RESULTS REPORT 2016

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

UGANDA

DGD CODE : NN 3016425
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Acronyms

BTC	Belgian Development Agency
DEV	Development
DGD	Directorate General for Development
DHO	District Health Office / District Health Officer
DHT	District Health Team
FCC	Finance & Contract Coordinator
FIN	Financial
GH	General Hospital
GoU	Government of Uganda
HC	Health Centre
HDP	Health Development Partners
HPAC	Health Policy Advisory Committee
HQ	Headquarters
HSDP	Health Sector Development Plan
ICB II	Institutional Capacity Building project phase 2
JICA	Japan International Cooperation Agency
JMS	Joint Medical Stores
JRM	Joint Review Mission
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NMS	National Medical Stores
NTA	National Technical Assistant
OPD	Outpatient Department
OPS	Operations
PBF	Performance-Based Financing
PMT	Project Management Team
PNFP	Private Not For Profit
Qx	Quarter
RBF	Results-Based Financing
RR	Resident Representative / BTC Representation Uganda
SMC	Senior Management Committee
TFF	Technical and Financial File
TWG	Technical Working Group

1 Intervention at a glance (max. 2 pages)

1.1 Intervention form

Intervention title	**Institutional Capacity Building Project in Planning, Leadership and Management in the Uganda Health Sector – ICB Phase II**
Intervention code	**UGA 1402811**
Location	**Uganda – Ministry of Health**
Total budget	**EUR 5,000,000**
Partner Institution	**Ministry of Health Uganda**
Start date Specific Agreement	**28th of July 2015**
Date intervention start /Opening steering committee	**28th of July 2015**
Planned end date of execution period	**30th of June 2018**
End date Specific Agreement	**27th of July 2019**
Target groups	**Ministry of Health, public health facilities and institutions in Rwenzori and West Nile region, personnel of these facilities, population of Rwenzori and West Nile**
Impact	**To further improve effective delivery of an integrated Uganda Minimum Health Care Package**
Outcome	**To strengthen the planning, leadership & management capacities of (public) health staff – particularly at local government level. This should include the provision of quality services within an integrated health system**
Outputs	1. The quality of care at general hospital and HC IV is strengthened
	2. District health offices and management teams are strengthened in their capacity to manage integrated district health systems and to strengthen quality of care
	3. Integrated regional network of health facilities in place
	4. The normative role of the MoH is strengthened
Year covered by the report	**2016**

1.2 Budget execution

	Budget	Expenditure		Balance	Disburse-ment rate at the end of year 2016
		Previous years (2015)	Year covered by report (2016)		
Total	**5.000.000 €**	***63 352 €***	**499 347 €**	**4 437 301 €**	**11 %**
Output 1	1.525.500 €	0 €	71 562 €	1 453 948 €	5 %
Output 2	1.475.500 €	0 €	28 787 €	1 446 713 €	2 %
Output 3	397.600 €	44.742 €	95 138 €	257 720 €	35 %
Output 4	870.150 €	5.947 €	184 459 €	679 745 €	22 %
Budg.res	137.850 €	0 €	€	137 850 €	0 %
General means	593.400 €	12 663 €	119 412 €	461 325 €	22 %

Budget execution for output 4 and general means is in line with the project progress in time and according to planning.
Output 3 expenditure surpasses planning due to unplanned support to the pilot Pre-Joint Review Mission Regional Review Meetings.
Output 1 and 2 expenditure remains low because RBF payments, representing 60% of these 2 outputs, will only start in May 2017 (for payment of 2017 Q1).

1.3 Self-assessment performance

1.3.1 Relevance

	Performance
Relevance	B

Results-Based Financing, the ambulance referral system and regionalisation are all topics that are presently of particular interest to the Ugandan MoH.

The MoH announced that the financing of the Health Sector Development Plan 2015/16 – 2019/20 will be reformed to "transform the financing mechanisms from an input focus to a results oriented thus improving decision making and accountability." The same message can be found in the Health Financing Strategy 2015/16 – 2024/25 (MoH, 2016): "The sector shall emphasise Results Based Financing (RBF)/Performance Based Financing (PBF) as a mode of output based provider payment. This will be rolled out systematically and progressively to cover the whole country by the end of this Health Financing Strategy."

The support to the ambulance referral system that the project provides in the 15 districts of intervention is similarly in line with the Health Sector Development Plan 205/16 - 2019/20 which prioritises Emergency Medical Services / ambulance services as key intervention areas for introduction and scale up to improve the service delivery system. (p.64 HSDP)

The importance of an intermediary level in a country with 116 districts like Uganda is increasingly being recognized by the MoH. Different initiatives are being piloted for technical coordination at regional level. The existence of the quarterly Regional Health Forums in West Nile and Rwenzori region, initiated by the ICB I project and continued by the PNFP and ICB II projects, are a good foundation on which these new initiatives can be build. In 2016 a regional Joint Review Mission was piloted in West Nile and Rwenzori region.

All activities of the project are consistent with the Belgian strategy of developing an efficient and sustainable health system, which ensures quality health care for all. RBF payments to the health facilities, utilising the Ugandan system, is a prime example of implementation of aid effectiveness commitments.

Due to the budget limitations only selected health facilities will benefit from RBF support: 1) only around 30% of HC III will be included, 2) none of the HC II, and 3) only the best scoring and thus best equipped and performing health facilities will become accredited for RBF. Therefore the final outcome of the project will be rather the development of a model for RBF that can be used for rollout in the country by MoH, than a global support to the districts.

1.3.2 Effectiveness

	Performance
Effectiveness	B

The outcome will be achieved but with some limitations. Some activities, minor but nevertheless interesting, risk not to be implemented due to budget and/or time constraints. The TFF mentions several innovative activities[1] but implementation of all will not be possible and choices will have to be made.
The introduction of a completely new approach, which is as complex as the implementation of RBF in public health facilities, will encounter a multitude of hurdles and obstacles along the way. Up to now the project has managed to proceed smoothly towards implementation but the risk remains that changing circumstances delay or halt the process. In that case abandoning the strategy of RBF and adopting a new orientation to attain the same outcome is not an option.

1.3.3 Efficiency

	Performance
Efficiency	B

The close collaboration with the PNFP project as described during the formulation in the ICB II Technical & Financial File, forecasted that at its start the project could benefit from several realisations of the PNFP project. Due to various circumstances these actions (f.e. several cycles of RBF in health facilities, elaboration of coverage plans) were not yet achieved and still had to be realised or supported.
Some delays exist in comparison with the initial planning but do not exceed 2 months.

1.3.4 Potential sustainability

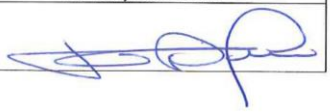
	Performance
Potential sustainability	B

The potential sustainability of the project has to be assessed in function of the interpretation of the TFF (see also 3.1.1).
If the final objective is considered a global support to the health system of the 15 districts of intervention, the RBF approach, with the biggest part of the payments linked to quantity output and thus running costs, is obviously not sustainable.
If, however, the project's aim is to provide the MOH with evidence on the positive effects and benefits of RBF for the health facilities and to provide a RBF implementation model for rollout in the rest of the country, the potential sustainability can be regarded with much more optimism.
This second option receives our preference. The choice to monitor the evolution of the indicators only for facilities that are included in the RBF scheme (approved by the Steering Committee) also reflects the second option to develop a tested model for RBF implementation in Uganda.
The performance score of B represents the mean between these 2 different interpretations.

[1] Creation of a nested health centre in general hospital, decentralization of mental health problems treatment (schizophrenia and epilepsy), creation of an ophthalmologic workshop in one of the Regional Referral Hospitals

1.4 Conclusions

- The ICB II project has progressed well towards its objective to implement RBF in qualified public health facilities in West Nile and Rwenzori region.
- Despite the complexity of the process of RBF implementation no major obstacles have significantly delayed the implementation
- All efforts since the start of the project have been geared towards speedy implementation of RBF, which is the main component of the project. The other activities will be implemented form 2017 onwards
- The "regional" component of the project (output 3) became more important as the MoH used the existing Regional Health Forum as the basis for the piloting of regional Joint Review Missions in West Nile and Rwenzori region

National execution official	BTC execution official
Dr. Sarah Byakika	Dr. Tony De Groote
	

Results Report 2016
ICB II
8

2 Results Monitoring[2]

2.1 Evolution of the context

2.1.1 General context

Despite the tense situation surrounding the general elections in February 2016, the project has not encountered mayor delays or obstacles.
Several local government elected representatives are new and have expressed their desire to support the work of BTC in the districts.

2.1.2 Institutional context

Institutionally the project is anchored in the MoH in the Planning and Development Directorate. This anchorage contributes the ownership and the potential sustainability of the project. The aim of the project to influence national health policies by the results from the experience in the field greatly benefits from this institutional embedment in the MoH.
The introduction of new approaches, like the implementation of RBF in the health facilities, is a very labour intensive process requiring substantial input, also from central level. Although the staff at the MoH is limited and has to respond to numerous concomitant requests for their attention, we have no complaints about their involvement in the activities of the project.

At the beginning of 2016, Dr. Sarah Byakika the Ag. Commissioner Planning was assigned as the Projector Manager. In June 2016, Dr. Jane Aceng 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.

2.1.3 Management context: execution modalities

ICB II is a project in co-management.
However, following the lessons learned form the ICB I project, most of the budget lines are in BTC management modality to facilitate efficient execution of routine activities and public tenders. The budget lines for RBF payment, representing 36% of the total project budget, remain in co-management and use the Ugandan system to increase ownership.

The project did not experience delays or other difficulties in execution as a result of the execution modalities.

There has been no change in execution modalities in 2016.

2.1.4 Harmo context

The closest collaboration of the ICB II project is with the PNFP project that has the same main focus of introduction of RBF and with whom it shares procedures and staff. This bicephalic construction with a common body streamlines the BTC approach and increases efficiency by sharing of resources. ICB II has been able to progressively integrate its activities with those from the already established PNFP project and currently the joint implementation takes on the form of a single program.

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

Collaboration with the Skills Development for Human Resources project has been limited to participation in approval of the training plans of the institutions and information sharing. During 2017 it is foreseen to intensify the collaboration significantly when the actual training start.
The project is continuously searching for harmonisation with other partners. Contacts are made with Baylor, JICA, Quality Medicines for All. Concrete complementary activities are expected to start in 2017 when the RBF implementation has started.

The anchorage within the MoH and involvement of MoH in all steps of the programme, included formal approval, even for activities under BTC management modality where not strictly required, assures the alignment with the national policies and guidelines and contributes to ownership.

There has been no major changes in 2016.

2.2 Performance outcome

2.2.1 Progress of indicators

Outcome: To strengthen the planning, leadership and management capacities of (public) health staff – particularly at local government level					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2016**	**End Target**
Performance Improvement Plans for hospitals are institutionalised at national level	**No**	**No**	**No**	**No**	**Yes**
The National Health Planning Guidelines are implemented at district level	**No**	**No**	**No**	**No**	**Yes**
Utilisation rate for supported HC III	**1.2**	**1.2**		**1.2**	**+20%**
Hospitalisation rate for supported GH and HC IV	**7.2/100**	**7.2**		**7.2**	**+20%**

Baseline values in red represent the national values and are for information purpose only. The baseline values will be adapted once the RBF activities start and it is clear which health facilities will be supported.

Only a fraction of the health facilities in the 15 districts will be supported. Data from the complete district will not reflect sufficiently and clearly the impact of the project. Therefore, only data from the supported health facilities will be monitored and presented in aggregate form. The selection of health facilities will only be made in the course of 2017 and therefore most of the quantitative indicators are not yet available at the moment.

2.2.2 Analysis of progress made

The outcome indicators all reflect the main component of the project, namely the implementation of RBF in public health facilities in West Nile and Rwenzori region, be it as an improvement in the planning process in the health system (indicator 1 and 2) or as its consequence of improved access to care for the population (indicator 3 and 4).
The road towards implementation of RBF consists of different consecutive steps to assure that the selected health facilities are able to provide minimal standards of quality

of care : self-assessment by the health facilities, formal accreditation visits and training, culminating in the signing of the execution agreements.
The self-assessment exercise alone took some more time than planned to be finalised due to the high number of public health facilities in the 2 regions. 163 health facilities returned their self-assessment: 7 General Hospitals, 18 HC IV and 138 HC III. In the next step 77 health facilities were visited for a formal accreditation visit and 29 of them met the criteria to be accepted for the RBF program:

Facilities accredited and accepted to be included in the RBF programme on 31st of December 2016.

	West Nile	Rwenzori	Total
GH	2	2	**4**
HC IV	1	3	**4**
HC III	11	10	**21**
Total	**14**	**15**	**29**

In the beginning of 2017, all efforts will be made to implement the start of RBF in these facilities in the first Quarter of the calendar year.
It will be analysed how the health facilities that failed the first accreditation visit, can be supported to increase their score to the qualifying level.

2.2.3 Potential Impact

It is highly probable that the correct implementation of RBF in the public health facilities, as described in the TFF, will have the desired impact (To further improve effective delivery of an integrated Uganda Minimum Health Care Package).
It is however too early in the course of the project to see actual results but the steady progress in implementation of the activities indicates an advancement on the right track .

2.3 Performance output 1

2.3.1 Progress of indicators

Output 1: The quality of care at hospital and HC IV is strengthened					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2016**	**End Target**
Number of HC IV providing the full package of hospital care as defined by MoH	**7**	**NA**	**7**	**3**	**8 (out of 22)**
% of essential drugs out-of-stock during > 1 week for the 6 tracer medicines[3]	**48%**	**48%**	**48%**	**48%**	**0%**
Number of facilities with training plan and % completion of the plan	**Data available after start RBF**	**NA**	**NA**	**NA**	**80%**

2.3.2 Progress of main activities

Progress of main activities [4]	**Progress:**			
	A	B	C	D
1 Develop regional coverage plan for general hospitals and HC IV			X	
2 Support priority hospitals and HC-IV to realize a performance improvemnt plan		X		
3 Support basic requirements for quality of care		X		
4 Improve drugs and medical supplies management			X	
5 Introduce e-patient files			X	
6 Implement PBF approach in general hospitals and HC-IV			X	

2.3.3 Analysis of progress made

Activities 2,5 and 6 have not started yet and will not be discussed.

Activity 1: Develop regional coverage plan for general hospitals and HC IV
After some delay, this activity is on its way to elaborate the coverage plans, which will be an important, planning tool for the districts. A rational organisation of the districts with the HC II and III as entry point to the health system will allow the general hospitals and HC

[3] The six tracer EMHS include Artemether 20mg+Lumefantrine 120mg (strip of 24 tablets), co-packaged ORS and Zinc tablets, Cotrimoxazole 480mg tablet, Oral Rehydration Salts for 1lt, Pyrimethamine 25mg+Sulfadoxine 500mg tablet, Medroxyprogesterone Acetate 150mg/Ml w/syringe and Measles vaccine 10 dose vial.

[4] A: The activities are ahead of schedule
B The activities are on schedule
C The activities are delayed, corrective measures are required.
D The activities are seriously delayed (more than 6 months). Substantial corrective measures are required.

IVs to concentrate on their function as referral function, resulting in better quality of care at all levels of the district health system.

Activity 3: Support basic requirements for quality of care

This comprises the activities in the preparation of the implementation of RBF in the health facilities (self-assessment, accreditation visits, trainings).

The implementation of RBF in the health facilities is expected to improve quality of care (see also under Outcome)

The application of the self-assessment quality criteria checklist in the public health facilities (HC III, HC IV and General Hospital) resulted in a comprehensive database about the present situation of the health facilities with regards to the structure[5] for quality of care. DHOs mentioned that they already use this information for reference and planning purposes in their districts.

Activity 4: Improve drugs and medical supplies management

The consultancy for improvement of the medicines and medical supplies management took place in October – November 2016 and the project is currently preparing the implementation of the recommendations. The most radical recommendation is to allow the health facilities to use part of the RBF funds to purchase medicines and medical supplies from Joint Medical Stores (JMS) to supplement their normal supply from the National Medical Stores (NMS). Although it is not a policy change, it is a profound modification of the present way of functioning and it needs the consecutive approval of various governance structures (Technical Working Group (TWG) Medicines, Senior Management Committee (SMC) MoH, Health Policy Advisory Committee (HPAC), Top Management MoH). The TWG Medicines has already reviewed and discussed the proposal early 2017 but if the meetings of the other Committees are not organised timely or if the proposal is not accepted, there is the risk for delay in the implementation of RBF.

The proposal can be considered as an essential pre-condition for successful implementation of RBF. The present situation (insufficient supply by NMS and fixed value of drugs irrespective of performance of the facility) will put an external limit on the output of the facility, which goes against the basic principles of RBF.

[5] "Structure" is used here as in the quality of care framework by Donabedian

2.4 Performance output 2

2.4.1 Progress of indicators

Output 2: District health offices and management teams at sub-districts are strengthened in their capacity to integrate district health systems and to strengthen quality of care					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2016**	**End Target**
FP services, including access to modern contraceptives, are integrated and 100% of public HC III provide the service	**93%**	**93%**	**93%**	**93%**	**100%**
HIV care and treatment services, including PMTCT, are integrated and performance conforming to RBF quality norms in supported facilities	**Data available after start RBF**	**NA**	**NA**	**NA**	**95%**
HC III based deliveries conforming to RBF quality norms, have increased in supported facilities	**Data available after start RBF**	**NA**	**NA**	**NA**	**+20%**
> 75% of the supported HC III obtain a score of at least 3 star according to the Quality of Care Assessment of MoH	**Data available after start RBF**	**NA**	**NA**	**NA**	**75%**
Degree of implementation of the integrated district plan	**Data available after start RBF**	**NA**	**NA**	**NA**	**85%**

Only a fraction of the health facilities in the 15 districts will be supported. Data from the complete district will not reflect sufficiently and clearly the impact of the project. Therefore, only data from the supported health facilities will be monitored and presented in aggregate form. The selection of health facilities will only be made in the course of 2017 and therefore most of the quantitative indicators are not yet available at the moment.

2.4.2 Progress of main activities

Progress of main activities [6]	**Progress:**			
	A	B	C	D
1 Interpret coverage plan for HCIII and II			X	
2 Adjust district development plan according to coverage plan conclusions		X		
3 Support basic requirements for quality of care		X		
4 implement PBF financing through execution agreements			X	
5 Assure Quality of care through support supervision and continuous training			X	
6 Improve ambulance services and referral system at district		X		

[6] A: The activities are ahead of schedule
B The activities are on schedule
C The activities are delayed, corrective measures are required.
D The activities are seriously delayed (more than 6 months). Substantial corrective measures are required.

2.4.3 Analysis of progress made

Activities 2,4 and 5 have not started yet and will not be discussed.

All indicators are related to RBF implementation or will only be collected for health facilities enrolled in the RBF scheme. Results are expected from 2017 onwards.

Activity 1: Interpret coverage plan for HC III and II
See Activity 1 of Output 1 under 2.3.3

Activity 3: Support basic requirements for quality of care
See activity 3 of Output 1 under 2.3.3

Activity 6: Improve ambulance services and referral system at district
This activity is a continuation of ICB I.
For the moment it consists merely of financial support. During 2017 the project will work on rationalisation and improvement of the referral system and will search for solutions to achieve financial sustainability for the ambulance referral system.
A well functioning ambulance system is an essential building block of an integrated district health system.

2.5 Performance output 3

2.5.1 Progress of indicators

Output 3: Integrated regional network of health facilities in place					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2016**	**End Target**
A regional Joint Review Mission is organised in at least 5 of the 14 regions before the end of the project	**0**	**0**	**2**	**2**	**5**
Regional coordination for ambulance services is functional	**No**	**Partially**	**Partially**	**Partially**	**Yes**

2.5.2 Progress of main activities

Progress of main activities [7]	**Progress:**			
	A	B	C	D
1 Regional project team		X		
2 Organize quarterly regional health forum in the Ruwenzori and West Nile regions		X		
3 Install a coordination body for integrated referral system		X		
4 Support continuous training from regional hospital specialists		X		

2.5.3 Analysis of progress made

Activities 3 and 4 have not started yet and will not be discussed.

Activity 1: Regional project team

During 2016 personnel for the regions have been recruited and the 2 regional teams in West Nile and Rwenzori region are complete since mid June 2016. Each team consists of 1 NTA Health System Strengthening, 1 NTA Health Financing, 1 Financial Officer and 2 drivers. The NTA Health System Strengthening and 1 driver are on the ICB II payroll and the project also contributes to the salary of the Financial Officer for 50%. In practice, all the regional team members work for both ICB II and PNFP projects.

The presence of a team in the regions of implementation is essential for the support to the health facilities and district health teams. Their contribution goes well beyond output 3 and covers all aspects of the project.

While the activities in 2016 consisted mainly of well-defined activities of longer duration (6 weeks of self-assessment, 2 weeks of training, 2 weeks of verification), in the future extra attention should paid to the inclusion in their workplans of their main activity: continuous support to the health facilities (as support supervisions together with the DHT).

Activity 2: Organize quarterly regional health forum in the Ruwenzori and West Nile

[7] A: The activities are ahead of schedule
B The activities are on schedule
C The activities are delayed, corrective measures are required.
D The activities are seriously delayed (more than 6 months). Substantial corrective measures are required.

regions

The Regional Health Forums, already started under ICB I project, have been continued as planned. The scope of participants has been expanded to include also representatives of District Local Government which are key players for a good functioning of the districts. The content of these meetings is not limited to project activities but takes a more global view on district performance and sharing of good experiences. The participating districts expressed appreciation for the information about succes stories in the region that can be reproduced and the motivational force of competition by presenting the district performance in front of your peers.

A Regional Joint Review Mission (JRM) has been piloted in West Nile and Rwenzori region. This decentralised version of the National JRM was exceptionally well attended and could count on a positive and enthusiastic evaluation of all participants. By bringing together a wide variety of actors in the health sector, it turned out that several common problems for the districts in the region can easily be solved at the local level and don't need interventions from the central level. During this 2 day meeting there was ample time to discuss each district (8 in West Nile and 7 in Rwenzori) in detail; an impossibility in the one-day National JRM for 114 districts.

Feedback for this regional JRM was very positive. The attention given to each district individually and the elaboration of a realistic action plan to overcome problems for the region, endorsed by a wide variety of actors (MPs, MoH, cultural leaders, DLG, District Commissioner, DHT, HDP, etc.) were appreciated the most.

2.6 Performance output 4

2.6.1 Progress of indicators

Output 4: The normative role of the MoH is strengthened					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2016**	**End Target**
National RBF policy approved	**No**	**No**	**Yes**	**Yes**	**Yes**
At least 5 strategic topics of attention have been subject of a national reflection exercise	**0**	**0**	**0**	**0**	**5**

2.6.2 Progress of main activities

Progress of main activities [8]	**Progress:**			
	A	B	C	D
1 Ensure overall management and governance of the project within MoH		X		
2 Capitalize from field experiences developed in Ruwenzori and West Nile regions		X		
3 Strengthen continuous training policies and modalities		X		
4 Develop model and strategies for a social health insurance		X		

2.6.3 Analysis of progress made

Activities 3 and 4 have not started yet and will not be discussed.

Activity 1: Ensure overall management and governance of the project within MoH
This activity comprises salary for the ITA, purchase and maintenance of project cars and responsibility allowance for the Project Manager. These components can be regarded as pre-conditions for the well functioning of the project and as thus contribute to all the outputs and the overall outcome of the project.

Activity 2: Capitalize from field experiences developed in Rwenzori and West Nile regions
The documentation of the field experiences and the analysis of its results enters in the objective of all BTC health projects to develop evidence-based field-tested interventions that can be endorsed as new national health policies.
The main focus will of course be on RBF. The implementation of RBF will yield a wealth of quantitative indicators that will be analysed (see Mid-Term Review PNFP for proposal) to adapt the RBF scheme. Additionally an analytical framework, based on the analogy of RBF with the Principal – Agent Theory, has been developed that looks at the reaction to the changes induced, allowing for analysis on a deeper level and a better understanding of the mechanisms set in motion by the introduction of RBF.
Information has been gathered on other topics of interest: regionalisation in Uganda, the ambulance system, coverage plans as a planning tool.

[8] A: The activities are ahead of schedule
B The activities are on schedule
C The activities are delayed, corrective measures are required.
D The activities are seriously delayed (more than 6 months). Substantial corrective measures are required.

It is too early in the implementation stage to already have meaningful results.
It is obvious that the existence of evidence-based and field-tested interventions will strengthen the normative role of MoH.

2.7 Transversal Themes

2.7.1 Gender

The gender dimension is showcased by the special focus given to maternal health in the RBF scheme: at first level 3 out of the 12 indicator deal specifically with maternal health and 2 of the 10 indicators for the referral level. Furthermore, an attractive tariff is linked to these specific indicators to assure that they receive some extra attention.
For the other, general indicators (OPD contacts, admissions, etc.) it is known that women and children are the biggest users of health services.
Where possible, indicators disaggregated for gender will be collected.

2.7.2 Environment

The list of criteria for pre-qualification of the health facilities for RBF search explicitly for correct management of medical waste in all departments. Facilities that fail to meet those criteria can be supported by the project to remedy this.

2.8 Risk management

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

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue		
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline
Availability of MoH staff at all levels due to other MoH and HDP programs and activities	2016 Q2	OPS	Medium	Medium	Medium Risk	Dialogue and awareness raising, searching for complementarity with other interventions, motivation of MoH staff	PMT, MoH, Regional Team	On-going
Delays in implementation of activities can have considerable impact because of the short implementation period of the project	2016 Q2	OPS	Medium	High	High Risk	Realistic but strict planning of activities	PMT, Regional Team, MoH	2018 Q2
						Close and constant follow up of processes and implementation	PMT, Regional Team, Financial team, MoH	2018 Q2
						Continuous motivation of MoH staff al all levels to assure collaboration	PMT, Regional Team	2018 Q2

						Efficient handling of approval and payment processes	Financial Team	2018 Q2
High workload for financial team combining 2 projects with RBF funds (more than 100 grants if fully running) including other finance and administration tasks	2016 Q4	FIN	Medium	Medium	Medium Risk	Close follow up after first quarters to see impact and quality of work	FCC	2017 Q2
						Extra financial staff if needed	PMT	2017 Q4

Risks to Result 1 (The quality of care at general hospital and HC IV is strengthened) and **Result 2** (District health offices and management teams are strengthened in their capacity to manage integrated district health and to strengthen quality of care

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue		
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline
The GoU/MoH is not capable to organise an alternative financing mechanism and to reorient its actual budgeting efforts	Formulation	DEV	Medium	Medium	Medium Risk	Donor coordination and policy dialogue	Embassy, RR	On-going
						National workshops and participation in technical workgroups organised by MoH	PMT	On-going
						Correct capitalisation of experiences	PMT	2018 Q2
						Sufficiently long support to the health sector	DGD	2017 Q3
Misuse of funds, wrong accounting information	Formulation	FIN	Medium	Medium	Medium Risk	Strong follow-up by Finance and Technical team at project level (ITA and FCC at national level and regional antennas)	PMT, Regional Team, Financial Team	On-going
						Control mechanisms to put in place	Financial Team, PMT	2016 Q3
High transaction cost	Formulation	FIN	Low	Low	Low Risk	Cost sharing with PNFP	PMT	On-going
						Use of PNFP systems in place	PMT	2016

								Q3
Drug supply system regulations and free health care in the public health facilities are complicating the implementation of an output-based financing mechanism	2016 Q2	OPS	Medium	Medium	Medium Risk	Structure donor coordination and policy dialogue	PMT, RR, Embassy	On-going
						Use PNFP project to demonstrate alternatives in terms of drug supply and user fee policies	PMT, MoH	On-going
						Discuss the problem in national workshops to demonstrate the drawbacks of the system	PMT	On-going

Uncertainty on number of public health facilities eligible for inclusion in RBF scheme because level of fulfilment of accreditation criteria not known	2016 Q2	OPS	Medium	Medium	Medium Risk	Presence of small investment budget to help HF to reach accreditation threshold	PMT, MoH, Financial team	2017 Q2
						Revision of accreditation criteria	PMT, MoH	2016 Q4
Selection process of public health facilities to be included in RBF scheme influenced by political or other non technical based pressure	2016 Q2	OPS	Medium	Medium	Medium Risk	Development of objective criteria for selection of health facilities	PMT, MoH	2016 Q3
						Elaboration of coverage plans for the districts	PMT, MoH	2016 Q3
Feasibility of workload for verification and validation of	2016 Q4	FIN	Medium	High	High Risk	Evaluation after first quarter of RBF payments	FCC	2017 Q2

RBF grants						Extra financial staff if needed		2017 Q3
Delay in reporting and/or incomplete reporting of facilities for RBF grants	2016 Q4	FIN	High	High	Very High Risk	Strict follow up of grant procedures	FCC	2017 Q2
						Extra support to facilities in financial management	Financial team	2017 Q4
						Extra support by the NTA to the DHMT and facilities in understanding responsibilities and role in RBF grants	NTA	2017 Q2

3 Steering and Learning

3.1 Strategic re-orientations

There have been no strategic re-orientations during 2016.

3.2 Recommendations

Recommendations	Actor	Deadline
See 3.1: there are no strategic re-orientations		

3.3 Lessons Learned

Lessons learned	Target audience
For multi-level interventions like RBF (health facility – District Health Team – central MoH) support to al levels should be provided	BTC HQ
In case of programme-like close collaboration and complementarity between 2 or more projects, formal cooperation structures should be foreseen and put into practice[9]	BTC HQ, Representation

[9] As mentioned in the report, there are no major problems in the collaboration between ICB II and PNFP. However, this is the result of individual willingness and efforts and in the current setup it could have turned out quite differently.

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**
			X		
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.			
X	**B**	Still fits well in national policies and Belgian strategy (without always being explicit), reasonably compatible with aid effectiveness commitments, relevant to target group's needs.			
	C	Some issues regarding consistency with national policies and Belgian strategy, aid effectiveness or relevance.			
	D	Contradictions with national policies and Belgian strategy, aid efficiency commitments; relevance to needs is questionable. Major adaptations needed.			
1.2 As presently designed, is the intervention logic still holding true?					
	A	Clear and well-structured intervention logic; feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable).			
X	**B**	Adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions.			
	C	Problems with intervention logic may affect performance of intervention and capacity to monitor and evaluate progress; improvements necessary.			
	D	Intervention logic is faulty and requires major revision for the intervention to have a chance of success.			

2. EFFICIENCY OF IMPLEMENTATION TO DATE: Degree to which the resources of the intervention (funds, expertise, time, etc.) have been converted into results in an economical way					
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**
			X		
2.1 How well are inputs (financial, HR, goods & equipment) managed?					
	A	All inputs are available on time and within budget.			
X	**B**	Most inputs are available in reasonable time and do not require substantial budget adjustments. However there is room for improvement.			
	C	Availability and usage of inputs face problems, which need to be addressed; otherwise results may be at risk.			
	D	Availability and management of inputs have serious deficiencies, which threaten the achievement of results. Substantial change is needed.			

2.2 How well is the implementation of activities managed?		
	A	Activities implemented on schedule
X	**B**	Most activities are on schedule. Delays exist, but do not harm the delivery of outputs
	C	Activities are delayed. Corrections are necessary to deliver without too much delay.
	D	Serious delay. Outputs will not be delivered unless major changes in planning.
2.3 How well are outputs achieved?		
	A	All outputs have been and most likely will be delivered as scheduled with good quality contributing to outcomes as planned.
X	**B**	Output delivery is and will most likely be according to plan, but there is room for improvement in terms of quality, coverage and timing.
	C	Some output are/will be not delivered on time or with good quality. Adjustments are necessary.
	D	Quality and delivery of outputs has and most likely will have serious deficiencies. Major adjustments are needed to ensure that at least the key outputs are delivered on time.

3. EFFECTIVENESS TO DATE: Degree to which the outcome (Specific Objective) is achieved as planned at the end of year 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**
		X
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.
X	**B**	Outcome will be achieved with minor limitations; negative effects (if any) have not caused much harm.
	C	Outcome will be achieved only partially among others because of negative effects to which management was not able to fully adapt. Corrective measures have to be taken to improve ability to achieve outcome.
	D	The intervention will not achieve its outcome unless major, fundamental measures are taken.
3.2 Are activities and outputs adapted (when needed), in order to achieve the outcome?		
	A	The intervention is successful in adapting its strategies / activities and outputs to changing external conditions in order to achieve the outcome. Risks and assumptions are managed in a proactive manner.
X	**B**	The intervention is relatively successful in adapting its strategies to changing external conditions in order to achieve its outcome. Risks management is rather passive.
	C	The intervention has not entirely succeeded in adapting its strategies to changing external conditions in a timely or adequate manner. Risk management has been rather static. An important change in strategies is necessary in order to ensure the intervention can achieve its outcome.
	D	The intervention has failed to respond to changing external conditions, risks were insufficiently managed. Major changes are needed to attain the outcome.

4. POTENTIAL SUSTAINABILITY: The degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention).		
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**	
		X
	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.
X	**C**	Problems need to be addressed regarding financial sustainability either in terms of institutional or target groups costs or changing economic context.
	D	Financial/economic sustainability is very questionable unless major changes are made.
4.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support?		
	A	The steering committee and other relevant local structures are strongly involved in all stages of implementation and are committed to continue producing and using results.
X	**B**	Implementation is based in a good part on the steering committee and other relevant local structures, which are also somewhat involved in decision-making. Likeliness of sustainability is good, but there is room for improvement.
	C	The intervention uses mainly ad-hoc arrangements and the steering committee and other relevant local structures to ensure sustainability. Continued results are not guaranteed. Corrective measures are needed.
	D	The intervention depends completely on ad-hoc structures with no prospect of sustainability. Fundamental changes are needed to enable sustainability.
4.3 What is the level of policy support provided and the degree of interaction between intervention and policy level?		
X	**A**	Policy and institutions have been highly supportive of intervention and will continue to be so.
	B	Policy and policy enforcing institutions have been generally supportive, or at least have not hindered the intervention, and are likely to continue to be so.
	C	Intervention sustainability is limited due to lack of policy support. Corrective measures are needed.
	D	Policies have been and likely will be in contradiction with the intervention. Fundamental changes needed to make intervention sustainable.
4.4 How well is the intervention contributing to institutional and management capacity?		
	A	Intervention is embedded in institutional structures and has contributed to improve the institutional and management capacity (even if this is not an explicit goal).
X	**B**	Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible.
	C	Intervention relies too much on ad-hoc structures instead of institutions; capacity building has not been sufficient to fully ensure sustainability. Corrective measures are needed.
	D	Intervention is relying on ad hoc and capacity transfer to existing institutions, which could guarantee sustainability, is unlikely unless fundamental changes are undertaken.

4.2 Decisions taken by the steering committee and follow-up

There have been 2 meetings of the Steering Committee: one at the start of the project on 10th of February 2016 and one on 11th of October 2016. The items discussed were normal current operations and no important strategic decisions were taken, nor needed.

Decision to take					Action			Follow-up	
Decision to take	**Period of identification**	**Timing**	**Source**	**Actor**	**Action(s)**	**Resp.**	**Deadline**	**Progress**	**Stat**
Adapt indicators to better reflect activities and expected outputs and outcome	2016 Q2		Baseline report	Project team	Propose change of indicators	Project team, BTC HQ	2016 Q3	Realised	
					Approve new indicators	Steering Committee	2016 Q 4	Realised	

4.3 Updated Logical framework

A revision of the indicators foreseen in the Technical and Financial File of the ICB II project for the Baseline study revealed that not all indicators remain completely relevant. A proposal to change some of the indicators to be better aligned with the activities to be implemented by the project, while still reflecting the specific objective and expected results, was elaborated and accepted by the Steering Committee of 11th of October 2016.

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

Indicator TFF	Comments	Accepted new indicator
Business plans for hospitals are institutionalised at national level	Name of the plan has changed	Performance Improvement Plans for hospitals and HC IV are institutionalised at national level
District health plans, as developed by the ICB project are institutionalised at national level	National Planning Guidelines already exist	The National Health Planning Guidelines are implemented at district level
The national supervision approach is adapted	There are no activities planned in the project to analyse or change the current approach. Proposal to add an indicator that reflects some of the outcomes of the implementation of RBF: utilisation rate	1. Utilisation rate for curative consultation at HC III level and 2. Hospitalisation rate for GH and HC IV for supported facilities

Output 1: The quality of care at hospital and HC IV is strengthened

Indicator TFF	Comments	Accepted new indicator
Number of HC IV providing the full package of hospital care as defined by RBF	The packages are defined by MoH and not by RBF	Number of HC IV providing the full package of hospital care as defined by MoH
Number of HC IV and GH with approved business plans	This number would be equal on the number of facilities accepted in RBF as we will not present nor support the not-accepted for developing their business plan by lack of time and budget. The quality improvement plan is already mentioned in the outcome indicators.	Indicator deleted
% of essential drugs out-of-stock during > 1 week	To add which essential drugs	% of essential drugs out-of-stock during > 1 week for the 6 tracer medicines
% of personnel having followed sufficient continuous training	Proposal to use a more general indicator which is easier to obtain	Number of facilities with training plan and % completion of the plan

according to national requirements		

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

Indicator TFF	Comments	Accepted new indicator
FP services, including access to modern contraceptives, are integrated and 75% of all HC III and supported HC II provide the service	No HC II will be supported National target is 100%	FP services, including access to modern contraceptives, are integrated and 100% of public HC III provide the service
HIV care and treatment services, including PMTCT, are integrated and functioning at 95% of performance or more conform RBF norms	Only 30% of HC III will be supported RBF norms don't work with percentage but YES/NO	HIV care and treatment services, including PMTCT, are integrated and performance conforming to RBF quality norms in supported facilities
HC III based deliveries have increased and the average quality is > 75% according to RBF norms	Only 30% of HC III will be supported RBF norms don't work with percentage but YES/NO	HC III based deliveries have increased in supported facilities
Number and % of HC III per district providing the complete national minimum health care package	How will the project influence this? The limited time and budget will not permit to "upgrade" a lot of HC III	Indicator deleted
Composed Quality of Care indicator according to RBF procedures for HC III performance is reached in > 75% of the HC III and supported HC II in both regions	Target level for the indicator is not given ("is reached")	> 75% of the supported HC III obtain a score of at least 3 stars according to the Quality of Care Assessment of MoH
Degree of implementation of the integrated district plan (financial absorption capacity of the districts relative to the execution agreement)	No grant agreements will be signed, DHMT will be financed / rewarded through RBF scheme. But indicator remains valid	Degree of implementation of the integrated district plan

Output 3: Integrated regional network of health facilities in place

Indicator TFF	Comments	Accepted new indicator
National vision on regional coordination developed	Too vague	A regional Joint Review Mission is organised in at least 5 of the 14 regions before the end of the project
Regional coordination for		No change proposed

ambulance services is functional		

Output 4: The normative role of the MoH is strengthened

Indicator TFF	Comments	Accepted new indicator
RBF implemented in 70% of HC IV and GH in the 2 regions	Why is this in result 4?	Indicator deleted
National RBF policy approved		No change proposed
At least 5 strategic topics of attention have been subject of a national reflection exercise		No change proposed

4.4 MoRe Results at a glance

Logical framework's results or indicators modified in last 12 months?	YES (indicators. See 4.3)
Baseline Report registered on PIT?	YES
Planning MTR (registration of report)	2017 Q4
Planning ETR (registration of report)	2018 Q3
Backstopping missions since 01/01/2016	Backstopping Paul Bossyns (EST BTC HQ) to support implementation of RBF from 7 till 13 July 2016

4.5 “Budget versus current (y – m)” Report

Budget vs Actuals (Year to Month) of UGA1402811

Project Title : **Institutional Capacity Building project in Planning, Leadership and Management in the Uganda Health sector**

Budget Version: **C02**
Year to month : 31/12/2016
Currency : EUR
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			4.268.750,00	50.689,07	**379.935,41**	430.624,48	3.838.125,52	**10%**
01 The quality of care at hospital and HC IV is strengthened			1.525.500,00	0,00	**71.552,31**	71.552,31	1.453.947,69	**5%**
01 Develop regional coverage plan for general hospitals and		REGIE	35.500,00	0,00	**17.963,07**	17.963,07	17.536,93	51%
02 Support priority hospitals and HC-IV to realize a business		REGIE	62.000,00	0,00	**96,13**	96,13	61.903,87	0%
03 Support basic requirements for quality of care		REGIE	270.000,00	0,00	**22.709,62**	22.709,62	247.290,38	8%
04 Improve drugs and medical supplies managements		REGIE	54.000,00	0,00	**30.783,49**	30.783,49	23.216,51	57%
05 Introduce e-patient files		REGIE	204.000,00	0,00	**0,00**	0,00	204.000,00	0%
06 Implement RBF approach in general hospitals and HC-IV		COGES	900.000,00	0,00	**0,00**	0,00	900.000,00	0%
02 District health offices and management teams are			1.475.500,00	0,00	**28.786,67**	28.786,67	1.446.713,33	**2%**
01 Interpret coverage plan for HCIII and II		REGIE	31.500,00	0,00	**0,00**	0,00	31.500,00	0%
02 Adjust district development plan according to coverage		REGIE	30.000,00	0,00	**0,00**	0,00	30.000,00	0%
03 Support basic requirements for quality of care		REGIE	150.000,00	0,00	**6.445,84**	6.445,84	143.554,16	4%
04 Implement RBF financing through execution agreements		COGES	900.000,00	0,00	**0,00**	0,00	900.000,00	0%
05 Assure Quality of care through support supervision and		REGIE	202.000,00	0,00	**0,00**	0,00	202.000,00	0%
06 Improve ambulance services and referral system at district		REGIE	162.000,00	0,00	**22.340,83**	22.340,83	139.659,17	14%
03 Integrated regional network of health facilities in place			397.600,00	44.742,44	**95.137,71**	139.880,15	257.719,85	**35%**
01 Regional project team		REGIE	269.600,00	44.742,44	**44.771,05**	89.513,49	180.086,51	33%
02 Organize quarterly regional health forum in the Ruwenzori		REGIE	36.000,00	0,00	**47.389,52**	47.389,52	-11.389,52	132%
03 Install a coordination body for integrated referral system		REGIE	0,00	0,00	**0,00**	0,00	0,00	?%
04 Support continuous training from regional hospital		REGIE	92.000,00	0,00	**2.977,14**	2.977,14	89.022,86	3%
04 The normative role of the MoH is strengthened			870.150,00	5.946,63	**184.458,72**	190.405,35	679.744,65	**22%**
		REGIE	3.152.150,00	63.351,81	**499.347,25**	562.699,06	2.589.450,94	18%
		COGEST	1.847.850,00	0,00	**0,00**	0,00	1.847.850,00	0%
		TOTAL	5.000.000,00	63.351,81	**499.347,25**	562.699,06	4.437.300,94	11%

Budget vs Actuals (Year to Month) of UGA1402811

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	Status	Fin Mode	Amount	Start to 2015	Expenses 2016	Total	Balance	% Exec
01 Ensure overall management and governance of the project		REGIE	633.400,00	5.946,63	**180.810,16**	186.756,79	446.643,21	29%
02 Capitalize from field experiences developed in Ruwenzori		REGIE	104.000,00	0,00	**1.153,30**	1.153,30	102.846,70	1%
03 Strengthen continuous training policies and modalities		REGIE	54.000,00	0,00	**2.495,26**	2.495,26	51.504,74	5%
04 Develop a model and strategies for a social health		REGIE	78.750,00	0,00	**0,00**	0,00	78.750,00	0%
K BUDGETARY RESERVE (MAX 5% OF TOTAL ACTIVITIES)			137.850,00	0,00	**0,00**	0,00	137.850,00	0%
01 budgetary reserve			137.850,00	0,00	**0,00**	0,00	137.850,00	0%
01 Budgetary reserve Co-management		COGES	47.850,00	0,00	**0,00**	0,00	47.850,00	0%
02 Budgetary reserve BTC management		REGIE	90.000,00	0,00	**0,00**	0,00	90.000,00	0%
Z GENERAL MEANS			593.400,00	12.662,74	**119.411,84**	132.074,58	461.325,42	22%
01 Staff costs			406.800,00	12.628,62	**91.604,70**	104.233,32	302.566,68	26%
01 International administrative and finance Responsible		REGIE	270.000,00	12.628,62	**74.954,56**	87.583,18	182.416,82	32%
02 Support staff		REGIE	136.800,00	0,00	**16.650,14**	16.650,14	120.149,86	12%
02 Investments			13.400,00	0,00	**8.597,49**	8.597,49	4.802,51	64%
01 Office and ICT equipment		REGIE	13.400,00	0,00	**8.597,49**	8.597,49	4.802,51	64%
03 Running costs			49.200,00	34,12	**14.206,71**	14.240,83	34.959,17	29%
01 Office recurrent costs		REGIE	20.400,00	34,12	**7.860,61**	7.894,73	12.505,27	39%
02 Missions		REGIE	28.800,00	0,00	**6.346,10**	6.346,10	22.453,90	22%
04 Audit and monitoring and evaluation			124.000,00	0,00	**0,00**	0,00	124.000,00	0%
01 Evaluation & Monitoring		REGIE	70.000,00	0,00	**0,00**	0,00	70.000,00	0%
02 Audit		REGIE	30.000,00	0,00	**0,00**	0,00	30.000,00	0%
03 Backstopping		REGIE	24.000,00	0,00	**0,00**	0,00	24.000,00	0%
		REGIE	3.152.150,00	63.351,81	**499.347,25**	562.699,06	2.589.450,94	18%
		COGEST	1.847.850,00	0,00	**0,00**	0,00	1.847.850,00	0%
		TOTAL	5.000.000,00	63.351,81	**499.347,25**	562.699,06	4.437.300,94	11%

Budget vs Actuals (Year to Month) of UGA1402811

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Year to month : 31/12/2016
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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
10 VAT			0,00	0,00	**5.002,95**	5.002,95	-5.002,95	?%
01 VAT_Regie		REGIE	0,00	0,00	**5.002,95**	5.002,95	-5.002,95	?%
02 VAT_comgt		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
99 Conversion rate adjustment			0,00	0,00	**-0,01**	-0,01	0,01	?%
98 Conversion rate adjustment		REGIE	0,00	0,00	**-0,01**	-0,01	0,01	?%

REGIE	3.152.150,00	63.351,81	**499.347,25**	562.699,06	2.589.450,94	18%
COGEST	1.847.850,00	0,00	**0,00**	0,00	1.847.850,00	0%
TOTAL	5.000.000,00	63.351,81	**499.347,25**	562.699,06	4.437.300,94	11%