations with registered members at the sub-county and district levels, coordinated by District Cultural Officers but many remain unaffiliated to any association. More recently, a number of non-indigenous traditional or "complementary" medical practices have been introduced into the country. Complementary medicine is provisionally defined as the art of using natural, physical or psychic means or products to cure or modify disease or promote health through mechanisms different from standard western type medicine. Current complementary medicine providers in Uganda include practitioners of Chinese and Ayurvedic medicine, chiropractic medicine, homeopathy and reflexology.

A detailed overview of the private subsector can be found in Annex, see Annex 7.9.

1.2.10.2 The Private-Not-for-Profit (PNFP) Health Subsector

Medical Bureaus

About 75% of the PNFP facilities are represented by Medical Bureaus (MB) which are institutional structures to govern their members in these faith-based networks, while the others fall under other humanitarian and Community Based health care Organizations (CBO).

The Medical Bureaus fulfil three major roles towards their affiliated health facilities: technical, advisory and regulatory through provision of services in exchange for compliance with set standards, guidelines and priorities agreed upon with the health facility managers and boards. Other roles and responsibilities of the MB are resource mobilisation, health data collection and reporting (through HMIS), support supervision, capacity building (through trainings targeting health workers and facility managers), information sharing and proving advisory and technical assistance.

The Ugandan Catholic Medical Bureau (UCMB), the Ugandan Protestant Medical Bureau (UPMB), and the Ugandan Muslim Medical Bureau (UMMB) have developed their respective institutional structures to accredit and coordinate their members and have training schools within their networks. UCMB has 37% of the FB-PNFP while UPMB has 31%, with the remainder shared between the other organizations. The Ugandan Orthodox Medical Bureau (UOMB) is the latest and smallest MB.

Increasingly, the bureaus work together to address common challenges such as medicine procurements, workforce shortages, and upgrading the capacity of their health training schools and to engage in the policy dialogue with MoH. They regularly convene and share essential information. Decentralized governance structures, PNFP Coordination Bodies (PNFPCB), have been established such as the Diocesan Health Coordinators (DHC) and the hospital Boards of

Governors (BOG) to support their health facilities. UCMB, for example has a curriculum for orienting new BOG to their roles in ensuring good governance and operational efficiency of the health facilities.

A good collaboration exists between the MoH and the MB. MB often participate in national level policy, strategic and technical deliberations at the central level.

Common challenges for the four MB with an effect on the execution of their mandates are:

- The direct approach and negotiation of HDP with facilities for intended support without involving them. Lately, a positive trend is seen with health facilities informing their respective MB to seek for advice and active involvement when dealing with HDP.
- The high staff turn-over in PNFP facilities arising from de-harmonised salary policies e.g. the unilateral salary increment by the government. This strains the already meagre human resources available and causes loss of experienced and trained health personnel shifting from PNFP to government facilities. It affects human resource planning and development forecasts of the MB.
- Timely communications from the MoH for key meetings and full involvement of the MB in key technical discussions in some of the TWG, especially the Sector Budget TWG, leading to missed opportunities to contribute in the development of national financial policies, guidelines and strategies (for example the Health Financing Strategy).

Institutional Capacity Assessment of the MB

A study mission[9] was conducted in July 2013 with the objective to assess the institutional structures and organization of the PNFP subsector and provide additional information to identify opportunities and, possibly, relevant interventions to strengthen the institutional capacities of the structures involved in the governance, coordination and financing of the PNFP subsector.

Details of each MB regarding its capacity to assume its different roles and responsibilities are described in the study report. In general the respective PNFP Umbrella Organisations are at varying levels with respect to institutional and organisational capacities. The UCMB and UPMB exhibit stronger institutional capacities, compared to the UMMB, UOMB and the Uganda Community Based Health Care Association for the non-Faith based PNFP. The UCMB and UPMB have stronger abilities to engage with the government and to lobby. They have stronger legal, policy and regulatory frameworks and stable governance and human resource structures down to regional level. They have advanced management information systems, stronger coordination, capacity building & supervisory mechanisms for member facilities and integrated reporting systems linked with the national HMIS (DHIS2). They possess stronger financial portfolios and fiduciary risk management. The UCMB and UPMB have a better functional accreditation systems and maintain tangible partnerships with multiple HDP in comparison with the other MB. They also master a stronger technical expertise in execution of health related policies, guidelines, strategies and interventions.

UMMB and the UOMB have limited capacity to directly coordinate and monitor affiliated facilities to ensure conformance to all MoH policies and regulatory guidelines with respect to maintaining quality standards in service provision. The affiliated health facilities of the UMMB (5 Hospitals, 24 HCIII & 19 HCII) are legally owned by Mosques/Muslim communities under the Islam Faith operating in a decentralised system that encompasses four regions (East/North-West/Central)

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[9]Preliminary Study Report, BTC, July 2013: A National Assessment of the PNFP Health Subsector.

each under the coordination of a Regional Coordinator (often staff of one of the affiliated facility in region) countrywide. UOMB affiliated health facilities (1 Hospital, 3 HCIII & 11 HCII) are legally owned by the church/Orthodox communities operating in a decentralised system that constitutes 10 Dinaries under the coordination of a Dinary Coordinator.

Facility-Based PNFP (FB-PNFP)

FB-PNFP providers form a large network of hospitals and health centres which offer comprehensive preventive and curative care. They currently operate nearly 30% of the health care facilities in Uganda with a considerable percentage of these units located in rural areas[10]. About 41% of the hospitals and 22% of the lower-level facilities belong to FB-PNFP. Many of these PNFP facilities provide health services as well as train health workers.

Non-facility-based PNFP (NFB-PNFP)

NFB-PNFP carry out advocacy, health education and technical assistance, community mobilization and community health services. These organisations include Civil Society Organizations (CSO) which may not directly operate through health facilities, but which support or undertake health development activities in partnership with central and Local Government, with facility-based and other PNFP health providers, with private practitioners, and with communities. Diversity within this category of providers exists by a large combination of characteristics including size, means of and access to finance, control, and motivation.

1.2.10.3 Funding of PNFP subsector

Unlike government facilities, the private health facilities charge user fees which limit access to health services for the poor population. PNFP are also subsidized by Government and HDP. Since 1997 PNFP facilities receive funding from government as a contribution to their recurrent costs through Primary Health Care (PHC) Conditional grants, secondment of health staff and, essential medicines and laboratory supplies through credit lines managed by the Joint Medical Stores. Funds were originally dispatched to district accounts, who resultantly disbursed them to the respective PNFP facilities. This system faced numerous challenges characterized by protracted delays in facilities accessing funds (up to six months), misallocation of funds at district level and financial leakages amounting to over 25% of the total funds released by government. Against this background, starting 1st July 2013, the government has instituted a new financial allocation mechanism of direct transfer of allocated funds from the Ministry of Finance to the recipient health facility bank accounts through an Integrated Financial Management System (IFMS). All districts and PNFP facilities through their representative Medical Bureaus have been directed to submit independent account details. The government grant to PNFP is 7% of the total health sector budget.

There is general awareness, appreciation and optimism amongst all key players at central (MoH, MB and PPP Unit) and district (DHO and PNFP facilities) with respect to the new mechanism as it should be more transparent, accountable and efficient. However, critical issues remain which may have an impact on the public-private partnerships at policy level. Challenges regarding this new mechanism, are[11]:

- The start of the implementation of the new mechanism as it is expected to be initiated during the 1st quarter of the 2013 – 2014 financial year

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[10]Health Facilities Inventory MoH, 2010

[11] Summary extracted from the Preliminary study: “Institutional capacity building and policy analysis” A National Assessment of the PNFP Health Subsector (may 2013) - Harold Bisase

- The roles and responsibilities of the key stakeholders (both public and private) in the operationalization of the mechanism
- The concerns from the district officials that they would lose the control on the PNFP facilities. Formerly, the PHC grants were used to ensure that the facilities would report before receiving the grants
- The administrative burden for the facilities
- The capacity of the government (MoH) to enforce countrywide regulation and conformance to acceptable quality standards.

The MB who represent the PNFP facilities participate in the SWAp Health Policy Advisory Committee (HPAC), in the annual stakeholder review missions and in the budget allocation discussions for the health sector. Such involvement has also opened the way for the interaction of the MB at policy levels even beyond the MoH, in particular with the Ministry of Finance, Planning and Economic Development (MoFPED).

1.2.11 Public Private Partnership in Health

1.2.11.1 PPP unit in MoH

The PPP unit is the central coordination structure to execute the countrywide implementation of PPPH interventions. It is located in the Directorate of Planning and Development of the MoH. However currently it lacks adequate resources (Human Resource, financial, Infrastructure) and adequate governance capacity (at both central & district levels) to execute effective coordination of all players in the health sector and implementation of partnership interventions. Decentralized partnership coordination structures to be put in place are the PPP Sections and the Private Sector Coordination Committees. A detailed organogram of the Directorate of Planning and Development with the PPP unit can be found in Annex 7.5.

1.2.11.2 The Public Private Partnerships regarding Public Oriented Health Service Provision

Partnership Situation

The MoH and the PNFP health service stakeholders recognize the partnership that exists between them. A partnership is a term that stems initially from economics and private enterprise and can be defined as a contractual agreement between two or more autonomous and equal parties that share a common objective and believe that by working together they will create synergies to the benefit of all parties and for the common objective.

This is clearly the case for MoH and PNFP facilities, with the shared objective of providing accessible quality health care services for the public, taking into account the financial constraints of the latter.

A partnership implies that both parties have obligations and rights of which the first one is the right to exert control over the other with respect of fulfilling its obligations. In case of dispute consultation procedures must exist.

Synergies do not occur spontaneously but need to be actively looked for. This implies intensive consultation and definition of joint ventures with complementary action. The project should look into creating and/or reinforcing the exchange and consultation structures and facilitate opportunities for effective collaboration.

The stronger each partner, the more the partnership relation will come to lasting and important results. It is therefore important that the project recognizes the strengths and weaknesses of

both and that both receive active support.

Management of Disparities to Address Inequitable Access to Health Services

Although PNFP actors and the public sector share objectives, they are different organizations and although they are in principle equal in the partnership, important differences exist between them. Well recognized are the disparities in personnel and wage structures which cause a shift of personnel from PNFP facilities towards government structures. The MoH has the tendency to handle higher standards for PNFP facilities than for their own facilities regarding accreditation conditions. At district level PNFP facilities tend not to receive the same attention from the DHMT as do the government facilities, e.g. in support supervision.

Less recognized are the disadvantages public services face in certain areas. They have less chances and fewer opportunities to attract **donor support** and little independent **decision-making** powers. They have less flexibility in spending money, because they have to respect public tender procedures for instance. These problems are difficult to overcome and cause an additional financial and operational burden for public services.

Also the **fee-paying system** creates much confusion at the moment. Disparities exist between different PNFP, but most importantly, the free health care policy of the public sector seems to be contradictory with the fee-paying system of the PNFP. Fees cause an important barrier for a poor population. On the other hand, it represents a crucial source of income for the facilities that do charge fees to deliver quality of care. For a rational uniform health system, more harmonization is highly needed.

A project that supports unilaterally PNFP facilities has the risk to create additional inequities by providing substantially more subsidies for one facility against the other (especially when situated in the same district). Especially at the level of HC II and III the risk might be real. The presence of the ICB project might mitigate this risk (see further). A practical field experience in this sense are the different reproductive health projects providing vouchers to pregnant women for their maternity care, including C-section when needed. The voucher system shifted the majority of women towards the PNFP facility in Fort-Portal but once the project stopped, the public hospital was again overwhelmingly solicited. The free health care policy of the MoH has also caused a major shift from PNFP to public government facility use. Unwillingly, policies do cause new inequities with consequences for the difficult balance, for the creation of a rational and unique public health system and a fructuous partnership between government facilities and the PNFP.

The field visits by the formulation team permitted also to observe spontaneous solidarity between the government and the PNFP facilities, for instance when a (sub-)district allocates staff to PNFP facilities when the needs are more important at that level.

The project should try to address these inequities and try to lower the gaps between the two partners by introducing health coverage plans and RBF. MoH has an important responsibility in this matter and should explore mechanisms to combat inequities.

Overcoming barriers to functional integration: Planning health coverage by public and PNFP health centers and hospitals

PNFP facilities and public facilities should constitute one functionally integrated health system. The facilities should provide access to the UMHCP for the population and this through a single network of HC II and III. In the past, HC implantation (construction and location) did not always happen according to coverage criteria which led to irrational distribution of HC facilities in some districts: In the same district, overlap between facilities in offering health services and in the population they cover, can be seen in some areas, making some of them less viable and inefficient or even redundant investments, while other areas are being underserved.

Rational health coverage plans can avoid these situations of disparity in health facility implantation. Such plans study the actual distribution of facilities and the coverage of the population for both the UMHCP and complementary package. Although it is difficult to close down health facilities when overlap is virtually 100%, identifying opportunities for upgrading HC II to III should take the overlap situation into consideration as the additional investment will lead to more expensive units with even more overlap. Equally important should be the joint identification by the government and PNFP of territorial gaps which should feed the decision where further expansion of the HC network should occur. In this way, health coverage plans will help the DHMT to orient PNFP stakeholders in their decision to invest in new facilities.

The same goes for hospital care coverage and the decision of upgrading HC IV to hospital level. Such decision should be based on a rational coverage plan of hospitals for the population and the area. An unnecessary additional burden for the system is created if HC IV are upgraded in the vicinity of other hospitals, irrespective if they are PNFP or government institutions. More detailed technical information on health coverage plans can be found in Annex 7.8.

Again much has been realized by the ICB project. Sharing the information might be sufficient in those districts that have realized already a comprehensive health coverage plan.

A short comparative SWOT-analysis for PNFP and Government facilities is annexed in 7.6.

1.3 Development Cooperation

1.3.1 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 activities are mainly in the Western part of the country.

Since the Joint commission of 2008 the cornerstone of the Belgian program in Uganda has been a well-considered “portfolio approach”, aiming at one strategic objective while working through a mix of modalities (projects and budget support). There are two interventions currently ongoing in the health sector: the Institutional Capacity Building (ICB) project en the Budget Support (BS), which are designed to operate in a complementary and synergetic way.

- **ICB**: the Institutional Capacity Building in planning, leadership and management in the Ugandan health sector (HPLM) project is being executed from June 2010 till June 2014 with a budget of 7,850,000 EUR to improve the effective delivery of an 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.
- **BS**: In the IDCP 2008-2012, 20 million EUR has been allocated as budget support to the health sector of which 15 million EUR has been disbursed. In the new IDCP 2012-2016 another 12 million EUR has been allocated to health sector budget support.

1.3.2 Donor Harmonization and Coordination between the Health Development Partners

The main actors within the Ugandan health system, recognized by the national policies for health, are the public sector (Government and MoH), the private sector (PNFP, PHP and TCMP) and the **Health Development Partners** (HDP).

The mandate of HDP is to collaborate with the government and all key stakeholders to contribute towards the 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.

Uganda has implemented a Sector Wide Approach (SWAp) in health for the previous ten years. A Memorandum of Understanding (MoU) exists between MoH and the HDP. The Uganda Health SWAp is a sustained partnership whose goal is to achieve improvement in people's health through a collaborative programme of work, with established structures and processes for negotiating policy, strategic and management issues, and reviewing sectoral 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 MDG.

Several HDP like DFID, the Swedish Embassy, USAID and the World Bank (WB) are already intervening in the same subsector. It is important that these initiatives, which at this moment are rather diverse, will finally result in one national approach. The Belgian project being anchored at the MoH level is probably well positioned to stimulate the harmonization between donors and to coordinate the dialogue in this matter with the MoH.

There seems a common interest among donors to create output-based financing mechanisms for the public health sector, including PNFP.

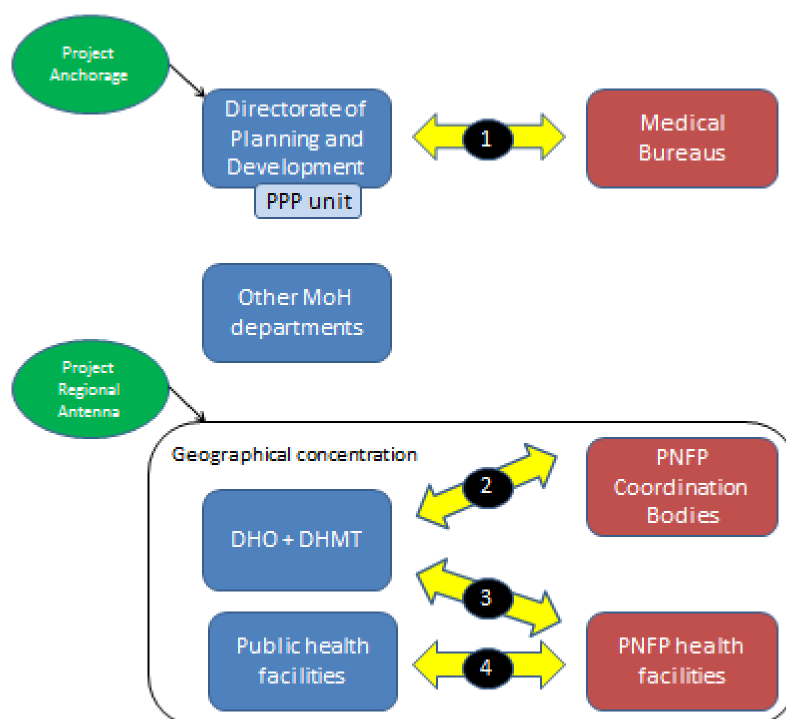
2 STRATEGIC ORIENTATIONS

2.1 General Project Architecture: a Connection between Support to PPPH National Policy and Strengthening of PNFP as part of the Health Care System

This project will work at various levels of the health system where the partnership between the government and the PNFP needs to be strengthened: (1) between MoH and Medical Bureaus, (2) between PNFPCB and DHO, (3) between DHO and PNFP health facilities, and (4) between the public and the PNFP health facilities.

It will be anchored at the Directorate of Planning and Development in the MoH and will cover the same regions as the ICB project, namely the regions of West Nile and Ruwenzori (geographical concentration) with a possibility to expand to neighbouring districts. The figure here below visualizes the architectural concept of the project.

Figure 1: Conceptual visualization of the project's architecture



2.1.1 Anchorage in the Ministry of Health

The project will be anchored in the Directorate of Planning and Development, which holds the PPP unit. This is strategically chosen so as 1) to give the opportunity to the project to support the MoH in policy and guideline revision and design, and 2) to position the project so that it will be easily linked to other departments in MoH such as HRH and clinical services.

2.1.2 Piloting New Strategies and Concentrating Funds through Geographical Concentration

The project will have to limit its geographical scope for its financial inputs to remain substantial

and to permit significantly increased health outputs. Therefore the actual phase of the project will limit itself to the same regions as the ICB project, namely the Ruwenzori and West Nile region. The ICB project created many of the important conditions for this project already, which creates the potential for a relatively quick start-up of the support to PNFP: the District Health Management Teams (DHMT) are reinforced in their supervision activities and in the organization of the referral system. ICB is also contributing to create a form of regional support to the districts by organizing exchange meetings between districts at regional level to share good practices. See also the table in section 2.6.

Geographical concentration is also inspired by the operational problems a project is facing when acting nation-wide. It is not feasible for the project to introduce new initiatives like joint planning and supervision, staff allocation across the boundaries of government and PNFP, and particularly the Results-Based Financing mechanisms in every regions or district. The latter will absorb a significant initial investment in time and capacity to put the system in place and to create sufficient capacity and understanding of the system across all stakeholders before implementation will be possible. Introducing in a small area to learn from this experience is more strategic to start with. The long-term vision remains of course to create a sustainable financing and technical support system for the whole country. Its realization will depend on the definition of an operational model which is shared between the MoH, PNFP stakeholders and the donor community and the creation of a pooled financing mechanism (see Results-Based Financing). Once this model and the financial leverage are in place, a relatively fast roll-out mechanism can be set up.

However, extension of the preparatory activities (training, communication, RBF support) to a few neighbouring districts might be considered. With buy-in of other HDP during the project duration, a quicker scaling up of the local experience into the neighbouring districts might be possible. This will be examined during the implementation phase of the project. In this regard, taking other development partners on board, might represent another opportunity to extend the initiative geographically.

2.2 Strengthening of PPP through the Strengthening of Key Actors

2.2.1 Strengthening MoH

2.2.1.1 Support to PNFP Policy and Guidelines

MoH has formulated PPPH policy and other policy documents regarding more precise subjects. The translation of this policy in practical guidelines lags behind though, as well as the lessons learned from field application of the guidelines (reality checks). The project is positioned at the ministry’s level, but intervenes at the district level creates the potential and possibility to support the MoH in producing the guidelines and to monitor and evaluate their application under field conditions.

2.2.1.2 Reinforce the PPP unit at the MoH

The MoH has created a PPP unit under the Directorate of Planning and Development in the ministry. The unit still remains understaffed and has insufficient capacity. The PPP unit should become the most important entry point for the PNFP stakeholders to establish a dialogue with the MoH. The PPP unit represents MoH and therefore defends the public sector agenda in the dialogue with the MB and other PNFP stakeholders. It is therefore the most important structure to realize the partnership goals at the national level.

It is therefore important that the project will support this unit by reinforcing its capacity of

initiating and maintaining a strong partnership dialogue, in developing its capacity of providing technical consultation for joint initiatives and in realizing concrete partnership synergies at operational level.

It is the PPP unit that will be supported by the project to translate policies into practical guidelines and to communicate and negotiate with the PNFP counterpart. It should also monitor that proper communication and eventually training needs are addressed at the operational level for all stakeholders.

The PPP unit is expected to:

- Serve as the privileged entry point of PNFP and PHP for partner dialogue with MoH
- Assure that the dialogue involves other departments in the MoH when necessary and provide a feedback to head of department planning virtually on a daily basis
- Monitor the implementation of the PPPH policy and develop and monitor the practical guidelines that are derived from this policy. Assure that general health policy changes are absorbed into the private sector practices
- Identify new opportunities for diversifying or intensifying public private partnerships
- Monitor, evaluate and provide feedback to private partners on the performance of private stakeholders and the partnership quality.

From this, it can be derived that this unit needs:

- A senior public health specialist with medical background, heading the unit (health planner)
- One or two assistants for monitoring and evaluation (PNFP, PHP)
- Two administrative staff (one secretary and administrative officer)

The MoH foresees that after two to three years, the opportunity of having a specific PPP unit will be evaluated. On this occasion a fully institutionalized structure can be decided upon.

2.2.2 Strengthen Medical Bureaus, the Diocese Health Coordinators and other PNFP Coordination Bodies

The Medical Bureaus (MB) and PNFP Coordination Bodies (PNFPCB) are important stakeholders in the partnership between MoH and PNFP organizations. They represent the PNFP health facilities in the policy debate at the ministry's, the regional and the district level.

MB and PNFPCB bring support to the PNFP health facilities through support supervision and by actively monitoring the HMIS indicators. These contributions to the quality of care can be optimized with a more intense dialogue and coordination with for example the DHMT and PNFPCB at the operational level.

For operational reasons, PNFPCB are geographically better positioned than MB to realize hospital supervision, but they do not have enough manpower nor individual capacity for such activity. Capacity building at that level and facilitating visits to the districts might go a long way to improve the necessary coordination.

The UMMB and the UOMB are much smaller or even hardly existing, but at the same time represent far less health facilities than the UCMB and UPMB. However the project could provide support to enable them to fulfill at least their basic functions.

UCMB being the most important MB, represents the other MB on a regular basis in important meetings and processes at central level. Delegation of tasks also at operational level might be

explored as a possibility to unite forces. Therefore also at this level Inter-MB dialogue should be supported. The PNFP coordination committees might represent a first opportunity to realize better collaboration on the ground.

MB will be involved in every phase of the conception of the different approaches and their follow-up in the field. Examples are RBF, coverage plans, business plans and RBF control and evaluation missions.

2.2.3 Strengthen District Health Offices and District Health Management Teams

2.2.3.1 Integrated planning and integrated, non-discriminatory support supervision

District Health Management Teams (DHMT) are responsible for the health and the health care of their population. They exert this responsibility by managing and supporting health services in their respective districts. These services include FB- and NFB PNFP and in principle also the PHP services. For the PHP facilities, the responsibility of the DHMT is rather restricted to control of quality and ethical practices. But the DHMT technical support and to a certain extent the financial support should not discriminate between public and PNFP facilities in order to create and maintain one uniform health service system in the district.

Joint planning through the recently institutionalized PNFP Coordination Committee (CC) should become routine and be strengthened. A functional PNFP Coordination Committee and integrated annual action and investment plans constitute preconditions for financial support to the DHMT and the PNFP facilities in the district.

Integrated support supervision of all health facilities without discrimination between public and PNFP facilities is equally important for the district health system to function and for the partnership between MoH and PNFP to deliver concrete results at the operational level. Inclusion of MB and or PNFPCB into the visits, the reporting and the analysis of the results of these visits should become routine as well.

Many efforts (strengthening of the DHMT, supervision, referral system) have been put in place by the ICB project in most of the districts in the two regions and the PNFP project will be able to make use of these results (see also 2.6).

Essential planning and supervision activities are already largely shared in districts that cover several sub-districts, while in other districts, district and sub-district are confounded. Therefore the project does not want to distinguish between districts and sub-districts, and will consider them as one integrated management team. This enables especially larger districts to rationalize and render efficient the supervision activities in their territories. It is known that a multitude of authority levels and stakeholders creates too much overlap and irrational needs, that it leads to unrealistic norms in terms of workload and financial means (transport costs – perdiems) for supervisory visits when sub-districts and districts are handling in isolation and that it creates a duplication of efforts. One integrated, realistic (workload) supervision plan with clear division of labour should be put in place in each district.

2.2.3.2 Joint Services and Activities

The joint planning and the joint comprehensive supervision of all health facilities in the district will un-doubtfully enable other joint activities such as medicines and medical supplies distribution and exchange, control of epidemics and a unique integrated emergency evacuation system. These are practical examples of synergies that can be realized at the decentralized operational level. The impact of a rational emergency evacuation system for all public facilities

on access to appropriate health care levels has been sufficiently proven by the ICB project. Field observation shows an important appropriation of the system by district authorities.

This is also valid for the organization of hospital care. In towns where PNFP and government facilities co-exist, both partners should go into a dialogue in order to diminish overlap in services and to come to a better division of labour. Ambulance services, night duties for laboratories, epidemic controls are some examples whereby mutual consultation might result in more efficient health care organization.

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

2.3.1 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.

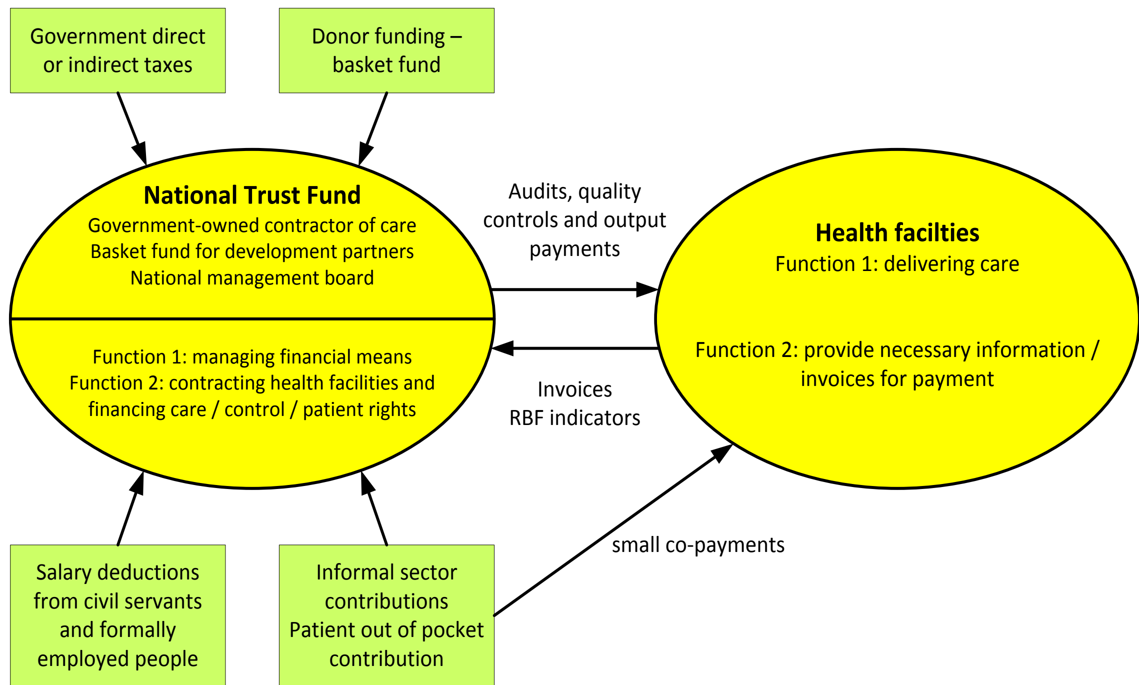
- Using the funds for savings. This is a rather particular perverse effect that HC do not inject the received funds back into the system but save them for more precarious periods. Rules should be put in place that oppose this tendency e.g. savings should not represent more than a certain percentage of 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 2 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.

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.

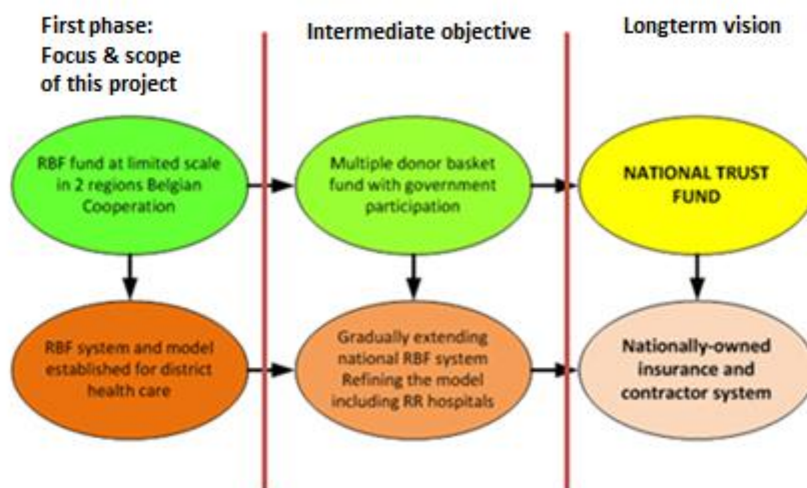
Figure 2: Model of financing mechanism that insures affordable and quality care for a large population



The above model (

Figure 2) 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 3. 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 3: Phasing the introduction of a national health insurance and financing system



2.3.2 Initial Conditions – Creating an Enabling Environment

2.3.2.1 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.

2.3.2.2 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 7.8.

2.3.3 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 scholarship program.

Only fully accredited facilities will be taken into account.

2.3.4 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.

2.4 Support to PNFP Training Centers

The majority of nursing and midwifery schools are being run by PNFP facilities in Uganda. Problems of how to run and fund training institutes and how to assure quality of training demands a different expertise and intervention logic than supporting health care facilities. In this initial phase, no specific funding or activities are foreseen by the project because it would diversify the technical scope and expertise, dilute further funds and add to operational follow-up problems.

Moreover, synergies with the Belgian scholarship program should be actively looked into, and PNFP training institutions could be potential beneficiaries of these funds.

2.5 Support to NFB-PNFP Initiatives

(Sub-)Districts will receive a yearly budget targeting small activities of NFB-PNFP organizations, as long as these activities are integrated in the district plans, a transparent use of the budgets can be guaranteed and that there is no overlap or substitution with NGO or other donor funds.

These funds will be earmarked but integrated in the Results-Based Financing mechanisms at the district level. The districts will be overall responsible for the planning, execution and justification of the funds towards the project.

Specifically activities from the Ugandan National Health Consumers Organization (UNHCO) should be considered as they stimulate giving voice to the local communities and give feedback to the local and more distant health authorities on patient satisfaction and rights. This organization at national level might be candidate to become an important partner in governing a trust-fund and a future national Results-Based Financing mechanism, representing a variety of Community Based Organizations (CBO) and Civil Society Organizations (CSO) and rights.

2.6 Synergies with other health interventions

2.6.1 Synergies with the ICB project

This project proposes to intervene in the same regions as the ICB project. Many conditions to have a proper kick-off are already, at least partially, addressed by the ICB project. The ambulance service in most of the districts, a competent and functional DHMT and sub- DHMT, equipment for upgrading the HC IV are but some examples where the ICB project has eased already the field.

For the coming years, the two projects will have to work together and share the specific expertise of each of the ITA in either project when needed (see chapter 5).

Regular joint planning, monitoring and coordination meetings between the two should identify common activities and reflections on policy and policy implementation. The organization of emergency evacuation service, the (sub-)district coverage plans and outreach activities by HC, the RBF conception and preparation, are but some of the subjects they might handle jointly.

Only one steering committee should deal with both projects at the same time and they should regard them as two sides of the same coin. The international financial and administrative responsible will be shared between the two interventions.

At the MoH the two projects will both strengthen MoH management and leadership capacities.

The following table gives an overview of opportunities for synergies between the different interventions. The list in the table is not complete and the different interventions will have to look into opportunities as they will present during the execution. The results and activities of the individual projects are not presented here. The colours of the table indicate which project contributes to the realization of the others.

Table 3: Synergies between the health projects

ICB project	PNFP project	Scholarship programme
Provide trainings for health personnel in general and health managers, complementary to the capacity building in management and leadership Organise trainings	Performing DHMT Control of RBF indicators Training in supervision for DHMT Conception of RBF and its rules and regulation Conception and diffusion of information on universal coverage Creation of ambulance services, purchase of vehicles, monitoring system Coordination meetings at regional level Capacity building at the MoH level	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)

Intervening at the operational level, complementary to ICB approach Reinforcing DHMT Control on supervisory activities RBF rules for DHMT RBF conception for government facilities Conception of the regional authorities 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	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)

2.6.2 Synergies with the Health Budget Support

Synergies with the budget support (BS) initiative are equally important. Field experiences from ICB project are already taken up by Belgian BS, but also by other health development partners (HDP) in their policy dialogue with the MoH. Definitely, the PNFP project will have synergies with the BS initiative as well. Subjects are the partnership relation which is already now one of the technical working groups that meet regularly, coverage plans, business plans, RBF and many more subjects that will be subject of national debate and where the donor community as a whole will need to get involved.

The MoH and HDP are actually in the first phase of the conception of a new health service financing strategy ("Health financing strategy 2013-2023") in which the BS sector expert is actively involved[12]. The PNFP project will offer an excellent opportunity to contribute to this debate through its conception of RBF and the practical experience of it under field conditions.

2.6.3 Synergies with the Belgian Scholarship Program

The scholarship program concentrates primarily on the sectors in which the Belgian cooperation is active. Health is one of them.

Personnel at HC and sub-district level are in need of additional training. Regular consultation between the projects should allow the scholarship program to support trainings that will directly influence the results of the PNFP support project. Look as well into table 3 of section 2.6.

2.7 Mainstreaming of the Crosscutting Issues

The project has identified the following crosscutting issues: environment, gender, sexual and reproductive health (including ASRH) and HIV/AIDS. These issues will be mainstreamed throughout the project implementation process. The mainstreaming will be aligned with the national strategies, policies and guidelines as well as with the priorities set forward by the districts. In order to ensure that real progress will be made in the mainstreaming of crosscutting issues, the project has also identified a limited number of indicators that should allow for proper monitoring and evaluation as well as for proper capitalization of the approach taken.

[12] Notes from the HDP core team meeting on the Health Financing Strategy – 14th January 2014

3 INTERVENTION FRAMEWORK

3.1 General Objective

Contribute to strengthen service delivery capacity at district level to effectively implement PHC activities and deliver the UNMHCP to the target population.

3.2 Specific Objective

PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.

3.3 Expected Results

With respect to the above analysis of the situation and strategies to be developed (chapters 1 and 2), the following results for this project are proposed:

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

3.4 Activities

3.4.1 Activities for Result 1: MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies

As explained before, the project will be anchored at the Directorate of Planning and Development in the MoH. An International Technical Assistant (ITA) will be based at that level and will co-manage the project together with the head of the Directorate (see responsibilities in Annex 7.5). He will liaise functionally with the PPP unit and will ensure the smooth connection between this unit and other units and departments within the MoH. As a consequence, this will strengthen PPP unit in its function of coordination and intermediary between key stakeholders of MoH and outside MoH in PPPH policy design and implementation. A National Technical Assistant (NTA), expert in Policy analysis and M&E will assist the PPP unit in the Directorate of

Planning and Development. As one of the key functions of the PPP unit is to assemble reliable and credible data on private providers, he will have specific skills in monitoring and data management (see his ToR in Annex 7.4).

A.1.1 Support the planning, management and administration of the PPP unit in the Directorate of Planning and Development

The project will support the PPP unit in its planning, management and administration tasks in order to facilitate the development of the partnership of the MoH with the PNFP subsector.

Possible sub activities are:

- The elaboration and/or revision of the Terms of References (ToR) of the members of the PPP unit. The ToR of the PPP unit coordinator are given in Annex 7.5.2.
- Ensure the functionality of the PPP unit
- Support organisational development activities

Resources needed include:

- Procurement of office equipment and tools for information management for the PPP unit
- Annual salary support for the FB PNFP Assistant in the PPP unit

A.1.2 Review PPPH related policies and guidelines

Various policies/guidelines related to PPPH will be developed, reviewed and produced. Topics to be considered, are:

- Posting and secondment of HRH to PNFP health facilities (involving the MoH departments of Clinical services and HRH)
- Establishing an integrated referral system: Sharing of ambulance services and organizing the financial aspects between public and PNFP health facilities (involving the MoH departments of Clinical services and Community health, and Local Government)
- Public funded scholarships for PNFP (involving the MoH departments of Clinical services and HRH)
- Memoranda of Understanding (MoU) and contracts between Central & Local Governments and Local Governments & PNFP
- Joint Health Coverage plans
- Establishing a RBF system
- Universal Health Insurance

Possible sub-activities include:

- The redaction of policy briefs and guidelines targeting key stakeholders
- Support the function, organisation, management, reporting and coordination activities of Technical Working Groups and Sub Working Group such as the TWG on PPPH
- Organise meetings/workshops/seminars to discuss, elaborate and revise PPPH related policies and guidelines to improve knowledge and implementation support, and this for:

- Relevant departments within of the MoH such as Clinical services, Quality assurance, HRH, Resource Centre, Nursing
- Medical and Dental Profession Councils
- TWG Groups and Sub Working Groups such as the TWG of Monitoring and Evaluation
- Relevant line ministries such as the Ministry of Local Government, the Ministry of Finance Planning and Economic Development, the Ministry of Education and Sport, the Ministry of Public Service and the Parliamentary Committee on Social services
- MB, PNFPCB
- Local Government

A.1.3 Disseminate policies and guidelines and do advocacy through communication activities

As for many policies, dissemination remains a challenge. Specific activities will be organized to enhance communication and advocacy on new and revised policies and guidelines.

Possible sub-activities include:

- Design, reproduce and distribute relevant Information, Communication and Education (IEC) materials on the PPPH Policy and PNFP policy guidelines for advocacy targeting the political leaders, Local Governments, PNFP subsector and communities
- Conduct meetings/workshops/seminars to disseminate the PPPH Policy and Policy operational guidelines
- Disseminate national strategies and policies in the areas of gender and health, environment and health, SRH and HIV and adapt them to the local needs and circumstances.

The following resources will be necessary:

- Printing and communication material
- The financing of the meetings / workshops / seminars as mentioned in A.1.2.

A.1.4 Perform field visits

Field visits to the sub-national level (dioceses/regional PNFP facilities and districts) to provide technical support will be facilitated on a quarterly base.

A.1.5 Organize country study tours

Inter-country study tours will be conducted. These will involve MoH, DHO and PNFP representatives to learn from best practice partnership models in the sub-region (during the first and second year of the project a maximum of one study tour a year will be planned for a maximum of six people per tour).

A.1.6 Perform technical and scientific follow-up and evaluation to feed policy design

In order to feed policies with the evidence of the strategies tested in the two regions (i.e. coverage plans, RBF in PNFP health facilities, etc.) a technical and scientific follow-up will be organised to support this process. This scientific follow-up is indeed highly needed as applying a RBF system on such a scale is a new initiative for Uganda. The follow-up will allow to refine the model and the vision on RBF and eventually as well to address certain perversities.

The ICB project profits already from such a follow-up support, therefore an articulation and integration will be search for.

Possible sub-activities include:

- A **technical committee**, called "**Project Technical orientation and follow-up committee** (PTFC)" will be established and will meet quarterly. It will include the principal stakeholders on the partnership between governments and PNFP (Project management team, MB, MoH representatives of technical departments, DHO representatives, focal points of the Regional Referral Hospitals, HDP etc.) and will be put in place at the beginning of the project.

  Role and functions:

  - The Committee will discuss and orient (take decisions) strategies and approaches on topics such as coverage plans, RBF system for PNFP facilities … It will also serve to refine the models and visions through lessons learned from the project pilot experiences in the 2 regions.
  - The PTFC will ensure a participatory approach of the relevant stakeholders, make the link with National Strategies and ensure through exchanges that the systems are nationally-owned.
  - Through the participation of other donors and BTC other health bilateral cooperation projects/Budget support, harmonization and complementarity should also be guaranteed.
  - The committee ensures integration of the inputs of the scientific follow-up for its work (the terms of reference of the scientific follow-up are prepared by the project management team, the scientific institution reports back to the project team who systematically shares the results with the PTFC).
  - The Project team acts as the Secretariat for the PFTC and provides the necessary information to its members in advance of each meeting.
- A **scientific follow-up** will be ensured by an international and national scientific institute or university (twinning). It will report to the technical committee.
- Organisation of national workshops to disseminate lessons learned. Development partners should take part in these workshops and should be coordinated through these exchanges as to keep the system nationally-owned without too much diversity in the country.
- The establishment of a feed-back mechanism between PNFP and the technical working groups and coordinating mechanisms in the field of gender, SRH and HIV/AIDS.

Resources needed include:

- Financial means to organize the meetings of the committees (quarterly meetings) and the yearly one day capitalization workshop
- International and national consultants: 20 man-days of mission and 20 man-days for the follow-up will perform twice a year a missions of 10 days each.

3.4.2 Activities for Result 2: Medical Bureaus and the PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions

The strengthening of the partnership between PNFP and MoH or DHO will need a strengthening of two groups of PNFP actors, namely the Medical Bureaus (MB) at central level and the Diocesan Health Coordinators (DHC) or PNFP coordinators (PNFPCB) at peripheral level.

A.2.1 Support the installation and equipment of MB

Medical bureaus have unequal resources and some of them may need inputs for the installation of their office to ensure their functionality. For example, the Uganda Orthodox Medical Bureau is presently based in one of the Orthodox Hospitals. They wish to setup an office detached from the hospital. The project can support the MB in the procurement of basic office equipment and tools, based on the needs.

A.2.2 Support exchange, coordination and cross-fertilizing activities between MB and with MoH

The four MB are each at a different level of development and each of them has its own strengths and weaknesses. They sometimes lack the necessary information or skills to understand and analyse new policies or guidelines. Mechanisms of exchanges and cross-fertilizing activities will be enhanced.

Possible sub-activities include:

- The organization of regular meetings (quarterly) between the MB
- Sharing of documents
- Organizing training sessions (six monthly) in collaboration with the scholarship program (financed through the scholarship program)
- Produce leaflets and other material to inform their members on new policies

Resources needed include:

- Financing of meetings and seminars
- Printing and design of communication material

A.2.3 Support of MB to PNFPCB through supervision, workshops and meetings

The project will strengthen the technical support the MB are offering to the PNFPCB. One aspect of particular attention will be the search for standardisation of the PNFPCB functions to decrease the actual (relative) disparity in roles, function, qualification and performance appraisal of PNFPCB and representatives of MB at the operational level. The MB should elaborate and propose a standardised function which will make their partnership with DHO more functional.

Possible sub-activities include :

- The organization of regular meetings (quarterly) between MB and PNFPCB, and between the four MB
- The facilitation of visit to the districts during PPPH coordination meetings (maximum three days quarterly)
- The organisation of one yearly Workshop.

3.4.3 Activities for Result 3: District and Subdistrict Health Management Teams are sufficiently functional to support all health facilities in their territory without any discrimination for PNFP facilities and organizations

Activities within this result will have to be organized in synergy with the ICB project as this result is already being covered in part by that project.

A.3.1 Perform supervision activities and joint meetings between DHO and PNFPCB

PPPH coordination committees will be supported according to the PPPH implementation policy guidelines. These committees will meet quarterly in each (sub-)district of the Western Nile and Ruwenzori regions to improve the function of supervision activities.

Additionally, shared supervision activities between district and PNFPCB of targeted PNFP facilities will be organized on quarterly base. This will be articulated with the RBF supervision activities (see below).

The supervision activities will pay specific attention to the performance of the PNFP with respect to medical waste disposal, SRH and HIV.

The resources provided by the project will facilitate the meetings and the supervision activities (financial and logistic means).

A.3.2 Organize exchange activities between districts at regional level

Joint regional meetings are already organized through the ICB project. These activities will incorporate exchanges on experiences over PPP.

If not already financed by ICB, joint evaluations and exchange visits will be organised (6 monthly or yearly) to learn from each other and to share best practices.

3.4.4 Activities for Result 4: MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities

This result will be achieved through three groups of activities. In a first stage a RBF model will be designed for PNFP facilities. It will then be implemented in selected facilities and finally evaluated and disseminated to strengthen/review national policies. The initial design process that will probably take the first year of the project, will be based on nation-wide participation of all stakeholders, including evidently the MB, the donor community that lived an experience in the country and field staff involved in it. MoH will have the lead in this process and might involve other ministries such as Ministry of Public Service.

A.4.1 Review existing and past RBF related experiences and policies in Uganda and conduct complementary studies

Various projects have recently used a RBF system or are still busy implementing one (i.e. DFID, Cordaid, …). Each of them has their own vision and strategic options related to RBF. They have generated specific lessons, but also tools and useful procedures.

At the same time, MoH is developing a conceptual document and guideline on a health financing strategy and national health insurance.

A comprehensive review of RBF projects and evaluation documents and of the existing policies will be done to avoid “re-inventing the wheel” or restarting an additional “pilot” study. This review will focus on the various aspects of the RBF strategy that could be useful for the future design and implementation of a national RBF system (constitution of a “Trust” / “basket” fund,

purchasing procedure such as contract, mode of payment including formula, monitoring of performance, auditing procedure, link with health facilities business, influence on fee paying system and population access, on health personnel performance…).

This will result in a document where areas of consensus and differences will be identified. Gaps in knowledge will also be highlighted. As a consequence, short descriptive studies may therefore be needed to feed the design of the RBF scheme. This may include hospital and health centre cost studies (i.e. comparing differential costs between PNFP and Government health units).

Possible sub-activities include:

- Organisation of meetings, TWG and seminars to review of RBF projects, evaluation documents and of existing policies
- Conduct of additional studies (health facility costing studies)
- Elaboration of a RBF consensus document

Resources for these activities include:

- The hiring of a short term international and/or national consultant
- Financial resources to organize the meetings/workshops/seminars

A.4.2 Design a RBF scheme to fund PNFP health facilities

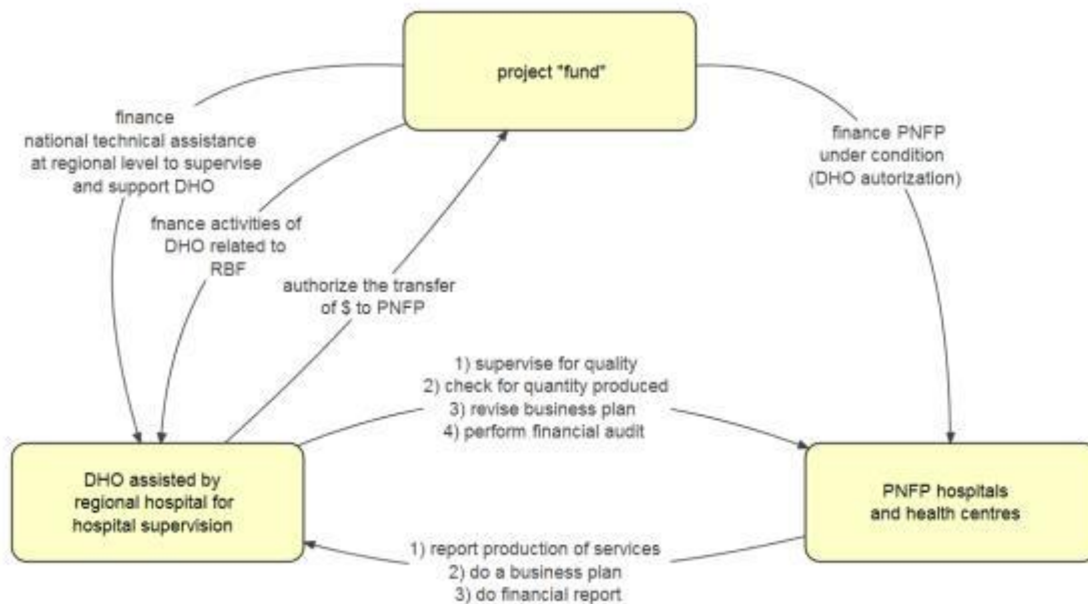
Basically, the development and design of the overall “architecture” of the RBF system is foreseen to evolve during the entire time span of the project (see also chapter 2 for the strategy, chapter 5 for the modalities and Annex 7.7 for more technical details). In the first year a first version of the initial design should be adopted for implementation.

The main elements of the RBF scheme are the following:

- The “funds” of the RBF will be managed by the project for the duration of the project (the objective in the long term is to come to the establishment of a public execution agency).
    - Subventions will be transferred to the PNFP, based on the RBF procedures and monitoring results
    - Activities of the DHO, pertaining to RBF, will be financed
- The project will locate National Technical Assistance (NTA) in both regions. They will assist and supervise the DHO in their activities for the functioning of the RBF
- The DHO will ensure the monitoring and supervision of the PNFP health units (quarterly checks of the production of the services, quarterly supervision of the quality, yearly evaluation of the business plan and financial report). They will give their agreement to transfer the money to the PNFP health units. They will be supported by NTA especially in the first stage of introduction and by the RRH direction if the need is confirmed during the design phase. DHO will get controlled in turn by MoH and MB representatives to insure transparency and to evaluate the initial RBF model.
- The PNFP health units will submit a quarterly report of health services production, an annual business plan and an annual financial report
- As a consequence of their subvention, they will reduce their fee-paying system.

The overall scheme is represented in the figure here below.

Figure 4: **RBF conceptual scheme**



Possible sub-activities include:

- Redaction and approval by all stakeholders of:
  - A strategic document with the vision, key concepts and options taken in the RBF scheme
  - A manual of tools and procedures for the RBF scheme implementation (including clinical and financial audit mechanisms)
- The outputs of these activities will be based on the results of activity A.4.1. Technical work (legal, accounting, health information system, …) and meetings to reach a consensus (with the key stakeholders) will be needed. It is expected that the MB participate actively in this process.
- Elaboration of tools and procedures based as much as possible upon the existing ones. However, adaptation and conception of new ones will probably be necessary.
- A short "pretesting" phase to assess the implementation of the manual of procedure will be done.
- For the sake of this project, the design should also include selection criteria (minimal quality standards, coverage plans, ..) for eligible PNFP facilities.

Resources needed include:

- Short term international consultancy with expertise in economics, health systems and legal affaires
- Printing tools and material for RBF scheme

A.4.3 Train management and health professionals in RBF

Two levels of training will be necessary in order to launch the RBF:

- Reorientation of skilled people working at MoH and regional level in accountancy, fiduciary, auditing, health information system,…(one week reorientation maximum)

- Training of people at district level (DHO and PNFPCB), at regional hospitals and PNFP level (maximum a two week training), followed by tutoring visits in the field to train them “by-doing”.

The NTA at regional level will participate actively in that training.

A.4.4 Implement the RBF procedures and tools (information system, fiduciary system, contracts, business plans, M&E etc.)

The RBF scheme may not start directly in all accredited PNFP health facilities for all health activities.

In an initial phase, the RBF scheme will be only implemented in a few PNFP health facilities of selected (sub-) districts in order to test the scheme and to make the necessary adjustments before increasing the coverage. Basic medical equipment will be provided to the selected PNFP facilities that enter the RBF system, based on their needs.

Progressively more PNFP health facilities in more (sub-) districts will be included, with more services. The necessary control activities demand sound M&E tools to be in place. HC staff will have to fill out several monitoring tools and do simple bookkeeping at their level. The availability of a NTA in each region will facilitate the implementation process and the follow-up.

A.4.5 Develop and conduct communication and advocacy activities

RBF and related concepts are ill-defined and they are often interpreted in various ways. A comprehensive communication strategy with intensive communication activities will be needed to inform and explain the intended schemes (including change in fee paying system, eventual changes in services provision, etc.) and this prior to the implementation. All stakeholders (politicians, community and health services users, health providers and managers) will have to be informed on the new system. During the entire time span of the project, various means of communication will be used to inform the various stakeholders on the evolution of the RBF scheme.

Possible sub-activities include:

- The organization of a national workshop and two regional workshops (one in West Nile and another in Ruwenzori region)
- The development of a communication strategy
- The production and dissemination of leaflets, local radio spots etc.

3.4.5 Activities for Result 5: PNFP HC II, III and IV of the regions of West Nile and Ruwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF

A.5.1 Elaborate a complete health coverage plan per district, including HC II, III and IV and adapt it on a yearly basis according to evolutions in the district

The importance of health coverage plans and the way to go about it are described in chapter 2 and in Annex 7.8. They should allow for:

- Programming implantation of new health facilities in the districts
- Knowing the population for which the health facility is responsible
- Plotting outreach activities to serve populations with little physical access to the facility

- Programming the upgrading of HC II towards HC III or HC IV to general hospital if responding to the system's requirements
- Programming the staffing needs and where possible and indicated re-affectation of existing staff within the district (from government to PNFP)
- Programming an optimal emergency evacuation system for the (sub-)district (make the link with the hospitals)
- Achieving the SRH and HIV related targets.

All districts willing to benefit from RBF should do this exercise in the first year of the project, because the RBF fund should avoid financing irrational developments in the health system.

Sub-activities to be foreseen are:

- Train DHMT and sub-district authorities, including key stakeholders from MoH Directorate of Planning and Development and the MB in the concepts and their operationalization
- Contract a national expert mastering Geographical Information Systems (GIS) technology
- Set up a data collection system in the HC (PNFP and Public) for utilization and population estimates
- Organise two workshops per sub-district for analysing the data and completing the coverage plans
- Printing the plans
- Organise a capitalisation workshop at MoH level (three days)

In each region, the first two plans to be developed should be accompanied by an international consultant and two public health personnel of the MoH of the Directorate of Planning and Development to familiarise with the process and the results. DHMT from other districts should participate as observers for the same reasons. MoH will thereafter continue to participate in the further development of coverage plans for the other districts.

This activity will take time and is estimated to happen during the first 24 months of the project to cover all the districts in the two regions. At least one third of the districts (5) should be covered before the end of the first year, the other 2/3 before the end of the second year of the project.

A.5.2 Support yearly planning, taking into account the conclusions and projections of the coverage plans, and assist in elaborating business plans in the concerned facilities once RBF funding has started

DHMT already plan on a yearly basis. The RBF system will have to assure that the HC that will be benefitting of the funding respond to basic quality criteria, of which having at least two qualified staff, is an absolute requirement. Largely under-utilised HC, because of existing overlap with other available centres, will be equally excluded.

The RBF system will also verify if appropriate 'business plans' are integrated in the district plans for reinvesting the received financial means.

For this activity but also for the other activities under this Result 5, a National Technical Assistant (NTA) for each region has to be recruited to help the DHO offices but also to verify independently performance and application difficulties (profile and job description of the NTA: See Annex 7.4).

Visits to the districts will be needed to help DHMT and PNFP personnel for doing the financial

analysis and to look into the fee-paying system. MB should be invited to join these occasions for analysis of business plans and adjustment of fee-paying system to the new financial situation of the concerned facilities.

Possible sub-activities are:

- Support visits to the (sub-)districts for yearly planning, analysis of budget plans and adjustment of the fee-paying system
- Invite MB and MoH personnel to join these visits
- Elaboration of business plans
- Training in developing business plans

A.5.3 Build the skills of PNFP HC staff for RBF to function in their facility

The training of district and sub-district health authorities to initiate RBF in the districts has been programmed under Result 4. The training should include the concepts, the monitoring tools, the payment system, business plans, monitoring and evaluation tools, support and control visits, etc.

Also Local Government authorities, local politicians and regional government authorities need information. An information workshop will be organized for that purpose (see Result 4).

RBF tools will be made available and division of tasks among the team members will be decided upon. A detailed operational plan per sub-district for the first three months of introduction of RBF will be elaborated.

PNFP HC staff recognized in the coverage plans needs to be trained in the concepts and the use of the specific tools for RBF. Support supervision and control visits will be needed for continuous training and smaller adjustments of the RBF system. These visits will be relatively intensive in the first quarter after introduction of the system. DHMT members will need to be supported.

Possible sub-activities are:

- Initial training workshop per district, follow-up workshop 1 year after introduction
- Initially monthly, later quarterly support supervision and control visits by DHMT (and sub-district authorities) to the health facilities. MB, PNFPCB and MoH Planning en finance department should be involved on a regular basis.

A.5.4 Finance PNFP health centres through RBF

Financing PNFP HC facilities means that the health centres fill in the necessary monitoring tools, that they are verified by the RBF controlling mechanism (Project representative together with DHMT member – depending on design of RBF see Result 4) and that the HC receive the corresponding amount on their individual account. It also means that they reinvest the money for their recurrent costs (approved by DHO) and when financially possible, they will do more important investments in equipment or small rehabilitation for instance, through a yearly business (investment) plan that will be part of the overall district plan and therefore approved by the district.

Eligibility criteria for HC to be supported need to be established before actual implementation. Specifically for HC II, its minimal quality standards and opportunity to be upgraded to HC III (including full maternity care) should be examined. It might be that certain HC need to upgrade their quality first to respond to minimal quality standards before they can be included in the RBF scheme.

The activities eligible in the business plans will increase in complexity as the HC become more performing. In the first months, only recurrent costs for medicines and medical supplies and sundries will be allowed.

Sub-activities could be:

- Control visits, more intensively the first year. MB and MoH Planning and Finance department will be involved on a regular basis
- Support to annual district plans and individual HC business plans by the NTA at regional level
- Official approval and versing the amounts
- Financial analysis and projections for lowering the fees.

The amount reserved for the financing of the PNFP health facilities participating in RBF is 2,013,600 EUR. This amount includes the control visits of DHO, the visits of MB and MoH and the financing of the HC through RBF. The formula for the calculation of the envelope (1,731,600 EUR) to finance the HC is based on the amount of an average of 925 EUR a month per HC, for a total of 52 HC, during 3 years. The exact RBF formula to apply for each HC will be determined during the first year of the project when the RBF system is being designed in detail but it will not exceed the average of 925 EUR per HC per month.

Finance PNFP health centres through RBF	Number	Amount	Total
Control visits, more intensively the first year by DHO	36	7,500	270,000
Visit of members from MB and MoH (2X a year)	6	2,000	12,000
Financing PNFP health centres	1,872	925	1,731,600
Total			**2,013,600**

3.4.6 Activities for Result 6: PNFP hospital care of West Nile and Ruwenzori is more affordable for the population without loss of quality of care through RBF

A.6.1 Perform and implement the conclusions of a hospital care coverage and care provision study (mapping of hospitals, types and utilisation of services and utilisation, etc.)

This activity is very parallel to A.5.1 which describes the development of coverage plans at district level including all HC. However, the hospital coverage plan needs to be conducted at regional level because their catchment areas are not confined to district boundaries. Overlap of hospitals might be territorial but also in specialized services. Regional and general referral hospitals should respond to certain norms and qualifications. An important link with costing studies (see further) has to be made internal ("are the means within de hospital well distributed?")- and external ("are there no duplications of services between hospitals with underutilisation in each as a consequence?"- efficiency).

Closing down some services (government or PNFP) and opening new (complementary) services are among the possibilities. Exchanging personnel belongs to the possibilities (government personnel allocated to PNFP for more optimal use of competencies and services).

Supervision from regional referral to general hospitals could be influenced by the coverage plans as well.

An international consultant and 2 national consultants will be needed to initiate the process and to conduct the first studies. MoH Directorate of Planning and Development, the Directorate of

financing department and the MB should be involved during the whole process.

Approved (by MoH Directorate of Planning and Development) coverage plans are a precondition for the RBF exercise to start. The ICB project might take the initiative to conduct similar studies for public hospitals in the same region in a complementary way.

Possible sub-activities are:

- Map the hospitals (public and PNFP) in the two regions taking into account important hospitals in the nearby surrounding regions. The plan should also illustrate the health care services per hospital, the catchment area populations (theoretical and in practice), the ambulance service, the (overlap) populations, the number of beds per inhabitant in the catchment areas, etc. Links should be made with the costing studies.
- Disseminate the methodology, the results and conclusions at national level, involving MoH, MB, HDP, other districts. This will be done through a capitalization workshop

A.6.2 Conduct costing studies per hospital and comparative costing studies between the hospitals

One of the objectives of financing PNFP hospitals through a RBF system, is to make them that viable that they can reduce out-of-pocket payments by the public. The actual rates are real barriers for utilization.

To be able to do so, hospitals need tools that allow them to perform analytical accounting and for instance predict what would be the impact on their financial viability when fees would be reduced. The studies should also make clear what and in what amounts, RBF can reasonably finance different units of hospitals.

Essentially, such studies should describe the general recurrent costs, where possible per operational unit, with salaries separated from medicines and medical supplies and sundries and direct health care costs separated from support services such as administrative departments, maintenance and logistics. Workloads should be estimated per operational department and compared with the full-time equivalents in staffing that are assigned to them.

These studies should not go into too much detail. In a first stage, RBF cannot engage in rationalizing prescription behaviour for instance, but as the RBF financing will work with lump sums where possible, the facilities will not have incentives for irrationally increasing medical acts and prescriptions. Costing studies (comparative) on pathologies or groups of pathologies will be conducted later in the process to detect other opportunities for the hospitals to become more efficient and RBF to refine its financing mechanisms.

The studies should be highly participative and include the concerned hospital direction to ensure appropriation and understanding of the content and conclusions of the studies.

The comparative costing study will allow individual hospitals to recognize inefficiencies in their organization, when compared to other similar institutions.

The costing of the outpatient departments (OPD) where primary health care activities are conducted should get particular attention as these activities should normally not be organized in a relatively expensive hospital environment. Opportunities should be sought to externalize these services to urban health centers in the town's neighbourhoods, with the medical equipment and personnel newly allocated in these centres. At least in one hospital per region (probably in a smaller urban environment where one or two urban HC suffice), urban health centre alternatives for primary care OPD will be tested (see A.6.5).

Similar operational units should be compared between hospitals, and related to the levied fees in the different establishments.

The costing studies will also pay attention to ensuring the availability and accessibility of quality SRH and HIV related services.

The studies should be disseminated at central level, but also between hospitals outside the two concerned regions and amongst development partners. A national workshop can be organised to that purpose.

An international consultant and two national consultants (expertise in hospital organisation-public health and in auditing) will be needed to initiate the process and to conduct the first studies. MoH Directorate of Planning and Development, the Directorate of financing and the MB should be involved during the whole initial process.

The costing studies are a second precondition for the RBF exercise to start. One third of the hospitals (3) should be covered before the end of the first year, the other 2/3 before the end of the second year of the project. ICB project might also here conduct similar studies for public hospitals in a similar way.

Sub-activities could be:

- Establish study protocols in a participative way and data collection tools
- Recruit international and national expertise and organise the field visits
- Organise and conduct data collection. Some aspects might need prospective data collections, but they should be avoided in an initial stage.
- Do the analysis and write the report with clear recommendations for the hospital organisation. Especially the comparative study might be of interest in this regard (hospitals learning from each other).
- Disseminate the results and conclusions at national level, involving MoH, MB, HDP and other districts.

A.6.3 Prepare the PNFP hospitals for initiating RBF

Hospitals that went through the coverage plan and costing study, approved by ITA/NTA and MoH/MB can benefit from a lump sum to improve their initial situation, before starting RBF. Basic services are targeted (not specialist services at this stage) and medicines and medical supplies, sundries and basic medical equipment are eligible for financing.

As for the HC, the hospital staff will need training in the concepts and the processes involved in RBF (see activity A.4.3). The tools will be more complex and handled by more different staff members, compared to HC. Several training sessions need to be organised according to the type of personnel covered. The ICB project might delegate hospital staff from public hospitals to participate in the training (especially hospital direction members), realising synergies between the two projects.

Possible sub-activities are:

- Make an inventory of the needs
- Realise purchases
- Organise training sessions for different types of personnel (see activity A.4.3)

A.6.4 Finance PNFP hospitals through RBF

Financing PNFP hospitals signifies that the facilities fill in the necessary monitoring tools, that they are verified by the RBF controlling mechanism (Project representative together with DHMT member – depending on design of RBF see Result 4) and that the hospitals receive the corresponding amount on their individual account. It also means that they reinvest the money for their recurrent costs (approved by DHO) and when financially possible, they will do more important investments in equipment or small rehabilitation for instance, through a yearly business (investment) plan (approved / controlled by DHO).

Hospital business plans are far more complex than HC plans. The additional investments should probably start timidly.

Sub-activities could be:

- Control visits (in this initial stage) by NTA/ITA and designated auditors, more intensively the first year. MB and MoH Directorate of Planning and Development and the Directorate of Financing will be involved on a regular basis.
- Support the hospital direction and administrators to analyse the data and to develop subsequent business and investment plans
- Support the hospital direction and administrators to make a financial analysis allowing fees for patients to diminish, especially for the vulnerable groups. This is a major objective of RBF and a condition to pursue RBF at this level of health care.
- Official approval of invoices and versing the corresponding amounts

The amount reserved for the financing of the PNFP hospitals participating in RBF is 1,640,100 EUR. This amount includes the control visits of DHO, the visits of MB and MoH and the financing of the hospitals through RBF. The formula for the calculation of the envelope (1,425,600 EUR) to finance the hospitals is based on the amount of 4,400 EUR a month per hospital, for a total of 9 hospitals, during 3 years. The exact RBF formula to apply for each hospital will be determined during the first year of the project when the RBF system is being designed in detail but it will not exceed the average amount of 4,400 EUR per hospital per month.

Finance PNFP hospitals through RBF	Number	Amount	Total
Control visits, more intensively the first year by DHO	27	7,500	202,500
Visit of members from MB and MoH (2X a year)	6	2,000	12,000
Financing PNFP hospitals	324	4,400	**1,425,600**
Total			**1,640,100**

A.6.5 Experiment with urban primary care centres outside the hospital environment

Organising primary health care services in hospitals in an urban environment is an expensive way of providing primary care. Primary care and secondary referral care are often mixed. Moreover, the structures need to be huge because of the workload, with complex human resource management and coordination and often a ‘supermarket approach’ for preventive services. (for more details, see Annex 7.8 on coverage plans).

It is not easy to reverse this logic and way of organising. Any important reform starts with a clear

vision and with an introduction of the reform at a limited scale. The project will introduce an urban health centre approach in one urban area per region, where the primary care component is completely dislocated from the hospital to urban primary care centres. Personnel would come from the hospital facilities, the facility could be provided by Local Government or other authorities in town, but hiring a building is not excluded. The local PNFP hospital can equally become the organising body.

This activity will only effectively start in the third year of the intervention, but the costing studies and preparatory discussions and analysis of the situation can start the second year.

In such setting, people that bypass the urban centre and cannot be considered as emergencies should be paying extra for the direct access to hospital care (financial discouragement, gatekeeping function).

The first discussions on such initiative have to take place already during the establishment of coverage maps. The concept will need more in depth analysis at ministry's level and with the donor community before an initiative can be taken.

Possible sub-activities:

- Train selected hospitals and LG authorities on the concepts
- Conduct a baseline study on the costs of primary care in the concerned hospitals
- Study the possibility of creating urban HC in terms of HRH and physical facilities
- Prepare the facilities (1 HC per 7,000 inhabitants)
- Inform the population on the changes
- Prepare the affected personnel
- Run the centres under RBF regime
- M&E of the financing and cost of urban HC
- Dissemination of the results at national level (TWG, workshop at national level).

3.4.7 Joint costs to achieve Result 1 to 6:

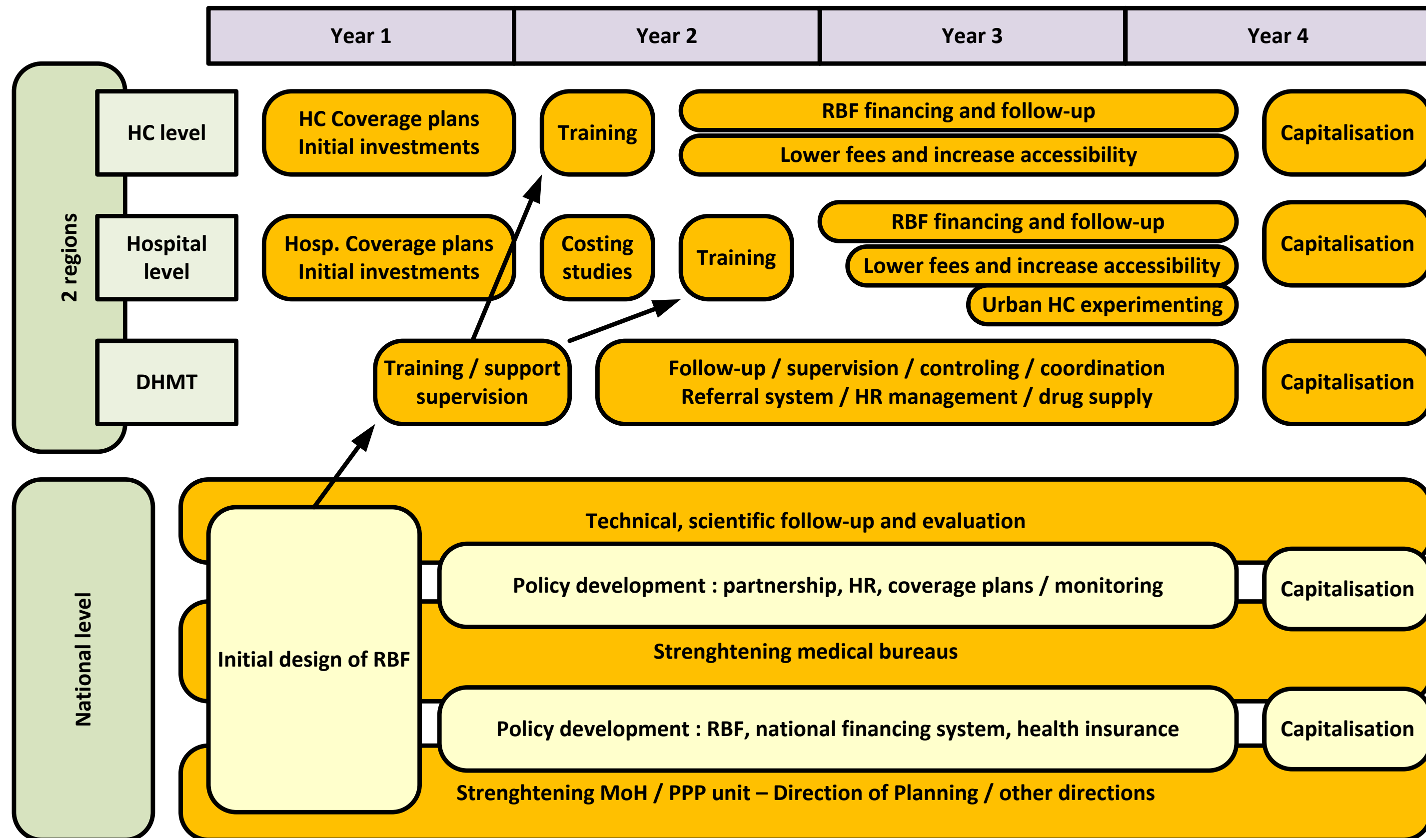
B.1 Costs directly related to the activities/results

Costs directly related to the activities/results	Number	Amount	Total in €
Scientific follow-up and evaluation of the various strategies implemented. This follow-up is linked to Activity 1.6 *(Inclusive of accommodation, travel etc)*	80 days	1,500	120,000
Short term international and national consultancies. These consultancies are linked to: • Activity A.04.01 & A.04.02 • Activity A.05.01 • Activity A.06.01 & A.06.02 *(Inclusive of accommodation, travel etc)*	4 Missions	38,000	152,000
National technical Assistant (Policy analysis and M&E)	48 months	2,200	105,600
1 National Technical Assistant in each of the 2 Regions	96 months	2,200	211,200

Basic equipment HC (on the base of need assessment) to be supplied on a bi-annual basis)	312	750	234,000
Basic equipment hospitals(on the base of need assessment) to be supplied on a bi-annual basis)	54	4,700	253,800
Procurement of vehicles	3	33,000	99,000
Running cost of vehicles (Maintenance, fuel and insurance of vehicles)	144 month	900	129,600
Total			**1,305,200**

An overall logical relation between activities is presented in the figure here below. It articulates the various activities of the project in a coherent way over time and between regions.

Figure 5: Conceptualisation of implementing RBF



3.5 Indicators and Means of Verification

In the first year of the project, concomitant with the development of the RBF mechanisms, the project should revise and complete the proposed indicators and establish a baseline for them. Minimal specific data collection will be needed because most of the indicators are available through the National HMIS system. Other indicators will be established when costing studies and RBF policies are put in place.

The visits to the health facilities to establish a complete baseline should be the occasion by excellence to establish at the same time a list of equipment needs and to introduce the preparatory data collection at that level to establish district health coverage plans.

3.5.1 Indicators for the General Objective

The HSSIP indicators and a selection out of the national HMIS system can be chosen to measure the general objective.

3.5.2 Indicators for the Specific Objective

- Number of districts nation-wide joining the RBF scheme
- Policy approved concerning support to HRH to PNFP facilities
- Number of HDP co-financing PNFP

3.5.3 Indicators for the Results

R1	• Staff completed according to norms • Number of meetings between MoH and PNFP organizations, coordinated by the PPP unit • Number of policies translated into practical guidelines • Number of new policy documents • Percentage of PNPF implementing the national SRH/HIV policies • Percentage of PNFP implementing the guidelines for medical waste disposal • Percentage of PNFP with a gender activity plan.
R2	• Regularity of reporting of indicators • Number of coordinating meetings and district level against the number of meetings planned on a yearly basis • Number of joint support supervisions realized on a yearly basis with relation to the number planned for • Number of visits by MB to the hospital facilities on a yearly basis
R3	• Number of health coverage plans completed • Number of support supervision visits completed for all the HC in the area • Execution rate of the year plans

	• Financial absorption of the RBF funds • Number of patients evacuated via ambulance system • Number of District health coordination committee meetings on a yearly basis • RBF indicators to be determined • Percentage of HC delivering the full HIV package for maternal and child health and HIV/AIDS (including MTCT) • % of HC organizing outreach activities • Number of regular outreach visits per HC
R4	• RBF Model, accepted by MoH and GoU as the national model, available • Number of HDP financing the RBF approach • Number of people trained at central level on the concepts of RBF
R5	• HMIS indicators on maternal and child health and HIV/AIDS • Number of outreaches per catchment areas and regularity of the visits • RBF indicators • Evolution of fee levels
R6	• HMIS indicators for hospital inpatient care • Number of referred patients and percentage of referred patients among Out-Patient Department (OPD) clients • Number of referred deliveries / obstetric cases • RBF indicators • Number of patients (in-patients or referred patients in OPD) per type of activity / department • Evolution of the fee levels

3.6 Description of Beneficiaries

The project works around the quality of the partnership that exists between MoH and PNFP facilities and organizations. MoH is the first beneficiary of this project, not as such 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 access, in geographical and financial terms, to quality health care. It is the MoH who is in charge of the intervention.

MoH will be strengthened very concretely by:

- An improved partnership with the PNFP sector with more explicit and a variety (scope) of relationships
- 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 HRH

- An alternative model for financing health services, tested in the field, and which can be expanded nation-wide if proven positive in the Ugandan political context.

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

Special mention should be made for the personnel of the PNFP facilities in the intervention regions of Ruwenzori and West Nile, particularly those in rural areas. They will be partially motivated through the RBF mechanisms but more even by the fact that the project will contribute to lower their physical and intellectual isolation.

In concrete terms, the project will ensure:

- A lasting and better structured partnership of PNFP with MoH, with more pronounced support from the latter in terms of personnel and subsidies to render the services more affordable
- The upgrading of PNFP health facilities in the covered regions
- The increase of technical capacity of the PNFP personnel.

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. Maternal and child care will be discriminated positively because mothers and children can be considered in general as the most vulnerable subpopulation/group in society, especially concerning health. The population of Western Nile and Ruwenzori mountains is estimated at roughly 5.25 million people.

3.7 Risk Analysis

3.7.1 Implementation Risks

The project is complex and ambitious, especially regarding Result 5 and 6 on the application of RBF in health facilities. The MoH disposes of relatively few staff that it can put to the benefit of the project's realisations during the execution period. Therefore the project will work with a number of NTA, besides the ITA, in order to absorb the workload. This measure will attenuate also the fact that the project is executed over a vast territory of two regions, covering five million people, 15 Districts, about 35 sub-districts, nine hospitals and 150 HC scattered all over these regions. Two NTA will be based in the regions to create proximity.

Additionally, the relative lack of qualified staff at the ministry's level might delay or even cause paralysis of decision making processes at that level. The project cannot and does not want to take decisions unilaterally. As the RBF is an ambitious innovation on demand of the MOH, timely decision-making is crucial for the project to keep track. It is therefore proposed to create a technical committee with members of the MoH, HDP and the TA of the project, to follow the process and to create leverage for decisions. Such a committee will at the same time stimulate coordination of the donors and will assure that individual interventions and initiatives are absorbed and guided by one national approach and policy.

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

Risks	Risk Level	Alleviation measure
Objective • Large scope of the project • MoH lacks sufficient high competentent profiles • Vision on PNFP partnership underdeveloped	Intermediate	• Recruitment of NTA • The use of consultancies, united in one public tender, to make expertise readily available throughout the projects' duration • Recruitment of an international administrative and financial officer to facilitate the aspects of execution • The dedication of one result completely to the development of a long-term vision on Partnership between MoH and PNFP facilities • Regional concentration in two regions
Result 1 • PPP unit understaffed and under-skilled • Lack of an elaborated vision on the role of the PPP unit	Fairly high	• Anchorage of the project at the direction of planning • Recruitment of NTA • Recruitment of additional staff members in PPP unit
Result 2	Low	
Result 3	Low	• Establishment of synergies with the ICB project
Result 4 • Shortage of sufficient national expertise at different levels	Low	• Expertise to be made available • Offering capacity building by the programme and in synergy with scholarship programme
Result 5 • Large scope • Need for intensive follow-up • Strategy and procedures yet to develop	Fairly high	• Availability of NTA in every region • Use of international and national consultancies • Stimulation of multi-stakeholder coordination • Use of the existing synergies with ICB project • Gradual scaling-up
Result 6 • Large scope • Need for intensive follow-up • Strategy and procedures yet to develop	Fairly high	• Assuring presence of NTA in every region • Making international and national consultancies possible • Support of multi-stakeholder coordination • Gradual scaling-up

3.7.2 Management Risks

Two types of management risks can be identified for the project. The first risk is the fact that the execution of the project might get compromised by the limited capacity of the MoH. This will be addressed by the presence of an international administrative and financial officer and the programme support staff.

The second risk is the multitude of stakeholders the project has to deal with, which will not facilitate the management of the project. This will be addressed by using national and international technical expertise and offering capacity building initiatives by the programme and through synergies with the scholarship programme. MB, dioceses and PNFP facilities belong to the identified beneficiary institutes of the scholarship programme.

Management risks	Risk Level	Alleviation measure
Objective: • Low management capacity within MoH		• Recruitment of an international administrative and financial officer
Result 1	Low	• Offering capacity building • Using the synergy with the scholarship programme
Result 2	Low	• Offering capacity building • Using the synergy with the scholarship programme
Result 3	Low	• Using the synergy with the ICB project. • Enrolment of the DHO in the scholarship programme as they are among the beneficiary institutes of the scholarship programme
Result 4	Low	
Result 5 • High technicality • Need for follow-up • Need for financial control	Intermediate	• Recruitment and proximity of NTA • The conduct of regular audits by the programme • Create the condition of developing business plans • Use of international expertise to develop the procedures
Result 6 • High technicality • Need for follow-up • Need for financial control • Willingness of PNFP hospitals to be fully transparent on third party financing	Intermediate	• Recruitment and proximity of NTA • The conduct of regular audits by programme • Create the condition of developing business plans • Use of international expertise to develop the procedures

3.7.3 Effectiveness Risks

In general, the effectiveness risk for this intervention is considered as very low. Most of the budget will directly reach the PNFP facilities through the development of the RBF system. In return they will be obliged to reinvest these additional resources into the system. This will automatically render them more viable.

However there exists a certain effectiveness risk in Result 5 and 6 if PNFP would not agree to lower their fees for service. The most important reason for that would be mistrust towards long-term engagements by the government and/or the programme. This is especially true for the hospitals for which the financial analysis and projections are far more complex and the financial risk, in absolute terms, is much higher.

Effectiveness risks	Risk Level	Alleviation measure
Objective	Low	
Result 1	Low	
Result 2	Low	
Result 3	Low	
Result 4	Low	
Result 5 • PNFP HC III and IV refuse to lower the user fees	Intermediate	• The conduct of a joint analysis of the financial status • Offering assistance to make realistic business plans
Result 6 • PNFP hospitals refuse to lower the user fees	High	• The conduct of a joint analysis of the financial status • andOffering assistance to make realistic business plans • Engagement of the project in bearing the financial risk of the hospitals by increasing the support if the financial balance would become negative

3.7.4 Sustainability Risks

Sustainable solutions for some of the objectives will only be found in the next five to 10 years to come. For instance, this project uses a long-term vision to intervene in the field of social protection. Even though the project is in line with MoH policy and the president's programme, short, medium- and long-term sustainability problems can still occur. The occurrence of short and medium-term sustainability problems will depend of the degree of engagement of the MoH in its political willingness to progress in the conception of partnership with the PNFP facilities and in its vision on a nation-wide social protection system.

Therefore the programme will support the MoH directly in the development of these concepts and visions and the piloting at a limited scale will definitely help the ministry to find its way in the many technical and political aspects of these matters. Additionally, 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 guarantees to a certain level the financial sustainability over a period which is longer than the programme's life-time of four years.

The gradual introduction of the programme, the efforts at the level of capacity building for all stakeholders and the synergies with the scholarship programme should create a technically sound environment that will be able to sustain the programme's initiatives beyond the programme's four years.

Sustainability risks	Risk Level	Alleviation measure
Objective • The national government does not fulfil its long-term engagements due to political or economic developments	Low	• Facilitating donor coordination • Conducting and maintaining the policy dialogue
Result 1 • MoH does not engage in a sincere partnership with PNFP • MB do not engage in a sincere partnership with MoH	Low	• Facilitating donor coordination • Stimulation of continuous policy dialogue • Creation of transparency • Facilitation of the dialogue between the two partners • Making international expertise available that can maintain an objectivity towards both partners • Documenting the experiences
Result 2 • MB do not have the competences		• Capacity building activities • Create possibilities to increase competences through the Scholarship program
Result 3		
Result 4		
Result 5 • MoH and Donor community do not provide long-term financial means	Intermediate	• Support of the donor coordination • Development of clear pathways and procedures • Development of a long-term vision and perspectives for donor agencies, including the development of a basket fund (preparation)
Result 6 • MoH and Donor community do not provide long-term financial means	Intermediate	• Support of the donor coordination • Development of clear pathways and procedures • Development of a long-term vision and perspectives for donor agencies, including the development of a basket fund (preparation)

3.7.5 Fiduciary Risks

Risks	Risk Level	Alleviation measure
Objective		• Not applicable
Result 1 • Low management capacity	Low	• Limited investments
Result 2	Low	• Limited investments
Result 3 • Multiple actors, outside MoH at a distance	Low	• Presence of NTA paid by BTC project • Payments only after verification of achievement of activities
Result 4	Low	• Limited investments

Result 5 • Large scope • Need for intensive follow-up • Strategy and procedures yet to develop	Low	• Presence of NTA paid by BTC project • Payments only after verification of achievement of activities • Multiple occasions for verification • Direct payment on individual accounts
Result 6 • Large scope • Need for intensive follow-up • Strategy and procedures yet to develop	Low	• Presence of NTA paid by BTC project • Payments only after verification of achievement of activities • Multiple occasions for verification • Direct payment on individual accounts

4 RESOURCES

4.1 Financial resources

4.1.1 Ugandan Contribution

The Ugandan contribution to the project will be “in kind” (See section 4.2 and 4.3).

4.1.2 Belgian Contribution

The Belgian contribution amounts to 8,000,000 EUR.

The detail of the project budget is provided here below:

TOTAL BUDGET - UGA 13 026 11				Execution modality	TOTAL BUDGET	%	year 1	year 2	year 3	year 4
A			**Specific objective**		**6.088.550**	**76%**	**996.667**	**1.220.817**	**1.989.242**	**1.881.825**
A	*01*		*MoH is strengthened in its capacity of policy and implementation guideline design, review, dissemination and use in partnership with PNFP facilities and organizing bodies*		*305.950*	*4%*	*91.800*	*91.800*	*69.300*	*53.050*
A	01	01	Support the planning, management and administration of the PPP unit in the Directorate of Planning and Development	BTC management	112.200		39.300	39.300	16.800	16.800
A	01	02	Review PPPH related policies and guidelines	co-management	80.000		20.000	20.000	20.000	20.000
A	01	03	Disseminate policies and guidelines and do advocacy through communication activities	co-management	25.000		6.250	6.250	6.250	6.250
A	01	04	Perform field visits	co-management	16.000		4.000	4.000	4.000	4.000
A	01	05	Organize country study tours	co-management	48.750		16.250	16.250	16.250	
A	01	06	Perform technical and scientific follow-up and evaluation to feed policy design	co-management	24.000		6.000	6.000	6.000	6.000
A	*02*		*Medical Bureaus and the PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions*		*163.200*	*2%*	*50.800*	*50.800*	*30.800*	*30.800*
A	02	01	Support the installation and equipment of MB	BTC management	40.000		20.000	20.000	-	-
A	02	02	Support exchange, coordination and cross-fertilizing activities between MB and with MoH	co-management	64.000		16.000	16.000	16.000	16.000
A	02	03	Support of MB to PNFPCB through supervision, workshops and meetings	co-management	59.200		14.800	14.800	14.800	14.800
A	*03*		*District and Subdistrict Health Management Teams are strenghtened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations*		*42.000*	*0,5%*	*9.000*	*9.000*	*12.000*	*12.000*
A	03	01	Perform supervision activities and joint meetings between DHO and PNFPCB	co-management	36.000		9.000	9.000	9.000	9.000
A	03	02	Organize exchange activities between districts at regional level	co-management	6.000				3.000	3.000
A	*04*		*MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities*		*69.000*	*1%*	*10.000*	*31.000*	*18.000*	*10.000*
A	04	01	Review existing and past RBF related experiences and policies in Uganda and conduct complementary studies	co-management	4.000		2.000	2.000	-	-
A	04	02	Design a RBF scheme to fund PNFP health facilities	co-management	8.000		4.000	4.000		-
A	04	03	Train management and health professionals in RBF	co-management	35.000		4.000	13.000	13.000	5.000
A	04	04	Implement the RBF procedures and tools	co-management	15.000			5.000	5.000	5.000
A	04	05	Develop and conduct communication and advocacy activities	co-management	7.000		-	7.000	-	-
A	*05*		*PNFP HC II, III and IV of the regions of West Nile and Ruwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF*		*2.248.600*	*28%*	*51.000*	*467.100*	*876.500*	*854.000*
A	05	01	Elaborate a complete health coverage plan per district, including HC II, III and IV and adapt it on a yearly basis according to evolutions in the district	co-management	40.000		36.000	4.000		
A	05	02	Support yearly planning, taking into account the conclusions and projections of the coverage plans, and assist in elaborating business plans in the concerned facilities once RBF funding has started	co-management	60.000		15.000	15.000	15.000	15.000
A	05	03	Build the skills of PNFP HC staff for RBF to function in their facility	co-management	135.000			112.500	22.500	
A	05	04	Finance PNFP health centres through RBF	co-management	2.013.600			335.600	839.000	839.000

A	*06*		*PNFP hospital care of West Nile and Ruwenzori is more affordable for the population without loss of quality of care through RBF*		*1.954.600*	*24%*	*5.000*	*378.850*	*790.375*	*780.375*
A	06	01	Perform and implement the conclusions of a hospital care coverage and care provision study	co-management	7.500		5.000	2.500		
A	06	02	Conduct costing studies per hospital and do comparative costing studies between the hospitals	co-management	6.000			6.000		
A	06	03	Prepare the PNFP hospitals for initiating RBF	co-management	81.000			27.000	27.000	27.000
A	06	04	Finance PNFP hospitals through RBF	co-management	1.640.100			273.350	683.375	683.375
A	06	05	Experiment with urban primary care centres outside the hospital environment	co-management	220.000			70.000	80.000	70.000
B			**Common costs directly related to the activities/results**		**1.305.200**	**16%**	**779.067**	**192.267**	**192.267**	**141.600**
B	*01*		*Results*	BTC management	*1.305.200*	**16%**	*779.067*	*192.267*	*192.267*	*141.600*
X			**Reserve budget (max 5% of total activities)**		**287.650**	**4%**				**287.650**
X	*01*		*Reserve budget*		*287.650*	*4%*				*287.650*
X	01	01	Reserve budget co-management	co-management	143.825					143.825
X	01	02	Reserve budget BTC direct management	BTC management	143.825					143.825
Z			**General Means**		**1.623.800**	**20%**	**446.700**	**409.700**	**351.200**	**416.200**
Z	*01*		*Staff costs*		*1.291.200*	*16%*	*322.800*	*322.800*	*322.800*	*322.800*
Z	01	01	International Technical assistant (Co-manager)	BTC management	720.000		180.000	180.000	180.000	180.000
Z	01	02	International administrative and finance Responsible (RAFI)	BTC management	360.000		90.000	90.000	90.000	90.000
Z	01	04	Accountant	BTC management	48.000		12.000	12.000	12.000	12.000
Z	01	05	Secretary	BTC management	86.400		21.600	21.600	21.600	21.600
Z	01	06	Drivers (4)	BTC management	76.800		19.200	19.200	19.200	19.200
Z	*02*		*Investments*		*52.000*	*1%*	*47.000*	*5.000*	*-*	*-*
Z	02	01	Vehicle	BTC management	33.000		33.000			
Z	02	02	Office equipment	BTC management	4.000		3.000	1.000		
Z	02	03	IT Office equipment	BTC management	12.000		8.000	4.000		
Z	02	05	Office refurbishment	BTC management	3.000		3.000			
Z	*03*		*Running costs*		*99.600*	*1%*	*24.900*	*24.900*	*24.900*	*24.900*
Z	03	01	Maintenance, fuel and insurance of vehicles (1)	BTC management	43.200		10.800	10.800	10.800	10.800
Z	03	02	Offices maintenance and supply	BTC management	28.800		7.200	7.200	7.200	7.200
Z	03	03	Télécommunications (5 Mobile phones)	BTC management	21.600		5.400	5.400	5.400	5.400
Z	03	04	Representation and external costs	BTC management	5.000		1.250	1.250	1.250	1.250
Z	03	05	Financial costs (ledger fees including exchange loss)	BTC management	1.000		250	250	250	250
Z	*04*		*Audit et Suivi et Evaluation*		*181.000*	*2%*	*52.000*	*57.000*	*3.500*	*68.500*
Z	04	01	Evaluation & Monitoring	BTC management	100.000			50.000		50.000
Z	04	02	Baseline	BTC management	30.000		30.000			
Z	04	03	Audit	BTC management	30.000		15.000			15.000
Z	04	04	Backstopping	BTC management	21.000		7.000	7.000	3.500	3.500
TOTAL					**8.000.000**		**1.443.367**	**1.630.517**	**2.340.442**	**2.585.675**

BTC management	**3.225.025**		**1.285.067**	**661.267**	**560.267**	**718.425**
co-management	**4.631.150**		**158.300**	**969.250**	**1.780.175**	**1.723.425**

4.2 Human Resources

The project staff 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 Ruwenzori and West Nile region.

It will be composed of:

Within the MoH Directorate of Planning and Development

- 1 Project Manager (the head of the Directorate of Planning and Development)
- 1 International Technical Assistant (ITA) who functions as the project co-manager
- 1 International Administrative & Financial Responsible (RAFI)
- 1 National Technical Assistant (NTA) responsible for policy design and general monitoring and evaluation
- 1 accountant
- 1 secretary
- 2 drivers

Within the regions:

- 2 NTA responsible for supporting the implementation of RBF and capacity building in the PNPF and districts.
- 2 administration & finance officers
- 2 drivers

Project Staff	Number of months	Contracting Party
Project Manager	48 Months	MoH
Project Co-Manager (ITA)	48 months	BTC
Administrative & Financial Responsible (RAFI)	48 months (Half time)	BTC
Policy and Monitoring and Evaluation Expert (NTA)	48 months	BTC
2 Economics & Management Experts (NTA in the regions)	2*48 months	BTC
Accountant	48 Months	BTC
2 Administrative & Financial officers	2*48 months	BTC
Secretary	48 months	BTC
Drivers (4)	4*48 months	BTC

A description of the main functions and profiles is to be found in Annex 7.3 and 7.4.

Junior assistants can also be recruited by BTC, without additional salary costs on the project budget. The focus of their ToR would be on communication (1 at central level) and economics (1 in each of the 2 project's regions)

Project stakeholders will ensure participation of staff through nominating **Focal Points**:

- MoH: PPP Unit, the Directorates of HRH and Clinical Care

- Medical Bureaus (MB): one per bureau
- Regional Referral hospitals (RRH)
- DHO: District Health Management Team (DHMT).

The MoH will ensure that the PPP unit has sufficient staff for the unit to be functional.

4.3 Other Resources

4.3.1 Services

Belgian contribution (project Budget)

- Consultancies
- Vehicle maintenance
- Communication costs
- Trainings …

4.3.2 Investments

Belgian contribution (project Budget)

- Purchase of 4 vehicles
- Purchase of equipment needed for the project team at national and regional level
- Purchase of office equipment (PPP Unit, MB, PNFP Coordination Bodies, PNFP)
- Purchase of basic equipment (medical equipment, transport means) for the PNFP facilities according to a needs assessment (cf. coverage plans)

4.3.3 Others

Belgian contribution (project Budget)

- The project will channel funds to PNFP according to the Results-Based Financing (RBF) system
- The project will pay for the salary of an assistant recruited by the MoH for the PPP unit.

Ugandan contribution:

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

Costs directly related to the activities/results	Number	Amount	Total
Scientific follow-up and evaluation of the various strategies implemented	80	1,000	120,000
Short term international and national consultancies	4	25,000	152,000
National technical Assistant (Policy analysis and M&E)	48	2,200	105,600
1 National Technical Assistant in each of the 2 Regions	96	2,200	211,200
Basic equipment HC (on the base of need assessment)	312	750	234,000
Basic equipment hospitals(on the base of need assessment)	54	4,700	253,800
Vehicles	3	33,000	99,000
Maintenance, fuel and insurance of vehicles	144	900	129,600
Total			**1,305,200**

5 IMPLEMENTATION MODALITIES

5.1 Contractual Framework and Administrative Responsibilities

The legal Framework of the project «Institutional Support for the private-non-for-profit (PNFP) health sub-sector to promote universal health coverage in Uganda » 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 Cooperation (DGD) represented by the attaché for International Cooperation in Kampala as the Belgian entity responsible for the Belgian contribution.

DGD delegates the fulfillment 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, where the PPP unit is located.

The project will also have antennas in West Nile and Ruwenzori 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 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 72 months, as from the date of its signature.

The project execution period is planned for 48 months. The project life cycle entails the following 3 phases:

5.4.1 Preparation Phase

Validation of TFF – Implementation Agreement Notification (CMO)

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

- MoH prepares regulatory arrangements
- Launch of international and national HR recruitment processes
- Opening of main project account
- Start launching procurement of material & logistics
- Preparation of necessary procurements for outsourced parts of the baseline
- ….

Some expenses (pre-CMO expenditures) can be done but only those linked to recruitment processes and logistics.

HR	Costs
HR recruitment costs	5,000 EUR
Logistics	
Procurement of cars (max 4)	132,000 EUR
Procurement of IT equipment	4,000 EUR
Total	**141,000 EUR**

5.4.2 Execution Phase

Effective Start-up Phase of the Project

Implementation Agreement Notification (CMO) – PSC1 (Validation of the Start-up report)

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…) and the first cash call.

The start-up report comprises:

- Signed minutes of the PSC1 meeting
- Approval of the recruited project team
- Project operational manual
- Baseline work plan
- Operational and financial planning for the 1st year

Operational Implementation Phase of the Project

PSC1 – PSC Closure programming (Operational closure planning is approved)

Both the Midterm Review (MTR) and the End term Review (ETR) happen during this phase.

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

Operational Closure of the Project

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. The project final report is produced after the end of the execution period.

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

The final report contains:

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

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

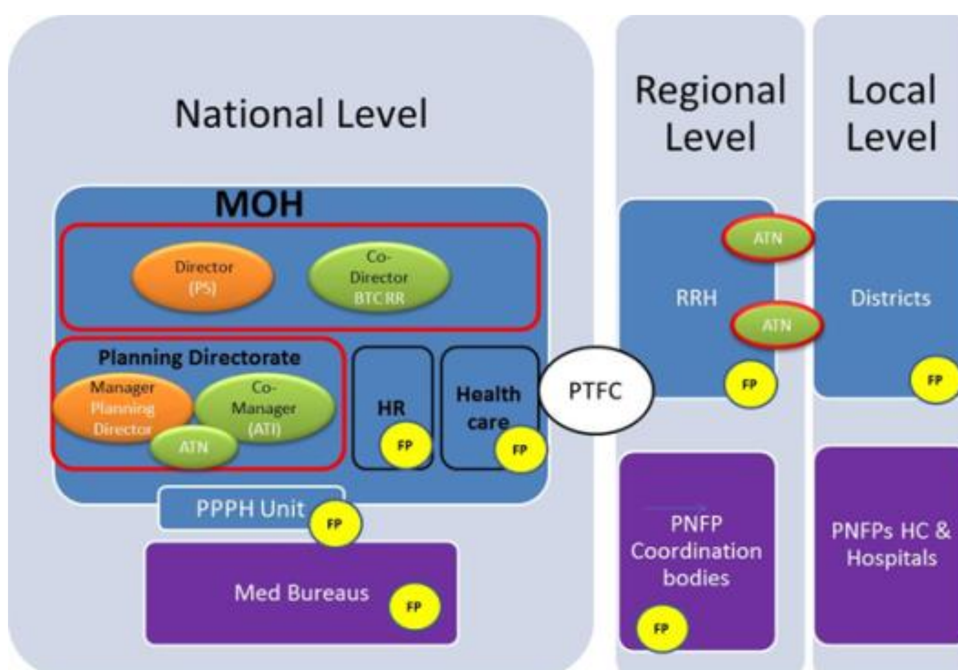
5.4.3 Administrative Closure Phase

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

5.5 Steering and Implementation Structures

5.5.1 General presentation

Figure 6: The Project's organizational set-up



FP = Focal Points collaborating with the project

5.5.2 Project Steering Committee

Ugandan and Belgian parties agree to create a Joint Project Steering Committee (PSC) that is the

highest level of decision in the project and will strategically steer the project.

Composition:

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

- MoH (Permanent Secretary), chair
- Ministry of Finance, Planning and Economic Development
- Ministry of Local Government
- Medical Bureaus (the executive secretary) (PNFP)
- BTC (Resident Representative) co-chair.

The PSC may invite external experts or other stakeholders as resource persons on an ad hoc basis. The steering committee will specifically invite on a regular basis (not systematically) representatives of other MB.

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 hold its meetings jointly with the PSC meetings of the "Institutional capacity building in planning, leadership and management in the health sector project" (UGA 0901701)
- 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 PSC and will provide the necessary information to its members in advance of each meeting.

5.5.3 Project Management Team

The Project Management Team (PM) is the team at the operational level in the project.

The MoH designates the director of the Directorate of Planning and Development as the **Manager** of the project and BTC contracts – After Non Objection (ANO) from the MoH – an International Technical Assistant (ATI) 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 Administration and Finance Responsible (RAFI)** who will be shared with the "Institutional capacity building in planning, leadership and management in the health sector project" (ICB, UGA 0901701) and any future Belgian/Ugandan bilateral project in the health sector.

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.

5.6.1 Human Resources Management

	Manager	Co-Manager	RAFI	NTA	Support Staff
Funded by	MoH	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

5.6.2 Financial Management

5.6.2.1 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 – PNFP “ 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.

5.6.2.2 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 coordination team (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.

5.6.2.3 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. Section 5.6.8).

5.6.2.4 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. Section 5.6.8).

5.6.2.5 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 Manager and Co-Manager

and sent to the Authorizing Officer (Permanent Secretary) and the Co-Authorizing Officer (BTC Resident Representative).

The accounting documents that must be forwarded to the BTC Representation include an electronic file, the supporting documents as well as the bank statements and petty cash statements

The accounting documents must be up to date, accurate, 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.

5.6.2.6 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 change:

Overshooting of the budget at the level of the results (A_01, A_02, . . .to A_06) or General means section (Z_01) is only authorized if the overrun is limited to maximum 10 % of the approved budget.

At budget line level, budget overspending is allowed if it is less than 10% of the initial budget amount for this line and if 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 overspending cannot be more than 5%.

In case a 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.

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 2003, 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 5,000EUR. 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):

- Staff contracting
- All investments (Except operational/running costs)
- All the consultancies
- Audits
- Mid-term and End-term Reviews (MTR and ETR)
- …

5.6.4 Financing PNFP health facilities through the Results-Based Financing Mechanism

This project will introduce RBF at the level of the accredited PNFP health care organizations: at HC II, III and IV level and at district 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. Section 5.1), the MoH (as delegated by MoPFED in the Specific Agreement) is the entity responsible for the RBF mechanism.

Modalities (to be confirmed by the project management team at the time of the execution after further analysis and confirmation that the choice is still relevant):

Selection of the PNFP that will beneficiate of the RBF system:

The PNFP beneficiaries of the RBF are defined by the MoH according to objective criteria. The selection of the beneficiaries PNFP of the project will be done according to the Health Coverage plan established by the district, validated by the MoH and with BTC after no objection.

Setting up the RBF conditions:

As it is foreseen in the Ugandan system concerning grants in the context of specific projects, the beneficiary PNFP shall sign a Memorandum of Understanding (MoU) with the Districts (Local Government) to beneficiate from the RBF grants.

Those MoUs will refer to an Agreement between the project and the district.

The project (MoH and BTC in co-management) will sign **Agreements** with the Districts[13] in the Rwenzori and West Nile regions to define:

- The PNFP beneficiaries selected by the MoH

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[13] The concerned districts have already undergone an organizational assessment in the framework of the ICB project (UGA 0901701) in November /December 2013.

- 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 PNFP beneficiaries through MoUs, verify the RBF results through PNFP supervisions, evaluate RBF reports, ….)
- The support that the project will give for the implementation of the RBF mechanism at district and PNFP health care organization level.

The management of the RBF budget for the PNFP will not be part of the Agreement but the Agreements will comprise a specific budget to support the districts in playing their role in the RBF mechanism.

Reporting and channelling of RBF funds:

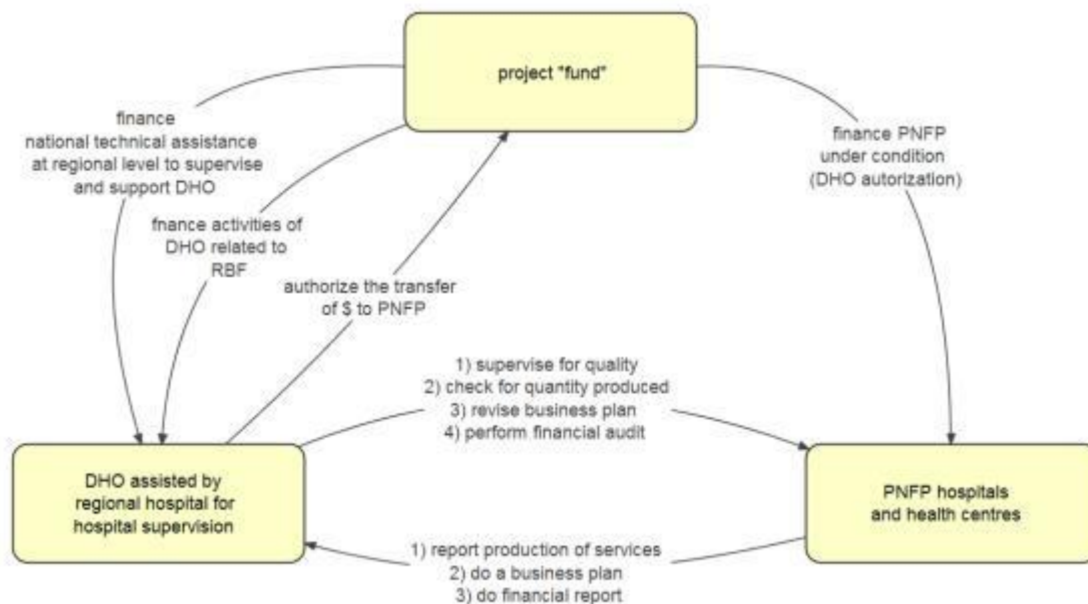
PNFP will report quarterly to the DHO and issue the corresponding invoice according to the conditions set in the MoUs.

The DHO will evaluate the reports and transfer them to the project for final approval.

The project will give a final approval to the reporting before transferring the corresponding funds directly to the PNFP accounts.

The figure below illustrates the RBF conceptual scheme. Chapters 2 and 3 provide in detail the technical details of the RBF mechanism.

Figure 7: **RBF conceptual scheme**



5.6.5 Monitoring & Evaluation

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	Results 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

The Baseline Report needs to be established by the Project Team at the beginning of the project (ideally within the nine months after the first project steering committee meeting-PSC1).

The baseline report comprises:

- A monitoring matrix
- 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. The Baseline report will be attached to the corresponding annual report.

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 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, partner, 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.

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 PM 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 execution modalities

- The project results and activities and their respective budgets
- The composition, attributions and responsibilities of the Steering Committee
- The mechanism to change the TFF.

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 Attaché for International Cooperation (DGD) in Kampala.

6 CROSS CUTTING THEMES

6.1 Environment

Measures will be taken to ensure proper disposal of medical waste through the dissemination of national policies and guidelines, the adaptation of these policies and guidelines to local needs and circumstances and supervision of their implementation.

Environmental health is also part of Cluster 1 of the UMHCP. The actual implementation of this aspect, however, is not yet fully developed. The project will start with ensuring that key environmental issues are taken into account such as ensuring proper disposal of medical waste through the dissemination of national policies and guidelines, the adaptation of these policies and guidelines to local needs and circumstances and supervision of their implementation.

6.2 Gender, Sexual and Reproductive Health and HIV/AIDS

6.2.1 Gender and Health

The 2nd National Health Policy (NHP II) and the current Health Sector Strategic and Investment Plan (HSSIP) emphasize the need for a gender-sensitive and responsive national health delivery system to be achieved and strengthened through mainstreaming gender in planning and implementation of all health programs. Gender is an important determinant in health seeking behaviour and decision making. This is particularly the case in a context where women lack the power to take decisions about their health, which may result in a delay or even denial of the need for seeking appropriate health care. The Uganda Demographic and Health Survey (UDHS) 2011 reveals that husbands are still the most important decision makers on women's health and that only 23% of married women independently decide on their own health care. The survey also points out that poor health seeking behaviour at personal/family/women/community level – including the lack of partner support - is the second commonest avoidable cause of maternal mortality.

6.2.2 Sexual and Reproductive Health

In Uganda maternal mortality has been stagnating for several years and is still at an unacceptably high level. With 438 maternal deaths per 100,000 live births the country is still far from achieving the MDG target to reduce maternal mortality by 75% to 131 deaths per 100,000 live. Maternal deaths account for 18% of all deaths among women aged 15-49. The high maternal mortality ratio is in contrast with the increase in the proportion of live births attended by skilled health personnel, which has increased from 38% in 1995 to 58% in 2011, 44% of which occurred in public health facilities, 13% in the private sector and 42% at home.

Almost none of the health facilities in the country dispose of the full package of items 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). The HC IV strategy to improve access to comprehensive EmOC is showing slow progress. In spite of investments in renovation, equipment and alternative sources of power for – a number of - HC IV all over the country only 25% of HC IV are "functional", i.e. having the ability of providing a caesarean section and blood transfusion. The non-functionality is mainly due to a shortage of critical staff (medical officers, midwives, anaesthetists and laboratory technicians) for the delivery of health services. The number of deliveries at PNFP decreased with 1.4% compared to a previous increase of 6.3% in 2010/11.

Maternal mortality and morbidity is also closely related to poor access to **family planning** (FP) services, including information, education and supply of modern contraceptives. The National

Development Plan 2010/11-2014/15 acknowledges that limited access to family planning services hinders overall development of the society and of women in particular. One of the objectives outlined in the plan is to reduce the unmet need for family planning by ensuring access to family planning services for women and girls, especially in rural areas. Goals include provision of integrated family planning services in all health facilities at all levels, procurement and distribution of contraceptives to men and women of reproductive age, and design of programmes to engage men in family planning services and use.

The contraceptive prevalence rate increased from 24% in 2006 to 30% in 2011, but is still far below the HSSIP target of 40%. Uganda has a national fertility rate of 6.2 children per woman. Rural women have almost twice as many children as urban women. 34% of married women have an unmet need of family planning. Currently 81% of the health facilities provide modern contraceptives, of which male condoms (78%) and injectables (78%) are the commonest.

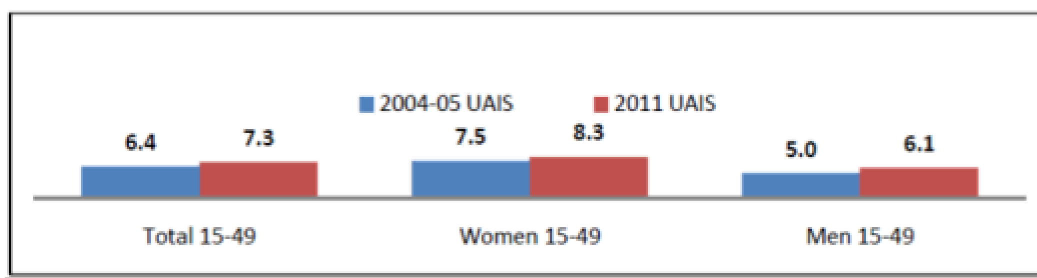
The public sector is the main provider of contraceptives. Particularly among the catholic PNFP resistance against the promotion of modern contraceptives remains high. They rather focus on the promotion of natural contraceptive methods for married couples. Depending of the religious affiliation of the PNFP facilities Family Planning (FP) services are offered or not and women in need of FP are referred to facilities where these services are provided.

The RBF mechanism of financing the health facilities is a leverage for stimulating FP. Because these services are undersupplying, a relatively important financing will be attributed to FP services. The project will remain vigilant in the national dialogue on this issue and will try to negotiate further with PNFP facilities.

6.2.3 HIV/AIDS

In spite of earlier successes in the fight against HIV and AIDS 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%).

Trends in HIV Prevalence among Men and Women



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% 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.

According to the priorities set forward in the National Development Plan (2010-15) HIV prevention remains one of the key priorities to be addressed. In spite of all efforts Uganda continues to experience a growing number of new HIV infections every year, which were estimated at 124,000

in 2009 and 128,000 in 2010. The number of new infections surpasses the annual enrolment into Anti-Retroviral Therapy (ART) by two-fold. If the status quo continues, the HIV burden is projected to increase by 700,000 new infections over the next five years.

The National HIV Prevention Strategy (2011-2015) is aligned with the National Development Plan, National Strategic Plan for HIV/AIDS, Second National Health Policy, and Health Sector Strategic and Investment Plan (2010-15). The National HIV Prevention Strategy identifies minimum HIV prevention packages for the general population, key populations, People Living with HIV and other population groups. Key evidence informed interventions in the packages that must be scaled up to critical levels of 80-90 % coverage are: Evidence-informed behaviour change interventions, Prevention of Mother to Child Transmission, Safe Male Circumcision, Anti-Retroviral Therapy and condom promotion.

6.3 Rights of the Child

6.3.1 Reduction of the Under-Five Mortality Rate

The survival of children under-five years of age is another major public health concern. Over the past two decades modest progress in child survival has been made but the country is still far from achieving MDG 4 on the reduction of child mortality. The infant mortality rate has decreased from 101 infant deaths per 1,000 live births in 1990 to 54 infant deaths per 1000 live births in 2011 (reduction with 49%; HSSIP 2015 target: 41). The under-five mortality rate has decreased from 180 under-five deaths in 1990 to 90 under-five deaths in 2011 (reduction with 50%; HSSIP 2015 target: 56). Progress made in neonatal mortality has been much slower and remains at 27 neonatal dates per 1000 live births (HSSIP 2015 target: 23). Major factors underlying perinatal death are related to health personnel. Particularly the issue of inadequate numbers of staff is affecting perinatal death, but there are also other factors such as absence of critical human resources, lack of expertise, misguided action, non-action and staff oversight.

The Government of Uganda developed a Child Survival Strategy to address the main bottlenecks of child health and aimed at the achievement of MDG 4 on the reduction of child mortality, and more particularly on the reduction of the under-five mortality rate. The Child Survival Strategy focuses on the effective coverage of a priority package of cost-effective child survival interventions such as immunization but also through health education and increasing the capacity of health workers at all levels of care both through in-service an pre-service training. The MoH recommends a scaling-up of the Child Survival Strategy in view of achieving MDG 4.

6.3.2 Adolescent Health

The high maternal mortality rate is also closely related to the high adolescent pregnancy rate in Uganda, which is the highest in Sub-Saharan Africa. 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% and 31.1% respectively. The culture of marriages amongst adolescent girls is partly responsible for the country's high maternal mortality ratio and high fertility rate. One of the HSSIP strategies aimed at improving sexual and reproductive health is the strengthening of adolescent sexual and reproductive health (ASRH) services. This includes increasing the number of health facilities providing adolescent friendly SRH services through proper training of health staff with the aim to improve their understanding of ASRH and develop their skills to properly address adolescents' health needs. Currently 47 % of the health facilities provide ASRH services.

6.4 Overview of Related Activities and Indicators

The project has already included a minimum number of activities and indicators that should contribute to scaling up the performance of the PNFP in view of achieving the targets related to maternal health, child health, HIV/AIDS, gender and environment. These indicators will also be measured both at the district and at the national level. They will systematically be discussed at the HDP coordination meetings and the annual review meetings.

Results	Activities	Indicator
R1 MoH is strengthened in its capacity of reviewing, disseminating and using PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies	A.1.3 Dissemination of national strategies and policies in the areas of gender and health, environment and health, SRH and HIV and their adaptation to the local needs and circumstances. A.1.6 The establishment of feed-back mechanisms between the PNFPs and the technical working groups and coordinating mechanisms in the field of gender, SRH and HIV/AIDS.	Percentage of PNPF implementing the national SRH/HIV policies. Percentage of PNFP respecting the guidelines for medical waste disposal. Percentage of PNFP with a gender activity plan.
R3 District and sub-district health management teams are strengthened in their capacity to support all health facilities in their territory without any discrimination of PNFP facilities and organisations	A.3.1 Supervision activities paying specific attention to the performance of the PNFP with respect to medical waste disposal management, SRH and HIV.	
R5 PNFP HC II, III and IV of the regions of West Nile and Ruwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF	A.5.1 In the elaboration of the district health coverage plans attention is paid to the achievement of the SRH and HIV related targets.	HMIS indicators on maternal and child health and HIV/AIDS
R6 PNFP hospital care of West Nile and Ruwenzori is more affordable for the population without loss of quality of care through RBF	A.6.1 Attention is paid to ensuring appropriate coverage of SRH and HIV related services. A.6.2 The costing studies will pay attention to ensuring the availability and accessibility of quality SRH and HIV related services.	Number of referred deliveries / obstetric cases

7 ANNEXES

7.1 Logical Framework

	Logical of the intervention	Indicators	Sources of verification	Hypotheses
GO	Global objective Contribute to strengthen service delivery capacity at district level to effectively implement PHC activities and deliver the UNMHCP to the target population			
SO	Specific objective PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system	• Number of districts nation-wide joining the RBF scheme • Policy approved concerning support to HR to PNFP facilities • Number of HDP co-financing PNFP		
R 1	Result 1 MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies	• Number of joint field visits MoH / MB • Number of jointly organised workshops • Staff appointed/nominated in the PPP Unit • Number of PPP Unit meetings and % attended by other relevant departments (Clinical services, Quality assurance, Human	• Project reports / plans • Appointment/nomination letter • Meeting minutes • Activity reports	If collaboration between Ministry and MB increases, joint activities will increase

		Resources, Resource Centre, Nursing, Professional Councils, and Monitoring and Evaluation TWG) of the MoH • Joint planning, monitoring and evaluation with other relevant departments of MoH instituted • Number of PPPH TWG meetings held in a year		
R 2	Result 2: MB and PNFP regional health coordination offices are functional and strengthened in their organizational as well as partnership functions	• Number of trainings provided • Number of scholarship oriented towards MB as beneficiary institutes • Number of joint national workshops organized • Number of PPP Unit meetings and % attended by MB • Number of regional supervisory/field visits in which MBs are represented • Number of inter-bureau meetings and % attended by PPP unit representative	• Project reports / plans • Meeting minutes • Supervision/field visit reports	
R 3	Result 3: District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities	• Support supervisions realised for PNFP facilities • Number of joint visits with PNFPCB • Number of DHMT having	• Nomination letters • Meeting minutes • Supervision reports • Reports by coordination structures	

	and organizations	designated a focal person for PNFP matters among its members • Number of PPPH District Desk Officers nominated and functional • Number of DHMT meetings and % attended by PNFP • Number of PNFP Coordination Committees established and functional • Coordination meetings held at district level • Number of joint support supervision visits • Joint district work plan with indicators and targets by facilities • Health Sub-district team includes representatives from public and PNFP sector		
R 4	Result 4: MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities	• Document on vision and implementation modalities available • Number of newly developed implementation tools effectively applied • Number of national workshops held to disseminate the vision and implementation • Number of HDP joining the	• Project reports / plans • National review meeting reports • Donor coordination meetings reports	

		national RBF programme • Number of districts at national scale joining the RBF initiative		
R 5	Result 5: PNFP HC III and IV of the regions of West Nile and Ruwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF	• Increased utilisation per service: • Curative, ANC, Vaccination rate, deliveries, referral rates calculated in "new cases" • Evolution of % of stock-outs of medicines and medical supplies • Evolution of user fees • Number of policies that are fine-tuned • Number of PNFP with defined areas of operation and responsibility • Percentage of health units serving a number of people consistent with their grade according to level, standards and guidelines • Percentage of funds disbursed and percentage utilized • User's fees levels in PNFP units	• National health information system • Pharmacy registers • Revised Policies documents • RBF M&E	The hypothesis is that RBF will allow the PNFP facilities to lower the fees for patients / clients, which in turn will cause the utilisation to go up
R 6	Result 6: PNFP hospital care of West Nile and Ruwenzori is more accessible for the population without loss of quality of care through RBF	• Increased utilisation per service: • Bed occupation and length of stay per operational unit (paediatrics, internal medicine, surgery, obstetrics)	• National health information system • RBF M&E • Pharmacy registers • Revised policies documents	The hypothesis is that RBF will allow the PNFP facilities to lower the fees for patients / clients, which in turn will cause the utilisation to go up

		• Evolution of % of stock-outs of medicines and medical supplies • Evolution of user fees • Number of policies that are fine-tuned		

	Activities to reach Result 1	Means	Belgian Contribution
R 1	Result 1 MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies		Costs in EUR
A 1.1	A.1.1 Support the planning, management and administration of the PPP unit in the Directorate of Planning and Development	• Procurement and maintenance of office equipment and tools • Annual salary support for the FB PNFP Assistant in the PPP unit	112,200
A 1.2	A.1.2 Review PPPH related policies and guidelines	• Working groups, meetings /Workshops /Seminars	80,000
A.1.3	A.1.3 Disseminate policies and guidelines and do advocacy through communication activities	• Communication means (media, printing, …) • Junior technical assistant on communication (Pro memory)	25,000
A 1.4.	A.1.4 Perform field visits	• Travel allowances	16,000

A.1.5	A.1.5 Organize country study tours	• Transport (Flights, etc) • Accommodations (5 people * 7 days * 3 trips) • Travel allowances	48,750
A.1.6	A.1.6 Perform technical and scientific follow-up and evaluation to feed policy design	• Technical orientation and follow-up committee quarterly meeting • Scientific follow-up and evaluation of the various strategies implemented • Yearly capitalization workshop at MoH level (1 day) and final (3 days)	24,000 Consultancy envelope

	Activities to reach Result 2	Means	Belgian Contribution
R 2	Result 2 MB and PNFP Coordination Bodies (PNFPCB) are functional and strengthened in their organizational as well as partnership functions		Costs in EUR
A.2.1	A.2.1 Support the installation and equipment of MB	• Procurement of office equipment and tools	40,000
A.2.2	A.2.2 Support exchange, coordination and cross-fertilizing activities between MB and with MoH	• Quarterly meetings • Six monthly training session • Printing and design of communication material	64,000
A.2.3	A.2.3 Support of MB to PNFPCB through supervision, workshops and meetings	• Working group and meeting (quarterly)	59,200

		Means	
		• Annual workshop • Visit to the districts during PPP coordination meetings (3 days - quarterly)	

	Activities to reach Result 3	Means	Belgian Contribution
R 3	Result 3 District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations		Costs in EUR Synergies with ICB project
A.3.1	A.3.1 Perform supervision activities and joint meetings between DHO and PNFPCB	• Quarterly in each district of both regions • Quarterly supervisions	36,000
A.3.2	A.3.2 Organize exchange activities between districts at regional level	• Working group and meeting (quarterly) • Annual workshop • Visit to the districts during PPP coordination meetings (3 days - quarterly)	6,000

	Activities to reach Result 4	Means	Belgian Contribution
R 4	Result 4 MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities		Costs in EUR
A.4.1	A.4.1 Review existing and past RBF related experiences and policies in Uganda and conduct complementary studies	• Short term international consultancy	4,000 Consultancy envelope
A.4.2	A.4.2 Design a RBF scheme to fund PNFP health facilities	• Short term international consultancy • Printing tools and material for RBF scheme	8,000 Consultancy envelope
A.4.3	A.4.3 Train management and health professionals in RBF	• Reorientation of skilled people at central level (1 week training) • Full training of people at district (including PNFPCB) and PNFP level – 2 week training • Tutoring visits in the field to train them “by-doing”	35,000
A.4.4	A.4.4 Implement the RBF procedures and tools	• Tutoring visits in the field to train them “by-doing”	15,000
A.4.5	A.4.5 Develop and conduct communication and advocacy activities	• 1 national workshop • 2 regional workshops • Leaflets, local radio spots	7,000

	Activities to reach Result 5	Means	Belgian Contribution
R 5	Result 5 PNFP HC II, III and IV of the regions of West Nile and Ruwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF		Costs in EUR
A.5.1	A.5.1 Elaborate a complete health coverage plan per district, including HC II, III and IV and adapt it on a yearly basis according to evolutions in the district	• Train DHMT and sub-district authorities, including key stakeholders from MoH department of Planning and medical bureaux • Contract a national expert mastering Geographical Information Systems (GIS) technology • Set up a data collection in the HC (PNFP and Public) • 2 workshops per sub-district for analysing the data and completing the coverage plans • Printing the plans	40,000
A.5.2	A.5.2 Support yearly planning taking into account the conclusions and projections of the coverage plans and assist in elaborating business plans in the concerned facilities once RBF funding has started	• 2 regional technical assistants • Support visits to the (sub-)districts for yearly planning	60,000
A.5.3	A.5.3 Build the skill of PNFP HC staff for RBF to function in their facility	• Basic equipment (on the base of need assessment) • Initial training workshop per district, follow-up workshop 1 year after introduction • Initially monthly, later quarterly	135,000

		support supervision and control visits by DHMT (and sub-district authorities) to the health facilities	
A.5.4	A.5.4 Finance PNFP health centers through RBF	• Control visits, more intensively the first year by DHO • Visit of members from MB and MoH (2 times a year) • Financing PNFP health centres	2,028,533

	Activities to reach Result 6	Means	Belgian Contribution
R 6	Result 6 PNFP hospital care of West Nile and Ruwenzori is more accessible for the population without loss of quality of care through RBF		Costs in EUR
A.6.1	A.6.1 Perform and implement the conclusions of a hospital care coverage and care provision study	• Short term international consultancy (1 international and 2 national consult) • Set up a data collection in the HC (PNFP and Public) • 2 workshops per region for analysing the data and completing the coverage plans • Printing the plans	7,500 Consultancy envelope
A.6.2	A.6.2 Conduct costing studies per hospital and do comparative costing studies between the hospitals	• Short term international consultancy (1 international and 2 national consult) • Visits in the regions to perform the	6,000 Consultancy envelope

		work • Workshop to disseminate the methodology	
A.6.3	A.6.3 Prepare the PNFP hospitals for initiating RBF	• Basic equipment (on the base of need assessment) • Initial training workshop per district, follow-up workshop 1 year after introduction • Initially monthly, later quarterly support supervision and control visits by DHMT (and sub-district authorities) to the health facilities	81,000
A.6.4	A.6.4 Finance PNFP hospitals through RBF	• Control visits, more intensively the first year by DHO • Visit of members from MB and MoH (2 times a year) • Financing PNFP hospitals	1,642,817
A.6.5	A.6.5 Experiment with urban primary care centres outside the hospital environment	• Operational Research	220,000

7.2 Implementation Calendar (Chronogram)

	Activities to reach Result 1	Year 1				Year 2	Year 3	Year 4
R 1	Result 1 MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies							
A.1.1	A.1.1 Support the planning, management and administration of the PPP unit in the Directorate of Planning and Development							
A.1.2	A.1.2 Review PPPH related policies and guidelines							
A.1.3	A.1.3 Disseminate policies and guidelines and do advocacy through communication activities							
A.1.4	A.1.4 Perform field visits							
A.1.5	A.1.5 Organize country study tours							
A.1.6	A.1.6 Perform technical and scientific follow-up and evaluation to feed policy design							
	Activities to reach Result 2							
R 2	Result 2 MB and PNFP regional health coordination offices (PNFPCB) are functional and strengthened in their organizational as well as partnership functions							
A.2.1	A.2.1 Support the installation and equipment of MB							
A.2.2	A.2.2 Support exchange, coordination and cross-fertilizing activities between MB and with MoH							
A.2.3	A.2.3 Support of MB to PNFPCB through supervision, workshops and meetings							
	Activities to reach Result 3							

R 3	Result 3 District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations							
A.3.1	A.3.1 Perform supervision activities and joint meetings between DHO and PNFPCB							
A.3.2	A.3.2 Organize exchange activities between districts at regional level							
	Activities to reach Result 4							
R 4	Result 4 MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities							
A.4.1	A.4.1 Review existing and past RBF related experiences and policies in Uganda and conduct complementary studies							
A.4.2	A.4.2 Design a RBF scheme to fund PNFP health facilities							
A.4.3	A.4.3 Train management and health professionals in RBF							
A.4.4	A.4.4 Implement the RBF procedures and							
A.4.5	A.4.5 Develop and conduct communication and advocacy activities							
	Activities to reach Result 5							
R 5	Result 5 PNFP HC II, III and IV of the regions of West Nile and Ruwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF							
A.5.1	A.5.1 Elaborate a complete health coverage plan per district, including HC II, III and IV and adapt it on a yearly basis according to evolutions in the district							

A.5.2	A.5.2 Support yearly planning taking into account the conclusions and projections of the coverage plans and assist in elaborating business plans in the concerned facilities once RBF funding has started							
A.5.3	A.5.3 Build the skills of PNFP HC staff for RBF to function in their facility							
A.5.4	A.5.4 Finance PNFP health centers through RBF							
	Activities to reach Result 6							
R 6	Result 6 PNFP hospital care of West Nile and Ruwenzori is more accessible for the population without loss of quality of care through RBF							
A.6.1	A.6.1 Perform and implement the conclusions of a hospital care coverage and care provision study							
A.6.2	A.6.2 Conduct costing studies per hospital and do comparative costing studies between the hospitals							
A.6.3	A.6.3 Prepare the PNFP hospitals for initiating RBF							
A.6.4	A.6.4 Finance PNFP hospitals through RBF							
A.6.5	A.6.5 Experiment with urban primary care centres outside the hospital environment							

7.3 ToR International Long-Term Personnel

7.3.1 International Technical Assistance Public Health (ITA PH)

Responsibilities and tasks

Technical component

The ITA will be the overall responsible for the technical support related to all the results during the whole period of the project.

The tasks related to this component will include:

- Support the MoH in its efforts to coordinate all activities related to the implementation and evaluation of PPPH (mainly with PNFP)
- Support particularly the conception, implementation and follow-up of the health coverage plan in the perspective of improving functional integration of PNFP within districts
- Support particularly the conception, implementation and follow-up of the financing mechanisms for PNFP (RBF) …
- Support the MoH in capitalising experiences generated at the operational level and translate them in a national policy. This should include the organisation of a scientific support.

Management component

The ITA will be responsible with the national director for the co-management procedures of the project. He will be assisted in administration issues by an International Administrative and Finance Manager (RAFI)

The task related to this component will include:

- Responsible for the co-management procedures in the project
- Actively assist in the planning and budgeting of activities
- Support coordination with all stakeholders
- Ensure shared understanding of concepts and principles related to project strategies
- Contribute to a good collaborating climate within the project team.
- Ensure the redaction of ToR for studies, external consultancies and perform a follow-up of their work
- Ensure the inclusion of transversal themes (gender, environment, etc) in the various activities of the project

Profile

Qualifications

- Degree in Medicine (MD)
- Degree in Public Health (MPH)

- Training in health economics or anther degrees can be considered if long-term proven experiences in the domain of health financing prove equivalence in competence.

Experience

At least 10 years in the field of public health and health service organisation of which at least five years in development countries.

- Experience in institutional support and work at a ministry's level
- Experience in effective management of health care facilities (HSD management)
- Knowledge of / experience with financing mechanisms, including PBF and/or RBF.

Skills

- 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)
- Team spirit and skills to animate and train groups
- Excellent knowledge of English
- Strong capacity to manage usual software (Word, Excel, PowerPoint, Database software…).

Place of work

Kampala, Uganda, with frequent travelling in the two regions of the project.

The ATI will be based at the MoH in the Directorate of Planning and Development at the level of the head of the Directorate.

Duration

Four years

Selection process

Recruitment through BTC Brussels through international tender. The candidate will be selected by BTC and presented to the Ugandan partner for non-objection.

Management of the contract

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

Hierarchical superior

The BTC permanent representative in Kampala.

7.3.2 International Administrative and Financial Responsible (RAFI)

Responsibilities and tasks

The RAFI will be a member of the PCT. He will be responsible for:

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 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 Referral 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.

Profile

- University degree in (applied) economics; or equivalent through experience
- Minimum 5 years' experience in financial management or audit
- 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.

Place of work

Kampala, Uganda, with frequent travelling in the two regions of the project.

The RAFI will be based at the MoH in the Directorate of Planning and Development.

Duration

Four years

Selection process

Recruitment through BTC Brussels through international tender. The candidate will be selected by BTC and presented to the Ugandan partner for non-objection.

Management of the contract

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

Hierarchical superior

The co-manager of the project.

7.4 National Technical Assistant Economist (NTA econ)

Responsibilities and tasks

Two national technical assistants will be recruited to work at regional level (one in West Nile region and one at Ruwenzori region). They will assist the project manager and the ITA in developing particular duties, specifically the design and implementation of the RBF mechanisms in the field.

The 2 NTA – Econ will work hand in hand with the NTA from the ICB project.

The main tasks of the NTA at regional level will be:

- Support DHMT and DHO office in their work related to the RBF implementation
- Ensure that DHMT perform adequately the support and control of PNFP business plans, yearly financial reports, and health services production reports.
- Support DHMT and PNFP in costing exercises

Profile

Qualifications

- Degree in health economics (Master level)
- Preferably degree in public health or equivalent (MPH)

Experience

- At least 7 years in the field of health economics.
- Experience in implementation of PBF or RBF mechanisms.
- Experience in the design, implementation, M&E of business plan in health facilities

Skills

- 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)
- Excellent knowledge of English
- Strong capacity to manage usual software (Word, Excel, PowerPoint, Database software…).

Place of work

One NTA in Ruwenzori region and one NTA in West Nile region

Duration

Four years

Selection process

Recruitment through BTC Representation in Kampala. The candidates will be selected by BTC and presented to the Ugandan partner for non-objection.

Management of the contract

The contract will be managed by BTC, under Ugandan law.

Hierarchical superior

The co-manager of the project.

7.4.1 National Technical Assistant at MoH level (NTA central)

Responsibilities and functions-tasks

The national technical assistant working at MoH level will assist the project manager and the ITA in developing particular duties, specifically, strengthening the M&E system for the PNFP and supporting PPP in policy dissemination, and implementation.

The main tasks of the NTA at MoH level will be:

- Developing mechanisms to strengthen the circulation of information from PNFP to MoH
- Supporting the appropriate analysis and use of the information from the PNFP to feed the various instances of partnership between MoH and PNFP
- Take responsibilities in the process of policies dissemination and implementation
- Contribute to the design and development of the RBF, for the M&E aspects
- Ensure the redaction of ToR for studies related to M&E, policy dissemination and implementation, external consultancies and perform a follow-up of their work
- Ensure the inclusion of transversal themes (gender, environment, etc.) in the various activities of the project.

Profile

Qualifications

- Degree in Public Health (MPH)
- Training in health statistics and knowledge in policy dissemination process.

Experience

- At least 10 years in the field of public health, health service organisation (and policy dialogue)
- Experience national health system management
- Experience of working at central level (MoH)

Skills

- 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)
- Excellent knowledge of English

- Strong capacity to manage usual software (Word, Excel, PowerPoint, Database software…).

Place of work

Kampala, Uganda, with frequent travel to the two regions of the project.

The NTA will be based in the MoH Directorate of Planning and Development.

Duration

Four years

Selection process

Recruitment through BTC Representation in Kampala. The candidates will be selected by BTC and presented to the Ugandan partner for non-objection.

Management of the contract

The contract will be managed by BTC, under Ugandan law.

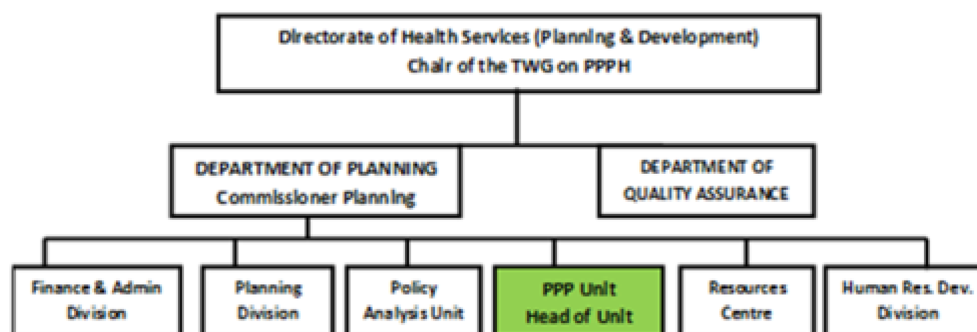
Hierarchical superior

The co-manager of the project.

7.5 The PPP Unit

7.5.1 Organigram Directorate of Planning and Development in MoH

Figure 8: Directorate of Planning and Development MoH



7.5.2 Terms of Reference for the Head of the PPP Unit:

Overall leadership of the PPP Unit in the Department of Policy and Planning

- Monitoring the implementation of National Policy on PPPH
- Secretariat to PPPH Technical Working Group
- Professional guidance and advice to PPPH TWG on Government systems and procedures
- Coordinate collaboration and linkages between public sector and PNFP, PHP and TCMP
- Guidance and Interpretation to Private Sector stakeholders in Health on implications of Public Policies on their work
- Preparation and Coordination of PPPH TWG meetings
- Coordinate generation of Private Sector performance reports for incorporation into the Health Sector Performance Reports
- Resource mobilization for Partnership activities
- Provide Guidance in situations of Conflict to PPPH stakeholders
- Guidance on reform of partnership structures to suit health market trends
- Advocacy for growth of the Partnership
- Co-opt member of private sector coordination structures (when deemed essential)
- Maintain an accurate Data Base on Private Sector Facilities and Stakeholders (inventory, performance data, human resources, finances etc.)
- Coordinate operational researches in PPPH
- Works with the Resource Centre, and the Monitoring and Evaluation TWG to modify the HMIS tools to be able to demonstrate contribution of the private sector to the HSSIP outputs

- Participate to support supervision
- Act as a coordinator for all partnership staff (District Desk Officers, Partnership Unit Assistants)

7.6 SWOT Analysis of PPPH

<table>
<tr><th>PNFP</th><th>Government</th></tr>
<tr><td>Strengths</td><td>Strengths</td></tr>
<tr><td>

- Cover 30% of all health facilities
- Have a tradition of providing health care (at least the Catholics and protestants)
- MB have technical skills (Catholics)
- HRH: in 2010 11,000 in PNFP versus 26,000 in Gov
- Existing accreditation system
- Good capacity for resource mobilisation
- Have their own medicines and medical supplies supply system

</td><td>

- Strong policy framework with a declared will to strengthen PPPH
- Strong health information system
- History of financing PNFP

</td></tr>
<tr><td>Weaknesses</td><td>Weaknesses</td></tr>
<tr><td>

- Traditional strong role of PNFP threatened by:
  - Better working conditions in the public sector (HRH)
  - Free health care policy in public services
  - Stagnation of government funding in context of SWAp (pooling of funds) and temptation to go for « vertical » funding
- New PNFP actors:
  - Old (UCMB and UPMB) and new medical bureaus → need to look at new equilibrium between bureaus? And how complementary is the coverage between them?
  - Some health units are pretending to be affiliated to a MB but are not accreditated by them
- MB do not have authority on the diocesan health department and facilities
- PNFP are afraid of too much influence by the government and of losing autonomy. Mistrust is a barrier for good partnership

</td><td>

- Difficulty in using various leverages:
  - financial leverage - Apparently weak system to channel funds from government to PNFP → new financing strategy shortcutting the districts
  - Information system leverage – strong DHIS2 but difficulty to access information (strong restrictions to access)
  - Structures for negociation and dialogue between public and private – at central level TWG OK but new unit not yet functional – at peripheral level new districts subdivision disconnect the gov peripheral management structures from PNFP management structures
  - Legislation and policies leverage - but new framework only known at central level and operationalisation unclear
- Political factors threatens:
  - Fear of privatisation (due to feeling of competition between public and PNFP) and therefore resistance to finance
  - Local political influence to multiply the health units even when closeby a PNFP unit exists

</td></tr>
<tr><td colspan="2">Some of the threats for future partnership</td></tr>
<tr><td colspan="2">

- Free health care policy in Gov Units
- HRH drain from PNFP to Gov Facilities
- …

</td></tr>
</table>

7.7 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 :

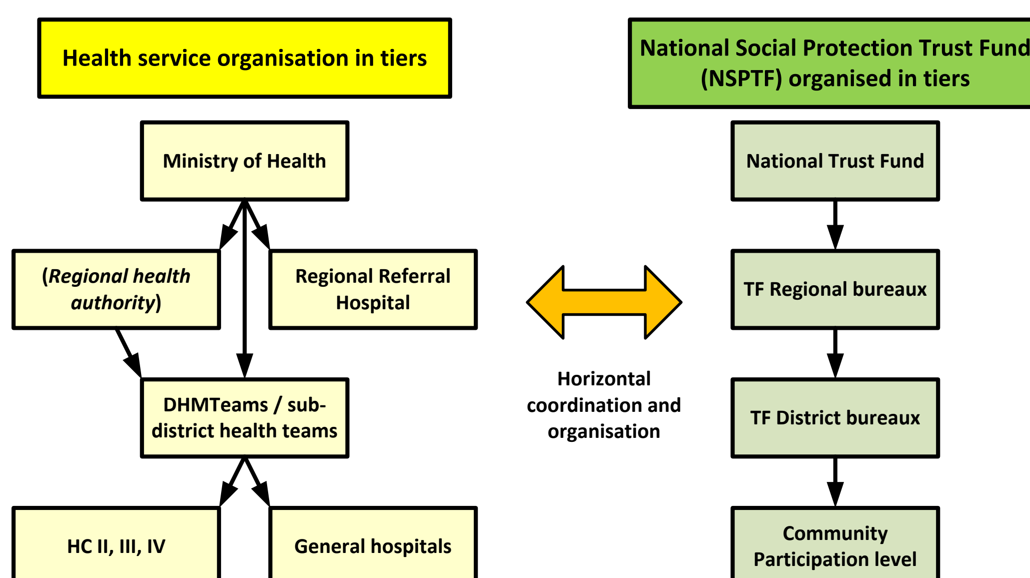
- RBF does not bring the necessary changes in the system when taken in isolation and if other regulating mechanisms for dealing with quality service organization are not developed in parallel.
- Important negative side-effects are inherent to RBF. They actually become predictable as the knowledge on 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 described already in the TFF chapter 2, section 2.3, 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 8 underneath represents a possible operational organisation of a NSPTF.

Figure 9: 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

7.7.1 Mitigating elements in the design of the RBF initiative in Uganda

The structure of the performance measure are:

Level of performance	Type of activity							
Global service indicator performance	Curative consultation	ANC	Under 5 clinic	Vaccination	Family planning	HIV preventive care	Administration e.g. HIS, pharmacy stock keeping, business plans, etc.	Other activities e.g. outreaches, etc.
Basic	0-40 % of points							
Normal	40 to 60% of points							
Good	60 to 80 % of points							
Excellent	> 80 % of points							
Quantitative Performance indicators	A = …. B = …… C = …..						NA	
Total score								
Payment								

In the setting as presented above, the financing is all inclusive (all elements of package of services are included). Every element of the minimal package of care gets a score determined by general performance estimation, completed by a quantitative performance factor (combination of indicators if needed). The combination of the two gives a total score that will correspond with an amount to be paid.

Salary topping-ups are to be allocated after the recurrent costs of the covered period are covered (deduced) and according a repartition key to be convened still. Topping-ups should never pass a certain percentage of the basic salary and payments of such bonuses should not prevent the facilities of having resources for investments.

At hospital level the same principles should be applied but the situation is evidently far more complex to apply. Lowering fee-paying for patients in general or for vulnerable groups in particular is an essential element in the financing strategy. Revenue will lower by diminishing user fees but this will be partly compensated by an increased number of users.

7.7.2 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.

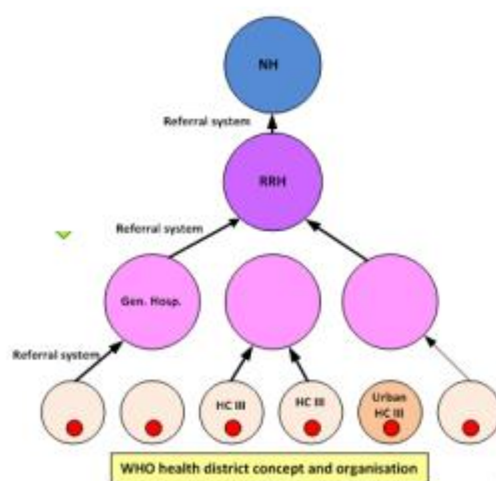
7.8 Health Coverage Plans: Content, Use and Importance

7.8.1 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.

7.8.2 General Considerations

Figure 10: The WHO Health District concept of complementary tiers



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[14] for hospitalizing patients at the

[14] Service delay : delay in appropriate treatment for the patient due to factors caused by 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.

7.8.3 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 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.

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health service. This is contrary to patient delay, when it is the patient (or his family) who causes the delay.

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

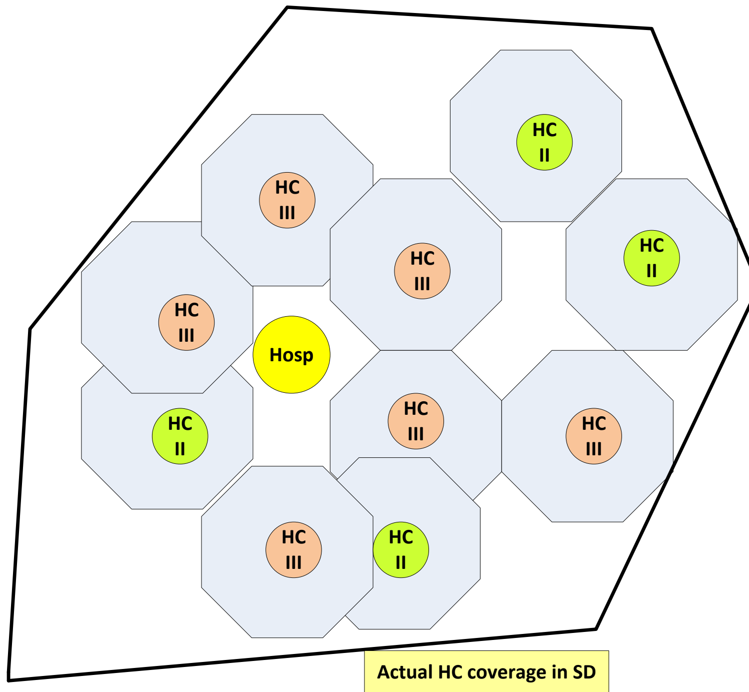
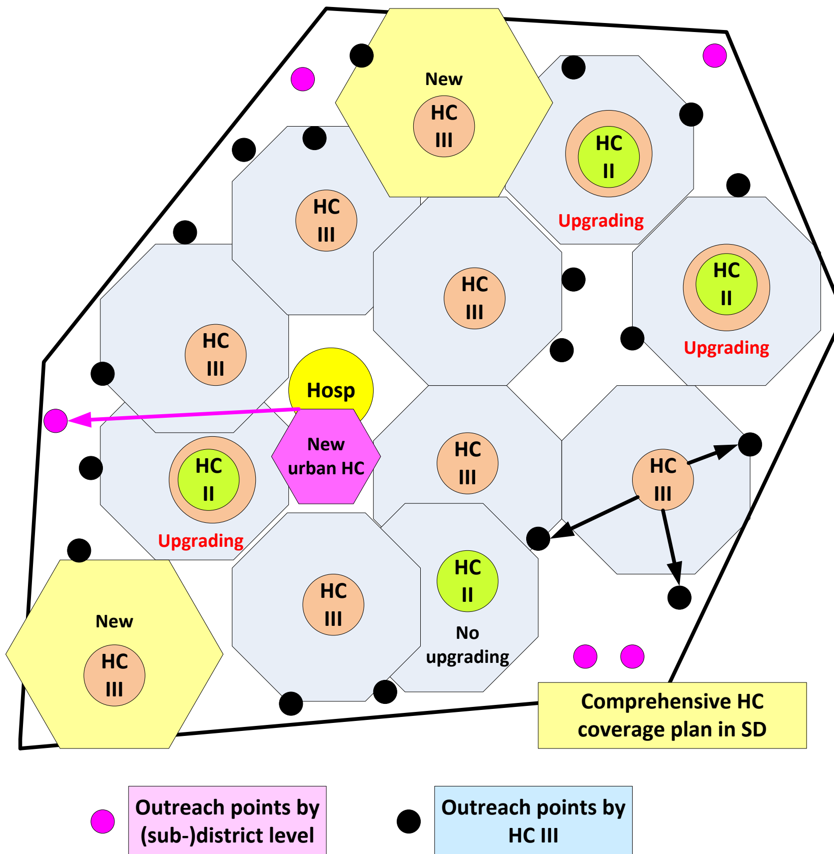


Figure 12: Completed HC coverage plan for a given sub-district



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.

7.8.4 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.

7.8.5 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.

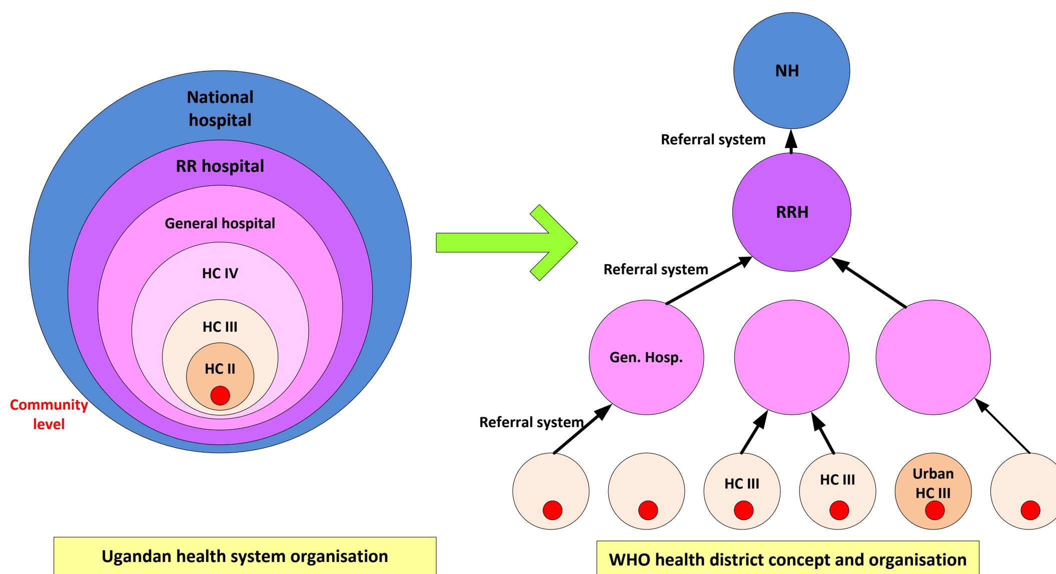
7.8.6 WHO versus Uganda

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.

7.9 Overview Health Service Providers in Uganda

The formal health sector in Uganda consists of both public and private sector service providers. The public sub sector consists of government-owned and operated health facilities. The private sub sector consists of three broad categories of service providers which are: i) the Private not for Profit (PNFP), ii) the Private for profit (PFP), and iii) the Traditional and Complementary Medicine service providers (TCMP). The PNFP are divided into two groups: the facility-based PNFP (FB-PNFP) which offer comprehensive preventive and curative care; and the non-facility-based PNFP (NFB-PNFP), which do not offer comprehensive services but rather offer selective curative, preventive, rehabilitative or palliative care.

Through the recently approved PPPH policy the government of Uganda acknowledges the important role played by the private sector in health service delivery. Overall it is estimated that 50% of the health outputs in the country are attributable to the private sector. Of all the private sector providers the facility based PNFP are currently the most organized and aligned with GoU priorities including provision of services to rural populations.

7.9.1 PNFP Subsector in Health

The PNFP health sector in Uganda is a group of large networks of service delivery points spread all across the country. The PNFP health sector is constituted by autonomous institutions that range from hospitals to the different tiers of lower level units: HC-II, HC-III and HC-IV. The existence of the faith-based PNFP health services in Uganda dates back to the colonial period when missionary groups set up hospitals towards the end of the 19th century. The GOU recognizes the important role the PNFP facilities have played; by their presence in underserved areas they made the health sector resilient to shocks during the periods of civil strife. For example, soon after independence the Uganda public health care system was considered one of the best in Sub Saharan Africa; however, with the political turmoil of the 1970s and early 1980s and later in the North because of the LRA insurgency, in particular the public health system collapsed and this left a gap that was filled mainly by the private not-for-profit sector. In addition the PNFP are currently the back-bone for resilience in health care in conflict-affected zones especially in the North, North-east and East. The PNFP sector has a significant presence in rural areas.

7.9.1.1 Facility based PNFP (FB-PNFP)

The PPPH policy distinguishes between Facility and non-Facility based PNFP. The facility based PNFP provide services from static health facilities and the non-facility based PNFP provide community based services and technical assistance. The National PPPH Policy states that PNFP health facilities have the following general characteristics:

- Are private organizations operating under the guidance of a written charter /constitution.
- Do not distribute surplus to their owners or directors.
- Are self-governing entities.
- Have substantial capital/infrastructural investment in static health units ("facility")
- Have paid staff
- Have some meaningful voluntary component such as voluntary labour, management and income or provisions for subsidy of fees.

The FB-PNFP facilities provide the same range of services as the public sector by applying the Uganda National Minimum Health Care Package (UNMHCP). At District level, the PNFP subsector is involved in all preventive programs both in its static facilities and by way of outreach services. A number of the faith-based PNFP facilities also function as heads of health sub – districts (HSDs) providing leadership, technical supervision and support to all service aspects of the lower level facilities in the HSD irrespective of the ownership of these facilities.

The FB-PNFP also has considerable resources in the form of the infrastructure and equipment of health facilities and all the staff resources that are leveraged to address many of the public health goals outlined in HSSIP 2010/11-2014/15. Currently 43% percent of the hospitals and 22% of the lower-level facilities in Uganda belong to facility based-PNFP.

Table 4: Overview of health facilities by level and ownership

Year 2010	Ownership			
Level	GOU	PNFP	PRIVATE	TOTAL
Hospitals	64	56	9	129
Health centre IV	164	12	1	177
Health centre III	832	226	24	1082
Health centre II	1562	480	964	3066
Total	2622	774	998	4394
Health Training Institutions	8	19	=	27

Source: Uganda health sector strategic & investment plan 2010-2015

The facility based PNFP are further categorized into two main groups; those that are faith based and the non-faith based FB-PNFP.

The faith based, facility based PNFP

More than three-quarters of the facility based-PNFP belong to the faith-based umbrella organizations of Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau, Uganda Muslim Medical Bureau, and Uganda Orthodox Medical Bureau.

The legal ownership and existence is by and large linked to the Trustees of the respective denominations at local level (dioceses for Christian denominations or districts for other denominations). Governance is secured by Boards appointed by the legal owner which secure participation of various stakeholders including public administrators and local communities. The day to day running is entrusted to the staff in charge together with appointed management committees that are mostly composed by employees with a variable degree of participation of the population in lower level units.

The faith based FB-PNFP account for 40% of hospitals and 17% of lower level units in Uganda. 43% of the hospital beds in the country are located in their health facilities and 40% of clients on ART are served through this sub sector. 65% of the schools available for nursing, midwifery & laboratory professionals training belong under the faith based FB-PNFP with their hospitals serving an important role as practicum sites for the health training institutions. In 2010, it is estimated that the faith based FB-PNFP contributed to 29% immunizations, 35% institutional deliveries and 19% OPD attendances. 19 UCMB and 13 UPMB hospitals manage health sub districts on behalf of the Local Governments.

Since 1979 UPMB has in collaboration with the Uganda Catholic Medical Bureau ensured the supply of quality and affordable medicines and medical supplies to the population through the founding of the Joint Medical Store (JMS). The JMS today is the leading non-government medical store in the country. It is a professionally managed entity that has provided an important mechanism of support for procurement of medicines and medical supplies not only to the PNFP

but also to the public and private sector, thus a significant fall-back or alternative supply of medicines and other health supplies to the country.

7.9.1.2 The Non Faith based PNFP (NFB PNFP)

The non-faith based PNFP sector comprises two groups:

- Facility based PNFP

These currently comprise 25% of the facility based PNFP. They are owned by humanitarian and community based organizations. Their organizational and legal set-up of is very variable. Information regarding this sub category is scanty and a key concern is the lack of a single coordinating entity to which they belong.

- Non facility based PNFP

This sub sector does not directly own or operate health facilities but it supports/undertakes health development activities in partnership with government and includes international, national and local NGOs/CBOs. Non facility based PNFP have varying degrees of capacity, with the international NGOs and big national NGOs better equipped with skilled staff, financial resources, communication facilities, transport and other physical and material resources. CBOs and many district-based NGOs lack many aspects of capacity such as staffing, financial and communication resources. The annual health sector report for 2011/2012 noted the difficulty of reporting on the outputs of this sub sector which is yet to be integrated into the National HMIS. A 2008 report by the Action Group for Health, Human rights and HIV/AIDS (AGHA) Uganda revealed that the non-facility based PNFP in Uganda is extremely broad and diverse, creating difficulties in building consensus with very weak mechanisms for consultation and feedback.

7.9.2 The Public Private Partnership in Health in Uganda

7.9.2.1 Subsidies by and through the GoU: PHC-CG and credit lines

Since 1997/98 government of Uganda has been giving budget support to the PNFP facilities. Strategic reasons guided government and the PNFP into this renewed partnership in 1997/8. The colonial government had created mechanisms for partnership with the PNFP but these broke down during the prolonged period of civil strife in Uganda. In 1997, the shared vision was that of improved health outcomes for Ugandans regardless of socio economic status. By their sheer presence in particular in the rural areas, the PNFP facilities partly solved for GoU the problems of scaling up/coverage, geographical accessibility, responsibility for management and infrastructure development. Extending assistance in form of financial subsidies, medicines and medical supplies and personnel gave government potential leverage for demanding specific results and outputs including decreased user fees to increase economic accessibility for the poor and more harmonized contributions to sectoral goals. For the PNFP, which up to this point in time had struggled with the challenge of filling the gap created by the collapse of public systems, the assistance was greatly appreciated. Such assistance gave hope to the likelihood of sustainability at a time when external donations were beginning to show a definite downward trend. A lot of optimism therefore defined the spirit in which the PNFP entered into the partnership with the commitment from government to increase assistance in tandem with increased outputs and decreased user fees.

Over the years since 1997/98 the form of support from GOU to the PNFP has taken on several forms. In addition to the subsidies for recurrent expenditure through PHC Conditional grants, the PNFP health facilities have been supported with essential medicines and laboratory supplies provided through credit lines managed by the Joint Medical Store.

Trend analysis from 1997/1998 indicates that total budget support from GOU to the PNFP stagnated over the last six years at about 17billion UGX. PHC grants funded 15% of combined PNFP expenditure in 2009/10, compared to 19% and 36% in 2008/09 and 2002/03 respectively. More importantly the average nominal PHC Conditional Grant allocation per health facility showed a downward trend due to increasing number of health facilities getting onto the list of "FB-PNFP", this applies for based the faith based and the non-faith based FB-PNFP. The increasing number of beneficiary units at constant overall allocation translates into a net drop of government contribution to the PNFP facilities.

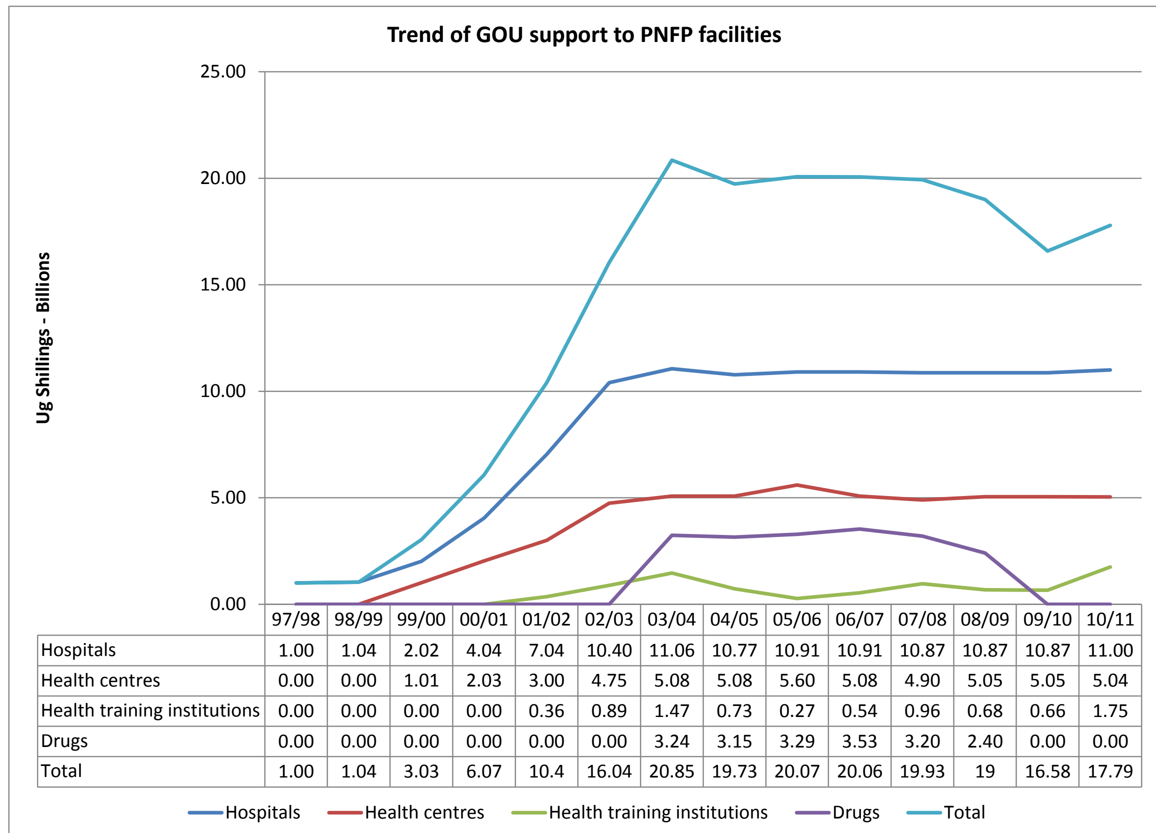
Essential medicines funding in Uganda has been heavily donor dependent. For example DANIDA's Health Sector Programme Support III (2005-2010) supported Vote 116 for essential medicines and medical supplies to the tune of 26 Million USD. This translated into an annual contribution of 6.7billion UGX for medicines, of which 3 billion UGX funded medicine credit lines for the PNFP sector. In June 2010, DANIDA officially withdrew from the health sector in Uganda leaving behind a huge gap in funding of essential medicines which threatened delivery of the minimum health care package by the PNFP. Although DANIDA contributed 3bn UGX as stop gap funding directly to the PNFP for the financial year 2010/2011 after its withdrawal, this support again hang in balance at the end of 2011. In 2012, USAID came in with a contribution directly to the PNFP to cover the equivalent of the PNFP needs for essential medicines for one year.

7.9.2.2 The MoH-HDP Bursary fund

The MOH-HDP bursary fund deserves mention as it provides a good illustration of how the PNFP could be strategically financed by GOU and HDP. In 2009, a program to support the training and bonding of nurses/midwives and laboratory assistants between the PNFP health training institutions (HTI), the Ministry of Health and some health development partners was initiated. This program: the MoH Health Development Partners bursary fund initiative aimed to improve staffing levels in government and PNFP health facilities located in hard to reach areas through strategic bonding of students in nursing/midwifery and laboratory training schools. The program aims to produce 950 bonded graduates in three years through the PNFP health training institutions for deployment to "hard to reach" districts. The health development partners mobilized UGX3.2bn for the three year period and a tripartite agreement was signed between MoH, the HDP (initially DANIDA then joined by the Italian Cooperation and Baylor Uganda in 2010) and the three medical bureaus with HTIs: UCMB, UPMB & UMMB. Implementation guidelines were developed to operationalise the MoU. The guidelines detailed regulations for the utilization of funds allocated to each health training institution and the relevant performance framework. The Ministry of Health was the budget holder, receiving funds from the health development partners and disbursing funds on a biannual basis to individual HTI accounts upon receipt and approval of reports and requisitions that had been screened and endorsed by UCMB and UPMB. In addition MoH was responsible for oversight, guideline setting and monitoring. Two committees were set up within the MoH for this purpose: a steering committee and implementation committee each drawing membership from the MoH, HDP and the MB. The medical bureaus played a significant role in the realization of this initiative. Firstly, they were key players in ensuring the readiness of the health training institutions to receive the funding and implement the bursaries in line with stakeholder expectations. The preparatory phase triggered the harmonization of management and governance tools in the PNFP HTI for example producing harmonized i) HTI rules and regulations ii) student selection policies iii) HTI accreditation policy iv) HTI support supervision guidelines and checklists. Although the bursary fund has not been evaluated, some of the challenges noted were the delays in disbursements of funds by the MoH and the failure of the MoH to ensure that the PHC conditional grants to the HTI flowed consistently as these were to be integrated into the

bursary fund as GOU contribution over a phased period. The fact that the funding channels were different with the PHC conditional grants flowing through the districts to the HTI may have contributed to this drawback.

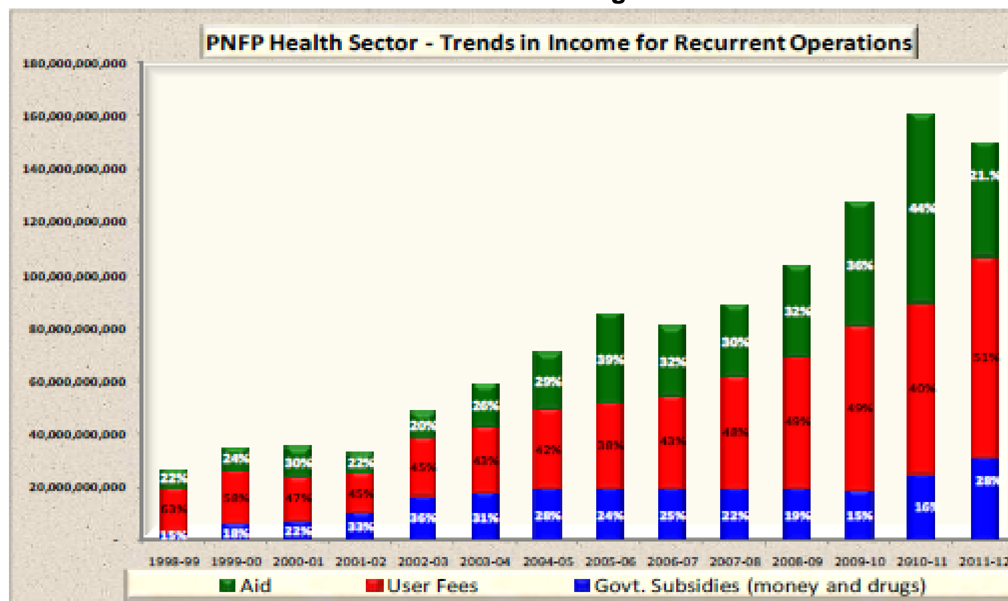
Figure 14: Trend FY 1997/98 – 2010/11of support by and through GOU to PNFP health facilities.



	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
Hospitals	1.00	1.04	2.02	4.04	7.04	10.40	11.06	10.77	10.91	10.91	10.87	10.87	10.87	11.00
Health centres	0.00	0.00	1.01	2.03	3.00	4.75	5.08	5.08	5.60	5.08	4.90	5.05	5.05	5.04
Health training institutions	0.00	0.00	0.00	0.00	0.36	0.89	1.47	0.73	0.27	0.54	0.96	0.68	0.66	1.75
Drugs	0.00	0.00	0.00	0.00	0.00	0.00	3.24	3.15	3.29	3.53	3.20	2.40	0.00	0.00
Total	1.00	1.04	3.03	6.07	10.4	16.04	20.85	19.73	20.07	20.06	19.93	19	16.58	17.79

Source: Medical Bureau databases

Figure 15: Trends FY 1998/99-2011/12 in income categories faith based FB PNFP



Source: Bureau databases

Figure 16:Trends FY 1998/99-2011/12 in income categories faith based FB Hospitals

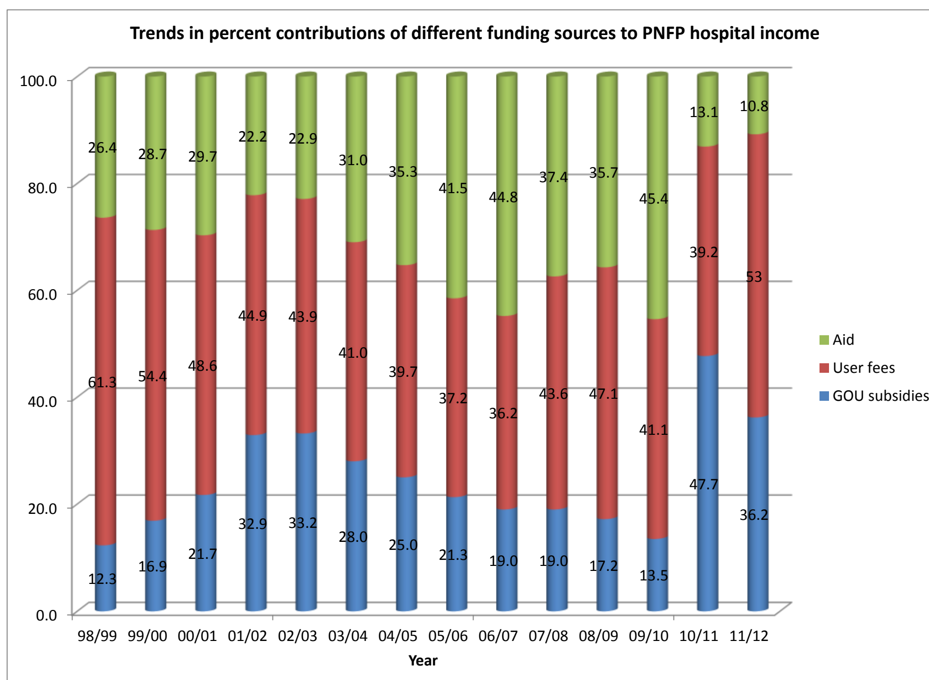
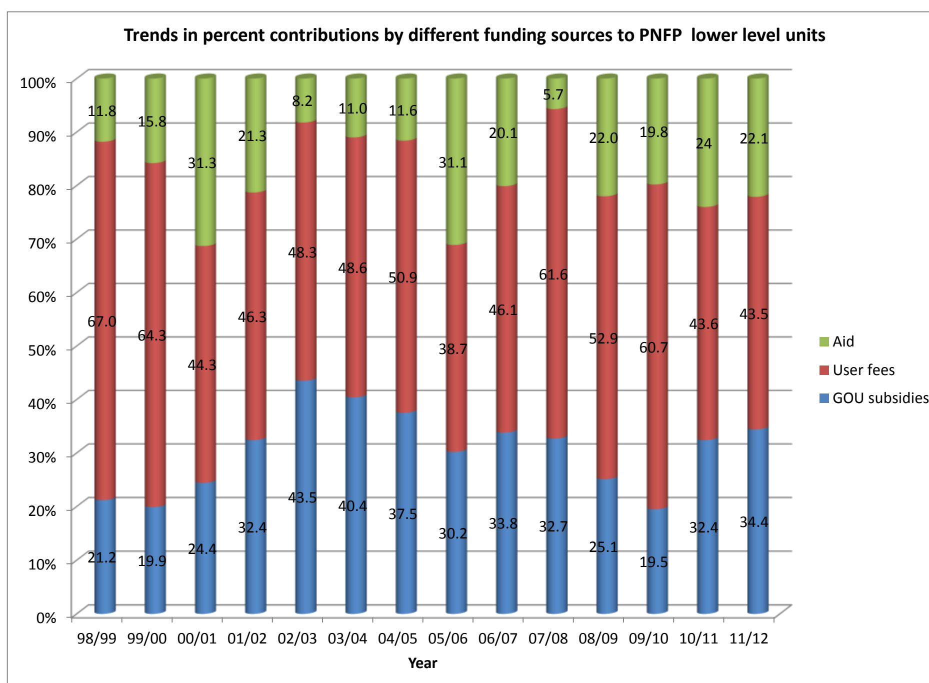


Figure 17: Trends FY 1998/99-2011/12 in income categories faith based FB PNFP for Lower level units



More recently the public private partnership for health in Uganda has made significant progress towards formalization. In March 2012 the PPPH policy was approved by the cabinet; this policy was officially launched by the MoH in October 2012. The current rationale for the policy is defined as follows:

- Joint ownership of national policies and plans through SWAP and IHPs
- Shared mission and objectives
- Improving equitable access to services
- Functional integration to optimize available resources
- Resource mobilization
- Human resource development
- Accreditation to support GOU regulatory function

7.9.2.3 Space for the PNFP in policy and planning processes

The MoH in Uganda has developed, under the sector wide approach, specific organizational structures designed to facilitate and foster communication and cooperation with the Private not for Profit service providers in the health sector. At central level the medical bureaus and representatives of the NFP PNFP participate in the SWAp mechanisms through the Health Policy Advisory Committee (HPAC) and its working committees; the joint annual planning and Joint Reviews.

All PNFP are expected to send institutional representatives who have the mandates of their constituency to these forums. Whereas representation works for the FB PNFP under the four Medical Bureaux, this is less obvious for the other 25% of the FB PNFP and for the Non FB PNFP; there it seems that it is more about individuals than representatives.

In spite of some positive trends noted on the partnership between the government and PNFP, there is a huge gap between the strong political discourse supportive of the role of PNFP and the operational bureaucracy dealt by the Ministry of Health.

When it comes to decision-making, there is an acknowledgement of the dominance of a few government actors in the process of decision-making on issues that directly or indirectly have an impact on the operations of the PNFP for example salary enhancements for government health workers and policies on essential medicines.

While there is a widespread expectation that the recently approved PPPH policy further legitimizes the participation of the PNFP in policy making and in sector planning processes (this is of significance particularly at the district/Local Government level where such participation has hitherto been limited), consultations of the Consultants with key informants revealed that:

There is still a lack of mutual trust between GOU and PNFP with negative effects on the development of suitable partnership methods and tools (such as tools for financial reporting).

In spite of the available opportunities allowed by GOU for the participation of the PNFP, sector, there is little to show for this in the broader strategic and development frameworks of the government or in the language of national plans and policies.

Developing and adhering to rules of accountability applicable to all stakeholders involved in the health system – government, FB-PNFP, NFB-PNFP, HDPs - is important.

7.9.2.4 Self-regulation and the evolving role of PNFP coordinating entities in the health system

In the 1960s, the medical bureaus played the role of administering and disbursing public subsidies to the affiliated units. When public subsidies to PNFP facilities were re-introduced in 1997/98, the medical bureaus made a strategic decision to allow the public subsidies to be

administered using the decentralized structures of government. This was considered an important step towards ensuring better integration of the PNFP facilities into the national health system.

The PNFP facilities under the medical bureaus now operate at a fairly advanced level of compliance with both Central and Local Government regulations. They report fully through the national HMIS, participate in Local Government structures for coordination such as the DHMTs where these are functional and generally submit their books of accounts to scrutiny by government auditors. They also as has been noted before provide their services as outlined in the UNMHCP.

Currently the MB play three major roles: technical, advisory and regulatory through provision of services to their affiliated health facilities in exchange for compliance with set standards, guidelines and priorities agreed upon with the health facility managers and boards. These pertain to compliance with statutory licensing by the UMDPC, provision of quarterly and/or annual reports to the medical bureaus, compliance with quality of service (or training for HTIs) guidelines which are often over and above those set by the government and meeting minimum management and governance criteria such as ensuring functionality of health unit management committees. On technical issues the medical bureaus ensure that their affiliated facilities deliver services guided by policies set by the Ministry of health through technical workshops, training and dissemination of the policies. The four medical bureaus are at different stages in terms of how effectively they deliver on these mandated roles.

However it is evident that for all four medical bureaus there exists a form of self-regulation that significantly enhances the limited regulation of the government over the private sector in health. The lack of similar self-regulation among the non-faith based FB-PNFP and the non-facility based PNFP featured prominently and was raised as a key concern by different stakeholders during the identification process.

Table 5: Overview registration and accreditation by the four Medical Bureaux

	Registration		Voluntary accreditation		
Bureau	Mandatory registration	Certificates of registration issued	Members meet specific standards based on quality improvement	Provides local recognition to members	Certificate of accreditation issued[15]
UCMB					
UPMB					
UMMB					
UOMB					

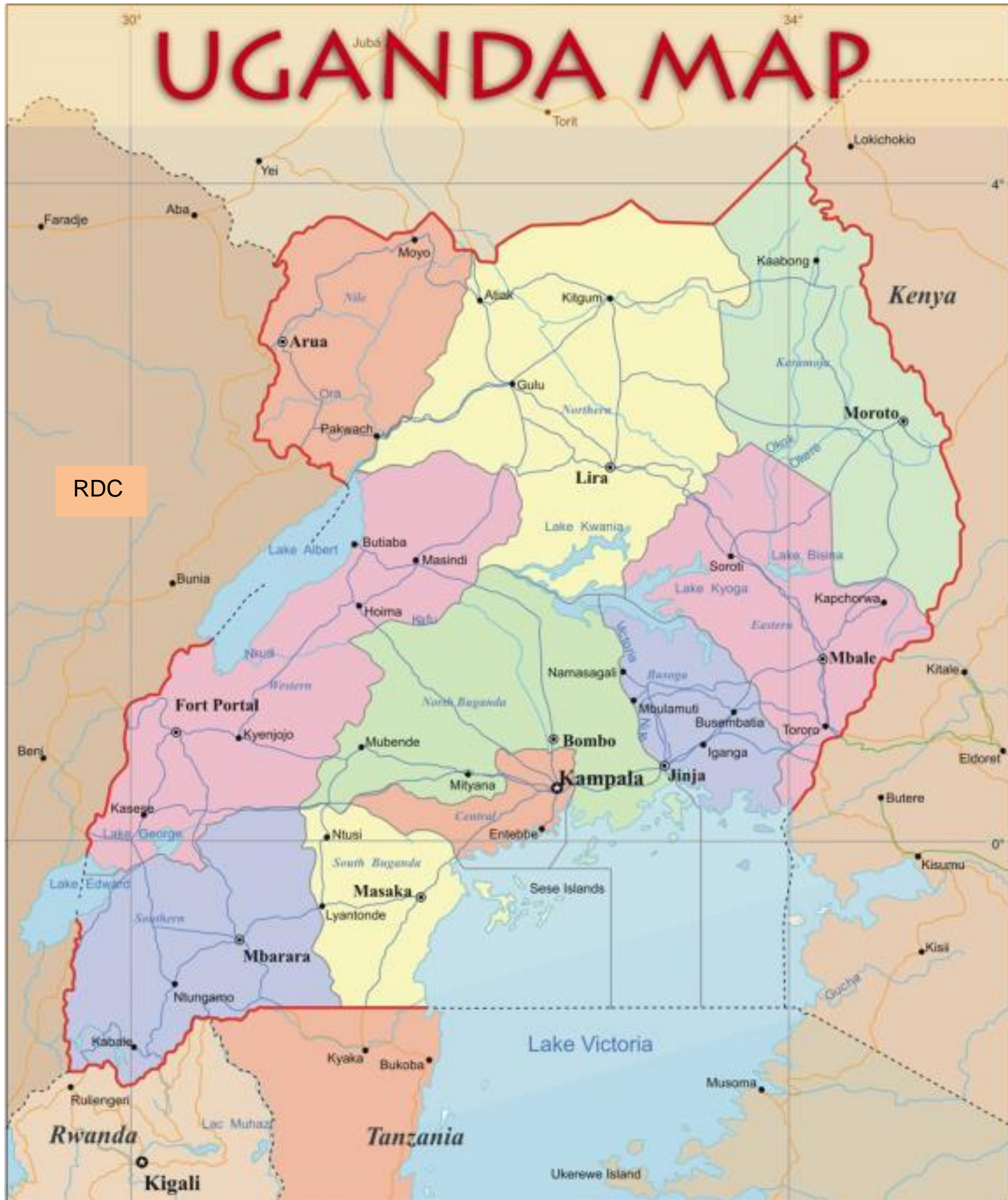
7.9.2.5 Resource mobilization role of the PNFP

The evidence shows that the PNFP are financed largely by resources mobilized by them through user fees and donations. In 2011/2012, 72% of the income needed for recurrent costs was mobilized by the faith based health facilities and the medical bureaus themselves. This would be even more considering that the 28% GOU contribution for that year includes the monetized cost of essential medicines which were funded by DANIDA through stop gap funding following negotiations spearheaded by the medical bureaus. An emerging phenomenon became apparent during our consultations with key informants; pushed to the brink by a drawn out human resources crisis and the challenges posed by increasing costs of providing health care to an

[15] UPMB issues accreditation certificates to health training institutions only, UCMB issues accreditation certificates to HTIs, hospitals and lower level units.

expanding population, the medical bureaus have taken on the role of mobilizing development partner funding on behalf of GOU. For example, the follow-on funding for essential medicines after the exhaustion of DANIDA stop gap funds was brokered by the medical bureaus/JMS and culminated into an MOU between USAID and JMS.

7.10 Map of Uganda



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