Enabel


# RESULTS REPORT 2017

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

## UGANDA

**DGD CODE : NN 3016425**

**NAVISION CODE : UGA 1402811**

# 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 |
| GDP | Gross Domestic Product |
| GH | General Hospital |
| GoU | Government of Uganda |
| HC | Health Centre |
| HDP | Health Development Partners |
| HMIS | Health Management Information System |
| HQ | Headquarters |
| HSDP | Health Sector Development Plan |
| ICB II | Institutional Capacity Building project phase 2 |
| IP | Implementing Partners |
| JMS | Joint Medical Stores |
| JRM | Joint Review Mission |
| M&E | Monitoring and Evaluation |
| MoH | Ministry of Health |
| MTR | Mid-Term Review |
| NMS | National Medical Stores |
| NTA | National Technical Assistant |
| OPD | Outpatient Department |
| OPS | Operations |
| PBF | Performance-Based Financing |
| PIP | Performance Improvement Plan |
| PMT | Project Management Team |
| PNFP | Private Not For Profit |
| Qx | Quarter |
| RBF | Results-Based Financing |
| RR | Resident Representative / BTC Representation Uganda |
| RRH | Regional Referral Hospital |
| SDHR | Support to the Development of Human Resources |
| SIDA | Swedish International Development Agency |
| SPHU | Strategic Purchasing for Health in Uganda |
| TFF | Technical and Financial File |
| TWG | Technical Working Group |
| URMC HIP | Ugandan Reproductive Maternal Neonatal Child and Adolescent Health Services Improvement Project |

# 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** | **31st of December 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** | **2017** |

## 1.2 Budget execution

| | Budget | Expenditure | | Balance | Disbursement rate at the end of year 2017 |
|---|---|---|---|---|---|
| | | Previous years (2015+2016) | Year covered by report (2017) | | |
| **Total** | **5 000 000 €** | ***569 839 €*** | **1 345 213 €** | **3 084 948 €** | **38.3 %** |
| **Output 1** | 1 525 500 € | 73 023 € | 329 584 € | 1 122 893 € | 26.4 % |
| **Output 2** | 1 475 500 € | 28 863 € | 499 292 € | 947 345 € | 35.8 % |
| **Output 3** | 487 600 € | 139 880 € | 108 550 € | 239 170 € | 50.9 % |
| **Output 4** | 870 150 € | 194 834 € | 223 332 € | 451 984 € | 48.1 % |
| **Budg.res** | 47 850 € | 0 € | 0 € | 47 850 € | 0 % |
| **General means** | 593 400 € | 132 075 € | 184 455 € | 276 870 € | 53.3 % |

Budget execution for output 3, output 4 and general means is in line with the project progress in time and according to planning at around 50%.
Output 1 and 2 expenditure remains low because only 1 quarterly Results-Based Financing (RBF) payment has been executed.
Taking into account the commitments (already signed RBF grant agreements until June 2018 and public tenders), the total expenditure increases to 65%.

## 1.3 Self-assessment performance

### 1.3.1 Relevance

| | Performance |
|---|---|
| **Relevance** | A |

Results-Based Financing (RBF), the ambulance referral system and regionalisation are all topics that are presently of particular interest to the Ministry of Health (MoH) in Uganda.

The MoH announced that the financing of the Health Sector Development Plan (HSDP) 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 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 HSDP 2015/16 - 2019/20 which prioritises Emergency Medical Services (EMS) / ambulance services as key intervention areas for introduction and scale up to improve the service delivery system. (p.64 HSDP). In 2017, the MoH even established a new Department of EMS to improve the implementation of this identified priority.

The importance of an intermediary level in a country with 122 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 Institutional Capacity Building (ICB) I project and continued by the Private Not-For Profit (PNFP) and ICB II projects, are a good foundation on which these new initiatives can be build. In 2017 the regional Joint Review Mission was repeated 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.

The Mid-Term review (MTR) report also assigns the maximum score of A for relevance of the ICB II project. *All topics addressed by the project respond to real existing needs, the project's strategies are in line with the national policies and strategies, well aligned with other development partners' interventions, and in line with the Belgian priorities and Belgian Development Agency's (BTC) strategic approach*

### 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 Technical and Financial File of the project mentions several innovative activities but implementation of all will not be possible.

Some activities will be started but full results will only be attained under the Strategic Purchasing for Health in Uganda (SPHU) project. The delayed and slower implementation of these activities is fully compensated by better quality and higher potential for sustainability (see also 2.2.2 Analysis of progress made).

The introduction of a completely new approach, which is as complex as the implementation of RBF in public health facilities, is bound to encounter a multitude of hurdles and obstacles along the way. Nevertheless, by careful preparation and planning the project has pro-actively avoided the risks and managed to proceed smoothly with the implementation.

In the opinion of the Mid-Term Review consultants *"The project will without doubt have a substantial effect on the improvement of quality of care at those facilities supported through the RBF, but not in the entire districts or regions. The effect of other activities, such as the regional inter-district structures, the coverage maps and the national-level capacity strengthening is more difficult to assess or will be limited."*

### 1.3.3 Efficiency

| | Performance |
|---|---|
| **Efficiency** | B |

It can not be denied that there exist delays in the implementation of the activities compared to the original planning. However, now that all principal activities have already started or will start in 2018 Quarter 1 and with the extension of the implementation period until December 2018, it can be assumed that financial execution by the end of the project will be near 100%.

RBF is the main intervention of the ICB II project and represents a substantial part of the project's budget. The original planning from 2015 for RBF implementation, trying to squeeze the preparation and 1 year of RBF implementation followed by capitalisation into the short real implementation period of 27 months, was too optimistic. The long preparation phase and accompanying low financial execution rate raised some concerns but, as has been proven by the PNFP project, these concerns were unjustified and once RBF is effectively implemented, financial execution increases significantly. Furthermore, the identification of SPHU project as continuation of the activities of ICB II and PNFP has changed the planning horizon. In retrospect, the delay in implementation has also its advantages: if RBF implementation would have started earlier, there would have been a gap between the end of ICB II RBF implementation and the start of SPHU RBF implementation. As the situation is now, the RBF implementation in the selected health facilities can transition seamlessly from one project to the next.

The MTR draft report states: *"Overall the project is efficiently implemented, the inputs are*

*efficiently used, the quality of most outputs is good, and the organisational structure is adequate. However, most activities started with important delays, some of the planned activities will probably not be implemented, the quality of some outputs is less and the organisational alignment with the PNFP project was sub-optimal."*

### 1.3.4 Potential sustainability

| | Performance |
|---|---|
| **Potential sustainability** | B |

The MTR team subscribes to the reasoning in last year's Results Report 2016 that the main objective of the ICB II project is in the development of an RBF model and not so much an improvement in the health status of the population in all districts of intervention.
*"The most important expected impact of the project will be on policy making. Together with the PNFP project, the ICB II project is leading the way to institutionalising RBF as an alternative financing mechanism. The project is considered by the project staff as well as by the MoH counterparts, as such. It is said to be a pilot project, that tests and capitalises new approaches, and of which the major expected outcome is that policies are developed and not that health is already improved in the two covered regions."*

The intended impact on policy is not limited to the development of a robust RBF model but entails furthermore the creation of a sustainable environment for RBF within the MoH (and Government of Uganda) and among the Health Development Partners (HDP).
The MoH and the Ministry of Finance adopted the approach as a possible additional financing mechanism, a National RBF framework was developed, RBF focal persons have been assigned, the necessary structures, such as an RBF unit at central level, are being put in place, and districts and facilities show ownership. Nevertheless, progress is slow and still more efforts are needed to enhance the capacity at the MoH but the SPHU project will put more emphasis on support to the central level.
The World Bank and the Swedish International Development Agency (SIDA) have already jumped on the RBF wagon in Uganda and USAID implements voucher programmes (demand-side output based financing). USAID is interested in expanding their activities in RBF by adding offer-side RBF financing. Also, UNICEF and UNFPA were said to be interested, at least for certain services.

For some of the other important initiatives the potential sustainability is more mixed.

The search for financial autonomy for the ambulance services is now completely integrated with the MoH EMS Department. The policy option to pursue community financing to increase financial autonomy for emergency evacuations is a significant step towards sustainability but will take much effort and a long time to be implemented. The use of the RBF funds that the health facilities receive from the project to pay for the ambulances is evidently not a sustainable solution.

Although the regional initiatives, quarterly Regional Health Forum and yearly Regional Joint Review, are greatly appreciated by all, the budget of the MoH doesn't include funds to roll out these meetings to the other regions in the country. It is doubtful that these regional opportunities for sharing of experiences and joint planning will continue after the closure of the projects.

## 1.4 Conclusions

- During 2017 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 been encountered
- The presence of the SPHU project (2018-2021) provides a continuation of all major activities of the ICB II project. A longer-term vision with increased emphasis on the quality and sustainability of the activities has been integrated in the project.

*Sources of information:*

- *The main sources of information for this report are the quarterly project reports and other project documents.*
- *The ICB II Mid-Term Review took place from the 21st of October to the 21st of November 2017. Although for the moment only the draft report is available, it is not expected that the major conclusions will change in the final report. The general content of the report is integrated in this report*
- *On the 19th of January a stakeholders meeting was organised with representatives of all levels of implementation. The comments and conclusions of this meeting are integrated in this report.*

| National execution official<br><br>Dr. Sarah Byakika | Enabel execution official<br><br>Dr. Tony De Groote |
|---|---|
|  |  |

# 2 Results Monitoring[1]

## 2.1 Evolution of the context

### 2.1.1 General context

There have been no major changes in 2017 and the general situation in Uganda remains stable. His Excellence President, Yoweri Museveni, and his National Resistance Movement retain a tight grip on power.

Policy will focus on boosting productivity and tackling infrastructure bottlenecks, but execution of the government's ambitious public investment plan might be inhibited by funding shortfalls and weak institutional capacity.

Real Gross Domestic Product (GDP) growth will recover in 2018, to 4.6%, amid stronger private consumption. Thereafter, increased investment in infrastructure and the oil sector will spur growth to an annual average of 5.5% in 2019-22.

There has been no significant change in 2017 and the stability in the country provides a conducive environment for the project.

### 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.

Two new districts have been created in 2017 in the regions of intervention:

- Pakwach district in West Nile region; formerly part of Nebbi district; there is no RBF supported public health facility in this new district
- Bunyangabu district in Rwenzori region; formerly part of Kabarole district; there is one RBF supported public health facility in this district, Kisomoro which will start RBF ih February 2018

### 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 Enabel own 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 experienced delays for payments under co-management (RBF payments) While timely payments are an essential condition for a well-functioning RBF system. There were no significant delays for the activities under own management as a result of

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

the execution modalities.

There has been no change in execution modalities in 2017.

### 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 bi-cephalic construction with a common body streamlines the Enabel approach and increases efficiency by sharing of resources. Unfortunately, the current organisational structure of the 2 projects in parallel and administrative requirements of Enabel which are project-focused and don't take the programme approach into account, put a limit to the degree of integration and thus collaboration between the 2 projects.

Collaboration with the Enabel Support to the Development for Human Resources (SDHR) project has been limited to participation in tender evaluation and information sharing. During 2018, when the SDHR training programmes actually start, it is foreseen to intensify the collaboration significantly.

Coordination of the interventions from different Implementing Partners (IP) by the MoH remains minimal. However, due to the autonomy in spending of the RBF funds by the health facilities and the District Health Teams (DHT) and the pronounced presence of our National Technical Assistants (NTA) in the field, complementarity with other interventions (mainly vertical programme support or punctual interventions) is achieved and duplication is avoided.

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

There has been no major changes in 2017.

## 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 2017** | **Target year 2017** | **End Target** |
| Performance Improvement Plans for hospitals are institutionalised at national level | **No** | **Only for GH and HC IV enrolled in RBF** | **Partially** | **Yes** |
| The National Health Planning Guidelines are implemented at district level | **No** | **Yes** | **Partially** | **Yes** |

| | | | | |
|---|---|---|---|---|
| Utilisation rate for supported HC III | **X (0.91)** | **0.67 (0.92)** | **0.73** | **0.80** |
| Hospitalisation rate for supported GH and HC IV per 100 population | **X (2.53)** | **1.53 (1.99)** | **1.68** | **1.83** |

*For utilisation rate and hospitalisation rate the first figure shows the verified cases (complying with minimum quality criteria as defined for RBF) and the figure in parenthesis shows the number declared to HMIS. Verified cases were not available before the start of RBF. The data are only available for 2017 Q3, the first quarter of implementation of RBF for the public facilities. Data for 2017 Q4, which would complete the performance of 2017, will be available by end of February 2018.*
*The targets have been adapted to represent an increase of the number of verified cases, taking the results of the first quarter of implementation (2017 Q3) as baseline.*

*Only a fraction of the health facilities in the 17 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.*

### 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 quality care for the population (indicator 3 and 4).

Facilities accredited and accepted to be included in the RBF programme on 31st of December 2017.

| | West Nile | Rwenzori | Total |
|---|---|---|---|
| **GH** | 2 | 3 | **5** |
| **HC IV** | 1 | 3 | **4** |
| **HC III** | 16 | 15 | **31** |
| **Total** | **19** | **21** | **40** |

RBF has started for the first public health facilities and by the end of 2017, 27 health facilities had received their first quarterly payment. By the first quarter of 2018 all 40 selected health facilities will be actively implementing RBF.

The RBF implementation model, developed and already used for more than a year in the PNFP health facilities, has proven its robustness. Although some minor changes had to be introduced for implementation in the public health facilities, the basic principles and procedures are applicable regardless of ownership and concommitant differences in functionning. The RBF roll out to 78 districts under the Uganda Reproductive Maternal Neonatal Child and Adolescent Health Services Improvement Project (URMCHIP) 2017 – 2021 funded by the World Bank loan, Global Financing Facility (GFF) for Every Woman Every Child grant and Sida grant will make use of the same model with minimal changes.

The other activities of the project, complementary to RBF to improve the functioning of the district health system and to increase the quality of care, have experienced progress, although for some at a slower speed than planned at the beginning of the project. The presence of the new Enabel health project, SPHU (2018-2021), has given the ICB II project the possibility to apply a vision at longer term for its planning. Although not all activities will attain their final result at the end of the ICB II project, they will be continued by the SPHU project and thereby a better quality and especially a higher possibility of sustainability can be reached, albeit at a slower pace of implementation. Examples are: for the improvement in district referral system functionality and financial autonomy we now support the newly established Department of EMS from MoH to pilot their draft

national policy in some of our districts of intervention; for the e-patient file system we support a local NGO in the finalisation of their original e-patient file system, Nganisha, while in the TFF an international consultancy to decide on which system to use was foreseen.

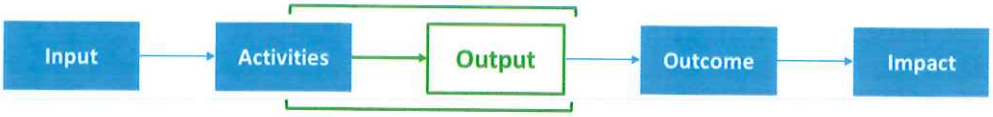
Overall, it can be concluded that the ICB II made significant progress during 2017. RBF is ongoing and the addition of extra facilities is now realised. The other activities have also started and all Terms of Reference for the public tenders, except one, have been finalised. Therefore project progress and accompanying financial execution will continue in 2018 with the same momentum as in 2017. Although not all activities will have reached their final result at the end of the project, by June 2018 the time- and labor-intensive phase of preparation and start-up of activities will have been finalised and the SPHU project will be ready to provide the further continuation.

### 2.2.3 Potential Impact

In 2017 the interest of both the MoH/GoU and the Health Development Partners in Uganda has increased dramatically.
Although initial reactions and results are very promising, in the second half of 2018, the Enabel health projects will be able to provide field-tested evidence to sustain the claims of benefits of RBF on the health system and to support the roll-out of RBF in the rest of the country (already starting under the URMCHIP (2017 - 2021).

According to the MTR report: *The most important expected impact is on policy making. The project will greatly contribute to the development of a national strategy and modalities for RBF, and possibly as well on the development of policies for ambulance services and regional structures.*

## 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 2017** | **Target year 2017** | **End Target** |
| Number of HC IV providing the full package of hospital care as defined by MoH | **7** | **8** | **3** | **8 (out of 17)** |
| % of essential drugs out-of-stock during > 1 week for the 6 tracer medicines[2] | **48%** | **NA** | **NA** | **0%** |
| Number of facilities with training plan and % completion of the plan | **Data not yet available** | **NA** | **NA** | **80%** |

### 2.3.2 Progress of main activities

| **Progress of main activities** [3] | **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 improvement 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

Activity 1: Develop regional coverage plan for general hospitals and HC IV (see also activity 1 & 2 of output 2)

Progress in the development of coverage maps for the districts has been slow and consists of the presence of district coverage maps at central level. Dissemination of the maps and support for utilisation by the districts for their planning relies on central level staff with limited availability. In order to achieve the intended output, the project will still

[2] 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.

[3] 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.

have to implement this second step, essential for the translation of the maps into a real district (HC II and HC III) and regional (HC IV and GHs) planning tool. This will require more involvement of the Central Level staff including the Health Information Division to supplement the capacity built in the Regional Performance Monitoring Teams whose contracts expired in June 2017. 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 IVs to concentrate on their function as referral function, resulting in better quality of care at all levels of the district health system.

Activity 2: Support priority hospitals and HC IV to realize a performance improvement plan (PIP)

All public health facilities enrolled in the RBF scheme, including the HC IVs and GHs, have elaborated their Performance Improvement Plan, commonly known as the Business Plan.

Institutionalisation of the PIP (see outcome indicator) has not been achieved yet. Although all the information can be found in the documents, the format needs to be revised to improve the coherence and relationship between the different parts and to improve the quality of the documents.

Staff from the district and health facilities remarked that there is still work to do to increase the ownership of the PIP and thereby improve the adherence to it.

The competencies in planning by district and health facility staff are also improved through a comprehensive, intermittent 12 month training programme in Strategic Planning implemented by the Junior Technical Assistant for the Enabel health projects.

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, training).

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

The DHTs and the staff from the public health facilities have benefitted from a training programme to prepare them for the implementation of RBF: RBF orientation training (5 days), training in medicine management (3 days) and financial management training (3 days). The benefits of this training, focused on the practical aspects of RBF implementation, are reflected in a smooth handling of the reporting requirements in the first quarter of RBF implementation.

Based on their needs the qualified GHs and HC IVs will receive some medical equipment, which, because of their cost, would be difficult to acquire with the RBF funds and are within the budgetary limits of the project (ultrasound, ECG machine, oxygen concentrator). This equipment will be delivered in 2018 Q2/3. These investments are essential inputs for the provision of quality of care.

Activity 4: Improve drugs and medical supplies management

The Permanent Secretary (PS) of the MoH has granted permission to the participating public health facilities to use part of their RBF for ordering of vital and essential medicines from Joint Medical Stores (JMS) on top of their normal supply from the public National Medical Stores (NMS).

This will undoubtedly improve the availability of medicines and health supplies in the health facilities and greatly contribute to improved quality of care for the population, both at hospital and health centre level.

Activity 5: Introduce e-patient files

The project will support a local company, which has started to develop an electronic patient file system adapted to the Ugandan context. ICB will finance the finalisation of this Nganisha health system by completing and expanding the already existing modules and

the pilot implementation in second line health facilities under RBF.
Some delay was encountered due to administrative issues (securing copyright and obtaining authorisation from the MoH) but the activities will start in 2018 Q1.
ICB II will only be able to start the implementation of the e-patient file system in some selected facilities but this activity, included in the workplan of the SPHU project, will be continued in the new Enabel health programme.
E-patient files are an important tool to facilitate health facility planning and management and their introduction in general hospitals and HC IVs in Uganda will be an important step for improving health facility performance and quality of care.

Activity 6: Implement PBF approach in GHs and HC IVs
The first batch of selected public health facilities started implementation of RBF in July 2017. The added conditionality of repayment of outstanding ICB I funds delayed this start date for some health facilities and up to end of 2017 Bundibugyo district (with 2 accredited health facilities) had not fulfilled this obligation.
The difference in functioning between PNFP and public health facilities necessitated changing some minor implementation issues but the basic principles are maintained.
The health facilities started their RBF journey in less than ideal circumstances due to late payment of the qualification incentive and late arrival of the initial donation of medicines and health supplies. These 2 support measures were introduced to allow the health facilities to counteract the delayed performance improvement in an output-based financing modality and it is then no surprise that the performance of the health facilities during their first quarter of implementation remained below the planned targets.
Nevertheless, the administrative handling of the reporting, verification and validation process went very smoothly and resulted in a payment of all (except 1) health facilities with a minimal delay of 2 weeks for the first quarter of implementation.

An additional 11 public health facilities have been selected to participate in the RBF scheme. Due to the evolution of the exchange rate of the Ugandan Shilling to the Euro, 1 extra General Hospital and 2 extra HC IIIs could be included compared to what was originally planned. The identification of these 11 new health facilities was more selective than the first 29 and guided by the aim to enrich the RBF model in development. Hereby we have now 2 districts with near complete coverage of the health facilities by RBF (from both the ICB II and PNFP project): Moyo district in West Nile with 81% coverage (13 out of the 16 health facilities) and Kyenjojo district in Rwenzori region with 63% coverage (12 out of the 19 health facilities). This will enrich the experience of RBF implementation and expand it from the influence of RBF on a single health facility to the impact on the district as a whole.

The effect of the introduction of RBF goes well beyond only improvement in the number of patients seen at the health facilities, as can be expected from a strategic purchasing mechanism. It is therefore expected that the capitalisation will provide also evidence on improved quality of care and better functioning of the district health system. Some of the additional areas of improvement that were mentioned are: better availability of medicines and health supplies, improvement in the quality of Health Management Information System (HMIS) data, better gatekeeping function by the HC III, improved staff commitment and motivation, competition amongst health facilities in the same district leading to better quality of care for the population.

The digitalisation of the RBF processes (declaration/invoicing, verification and validation) by BlueSquare will start in 2018 Q1.

From the draft MTR report we quote: *"The RBF has only just been initiated, but even so facilities claimed that it already resulted in increased staff motivation and service use. The greatest effect of the RBF is expected to be on an improved availability of drugs and medical supplies, and better conditions in terms of small equipment and infrastructure."*

## 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 2017** | **Target year 2017** | **End Target** |
| FP services, including access to modern contraceptives, are integrated and 100% of public HC III provide the service | **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** | **95%** |
| HC III based deliveries conforming to RBF quality norms, have increased in supported facilities | **X (45%)** | **51% (63%)** | **56%** | **61%** |
| > 75% of the supported HC III obtain a score of at least 3 star according to the Quality of Care Assessment of MoH | - | **(100%)** | **75%** | **75%** |
| Degree of implementation of the integrated district plan | **Data not yet available** | **NA** | **NA** | **85%** |

*Only a fraction of the health facilities in the 17 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.*

*For HC III based deliveries the first figure shows the verified cases (complying with minimum quality criteria) and the figure in parenthesis shows the number declared to HMIS. Verified cases were nor available before start of RBF. The data are only available for 2017 Q3, the first quarter of implementation of RBF for the public facilities. Data for 2017 Q4, which would complete the performance of 2017, will be available by end of February.*
*The targets have been adapted to represent an increase of the number of verified cases, taking the results of the first quarter of implementation (2017 Q3) as baseline.*

*For the quality score no data from MoH are available. The data shown are from the quarterly RBF quality assessment for the health facilities that participate in RBF.*

*The degree of implementation of the integrated district plan will be evaluated in the second half of 2018, after 1 year of implementation of RBF.*

## 2.4.2 Progress of main activities

| Progress of main activities [4] | 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 | |

## 2.4.3 Analysis of progress made

Activity 1 & 2: Interpret coverage plan for HC III and II and Adjust district development plan according to coverage plan conclusions
See under Activity 1 of Output 1 (2.3.3)

Activity 3: Support basic requirements for quality of care
See Activity 3 of Output 1 under 2.3.3 for training as preparation for RBF implementation.

All HC III enrolled in RBF received ICT equipment based on their needs. This donation enters completely in the Digitalisation for Development Strategy of the Belgian Cooperation. This will not only facilitate the implementation and administrative handling of RBF but can be utilised for a lot of other purposes.

Activity 4: Implement PBF financing through execution agreements
See Activity 6 under Output 1 (2.3.3)

Activity 5: Assure Quality of care through support supervision and continuous training
Support supervisions by the District Health Team are included in the grant agreements (Activity 4 of Output 2)

The project aided the MoH for support to the districts in West Nile and Rwenzori region for their planning for the Financial Year 2017/18. As a result, all supported districts are implementing the National Health Planning Guidelines (see outcome indicator 2)

An ambitious, 12-month programme by the Junior Technical Assistant aims at improving the strategic planning capacities of both PNFP and public RBF-selected health facilities. By the end of 2018, all participating health facilities should possess a strategic 5 year plan which will contribute to better integration of the district health system.

Activity 6: Improve ambulance services and referral system at district
With the establishment of a new Department for EMS at the MoH in the second half of 2017, the project now has a real counterpart to work on the referral system in the districts. An initial workshop has been organised in 2017 Q3 and during 2018 the draft

[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.

EMS policy will be field-tested in a few district with special emphasis on financial sustainability. This will not be completely achieved during the lifespan of the ICB II project but this activity will continue under the SPHU project.
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 2017** | **Target year 2017** | **End Target** |
| A regional Joint Review Mission is organised in at least 5 of the 14 regions before the end of the project | **0** | **2** | **2** | **5** |
| Regional coordination for ambulance services is functional | **No** | **No** | **Partially** | **Yes** |

### 2.5.2 Progress of main activities

| **Progress of main activities** [5] | **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 | | | | |
| 4 Support continuous training from regional hospital specialists | | | X | |

### 2.5.3 Analysis of progress made

Activity 1: Regional project team
The regional teams are present and functional. The NTAs now elaborate quarterly workplans and this has improved their performance.
The presence of a team in the regions of implementation is essential for the support to the health facilities and DHTs. Their contribution goes well beyond output 3 and covers all aspects of the project.
Staff from the districts and the health facilities again stressed that the regional teams are a key factor for the observed good performance of the project but argued for an increase in their decision-making space.

Activity 2: Organize quarterly regional health forum in the Rwenzori and West Nile regions
The Regional Health Forums are organised quarterly and are highly appreciated by all participants. The sharing of experiences and accountability for their performance amongst their peers are mentioned as the main reasons for the appreciation. There is however still room for improvement in the content treated at these fora to diminish repetition and to allow for more topics to be covered and more interactive discussions.

Once a year, the number of particpants invited is expanded for the regional Joint Review

[5] 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.

Mission which had its second edition in 2017. Participation is near-complete and the initiative is applauded and supported on all levels.
The MoH planned to organise a regional Joint Review Mission in 2 additional regions but failed to obtain financing on time.

The MTR remarked: "*The regional inter-district coordination structures, the quarterly regional health fora and the annual regional joint review meetings, are highly appreciated and districts claim they help in improving their planning …*"

Activity 3: Install a coordination body for integrated referral system
According to the draft Ugandan National Policy on EMS emphasis will first be put on well functionning district ambulance services and regional coordination will not (yet) be dealt with. In aligment with this national policy, this activity, which doesn't have budget attached to it, will not be pursued anymore.

Activity 4: Support continuous training from regional hospital specialists
Plans for mentorship visits by the hospital specialists have been elaborated in both regions. However, the Regional Referral hospital specialists claim a payment of extra honoraria as per Ugandan guidelines and additional payments to MoH staff is not allowed for Enabel in Uganda projects according to directives from the Representation. For the moment the mentorship teams only comprise nursing and paramedical staff and the results of this activity falls short of what was planned and expected.
The activities will be adapted and more emphasis will be put on in-servicee training of GH and HC IV staff in the departments of the Regional Referral Hospitals (RRH) and the installation and functionalisation of telemedicine facilities.

## 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 2017** | **Target year 2017** | **End Target** |
| National RBF policy approved | **No** | **Yes** | **Yes** | **Yes** |
| At least 5 strategic topics of attention have been subject of a national reflection exercise | **0** | **0** | **0** | **5** |

### 2.6.2 Progress of main activities

| **Progress of main activities** [6] | **Progress:** | | | |
|---|---|---|---|---|
| | A | B | C | D |
| 1 Ensure overall management and governance of the project within MoH | | X | | |
| 2 Capitalize from field experiences developed in Rwenzori and West Nile regions | | X | | |
| 3 Strengthen continuous training policies and modalities | | | | |
| 4 Develop model and strategies for a social health insurance | | X | | |

### 2.6.3 Analysis of progress made

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: Capitalise from field experiences developed in Rwenzori and West Nile regions
A considerable amount of data is being gathered during the course of the project, especially concerning RBF implementation. While the PNFP project already has data for more than 1 year of RBF implementation, at the time of the writing of the report the ICB II project only possesses information on 1 quarter of implementation.

Capitalisation of the experiences comes logically towards the end of the project. Systematisation of all the information has not yet received sufficient attention. It will be a priority for all project staff and interested counterparts during 2018 and methodological support of an academic institution will be sought to improve the outputs.

The documentation of the field experiences and the analysis of its results enters in the objective of all Enabel health projects to develop evidence-based field-tested

[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.

interventions that can be endorsed as new national health policies.
It is obvious that the existence of evidence-based and field-tested interventions will strengthen the normative role of MoH.

Activity 3: Strengthen continuous training policies and modalities
In the Special Partner Committee of April 26, 2017 it was decided that no further funding would be provided to the Health Manpower Development Centre (HMDC) from the Belgian Cooperation. As the HMDC was foreseen to be the mayor counterpart for the project concerning activities to strengthen continuous training policies and modalities, this activity has been abandoned.

Activity 4: Develop model and strategies for a social health insurance
The Law on Social Health Insurance is still a draft Bill and hasn't been passed by Parliament yet. On the other hand, this is the only budget line available to support activities at central level. Therefore, the funds have been used for more urgent matters that contribute to the overall output 4 of "The normative role of the MoH is strengthened". A visit of a team of MoH to Cameroon to study their implementation of RBF has been organised as well as the poster presentation of a MoH staff member to an international symposium on Quality Improvement in London to present a poster on Uganda's experience in implementing quality improvement.

## 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.

However, gender mainstreaming at every step of the implementation has not been performed, mainly due to limited knowledge of the project staff concerning this process and the lack of clear Enabel guidelines to assist the projects to apply the gender mainstreaming correctly.

### 2.7.2 Environment

The activities of the project in general don't pose a threat to the 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.

The project cars that have been purchased for use in Kampala (Suzuki Vitara) are smaller and less polluting than the classical big Toyota's.

## 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 |
| Retention and motivation of national project staff due to unattractive employment conditions | 2017 Q4 | OPS | High | Medium | High Risk | Revise employee benefits | REPUGA | 2018 Q1 |
| | | | | | | Refrain from constantly changing rules and procedures | REPUGA / FCC | On-going |

**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 |
| | | | | | | A new health project (Strategic Purchasing for Health in Uganda) will be implemented from 2018 to 2021 | DGD | On-going |
| 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 |
| | | | | | | Proposal to allow the health facilities to buy additional medicines from JMS has been approved | PMT, MoH | On-going |
| | | | | | | Discuss the problem in national workshops to demonstrate the drawbacks of the system | PMT | On-going |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Feasibility of workload for verification and validation of RBF grants | 2016 Q4 | FIN | Medium | High | High Risk | Evaluation after first quarter of RBF payments | FCC | 2017 Q2 |
| | | | | | | 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 |

# 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 | Enabel HQ |
| In case close collaboration and complementarity between 2 or more projects in search of a programme approach, formal cooperation structures should be foreseen and put into practice | Enabel HQ, Representation |
| The organisational structure of Enabel projects with the technical team and the finance/administrative team in parallel creates a situation in which nobody feels truly responsible for the final results of the project. Furthermore, it entails the risk that the existence of the finance/administrative team become an objective on its own before the task of providing support to the project activities. | Enabel HQ |

# 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** | **X** |
| | **B** | |
| | **C** | |
| | **D** | |
| **1.1 What is the present level of relevance of the intervention?** | | |
| X | A | Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group. |
| | 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?** | | |
| X | 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). |
| | 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** | **X** |
| | **C** | |
| | **D** | |
| **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 | C | D |
| | | 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 | B: X / 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?** | | |
| X | 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. |
| | 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?** | | |
| X | 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). |
| | 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 3 meetings of the Steering Committee: 17th of February 2017 (only approval of Results Report 2016), 28th of June 2017 and 20th of november 2017. Most of 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 | Status |
| 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 | Closed |
| | | | | | Approve new indicators | Steering Committee | 2016 Q 4 | Realised | |
| Extension implementation period project until December 2018 for finalisation of RBF and smooth transition to SPHU project | 2017 Q2 | | Identification report SPHU | REPUGA, HQ BXL | Approved | Steering Committee | 2017 Q2 | Approved | Closed |

## 4.3 Updated Logical framework

## 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) | 2017 Q4 |
| Planning ETR (registration of report) | 2018 Q3 |
| Backstopping missions since 01/01/2017 | None |

## 4.5 "Budget versus current (y – m)" Report

# Budget vs Actuals / Commitments (Year to Date) of UGA1402811

| | |
|---|---|
| Project Title : | **Institutional Capacity Building project in Planning, Leadership and Management in the Uganda Health sector** |
| Budget Version: | **C03** |
| Currency : | EUR |
| YtD : | **Report includes all valid transactions, registered up to today** |
| Comm. Balance : | **The remaining balance of the registered commitments** |

| | Status | Fin Mode | Amount | TtD expenses | Balance | Comm. Bal. | Est. Balance | % | % Est |
|---|---|---|---|---|---|---|---|---|---|
| **A SPECIFIC OBJECTIVE** | | | 4.358.750,00 | 1.597.359,15 | 2.761.390,85 | 1.351.873,86 | 1.409.516,99 | 37% | 68% |
| **01 The quality of care at hospital and HC IV is strengthened** | | | 1.525.500,00 | 402.607,67 | 1.122.892,33 | 838.445,06 | 284.447,27 | 26% | 81% |
| 01 Develop regional coverage plan for general hospitals and HCIV | | REGIE | 35.500,00 | 39.108,49 | -3.608,49 | 0,00 | -3.608,49 | 110% | 110% |
| 02 Support priority hospitals and HC-IV to realize a business plan and prepare | | REGIE | 62.000,00 | 52.678,84 | 9.321,16 | 0,00 | 9.321,16 | 85% | 85% |
| 03 Support basic requirements for quality of care | | REGIE | 270.000,00 | 130.684,50 | 139.315,50 | 148.372,61 | -9.057,11 | 48% | 103% |
| 04 Improve drugs and medical supplies managements | | REGIE | 54.000,00 | 43.435,09 | 10.564,91 | 0,00 | 10.564,91 | 80% | 80% |
| 05 Introduce e-patient files | | REGIE | 204.000,00 | 0,00 | 204.000,00 | 0,00 | 204.000,00 | 0% | 0% |
| 06 Implement RBF approach in general hospitals and HC-IV | | COGES | 900.000,00 | 136.700,75 | 763.299,25 | 690.072,45 | 73.226,80 | 15% | 92% |
| **02 District health offices and management teams are strengthened in their** | | | 1.475.500,00 | 528.156,04 | 947.343,96 | 460.539,43 | 486.804,53 | 36% | 67% |
| 01 Interpret coverage plan for HCIII and II | | REGIE | 31.500,00 | 100,22 | 31.399,78 | 0,00 | 31.399,78 | 0% | 0% |
| 02 Adjust district development plan according to coverage plan conclusions | | REGIE | 30.000,00 | 0,00 | 30.000,00 | 0,00 | 30.000,00 | 0% | 0% |
| 03 Support basic requirements for quality of care | | REGIE | 150.000,00 | 113.126,17 | 36.873,83 | 73.000,00 | -36.126,17 | 75% | 124% |
| 04 Implement RBF financing through execution agreements | | COGES | 900.000,00 | 161.120,09 | 738.879,91 | 367.607,15 | 371.272,76 | 18% | 59% |
| 05 Assure Quality of care through support supervision and continuous training | | REGIE | 202.000,00 | 78.852,81 | 123.147,19 | 19.932,28 | 103.214,91 | 39% | 49% |
| 06 Improve ambulance services and referral system at district | | REGIE | 162.000,00 | 174.956,75 | -12.956,75 | 0,00 | -12.956,75 | 108% | 108% |
| **03 Integrated regional network of health facilities in place** | | | 487.600,00 | 248.429,93 | 239.170,07 | 45.172,01 | 193.998,06 | 51% | 60% |
| 01 Regional project team | | REGIE | 269.600,00 | 163.306,69 | 106.293,31 | 8.095,28 | 98.198,03 | 61% | 64% |
| 02 Organize quarterly regional health forum in the Ruwenzori and West Nile | | REGIE | 126.000,00 | 76.810,59 | 49.189,41 | 15.291,13 | 33.898,28 | 61% | 73% |
| 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 specialists | | REGIE | 92.000,00 | 8.312,65 | 83.687,35 | 21.785,60 | 61.901,75 | 9% | 33% |
| **04 The normative role of the MoH is strengthened** | | | 870.150,00 | 418.165,51 | 451.984,49 | 7.717,36 | 444.267,13 | 48% | 49% |
| | | REGIE | 3.152.150,00 | 1.617.231,43 | 1.534.918,57 | 296.057,25 | 1.238.861,32 | 51% | 61% |
| | | COGEST | 1.847.850,00 | 297.820,84 | 1.550.029,16 | 1.057.679,60 | 492.349,56 | 16% | 73% |
| | | TOTAL | 5.000.000,00 | 1.915.052,27 | 3.084.947,73 | 1.353.736,85 | 1.731.210,88 | 38% | 65% |

| | |
|---|---|
| Project Title : | **Institutional Capacity Building project in Planning, Leadership and Management in the Uganda Health sector** |
| Budget Version: | **C03** |
| Currency : | EUR |
| YtD : | **Report includes all valid transactions, registered up to today** |
| Comm. Balance : | **The remaining balance of the registered commitments** |

| | Status | Fin Mode | Amount | YtD expenses | Balance | Comm. Bal. | Est. Balance | % Exec. | % Est |
|---|---|---|---|---|---|---|---|---|---|
| 01 Ensure overall management and governance of the project within MoH | | REGIE | 633.400,00 | 384.665,17 | 248.734,83 | 7.068,00 | 241.666,83 | 61% | 62% |
| 02 Capitalize from field experiences developed in Ruwenzori and West Nile | | REGIE | 104.000,00 | 15.419,05 | 88.580,95 | 649,36 | 87.931,59 | 15% | 15% |
| 03 Strengthen continuous training policies and modalities | | REGIE | 54.000,00 | 6.821,82 | 47.178,18 | 0,00 | 47.178,18 | 13% | 13% |
| 04 Develop a model and strategies for a social health insurance | | REGIE | 78.750,00 | 11.259,47 | 67.490,53 | 0,00 | 67.490,53 | 14% | 14% |
| **X BUDGETARY RESERVE (MAX 5% OF TOTAL ACTIVITIES)** | | | 47.850,00 | 0,00 | 47.850,00 | 0,00 | 47.850,00 | 0% | 0% |
| **01 budgetary reserve** | | | 47.850,00 | 0,00 | 47.850,00 | 0,00 | 47.850,00 | 0% | 0% |
| 01 Budgetary reserve Co-management | | COGES | 47.850,00 | 0,00 | 47.850,00 | 0,00 | 47.850,00 | 0% | 0% |
| 02 Budgetary reserve BTC management | | REGIE | 0,00 | 0,00 | 0,00 | 0,00 | 0,00 | ?% | ?% |
| **Z GENERAL MEANS** | | | 593.400,00 | 317.693,12 | 275.706,88 | 1.862,99 | 273.843,89 | 54% | 54% |
| **01 Staff costs** | | | 406.800,00 | 226.149,19 | 180.650,81 | 0,00 | 180.650,81 | 56% | 56% |
| 01 International administrative and finance Responsible (RAFI) | | REGIE | 270.000,00 | 161.885,75 | 108.114,25 | 0,00 | 108.114,25 | 60% | 60% |
| 02 Support staff | | REGIE | 136.800,00 | 64.263,44 | 72.536,56 | 0,00 | 72.536,56 | 47% | 47% |
| **02 Investments** | | | 13.400,00 | 10.618,61 | 2.781,39 | 0,00 | 2.781,39 | 79% | 79% |
| 01 Office and ICT equipment | | REGIE | 13.400,00 | 10.618,61 | 2.781,39 | 0,00 | 2.781,39 | 79% | 79% |
| **03 Running costs** | | | 49.200,00 | 49.006,79 | 193,21 | 0,00 | 193,21 | 100% | 100% |
| 01 Office recurrent costs | | REGIE | 20.400,00 | 31.960,73 | -11.560,73 | 0,00 | -11.560,73 | 157% | 157% |
| 02 Missions | | REGIE | 28.800,00 | 17.046,06 | 11.753,94 | 0,00 | 11.753,94 | 59% | 59% |
| **04 Audit and monitoring and evaluation** | | | 124.000,00 | 4.457,75 | 119.542,25 | 1.862,99 | 117.679,26 | 4% | 5% |
| 01 Evaluation & Monitoring | | REGIE | 70.000,00 | 4.457,75 | 65.542,25 | 1.862,99 | 63.679,26 | 6% | 9% |
| 02 Audit | | REGIE | 30.000,00 | 0,00 | 30.000,00 | 0,00 | 30.000,00 | 0% | 0% |
| 03 Backstopping | | REGIE | 24.000,00 | 0,00 | 24.000,00 | 0,00 | 24.000,00 | 0% | 0% |
| | | REGIE | 3.152.150,00 | 1.617.231,43 | 1.534.918,57 | 296.057,25 | 1.238.861,32 | 51% | 61% |
| | | COGEST | 1.847.850,00 | 297.820,84 | 1.550.029,16 | 1.057.679,60 | 492.349,56 | 16% | 73% |
| | | TOTAL | 5.000.000,00 | 1.915.052,27 | 3.084.947,73 | 1.353.736,85 | 1.731.210,88 | 38% | 65% |

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|---|---|
| Project Title : | **Institutional Capacity Building project in Planning, Leadership and Management in the Uganda Health sector** |
| Budget Version: | **C03** |
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| Comm. Balance : | **The remaining balance of the registered commitments** |

| | Status | Fin Mode | Amount | TtD expenses | Balance | Comm. Bal. | Est. Balance | % | % Est |
|---|---|---|---|---|---|---|---|---|---|
| **10 VAT** | | | 0,00 | 26.675,84 | -26.675,84 | 0,00 | -26.675,84 | ?% | ?% |
| 01 VAT_Regie | | REGIE | 0,00 | 26.675,84 | -26.675,84 | 0,00 | -26.675,84 | ?% | ?% |
| 02 VAT_comgt | | COGES | 0,00 | 0,00 | 0,00 | 0,00 | 0,00 | ?% | ?% |
| **99 Conversion rate adjustment** | | | 0,00 | 784,94 | -784,94 | 0,00 | -784,94 | ?% | ?% |
| 98 Conversion rate adjustment | | REGIE | 0,00 | 784,94 | -784,94 | 0,00 | -784,94 | ?% | ?% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| REGIE | 3.152.150,00 | 1.617.231,43 | 1.534.918,57 | 296.057,25 | 1.238.861,32 | 51% | 61% |
| COGEST | 1.847.850,00 | 297.820,84 | 1.550.029,16 | 1.057.679,60 | 492.349,56 | 16% | 73% |
| TOTAL | 5.000.000,00 | 1.915.052,27 | 3.084.947,73 | 1.353.736,85 | 1.731.210,88 | 38% | 65% |