FINAL REPORT

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

Table of Contents

TABLE OF CONTENTS 2
ACRONYMS 3
INTERVENTION FORM 5
GLOBAL APPRECIATION 6
PART 1: RESULTS ACHIEVED AND LESSONS LEARNED 7
1 ASSESSING THE INTERVENTION STRATEGY 7
1.1 CONTEXT 7
1.2 IMPORTANT CHANGES IN INTERVENTION STRATEGY 9
2 RESULTS ACHIEVED 11
2.1 MONITORING MATRIX 11
2.2 ANALYSIS OF RESULTS 12
3 LEARNING 19
3.1 LESSONS LEARNED 19
3.2 RECOMMENDATIONS 19
PART 2: SYNTHESIS OF (OPERATIONAL) MONITORING 21
1 FOLLOW-UP OF DECISIONS BY THE JLCB 21
2 EXPENSES 25
3 DISBURSEMENT RATE OF THE INTERVENTION 26
4 PERSONNEL OF THE INTERVENTION 27
5 PUBLIC PROCUREMENT 29
6 PUBLIC AGREEMENTS 31
7 EQUIPMENT 37
8 ORIGINAL LOGICAL FRAMEWORK FROM TFF : 41
9 COMPLETE MONITORING MATRIX 44
10 TOOLS AND PRODUCTS 45
ANNEX 1: EXECUTION AGREEMENT TEMPLATE 48

Acronyms

AHSPR	Annual Health Sector Performance Report
BTC	Belgian Technical Cooperation – Belgian Development Agency
CPD	Continuous Professional Development
DHO	District Health Officer / Office
DHS(P&D)	Director Health Services (Planning & Development)
DLG	District Local Government
DLT	District League Table
DMT	District Management Team
EA	Execution Agreement
ETR	End-of-Term-Review
GH	General Hospital
G&HHR	Gender & Health Human Rights
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GH	General Hospital
GLM	Governance, Leadership and Management
HC IV	Health Centre level IV
HDP	Health Development Partner
HMDC	Health Manpower Development Centre
HPAC	Health Policy Advisory Committee
HPD	Health Planning Department
HSD	Health Sub-District
HSDP	Health Sector Development Plan (2015/16 – 2019/20)
HSS	Health Systems Strengthening
HSSIP	Health Sector Strategic & Investment Plan (2010/11 – 2014/15)
HW	Health Worker(s)
ICB	Institutional Capacity Building
JLCB	Joint Local Consultative Body (Steering Committee)
JRM	Joint Review Mission / Meeting
M&E	Monitoring & Evaluation
MOH	Ministry of Health
MOFPED	Ministry of Finance, Planning and Economic Development
MOLG	Ministry of Local Government
NDP	National Development Plan
NRH	National Referral Hospital
PC	Project Coordinator
PDU	Procurement and Disposal Unit
PLM	Planning, Leadership & Management
PNFP	Private – Not – For - Profit
PS	Permanent Secretary
QAD	Quality Assurance Department
RC	Resource Centre
RHF	Regional Health Forum

R-PIC	Regional Project Implementation Committee
RRH	Regional Referral Hospital
SBS	Sector Budget Support
SC	Steering Committee
SIP	Strategic & Investment Plan
SIDA	Swedish International Development Agency
SMC	Senior Management Committee
TFF	Technical and Financial File
TSMC	Top Senior Management Committee (MOH)
TWG	Technical Working Groups (MOH)
UHSSP	Uganda Health Systems Strengthening Programme
UNMHCP	Ugandan National Minimum Health Care Package
WB	World Bank
WHO	World Health Organization

Intervention form

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

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

Global appreciation

Describe your global appreciation of the intervention (max 200 words):	**Describe** your global appreciation of the intervention (max 200 words):
	Implementation fully embedded in partner organization. Ownership of project interventions in regions at level of district local government (health departments). Experiences are shared with stakeholders and dissemination of lessons learned for influencing policy is taking place.
Score your global appreciation of the intervention[2]:	**Score** your global appreciation of the intervention[3]:
Very satisfactory	Very satisfactory
National execution official[4]	BTC execution official[5]
Dr Asuman LUKWAGO Permanent Secretary/MoH	Mr. Nebeyu SHONE Resident Representative/BTC

[2] Very satisfactory - Satisfactory - Non satisfactory, in spite of some positive elements - Non satisfactory

[3] Very satisfactory - Satisfactory - Non satisfactory, in spite of some positive elements - Non satisfactory

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

PART 1: Results achieved and lessons learned

1 Assessing the intervention strategy

1.1 Context

General context:
The ICB project started off in June 2010 with an existing leadership vacuum at the Ministry of Health. A new Permanent Secretary / Project Director was appointed in October 2010, while a new Minsister of Heath and Director General were only appointed in June 2011.
In 2013 and 2014, the president of Uganda changed the political leadership at the Ministry of Health, which resulteed in a period of leadership vacuum at the ministry HQ with negative effects on sector coordination.

The Belgian support to the health sector in Uganda faced a 3-year long interruption of the disbursement of Sector Budget Support for variuos reasons. It was only resumed during the second half of 2013. SBS funds were only disbursed once in 2013, without further disbursements in 2014. A new disbursement was made in July 2015.
The ICB project was formulated as an intervention complementary to the Sector Budget Support. As the only (Belgian supported) intervention in the sector for a specific period, the ICB project was made to operate outside its original mandate at times, with increasing workload for the project staff.

Presidential and parliamentary elections will take place in 2016. The campaigning process is affecting sector operations in 2015, both at national and at district level.

Institutional context:
The leadership vacuum in 2010 (start of project), hampered the project start-off and implementation. An initial review took place in April 2011, which resulted in change of project coordinator and establishment of regional project committees.

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

The co-management modality at Ministry of Health proved difficult in the areas of procurement and financial management.
Public procurements through the Procurement & Disposal Unit (PDU) at MOH experienced long delays, inefficiencies and failures. In order to accellerate project implementation, the Permanent Secretary approved use of the Belgian public procurement system in 2012 for project procurements.

The Bank of Uganda introduced eBanking for all its accounts under the Ministry of Health in 2014. Although this can be an efficient system once established, the introduction period created delays and errors in project transactions. With approval of PS MOH, the project was given authority to upload transactions directly, which reduced the earlier delays. Technical challenges, as well as availability of PS for approval are still affecting efficiency of the system.

During the project period, the regional coordination and collaboration has increased and the regional meetings developed into multi-stakeholder Regional Health Forums (RHF). The concept of Institutional Capacity Building has increasingly been better understood at various levels, with the introduction of Execution Agreements and involvement of the local district leadership.

The development of a regional ambulance / referral system is a successful and visible example of the project support, which is raising interest beyond the two implementation regions. The system evolved from 2012 and is an important component of improved service delivery at district and regional level.

The project support towards the revitalization of the Health Manpower Development Centre (HMDC) raised questions related to its sustainability. As the centre can be an important sector contributor to Continuous Professional Development for the health workers, MOH stewardship is needed to determine its future status. The process to prepare a cabinet request for an self-accounting status for HMDC has been completed and has reached the Top Senior Management Committee (TSMC) of the MOH.

Management context / execution modalities:
The project has been formulated under co-management modality, with MOH responsible for project implementation. In 2012 the Steering Committee approved transferring funds for procurements under the project to the BTC-management modality. Many procurement tenders were started and completed with support from BTC Headquarters, leading to high project execution rate.

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

HARMO context:
The Mid Term Review Report included a section on the assessment of the HARMO criteria under the ICB project, which is included here in italics:
The End of Term Review (ETR October 2015) did NOT included reference to HARMO criteria.

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

Alignment: The project formulation was fully aligned to the health sector strategic plan and the national health policy.
During the reformulation in July 2013, the project logframe has been reviewed and updated. It has not been adapted since as the project period was coming its end. The indicators and activities as reflected in the logframe are used in the quarterly (MONOP) and annual reporting.

Result-based management:
Over 2014/15, the focus has been on results and both efficiency and effectiveness increased. The quarterly regional meetings developed into a regional health forum with multiple stakeholder involvement. Also the involvement of the local leadership in health improved. Emphasis of project interventions in the areas of quality of care and gender and Health Human Rights increased over the years. The execution rate jumped from 40% to 66% and has reached close to 100%.
The impact in institutional strengthening is visible at regional and district level, however not at central level, where support is mostly output oriented.

Mutual responsibility MOH and BTC Uganda share the responsibility for project results.

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

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

1.2 Important changes in intervention strategy

The original Technical and Financial File (TFF) included orientation on selected districts (4) and hospitals (2 RRH and 4 GH) in the implementation regions only. At the request of the MOH, the orientation was redirected to full regional focus in 2011 with support to all 15 health districts. At the same time, support to the revitalization of the Health Manpower Development Centre (HMDC) was also included. The focus of the project changed to regional coordination and capacity building, and learning lessons for national policy. This included the establishment of Regional Project Implementation Committees (R-PIC), with a reduced role for the central project committee.

STEERING COMMITTEE

(In common with central level)

IMPLEMENTATION COMMITTEE

Chair: RRH DIRECTOR

Members: DHO, SDHO, PC, TA, PNFP

In attendance: other departmental heads, or other stakeholders on invitation

PROJECT OPERATION

Initiators: RRH DIRECTOR AND TA

All actors identified during the planning process (DHMT, SDHMT, PNFP, etc.)

Changing the public procurements from Ugandan to Belgian systems, resulted in a high workload for the existing project staff. Only after the MTR in 2013, the project team was expanded to cover both the technical and administrative aspects.

In order to increase project ownership at district and regional level, a system of decentralized project implementation through the use of Execution Agreements (EA) was set-up. Extensive organizational assessments of district systems were completed and workplans were developed to support targeted ICB areas. The phased implementation approach resulted in an accelerated project implementation rate. District experiences using funds under Execution Agreements are shared during the quarterly Regional Health Forum meetings.

Several attempt were made to develop a system of scientific support to the project. However, the potential benefits could not be clearly formulated at project level and were not well understood. The focus of the project on regional implementation and institutional support contributed to the limited priority given to scientific support. Experiences by other projects and in other countries showed limited benefits, were largely academic rather than practical and overlapped with technical backstopping. Scientific support was not pursued as a project result, but focus was shifted to capitalization of project experiences.

2 Results achieved

2.1 Monitoring matrix

Results / indicators	Baseline Value	End Target	End Value obtained	Comments
IMPACT: To improve effective delivery of an integrated Uganda National Minimum Health Care Package				
Selected health sector performance indicator improvement	**HSSP II**	**HSSIP (FY2014-15)**	**Improved**	
OUTCOME: The strengthening of the Planning, Leadership & Management capacities of health staff at national and local government levels				
Improved organizational and institutional performance of the Ministry of Health HQ and the health institutions in the two selected regions				
Central: MOH restructuring / reform plan in execution	**Draft restructuring plan MOH**	**Health sector restructured**	**MoPS submitted draft MOH restructurin g proposal**	**Restructuring to be included in HSDP 2015/16-2019/20**
Central: Meeting frequency of SWAP coordinating structures	**As scheduled**	**100%**	**HPAC 83% (10/12) SMC 67% (8/12)**	**Irregular meetings of MOH TWGs**
Regional: District annual league tables (position and score)	**AHSPR**	**See table**	**Improved**	**New population census data 2014**
Regional: Regional consolidated HMIS (HSSIP indicators progression)	**HSSP II**	**HSSIP (FY2014-15)**	**Improved**	
OUTPUT 1: The Ministry of Health is strengthened in its organisational and institutional capacity				
Number of TSMC retreats	**2008**	**Nil**	**biannual**	**ICB support to performance and planning retreat MOH**
Number of trainings supported (disaggregated by number of people, gender and type)	**No data available**	**No data available**	**No data available**	**No data available**
Number of annual Regional Planning meetings	**Annual**	**Annual**	**Annual**	**Reintroduced 2012**
Number of ICB Steering Committee meetings.	**N/A**	**SC: 2**	**SC: 2**	**Minimum 2 SC meetings every year**
OUTPUT 2: Institutional Capacity is developed in the health sector in Rwenzori and West-Nile region al all levels (regional coordination, RRHs, Districts, General Hospitals and Health Sub-district)				
Feasibility study report available	**Included in HSSIP**	**Report**	**Mapping**	**Commitment**

		available	**study completed**	**MOH**
Number of Regional project Implementation Committee meetings	**Nil**	**8**	**100%**	**Quarterly meetings in both regions**
Number of Execution Agreements signed	**N/A**	**18**	**18**	**15 DLG, 2 RRH, 1 HMDC**
Number of Governance. Leadership & Management (GLM) trainings	**N/A**	**N/A**	**Two regional cohorts (>300); Two RRH cohorts (60)**	**Roll-out at district level (EA support)**
OUTPUT 3: The training needs in L&M of the health sector are strengthened through transformation of the HMDC (Mbale) and the establishment of 2 regional satellite training centres				
Number of regional training centres established	**N/A**	**2**	**2**	**Virtual coordination centres at FP and Arua RRH**
Number of eLearning courses conducted (by number, gender and type)	**N/A**	**3**	**3**	**L&M; GHHR; Anti-corruption**
Number of GLM trainings (elearning)	**N/A**	**4**	**4**	**2 cohorts in each region**
OUTPUT 4: Capitalisation and Scientific support accompanies the capacity building process in the Ugandan health sector				
Scientific support	**N/A**	**Contract**	**Nil**	
Capitalization	**N/A**	**2**	**3**	**Framework conract BTC HQ with KIT Amsterdam**

2.2 Analysis of results

2.2.1 To what extent will the intervention contribute to the impact[6] (potential impact)?

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

[6] Terminology : Impact = General Objective ; Outcome = Specific Objective; Outputs = Expected Result

At regional and district level it has been noted that districts with strong leadership and management practices, perform better on management and cohort indicators.

2.2.2 To what extent has the outcome been achieved? Explain

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

Most of the 15 districts in the two project regions have improved their league table score during the project period.
The use of the league table is only one way to review district performance and is based largely on service indicators. However, there appears to be a link between league table score and 'leadership & management' aspects in the districts (e.g. timeliness of reporting, staffing levels, involvement of the local political leadership in health, cohort indicators, etc.)

In 2014 the (provisional) results of the population census were published. All districts in the two project regions which scored below the national average, had ***over-estimated populations***. This means that the denominator for a number of population-based indicators was too high and the league table score should have been higher.
At the same time, the populations of the high-performing districts were ***underestimated*** and their league table score should have been lower.

The leagues table score and position is not within the 'sphere of control of the project and it determined by many other contextual factors (e.g. political support to health; other implementing partners present; geographic location, etc.).

2.2.3 To what extent have outputs been achieved?

Output 1 (MOH HQ):
MOH has been supported it its planning and quality assurance activities, through policy development (e.g. Nursing policy), supervision review, performance review and reports, strategic plan development, and logistics support.
Although included in the original TOR, restructuring of the MOH establishment did not yet take place. A feasibility study on developing a regional health level and the central TA needs assessment and training plan were not completed. Due to the limited capacity of the planning and HR departments at MOH, these activity did not receive adequate support.

Output 2 (regional support):
Exection Agreements with all 15 District Local Goverments in the two regions have been signed in 2014. All districts have received funds and implemented activities as included in the approved workplan. Regular financial meetings are organized at regional

level to verify accountability and build capacity in financial management.
An "EA implementation manual" has been developed for follow-up of EA implementation through regular progess reports (at the time of requests for re-payment), standard quarterly reports for financial, output and outcome monitoring. The EA will continue to be supported until June 2016 (end of Financial Year)

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

The roll-out of ***Governance, Leadership and Management (GLM) training*** and over 300 officers successfully completed the course and obtained an MOH certificate. Further roll-out at distric level (for health Sub-District and facility managers) has been included in the district EA workplans. Two cohorts of senior managers of the two RRHs also were trained (60). An impact evaluation has been conducted in 2015. The course was considered very relevant and effective.

The development and introduction of a ***regional level within the health sector*** is reflected in the HSSIP and experience building in the two ICB supported regions has continued. The quarterly regional project meetings have evolved into a Regional Health Forum, with increasing experience sharing within the regions. The introduction of the Regional Performance Monitoring Teams (RPMTs) stengthened the regional approach and the teams are now permanent stakeholders in the regional meetings. Officers at MOH HQ also have ackowledged the benefits of the regional fora in West Nile and Rwenzori and increasingly show interest to participate.

The introduction and development of the ***regional ambulance and referral systems***, has become a case study for the country, as other initiatives are faced with extensive delays (i.e. development of the Uganda national Ambulance System (UNAS), ambulance service provision under the UHSSP/WB). A second vehicle assessment report, at the request of the Minister of Health, showed good use and management of both the ambulances and the utility vehicles in both regions. The number of referrals is increasing, vehicles are serviced on schedule and logbooks are kept. Ambulance committees have been established within most of the districts and are instrumental in mobilizing community contributions to support sustainable ambulance services.
The total number of functional ambulances (equipped and staffed by trained officers) has increased to 32 for both regions. A review of the experiences with the regional ambulance services has been done by UNAS unit at MOH and the assessment is very positive, with recommendations for national policy and implementation.

A number of procurements were completed to support the district and regional levels. These included theatre tables for hospitals and HCs IV, IT equipment and additional library books, PA systems, MOH and RRH websites development, ambulance uniforms,

motorcycles, solar systems and X-ray Kilembe.

Output 3 (support HMDC): the revitalization of HMDC has been partially achieved. The infrastructure has undergone rehabilitation, the centre has been equipped with IT, furniture and library books, a system of eLearning has been set-up and staff capacity in course development and eLearning was build.
The transformation process of HMDC to a self-accounting institution has been supported and a file for cabinet submission has been prepared. The file contains a Strategic and Investment Plan, a principles document for status change, reports on national and international benchmarking and a Regulatory Impact Assessment. The support towards HMDC by MOH is still insufficient and support (financial and human resource) has not been prioritized. TSMC will still need to take a decision on the request submission to cabinet.

Output 4 (capitalization) has been realized and an end-of-project booklet has been produced describing 7 case studies on project interventions. The case-studies were selected by partner and project stakeholders and describe the process, achievement and challenges of specific intervention at national and regional level. Each case study includes lessons-learned and policy recommendations.

2.2.4 To what extent did outputs contribute to the achievement of the outcome

The District League Table is an instrument used to assess performance of districts and rank them form high to low performers. Eleven indicators are scored and attached a weight to come to a total of 100 points. Most indicators selected are on service delivery and are not directly affected by interventions under the ICB project activity support. It is therefore only used as a proxy indicated to assess project outcome.

Some of the ‘management related indicators’, e.g. complete and timely HMIS reporting, are affected by activities under the IB support and have shown improvements over time.

Most importantly, the outputs contributed to awareness in both regions on the importance of performance assessments, the analysis of findings and actions towards improvements.

In West Nile and Rwenzori regions, district performance is consolidated in a regional performance score, and performance is reviewed quarterly. At district level, health facilities are now also ranked in a ‘district facility league table’, which provides the district with a tool for appreciation as well as for priority interventions. The example from the two regions is adopted by the national level and the last District League Table (2014-2015) is now organized into Regional League Tables.

Most districts within the ICB implementation regions introduced District Health Assemblies with the publication of District Annual Performance Reports. These assemblies have strengthened stakeholder involvement in health and built relations between them. This is now also advocated by MOH to be included in district plans.

2.2.5 Assess the most important influencing factors. What were major issues encountered? How were they addressed by the intervention?[7]

Turn-over of staff at national and district level is a challenge in many sectors and organizations. Fortunately, key staff members involved in the ICB project maintained their positions during the project period (i.e. Project Coordinator and Directors, Hospital Directors of RRH's, DHO's). This allowed for relation building over time and intense collaboration. In districts where DHO's or Medical Superintendents were replaced, new relations were quickly established, especially through the Regional Health Forum meetings.

As the environment in which the project operated has been changing, adaptations had to be made to the project set-up. Some of the national systems (e.g. procurement and finance) were not able to manage the project requirements and therefore part of the workload had to be shifted towards direct project implementation. The necessary staff adjustments and budget shifts were supported by MOH and helped to accelerate project implementation.

2.2.6 Assess the unexpected results, both negative and positive ones

A population census took place in 2014 and population figures were adjusted upwards or downwards. For some districts the changes were very big and this made follow-up of the District League Table scores unusable for outcome monitoring.

2.2.7 Assess the Integration of Transversal Themes in the intervention strategy

The ICB project did not have direct interaction with disease and service programme and therefore no direct interventions on HIV or Child Health.
Gender & Health Human Rights (GHHR) have been focus areas of the project interventions and several capacity building activities (e.g. advocacy, training) were done in the two regions. At national level, the GHHR desk in MOH has been non-functional for a long time, but became involved in project supported activities during the last phase of the project period.

Under the project a number of infrastructure interventions were supported. Functionalizing existing solar systems at selected health facilities and construction of a water harvesting system at Virika Hospital are two examples of support towards sustainable development. At the national training college, a hostel block is being reconstructed and attention is given to water harvesting and use of solar for warm water provision.

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[7] Only mention elements that aren't included 1.1 (Context), if any.

2.2.8 To what extent have M&E, backstopping activities and/or audits contributed to the attainment of results? How were recommendations dealt with?

Annual backstopping missions were essential for periodic adaptations in the changing environment. As the original planned 'scientific support' had not been implemented, backstopping also provided 'scientific' back-up.

During the period before the Mid-Term Review, during which the workload for the project team was excessive, the backstopping missions were valuable in refocusing on the priority areas.

At Mid-Term, a first audit took place, which was helpful as a number of systems weaknesses were identified. During the reformulation in July 2013, the audit recommendations were helpful for restructuring measures.

Sustainability

Before the closure of the ICB project, another institutional support project targeting the MOH and the Private-Not-For-Profit sub-sector was formulated and started operation. The project worked in synergy with the ICB project and operates in the same two regions. Activities, such as the Regional Health Forum meetings, were supported jointly.
The presence in the MOH and two implementation regions had created a fertile ground for the PNF project to start. Similarly, the presence of the PNFP project will ensure continuation of a number of activities initiated under the ICB project.

In 2015, the MOH and BTC formulated and agreed on an ICB Phase II project. This project will continue on the line of ICB I, and work in synergy with PNFP project on establishing Result Based Financing mechanisms in public health facilities.

3 Learning

3.1 Lessons Learned

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

3.2 Recommendations

A recommendation is a decision to be taken, to the attention of a user of the final report. Recommendations should be as specific as possible. Operationalise recommendations by adding 'Source' and 'Target Audience'.

The identification and formulation of a follow-up project was already completed at the time of the End-of-Term-Review (ETR) in September / October 2015.
During the process, lessons learned from the ICB project and recommendations for future support were already included in the TFF for the ICB Phase II project. The specific agreement for ICB II was isgned in July 2015.

The ETR formulated a number of recommendations to the attention of BTC and MOH in its report[8]:

To BTC:

- Support the MOH in the dissemination and emulation of outputs under ICB: nursing policy; operational assessments of districts; GLM modules and manual; EA modality and EA manual; nursing policy; e-courses on gender, corruption human health rights; ambulance operational guidelines. This in/outside ICB-II; possibility through finances under Health Basket Funding; advocacy among other DPs
- Support the MOH in a quick and solid decision making process on the status of the HMDC
- With the Belgian Government and MOH as contract partners at the start of ICB-II revisit aspects mentioned in this report concerning Specific Objectives I and 2 of ICB-II: EA not restricted to RBF; decision on the number of HF per level that can qualify for RBF; reconsider idea of not supporting under RBF first care services for hospitals/ HC-IV; ensure that the RBF modality in ICB-II is identical in substance to that of PNFP ensure adequate attention for SOs 3 and 4
- Revisit the idea of a real-life portfolio approach in the two regions under PNFP and ICB-II
- Consider to extend the life-time of ICB-II and PNFP using underutilised funds under HSBS/ HBF

To MOH:

- Reduce vacancy levels to the minimum possible and that of senior positions in particular
- Lead the process of revitalising the inter-ministerial committee as a fora through which the status change and budgetary consequences for HMDC can be discussed and fast tracked;
- Ensure that the gender-desk in the Planning department becomes operational
- Apply the format for Operational Assessments of Districts and Regional Referral Hospitals
- Introduce, promote and solicit resources in the other 10 health regions and their districts for:
    - the use of the GLM module and manual;
    - the use of e-learning courses that have been developed by HMDC under ICB;
    - using district/ regional ambulance referral systems developed under ICB
    - holding District Health Assemblies;
    - holding regular Regional Interdisciplinary meetings on health

[8] ETR draft report 30/10/2015

PART 2: Synthesis of (operational) monitoring

1 Follow-up of decisions by the JLCB

Major decision from steering committee	Action	
Decision	**Action(s)**	**Status**
19-Mar-13		
Monitor Ambulance Management in districst	Comprehensive assessment done with no management issues noted that required action.	Completed
Outstanding advances ICB project to be reviewed	Advances reviewed during audit May 2013. Active management by project secretariate.	Completed
02-Jul-13		
Approval MTR report		Completed
Extend project implementaion period to June 2015	Included in reformulation and workplan during mission in July 2013	Completed
Recruit International TA (Finance & Contracting)	included in reformulation and workplan	Completed (January 2014)
Develop Execution Agreements with district LG and RRHs	Included in reformulation and workplan	Completed
Recruit Regional project Officers	Included in reformulation and workplan	Completed; started Jan 2014
29-Sep-13		
Approval reformulation proposal	Reformulation approved, including workplans 2013-2014 and 2014-2015	
Approval Budget modification	Budget modification approved	
HMDC wall fence construction	Agreement with contractor reviewed and restarted	

Follow-up recommendations MTR	Action matrix	On going
20-Feb-14		
Approval Results Report 2013	Approved with adjustments noted to be included	
HMDC workplan and budget	To be presented to SC	
Follow-up recommendations MTR	Action matrix	On going
Follow-up recommendations Audit 2013	Action matrix	New audit Q1 2015
18-Jun-14		
Approval concept note ICB support HMDC	Support HMDC and regional CPD; Project Officer support	
Approval concept note ICB support G&HHR - G&HHR workplan	Workplan prioritazation: Support regional Gender mainstreaming in health and gender screening HSSDP 2015-2020.	
Approval workplan 2014-2015	Adjustments noted (G&HHR; EA's RRH); Procurement consultant for implementation procurement plan.	
Approval principles for budget modification	Budget modification to be prepared on approved workplan for validation by BTC HQ	
Establish MOH - BTC team for identification ICB phase II project	Concept note on principles for ICB Phase II, for presentation Joint Commission Oct 2014	Partner Committee 14/10/2014
19-Feb-15		
Approval Results Report 2014	Approved by SC	
PNFP - ICB coordination	ICB ITA to take-up coordination of PNFP and ICB projects at central and regional level.	Monthly joint meetings
Capitalization of project experiences using KIT framework contract	Approved; Scientific Support Result Area transformed to focus on capitalization	Scoping mission Uganda 4-10 March 2015
Extension Project Implementation Period	Workplan and budget expanded up to November 2015; addendums for Execution Agreeements to be signed before 30 June 2015	Completed

Proposal to introduce responsibility allowance for Project Coordinator	Approved, provided positive decision by BTC HQ	
Approval principles for budget modification	Approved. Budget modification and workplan aligned and	Completed
Roadmap for project closure	C&F ITA and PO REPUGA responsible for roadmap and coordination towards closure	On-going
25-Jun-15		
Approval Workplan and budget modification June 2015-November 2015	Workplan and budget modification adopted by SC.	
Approval addendum Execution Agreements FY 2015-2016	All workplans finalized for full FY 2015-2016. Addendum approved for continued funding under ICB I project upto June 2016 (ending September 30, 2016).	
Approval roadmap for project closure	SC meeting September (project implementation validation; final report); SC meeting November (project closure)	
Approval Project Implementation Manual (PIM)	PIM approved as working document for ICB I, PNFP and ICB II projects. Amendments to be presented to SC when required.	
Audit report and audit follow-up action matrix	Unqualified opinion on audit report; follow-up matrix on recommendations to be presented to each SC meeting	

2 Expenses

TranType	(Multiple Items)							
Sum of AmountBudCu		TranYear						
AccFinMode	Result Area	2010	2011	2012	2013	2014	2015	Grand Total
COGEST	General Means			(277,14)		(4.655,63)	(4.364,22)	(9.297,00)
	Reserve	(14,70)						(14,70)
	Result 1 MoH	(304,78)	(47.352,20)	(86.754,18)	(154.367,32)	(168.283,34)	(45.847,27)	(502.909,09)
	Result 2 Regional level	(11.550,91)	(22.437,59)	(116.962,63)	(210.722,93)	(710.392,42)	(378.129,35)	(1.450.195,83)
	Result 3 Training			(2.855,65)	(3.253,53)	(24.581,81)	(16.403,82)	(47.094,82)
COGEST Total		**(11.870,40)**	**(69.789,79)**	**(206.849,60)**	**(368.343,78)**	**(907.913,21)**	**(444.744,66)**	**(2.009.511,43)**
REGIE	General Means	(142.197,63)	(168.011,21)	(228.164,76)	(306.292,90)	(393.907,69)	(335.147,27)	(1.573.721,47)
	Result 1 MoH			(178.992,31)	(46.933,04)	(79.549,97)	(40.832,67)	(346.307,98)
	Result 2 Regional level			(1.071.384,42)	(329.347,78)	(710.792,72)	(516.446,59)	(2.627.971,51)
	Result 3 Training				(42.419,90)	(71.461,80)	(50.698,20)	(164.579,91)
	Result 4 Capitalization						(15.373,56)	(15.373,56)
REGIE Total		**(142.197,63)**	**(168.011,21)**	**(1.478.541,49)**	**(724.993,62)**	**(1.255.712,18)**	**(958.498,30)**	**(4.727.954,42)**
Grand Total		**(154.068,03)**	**(237.801,00)**	**(1.685.391,09)**	**(1.093.337,39)**	**(2.163.625,39)**	**(1.403.242,96)**	**(6.737.465,86)**

3 Disbursement rate of the intervention

Source of financing	Cumulated budget	Real cumulated expenses	Cumulated disbursement rate	Comments and remarks
Direct Belgian Contribution	6.500.000 €	5.366.238,86 € (Closing Sep 2015)	82.65%	100% committed (implementation of EA up to end of June 2016)
Contribution of the Partner Country	/			
Other source	1.508.350,00 € (SIDA ; inclusive 10% management revenue HQ IS)	1.508.350 €	100%	

4 Personnel of the intervention

Personnel (title and name)	Gender (M/F)	Duration of recruitment (start and end dates)
1. National personnel put at disposal by the Partner Country:		
Project Manager:		
a. Dr. Isaac Ezati, Director Health Services (Planning & Development), Ministry of Health	M	Sept 2011 – July 2015
b. Dr. Francis Runumi, Commisioner Health Services (Planning), Ministry of Health	M	June 2010 – August 2011
c. Dr. Henry Mwebesa, Commisioner Health Services (Quality Assurance), MOH	M	August – October 2015
2. Support personnel, locally recruited by BTC:		
Administrative Assistant - Dora Anek	F	1/9/2014-30/11/2015
Financial Officer - Tabitha Nandera	F	1/8/2015- 30/11/2015
HMDC/CPD Project Officer – Resty Kamya Mwogeza	F	1/9/2010-30/11/2015

Regional Project Officer (West Nile) – David Okia	M	7/1/2014-30/11/2015
Regional Project Officer (Rwenzori) – Damian Rutazaana	M	13/1/2014-30/11/2015
Driver - Sunday Deo	M	15/9/2014-30/11/2015
Project Officer – Ann MaryOtedor	F	01/05/2012 - 01/07/2014
Project Accountant – Nambafu, Godfrey	M	1/9/2013-30/04/2014
Project Accountant – Yiga, Godfrey	M	07/05/2012 – 14/06/2013
3. International experts (BTC):		
Technical Advisor (Co-Manager) - Hans Beks	M	1/5/2010-30/11/2015
Contract & Finance Coordinator - Robert Delhaye	M	10/1/2014-29/1/2015
Contract & Finance Coordinator - Inge Dumortier	F	10/01/2014-30/11/2015
Junior Assistant – Vincent Vanderputten	M	01/08/2012 – 01/08/2014
Junior Assistant – Lene Vos	F	05/04/2014 – 25/04/2014

5 Public procurement

A considerable number of procurements were made (under Belgium procurement laws) to support the functionality of districts and health facilities in both Rwenzori and West Nile regions. All were awarded before the project ended and most are also completed and paid. Works procurements were targeted mostly at revitalizing the training centre in Mbale (HMDC).
Procurement of consultancies supported a number of activities at Ministry level.
The list was handed over to the Ministry of Health during the final dissemination meeting on 23 November 2015.

Procurement	Beneficiary institutions:	No	Value (appr)
1. Supplies			
Solar equipment (awarded)	21 HFs WN / Rwenzori region	21	70,000 €
Ambulance Uniforms	32 5-man ambulance teams WN and Rw	160	44,000 €
Direct Digital X-ray	Kilembe Mines Hospital	1	160,000 €
Orthopedic equipment - surgery	FP RRH / Arua RRH / Kilembe GH	3	36,000 €
Theatre Tables	GH and HC IV WN and Rw regions	39	140,000 €
Motorcycles	DLG WN and Rw regions	75	150,000 €
Projectors and screens	DLG WN and Rw regions / HMDC / FPRRH / ARRH	18	10,000 €
Public Address systems	DLG WN and Rw regions / FPRRH / ARRH	17	120,000 €
Library books	MOH / RRHs / GH / HC IV		65,000 €
Utility vehicles	DLG WN and Rw regions / RRHs	10	350,000 €
Ambulance equipment (9 sets)	DLG WN and Rw regions	9	75,000 €
Ambulances	DLG WN and Rw regions	16	800,000 €
IT equipment	MOH / HMDC / WN / Rw districts		

Office furniture	MOH / HMDC / WN / Rw districts		
2. Works			
Reconstruction Hostel Block (awarded)	HMDC Mbale	1	75,000 €
Bore hole and elevated water tank (awarded)	Kyenjojo Hospital	1	24,000 €
Water Harvesting System	Virika Hospital	1	30,000 €
Rehabilitation classroom / dining / sanitation	HMDC	1	25,000 €
Re-roofing 4 staff houses	HMDC	1	20,000 €
Boundary Wallfence	HMDC	1	80,000 €
			2,274,000 €

6 Public agreements

Number of the Agreement	Execution modality	Budget code Activity	Name of partner institution	Entering into force (date)	Total amount (€)	Amount in (UGX)	New budget after addendum signed	Status	No transfer	Status Transfer	Date of transfer (performed or planned)	Amount (€)	Exec Rate
R1	joint management	B02-01	Kabarole District local government	28/01/2014	€ 84.405	UGX 278.536.500	€ 107.846	In progress	1	Realized	5/mrt/14	€ 16.616	
									2	Realized	10/jul/14	€ 13.023	
									3	Realized	4/sep/14	€ 6.585	
									4	Realized	15/dec/14	€ 13.663	
									5	Realized	15/mei/15	€ 14.869	
												€ 64.756	60%
R2	joint management	B02-01	Kasese District local government	28/01/2014	€ 122.227	UGX 403.349.100	€ 111.603	In progress	1	Realized	5/mrt/14	€ 24.157	
									2	Realized	4/jul/14	€ 15.431	
									3	Realized	26/nov/14	€ 19.061	
									4	Realized	16/mrt/15	€ 16.510	
												€ 75.159	67%
R3	joint managem	B02-01	Kygegegwa	28/01/2014	€ 66.004		€ 99.414	In progress	1	Realized	5/mrt/14	€ 12.994	

	ent		District Local Government			UGX 217.813.200			2	Realized	24/jun/14	€ 11.422	
									3	Realized	18/sep/14	€ 10.897	
									4	Realized	15/dec/14	€ 9.120	
									5	Realized	2/apr/15	€ 12.143	
									6	Realized	15/mei/15	€ 9.259	
									7	Realized	9/sep/15	€ 7.564	
												€ 73.399	74%
R4	joint management	B02*01	Bundibugyo Ditrict Local Government	30/04/2014	€ 58.001	UGX 191.403.300	€ 44.886	In progress	1	Realized	1/aug/14	11.038	
									2	Realized	16/mrt/15	4.237	
												€ 15.275	34%
R5	joint management	B02 01	Kamwenge District Local Government	27/05/20144	€ 80.638	UGX 266.105.400	€ 63.250	In progress	1	Realized	15/aug/14	€ 7.683	
									2	Realized	15/dec/14	€ 7.563	
									3	Realized	5/jun/15	€ 6.834	
									4	Realized	20/jul/15	€ 3.999	
												€ 26.079	41%
R6	joint management	B02-01	Kyenjojo Ditrict Local	27/05/2014	€ 68.949	UGX 227.531.700	€ 55.068	In progress	1	Realized	5/sep/14	€ 6.570	
									2	Realiz	11/mrt/15	€ 6.464	

			Government							ed			
									3	Realized	31/mrt/15	€ 6.451	
									4	Realized	6/jul/15	€ 1.374	
									5	Realized	9/sep/15	€ 4.529	
												€ 25.388	46%
R7	joint management	B02-01	Ntoroko District Local Government	27/05/2014	€ 47.219	UGX 155.822.700	€ 37.333	In progress	1	Realized	12/jun/14	€ 4.562	
									2	Realized	5/sep/14	€ 4.499	
									3	Realized	16/jan/15	€ 4.164	
												€ 13.225	35%
W1	joint management	B02-01	Nebbi Ditrict local government	28/01/2014	€ 71.617	UGX 236.336.100	€ 79.939	In progress	1	Realized	5/mrt/14	€ 14.098	
									2	Realized	24/sep/14	€ 11.334	
									3	Realized		€ 6.993	
									4	Realized	2/apr/15	€ 3.934	
									5	Realized	15/mei/15	€ 7.011	
												€ 43.370	54%
W2	joint management	B02-01	Moyo Ditrict local governm	28/01/2014	€ 72.040	UGX 237.732.000	€ 76.524	In progress	1	Realized	5/mrt/14	€ 14.182	
									2	Realized	10/jul/14	€ 9.152	

			ent						3	Realized	26/nov/14	€ 6.468	
									4	Realized	11/mrt/15	€ 9.942	
									5	Realized	20/jul/15	€ 2.865	
									6	Realized	9/sep/15	€ 8.847	
												€ 51.456	67%
W3	joint management	B02-01	Yumbe District local Government	28/01/2014	€ 77.405	UGX 255.436.500	€ 85.764	In progress	1	Realized	5/mrt/14	€ 15.238	
									2	Realized	10/jul/14	€ 12.717	
									3	Realized	22/dec/14	€ 10.642	
									4	Realized	1/jun/15	€ 7.649	
									5	Realized	20/jul/15	€ 3.871	
									6	Realized	9/sep/15	€ 8.887	
												€ 59.004	69%
W4	joint management	B02-01	Koboko District local Government	30/04/2014	€ 52.040	UGX 171.732.000	€ 60.531	In progress	1	Realized	4/jul/14	€ 9.914	
									2	Realized	26/nov/14	€ 7.766	
									3	Realized	11/mrt/15	€ 8.988	
									4	Realized	28/apr/15	€ 7.343	
												€ 34.011	56%

W5	joint management	B02-01	Maracha District local Government	27/05/2014	€ 101.029	UGX 333.395.700	€ 50.903	In progress	1	Realized	23/jul/14	€ 9.898	
									2	Realized	26/nov/14	€ 7.023	
									3	Realized	29/apr/15	€ 8.194	
									4	Realized	6/jul/15	€ 6.483	
												€ 31.598	62%
W6	joint management	B02-01	Adjumani District local Government	27/05/2014	€ 68.751	UGX 226.878.300	€ 48.708	In progress	1	Realized	7/okt/14	€ 6.591	
									2	Realized	25/mei/15	€ 5.590	
									3	Realized	9/sep/15	€ 13.099	
												€ 25.280	52%
W7	joint management	B02-01	Zombo District local government	27/05/2014	€ 97.982	UGX 323.340.600	€ 50.285	In progress	1	Realized	23/jul/14	€ 9.335	
									2	Realized	26/nov/14	€ 9.430	
									3	Realized	2/apr/15	€ 6.508	
									4	Realized	20/jul/15	€ 4.726	
									5	Realized	9/sep/15	€ 3.305	
									6	Realized	30/sep/15	€ 3.870	
												€ 37.174	74%
W8	joint managem	B02-01	Arua District	27/05/2014	€ 131.69	UGX 434.586.900	€ 72.906	In progress	1	Realized	30/sep/14	€ 12.144	

	ent		Local Governm ent		3				2	Realiz ed	16/jan/15	€ 9.450	
									3	Realiz ed	15/mei/15	€ 10.960	
									4	Realiz ed	6/jul/15	€ 8.533	
												€ 41.087	56%
					€ 1.200.000		€ 1.044.960						
												€ 616.262	
H1	joint managem ent	B02-03	Arua Regional Referral Hospital	27/05/2014	€ 60.000	UGX 198.000.000		In progress		Realiz ed	26/mrt/15	€ 1.707	
													3%
H2	joint managem ent	B02-03	Fort Portal Regional Referral Hospital	27/05/2014	€ 60.000	UGX 198.000.000		In progress		Realiz ed	4/mrt/15	€ 1.336	
										Realiz ed	19/aug/15	€ 12.749	
												€ 14.085	23%
HMDC	joint managem ent	B03-01	HMDC	1/05/2015	€ 20.000	UGX 66.000.000		In progress		Realiz ed	30/sep/15	€ 7.218	
													36%

7 Equipment

Equipment type	Cost		delivery date		Remarks
	budget	*real*	*budget*	*real*	
Computer - desktop					
Dell Optiplex 390		1.650.000			
Phillips Monitor					
Computer - Laptop					
Apple Macbook Air (ITA)			01/08/2013		
Toshiba Satellite C650					
Dell Insprion 5041		1.500.000			
Dell Inspiron 5050		1.750.000			
Dell Inspiron 5110		1.650.000			
Dell Inspiron 3521 Notebook		1.398.305	18/08/2014		
HP 450		€ 839,16			
Apple Macbook Air (DGHS MOH)		6.150.000	2/06/2015		
UPS / Stabilizer					
APC UPS 640					
JBS-WN3000W stabilizer					
APC UPS 500 VA		150.000			
Printer					
HP LaserJet P2035					
HP Photosmart C4783					
HP LaserJet P2035		395.000			
HP Laser Jet P2035		450.000			
HP Laserjet P1120		€ 95,76	21/11/2013		
HP Laserjet Pro 400			18/09/2015		

Photocopier					
Kyocera Ecosys FS 1035 MFP					
Scanner					
HP ScanJet G2411		190.000			
HP ScanJet G2411					
HP Scanjet 5590			18/09/2015		
Ext Hard Drive					
Toshiba					
LCD / Projector					
Dell projector 1210S					
Dell projector 1220					
Projector Screen					
Projector screen(mobile/tripod)					
TOYOTA PRADO					
TOYOTA PRADO					
Toshiba Table Fridge	1.422.500		15/10/2012		
WATER DISPENSER					
Water Dispenser	450.000		1/09/2015		
SAFES					
Fire & Burglury resistant Safe H385	650.000				
Filing Cabinet					
Filing Cabinet - 4 draws	406.780				
Filing Cabinet ZENITH	406.780				
Filing Cabinet ZENITH	406.780				
Filing Cabinet REXEL	500.000				
BOOKSHELVES					
Bookshelf with wooden doors	800.000				

Bookshelf Model208	708.000		4/03/2013		
Bookshelf Model AED	620.000		26/11/2014		
Bookshelf Model AED	620.000		26/11/2014		
Low Swinging Book Shelf	295.000		26/11/2014		
CHAIRS					
Task swivel chair	296.610				
Secretarial Chair	650.000		15/04/2013		
Visitors chair CM6407E			14/03/2013		
Visitors chair CM6407E			14/03/2013		
Visitors chair CM6407E			14/03/2013		
Airmesh Chair W/headrest	585.000		03/04/2013		
Visitors chair CM6407E			14/03/2013		
Visitors Chair	130.000		26/11/2014		
Visitors Chair	130.000		26/11/2014		
Low Back Chair	230.000		26/11/2014		
Low Back Chair	230.000		26/11/2014		
TABLES					
Office Desk					
Extension of office Desk	800.000				
Desk 606	807.500				
Computer Table	156.000				
Meeting Table H-5513			14/3/2014		
Office Desk Ge140	435.000		22/04/2014		
Office Desk Ge140	435.000		22/04/2014		
WORK STATION					
L-Shaped Workstation	1.060.000		26/11/2014		
NOTICE BOARDS					
Notice Board	250.000		18/10/2013		
Notice Board	250.000				

8 Original Logical Framework from TFF :

	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
General objective: “To improve effective delivery of an integrated Uganda National Minimum Health Care Package”			
Specific objective: The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels			
Result 1:The Ministry of Health is strengthened in its organisational and institutional capacity	• Reform plan in execution • Number of people trained by the project • Number of field visits for ➢ Coverage plan development ➢ Master plan designing ➢ Procedures manual identification • MoH Procedures manual in place • Support supervision policy	• Project Progress reports • Procedures manual • Planning manual • Annual work plan for the MoH • Framework for support	• Sanction/approval by the top and senior management at the MoH to conduct the activities required. • Availability and interest and willingness by MoH top managers and senior managers to participate and cooperate

	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
	paper renewed • Established procedures for training coordination	supervision • Evaluation reports • Meeting minutes • Interviews	
Result 2: One selected regional referral hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity	• Strategic plans incorporating master plans in place • Hospital mandate reflects efforts for complementary role definition • Number of support supervisions realised respecting new policy in the matter • Number of people trained	• Project Progress reports • Strategic plans • Master plans • Annual work plans • Evaluation reports • Meeting minutes	• Sanction/approval by the MoH and district authorities to conduct the activities required. • Availability and interest and willingness by hospital managers to participate and cooperate
Result 3: One further regional referral hospital (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational	• Strategic plans incorporating master plans in place • Hospital mandate reflects efforts for complementary role definition • Number of support supervisions realised respecting new policy in the matter • Number of people trained	• Project Progress reports • Strategic plans • Master plans • Annual work plans • Evaluation reports • Meeting minutes	• Sanction/approval by the MoH and district authorities to conduct the activities required. • Availability and interest and willingness by hospital managers to participate and cooperate

	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
capacity			
Result 4: District management teams are strengthened in their managerial capacity, leadership and planning functions	• Number of people trained • Number of support supervisions to GH realised • Number of support supervisions to HSDMT realised • Strategic plan developed, followed and discussed with LG • Level of understanding of coverage and master plans for strategic planning	• Project Progress reports • Minutes from meetings • Annual work plans. • Evaluation reports • Interviews	• Sanction/approval by the District authorities to conduct the activities required. • Key stakeholders willing to cooperate
Result 5: A comprehensive approach on capacity building of sub-district management teams is operational.	• Number of HSDMT members trained • Coverage plans, master plans and procedures manual reflected in strategic and yearly plans • Coverage plans discussed with LG authorities • Number of HSDMT meetings held • Number of HC II and III supervised by HSDMT	• Project Progress reports • Minutes from meetings • Annual work plans and reports • Coverage plans • Master plans • Evaluation reports	• Sanction/approval by the MoH to conduct the activities required. • Key stakeholders willing to cooperate
Result 6: Two training centres/demonstration sites for capacity building of health sub-	• Number of HSDMT members trained in training centres • Number of training sessions held • Number of HC II and II up to	• Training sessions evaluation reports • Project	• Sanction/approval by the MoH and district authorities to conduct the activities required.

	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
district management teams are functional	quality standard for receiving trainees • Evaluation of the first 2 years of functioning • Status training centres clarified	Progress reports • Field visits and observation • Evaluation report • Interviews • Policy note	• Identified HSDs/ key stakeholders willing to cooperate
Result 7: A scientific support team accompanies the capacity building process in the Ugandan health sector	• Policy paper on support supervision refined and approved • Policy paper on referral system refined and approved • Complementary roles of health facilities better defined and approved in policy paper • Continuous training policy for health personnel refined	• Evaluation reports • Minutes from meetings/semi nars • Policy documents • Interviews	

9 Complete Monitoring Matrix

10 Tools and products

Capitalization:

1) Booklet project case studies: “The life and time of the ICB project…” – launched 23 /11 / 2015
2) Documentary project achievements – launched 23 / 11 / 2015

List of project products :

Product	Date	Beneficiary institution:	Produced by:
ICB Reports (administrative)			
Backstopping missions BTC HQ			
Annual Report 2010			
Annual Report 2011			
Annual Report 2012			
Results Report 2013	Feb-13	BTC / MOH	ICB secr
Results Report 2014	Feb-15	BTC / MOH	ICB secr
Mid Term Review Report	Sep-13	BTC / MOH	
End of Term Review Report (draft)	Oct-15	BTC / MOH	
MOH reports			
MOH Website			
RRH website and LANs			

Procurement Assessment		MOH PDU / FP RRH and ARRH	
Nursing Policy		MOH Nursing Dep.	Brian
Supervision, Monitoring and Inspection framework MOH		QAD MOH	HSDG
Assessment Printing Unit MOH		PS MOH	ICB033 OPPMEZ
CBA Printing Unit MOH		PS MOH	ICB033 Mayenga
GLM impact evaluation	Oct-15	HRD MOH	ICB 038 CME
Regional Mapping Survey	Sep-15	HPD MOH	ICB039 Asiimwe
Cost Benefit Analysis – Oxygen plants	Oct-15	HPD / RRH	ICB046 Consultants
Regulatory Impact Assessment		HPA / HMDC	ICB047 Measure
Regional			
Organizational assessment report	Oct-13	BTC / MOH	Stoop
Strategic Investment Plans RRHs	Aug-13	Arua / FP RRH	CME consultants
Strategic Investment Plan HMDC	2013	HMDC	
Transport Assessment	2012		Wanyama
Ambulance use assessment 1	2013		SA Logistics

Ambulance use assessment 2	2014		Wanyama
Solar needs assessment	2015		Solar Now

Annex 1: Execution Agreement template

EXECUTION AGREEMENT FOR THE IMPLEMENTATION OF

ICB district-level health sector capacity building initiatives

under the

"INSTITUTIONAL CAPACITY BUILDING IN PLANNING, LEADERSHIP AND MANAGEMENT IN THE HEALTH SECTOR" PROJECT – the ICB Project

UGA 09 017 011

Number of the agreement *ICB-UGA-R-003*

The ***Belgian Development Agency, BTC,*** represented by **Mr. Nebeyu Shone**, with its registered office **Plot 1B, Lower Kololo Terrace, P.O. Box 40131, Kampala, Uganda**

WITH

The ***Ministry of Health, MoH,*** represented by **Dr. Asuman Lukwago**, with its registered office **Plot 6, Lourdel Road, P.O. Box 7272, Nakasero, Kampala, Uganda**

on one hand,

AND

The ***District Council (local government) of Kyegegwa*** represented by **Mr. David Kawooya**, Chief Administrative Officer, with its

registered office at **Kyegegwa District Local Government Office, P. O. Box 99, Kyegegwa, Uganda** (hereinafter referred to as "***the contracting party***")

on the other hand

have agreed on the following:

article 1 – Background

1.1 General background

The Ministry of Health (MoH) in partnership with BTC, the Belgian Development Agency, is implementing the ICB Project (Institutional Capacity Building in Planning, Leadership and Management in the Health Sector Project). The project has been designed to support the Ministry of Health (MoH) in Uganda in its endeavour to strengthen its capacity in different areas of the health system. The project's intervention strategy is in line with the ministry's priorities and with the strategic vision as laid out in the NHP II (the second National Health Policy). The project will support the implementation of the Health Sector Strategic and Investment Plan 2010/11 – 2014/15 (HSSIP).

The project intervenes in support of the MoH at national level, but also supports the institutional capacity building process at the various levels of the health pyramid in two regions (West Nile Region and Rwenzori Region) and at the national Health Manpower Development Centre (Mbale).

The specific objective of the ICB project is "*strengthening of the planning, leadership and management capacities of the health staff at national level and local government levels*".

At district level, in the two target regions, the project focuses on improved organizational and institutional performance and capacity of the district health team and of the local health facilities and organisations.

The Project Steering Committee on 27/09/2013 has opted for the implementation of district-level project activities through execution agreements with the districts. These agreements, allowing district-level execution of project activities, are expected to : (a) increase the local ownership, including the embedment of project activities in district-level steering and management of the health sector, (b) to contribute to building local capacity in leadership and management of the health sector and (c) to accelerate project implementation, through delegation of operational project management responsibilities from the MoH HQ in Kampala to the district-level local government authorities.

1.2 Institutional context

The contracting party is a district local government, governed by the laws, regulations and guidelines applicable to local governments in Uganda.

As a district local government, the mandate of the contracting party includes the planning, coordination and monitoring of district-level health service delivery, as well as the management of public health facilities at district level and at lower local government level. Therefore, the contracting party has the mandate to conduct the type of activities that may be funded under this agreement.

The contracting party, who must comply by generic governance requirements applicable to all district local governments in Uganda has sufficient capacity to take on the responsibilities and commitments defined in this agreement. The contracting party has prior experience in implementing comparable agreements (labelled as 'memorandum of understanding' – MoU) with other international development partners.

Article 2 – Object

2.1 In conformity with the principles of economy, effectiveness, efficiency and transparency, BTC and the MoH have signed this execution agreement (hereinafter referred to as "the agreement") with the contracting party.

In line with the general objective of the ICB project, *"contribute to effective delivery of an integrated Uganda National Minimum Health Care Package"*, this agreement is concluded *in view of implementing* ***district-level health sector capacity building initiatives*** *explicitly agreed-upon between the contracting party and the ICB project.*

2.2 Specific objective(s) and expected result(s)

The specific objective of this agreement is: *to improve the organizational and institutional performance and capacity of the district health team (DHT) and of the local health facilities and organisations administered and/or coordinated by the DHT and in particular to enhance the planning, leadership and management skills of their staff*.

The objectives, including concrete deliverables, to be achieved through the implementation of this agreement and the corresponding activities and budget allocations are defined in an annual work plan and detailed budget that must be explicitly agreed upon by the contracting party and the ICB Project before any project funds may be transferred and/or used for implementing this agreement.

The annual work plan, to be included as part of Annexe I of this agreement, distinguishes : (1) the *main activities'* (with objectives, including concrete deliverables, to be achieved) and (2) the underlying *'specific activities'*. The annual work plan specifies the corresponding performance indicators at both levels and will also mention the sources of verification of those indicators.

The activities (both the 'main activities' and the underlying 'specific activities') of such annual work plan must be in line with the specific objectives of both the District Development Plan and of the ICB project. After explicit agreement between the contracting party and the ICB project on the annual work plan and corresponding budget allocations, the contracting party ensures that the objectives (including concrete

deliverables) to be achieved and the corresponding activities of the approved annual work plan for this agreement are also formally incorporated in the overall consolidated annual activity plan and budget of the DHT.

2.3 Beneficiaries and intervention zone

The direct beneficiaries are the District Health Team (DHT) and its staff, including the ‘focal persons’ that are part-time assigned to the DHT, as well as the local health facilities and organisations that are managed, supervised and/or coordinated by the DHT and the staff of those health facilities and organisations, including those of the PNP (private not for profit) sector.

The indirect beneficiaries are the citizens living in the district and other people benefitting from preventive and/or curative health services provided by the district-level health facilities and organisations mentioned above.

The intervention zone is the district of Kyegegwa.

2.4 Execution body

The District Health Team (DHT), headed by the District Health Officer (DHO), is responsible for executing the agreed work plan, managing the corresponding activities and achieving the defined objectives (including concrete deliverables).

In view of the implementation of this agreement, the district authorities and officers are responsible for their respective roles in authorising expenditures, financial management, accounting, procurement, internal audit, etc.; as defined in applicable Ugandan Local Government legislation, regulations and guidelines. Such district authorities include the CAO (Chief Administrative Officer), the District Finance Office, the District Public Procurement and Disposal Unit, the District Internal Audit Team, etc.

The ICB project team, including its Regional Project Officer stationed in Arua (for the West-Nile region) or in Fort Portal (for the Rwenzori region), is responsible for providing technical and methodological support to the District Health Team in the following areas : (a) appropriate planning and monitoring of activities to be conducted under this agreement; (b) promoting effectiveness and sharing of good practices in capacity building of health sector staff and organisations active in the district; (c) proper accountability of operations conducted under this agreement and of the related use of resources; and (d) coordination of health services at regional level.

The ICB Project team will liaise with the DHO and with other district authorities involved as to ensure : (a) the timely approval of the annual work plan and budget for the implementation of this agreement and (b) appropriate and timely monitoring, audit and evaluation of the agreement’s implementation.

Article 3 – Contractual commitment of the parties

3.1 Commitment of the contracting party

The contracting party undertakes to respect the conditions under Art. II of the general conditions of this agreement (Annexe II).

Moreover, the contracting party undertakes to:

a) achieve the objectives, including concrete deliverables, defined in the annual work plan for the implementation of this agreement;

b) foster and monitor the efficient and effective use of resources made available with support of the ICB project;

c) foster and monitor the active contribution and added value of all participants to workshops, seminars, meeting, trainings, etc. funded under this agreement; including emphasis on meaningful contributions from participants to preparation, development and “post event” implementation of the implementation objectives;

d) open a specific separate bank account labelled “ICB Health”, to be used solely for funds related to this agreement;

e) allow this “ICB Health” bank account to receive advance funding related to this agreement through a direct transfer from the applicable bank account of the ICB Project;

f) ensure that this “ICB Health” bank account is managed by the authorised signatories and applying all governance procedures and internal controls that apply for use of DHT’s general bank account;

g) ensure a thorough commitment control, with a systematically updated registration of commitments made by the district related to this agreement and with a systematically updated overview of all outstanding local purchase orders and outstanding (received but not yet paid) invoices related to this agreement;

h) include in the quarterly execution reports a budget execution overview comprising both payments made and outstanding commitments; specified per ‘main activity’ and per ‘specific activity’ and complemented with an alternative budget overview per ‘type of cost’;

i) properly account for any expenditure made under this agreement and submit to the ICB project full accountability of such expenditures to be attached to any request for payment under this agreement;

j) timely submit a “request for payment”, in order to allow a timely replenishment of the advance funding and thus to ensure continuity of operations scheduled under this agreement and attach full accountability of expenditures made by the contracting party, as specified in article 7.1;

k) ensure that any expenditure made by the district is accounted for to the ICB Project within 3 months of the payment done by the contracting party;

l) ensure: (1) that the District Internal Audit Team conducts at least a half-yearly internal audit of the implementation of this execution agreement, (2) that a copy of the intern audit report is transmitted to the ICB Project and (3) that the documentation of the internal audit processes are available for the external auditors appointed by BTC;

m) provide full access to any information pertinent for monitoring, auditing and evaluation of this agreement (and its implementation) to the individuals and/or teams assigned by one of the contracting parties to conduct such monitoring, auditing and/or evaluation;

n) keep a continuously updated inventory / assets register of equipment and other assets funded by the ICB Project, including assets funded by the ICB Project before the start of this execution agreement and/or assets funded by the ICB Project through other funding modalities than the current agreement;

o) ensure that all assets funded by the ICB project, are: (1) used solely for objectives and activities in line with the ICB Project related activities, and (2) not used for personal interests;

p) to timely communicate to the other parties of this agreement any audit remark or audit recommendation received with respect to this agreement and its implementation;

q) keep all management responsibilities for advance funding provided under this agreement at the level of the District local government and not to delegate such responsibility to lower level local government or health facilities;

r) provide timely information to the ICB project on any pertinent issue that may influence the contracting party’s capacity proper implementation of this agreement, including pertinent changes in the staffing of the DHT, the District Finance Office, the District Internal Audit Team, etc.

3.2 Commitments of BTC and of MoH

Through the ICB project, BTC and MoH, undertake to fulfil their obligations as defined in this agreement and in the general

conditions of this agreement (Annexe II).

Moreover, generally through the ICB project team, BTC and MoH, undertake to :

a) provide timely information to the district authorities involved on any pertinent issue that may influence proper implementation of this agreement;

b) provide technical and methodological support to the District Health Team in the following areas : (a) coordination of health services at regional level; (b) development of medium-term strategic plans, annual work plans and health service coverage plans for the district-level health sector; (c) effective capacity building of health sector staff and organisations active in the district; etc.

c) liaise with the DHO and with other district authorities involved as to ensure the timely joint approval of the annual (district-level) work plan and budget for the implementation of this agreement;

d) diligently process “requests for payment” and attached “submitted accountability” (for expenditures made by the district under this agreement) within 6 weeks after their submission by the district and to return to the district the original receipts / accounting documents after having verified the submitted accountability;

e) immediately inform the DHO through CAO of any acceptance / refusal of a “request for payment” made by the district under this agreement and of any transfer made by the ICB project to the “ICB Health” bank account opened by the district specifically for managing the cash flow related to this agreement;

f) ensure appropriate and timely monitoring, support supervision, external audit and evaluation of the agreement’s implementation and of the involved partnership and appropriately coordinate with and involve the district authorities in these exercises;

g) provide full access to any information pertinent for monitoring, auditing and evaluation of this agreement (and its implementation) to the individuals and/or teams assigned by one of the contracting parties to conduct such monitoring, auditing and/or evaluation;

h) timely communicate to the other parties of this agreement any audit remark or audit recommendation received with respect to this agreement and its implementation;

i) properly inform the contracting party of other ICB Project funding modalities, outside this agreement, for well-justified investment in equipment, infrastructure, etc. in support of the DHT and/or health facilities in the district.

j) timely inform the district of any changes/additions in guidelines and or reporting formats/deadlines that might occur during the implementation of the project.

Article 4 – Entry into force and period of execution

4.1 The agreement enters into force on the date the last of both parties signs the agreement.
4.2 The agreement ends on 30th June 2015.
4.3 The execution period of the agreement starts on the date the agreement enters into force and ends on 30th June 2015.

Article 5– Applicable legislation and regulations

5.1 *Legislation of the Government of Uganda will apply in general. The contracting party shall refer to the applicable public contract regulations and in addition, will refer to all regulations, standards and procedures that govern the execution of this agreement as cited in **Annexe II.***

ARTICLE 6 - FINANCING

6.1 The total maximum budget for expenditures for activities under this agreement amounts to **66,003.85** Euro (or indicatively **217,812,695**[9] Ugandan Shilling), for the period from 1st January 2014 to 30th June 2015, in conformity with Annexe I.

The detailed budget and the expenditure schedule are provided as Annexe I. An initial budget and expenditure schedule, expressed in Ugandan Shilling, is provided in Annexe I for the January to June 2014 period and will be embedded in the DHT work plan and budget for Q3 and Q4 of fiscal year 2013-2014.

A detailed budget and expenditure schedule for the fiscal year 2014-2015 (July 2014 to June 2015) , expressed in Ugandan Shilling, will be prepared by the DHT in consultation with the ICB project and will be embedded in the DHT's annual work plan and budget. After approval by the contracting party on the one hand and by the ICB Project Steering Committee on the other hand, this detailed budget for the July 2014 to June 2015 period will be attached to this agreement as Annex I-B; such Annex I-B will be duly signed by the three parties of this agreement.

While the district will integrate the activities and funding related to this agreement in the annual operational and financial

[9] Exchange rate: 1 Euro = 3,300 Uganda Shillings

planning and reporting of the DHT (district health sector planning, budgeting and reporting); all planning, procurement, registration, accounting and reporting by or for the DHT will always distinguish per source of funding and will thus allow to single out the activities and expenditures undertaken under this agreement.

All budgeting, accounting and financial reporting by the contracting party shall be done in Ugandan Shilling.

6.2 In the context of the ICB project, within the limits set in Art. 6.1, BTC and MoH undertake to completely finance the « ICB District-level health sector capacity building initiatives » as scheduled in a detailed work plan and corresponding detailed budget, formally approved by all three parties to this agreement.
If fluctuations in the Euro - Ugandan Shilling exchange rate would lead to a situation where the approved detailed budget, expressed in Ugandan Shilling, cannot be fully funded within the total maximum budget of this agreement, expressed in Euro, then the payments by the ICB Project will be curtailed when the maximum budget ceiling expressed in Euro is reached. However, if possible and appropriate, the ICB Project Steering Committee may still consider to allocate budget reserves of the ICB project to fully or partly offset such exchange rate losses, if any.

6.3 The funds granted to the contracting party by BTC and MoH, in the context of the ICB Project, shall only to be used by the contracting party for the purposes defined in the agreement and in line with a detailed work plan and budget formally approved by all three parties mentioned above.

ARTICLE 7 – MODALITIES

7.1 Funding referred to in Art. 6 is released in the following way:

a) The ICB Project transfers, within 20 days after signature of the agreement, an advance funding amounting to 20% of the total budget for this (18 month's) agreement. To do so, the contracting party must submit to the ICB Project a signed request for payment (in conformity with the model given in Annexe IV).

b) In order to replenish the advance funding under this agreement, the contracting party may submit to the ICB Project a signed request for payment (in conformity with the model given in Annexe IV). Such request for payment may be done as soon as the accumulated amount of expenditures, made by the contracting party and still to be accounted for to the ICB

project, reaches 40% of the advance funding (or 8% of the total budget of the agreement). In order to allow continuity of operations, the contracting party shall submit such request for payment in a timely manner.

c) Together with the request for payment, the contracting party shall submit, to the ICB Project, full accountability of expenditures made by the contracting party. The expenditures will be detailed per activity (as defined in the annual work plan). Attached to the request for payment and for each conducted activity, the contracting party shall provide a concise statement of achievements, deliverables materialised and/or of the current status of the 'work in progress'.

d) The contracting party will attach the originals of receipts, invoices and other accounting documents to the signed accountability form to be submitted to the ICB project; doing so, the contracting party will keep a copy of all submitted documents.

e) Any expenditure made by the contracting party should be justified by the contracting party to the ICB project, within 3 months of the date of the corresponding payment by the contracting party. Therefore, even if the accumulated amount of expenditures to be accounted for to the ICB project has not yet reached the threshold of 40% of the initial advance funding, a request for payment and attached accountability should be submitted within three months after the date of the oldest payment still to be justified to the ICB project.

f) After having verified the validity of the justified expenditures, the ICB Project will replenish the advance funding (for the amount of the 'accepted expenditures' and up to limit of the budget ceiling for this agreement) and return to the contracting party all original receipts and other accounting documents. The ICB project shall diligently process any "requests for payment" and attached "submitted accountability" as to ensure that the advance funding is effectively replenished within 6 weeks after their submission by the contracting party.

g) However, if and whenever the contracting party is not fulfilling its reporting obligations as specified under this agreement, then the ICB Project shall halt the payments required for the replenishment of the advance funding, until the contracting party has sufficiently complied with such reporting obligations.

h) The ICB Project will execute the transfers in Uganda Shilling and will, each time, communicate to the contracting party both the counter value in Euro of such transfer and the remaining balance, in Euro, of the maximum budget of the agreement in Euro, as defined in art. 6.1.

7.2 The payments by the ICB project (both for the initial advance funding and for the subsequent replenishments of that advance funding) are done by direct transfer into the following bank account: **Account Name: Kyegegwa DLG-ICB Health**

Account Number: 8912100170
Bank: Centenary Bank
Branch: Mubende branch; being the "ICB Health" bank account opened by the contracting party in line with its obligations listed under art.3.1.

This bank account will be managed with the same signatories and applying all district governance procedures and internal controls that apply for the use of DHT's general bank account; while also complying with the principles stated in Art. XII of the general conditions.

7.3 Ex ante control

a) Funding provided for this agreement may only be used for activities specified in the work plan and in the detailed budget approved by the three parties of this agreement.

b) All generic district local government ex ante control on expenditures and budget implementation are also applicable to the use, by the DHT, of the funding provided under this agreement.

c) Any use of a "personal imprest", as required to implement activities under this agreement, should be well justified and systematically documented. A register of "outstanding imprest" under this agreement shall be maintained by the contracting party and systematically updated. Any imprest should be accounted for within a month by the individual concerned, with full justification of expenditures made and immediate reimbursement to the "ICB Health Bank Account" of any remaining balance.

d) Any procurement of goods or works (tools, equipment, furniture, refurbishment, etc) for an amount exceeding **2,000,000** Ugandan Shilling requires prior approval by the ICB project. This threshold being particularly low since other than the procurement of office supplies, fuel, etc. required for conducting the approved activities, this agreement is not conceived to fund the generic needs of equipment or infrastructure of the DHT and/or health facilities in the district. However, liaising with the ICB project and outside the funding for this agreement, the district may solicit additional support from the ICB project for well-justified investment in such equipment, infrastructure, etc.

e) Any procurement of services for an amount exceeding **2,000,000** Ugandan Shilling requires prior approval by the ICB project.

f) Budget reallocation :

1) Without exceeding the total approved budget allocation for a same 'main activity', the DHO may decide to reallocate approved budget amounts between 'specific activities' of a same 'main activity' up to a maximum of 5% (in plus or in minus) of the 'specific activities' involved. Such budget reallocations must be done in writing, immediately documented and explicitly mentioned in the quarterly report.

2) Without exceeding the total approved budget allocation for a same 'main activity', the CAO, on written request by the DHO, may decide to reallocate approved budget amounts between 'specific activities' of a same 'main activity' up to a maximum of 20% (in plus or in minus) of the 'specific activities' involved. Such budget reallocations must be done in writing immediately documented and explicitly mentioned in the quarterly report.

3) Without exceeding the total approved annual budget allocation for this agreement (GoU fiscal year), the CAO, on written request by the DHO, may decide to reallocate approved budget amounts between 'main activities' up to a maximum of 5% (in plus or in minus) of the 'main activities' involved. Such budget reallocations must be done in writing, immediately documented and explicitly mentioned in the quarterly report.

4) Without exceeding the total approved annual budget allocation for this agreement (GoU fiscal year), the CAO and the ICB project, on written request by the DHO, may jointly decide to reallocate approved budget amounts between 'main activities' up to a maximum of 20% (in plus or in minus) of the 'main activities' involved. Such budget reallocations must be done in writing immediately documented and explicitly mentioned in the quarterly report.

5) Any budget reallocation exceeding the above thresholds requires a more formal budget modification, with updated annual work plan and updated detailed budget to be duly approved by the three parties of this agreement.

7.4 Ex post control

a) All expenditures / payments made by the contracting party must be justified as part of a 'full accountability', to be submitted to the ICB project together with the next request for payment for the replenishment of the advance funding or anyhow within three months of the date of payment by the ICB project.

   1) The accountability submitted with any request for payment should include a copy of the bank statements since the initial advance funding or since the latest request for payment. Any use of funding not justified yet should be explained and corresponding accountability should be submitted by the contracting party within three months of such use of funding.

2) After analysis of the submitted accountability, the ICB project shall explicitly communicate to the contracting party the amount of "accepted expenditures".

3) Any refusal to accept expenditures submitted by the contracting party will be explicitly justified and communicated by the ICB project to the contracting party. Within three months of such refusal, the contracting party shall either provide additional acceptable justification for the expenditure or reimburse the rejected funding to the "ICB Health" bank account.

4) At the stage of "closing" the agreement, any advance funding made by the ICB project that has not been offset by "accepted expenditures", should be reimbursed by the contracting party to the ICB project.

b) The ICB project shall analyse the quarterly execution report, comprising operational and financial information, to be submitted by the contracting party before the end of the month following the concerned quarter. The ICB project may call upon external expertise in assisting the permanent ICB project team with the analysis of these quarterly reports and the related quarterly ex post control by the ICB project.

7.5 Reporting

a) The contracting party undertakes to report on the execution of the tasks that are entrusted to it in this agreement.

b) A quarterly execution report, shall be submitted by the contracting party to the District Council and to the ICB Project within 30 days after the end of the quarter. This execution report covers all activities and contains information about the execution of the tasks and the appropriate use of the funds received.

In line with Art. V of the general conditions, the minimum content of the quarterly execution report comprises the following.

1) An operational report providing a succinct description of the way in which each activity has been executed, indicating the state of progress of the activities defined and/or the rate of achievement of the objectives (including concrete deliverables) that were defined in the work plan. Per activity, the report provides at least a concise statement of achievements, deliverables materialised and/or of the current status of the 'work in progress'.

2) A financial report comprising:

(a) a detailed overview, specified per activity, of expenses effectively paid and of commitments made (including outstanding local purchase orders and invoices received but not paid yet);

(b) a detailed chronological financial overview showing the use made of the funds transferred to the contracting party with a copy of the bank statements for the corresponding quarter;

(c) a detailed overview of payments made that have not yet been integrated in a detailed accountability submitted to the ICB project;

(d) a detailed overview of all “outstanding imprest”, still to be accounted for by the individual responsible;

3) A detailed description of the operational and financial planning for the following quarters; thus providing (for the remaining quarters of the year) a (where required) updated version of the annual work plan and detailed budget, as defined in Annexe I of the agreement;

4) Information about the control and audit measures that the contracting party has been submitted to, as well as control measures that the beneficiaries of the funds were subject to, if applicable;

5) If an audit has been carried out, the summary report should be included, specifying the results of the controls, the recommendations given as well as, if applicable, the action plan that has been elaborated by the contracting party to remedy the problems found by the audit.

The format for reporting is provided in Annexe III.

c) Within 45 days after the end of the execution period, this is by 15th September 2015, the contracting party shall submit to the ICB Project a final report. This final report shall: (a) provide a summary of the execution of the activities covered in the agreement, (b) inform on the extent of achievement of the objectives targeted in the annual work plans, and (c) comprise final accounting for the use of the funds provided through this agreement.

7.6 Auditing

a) A half yearly internal audit of this agreement and its implementation will be conducted by the District Internal Audit Team. If required, non-wage operational expenses specifically needed for such internal audit activities, may be planned and budgeted in the annual work plan and corresponding detailed budget for implementing this agreement.

b) An external audit, mandated by BTC, will be conducted for the January-June 2014 period and subsequently for the fiscal year 2014-2015 (July 2014 to June 2015 period). The scope of such audit will be at least a ‘financial audit’, but BTC may decide to extend the audit scope to other types of audit, including ‘value for money auditing’.

c) Other types of audits may be decided upon at any stage by any of the three parties, signatories to this agreement, in line with art. XV of Annexe II.

ARTICLE 8 – MONITORING AND EVALUATION

8.1 All generic district local government monitoring and evaluation processes are also applicable to the use, by the DHT, of the funding provided under this agreement.

8.2 As specified in art. 7, the quarterly execution reports and the accountability of expenditures attached to any request for payment, allow for periodic monitoring by the ICB Project team.

8.3 A final evaluation of this agreement, including its implementation and the related partnership between the three parties involved in this agreement, will be undertaken. If appropriate, a limited interim evaluation will be conducted after the first phase (January – June 2014).

8.4 Other types of evaluations may be decided upon at any stage by any of the three parties, signatories to this agreement, in line with art. XV of Annexe II.

ARTICLE 9 – CORRESPONDENCE

9.1 All correspondence about the agreement shall be in writing, shall mention the number and the name of the agreement and shall be sent to the addresses listed below.

For BTC-ICB
Plot 1B, Lower Kololo Terrace, P.O. Box 40131, Kampala, Uganda
To the attention of **Mr. Nebeyu Shone** with copy to **Dr. Isaac Ezaati, ICB Project Manager and Dr. Hans Beks, ICB Project Technical Advisor.**

For MoH
Plot 6, Lourdel Road, P.O. Box 7272, Nakasero, Kampala, Uganda

To the attention of **Dr. Asuman Lukwago, Permanent Secretary, MoH**

For the contracting party:
Kyegegwa District Local Government Office, P. O. Box 99, Kyegegwa, Uganda
To the attention of **Mr. David Kawooya, Chief Accounting Officer.**

9.2 Requests for payment and the reports annexed thereto, including demands to change a bank account, are sent to the ICB Project at the following address: **ICB Project, Ministry of Health Headquarters, Plot 6, Lourdel Road, Office B105 and B113, Nakasero, Kampala, Uganda**

ARTICLE 10 – ANNEXES

The following documents are annexed to the agreement and are an integral part of the agreement:

Annexe I: Description of the detailed budget + operational schedule and financial planning

Annexe II: General conditions of BTC applicable to the agreement

Annexe III: Format for reporting

Annexe IV: Model of a request for payment

In case of conflict between provisions of the annexes and those of this agreement, the latter prevail.

Done in ....(*location)* in three copies, one for a representative of BTC, one for the representative of MoH and one

for the contracting party.

For the contracting party

Name

Capacity

Signature

Date

For BTC

Name

Capacity

Signature

Date

For MoH

Name

Capacity

Signature

Date