RESULT REPORT 2016

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

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Acronyms

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

SRH	Sexual and Reproductive Health
TFF	Technical and Financial File
UHC	Universal Health Coverage
UNMCHP	Uganda National Minimum Health Care Package

1 Intervention at a glance

1.1 Intervention form

Intervention title	**Institutional Support for the Private-Non-For-Profit (PNFP) health sub-sector to promote universal health coverage in Uganda.**
Intervention code	**UGA1302611**
Location	**Uganda: Kampala, West Nile region and Rwenzori region.**
Total budget	**€ 8 000 000**
Partner Institution	**Ministry of Health**
Start date Specific Agreement	**13 May 2014**
Date intervention start /Opening steering committee	**27 June 2014**
Planned end date of execution period	**30 June 2018**
End date Specific Agreement	**13 May 2020**
Target groups	• **Ministry of Health and Medical Bureaux** • **PNFP health facilities and institutions in West Nile and Rwenzori region.** • **Rural population of West Nile and Rwenzori region, in particular the mothers and children.**
Impact[1]	**Contribute to strengthen service delivery capacity at district level to effectively implement PHC activities and deliver the UNMCHP to the target population.**
Outcome	**PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.**

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

Outputs	**Result 1**	**MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies.**
	Result 2	**MB and PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions.**
	Result 3	**District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations.**
	Result 4	**MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities.**
	Result 5	**PNFP HC III and IV of the regions of West Nile and Rwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF.**
	Result 6	**PNFP hospital care of West Nile and Rwenzori is more accessible for the population without loss of quality of care through RBF.**
Year covered by the report		**2016**

1.2 Budget execution

	Budget	Expenditure		Balance	Disbursement rate at the end of year 2016
		Previous years	Year covered by report (2016)		
Total	**€ 8 000 000**	**1 178 779**	**1 494 369**	**5 326 852**	**33%**
Output 1	272 950	62 588	95 707	114 655	58%
Output 2	183.200	38 857	75 909	68 434	63%
Output 3	67 000	12 432	8 486	46 082	31%
Output 4	89 000	42 509	16 906	29 585	67%
Output 5	2 198 600	3 280	295 339	1 899 981	14%
Output 6	1 979 600	30 932	315 216	1 633 452	17%
Common costs related to the activities	1 455 340	353 640	315 591	786 109	46%
General means	1 610 108	616 410	356 441	637 256	60%

1.3 Self-assessment performance

The project provided technical and financial assistance to the Private not-for-Profit (PNFP) coordinating bodies, so that they can fulfil their advisory, technical and regulatory role towards their affiliated health facilities and regional coordination bodies. The partnership between PNFPs and Ministry of Health (MoH) at national level have been strengthened by provision of the needed support to the Medical Bureaus.

At regional level, the districts (DHO and DHMT) and health sub-districts (HSDs) were supported in their capacity to provide technical assistance to all health facilities by performing joint supervision and planning activities with the PNFPCBs (private not for profit coordinating bodies). At regional level, efforts have been made to improve the basic structural standards in the health facilities to foster the quality of services, hence to meet the basic structural standard required to enter the Result Based Financing (RBF) program initiated by the project.

The RBF mechanism in the health sector is an innovative fund allocation mechanism in which payments to health care providers are made following the achievement of specific outputs. It is a mechanism that renders health service providers responsible for their performance, granting greater spending autonomy, with real decentralization of decision-making, combined with a

financial motivational aspect. The MoH has identified the RBF as a viable strategy to improve performance in Uganda's public health sector and looks with particular interest to this project to provide further input in the discussion. The introduction of such RBF mechanism in the PNFP sub-sector in the Rwenzori and West Nile region will serve as a model for the MoH on how to institutionalize a national RBF mechanism to support the overall public health sector in Uganda. The long term objective is to create a National Trust Fund funded by contributions of the GoU and donors through basket funding with a national management board. Such a National Trust Fund would manage the financial resources, contract health facilities and control service delivery.

The RBF design has taken into account the best practices observed in other Low and middle Income countries, but also in other project implemented in Uganda (Acholi region and Jinja diocese). A comprehensive cost study has been conducted to inform the design of the RBF, in order to avoid underfinancing of health facilities, hence production of poor quality of services, knowing that poor quality is always more expensive to the community than safe and unharmed health services. In June 2016, RBF Grants agreements were signed between 15 beneficiaries District Local Governments represented by Chief Administrative Officer. The contracting authorities were the MoH represented by the Permanent Secretary and BTC represented by the country Resident Representative. In line with these grant agreements, performance contract were signed between 32 health facilities and their respective District Local Government.

14 more health facilities were qualified in September to enter the RBF program, but did not sign the performance agreement with their District Local Government in 2016 as expected. With up to 28 health facilities that may be contracted in 2017, the project is on track to roll out the RBF in all potential PNFP health facilities in West Nile and Rwenzori. The major challenge so far is the slow progress on the operationalization of the National RBF Unit at the Ministry of Health. The Unit has responsibility for the overall coordination of the RBF adoption and roll out in the health sector and therefore for all the functions related to purchasing services, regulation of RBF initiatives in the country and to oversee the verification of the quality and quantity of health services purchased.

1.3.1 Relevance

	Performance
Relevance	A

Anchored at the MoH's Directorate of Planning and Policy, the PNFP project is also working at regional level to strengthen the local health system. This twin anchorage at central and regional level is an opportunity to improve with the lessons learned from the field, the MoH's capacity in reviewing, disseminating and using the Public Private Partnership for Health (PPPH) policy and implementation guidelines, and in designing the country RBF framework.

The design and implementation of RBF in 15 District is totally in line with GoU Health Financing Strategy and with PPPH policy and implementation guidelines. The allocation of funds to the health facilities based on the production and the quality of the services delivered improves equity, efficiency and effectiveness in the use of resources, compare to the existing ex ante allocation formulas.

The RBF design seemed a little “too strategic” for some stakeholders. The project does not only aim to pilot the strategic purchasing of health services as prescribed by the country health financing strategy, but also to strengthened the overall health system at District and National level. The RBF program was then designed to address the key challenges identified in the second National Health Policy (NHP II) and support the roll out of the strategies defined in the Health Sector Development Plan (HSDP).

Moreover, RBF framework is totally relevant with PNFP mission and core values: to take care of the most vulnerable people. The PNFP facilities represent about 23% of the Health facilities in the country and 50% of the production of Health services but receive from the Government only 20% of the total expenditure on health facilities. Investing in their recurrent cost will have an important added value in term of improvement of access to and quality of health in the intervention area. Almost all of the HFs acknowledged that the quality component of the RBF system is useful: it helped them “to tighten the bolts of certain components a little wobbly”. The health workers and health facilities managers are positive about the RBF system, although some of them are not yet 100% sure that RBF will actually represent additional funding. It may just compensate lost revenues from patients, but it is too early to establish a comparative financial situation.

1.3.2 Effectiveness

	Performance
Effectiveness	A

The interventions planned in 2016 were fully supported by the MoH Directorate of health Services, the PNFP Medical bureaus and most of the District Local Governments. The achievement of the project outcome is very likely in terms of quality and coverage but it’s too early to measure the impact of the intervention through the DHIS2 data, as the RBF only started in July 2016 (not in March as planned) for the first batch of qualified health facilities. The grant template submitted by the project team in November 2015 was approve by BTC Headquarter in February 2016, but it took up to June to have the clearance of the Office of Solicitor General - Uganda.

On the other hand, the National Technical Assistants in the 2 regions of implementation (West Nile and Rwenzori) resigned before the end of the year 2015. The absence of the Technical Assistant resulted in the delay in the development of the District coverage plan and Health Facilities business plans. New Technical Assistants were recruited in April and June 2016. They had no or limited experience in RBF, and there were very little time left for them to master the RBF processes that started in July at health facility level. This may partly explain why first verification conducted in October and November was still somewhat shaky. The support of the TA was not enough to compensate the structural weaknesses of the DHMT. The verification process was then so weak that the validation process at central level, which should normally be a formal arithmetic final check, turned to be a counter-verification exercise. Obviously, the central level was not prepare for that.

Nevertheless, the whole RBF system can be considered as good and comprehensive enough for an installation/induction phase. The advantage of having put the focus on quality (overall

quality assessment + quality of outputs) is that health facilities are aware that RBF subsidies are not “easy money” (no free lunch).

1.3.3 Efficiency

	Performance
Efficiency	B

Most of the resources used at central level in 2016 were invested in training and supportive supervision toward the District level, assuming that the capacity building is the most efficient part of the project in the long run. The team composition for the field visits always include both staff of the MoH and Medical Bureaus, to enhance the team building for a better PPPH, but also to save the resources invested in the transport.

Regarding the RBF, the cost of verification was kept very low by using DHMTs. The hectic process of first verification exercise shows that DHMTs and NTA at regional level were not sufficiently skilled. Discussion will be made in the National RBF Unit on the appropriateness of using the DHMTs as verification bodies, and on the training methods for the District Teams. On site trainings, with coaching and mentorship may be more effective, even if time consuming and more expensive.

For efficiency purpose, all the RBF output indicators are part of DHIS2 indicators. The quality indicators are part of MoH health facility quality of care assessment tools. Although the quality assessment tool may appear to be heavy, it’s just part of the normal quality monitoring work of DHMTs that is not well performed to date.

With RBF, the fiduciary risks are transferred from the donor/fund holder to the provider: RBF pay for services that are already delivered, not for work plans to be implemented. Nevertheless, the pressure put on a USD spent through RBF is too much compared to the very same USD spent through other traditional financing systems, and the project may appear to be overambitious about the potential leverage effect of RBF: quantity, quality, accessibility and coverage increase, improved HRH management, improved essential medicines. In fact, tough control procedures were put in place at the very beginning of the RBF implementation to improve the quality of the service and management of health services, but also to convince the donors that the services paid for are of good quality. Moreover, the organizational weaknesses of health facilities and DHT are interconnected. Being a health system strengthening project, the PNFP project shall address the weaknesses identified by the MoH in strategic documents. We assumed that the quantity of produced services will increase only if there is improved financial access, improved responsiveness of the health facilities and better quality of services delivered. The increase coverage will be the consequence of increased utilization of services.

1.3.4 Potential sustainability

	Performance
Potential sustainability	B

A donor driven strategy as the RBF pilot project cannot be financially sustainable. Nevertheless, the major interventions outlined by the project theory of change will contribute to the capacity building of the MoH to oversee and regulate the health sector in the long run. For this reason, some of the project interventions have been designed to be implemented even without the RBF.

Developing and implementing a health coverage plan in the Districts and HSDs to enhance the geographic access to the health services will contribute to the rationalisation of health infrastructure investments to ensure that they effectively and efficiently contribute towards improved health service delivery. The tools developed by the PNFP project are used by some of the Medical Bureaus out of the intervention area. The same tools will be used to roll out the RBF in other districts by the coming RMNCH (Reproductive Maternal, Neonatal Child and Adolescent Health) Services Improvement project funded by the IDA loan and GFF (Global Financing Facility) grant. It's hoped that in the future, the licensing and accreditation process for Public and PNFP health facilities will become a routine in the health sector as foreseen in the MoH quality improvement strategy, regardless the implementation of the RBF, to strengthened continuous quality improvement and strategic management of health service, hence contribute to the improvement of quality of care and responsiveness of health facilities.

Taking advantage of the development of a national RBF model to define a complete package of service for the entire population and primary health care services user's entitlements will improve the transparency and equity in the allocation of public funds in the health sector. The RBF model has been designed to establish strategic purchasing of health services, and introduce a third party payment mechanism in Uganda's health sector, in order to convince the donors and the GoU to rise more funds for health financing. By demonstrating the achievements in service coverage, population coverage and financial protection of the population including the most vulnerable (mother, children and adolescent), the project may give an argument to the Belgian Cooperation in the policy dialogue in the health sector. Other donor may accept the pooling of resources to implement the RBF program, and in the future, build with the Government of Uganda a trust fund to finance the universal access to health services in the country.

1.4 Conclusions

- The project has spent considerable time on preparing health facilities (in a participative manner) to take on RBF. The start-up phase included preparing tools, guidelines and frameworks. This is time consuming but necessary for proper implementation of RBF in the long term.
- Project has taken the necessary steps to ensure full local ownership, hence the sustainability of the interventions.
- Project missions, meeting and discussions with partner institutions has learnt that the project's intervention (and its logic) is well understood, aligned with the national and Belgian policies and strategies, and very relevant.
- The MoH shall be supported to set up a strategic purchaser of health services that's will define the package of health service to be purchased and support the accreditation of health facilities.
- Effort shall be invested to keep the RBF implementation aligned with MoH strategy, to simplify the verification procedure and to give more autonomy to the health facility in the use of RBF grant.

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	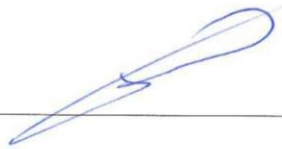

Results Report

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2 Results Monitoring

2.1 Evolution of the context

2.1.1 General context

The general context remained largely unchanged. There was no key evolution in sector policy or decentralization policy in 2016. The general elections did not affected the general political and socio-economic environment. There was no structural organizational change in any of the partner institutions. At the beginning of 2016, the Ag. Commissioner Planning was assigned as the Projector Coordinator. In June 2016, the former Director General was appointed the new Minister of Health and towards the end of the year a new Permanent Secretary was appointed. These changes at top management level didn't have negative effects on the project.

2.1.2 Institutional context

The project is anchored at the Directorate of Planning and Policy in the MoH. The project manager is the comissioner of planning. The proposed anchorage of the RBF unit that will act as strategic purchaser of the health services in the Department of planning, under the supervision of the PNFP Project Manager is favourable for the further scale up and institutionalization of RBF in the health sector. The RBF unit will be in charge of the RBF component of the upcoming RMNCAH Services Improvement project, a 140 million USD program funded by the IDA loan and GFF grant.

2.1.3 Management context: execution modalities

The project work plan was executed to an acceptable level. Budget modifications were approved by the steering committee to faciltated the implementation of the annual work plan.

2.1.4 Harmonisation context

A health Fianncing strategy and RBF framework for all RBF interventions nationwide have been adopted by the Health Sector Budget Working Group during the first quarter of 2016. The RBF implementation manual used by BTC health project is derived from the framework which will be enriched with the lessons learned from the field and endorsed by the Top Management of the MoH.

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

2.2 Performance outcome

2.2.1 Progress of indicators

Outcome: PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
Total value of debt in PNFP health facilities enrolled into RBF	**7.1bn**	**7.1bn**	**6,4bn**	**4bn**	**3.5bn**
Reported maternal death	**106**	**89**	**85**	**80**	**20**
Reported under-five death	**1647**	**1567**	**1317**	**1200**	**300**
% deliveries in health facilities	**40%**	**56%**	**50%**	**65%**	**80%**
Contraceptive Prevalence Rate	**15%**	**18%**	**37%**	**40%**	**50%**
Evolution of fee levels in PNFP health facilities	**31 905**	**40 516**	**46 066**	**45 000**	**22,000**

The indicators related to health service delivery have been reported for the period from July 2015 to June 2016, using the available district and health facility data from the regions of intervention.

2.2.2 Analysis of progress made

The performance of the last financial year cannot be attributed to the project interventions, as funding to the health facilities has just started in July 2016. Nevertheless, emphasis of the health facilities quality assessment and trainings on the improvement of health information system and clinical audits have probably improve the reporting of death by the health facilities. This may explain the increase of the number of reported under five and maternal death from July to December 2016 despite a slightly increase of deliveries in health facilities. During the same period, there was no significant change in contraceptive prevalence after the good performance of the financial year 2015/2016, thanks to the performance of public facilities.

On the other hand, the RBF funds received in December 2016 were representing only 6% of the total income of PNFP facilities that's signed a performance contract with District local Governments. The proportion was 11% in West Nile, but only 1% in Rwenzori were any hospital declare the outputs at the end of the first quarter of implementation, as the user fees were not reduced. With a low contribution and late payment of RBF funds, there is no significant change in the indebtedness (mostly toward JMS) of PNFP facilities within the intervention area. Nevertheless, the budget balance of the health facilities reflects a better performance. The total expenses were inferior to the total income, thanks to the start-up medicine granted to the health facilities, despite the reduction of user fees in many health facilities since august 2016 and the fact that the project start-up grant (essential medicines) did not cover the increase of activities in

many General hospitals. There is no evidence the reduction of user fees per patient in West Nile has any influence neither on the average user fees per patient (13 USD per admission), nor on the proportion of user fees on the total health facility income (61% in Rwenzori and 25% in West Nile) compare to the previous financial year. This may be explain by a higher cost-recovery rate, as more patients are able to pay their bill.

2.3 Performance output 1

2.3.1 Progress of indicators

Output 1: MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of approved posts filled by trained health workers.	**58%**	**63%**	**63%**	**70%**	**80%**
% of PNFP health facilities implementing the national SRH/HIV policies.	**90%**	**92%**	**93%**	**95%**	**98%**
Amount of GoU budget (conditional grant) allocated to PNFP health sub-sector.	**17bn**	**17bn**	**17bn**	**17bn**	**18bn**

2.3.2 Progress of main activities

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

2.3.3 Analysis of progress made

In 2016, the project completed the equipment of PPPH Node, supported the daily running of the office activities and ensured its functionality. The creation and functionality of the PPPH Node at MoH has provided through regular PPPH Technical Working Group meetings an excellent avenue for private health care providers, not only the PNFPs but the wider private health sector, to interface and engage in constructive dialogue with the MoH. One meeting of the PPPH Technical Working Group was supported per quarter, together with other donnors. The project also supported consultancy and stakeholders consultations to develop a country PPPH strategic plan to be adopted in 2017. Priorities actions in the strategic plan will be selected at the end of the process to be supported by the PNFP project.

The PPPH policy and implementation guidelines were disseminated in 45 districts out of the project implementation area, with a total of 135 District leaders involved. The assessment of PPPH implementation was also supported in eastern and Western Uganda, and routine monitoring of PPPH policy implementation was conducted in Mid Western and central Uganda. A total of 12 Districts were covered by these activities. It's to be hoped that the concerned District will appoint a PPPH focal point as prescribed by the guidelines.

The PPH Node organized joint MoH and Medical Bureaus field visits (inspections, training and supervisions) to monitor the implementation of PPPH policy at decentralised levels and supervise RBF activities. Nevertheless, many planned activities were posponed to 2017, partly due to the inssufiscient staff of the PPPH Node:

- International training of PPPH Node staff in Public private partnerships design and management
- Annual conference to share experiences and best practice on PPPH implementation not done
- Study tours for PPPH experience and roll out of accreditation procedures.
- Draft policy brief to inform policy makers regarding the problem of dual employment

Although the term of references were finalized, the Junior assistant in communication was not recruited as foreseen in the project TFF. The communication strategy for PPPH Node was not elaborated as well.

2.4 Performance output 2

2.4.1 Progress of indicators

Output 2: MB and PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of prequalified health facilities	**0**	**8%**	**64%**	**77%**	**80%**

2.4.2 Progress of main activities

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

2.4.3 Analysis of progress made

The joint accreditation tools elaborated in 2015 were used for RBF prequalification assessment. 64% of the PNFP health facilities, including all General Hospital and health Centre IV were qualified. This represent 77% of facilities that will potentially qualified to joint the RBF program during the project life. More than 50% of Health Centre III were qualified without any equipment donation, thanks to the support by the Medical Bureaus and District Local Government. In Nebbi District, the advocacy by the PNFP regional coordinators led to the secondment of key staff in PNFP facilities. All PNFP hospitals showed significant improvements in quality of care with 3 hospitals over 8 reporting five stars performance.

Identification of training and equipment needs for the Medical Bureaus was done and several challenges identified especially at regional coordination offices. The project supported all the medical bureaus to equip their regional offices with heavy duty printers and IT equipment, and provided some equipment to PNFP MB offices at national level.

Significant efforts were put on organisational developent of UMMB and UOMB that were supported to develop and adopt a 5 years strategic plan. All Medical Bureaus annual health assembly were supported at national and regional level. The Project also supported all Medical Bureaus to carry out on quarterly basis support supervision from central level to regional level, and from regional level to health facilities. UOMB specifically was supported to conduct accreditation process and support supervission outside the project areas, using the tools developed by the project. All these support visits were jointly organized with MoH Quality Assurance Department.

Training of hospital governing boards in oversight and fiduciary assurance were not conducted as planned.

2.5 Performance output 3

2.5.1 Progress of indicators

Output 3: District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of villages with trained VHTs per district.	**91%**	**93%**	**95%**	**95%**	**95%**
Number of health coverage plans completed.	**0**	**0**	**0**	**15**	**15**

2.5.2 Progress of main activities

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

2.5.3 Analysis of progress made

In collaboration with ICB project, the PNFP project organised regional health forum and first Regional Pre-Joint Review meetings which brough together all stakeholders in the health sector in the regions. The PNFP project has ensured that all PNFP representatives (Hospitals Directors and PNFP Coordinators) attend these meetings initiated by ICB II project, to enhance the PPPH at regional level, as regional performance is discussed and owned by all stakeholders.

The development of District coverage plans is ongoing, but the organization of regional workshops to discuss and finalise draft coverage plans inclunding Hospital Care Coverage and care provision study was posponed, due to delay in the training of five MoH staff in Geographic Information System at Brussels. The District coverage maps will be finalized in 2017 with the support of ICB II project.

In 2016, training of PNFP staff on health facility quality of care assessment program were organized in in West Nile and Rwenzori by the MoH and DHTs. MoH Quality Assurance Department was supported to conduct training of District Supervisory Teams and health facility assessments (all public and PNFP health facilities) in Rwenzori region.

PNFP regional coordinators were also facilitated to carry out joint support supervisionwith the DHT although the orientation workshops for MBs and districts on MOH supervision guideline were not conducted, as the supervision guidelines were under revision. To strenghtened these supervisions, but also other District coordination activities (DHT and quarterly performance review meeting) and verification of output and quality of care, RBF contract were signed with 15 DHT.

2.6 Performance output 4

2.6.1 Progress of indicators

Output 4: MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
RBF model accepted by MoH and GoU as the national model, available.	**0**	**0**	**1**	**1**	**1**
Number of districts nation-wide joining the RBF scheme.	**0**	**0**	**15**	**25**	**20**

2.6.2 Progress of main activities

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

2.6.3 Analysis of progress made

To foster the culture of quality improvement in the health facilities, Joint accreditation procedures developped with the support of the project were used for the selection of RBF beneficiaries health facilities. During the proces, improvement were noticed in most of the health facility before RBF start up, thanks to the dynamic of quality improvement after the self assessment.

Significant progress was registered in 2016 in the design of RBF scheme in uganda. The framework for the RBF in the health sector was approved in March 2016 by the MoH Top Management. The HSBWG. The HSBWG also authorized the PNFP project to start the pilot phase of the RBF and test the RBF Implementation Manual which will be improved with lessons learned from the field before the roll out. After these authorization and the appraisal of the RBF Grant agreement template by BTC Headquarter and the Ofice of Sollicitor General Uganda, the RBF started in July 2016.

Orientation training in RBF and training in planning were conducted for the qualified health facilities and District for a smooth the start up of RBF at District level. The training course at national level was replaced by several retreat to discuss RBF implementation manual and tools. International training of MoH and project staff in RBF was also replaced by participation to international workshops and symposium.

The training of Verification Team at regional level took place in August. Unfortunatly, the verification exercises without payment (dry testing) that were planned in september as part of the training for HFs, NTA, DHMTs were not conducted, except in Kamwenge District, due to structural weaknesses of some of the DHMT and administrative bottlenecks.

2.7 Performance output 5

2.7.1 Progress of indicators

Output 5: PNFP HC II, III and IV of the regions of West Nile and Rwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of PNFP health centres delivering the full HIV package for maternal and child health and HIV/AIDS (including MTCT).	**61%**	**58%**	**72%**	**80%**	**85%**
% of PNFP health centres without any stock-outs of 6 tracer medicines.	**83%**	**87%**	**88%**	**95%**	**100%**
% of health centres IV with functioning theatre (providing EMOC).	**100%**	**100%**	**100%**	**100%**	**100%**
% of children under one year immunized with 3rd dose Pentavalent vaccine.	**99%**	**96%**	**96%**	**97%**	**99%**
% of pregnant women attending 4 ANC sessions.	**30%**	**47%**	**56%**	**70%**	**80%**
% of pregnant women who have completed IPT2.	**44%**	**45%**	**55%**	**70%**	**80%**
% of eligible person receiving HIV therapy.	**70%**	**68%**	**72%**	**75%**	**70%**

2.7.2 Progress of main activities

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

The data reported for 2016 are from district data and includes public health facilities contribution.

2.7.3 Analysis of progress made

The coverage rate are quite good for immunization and HIV therapy. This justify the choice of the RBF framework to focus on the quality improvement issues as well as the quantity outputs in the Health facilities. RBF has just started in July and therefore the performance of the last financial year can't be attributed to project intervention.

Training of qualified Health facilitie's staff, District teams and PNFP regional coordinators in usage of the information system and planning was conducted. HMIS Registers and start up medicine were provided to all qualified health facilities. The health faciliities that were qualified with condition received equipment to forster their quality and prepare them to meet the prequalification standards during the next assessment. No intervention was conducted in the facilies that score less than 2 stars over five. This mean the most in need HFs (and their catchment population) are left aside. It's a deliberate choice to show how the result of a licensing procedure would be, hence motivate the the District Local Governments to invest in health infrastructures and workforce. Health facilities that are left aside are the one that do not meet the minimum of the standards define by the MoH, and which are potentially dangereaous for the community.

The qualified facilities are assessed every quarter for quality improvement initiatives. The quality assessment tool is derived from the health facility quality assessment tool. The indicators and the scoring are the same, for the RBF to be consistent with existing tools.

For the first payment; the proportion of quality subsidies on total subsidies in HC III was around 40%. With increase utilization of health facilities and increased proportion of patients managed according to the defined standards, this proportion will probably decrease in the future. For this proportion to be around 25% as anticipated in the RBF design, more support by the DHMT to HC III is needed to improve the utilization and responsiveness of health facilities. The situation is different in HC IV and GH were the weight of quality subsidies on total subsidies was only around 15% in HC4 and GH. The proportion of quality incentive that was taken from PHC Grant formula may need to be change in the future.

It was noted that 4 (out of 12) first level output indicators represent 82% of output earnings. The other indicators are kept to avoid neglected services in the health facilities, but also promote the public health agenda of the MoH. In order to ease the quarterly verification procedures, the verification teams may focus in the future on a random sample of indicators with few compulsory indicators, while the self-assessment of all indicators by the health facilities will remain compulsory.

2.8 Performance output 6

2.8.1 Progress of indicators

Output 6: PNFP hospital care of West Nile and Rwenzori is more affordable for the population without loss of quality of care through RBF.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
% of referred patients among out-patient department (OPD) clients.	**1%**	**1%**	**4%**	**7%**	**10%**
Ratio number of referred deliveries / total deliveries within the hospital.	**0.6**	**0,29**	**0,23**	**0,4**	**0.7**
% of post-surgery infections.	**2.5%**				**0.5%**

2.8.2 Progress of main activities

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

2.8.3 Analysis of progress made

After a first prequalification asessment in 2015, all the 8 General Hospitals and 4 Health Centre IV in the intervention area were qualified to enter the RBF program in 2016. Assessment of drug supply chain was done with the support of JMS, to improve the management at health facilities level before HC IV and GH receives a start up medicine (supply by JMS). HMIS registers and equipments were also provided, although the procurement of heavy equipment is delayed. The project started the computerisation of hospitals and HC IV. Computers were provided and LAN (local area network) installed in 2016. Initial training, software installation and technical support are jointly conducted by MOH and MB IT experts, but the project failed to involve the MoH Resources Centre as expected. The computerization of patient file will ease the verification process which is time consuming. It will also improve the quality of datas reported and hopefully, the awaredness on some issues like post surgical infections, adverse events and medical errors that are not routinely reported by the health facilities.

Except one (1) Health Centre IV that was awaiting the no objection of BTC up to December 2016, all of these facilities have signed the performance contract with their respective District local government. During the training in planning, the focus was on root cause analysis to understand the indebtness of PNFP health facilities, their financial dire situation and the poor accessibility of the rural population to health care services of good quality.

The project has supported the health facilities managers to conduct a costing study to inform the pricing of RBF indicators. Nevertheless, the decision making on the prices was not easy. There is a urge difference within the two regions and between West Nile and Rwenzori. The user fees represents about 29% PNFP health facilities total income in West Nile, but up to 60% in Rwenzori. In Rwenzori, the PHC grant represents only 6 to 15% (mean: 9%) of the total income versus 4 to 46% (mean: 21%) in West Nile. Because of these differences, it was not always easy to build a consensus on prices. The trend will be monitor during the project life and the prices will be adapted, while avoiding financing only the lower middle class in the community which appear to be the main users of some of the health facilities in Rwenzori. After stakeholder consultation meetings on financial analysis, adaptation and adjustment of the fee paying system, a workshop to disseminate the findings of the costing study that was initially planned in

2016 will be organized in 2017. More autonomy shall be given to the District in the negotiation of prices, to respect the decentralization nature of the health system, but also to take into account the remoteness of some health health facilities and the management of the District Budget. Despite some improvemnent during the last financial year, the referral system is still weak, which has direct impact on HFs RBF subsidies (e.g. output indicators that require formal referral documents. Nevertheless, some HFs witnessed already substantial increase of patients during the last semester of 2016. There are HC4 with more inpatients than beds, which may constitute a threat for their next quality assessment. This is a call to invest in the improvement of quality of services at lower level in both PNFP and public facilities.

2.9 Transversal Themes

2.9.1 Gender

The project took full account of gender, in particular the health status of pregnant women, young mothers and children, in its start-up phase. The RBF guidelines have been designed to ensure maternal services receive a higher subsidy. The subsidies for the delivery were representing for example 40% of the total RBF payment to HC III in 2016. It's to be hoped this will ensure that more women access better healthcare services.

2.9.2 Environment

The project puts emphasis quality of care including patient safety within the hospital environment. The project accreditation tools assess infection control and health facility waste disposal. All hospitals and HC IVs are assessed every quarter on the good practices regarding infection control. It is an accreditation requirement that all health facilities have amenities like an incinerator, placenta pits and garbage bins. Throughout the project period, the health facility business plans will include proper management of wastage according to national guidelines.

2.9.3 HIV/AIDS

Although there is almost no uncovered cost at health facility level to conduct the activities related to HIV, the diagnosis and treatment of HIV patients is included in the list of indicators to be rewarded by the RBF. Specific attention is given to the quality of prevention of mother to child transmission of HIV.

2.10 Risk management

PROJECT CODE	UGA 13 026 11
PROJECT NAME	Institutional Support for the Private-Non-For-Profit (PNFP) health sub-sector to promote universal health coverage in Uganda
YEAR OF REFERENCE	2016
QUARTER OF REFERENCE	Q1

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 1: MoH, and in particularly PPP unit understaffed.	June-15	OPS	Medium	Medium	Medium Risk	Recruitment of a Data Assistant to support data collection and reporting	DHS (P&D)	March-16	PPPH Unit has developed TOR and is lobbying for a donor to support the position	In progress
						Additional training of PPP Unit staff	DHS (P&D)	July-16	1 staff trained in PPPH strategies and structuring	Terminated
						Training of current PPPH staff	DHS (P&D	Decembe r-15	Project to support PPPH staff to train in PPP issues in 2017	In progress
Output 1: MoH, and in particularly PPP unit lack an elaborated vision on the role of the PPP unit	September-14	OPS	Low	High	Medium	*Elaboration of tactical plan of P&D; strategic and Annual Operational plan of the PPPH Unit*	DHS (P&D)	March-16	Consultation meetings have started	Terminated
						Elaboration of PPPH strategic plan	PPPH Unit desk officer	Decembe r-16	A strategic plan was finalized	Terminated
Output 1: MoH does not engage in a sincere partnership with PNFP	September-14	DEV	Low	High	Medium Risk	Facilitate dialogue between the two partners. Organize quarterly PPPH TWG meeting	Project Manager		Dialogue ongoing through the PPPH TWG quarterly meetings Team building during the joint supervision at regional level and health facility level	In progress

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 2: Some Medical Bureaus do not have the required technical, structural and financial competences	September-14	DEV	Low	High	Medium Risk	Capacity building activities	NTA	June-18	A training needs assessment was done in all the MBs. Each MB has a capacity building plan.	Terminated
						Build synergies with scholarship program to increase competences	ITA	December-15	There is a good collaboration with SDHR	In progress
						Elaboration of guidelines and standardization of tools	NTA	June-16	A joint support supervision tools is being developed. Accreditation tools are being harmonized	Terminated
Output 3: Weak leadership and management skills of multiple actors at regional level	September-14	DEV	Low	Medium	Low Risk	Presence of NTAs at regional level	NTA and ITA	January-15	Capacity building to be organized by NTA	Terminated
						Output based financing training and coaching for Health Districts	ITA and NPO	September-16	Trainings conducted at regional level	In progress
Output 4: Delays in gaining consensus on a national model for result based financing	September-15	OPS	Medium	Medium	Medium Risk	Use of available structures within MOH in the RBF institutional arrangements	ITA	June-16	An RBF taskforce has completed the RBF framework The Budget Support technical Working Group has instructed the project to pilot the RBF implementation manual	Terminated
						Engagement of all stakeholders especially MOH and development partners	ITA	June-16	Consultative meeting to develop RBF principles held in Qtr 4 2015	Terminated

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 4: Large scope of the project and strategies and procedures not yet developed.	September-14	OPS	Medium	Medium	Medium Risk	Availability of NTA in every region	ResRep	January-15	2 NTAs regional level are now available	Terminated
						Use of international and national consultancies	ITA	June-16	Support the development of accreditation tools and RBF curriculum, support health facility cost analysis	Terminated
						Use existing synergies with ICB project	ITA	June-18	Holding of joint regional meetings and developing health district coverage plans	In progress
						Gradual scaling-up of the RBF	ITA	June-17	21 contracts were signed at once in Q3 2016 11 more contracts expected in Q4 2016 will be signed in Q1 2016	In progress
						Lack of capacity in business planning at health facility level	NTA	July-17	Training and coaching are ongoing	In progress
						Delay in the contractualization	RAFI	December-16	More training and coaching of district teams in contractualization by the RAFI and the project administrative team is needed	In progress
						Direct payment on health facilities accounts	RPO, ITA and RAFI	June-16	The RBF framework and grant agreement authorizes RBF payments only in health facilities bank accounts	Terminated
						Multiple occasions for verification	BTC and MoH	June-18	NTA are members of verification teams Counter verification and audits are planned	In progress
						Payments only after verification of achievement of activities	BTC	June-18	Verification teams were trained	In progress
						Stimulation of multi-stakeholder coordination	BTC	June-18	Participation in the Budget Support technical Working Group and organization of multi-stakeholder consultation at district and national level	In progress

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 5: Insufficient skill to implement the interventions that required high technicality and financial control.	September-14	FIN	Medium	Medium	Medium Risk	NTA in the region are conducting coaching and supervision activities	RPO		2 NTA regional have been recruited and are in office	Terminated
						Development of business plans as condition to enter the RBF program	RPO	December-16	Business plan template have been be developed and disseminated Qualified health facilities were trained in planning	Terminated
						Use of international expertise to develop the procedures	ITA	December-16	The verification procedures and tools have been developed and tested	Terminated
						Availability of financial staff in the Regions	ResRep	December-15	2 RFAO have been recruited + 1 FPC and one junior expert in finance	Terminated
						Regular audits by the project	RAFI	December-16	Financial, IT and drugs management assessment has been conducted in all hospitals and HCIVs Continuous support of the project administrative and financial team will be given to beneficiary facilities	In progress

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 5: MoH and donor community do not provide long-term financial means	September -14	DEV	Medium	High	High Risk	Support donor coordination	ITA	Continuous	Project Manager and ITA are members of BSTWG	In progress
						Develop clear pathways and procedures	ITA	March 2016	Framework and implementation manual developed	Terminated
						Develop a long-term strategy for pooling of donor agencies resources	ITA and BTC EST	June-18	The roll out plan strategy is included in the RBF implementation manual The RBF is part of the country Health financing strategy	In progress
						Organize international workshop on RBF to do advocacy	ITA and BTC	June-18	International Orientation Workshop on PBF was organised and donors were convinced that RBF needs to be supported in Uganda Another international workshop is planned in 2017	In progress

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 5: PNFP health centres refuse to lower the user fees	September-14	DEV	Low	Low	Low Risk	Conduct cost study in all health facilities to establish standard cost of care	ITA and NTA	March-16	Cost study curriculum developed The managers of qualified health facilities were trained to conduct costing study before the negotiation on RBF prices	Terminated
						Offer assistance in developing realistic business plans	ITA and NTA	June-18	Business plan template developed and disseminated Health facility staff trained in planning	In progress
						introduce the flat fees before the start-up of the Result based financing	ITA	June-17	The results of the costing studies were used to inform the planning process and the decision on new user fees in the qualified health facilities	In progress
Output 5: MoH and donor community do not provide long-term financial means	September-14	DEV	Medium	High	High Risk	Support donor coordination	ITA			In progress
						Develop clear pathways and procedures	ITA			Terminated
						Develop a long-term vision perspectives for donor agencies, including the development of a basked fund.	ITA and BTC EST	June-18	Roll out plan strategy is included in the RBF implementation manual The RBF is part of the country Health financing strategy	In progress
						Organize international workshop on RBF to do advocacy	ITA and BTC	June-18	International Orientation Workshop on PBF was organised and donors were convinced that RBF needs to be supported in Uganda Another international workshop is planned in 2017	In progress

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 6: Large scope of the project and strategy	September-14	OPS	Medium	Low	Low Risk	Availability of NTA in every region	ResRep		2 NTAs regional level have been recruited and in office	Terminated
						gradual scaling-up	ITA			Terminated
						Conduct regular audits by the project	RAFI			In progress
						Payments only after verification of achievement of activities	NTA and RAFI			In progress
						Multiple occasions for verification	NTA			In progress
						direct payment on individual accounts	RAFI			In progress
						Set the development of business plans as a condition to enter the RBF program	ITA	June-17		Terminated
						Include realistic budgets in health facilities business plans	RAFI	June-17	Training and coaching of health centre IV and general hospital to be conducted by the project administrative team	In progress
						Delay in the contractualization	RAFI	December-16	More training and coaching of district teams in contractualization by the RAFI and the project administrative team is needed	In progress

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 6: PNFP hospitals refuse to lower the user fees	September-14	DEV	Low	Medium	Low Risk	Conduct of joint analysis of the financial status	ITA	June-18		Terminated
						Offer assistance to make realistic business plans	ITA and RAFI			Terminated
						Promote experience sharing with the health facilities that have lower their user fees	RAFI	June-18	Close monitoring of financial status of health facilities will guide the project	In progress
Output 6: MoH and donor community to not provide long-term financial means.	September-14	DEV	Medium	High	High Risk	Support the overall implementation of the country financing strategy, especially the mobilization of more funding for the health sector	Project manager			In progress
						Development of long-term vision and perspectives for donor agencies, including the development of a basket fund.	ResRep		The basket fund will probably not start during the project lifespam but the long term perspective is foreseen in the project design as well as in the country health financing strategy	In progress
						Support MB efforts to develop sustainability plans				In progress

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 6: PNFP hospitals refuse to lower the user fees	September -14	DEV	Low	Low	Low Risk	Conduct cost study in all health facilities to establish standard cost of care	ITA and NTA	March-16	curriculum for cost study already developed The managers of qualified health facilities were trained to conduct costing study before the negotiation on RBF indicator prices	Terminated
						Offer assistance in developing realistic business plans	ITA and NTA	June-18	Business plan template were developed and disseminated The health facility staff were trained planning and coaching are ongoing	In progress
						introduce the flat fees before the start-up of the Result based financing	ITA	June-17	The results of the costing studies were used to inform the planning process Negotiated user fees are applicable in qualified facilities	Terminated
						Include the maximum user fee rate for the services that are subsidized by the project fund	ITA		The maximum user fees have been agreed upon with the Health facility manager. The rate will be submit to the Medical bureaus and the RBF Task force	In progress
Output 6: MoH and donor community do not provide long-term financial means.	September -14	DEV	Medium	Medium	Medium Risk	Support donor coordination and contribute to the setup of a Health Basket fund	Project director			In progress
						Development of a realistic roll out plan for the Result based Financing	ITA			
						Support MB efforts to develop sustainability plans	NTA	Dec 2016		

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 6: Large scope of the project and strategy	September-14	OPS	Medium	Low	Low Risk	Availability of NTA in every region	ResRep		2 NTAs regional level have been recruited and in office	Terminated
						gradual scaling-up	ITA			Terminated
						Conduct regular audits by the project	RAFI			In progress
						Payments only after verification of achievement of activities	NTA and RAFI			In progress
						Multiple occasions for verification	NTA			In progress
						direct payment on individual accounts	RAFI			In progress
						Set the development of business plans as a condition to enter the RBF program	ITA	June-17		Terminated
						Include realistic budgets in health facilities business plans	RAFI	June-17	Training and coaching of health centre IV and general hospital to be conducted by the project administrative team	In progress
						Delay in the contractualization	RAFI	December-16	More training and coaching of district teams in contractualization by the RAFI and the project administrative team is needed	In progress

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Feasibility of workload for verification and validation of RBF grants	2016 Q4	FIN	Medium	Low	Low Risk	Computerization of verification tools	ITA	July 2017		In progress
Delay in reporting and/or incomplete reporting of facilities for RBF grants	2016 Q4	FIN	Low	Low	Low Risk	Coaching and mentorship of District Health Teams in grant management	RAFI	2017 Q2	There are specific constraints in the management of the BTC grant to be address, as well as the constraints in RBF implementation identified for the output 4, 5 and 6	In progress
						Coaching by the project administrative team of the DHTs to support the facilities in financial management	RAFI	2017Q4	As much as possible, the grant agreement shall not introduce new reporting tools, but use the existing information system	New
						Simplification of grant management procedure	RAFI	2017 Q2	RBF payment is a post payment mechanism, without fiduciary risk for the fund holder. More autonomy shall be given to the health facilities in the use of their resources	New
Misuse of RBF funds	2016 Q4	FIN	Low	Medium	Low Risk	Strict control mechanisms set up from central level	RAFI and FCC	2017 Q2	The RBF Implementation manual give to the Fund Holder the right to conduct audits and counter verification at any time	In progress
						Spot checks and counter verifications by financial team	RAFI and FCC	2017 Q4		In progress
						External audit for RBF grants	RAFI and FCC	2017 Q4		In progress

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
False reporting by facilities and /or DHMT verification team	2016 Q4	FIN	Low	Low	Low Risk	Multi stakeholder verification team	NTA	2017 Q4	These are the risks of all RBF project. There are mitigate by the RBF design	In progress
						Participation of NTA in the verification		2017 Q4		In progress
						Counter verification by the central level	ITA and RAFI	2017 Q4		In progress
Budget overshooting or under consumption of RBF grants	2016 Q4	FIN	Low	Low	Low Risk	Accurate estimation of RBF income for the Health facilities	FCC	2017 Q2	While offering technical assistance to the health facilities, the project RAFI and financial team will support them to estimate the RBF income	In progress
						Strict monitoring of RBF grants expenditure	RAFI	2018 Q2		In progress
						Review of the pricing of indicators if needed	ITA	2017 Q2		In progress
						Addenda to the grants if needed	RAFI	2017 Q2		In progress

3 Steering and Learning

3.1 Strategic re-orientations

The strategy outlined in the project's TFF remains valid and relevant. This strategy is imbedded in the HSDP. It's also in line with the Health Financing Strategy and the Quality Improvement Strategy developed by the MoH.

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

3.2 Recommendations

Recommendations	**Actor**	**Deadline**
Give specific attention to the RBF while implementing Public Private Partnership for health: • *How to discuss RBF results with medical bureaus and PNFP coordinating bodies?* • *How to make MB able to come with recommendations on how the RBF system should evolve?* • *How to disseminate RBF results within the private sector?*	*PPPH Unit coordinator*	*December 2017*
Organise a retreat of RBF Unit and Department of Planning to discuss the training module for the health facilities and District Health teams	Project Manager	June 2017
Identify the Human resources needs and organized the trainings of staff appointed for the start-up of the RBF Unit	Project manager	June 2017
Recruit a data manager to support the BTC Health projects and the start-up of the RBF Unit in the MoH. He will be in charge of: • The development of an RBF database (online) to store all RBF related data • The development of a dashboard: key performance indicators, automatic production of summary tables and graphs • The online RBF database will be showing facts and figures (coverage increases, and cost-effectiveness ratios) for advocacy	Project Co-manager and Project manager	July 2017
Report and analyse the trend of the project indicators on quarterly basis	NTA of PNFP project	Continuous activity
Simplify the verification procedure and give more autonomy to the health facility in the use of RBF grant. Revise the grant agreement	Project manager and Co-manager	June 2017

accordingly.		

3.3 Lessons Learned

Lessons learned	Target audience
Organising RBF training at national level for the implementers may not be relevant if the financing strategy of the country is not well defined. The training improve the knowledge of the participants, but not the skills in the RBF implementation in general, and the verification skill in particular	Result Based Financing implementers at national and international level
A cost study at health facility level is important in the management of the RBF budget, but also to have the Health facility managers and other stakeholder on board. It ease the advocacy for the Result Based Financing	Result Based Financing implementers at national and international level
The accreditation procedures may be easily implemented for private health facility.	Health Policy makers and health services managers
Regular monitoring of the cost of services is crucial during the first year of RBF implementation	Result Based Financing implementers and Health Policy makers

4 Annexes

4.1 Quality criteria

1. RELEVANCE: The degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries				
In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D'= C; at least one 'D' = D				
Assessment RELEVANCE: total score	**A**	**B**	**C**	**D**
1.1 What is the present level of relevance of the intervention?				
	A	Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group.		

1.2 As presently designed, is the intervention logic still holding true?		
	A	Clear and well-structured intervention logic; feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable).

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

2.1 How well are inputs (financial, HR, goods & equipment) managed?		
	A	All inputs are available on time and within budget.
	B	Most inputs are available in reasonable time and do not require substantial budget adjustments. However there is room for improvement.

2.2 How well is the implementation of activities managed?		
	A	Activities implemented on schedule
	B	Most activities are on schedule. Delays exist, but do not harm the delivery of outputs

2.3 How well are outputs achieved?		
	A	All outputs have been and most likely will be delivered as scheduled with good quality contributing to outcomes as planned.

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

3.1 As presently implemented what is the likelihood of the outcome to be achieved?		
	A	Full achievement of the outcome is likely in terms of quality and coverage. Negative effects (if any) have been mitigated.
	B	Outcome will be achieved with minor limitations; negative effects have caused some delay, but not much harm.

3.2 Are activities and outputs adapted in order to achieve the outcome?		
	A	The intervention is successful in adapting its strategies / activities and outputs to changing external conditions in order to achieve the outcome. Risks and assumptions are managed in a proactive manner.

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

4.1 Financial/economic viability?		
	A	Financial/economic sustainability is potentially very good: costs for services and maintenance are covered or affordable; external factors will not change that.
	B	Financial/economic sustainability is likely to be good, but problems might arise namely from changing external economic factors.

4.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support?		
	A	The steering committee and other relevant local structures are strongly involved in all stages of implementation and are committed to continue producing and using results.
	B	Implementation is based in a good part on the steering committee and other relevant local structures, which are also somewhat involved in decision-making. Likeliness of sustainability is good, but there is room for improvement.

4.3 What is the level of policy support provided and the degree of interaction between intervention and policy level?		
	A	Policy and institutions have been highly supportive of intervention and will continue to be so.

4.4 How well is the intervention contributing to institutional and management capacity?		
	B	Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible.

4.2 Decisions taken by the steering committee and follow-up

	PROJECT CODE	UGA 13 026 11
	PROJECT NAME	Institutional Support for the Private-Non-For-Profit (PNFP) health sub-sector to promote universal health coverage in Uganda
	YEAR OF REFERENCE	2016
	QUARTER OF REFERENCE	Q1

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

	Decision				Action			Follow-up	
N°	Decision	Identification period	Source*	Actor	Action(s)	Resp.	Deadline	Progress	Status
	SC 2:	Feb-15			MOH to give a specific date for the launch of the project	Project Manager	To be determined after consultations	Awaiting confirmation	OPEN
	SC5	October 2016			Budget modification	RAFI	Immediate		Completed

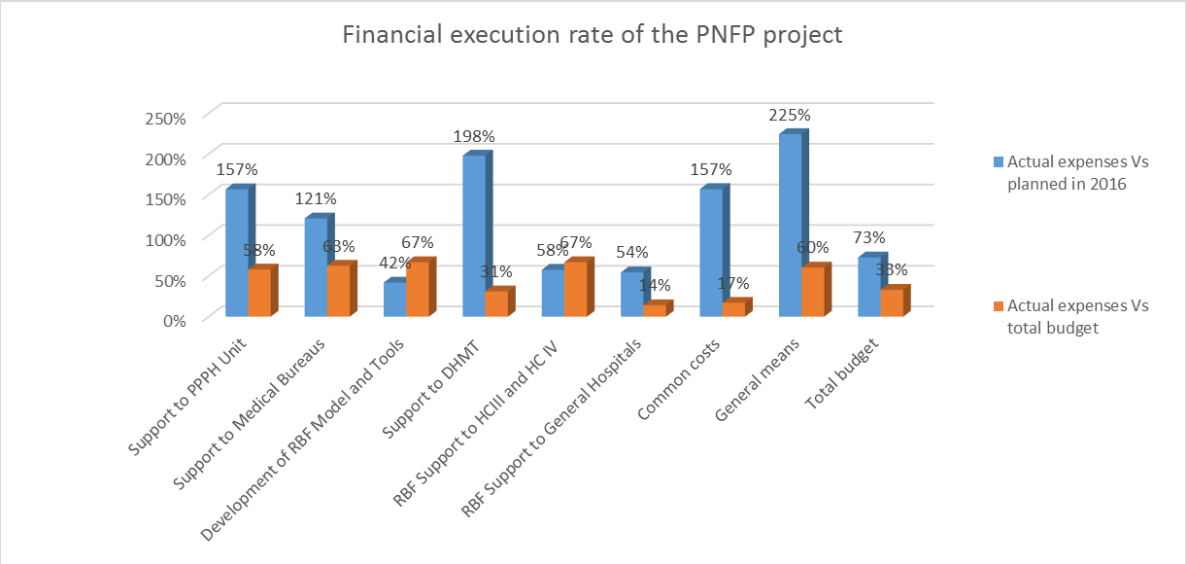
4.3 Updated Logical framework

No up-date of logical framework. The logical framework of the TFF is still valid.

4.4 More Results at a glance

Logical framework's results or indicators modified in last 12 months?	No.
Baseline Report registered on PIT?	Yes.
Planning MTR (registration of report)	01/2017: Done
Planning ETR (registration of report)	04/2018 (estimate)
Backstopping missions since 01/71/2014	20/10/2014 – 25/10/2014. 18/07/2015 – 26/07/2015 21/01/2016 – 27/01/2016 20/07/2016 – 27/07/2016

4.5 "Budget versus curent (y – m)" Report



Budget vs Actuals (Year to Month) of UGA1302611

Project Title : **Institutional support for the private-non-for profit (PNFP) health sub-sector to promote universal health coverage in Uganda**

Budget Version: **D02**
Currency : DGD
Year to month : 31/12/2016
YtM : **Report includes all closed transactions until the end date of the chosen closing**

	Status	Fin Mode	Amount	Start to 2015	Expenses 2016	Total	Balance	% Exec
A SPECIFIC OBJECTIVE			4.790.350,00	190.597,60	**807.563,82**	998.161,42	3.792.188,58	**21%**
01 MoH is strengthened in its capacity of policy and			272.950,00	62.587,77	**95.707,33**	158.295,10	114.654,90	**58%**
01 Support the planning, management and administration of		REGIE	99.200,00	38.709,09	**19.614,59**	58.323,68	40.876,32	59%
02 Review PPPH related policies and guidelines		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
03 Disseminate policies and guidelines and do advocacy		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Perform field visits		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
05 Organize country study tours		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
06 Perform technical and scientific follow-up and evaluation to		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
07 Review PPPH related policies and guidelines		REGIE	60.000,00	0,00	**39.540,19**	39.540,19	20.459,81	66%
08 Disseminate policies and guidelines and do advocacy		REGIE	25.000,00	6.378,16	**13.717,23**	20.095,39	4.904,61	80%
09 Perform field visits		REGIE	16.000,00	0,00	**3.512,56**	3.512,56	12.487,44	22%
10 Organize country study tours		REGIE	48.750,00	17.500,52	**18.644,38**	36.144,90	12.605,10	74%
11 Perform technical and scientific follow-up and evaluation to		REGIE	24.000,00	0,00	**678,38**	678,38	23.321,62	3%
02 Medical Bureaus and the PNFP Coordination Bodies are			183.200,00	38.857,19	**75.909,21**	114.766,40	68.433,60	**63%**
01 Support the installation and equipment of MB		REGIE	60.000,00	15.623,08	**30.926,96**	46.550,04	13.449,96	78%
02 Support exchange, coordination and cross-fertilizing		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
03 Support of MB to PNFPCB through supervision, workshops		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Support exchange, coordination and cross-fertilizing		REGIE	64.000,00	0,00	**16.777,72**	16.777,72	47.222,28	26%
05 Support of MB to PNFPCB through supervision, workshops		REGIE	59.200,00	23.234,11	**28.204,53**	51.438,64	7.761,36	87%
03 District and Subdistrict Health Management Teams are			67.000,00	12.431,89	**8.485,93**	20.917,82	46.082,18	**31%**
01 Perform supervision activities and joint meetings between		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
		REGIE	4.180.475,00	1.132.885,46	**1.084.684,49**	2.217.569,95	1.962.905,05	53%
		COGEST	3.819.525,00	45.893,79	**409.684,17**	455.577,96	3.363.947,04	12%
		TOTAL	8.000.000,00	1.178.779,25	**1.494.368,66**	2.673.147,91	5.326.852,09	33%

Budget vs Actuals (Year to Month) of UGA1302611

Project Title : **Institutional support for the private-non-for profit (PNFP) health sub-sector to promote universal health coverage in Uganda**

Budget Version: **D02**
Currency : DGD
Year to month : 31/12/2016
YtM : **Report includes all closed transactions until the end date of the chosen closing**

	Status	Fin Mode	Amount	Start to 2015	Expenses 2016	Total	Balance	% Exec
02 Organize exchange activities between districts at regional		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
03 Perform supervision activities and joint meetings between		REGIE	36.000,00	12.431,89	**1.431,70**	13.863,59	22.136,41	39%
04 Organize exchange activities between districts at regional		REGIE	31.000,00	0,00	**7.054,23**	7.054,23	23.945,77	23%
04 MoH has a model and a vision on how to institutionalize			89.000,00	42.509,21	**16.905,86**	59.415,07	29.584,93	**67%**
01 Review existing and past RBF related experiences and		COGES	12.000,00	9.600,67	**0,00**	9.600,67	2.399,33	80%
02 Design a RBF scheme to fund PNFP health facilities		COGES	10.000,00	11.440,10	**0,00**	11.440,10	-1.440,10	114%
03 Train management and health professionals in RBF		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Implement the RBF procedures and tools		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
05 Develop and conduct communication and advocacy		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
06 Train management and health professionals in RBF		REGIE	25.000,00	0,00	**7.640,41**	7.640,41	17.359,59	31%
07 Implement the RBF procedures and tools		REGIE	35.000,00	21.468,44	**9.265,45**	30.733,89	4.266,11	88%
08 Develop and conduct communication and advocacy		REGIE	7.000,00	0,00	**0,00**	0,00	7.000,00	0%
05 PNFP HC II, III and IV of the regions of West Nile and			2.198.600,00	3.279,55	**295.339,38**	298.618,93	1.899.981,07	**14%**
01 Elaborate a complete health coverage plan per district,		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
02 Support yearly planning, taking into account the		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
03 Build the skills of PNFP HC staff for RBF to function in their		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Finance PNFP health centres through RBF		COGES	2.013.600,00	18,31	**166.084,16**	166.102,47	1.847.497,53	8%
05 Elaborate a complete health coverage plan per district,		REGIE	30.000,00	2.039,22	**11.869,82**	13.909,04	16.090,96	46%
06 Support yearly planning, taking into account the		REGIE	50.000,00	0,00	**24.759,02**	24.759,02	25.240,98	50%
07 Build the skills of PNFP HC staff for RBF to function in their		REGIE	105.000,00	1.222,02	**92.626,38**	93.848,40	11.151,60	89%
06 PNFP hospital care of West Nile and Ruwenzori is more			1.979.600,00	30.931,99	**315.216,11**	346.148,10	1.633.451,90	**17%**
		REGIE	4.180.475,00	1.132.885,46	**1.084.684,49**	2.217.569,95	1.962.905,05	53%
		COGEST	3.819.525,00	45.893,79	**409.684,17**	455.577,96	3.363.947,04	12%
		TOTAL	8.000.000,00	1.178.779,25	**1.494.368,66**	2.673.147,91	5.326.852,09	33%

Budget vs Actuals (Year to Month) of UGA1302611

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Budget Version: **D02**
Currency : DGD
Year to month : 31/12/2016
YtM : **Report includes all closed transactions until the end date of the chosen closing**

	Status	Fin Mode	Amount	Start to 2015	Expenses 2016	Total	Balance	% Exec
01 Perform and implement the conclusions of a hospital care		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
02 Conduct costing studies per hospital and do comparative		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
03 Prepare the PNFP hospitals for initiating RBF		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
04 Finance PNFP hospitals through RBF		COGES	1.640.100,00	21.541,44	**241.784,21**	263.325,65	1.376.774,35	16%
05 Experiment with urban primary care centres outside the		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
06 Perform and implement the conclusions of a hospital care		REGIE	7.500,00	0,00	**2.230,36**	2.230,36	5.269,64	30%
07 Conduct costing studies per hospital and do comparative		REGIE	31.000,00	0,00	**19.762,99**	19.762,99	11.237,01	64%
08 Prepare the PNFP hospitals for initiating RBF		REGIE	81.000,00	9.390,55	**51.438,55**	60.829,10	20.170,90	75%
09 Experiment with urban primary care centres outside the		REGIE	220.000,00	0,00	**0,00**	0,00	220.000,00	0%
COMMON COSTS DIRECTLY RELATED TO THE			1.455.340,00	353.639,93	**315.591,01**	669.230,94	786.109,06	**46%**
01 Results			1.455.340,00	353.639,93	**315.591,01**	669.230,94	786.109,06	**46%**
01 Scientific follow-up and evaluation of the various strategies		REGIE	120.000,00	105,47	**0,00**	105,47	119.894,53	0%
02 Short term international and national consultancies		REGIE	171.000,00	78.668,63	**47.154,32**	125.822,95	45.177,05	74%
03 National technical Assistant (Policy analysis and M&E)		REGIE	120.223,00	39.183,23	**32.326,09**	71.509,32	48.713,68	59%
04 1 National Technical Assistant in each of the 2 Regions		REGIE	211.200,00	52.806,17	**48.982,24**	101.788,41	109.411,59	48%
05 Basic equipment HC (on the base of need assessment)		REGIE	234.000,00	0,00	**22.811,49**	22.811,49	211.188,51	10%
06 Basic equipment hospitals(on the base of need		REGIE	253.800,00	69.326,18	**105.254,22**	174.580,40	79.219,60	69%
07 Vehicles		REGIE	80.517,00	80.516,96	**735,82**	81.252,78	-735,78	101%
08 Maintenance, fuel and insurance of vehicles		REGIE	129.600,00	12.986,83	**11.039,21**	24.026,04	105.573,96	19%
09 Financial and Admin Officer in each of the 2 Regions		REGIE	105.000,00	14.705,79	**34.115,58**	48.821,37	56.178,63	46%
10 Missions		REGIE	30.000,00	5.340,67	**13.172,04**	18.512,71	11.487,29	62%
		REGIE	4.180.475,00	1.132.885,46	**1.084.684,49**	2.217.569,95	1.962.905,05	53%
		COGEST	3.819.525,00	45.893,79	**409.684,17**	455.577,96	3.363.947,04	12%
		TOTAL	8.000.000,00	1.178.779,25	**1.494.368,66**	2.673.147,91	5.326.852,09	33%

Budget vs Actuals (Year to Month) of UGA1302611

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Currency : DGD
Year to month : 31/12/2016
YtM : **Report includes all closed transactions until the end date of the chosen closing**

	Status	Fin Mode	Amount	Start to 2015	Expenses 2016	Total	Balance	% Exec
C VAT REFUND			0,00	18.131,32	**14.772,43**	32.903,75	-32.903,75	**?%**
01 VAT Refund Regie			0,00	14.838,05	**12.956,63**	27.794,68	-27.794,68	**?%**
01 VAT Refund Regie		REGIE	0,00	14.838,05	**12.956,63**	27.794,68	-27.794,68	?%
02 VAT Refund Cogest			0,00	3.293,27	**1.815,80**	5.109,07	-5.109,07	**?%**
01 VAT Refund Cogest		COGES	0,00	3.293,27	**1.815,80**	5.109,07	-5.109,07	?%
X RESERVE BUDGET (MAX 5% OF TOTAL ACTIVITIES)			144.202,00	0,00	**0,00**	0,00	144.202,00	**0%**
01 Reserve budget			144.202,00	0,00	**0,00**	0,00	144.202,00	**0%**
01 Reserve budget co-management		COGES	143.825,00	0,00	**0,00**	0,00	143.825,00	0%
02 Reserve budget BTC direct management		REGIE	377,00	0,00	**0,00**	0,00	377,00	0%
Z GENERAL MEANS			1.610.108,00	616.410,40	**356.441,40**	972.851,80	637.256,20	**60%**
01 Staff costs			1.258.719,00	487.716,79	**331.726,19**	819.442,98	439.276,02	**65%**
01 International Technical assistant (Co-manager)		REGIE	720.000,00	310.690,94	**199.184,61**	509.875,55	210.124,45	71%
02 International administrative and finance Responsible		REGIE	360.000,00	115.946,38	**78.084,27**	194.030,65	165.969,35	54%
03 Accountant		REGIE	48.000,00	20.700,91	**8.734,59**	29.435,50	18.564,50	61%
04 Secretary		REGIE	419,00	418,59	**213,07**	631,66	-212,66	151%
05 Drivers (4)		REGIE	76.800,00	32.299,99	**17.076,76**	49.376,75	27.423,25	64%
06 Project financial controller		REGIE	38.000,00	6.918,81	**20.485,80**	27.404,61	10.595,39	72%
07 FinAdmin & Logistic support		REGIE	15.500,00	741,17	**7.947,09**	8.688,26	6.811,74	56%
02 Investments			70.789,00	61.458,88	**2.243,78**	63.702,66	7.086,34	**90%**
01 Vehicle		REGIE	29.577,00	29.577,01	**456,71**	30.033,72	-456,72	102%
02 Office equipment		REGIE	17.832,00	9.432,39	**433,05**	9.865,44	7.966,56	55%
		REGIE	4.180.475,00	1.132.885,46	**1.084.684,49**	2.217.569,95	1.962.905,05	53%
		COGEST	3.819.525,00	45.893,79	**409.684,17**	455.577,96	3.363.947,04	12%
		TOTAL	8.000.000,00	1.178.779,25	**1.494.368,66**	2.673.147,91	5.326.852,09	33%

Budget vs Actuals (Year to Month) of UGA1302611

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	Status	Fin Mode	Amount	Start to 2015	Expenses 2016	Total	Balance	% Exec
03 IT Office equipment		REGIE	17.905,00	16.974,59	**1.320,86**	18.295,45	-390,45	102%
04 Office refurbishment		REGIE	5.475,00	5.474,89	**33,16**	5.508,05	-33,05	101%
03 Running costs			99.600,00	36.793,33	**14.567,85**	51.361,18	48.238,82	**52%**
01 Maintenance, fuel and insurance of vehicles (1)		REGIE	43.200,00	21.019,72	**6.473,25**	27.492,97	15.707,03	64%
02 Offices maintenance and supply		REGIE	28.800,00	8.937,29	**5.466,52**	14.403,81	14.396,19	50%
03 Télécommunications (5 Mobile phones)		REGIE	21.600,00	4.809,44	**3.522,49**	8.331,93	13.268,07	39%
04 Representation and external costs		REGIE	5.000,00	1.909,68	**0,00**	1.909,68	3.090,32	38%
05 Financial costs (ledger fees including exchange loss)		REGIE	1.000,00	117,20	**-894,41**	-777,21	1.777,21	-78%
04 Audit et Suivi et Evaluation			181.000,00	34.742,26	**7.971,84**	42.714,10	138.285,90	**24%**
01 Evaluation & Monitoring		REGIE	100.000,00	0,00	**0,00**	0,00	100.000,00	0%
02 Baseline		REGIE	30.000,00	28.916,62	**0,00**	28.916,62	1.083,38	96%
03 Audit		REGIE	30.000,00	0,00	**0,00**	0,00	30.000,00	0%
04 Backstopping		REGIE	21.000,00	5.825,64	**7.971,84**	13.797,48	7.202,52	66%
99 Conversion rate adjustment			0,00	-4.300,86	**-68,26**	-4.369,12	4.369,12	**?%**
98 Conversion rate adjustment		REGIE	0,00	-4.300,86	**-68,26**	-4.369,12	4.369,12	?%
99 Conversion rate adjustment		COGES	0,00	0,00	**0,00**	0,00	0,00	?%

REGIE	4.180.475,00	1.132.885,46	**1.084.684,49**	2.217.569,95	1.962.905,05	53%
COGEST	3.819.525,00	45.893,79	**409.684,17**	455.577,96	3.363.947,04	12%
TOTAL	8.000.000,00	1.178.779,25	**1.494.368,66**	2.673.147,91	5.326.852,09	33%

4.6 Communication resources

N/A.