BTC

MID-TERM REVIEW REPORT

INSTITUTIONAL CAPACITY BUILDING IN PLANNING, LEADERSHIP AND MANAGEMENT IN THE UGANDAN HEALTH SECTOR PROJECT, UGANDA

DATE	11 June 2013
Consultant	HERA & AEDES
CODE NAVISION	UGA09 017 011 and UGA10 023 1T
CODE DGCD	NN 3008322

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AEDES

Right to health and development

This intervention is realized in the framework of the cooperation between Uganda and Belgium.

This report has been drawn up by independent external experts.

The opinions expressed in this document are those of the authors and do not necessarily reflect the views of BTC, the Belgian Development Cooperation or the authorities of the countries concerned.

Reet, June 2013

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Mid-Term review report

Institutional Capacity Building in Planning, Leadership and Management in the Uganda Health sector

DGCD intervention number:	NN 3008322
Navision code BTC:	UGA09 017 011 and UGA10 023 1T
Partner institution:	Ministry of Health, Dept of Planning
Duration of intervention:	4 years
Duration of Specific Agreement:	6 years
Starting date of intervention:	December 2009
SIDA Contribution :	EUR 1,350,000
Belgian Contribution:	EUR 6,500,000
Total Contribution:	EUR 7,850,000
Intervention sectors:	DAC 12110, Health

Project summary

Goal	To improve effective delivery of an integrated Uganda National Minimum Health Care Package.
Specific Objective	The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels.
Result 1	The MoH is strengthened in its organisational and institutional capacity.
Result 2 *Modification*[1]	One selected Regional Referral Hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity. *Regional approach: support to all Health Districts and General Hospitals*
Result 3 *Modification*[2]	One further Regional Referral Hospital (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity. *Regional approach: support to all Health Districts and General Hospitals*
Result 4	District management teams are strengthened in their managerial capacity, leadership and planning functions
Result 5	A comprehensive approach on capacity building of HSD management teams is operational.
Result 6 *Modification*[3]	Two training centres/demonstration sites for capacity building of HSD management teams are functional *Focus on support towards re-vitalisation of Health Manpower Development Centre in Mbale (East Uganda), including satellite training centres in two Project implementation regions.*
Result 7	A scientific support team accompanies the capacity building process in the Ugandan health sector.

Evaluation team

Dr. Jaak Labeeuw, team leader

Dr. Ranieri Guerra

Dr. Edgar Mulogo

[1] Steering Committee October 2011

[2] Steering Committee October 2011

[3] Steering Committee October 2011

Acronyms and abbreviations

AHSPR	Annual Health Sector Performance Report
AMREF	African Medical Research and Education Foundation (an NGO)
BTC	Belgian Technical Cooperation – Belgian Development Agency
CAO	Chief Administrator Officer
CB	Capacity Building
CHD	Community Health Department
CIDA	Canadian International Development Agency
DHIS	District Health Information System
CPD	Continuous Professional Development
C-PIC	Central Project Implementation Committee
C-PIC	Central Project Implementation Committee
DANIDA	Danish International Development Agency
DGHS	Director General Health Services
DHMT	District Health Management Team
DHO	District Health Office
DHO	District Health Officer / Office
DHS	(P&D) Director Health Services (Planning & Development)
DHS	District Health Services
DISH	Delivery of Improved Services for Health
DL	Distance Learning
DLT	District League Table
EDF	European Development Fund
EPI	Expanded Programme on Immunisation
EU	European Union
FY	Fiscal Year
GAVI	Global Alliance for Vaccine Initiative
GD	General Duties
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GH	General Hospital
GoU	Government of Uganda
HC	Health Centre
HC IV	Health Centre level IV
HDP	Health Development Partner
HID	Health Infrastructure Division
HIV	Human Immunodeficiency Virus
HMDC	Human Manpower Development Centre
HMIS	Health Management Information System
HPD	Health Planning Department
HQ	Headquarters

HRH	Human Resources for Health
HR	human resource
HSC	Health Service Commission
HSD	Health Sub-District
HSDMT	Health Sub-District Management Team
HSS	Health Systems Strengthening
HSSIP	Health Sector Strategy and Investment Plan
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committees
ICB	Institutional Capacity Building
ICP	Indicative Cooperation Programme
ICT	Information and Communication Technology
IST	In-Service Training
ITM	Institute of Tropical Medicine, Antwerp, Belgium
JRM	Joint Review Mission / Meeting
JRM	Joint Review Mission
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute) - Netherlands
LC	Local Council
LG	Local Government
M&E	Monitoring and Evaluation
MakSPH	Makerere School of Public Health
MoE&S	Ministry of Education and Sports
MoFEPD	Ministry of Finance, Economy Planning and Development
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service
MoS	Minister of State
MoU	Memorandum of Understanding
MPH	Master in Public Health
MTR	Medium Term Review
NDP	National Development Plan
NGO	Non-Governmental Organisation
NHA	National Health Assembly
NRH	National Referral Hospital
OOP	Out of Pocket
PAF	Poverty Action Fund
PC	Project Coordinator
PD	Planning Department
PDU	Procurement and Disposal Unit
PFP	Private For Profit
PHC	Primary Health Care
PHP	Private Health Practitioners

PIC	Project Implementation Committee
PLM	Planning Leadership & Management
PNFP	Private Not for Profit
PPP	Public Private Partnership
PS	Permanent Secretary
QAD	Quality Assurance Department
QIF	Quality Improvement Framework
R-PIC	Regional Project Implementation Committee
RRH	Regional Referral Hospital
SAM	Service Availability Mapping
SBS	Sector Budget Support
SC	Steering Committee
SIDA	Swedish International Development Agency
SIP	Strategic & Investment Plan
SURE	Securing Ugandans' Right to Essential Medicines, a USAID project
SWAp	Sector Wide Approach
TA	Technical Assistant/Assistance
TB	Tuberculosis
TCMP	Traditional and Complementary Medicine Practitioners
TFF	Technical and Financial File
THE	Total Health Expenditure
ToR	Terms of Reference
ToT	Training of Trainer
UCMB	Uganda Catholic Medical Bureau
UGX	Ugandan Shilling
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UHSSP	Uganda Health Systems Strengthening Programme
USAID	United States Agency for International Development
WHO	World Health Organisation

1 Executive summary

Introduction

The Institutional Capacity Building (ICB) project in planning, leadership and management in the Ugandan health sector is part of the 2009-2012 Indicative Cooperation Programme signed between Belgium and Uganda. The project started on the 16th June 2010 for a duration of 6 years. A technical review of the project took place in April 2011. The Belgian contribution is € 6.500.000 and the Swedish contribution €1.350.000, through a Delegation Agreement between BTC and SIDA.

The overall objective of the mid-term review (MTR) is to assess the relevance, efficiency, effectiveness, potential sustainability and impact of the project. Special emphasis had to be laid on the adequacy of the logframe, ownership, decentralisation issues, and implementation modalities.

The MTR mission took place from 5th - 18th April 2013. The MTR team consisted of two international consultants, Dr.Jaak Labeeuw, team leader and Dr. Ranieri Guerra, and one national consultant, Dr. Edgar Mulogo. The team conducted a desktop review of documentation, interviews and focus group discussions at the MoH HQ and in the West-Nile and Rwenzori regions where the project operates.

Adequacy of the log frame

The project specific objective - to strengthen the planning, leadership and management capacities of the health staff at national level and local government levels – is relevant.

The Steering Committee has adapted the seven original project results in response to the recommendations of a Technical Review Mission in 2011. These results can de facto be grouped into four results and will be further discussed as such: i) capacity building at central level; ii) capacity building in Rwenzori and West-Nile regions consisting of a Regional Referral Hospital (RRH) and the 15 districts in their catchment area; iii) strengthening the Human Manpower Development Centre (HMDC) in Mbale for In-Service Training and Continuous Professional Development (IST/CPD); and iv) scientific support.

The project logframe was appropriate, but has unfortunately not been updated in the course of the project, in response to the Second National Health Policy, the new Health Sector Strategy and Investment Plan (HSSIP) 2010/11-2014/15, and the addendum to the project agreement when SIDA became a delegated partner. The logframe is in actual fact no longer used.

Achievement of results

Result 1: institutional capacity building at central level. The project assisted with institutional and individual training, refurbishing and equipping of senior staff offices and boardrooms, and an assessment of the Ministry of Health (MoH) Procurement and Disposal Unit (PDU). The project supported planning and strategy development e.g. on nursing and health financing, a Parliamentary visit to the 13 RRH, and on-going activities such as the Joint Review Mission of the health sector.

Various capacity assessments had been done in the past, so that this exercise was not repeated. So far, no consensus has been reached however on the way forward, so that no in-depth organisational or institutional reform has been implemented.

Result 2: strengthened regional level. The project has developed a Strategic and Investment Plan (SIP) and a master plan for both RRHs, undertakes an infrastructural assessment for two General Hospitals, and has assessed the functionality of District Health Offices (DHO) and Health Centre level IV (HCs IV). Thirteen ambulances and 11 general purpose vehicles have been handed over in February 2013, and 15 existing cars are being repaired. Drivers and ambulance staff have been trained. Ambulance guidelines are being developed, and an ambulance Memorandum of Understanding has been signed between the MoH and the Ministry of Local Government.

Other outputs include the review and supply of facility library packages, a contribution to the revitalization of regional health planning seminars, the revision of the hospital management boards guidelines, training, and the revitalisation of Specialist Outreach Services.

Result 3: strengthening HMDC. A draft SIP has been developed. Buildings have been rehabilitated, a fence wall is under construction, and equipment has been supplied. A concept note on e-learning is being developed. A Junior BTC Technical Assistant has been seconded for 2 years (on a separate budget).

No national In-Service Training or Continuous Professional Development IST/CPD strategy has been developed based on a situation analysis of training needs and potential providers from the public, PNPF, NGO or private sector, whether academia or others. The cost implications and complexities of a full-fledged e-learning system are little understood. Nor have the potential roles of the HMDC been spelled out, whether it should act as a training institute and/or provider of IST/CPD consultancy services to the MoH and other stakeholders/clients. Surprisingly, no national policy document refers to the HMDC, the Centre has neither a clear statute nor land title deeds. This suggests a low ownership and little sustainability as past experience has shown.

Result 4: scientific support. The concept of or the need for, scientific support has not been elaborated and no specific areas for support have been identified. Nor is the specific need to work with an international scientific institute on capacity building and leadership acknowledged.

Assessment

Strengthening and building of institutional capacities and leadership is very **relevant**. It meets a genuine need and corresponds to the stewardship objective of the HSSIP.

The project **efficiency** is low, though improving. The project started off slowly in the first year until the entire MoH top management was replaced. Though financial disbursements were low during this period, the project consistent engagement with the MoH contributed to its organizational change process. The technical review mission held in April 2011 provided a much needed reorientation in implementation modalities, especially with the creation of a central and two regional implementation committees which meet monthly, the appointment of a new project coordinator at the rank of Director (Health Planning and Development), and the geographic expansion to two full regions, where service delivery is supposedly integrated.

By the end of February 2013 only €2,110,000 (26%) had been spent out of the total project budget of €7,850,000. Half of the expenditures (€1,056,000) was for the procurement of vehicles and ambulances, excluding the costs of service contract, insurance, and their staff training. It is projected that expenditure will be €2,700,000 (34%) by the close of the financial year (June 2013).

Procurements have been cumbersome and slow, until procurement under Belgian law was adopted on 16th April 2012. Since then, 42% of funds foreseen under Belgian law have been utilized, against 9% previously under the Ugandan law. It is clear that these gains in efficiency and possibly in cost-effectiveness are being obtained at the expense of the central concept of capacity building under which the project was conceived. In retrospect, it would have been better to first negotiate about (i) the conditions for continuation of using the national procurement system, (ii) followed by possible procurement of specific Technical Assistance (TA) to enable the procurement department to operate more efficiently and transparently.

The project **effectiveness** is low, as few outputs have been achieved to date.

The potential **impact** remains equally low, as no transformational change is to be expected from a project that has so far mainly concentrated on supply of services and goods and provided training, without affecting the wider socio-political environment and the effectiveness of organizational arrangements.

The potential **sustainability** is relatively good in economic and financial terms, but poor in technical and institutional terms, as an ad hoc approach has been used so far.

There are mixed **ownership** signals. The project continues to suffer from a lack of common understanding of what capacity building entails. Unlike the regional Project Implementation Committee (PIC), the central PIC continues to be rather dysfunctional, with infrequent and sometimes unproductive meetings due to the absenteeism of key players. The project attempts to adhere to the MoH annual planning, which is testing as these plans are only available by the third or even last quarter half of the Fiscal Year. This planning is budget-driven rather than set by objectives and results. Moreover, at HQ level, project budget plans are not integrated into the departmental plans, leading to a fragmented approach.

The so-called demand-driven approach might well turn out to equate to a lack of long-term vision. So far, the project has no clear idea and no strategies on how to create and formulate relevant demand. This has resulted in scattered, mostly ad hoc interventions. The current approach to intervene in most if not all departments of the MoH does not help either.

The **decentralized implementation** of the support to the RRH, the districts and health sub-districts for the two regions remains inadequate. The health institutions, especially at district and sub-district level, are grossly underfunded as only 7% of the government funds reach those levels. Any additional funding is thus most welcome. A simplified simulation shows that if the current project expenditures for the central level and General Means remain the same, and if the project is extended until end 2015, the project could allocate on average €102,000 per district per year, which can be easily absorbed, even if SIDA intends to provide additional funding.

Currently, project funding is decided at central level without objective criteria. This approach greatly slows the disbursement rate, renders local planning difficult, does not incentivize managers, and impacts negatively on health system development and capacity building.

There is poor communication on project activities between the central land the subnational levels.

Local district strengths are insufficiently tapped. Thus, though the district performance is often poor, there is a great variation, with some encouraging examples. For example, Kabarole district, where Fort Portal is located, in Rwenzori ranked first in the national District League Table in FY 2011/2012. This contrasts with Ntoroko, located in the same region, which ranks 103 out of 112 districts, showing that peer exchange could become a powerful capacity building tool. Another cross-fertilization tool could be a closer collaboration between the public, PNPF and private sectors, with lesson sharing. Thus lessons could be learnt from the facility accreditation system introduced by the Uganda Catholic Medical Bureau.

The rapid increase in number of districts has rendered their supervision from the MoH HQ next to impossible. Districts are often only superficially supervised once or twice a year, where this should happen on a quarterly basis. The Regional Performance Monitoring Teams, which will shortly be established by the Global Fund Round 10 health system strengthening project, presents an opportunity for the project to pilot jointly the expansion of these Teams to regional coordination, support, supervision, and monitoring and evaluation centres. This regional approach, which has been advocated at all levels, could significantly enhance the decentralized performance.

The current project **implementation modalities** make it difficult or impossible to access project funds at lower level, whilst the capacity at MoH HQ for the wide roll-out of training to all facilities is limited or non-existent. The Technical Assistant spends up to 80% of his time on administrative duties, leaving hardly any time for creative and innovative planning and technical advice. The project becomes more and more an implementation unit aiming at short-term results, focusing on budget execution, and using traditional project approach at the expense of long-term institutional capacity building and strengthening processes and organizational development and change. There is however no easy solution, as the procurement paralysis has illustrated. Procurement under Belgian

law has therefore rightly been extended. The need to continue to strengthen the national procurement system, and possibly to revert to its use should however be kept in mind.

This project shows that there are no easy solutions to capacity building either. Sector budget support has been temporarily suspended because of corruption problems. At the same time, the project mode with its gradually increasing separate implementation modalities for the sake of short-term efficiency may be counter-productive for capacity building.

Recommendations

A set of recommendations is proposed. The most important recommendations include:

- ✓ **Project**: Formulate an updated project logframe by end Q3 2013 in line with the HSSIP 2010/11-2014/15 principles and objectives and the action plans of the beneficiary district, the RRH, and the identified MoH HQ support areas (e.g. planning department);
- ✓ **MoH and BTC**: Extend the project implementation period until June 2015, subject to the Logframe revision and the approval of the MTR recommendations
- ✓ **MoH and BTC**: Recruit an administrative and financial TA. He/she should:
  - Assist with the implementation of project financial and administrative duties thus relieving the current TA, enabling him to fulfil his public health duties;
  - Provide, in conjunction with the foreseen Public Finance Management Advisor of the BTC Representation, policy/expert advice on procurement, supply chain management at the MoH HQ;
  - Provide, in conjunction with the foreseen Public Finance Management Advisor of the BTC Representation, policy/expert advice at the interface between the MoH and the MoLG at regional and district level;
  - Develop a roadmap towards resuming procurement according to the Ugandan law instead of the current “régie” system.
- ✓ **MoH, BTC and Project**: Pilot the development of regional coordination, support, supervision, and monitoring and evaluation centres in collaboration with the forthcoming Global Fund supported “Regional Performance Monitoring Teams”;
- ✓ **Project, BTC, LG and RRH**: Decentralize the ICB project funding mechanism through execution agreements with districts and RRH;
- ✓ **MoH, LG and Project**: Link the project funding grants to the newly established Performance Agreements between the DHO and the CAO, and the hospital, HC IV managers and LC Chairs;
- ✓ **MoH**: Integrate project interventions into departmental budget lines to avoid fragmentation;
- ✓ **MoH**; Develop a national IST/CPD training strategy based on a needs assessment and a situation analysis of potential providers from the public, PNPF, NGO or private sector, whether academia or others. This exercise should enable current managers to acquire the skills and capacities needed to implement the national policies and plans and to anticipate the way the health system will develop accordingly;
- ✓ **MoH:** Outline the role of HMDC, either as a training institute and/or as a provider of IST/CPD consultancy services to the MoH and other stakeholders/clients, and accordingly review the HMDC Strategic Investment Plan and request Cabinet to grant a (semi-) autonomous status to the HMDC;
- ✓ **MoH and Project**: Generate evidence by supporting health managers to conduct operational and scientific research in collaboration with national and international academic institutions;
- ✓ **MoH and BTC**: Evaluate the advantages and disadvantages of recruiting an international administrative and financial TA for the project, so that the current TA can assume his technical duties full time;

- ✓ **Project**: Support the development of gender-based budgeting and support the development of a strong gender desk within the MoH and its operations.

2 Introduction

2.1 Short presentation of the project

The Institutional Capacity Building (ICB) project in planning, leadership and management in the Ugandan health sector is part of the 2009-2012 Indicative Cooperation Programme (ICP), signed between Belgium and Uganda.

The project Specific Agreement was signed on 11th December 2009 by Uganda and Belgium for a 5 year period and a total amount of €6 500 000. The project is implemented by the Ministry of Health of Uganda and the Belgian Development Agency (BTC) (UGA 09 017 11).

In July 2011, the Swedish International Development Cooperation Agency (SIDA) signed a Delegation Agreement with BTC, where SIDA agrees to co-finance the project for an amount of €1.350.000 and delegates the implementation to BTC (UGA10 023 1T), bringing the project's total budget to €7.850.000.

Following on an exchange of letters between the Belgian and Uganda governments, on the 6th of February 2012 it was agreed to extend the duration of the Specific Agreement from 5 to 6 Years (December 2009 - December 2015).

The project implementation started on the 16th June 2010 and a technical review of the project took place in April 2011. The Steering Committee (October 2011), approved the extension of the project period, but maintained the original project implementation period (48 months) (June 2010 – June 2014), which should be reviewed during the MTR.

2.2 Objectives and context of the mid-term review

The overall objective of the mid-term review is to assess the progress of the project activities against planning (**efficiency**), the responsibility of the MOH in the project implementation (**ownership**) and the extent to which the results and objectives are going to be achieved during the remaining course of the intervention (**effectiveness**).

The MTR assessed in particular:

i) How does the MOH HQ's assume its implementation responsibility? Is the ownership adequate, if not why?

ii) How is the project dealing with decentralised implementation?

iii) Are the implementation modalities described in the Technical and Financial File TFF (the way the project operates) adapted to the environment (central ministry)? Is it the right operating approach to allow the project to be actually results and objectives oriented? If not why?

iv) To what extent are the Logical Framework and its indicators adapted to the recent changes in the project and the actual situation to best respond to the identified beneficiaries' needs?

2.3 Methodology of the mid-term review

The MTR mission took place from 5th - 18th April 2013. The MTR team consisted of two international consultants, Dr.Jaak Labeeuw, team leader and Dr. Ranieri Guerra, and one national consultant, Dr. Edgar Mulogo.

The team conducted a desktop review of documentation, carried out interviews and focus group discussions, and administered a questionnaire (see annex 6) to the members of the central and regional project implementation committees. Project documentation studied included the project identification and formulation reports, the Technical and Financial File (TFF), minutes of the steering committee meetings, progress reports, and consultancy reports. Key health sector reports included the National Health Policy, the Health Strategic and Investment Plan 2009/2010 – 2014/2015, and various capacity building and leadership documents of the Ministry of Health and health development partners. Finally, international literature on capacity building and leadership was reviewed.

The MTR team interviewed members of the Project Steering Committee, the central and regional project implementation committee members, and various other key informants, at MoH Headquarter level, in the regional referral hospitals, the district general hospitals, health centres and district health offices, and Health Development Partners. The team leader visited the Ruwenzori region for three days and the other two consultants visited the West-Nile region during a three-day field trip as well as the Health Manpower Development Centre (HMDC) for another day. The team leader interviewed health staff in the Rwenzori region, while the other consultants interviewed staff in the West Nile region and staff at the HMDC HQ in Mbale and in Arua where an e-learning hub is planned. Hospitals and health centres up to level III were visited in those areas. At the end of the field mission, focus group discussions were held with the members of both regional implementation committee members.

The review methodology was based on the following steps:

- Desk review of relevant documents;
- Field visits to the implementation regions and HMDC;
- Meetings and interviews with all the sector stakeholders;
- Questionnaire administration and data collection, analysis and feed-back;
- Regional debriefing workshops with members of the Regional Implementation Committee in both regions;
- Final debriefing workshop with the Steering Committee and members of the Regional Implementation Committee in Kampala;
- De-briefing at BTC HQ; and
- Drafting of MTR report with integration of BTC and field comments

2.4 Limitations of the mid-term review

The study has not looked at the post-project period. This was not included in the ToR and it is typically a task of an end-of-project evaluation.

The recommendations of the procurement assessment report have been studied, but it was beyond the scope of this mid-term review to provide guidance on how to implement those recommendations, which is rather a task for the project team.

Team members failed to contact the gender officer in the MoH, even though several attempts were made. This has to a certain extent hampered the study of the gender impact of the project.

The team received the identification document of the proposed Private not for Profit (PNFP) project document after the mission.

3 Background and context

3.1 Preparation of the intervention

3.1.1 Programming

The second Belgium-Uganda Indicative Cooperation Programme (ICP II, 2008-2012), signed in November 2008 retained two priority sectors for the bilateral cooperation, education and health. The ICP supports the health sector strategic plans through:

- Earmarked health sector budget support (€ 20m), via the Poverty Action Fund (PAF) budget lines, with focus on improving Primary Health Care services in the districts;
- Program/project support (€ 6.5m) for the attainment of the following two objectives:
  - Contribute, in coordination with other donors, to the implementation of the human resources development plan of the Ministry of Health;
  - Strengthen the leadership and management capacities of the health staff at district and health centres level, taking the experiences of the on-going pilot project between the Institute of Tropical Medicine of Antwerp, Belgium and Makerere University into consideration.

At least 70% of the budget is be used to improve the planning and management capacities of the health staff at district and health centres level

In addition, the ICP II made the following provisions:

- Delegated cooperation with other donors in other sectors (€ 3m), especially private sector development, good governance, gender mainstreaming, the dialogue between government and civil society, etc.;
- Scholarships (€ 4m) with at least 50% allocated to the health and education sectors, a maximum of 25% of the envelope for scholarships in health and education to be used for studies in Belgium and other European countries, and at least 50 % of the scholarships to be allocated to girls and women.
- Study and Consultancy Fund (€ 2m) especially for the health and education sectors.

Lastly, the Institute of Tropical Medicine in Antwerp, has conducted a multi-country capacity strengthening action within a health systems research and health policy development project since 2008. In Uganda, the implementing partner was the Institute of Public Health of Makerere University, with which a capacity building Masters programme has now been developed.

3.1.2 Identification

The project identification mission, finalized in March 2009, proposed what follows:

- to investigate whether to extend capacity building to autonomous bodies, e.g. the National Medical Stores, the Health Service Commission, and the National Drug Authority;
- that the project complements the sector budget support; and
- to promote synergies with other donor projects, including the project administered by Antwerp Institute for Tropical Medicine in support of Makerere University, that builds capacity in three districts.

Finally, it was reiterated that 70% of the project funds should be used at district level.

3.1.3 Formulation

The formulation, which started during mid-august 2009, referred to the first National Health Policy and the Health Sector Strategic Plan II (HSSP-II) 2005/06 – 2009/10. The HSSP-II had four programme objectives. One of the five objectives of the current Health Sector Strategic and Investment Plan 2010/11 – 2014/15 (HSSIP) is to deepen sector stewardship, which is the object of capacity building at national level. This objective has seven 'focus areas' with associated strategies and key interventions, indicators with targets, and implementation arrangements.

The TFF acknowledges that Capacity Building (CB) is a murky process and describes the concept of CB as a tool in developing or strengthening health systems. It identified three major areas of capacity weaknesses at national and local government levels: i) in leadership and management; ii) in support supervision; and iii) in planning. A number of Capacity Building (CB) guiding principles followed by a hierarchy of CB concepts and needs were then given: i) system's CB; ii) institutional CB; iii) individual CB[4]; and iv) development of tools for management. It is acknowledged that CB is a murky, incremental and iterative process, where three stages can be recognized: i) diagnosis; ii) planning; and iii) implementation and monitoring. Finally, a capacity assessment leads to three minimal outcomes: i) a reorganisation plan; ii) the correction of human capacity gaps; and iii) management tools[5]. These outcomes were to be achieved through outputs at national, RRH, district and sub-district level. This framework was further elaborated during project implementation by applying the model developed by C. Potter et *al*.[6] which identifies a pyramid of nine separate but interdependent components forming a four-tier hierarchy of capacity building needs: i) structures, systems and roles, ii) staff and facilities, iii) skills, and iv) tools.

[4] The TFF describes the system's and institutional capacity building as follows:

System's capacity looks specifically into how the system defines the roles and responsibilities of its lower levels. System's capacity is nothing else than the quality of the policies, strategies and norms handled by an organisation. The more these are consistent, effective and efficient, complete, unambiguous and realistic (among other things, realistic in function of the needed resources) at the same time, the more the system's capacity will enable the other levels in the hierarchy of capacity and CB;

Institutional capacity can be defined as the level of performance, hence the level of outputs and institution can provide in accordance with its mandate.

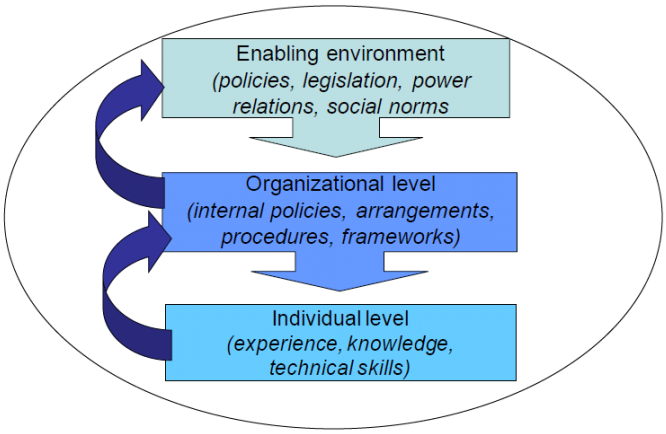
It is important that **individual capacity** needs are identified through the process of institutional capacity assessment. Only in that way, one can identify the pertinent capacity gaps at individual level that will reinforce institutional capacity

[5] The TFF expands on these three minimum outcomes as follows: reorganisation plan for personnel, infrastructure, equipment, budgeting and procedures; ii) human capacity gaps corrected through internal redeployment, recruitment and capacity building/training; and management tools such as procedures manual and others.

[6] See Christopher Potter and Richard Brough, Health Policy and Planning; 19(5): 336-345, 2004 http://heapol.oxfordjournals.org/content/19/5/336.abstract

A myriad of capacity building models exists[7]. They all emphasize the differentiation between capacity for development and capacity development[8], the interaction between the enabling environment, organisational level, and individual level (see Figure 1), and the need to link CB to development goals and outputs. The TFF model and the currently used Potter model seem to undervalue the first two points.

Figure 1: Levels of capacity: a systemic approach



Source: UNDP Capacity Development Practice Note, 2008

The TFF highlights two major interventions areas: i) institutional capacity building; and ii) the development of management tools.

The project institutional capacity building intends to target gaps identified during the assessment stage. Special emphasis is laid on supportive supervision, the referral system, and on supporting the MoH in refining its policies, strategies and definitions of norms and regulations. Details are not given on how to accomplish this latter massive task.

Proposed management tools include procedures/operational manuals for the various institutions, strategic plans and master plans, and coverage plans.

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[7] See for example the Capacity Development Results Framework: Results Framework: A strategic and result-oriented approach to learning for capacity development, the World Bank Institute, 2009 http://siteresources.worldbank.org/EXTCDRC/Resources/CDRF_Paper.pdf;

Or the Toolkit for Capacity Development, Europaid, 2010, http://ec.europa.eu/europeaid/how/ensure-aid-effectiveness/documents/toolkit_cd_en_web_en.pdf

Or the UNDP Capacity Development Practice Note, 2008
http://www.unpcdc.org/media/8651/pn_capacity_development.pdf

[8] The World Bank defines **Capacity for development** as the availability of resources and the efficiency and effectiveness with which societies deploy those resources to identify and pursue their development goals on a sustainable basis. This definition relies on three subsidiary definitions:

- The availability of resources (human, financial, technical) is a necessary but not sufficient condition for achieving the development goals of a society or an administrative entity.
- The effectiveness and efficiency with which resources are acquired and used depend on specific configurations of socio-political, policy-related (institutional), and organizational factors that condition the behavior of political and economic actors.
- Social and economic development is sustainable when results and performance are locally owned and can be replicated and scaled up by local actors.

Capacity development is then defined as a locally driven process of learning by leaders, coalitions and other agents of change that brings about changes in socio-political, policy-related, and organizational factors to enhance local ownership for and the effectiveness and efficiency of efforts to achieve a development goal.

The TFF defines procedures/operational manuals as a detailed description of how an organisation and its people should function together, forming a contract between supervisors and their personnel. Though this is a necessary first step towards Performance Based Financing, it misses the important "political" dimension[9] under which any organisation operates, besides its "Functional-rational" dimension.

Strategic plans and master plans are very relevant, as the MoFEPD has made them mandatory for the full release of the RRH development budget.

The coverage plans are equally appropriate and could build on the Service Availability Mapping (SAM) conducted by the MoH in 2004, with technical support from WHO[10].

3.2 Political and institutional context

3.2.1 General context

Uganda's population is estimated at 33,640,833 in 2012 with 88% of the population resident in rural areas and an annual growth rate of 3.2%, or approximately 1 million people per year.

The economy has been improving since the '90's. The real economic growth per capita is estimated at 2.9%, 2.7%, 1.2% and 1.8% in 2010 - 2013[11] and the per capita purchasing power parity GDP at $1,400 in 2012. In 2009, an estimated 24.5% of the population were living below the poverty line, with northern Uganda having the highest proportion of people classified as poor.

Administratively, Uganda is divided into districts which are further sub-divided into lower administrative units namely counties, sub-counties and parishes. The numbers of districts and lower level administrative units have increased from 34 in 1990 straining delivery of health services. Service delivery is decentralized and guided by the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997).

[9] The political dimension includes sub-groups with self-interests, power and loyalty systems, extrinsic intensives, coalition-building

[10] The availability and distribution of key health services were assessed by interviewing the district director of health services and his/her team in all districts. The geographic coordinates of health facilities in the country were collected using Global Positioning System (GPS) and the data were uploaded in WHO's Health Mapper. Maps for selected services were thus produced.

[11] http://www.africaneconomicoutlook.org/en/countries/east-africa/uganda/

3.2.2 National health system

Health services are structured into National Referral Hospitals (NRHs) and Regional Referral Hospitals (RRHs), General Hospitals, Health Centre (HC) IVs, HC IIIs, HC IIs and Village Health Teams (HC Is)[12]. The RRHs have been granted self-accounting status and remain under MoH oversight. LGs manage public general hospitals and HCs and supervise and monitor all health activities (including those in the private sector) in their respective areas of responsibility. The private sector consists of Private Not for Profit (PNFPs) providers, Private Health Practitioners (PHPs), and the Traditional and Complementary Medicine Practitioners (TCMPs). All PNFP hospitals are autonomous as granted by their respective legal proprietors. The public private partnership (PPP) at district level is however still weak and skewed. The description of the building blocks below is extracted from the health assessment conducted in 2011[13]

Governance. The Second National Health Policy, the Health Sector Strategy and Investment Plan (HSSIP) 2010/11-2014/15 and related policies and regulations are adequate. However, the HSSIP focuses exclusively on the public and private not-for-profit (PNFP) sectors and does not include strategies to harness PFP health sector resources. The increase in the number of districts also strains governance structures. Corruption scandals in the MoH broke out in 2005 related to GAVI and GFATM funds administration: as a consequence, a new top MoH leadership was appointed. Generally, performance of the governance structures was suboptimal in FY 2011/12, with the exception of the Health Policy Advisory Committee and Senior Management Committee that held most of the planned meetings. Attendance and outputs for most of the sector Technical Working Groups was poor, indicating challenges in sector monitoring and coordination. Based on the District League Table, there was a substantial improvement in the functionality of DHMTs. The report from the Auditor General for the period 2010/11 indicated gaps in sector accountability and financial control mechanisms.

The Ministry of Public Service launched in April 2010 performance agreements[14] procedures.

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[12] ***RRH*** offer specialist clinical services such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, higher level surgical and medical services, and clinical support services (laboratory, medical imaging and pathology). They are also involved in teaching and research. This is in addition to services provided by general hospitals.

General Hospitals provide preventive, promotive, curative, maternity, in-patient health services, surgery, blood transfusion, laboratory and medical imaging services. They also provide in-service training, consultation and operational research in support of the community-based health care programmes.

HCs IV provide preventive, promotive, curative, maternity, in-patient health services, emergency surgery, blood transfusion and basic laboratory services

HCs III, II and Village Health Teams (HC I). HC IIIs provide basic preventive, promotive and curative care. They also provide support supervision of the community and HC IIs under their jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county. The HC IIs provide the first level of interaction between the formal health sector and the communities. HC IIs only provide out patient care, community outreach services and linkages with the Village Health Teams (VHTs).

[13] Uganda Health System Assessment 2011, USAID, Makerere University School of Public Health, Health Systems 20/20

[14] These performance agreements are rolled out in a phased manner: July 2010, all Permanent Secretaries, Chief Administrative Officers and Town Clerks; January 2011, all Hospital Directors and Primary School Heads; July 2011: all Directors, Heads of Department, Deputy Chief Administrative Officers and Deputy Town Clerks; July 2012, all Accounting Officers of Government Agencies and Institutions; July 2013: All Heads of District Health Facilities and Secondary school.

Health financing. Uganda's Total Health Expenditure (THE) was 3,235 billion UGX ($1.6 billion) in FY2009/10[15]. Private funds from households, PNFPs, local NGOs and private firms made up half of THE, while public funds made up only 15% in 2009/10. Out-of-Pocket (OOP) payments remain the largest form of payment and household managed around 40% of THE. Other funds came from donors, international NGOs and Global Health Initiatives, making up 36% in 2009/10. Government spending on health was 8.3% of total GoU expenditure in FY 2011/12[16]. The public sector, which includes central government and district level, managed only 22% of total funds spent on health in 2009/10, and district health services 7%[17]. Moreover, social security is little developed so that the ability of government is limited in determining priority areas in which funds should be allocated in order to improve the country's health indicators.

Government needs to explore alternative financing mechanism to increase resources for health sector, reduce dependency on donors, improve resource allocation criteria to address inequities, build a better link with the private sector and better coordination of partners to attain policy goals and improvement of accounting systems. This crucial issue might have been selected as a key objective for the project.

Service delivery. Most Ugandans now live within five kilometers from a health center. Significant challenges remain to be addressed, such as high infant and maternal mortality rates and the low quality of service delivered. The Uganda Catholic Medical Bureau (UCMB) and HIV programmes have established an accreditation system to contribute to quality improvement. However, the referral system is still inadequate, and patients often ignore secondary or tertiary care due to the high costs involved. Stock-outs of drugs and supplies and inadequate HRH availability impact the quality of service delivery. Many services, including those related to HIV and tuberculosis (TB), are not well integrated into the general health delivery system and continue to be provided vertically. The need to rationalize apparently cost-ineffective lower-level facilities is addressed in several studies and reports. Evidence-based medicine is not consistently followed and facility-based quality improvement initiatives, while they exist, have not been institutionalized uniformly.

Medical Products, Vaccines, and Technologies. Management of medicines and medical products has improved significantly, amongst others through the introduction of a kit-based push system to health centres. Stock-outs in public sector facilities, informal payments in the public sector, and high prices in the private sector continue to pose challenges to equity and access and about 65% of households in the lowest socioeconomic bracket face monthly catastrophic expenditures on pharmaceuticals.

Health Information Systems. The computerized web-based District Health Information System (DHIS2) has been rolled in 90% (100/112) of the districts, the Human Resource Information System in 66% (74/112), and m-Trac[18] for monitoring service delivery and medicines availability in 24% (27/112). However, data are not used optimally for planning and budgeting.

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[15] See the draft National Health Accounts (NHA), 2013

[16] African Union countries meeting in Abuja, Nigeria, in April 2001, pledged to increase government funding for health to at least 15%, and urged donor countries to scale up support.

[17] Transfers to districts occur through following grants: Primary Health Care (PHC) Wage; PHC Recurrent Non-Wage; NGO Hospital; District General Hospital; NGO Wage subvention; and Primary Health Care Development. The PHC Recurrent Non-Wage grant is formula based on population and needs. It must be used according to certain criteria, e.g. 20% for the District Health Office, and so on. Transfers to Referral Hospital occur through: Recurrent Non-Wage; Wage; and Development

[18] M-Trac is a SMS-based disease surveillance and medicine tracking system. It provides real-time data for response while monitoring health service delivery performance. The initiative also integrates governance and accountability through citizen feedback, an anonymous hotline and public dialogue sessions. UNICEF Uganda

Human Resources for Health. The Health Service Commission (HSC) is responsible for the recruitment and deployment of public HRH at Central and Regional Referral Hospital levels. In the districts, this function is carried out by the District Service Commissions. Significant progress has been made in recent years in increasing the output of health professional and in producing a multi-purpose nursing cadre capable to perform both nursing and midwifery tasks. Availability of data on the public sector health workforce has also improved. A comprehensive HRH policy and strategy to address priority HRH constraints is in place, although its implementation needs to improve. Another encouraging development is the recognition of the need for human resource management and leadership training. The wage bill limits the ability of the public sector to fill its vacant positions and to absorb the increasing numbers of health workers produced. New incentives have been created in 2012 to attract doctors to General Hospitals and HC IV.

The **Human Manpower Development Centre (HMDC)** was established in Mbale in 1982 as a national centre for continuing education of health workers, through the Uganda Health Training and Planning Project funded by CIDA, Canada, and implemented by the MOH and AMREF. HMDC was gazetted in 1987. A Distance Education Unit was established eventually aiming at providing continuing education to health workers working in government and NGO hospitals, dispensaries, health centres and sub-dispensaries. Support was granted by several entities, such as Irish Aid, Health Sector Support Programme of the World Bank, USAID, European Development Fund/Rural Health Programme (EDF), UNICEF, DANIDA[19]. HMDC activities were largely donor-dependent and when the various projects wound up, the activities stalled. The MoH Restructuring Report stated that the in-service training institutions should be retained by the MoH. As a consequence, HMDC was neither placed under MoE&S nor under the MoH. In practice, HMDC has no legal mandate and was excluded from government funding, as the MoE&S ceased making monthly releases through the Mbale District Chief Administrative Officer (CAO). Owing to its historical attachment, the MoH took over support, without addressing the HMDC's on-going ambiguous status, despite several attempts made to pass a cabinet paper establishing the centre at least as a semi-autonomous entity, capable to establish fees, retain funds and formulate and adopt its own investment plan.

The HMDC trained district health teams in planning and management prior to 2003, when it focused also on training Health Sub-District (HSD) managers, covering 102 HSD teams from 33 districts in a programme created by the MOH and assisted by WHO. A second cluster of HSDs was covered in 2009.

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and the Ministry of Health are currently rolling this out nationwide (2012-2014). M-Trac is supplemented by uReport which uses free SMS (texting) to hear from young people in remote area.

[19] See: Study of the health sector reforms in Uganda – lessons for the health sector strategic and investment plan (HSSIP), 2010-2015, August 2011

4 Analysis of the logical framework

4.1 Specific objective

The specific objective - to strengthen the planning, leadership and management capacities of the health staff at national level and local government levels – is relevant. It has not been described in terms of capacity indicators targeted for change, viz. improved stewardship at national level or improved health service delivery at peripheral level, though the latter is captured in the overall objective. It reflects individual rather than institutional capacity.

4.2 Results

The project results, as described in the project technical and financial file, have been gradually adapted through the quarterly and yearly work plans adopted by the Steering Committee, and as per the recommendations of the technical support mission of April 2011.

Originally, results 2 and 3 foresaw the strengthening of the organisational and institutional capacity of the Regional Referral Hospitals (RRH) in Arua, covering the West-Nile region, and in Fort Portal, Rwenzori region, and of two General Hospitals within their catchment area. Results 4 and 5 foresaw the strengthening of six District and ten Health Sub-District (HSD) management teams within the catchment area of the two RRHs. As the Steering Committee decided to include all 15 districts and facilities within the catchment area of the two RRHs, facilities were de facto limited to HC IV level for practical reasons, as it was not deemed feasible to reach out to all 500 and more health facilities.

Result 6 - two training/demonstration sites for CB of HSD management teams are functional, has also been changed by the Steering Committee as per the recommendation of the Technical Support Mission (April 2011). The new result reads “supporting the revitalisation of the Health Manpower Development Centre (HMDC) in Mbale, Eastern Uganda, and possibly the establishment of regional satellites centres in West Nile and Rwenzori”.

Result 7- a scientific support team accompanies the capacity building process in the Ugandan health sector) has in principle not been changed, although it is still to be addressed and no actions have been implemented.

In view of these project modifications, the expected results can be redefined and regrouped as described in Chapter 4: “Achievement of results”.

4.3 Indicators

Sixteen indicators of the HSSP II[20] and the Joint Budget Support Operations[21] have been proposed for the specific objective. These include input indicators, such as the proportion of PHC Conditional Grants released on time to the sector, process and health service delivery output indicators. These indicators do not pose an additional burden on the country and reflect improved health service delivery. The TTF stipulates that it is up to the project to identify local baseline values and targets to assess the project contribution to the sector. The TFF recommends additional routine indicators on maternal health, child health, and health facility performance to assess the performance and outcome of the concerned facilities.

[20] The current HSSIP uses the same indicators

[21] The Joint Budget Support Operations refer to the joint Health Donor Partner support to the budget earmarked for the health sector. The current HISSP

Though all these indicators are reported in the Annual Health Sector Performance Report, it becomes very tedious for the project to follow these indicators for the two project regions and the multitude of indicators renders their interpretation difficult. The existing composite District League Table (DLT) could overcome this complexity, even though it may include reporting and population census biases. The DLT consists of 8 coverage and quality of care indicators with a collective weight of 75% and 4 management indicators with a weight of 25%[22]. Some districts, like Kabarole, in Rwenzori region, already disaggregate the DLT ranking at Health Sub-District level, and some stakeholders proposed to aggregate the ranking to the regional level. The progress in the ranking of the supported districts could thus become a powerful tool to assess the project's contribution.

At results level, input and process indicators are proposed, without targets, which have not been added during the project inception. The agreement addendum signed on 12th October 2011 on the occasion of the SIDA contribution as a silent partner has expanded the scope, duration and budget of the project. The list of additional interventions proposed in this addendum have been interpreted as a set of additional process or output indicators for the sake of this review

4.4 Assumptions and risks

There are no assumptions at the specific objective level. This would suggest that strengthened capacity at national MoH and local government level are per se sufficient to improve health service delivery, even though other stakeholders such as the MoFEPD, the MPS, the private sector, and Health Development Partners (HDP) play obviously a major role. The latter are only partially considered in the project design, and are not actively involved in its activities.

Each result is accompanied by two assumptions in the TFF logframe, viz. the approval by the respective top-level authorities to conduct the required activities and their cooperation. These assumptions are not further analysed in the TFF.

A more detailed project implementation, management, effectiveness, sustainability and fiduciary risk analysis is given in the formulation report. The creation of training centres (result 6) is rightly viewed as the biggest implementation risk as building and equipping those centres must be supplemented with a mix of other inputs, such as staffing and a tailored and realistic business plan, to ensure their functionality. This result has meanwhile been changed to the strengthening of the existing HMDC, which has over the years only survived with external donor support. Many prerequisites are needed for this Centre to become functional as will be discussed under the section on results.

A second major identified implementation risk is the pervasiveness of capacity building needs throughout the health sector, requiring the involvement of a multitude of stakeholders, both at national and peripheral level. Proposed risk mitigation includes co-management, geographical restriction, and external expert support. It is however unlikely for a project to build capacity covering the six building blocks of a health system[23], as this requires the concerted action of all stakeholders involved as is done in a SWAp and through budget support. The project must therefore restrict its area of intervention, not only in geographic terms but also in its scope of work.

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[22] Coverage and quality of care indicators (75%) include: i) DPT3 Coverage; ii) deliveries in gov't and PNFP facilities; iii) OPD per capita; iv) HIV testing in children born to HIV positive women; v) latrine coverage in households; vi) IPT2; vii) ANC4; viii) TB success rate. Management indicators (25%) include: i) approved posts that are filled; ii) HMIS reporting completeness and timeliness, which has four components; iii) functionality of DHMT; and iv) medicine orders submitted timely.

[23] According to WHO, the six health system building blocks include: i) delivery of effective, safe, quality personal and non-personal health interventions; ii) a well-performing health workforce; iii) a well-functioning health information system; iv) equitable access to essential medical products, vaccines and technologies; v) a good health financing system; and vi) leadership and governance ensuring strategic policy.

Staff retention is also seen as an issue, which was to be mitigated through the involvement of key staff within and outside the MoH. It is however not specified what this practically means and no innovative procedures are devised.

Capacity assessment during the inception phase of the project may elicit emotional reactions and affect power relations, which can be mitigated by allowing sufficient time for a bottom up approach and by providing appropriate facilitation by (international) experts. The six months suggested for this phase is too limited, and the main CB impetus must come from within the organisation.

The integrated planning foreseen entails that no project activities can be implemented if they do not feature in the annual work-plans of the respective collaborating institutions. This carries an implicit risk, as some of the institutions, especially the MoH Planning Department have weak planning capacities. This risk was to be mitigated by assisting the institutions in their planning process. A problem however has been that the project team itself is overstretched. The Technical Assistant is mostly engaged in administrative and financial matters and may not have all the skills needed by the different sub-sectors.

Attitudinal problems are also seen as a risk, to be mitigated by e.g., supportive supervision. Strengthening motivation however is complex and may require broad based interventions on conditions of work involving other Ministries, especially the Ministry of Public Service

The management, effectiveness, sustainability and fiduciary risks will be discussed in following chapters.

5 Achievement of results

The project has been demand driven and implemented through the MoH annual work plans taking into account following changes:

i) activities have been reoriented according to a technical review (SC 20/06/2011);

ii) the project scope, funding and timeline were expanded through an addendum to the TFF, as SIDA committed additional funds as a silent partner in delegated cooperation (SC 12/10/2011);

iii) a change in procurement modality was agreed (SC 16/04/2012); and

The Steering Committee has the responsibility and authority to propose, if deemed necessary, changes to the project logframe[24]. This has not happened and the original logframe results and indicators were neither adhered to, nor updated.

Taking into account the Addendum to the Agreement of 12 October 2011, and the current implementation modalities, the MTR has examined the expected results 2-5 jointly. Four expected results will thus be discussed as shown in the table below:

Table 1: Rearrangement of results for discussion

Result according to Logframe	Rearranged results for analysis
Result 1: The MoH is strengthened in its organisational and institutional capacity.	**Result 1**: The MoH is strengthened in its organisational and institutional capacity.
Result 2: One selected Regional Referral Hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity. *Modification[25] : Regional approach: support to all Health Districts and General Hospitals*	**Result 2**: Strengthened organisational and institutional capacity of the RRH in West-Nile and Rwenzori and the health structures in their catchment area
Result 3: One further RRH (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity. *Modification[26] : Regional approach: support to all Health Districts and General Hospitals*	
Result 4: District management teams are strengthened in their managerial capacity, leadership and planning functions	
Result 5: A comprehensive approach on capacity building of HSD management teams is operational.	

[24] These modifications must be endorsed through an exchange of letters between the signing Authorities (MoFPED and Embassy of Belgium) if they imply amendments to the Specific Agreement.

[25] Steering Committee October 2011

[26] Ibid.

Result 6: Two training centres/demonstration sites for capacity building of HSD management teams are functional *Modification[27] : Focus on support towards re-vitalisation of Health Manpower Development Centre in Mbale (East Uganda), including satellite training centres in two Project implementation regions.*	**Result 3**: Strengthened Health Manpower Development Centre (HMDC) in Mbale, including a satellite centre in each of the two regions
Result 7: A scientific support team accompanies the capacity building process in the Ugandan health sector.	**Result 4**: A scientific support team accompanies the capacity building process in the Ugandan health sector.

The MTR team has grouped the logframe indicators correspondingly. The Agreement Addendum contains a set of additional process and output indicators. These have been marked in brackets *Addendum Item*, followed by its reference number.

5.1 Result 1: MoH HQ

Strengthened organisational and institutional capacity of the MoH HQ

5.1.1 Progress

No institutional capacity assessment of the MoH has been done as the Ministry of Public Service (MoPS), the MoH, and various donors had already conducted such assessments over the last years. So far, no consensus has been reached however on the way forward, so that no in-depth organisational or institutional reform has been implemented.

Institutional and financial support has been provided for:

- ✓ The training of 20 trainers (ToT) in Governance, Leadership & Management. An AMREF curriculum has been used and a roadmap for the course roll-out has been developed;
- ✓ A Parliamentary visit by approximately 50 Members of the Social Service Commission in conjunction with senior MoH staff of the 13 Regional Referral Hospitals (RRHs) nationwide;
- ✓ The refurbishment and equipment of offices for the Minister of Health, the Minister of State (MOS) General Duties (GD), the MOS Primary Health Care (PHC), the Permanent Secretary (PS), and the Director General Health Services (DGHS);
- ✓ Material support (stationary and airtime) to the Director for Health Services (Planning and Development), who is also the project director;
- ✓ The Joint Review Mission (JRM), the quarterly performance review, and the compilation of the Annual Health Sector Performance Report (AHSPR). It should be noted that the FY 2011/12 AHSPR is the first report compiled without external consultant support;

[27] Ibid.

- ✓ A procurement assessment at MoH HQ, Arua, and Fort Portal Referral Hospitals[28]. As a result, a new PDU head has been appointed, but staffing remains inadequate. Office space for the PDU has been increased and the project has procured furniture and IT equipment. A Procurement Planning training is organized for the MoH user departments, and consultancy services are being procured for the development of a Procurement Strategy;
- ✓ A one day national health planning meeting;
- ✓ Consultancy services to develop a national nursing policy (on-going);
- ✓ The forthcoming printing of national infection control guidelines;
- ✓ A five day workshop for 15-20 participants to formulate a Health Financing Strategy, which was initially the task of the MoH Special Presidential Advisor;
- ✓ A one day national planning cycle seminar for 80 participants;
- ✓ A 5 day budget conference for 160 participants;
- ✓ The development of the ToR for the review of the MoH supervision framework.

Individual capacity building was supported through:

- ✓ A two week performance-based financing course for 6 participants in Mombasa, Kenya;
- ✓ A one week executive secretary management course for 3 executive secretaries in Durban, South Africa;
- ✓ A two week health reforms and finance course for 1 participant in Amsterdam KIT, the Netherlands;
- ✓ A 3-4 days health economics course for 1 participant in Senegal;
- ✓ The attendance of 2 participants to a two day e-Health Africa seminar in Nairobi, Kenya;
- ✓ The forthcoming attendance of 3 participants to a three days e-learning conference in Namibia (May 2013).

5.1.2 Indicators

Table 2: Indicators on Result 1, MoH HQ Capacity, and their achievement

Indicator	Achievement
Reform plan in execution	Not done. The project has however helped in the formulation of a health financing strategy for the sector,
Number of people trained by the project	20 ToT Individual: 14
Number of field visits for: - Coverage plan development - Master plan designing - Procedures manual identification	Field visits have been conducted for each of these areas, though no statistics are available.
MoH Procedures manual in place	Not done
Support supervision policy paper renewed	Tender rejected twice. Third tender published
Established procedures for training coordination	Not done

[28] The major recommendations included: to develop a procurement strategy and plan based on the MTEF; to develop a procurement manual setting the internal operations; to improve the PDU staffing and organisational structure; to provide PDU training; to remunerate attendance to the PDU Evaluation Committee like for any other committee; to appropriately house and equip the PDU; and to consider making the PDU a cost centre. Similar recommendations were made for the PDU of both RRH.

Strengthen operational research perspective, e.g. financial management, accountability issues (ADDENDUM ITEM 5.4)	- Procurement assessment at MoH HQ, Fort Portal and Arua RRHs; - Workshop on financial management - No operational research done
Investment support for the MoH HQ (ADDENDUM ITEM 5.2)	Done
Engendering of the sector strengthened (ADDENDUM ITEM 5.5)	Not done
Involvement of institutions of higher learning (ADDENDUM ITEM 5.6)	Not done
Regional health level developed ((ADDENDUM ITEM 6.2)	Not done

5.1.3 Difficulties

The MoH has received a new impetus with top level appointments in 2010 and 2011, including the Minister of Health, two Ministers of State, and the Director General of Health Services. The Permanent Secretary is still acting, which may affect the decision-making process.

The prevailing organogram does not correspond to the one proposed in the HSSIP. As an example, the resource centre and the policy analysis unit are still under the Directorate of Planning and Development and not directly reporting to the Director General Health Services. Moreover, the HSSIP organogram has its own inconsistencies. Thus, the Divisions of Human Resource Development and Human Resource Management fall respectively under the Health Planning Department (PD), reporting to the Director General, and the Department of Finance and Administration, reporting directly to the Permanent Secretary. Health Development Partners have been requesting for many years that both divisions fall under one directorate to enhance their collaboration.

The annual work-plan budget for the MoH is structured along its departments, followed by the various projects supporting the MoH[29]. This presentation is not conducive to develop comprehensive planning for the departments and may lead to fragmentation.

The project has known serious delays through the malfunctioning of the MoH Procurement and Disposal Unit (PDU). An assessment of the MoH PDU, and the PDUs at Fort Portal and Arua Hospitals was done and related recommendations were implemented as shown above, while others need still be done, especially the development of a procurement manual setting the internal operations, the improvement of the PDU staffing and organisational structure; remunerating the attendance to the PDU Evaluation Committee like for any other committee; and making the PDU a cost centre. To overcome these shortcomings, the Steering Committee decided to apply the Belgian law (“régie”) for most procurement. They also endorsed the recruitment of a project accountant and the temporary recruitment of a procurement officer. The project accountant was eventually recruited in May 2012, together with the project officer who had been meanwhile on maternity leave for three months. The procurement officer joined the project in September 2012. All of this laid, and continues to lay a huge administrative and financial burden on the Technical Assistant, who continues to spend the majority of his time on non-technical issues.

It is probably neither realistic nor needed to support all MoH Divisions. Various donors already support key areas, such as the resource centre, for which partners supporting evidence-based decision-making have recently written a briefing to reposition the centre. This centre has four units, ICT and e-health, library and database, Monitoring and Evaluation; and Health Management Information System (HMIS). This latter system has a relatively well functioning web based routine data collection system (www.DHIS2.org). It also includes a manual human resource (HR) and drug and logistics databases, which seem to be a duplication of the databases maintained by the HR

[29] Eleven projects are included, e.g. the World Bank Health Systems Strengthening project, the ICB project, and so on

Development Division in conjunction with the USAID, sponsored Uganda Capacity Project, and the drug supply database, maintained in conjunction with the USAID sponsored SURE project. The Resource Centre Task force members have expressed their worry about the management and leadership of the Centre, the data sharing policies, and the personnel deployment and retention policies.

The Health Planning Department cannot cope with its workload, caused by serious staff shortages, weak capacity planning and weak leadership. There are currently only two planners, against 7 until a few years ago. These results in a focus directed on budgeting, rather than on priority setting and planning, with limited analytical capacity to support policy formulation. Departments plan their own activities individually, based on indicative budgets provided. The publication of a consolidated MoH work-plan has been delayed until the 3rd or 4th quarter of the financial year, rendering the planning exercise futile.

Theoretically, the MoH Area Teams coordinated under the Quality Assurance Department (QAD) conduct quarterly supervisory and support visits to all districts. However, Uganda counts 112 districts, established since 2010. The number of districts has almost tripled since 1990 (34) and doubled since 2000 (56). Thus, HQ supervision becomes not only very expensive, but also virtually impossible. Most districts are only visited once a year and for no longer than a couple of days. The HSSIP has therefore recommended to pilot a regional tier[30]. This is already partially implemented by various programmes. The Round 10 Global Fund health system strengthening programme has started recruiting 12 teams of 7 staff to establish Regional Performance Monitoring Teams. These teams will be attached to the RRH, either within its CHD or as stand-alone secretariats, according to the local context. It remains to be seen whether these teams will be perceived as Global Fund teams or true MoH teams.

5.1.4 Recommendations

1) **Office of the President**: Nominate a PS (as an acting PS has insufficient authority to lead the health sector reforms process)
2) **MoH and Project**: Review and make a realistic update of the institutional assessments of the MoH conducted so far, taking into account the prevailing budgetary and civil service constraints
3) **MoH**: Review, adopt and implement the recommendations made in the procurement assessment report commissioned by the project and which have not yet been addressed, especially the development of a procurement manual setting the internal operations, the improvement of the PDU staffing and organisational structure; remunerating the attendance to the PDU Evaluation Committee like for any other committee; and making the PDU a cost centre.
4) **MoH and Project**: Reorient the Resource Centre and the Quality Assurance Department to strengthen their support to the periphery

[30] In Uganda, regions do not exist as a political or administrative entity. However, the HSSIP recommends the piloting of regions and various health sector programmes already use the regional concept: Quality Assurance programme has 14 Area Teams; the Reproductive Health Programme uses 4 regions; the National AIDS Control Programme uses 8 regions; the National Malaria Control Programme uses 14 regions, the National Leprosy and Tuberculosis Control Programme works with 8 regions out of which 6 are functional; the Uganda AIDS Commission uses 8 regions. Other Ministries use different regions, e.g. the Ministry of Gender 9, the Ministry of Water and environment 4.

5) **MoH**: reformat the MoH HQ annual work-plan template, incorporating the project interventions into the departmental activities, while assigning a column for the funder, either a specific project or the Government. This will prevent a fragmentation of interventions

6) **Project**: Support the development of gender-based budgeting and of a strong gender desk within the MoH, and its operations

7) **Project**: Redesign the ICB project and formulate an updated project logframe by the end of Q3, 2013. This logframe should follow the HSSIP 2010/11-2014/15 principles and objectives, limit the number of priority areas, and be based on the action plans of the beneficiary districts, the RRHs, and the identified MoH HQ support areas. The proposal given in the main findings of the conclusion (see above) could be used as a guide.

8) **Project**: Prioritize capacity building and leadership interventions at the MoH HQ, investing in one or at the most two Divisions with the greatest potential impact on service delivery. The most likely candidate is the Department of Planning

9) **MoH, BTC and Project**: Pilot in collaboration with the forthcoming Global Fund supported "Regional Performance Monitoring Teams" a regional level structure to ease coordination in line with key innovations proposed in the HSSIP, the MoH Quality Improvement Framework (QIF) and Strategy, 2011, and the regional ambulance network setup by the project:

    a. Use the Community Health Departments (CHDs) at the Regional Referral Hospitals as a concentrated office for the MoH HQ; the CHDs implement regional activities such as EPI supported by WHO and are therefore seen to have a regional mandate. The CHDs could be strengthened with additional manpower in order to develop a regional support and coordination plan
    b. Expand the Regional Implementation Committee to include the major health stakeholders from the public and private sector
    c. Consider appointing a high level administrative and financing officer or team coordinator in both regions, who could eventually be taken over by the MPS as the Global Fund is planning to do

10) **MoH and BTC**: Extend the project implementation period until June 2015, subject to the Logframe revision and the approval of the MTR recommendations

11) **MoH and BTC**: Recruit an administrative and financial TA. He/she should:

    a. Assist with the implementation of project financial and administrative duties thus relieving the current TA, enabling him to fulfil his public health duties;
    b. Provide, in conjunction with the foreseen Public Finance Management Advisor of the BTC Representation, policy/expert advice on procurement, supply chain management at the MoH HQ;
    c. Provide, in conjunction with the foreseen Public Finance Management Advisor of the BTC Representation, policy/expert advice at the interface between the MoH and the MoLG at regional and district level;
    d. Develop a roadmap towards resuming procurement according to the Ugandan law instead of the current "régie" system.

12) **BTC HQ**: Consider adapting the annual reporting format to include a reporting on the achievements of the indicator targets

13) **Belgian Embassy**: Resume budget support for the health sector if the Joint Assessment Framework criteria have been met in order to increase the health sector budget and enhance policy dialogue

5.2 Result 2: Regional level

Strengthened organisational and institutional capacity of the RRH in West Nile and Rwenzori and the health structures in their catchment area

5.2.1 Progress

The logframe results 2 to 5 relate to the organisational and institutional capacity building of the health service delivery system. In view of their interdependency, their progress is reviewed jointly.

The project hired external consultants are finalizing the 5-year annualized and budgeted Strategic and Investment Plans (SIP) and the master plans for both RRHs. Completion is expected by April 2013.

An infrastructural assessment for Bwera and Adjumani General Hospitals is undertaken by the Health Infrastructure Division of the MoH. Both hospitals had originally been selected for ICB support under Result 2 and 3.

Consultants of the National Hospital have, together with MoH HID engineers, assessed the functionality of HC IV in terms of infrastructure, equipment, electricity, and water (for which an additional mission was needed). Solar power needs have been assessed for all hospitals, District Health Offices (DHO) and HCs IV. The DHO IT infrastructure has equally been assessed. Tenders are in progress for the purchase of solar power systems, provision of boreholes, medical equipment for ambulances and facilities, theatre tables, X-Ray equipment for Kilembe Mines Hospital in Kasese District and the rehabilitation of Karugutu health centre in Ntoroko district[31].

The health sector transport needs have been comprehensively assessed in both regions. As a result, 13 ambulances and 11 general purpose vehicles have been procured with service contract and insurance. The MoH handed them over in February 2013. In addition, 15 existing cars are being repaired. Drivers and ambulance staff have been trained.

Ambulance guidelines are being developed, and an ambulance MoU has been signed between the MoH and the MoLG.

Facility library packages have been developed and library handbooks have been procured and delivered to public and PNPF health facilities in both regions.

With the help of the HDP, the MoH has revitalized nationwide the regional health planning seminars which had been discontinued for the past 5 years for lack of funds. Thus, the project has facilitated a two-day seminar for 100 participants in West-Nile and Rwenzori Regions to orient staff on health sector priorities and update them on the expected planning format.

The project has supported the revision of the hospital management boards guidelines. The hospital management board of Fort Portal RRH has been trained and a training roll out plan to other hospital boards is being prepared.

Seventy staff from Arua and Fort Portal RRHs each have been trained on pre-retirement and 80 on civil service induction during 3 days. The training sessions were conducted in collaboration with the Public Service Training College. It is still debated whether the curriculum should be updated and the training rolled-out to districts, especially in view of the recent accelerated recruitment of 5,000 new staff for HC IV and hospital.

[31] Ntoroko district ranks exceptionally low in the District League Table compared to the other districts in Rwenzori.

In Rwenzori region, 4 district teams of 7 participants each have been trained in Human Resource leadership and management. This six-month course conducted in collaboration with the Uganda Capacity Project (USAID) consisted of theoretical sessions sandwiched between on-site field practices, followed by a dissertation. The possible roll-out of this training is currently under review.

Training of trainers (2) on Health Unit Management Committees (HUMC) has been conducted in each region.

In order to improve HC IV functionality, a surgical skills training has been developed and consultants from Fort Portal Regional Referral Hospital (RRH) have trained four HC IV teams on surgical skills and theatre management. The training lasted 4 weeks - 2 weeks at the RRH and 2 week on-site at the HC IV.

Districts have been trained on the newly introduced web based (www.DHIS2.org) Health Management Information System (HMIS). Four health information officers in each district were trained during 1 week and all DHO during 3 days. One-week data quality workshops were held in each district and in both RRHs. Quarterly regional HMIS reviews have been introduced.

5.2.2 Indicators

Table 3: Indicators on Result 2, regional capacity and their achievement

Indicator	Achievement
Regional Referral Hospital (RRH) Strategic plans incorporating master plans in place	Expected date of completion April 2013
RRH mandate reflects efforts for complementary role definition	No work has been done on the mandate of the RRH within the region The regional health planning seminars have been revitalized
# Support supervisions realised respecting new policy in the matter	No data available on the supervision frequency, which are reportedly irregular, often only once per year instead of quarterly. Tender for revision of supervision guidelines failed twice, third tender now published.
# People trained	No exact data available
#DHO support supervisions to General Hospitals realised	No data available
# support supervisions to Health Sub District Management Team (HSDMT) realised	No data available
DHO strategic plan developed, followed and discussed with MoLG	Districts develop annual plans. The project has not yet contributed to these plans or to medium term strategic plans
DHO Level of understanding of coverage and master plans for strategic planning	No strategic planning training conducted so far for DHO. It is therefore likely that their level of understanding has remained the same
HSD coverage plans, master plans and procedures manual reflected in strategic and yearly plans	Not done
Coverage plans discussed with LG authorities	Not done
# HSDMT meetings held	No data available

# HC II and III supervised by HSDMT	No data available
Investment support revised for 2 RRH, 4 GHs for support to transport, minor renovation, computers, furniture and other accessories (ADDENDUM ITEM 5.3)	Done
Regional health level developed (ADDENDUM ITEM 6.2)	Not done
Inclusion of PNFP sector in ICB project (ADDENDUM ITEM 5.1)	PNPF has been included in ambulance and vehicle system, and in the supply of books

5.2.3 Difficulties

Though some statistics may be available, e.g. on the number of supervisory visits, the project has not attempted to collect/compile these for measuring the attainment of the indicator targets.

In the past, the MoFPED had requested RRHs to develop a Strategic Investment Plan (SIP) and a Master plan, and started recently to penalize 11 RRHs (out of 13) who had not complied. Previous attempts to develop those plans through the Procurement and Disposal Unit (PDU) of the MoH and then through the PDU of the RRH failed. Procurement difficulties pervaded all tenders, thus seriously delaying outputs, until the project started procuring under Belgian law ("Régie"). The master plan will outline the RRH regional mandate, which should be further defined with the regional stakeholders. This latter has not yet been done for lack of a regional planning forum.

There is still no common understanding of what capacity building and leadership support entails. The local cross-sectoral leadership has been insufficiently involved in the project.

The communication on the project activities between the central level and the periphery is perceived as inadequate.

There are no objective project fund allocation criteria between RRHs and districts and within districts. The lack of an indicative project budget renders local planning difficult and thus impacts negatively on health system development and capacity building of the districts.

Many districts continue to experience difficulties in strategic planning, mainly because of insufficient planning skills, and problems with funding flows

Many hurdles remain in the development of ambulance service guidelines. Thus, the ambulances allocated to the PNPF sector remain with the DHO in Fort Portal, and their ownership remains unclear. Sustainability issues of the recurrent costs for servicing and fuel are equally not yet resolved.

The roll out of leadership and institutional capacity training to all institutions is problematic: some hospital management boards have not been appointed; many health unit management committees are not operational; there is a high turnover of staff in management positions; many facilities and district health offices are understaffed, especially in new districts; districts have no budget to roll-out training and it is difficult or impossible to access project funds at lower level with the current funding modalities; the capacity at MoH HQ for the wide roll-out of training to all facilities is limited or non-existent.

Similar problems apply to supervision: the MoH HQ based Regional Area Teams have no longer the capacity to supervise all 112 districts in the country; the districts have often no budget, transport or human resources to supervise at lower level. The Quality Assurance Department has planned to update the supervision guidelines after the supervision framework has been revised with the support of the project.

From the table below, it can be seen that West-Nile had a population of almost 3m in 2011, and Rwenzori 2.3m. They have respectively 246 and 266 health facilities. Between the two regions, there are some clear differences as to the type and quality of the health services. Rwenzori has relatively more health facilities, including 21 private health facilities. In West-Nile, more hospitals and HC IV belong to the PNPF sector. The quality of services is strikingly better in Rwenzori, as evidenced by the District League Table ranking: Kabarole district, where Fort Portal is located, ranks first nationwide, and the other districts are in the top third, except for two districts which are far behind. Notwithstanding these major differences, district peer learning is little promoted.

Table 4: Description of the West-Nile and Rwenzori regions

District	# Counties	Population 2011	Rank District League Table	Gov't Hospital	NGO Hospital	Gov't HCIV	NGO HC IV	Gov't HCIII	NGO HC III	Gov't HCII	NGO HC II	Priv Facilities	Total Facilities
Nebbi	12	337.400	28	1	2	1	0	18	8	23	4		57
Maracha	6	207.200	42	0	2	1	0	15	3	11	1		33
Koboko	5	222.900	44	0	0	1	0	4	1	7	0		13
Moyo	8	382.400	72	1	0	1	0	9	3	21	4		39
Zombo*	7	214.200	73										
Yumbe	8	504.500	87	1	0	1	0	6	2	12	0		22
Arua	25	737.700	90	1	1	3	0	14	3	16	8	1	47
Adjumani	6	353.200	93	1	0	1	0	5	5	12	11		35
West-Nile	**77**	**2.959.500**		**5**	**5**	**9**	**0**	**71**	**25**	**102**	**28**	**1**	**246**
Kabarole	14	409.400	1	1	2	2	0	17	6	21	7	4	60
Kyegegwa*	5	154.000	18										
Bundibugyo	7	248.900	21	1	0	3	0	7	2	17	2	2	34
Kamwenge	9	324.400	30	0	0	2	0	7	2	16	6	0	33
Kyenjojo	9	369.700	32	1	0	2	0	14	5	13	5	0	40
Kasese	21	721.400	60	1	2	0	2	20	11	46	2	15	99
Ntoroko*	3	79.900	103										
Rwenzori	**68**	**2.307.700**		**4**	**4**	**9**	**2**	**65**	**26**	**113**	**22**	**21**	**266**
Grand Total	**145**	**5.267.200**											
Total Uganda		**32.939.800**											

*District missing data are included in the figures of their mother district

The ICT Commission installed web-based telemedicine equipment in all RRHs in 2010. However, technical support was not provided, and the equipment has remained idle since then.

5.2.4 Recommendations

1) **Project**: Focus on building capacity and leadership skills at the peripheral level and emphasize building dialogue between the various tiers of the healthcare system, including the health sub-district level.

2) **Project**: Ensure the local leadership buy-in by:

   a) Supporting regional coordination and governance mechanisms. Regional Health Assemblies along the lines of the National Health Assembly could be piloted to this effect;

   b) Supporting technically the District Stakeholders Meetings;

   c) Building the capacity of hospital management boards and Health Unit Management Committees (HUMC), e.g. through exchange visits, training where needed and strengthening community demands; and

   d) Building the capacity of the extended district health management teams, and the district social services committee members through similar means as above.

3) **Project, BTC, LG and RRH**: Decentralize the ICB project funding mechanism through:

   a) Execution agreements with the beneficiary local governments based on their action plans. The LG will then be expected to make sub-grant agreements with the various institutions according to their annual work-plans; and

   b) Execution agreements with the Regional Referral Hospitals based on their annual work-plans

   These execution agreements should be in the form of activity and performance based Memoranda of Understanding

4) **Project**: Assist the beneficiary districts to develop a medium term strategic plan and a costed rolling work-plan, integrating all inputs from the Government, HDP, and PNPF for FY 2013/2014, based on the budget foreseen in the Non-Wage Conditional PHC Grant plus additional ICB project funding. This systems approach would thus replace the current ad-hoc project funding

5) **Project**: Assist the beneficiary Regional Referral Hospitals to:

   a) Finalize their medium term Investment Plan and hospital master plan by end of 2013; and

   b) Develop a recurrent hospital expenditure work plan for FY 2013/2014 based on the budget of the RRH allocation formula plus ICB funding, based on the same formula

6) **MoH, LG and Project**: Link the project funding to the Performance Agreement between the DHO and the CAO, and the forthcoming (from FY 2013/2014 onwards) hospital, HC IV managers and corresponding LC Chairs

7) **RRH**: Fund the RRH Community Health Departments as per the 2003 guidelines

8) **Project**: Strengthen the communication line and feedback between the project and the beneficiary entities at the periphery, e.g. by publishing project documentation on the MoH/BTC website and establishing a regional electronic discussion forum

9) **Project**: Establish a dialogue between the MoH and the BTC representation to identify opportunities for innovative PPP schemes, e.g. outsourcing of non-core services, as suggested in the National Health Policy

10) **MoH and Project**: promote exchange and peer learning between districts through study visits and other innovative approaches

11) **Project, MoH**: Encourage and support piloting of local scale innovative initiatives by the service managers, for example regional league table, facility league table, community monitoring of health worker attendance, etc.

12) **BTC and MoH**: Operationalize a bonding scheme for the BTC scholarship programme to areas of high need within and outside the assisted regions

5.3 Result 3: HMDC

Revitalisation of the Health Manpower Development Centre in Mbale, Eastern Uganda, including satellite training centres in two HICB implementation regions

5.3.1 Progress

- A three day workshop with 20 participants has been held to develop a concept note on reforming the HMDC;
- A consultant finalized a draft Strategic Investment Plan (SIP) based on the concept note;
- A fence wall is under construction. Completion expected by July 2013;
- Buildings have been rehabilitated, e.g. kitchen repair, inside and outside painting, electrical wiring of lecture room;
- IT equipment, office and classroom furniture have been supplied;
- A one day workshop has been held to develop a concept note on e-Learning
- A Junior BTC Technical Assistant has been seconded to the HMDC in August 2012 for a period of 2 years. This TA is not on the project budget.

5.3.2 Indicators

Table 5: Indicators of Result 3, HMDC capacity and their achievement

Indicator	Achievement
# HSDMT members trained in training centres	See Result 2
# Training sessions held	See Result 2
# HC II and III up to quality standard for receiving trainees	Not done as training has been shifted to HMDC
Status of training centres clarified	Strategic and Investment plan developed but not yet approved. Some pre-conditions such as legal status not yet defined
Involvement of institutions of higher learning in ICB facilitated (ADDENDUM ITEM, 5.6)	Not done
The HMDC revitalised and two regional In-service Training/Continuing Professional Development (IST/CPD) centres established (ADDENDUM ITEM 6.4) (see also activities TFF)	- No consultancy services provided yet for: - developing HMDC master plan; - developing HSDMT training strategy and programme; - supporting the establishment of the first HSDMT training course;

	- HSD training evaluation/ impact assessment - Slow implementation progress as approval of SIP is awaited - Support to the regional IST/CPD centres in West-Nile has not yet started - A regional IST/CPD centre has not been established in Rwenzori region yet

5.3.3 Difficulties

As the formulation report emphasized that creating training centres was subject to major implementation and sustainability risks, the project's full involvement in the HMDC has been rightly submitted to the prior approval of its draft Strategic and Investment Plan (SIP).

In addition, the TFF lists a number of key MoH decisions needed to ensure the success of this Result. The table below shows that most of these have not been taken yet.

Table 6: Training decisions to be taken and their implementation status

MoH Decision to be taken on:	Implementation status
The legal status of the training centre	No decision taken to date
The future financing modalities: central MoH budget, regional or HSD budget, tuition fees, donor community	Not yet addressed
Collaboration with universities or other training institutions	Some collaboration with Makerere University in view of accreditation No formal alliances have been instituted with established educational and academic bodies who are rather seen as competitors
Collaboration with MoH	Collaboration exists on paper, but less so in practice. The MoH does not concentrate its training at the HMDC, not even those financed by the project. A major opportunity is thus lost to strengthen the capacity and credibility of the HMDC and to contribute to its recurrent budget through tuition and accommodation fees.
Other training opportunities outside HSD management teams (HSDMT)	As above
Staffing: norms, profile, quantity, articulation and integration with local HSDMTs	HMDC staffing has increased and one junior TA has been seconded. The current staff number and profile are grossly inadequate to operationalize even a minimal part of the SIP draft. It is understood that staffing needs will be addressed upon approval of the SIP However, major organizational changes are needed now to plan, prepare, and in the future implement tasks, which are currently perceived as HMDC core functions, such as e-learning.
The local HSDMT teams should get extra workforce as well. The minimal staff for the training centre should consist of a public health physician as director, one senior nurse, an administrator – financial officer and a driver	The issue of the planned two satellite centres will be addressed once the HMDC has been revitalized. However, no contingency plan exists in case the HMDC SIP is rejected or amended.

No national IST/CPD strategy has been developed based on a situation analysis of training needs and potential providers from the public, PNPF, NGO or private sector, whether academia or others. Neither have the potential roles of the HMDC been spelled out, whether it should act as a training institute and/or provider of IST/CPD consultancy services to the MoH and other stakeholders/clients[32].

Surprisingly, neither the Human Resources for Health Country Profile, Uganda, 2009 (EU, WHO), nor the Human Resources for Health Biannual Report, MoH, April - September 2011, nor the Health Sector Strategic & Investment Plan 2010/11- 2014/15, nor even the Second National Health Policy, MoH, July 2010, make any reference to the HMDC. This raises the question whether a MoH/cross-sectoral ownership of HMDC truly exists. Investments in HMDC will probably continue to be wasted, as shown above in Section 2.2.2 National Health System. No assistance should be provided, as long as this fundamental ownership prerequisite is not fully met.

HMDC has no title deeds for its land, thus potentially compromising investments in its infrastructure. Indeed, hospital land elsewhere in the country has been lost to other developers in the past. It has been suggested that with the expansion of the neighbouring Mbale RRH, which will act as teaching hospital for a new University in the region (Busitema University), a similar scenario may occur.

The HMDC current weak leadership, stewardship and staffing structure jeopardize its revitalization.

The complexities and implications of a well-planned, credible and authoritative e-learning hub are insufficiently understood and addressed. The current emphasis is too much on technology infrastructure or specific digital (ized) learning materials for individual training needs, with little attention to the development of a solid e-learning framework. The cost implications of a full-fledged e-learning system are little understood.

Even though HMDC has no (semi-) autonomous status yet, allowing it to raise and retain revenues, it could already have been used as a project training/planning venue[33], potentially reducing the cost of these events while showing that is possible to raise revenue for HMDC.

5.3.4 Recommendations

1) **MoH**; Develop a national IST/CPD training strategy based on a thorough situation analysis of training needs and potential providers from the public, PNPF, NGO or private sector, whether academia or others

2) **MoH:** Outline the role of HMDC, either as a training institute and/or as a provider of IST/CPD consultancy services to the MoH and other stakeholders/clients

3) **MoH:** review the HMDC Strategic Investment Plan in view of the above two recommendations, and submit a final draft to the Cabinet for approval and implementation

4) **Cabinet**: Approve or amend the HMDC Strategic Investment Plan (SIP), taking into account the need to progress in realistic, implementable steps and to invest in innovation and knowledge, so

[32] Examples include: assessment of top and senior management training needs in Leadership and Management; support development of national training plan for pre- and in-service; support HMB induction training RRHs and GHs; review of induction training for health managers; revise and support induction training ; training needs assessments; evaluation, impact assessment, implementation of hospital management training.

[33] Examples include: retreat of the Directorate Health Services (Planning & Development); senior Management Committee retreat on L&M, ICB orientation; hospital management training; facilitator Leadership workshop; health reforms, health systems, management and financing course, part of clinical skills training surgery (Obs&Gyn) for surgical teams HC IV and general hospitals; HR leadership and management course to 15 districts in Fort Portal and Arua regions. Potential cost savings will amongst others depend on transport and the need to pay per diem costs.

that HMDC becomes a reputable institution able to attract innovative or project financing from the Health Development Partners (HDP), other donors and the private sector

5) **Cabinet**: Grant a (semi-) autonomous status to the HMDC while the MoH remains its regulator and main client. This is vital for the sustainability of the Centre and should enable HMDC to issue certificates, raise and retain revenues through fees and other means, and invest in its infrastructure and technical capacity

6) **Local Government**: Grant HMDC land title deeds

7) **Project:** Assist HMDC to develop an advocacy plan once it becomes sufficiently clear that the above recommendations will be implemented. Advocacy may include the need to concentrate most MoH events at the HMDC once the guestroom and other residential facilities have been properly refurbished, taking into account transport and per diem costs.

8) **MoH** and **HMDC:** Proceed in a careful, phased manner with the planned establishment of an e-learning system by:

   a. Revitalizing and strengthening the current HMDC Distance Education Unit, possibly with the virtualization of learning materials[34]

   b. Commissioning a detailed economic and operational feasibility study;

   c. Developing a national sound, costed strategic plan;

   d. Initiating small scale pilot activities while building the system, based on existing best practices.

9) **Project:** If, and only if the above HMDC sustainability pre-conditions have been met, accompany and coach HMDC in its endeavour to establish an e-learning centre by sponsoring needed studies, providing documentation, and networking with existing CPD programmes and systems[35], and supporting twinning mechanisms with qualified entities who manage e-learning

An alternative to the above recommendations is that a university takes over the HMDC and that further MoH events are outsourced to universities. It is obvious that the project support can take a totally different shape depending on decisions taken and, importantly, the MoH formal commitment to the HMDC.

5.4 Result 4: Scientific support

A scientific support team accompanies the CB process in the Ugandan health sector

5.4.1 Progress

No progress

[34] Possibly harmonized with the "DISH Distance Learning (DL) Strategy Document", available at: http://www.ugandadish.org/resources/DistanceLearning.shtml, accessed March, 2013

[35] Some of the many examples include http://www.elearning-africa.com, http://elearning.africa-devnet.org, the University of South Africa (UNISA), www.who.int/healthacademy/courses/en, ECA e-learning, the European Distance and E-Learning Network (http://www.eden-online.org), the European Foundation for Quality in e-Learning (http://efquel.org/), EU Member States that have a sound and consolidated policy on e-learning regulatory CPD systems (such as Italy: http://ape.agenas.it/

5.4.2 Indicators

Table 7: Indicators on Result 4, scientific support, and their achievement

Indicator	Achievement
Policy paper on support supervision refined and approved	Not done
Policy paper on referral system refined and approved	Not done
Complementary roles of health facilities better defined and approved in policy paper	Not done
Continuous training policy for health personnel refined	Not done

5.4.3 Difficulties

The TFF has outlined the rationale and activities for the scientific support, but not its modalities. The subject was purposely left open. The concept of or the need for scientific support have not been further elaborated during the project implementation, and no specific areas for support have been identified. Nor is the specific need to work with an international scientific institute on capacity building and leadership acknowledged

The MoH has developed a concept of pooled technical assistance with the Health Development Partners, which has, however, not materialized in practice

The MoH has signed an MoU with Makerere University School of Public Health (MakSPH), the Public Health Association, and the Institute of Tropical Medicine, Antwerp, Belgium (ITM) on a Fellowship Programme in health systems management, jointly launched by MakSPH and ITM in 2012. Yet, the MoH and the project do not seem to find ways and means to collaborate on this innovative course, for reasons that are not clear to the MTR team.

5.4.4 Recommendations

1) **MoH and Project**: generate evidence by supporting health managers to conduct operational and scientific research in collaboration with national and international academic institutions
2) **MoH and Project**: collaborate with the MakSPH/ITM Fellowship Programme in health systems management

6 Assessment

6.1 Basic criteria

6.1.1 Relevance

The institutional capacity building and leadership project has been designed to complement and support donor (including Belgian) health sector budget support, and related capacity building projects. A hierarchy of capacities were to be addressed: system's capacity referring to the quality of policies, strategies, and norms; institutional capacity determining its performance; individual capacity; and the development of tools for management.

Policies, strategies, organisational setup, and the availability of health resources have evolved since the project formulation, all affecting healthcare. The Second National Health Policy launched in 2010, emphasizes (like its predecessor) health system strengthening and the delivery of a basic healthcare package. Its targets and strategies, elaborated in the Health Sector Strategic and Investment Plan 2010/2011-2014/2015 (HSSIP) have been updated. The HSSIP has five objectives, including the deepening of the sector stewardship, to be achieved through seven sub-objectives. The MoH has suffered from a series of setbacks with a major reshuffle of its top management. The health budget has nominally little grown over the last 5 years and decreased in real terms. The decentralisation process is de facto being reversed as only 13% of the national budget reaches local governments, against 45% a few years ago. Donors have suspended their budget support because of corruption scandals.

In addition to this changed environment, the project has suffered - and continues to suffer - from a lack of common understanding of its mandate. In response to these difficulties, an institutional support mission held in April 2011 partially redesigned the project, placing a greater emphasis on the peripheral level and setting up regional implementation modalities. This has improved the relevance of the project, and also the ownership by the national authorities. This growing ownership is however partly due to the gap-filling role of the project at the various levels, rather than to a buy-in on the project's mandate.

The project's role at district and sub-district levels (expected result 4), especially in times of constrained budget. The needs for scientific support (expected result 6) have not yet been identified.

The project log frame is no longer used, and is supposedly replaced by national planning tools, which are in practice often not available. Similarly, HSSIP indicators and targets are supposedly used, but none have been specifically highlighted and no capacity building process indicators are used.

6.1.2 Efficiency

The MoH senior management was not involved in the project during the first year. As a result, no major activities took place. The Project was therefore re-launched on 20th June 2011 after a general overhaul of senior management. The financial disbursement stands now at 25%. Delays in the accounting process by beneficiaries have at times affected disbursements. Districts do not yet receive block grants, so that every single expenditure has to be paid for by the central level, requiring three signatures (Permanent Secretary, the Project Coordinator, and the Project Advisor), which is a deviation from the financial procedures between central and local government. This has led to central level decision making on behalf of the periphery on funding activities, in the absence of clear, objective criteria.

The Technical Advisor joined the project since its onset. The project officer and accountant joined the project team in May 2012, and the procurement officer did so in September 2012. These latter appointments enhanced the efficiency of the project, though the Technical Advisor still spends an unnecessary proportion of his time on administration.

The HMDC is only occasionally used as a training venue, and most training sessions happen in hotels thus increasing their cost.

Procurements have been cumbersome and slow, until procurement under Belgian law was adopted on 16th April 2012. Since then, 42% of funds foreseen under "régie" have been utilized, against 9% previously under the Ugandan law. It is clear that these gains in efficiency and possibly in cost-effectiveness are being obtained at the expense of the central concept of capacity building under which the project was conceived[36]. The reorganisation of the procurement should have been discussed at a different level, e.g. with the MoFPED, which manages the procurement sector. In retrospect, it would have been better to first negotiate about (i) the conditions for continuation of using the national procurement system, (ii) followed by possible procurement of specific TA to enable the procurement department to operate more efficiently and transparently.

Outputs achieved so far consist of individual trainings, trainings of trainers in various topics, policy, planning and operational support, the refurbishing and equipping of senior managers' offices and board rooms, ad hoc support to on-going activities, the supply of 11 general duties vehicles and 13 ambulances for districts and hospitals in the two supported regions, and some basic strategic and logistic support to the HMDC.

The quality of the outputs has been variable; some activities have not led to satisfactory outputs, e.g. the drafting of a Hospital Operations Manual for which approximately 20 participants gathered during a one-week residential workshop.

6.1.3 Effectiveness

In result areas 1 -3 the project has undertaken activities mainly related to the supply of tools for management, renovations, furniture, equipment and transport at both the central and regional levels. These have to some extent improved organizational capacity at the regional level. However, at both levels the envisioned strengthening in leadership, planning and management capacities is yet to be realized. The strengthening of district management teams (result 4) is mainly restricted to health facility management boards/committees. It does not embrace other vital stakeholders such as the district health management team (DHMT) and district social services committees (who are critical for advocacy). Capacity building of the HSD management teams (result 5) is yet to commence and is behind schedule (was to be implemented during Q3 and Q4, 2011/2012). This will hinder the expected assessment of the outcomes related to this capacity building function within the lifespan of the project. The HMDC is in the process of being revitalized (result 6) with the development of a strategic and investment plan that will - if approved - transform the centre into a semi-autonomous entity. This is likely to be a long drawn out process that will need buy-in from mainly the MoH stewards to ensure approval by the executive and legislative arms of government. Currently, the HMDC has limited technical capacity and does not have the mandate to award professional development qualifications. An interface of HMDC with national academic institutions to support result areas 4 and 5 is therefore necessary. Scientific support to the capacity building process (result area 7) has not been initiated by the project to-date.

[36] The Annual Report 2011 commented that: "Although the focus of the project will remain on strengthening the 'institutional capacity' (including the procurement processes), some procurement will be transferred from co-management to regie in order to improve efficiency and increase in execution rate (e.g. short time consultancies; investments that can be done under BTC international framework contracts (e.g. ambulances)"

There is a need to initiate a dialogue with potential institutions/ departments, such as the academic institutions and the MoH Resource centre to ensure that scientific support to the project becomes operational.

6.1.4 Sustainability

The economic and financial sustainability is favourable. The project had to provide essential commodities that should be procured by the Government or under budget support. Within those constraints, the ICB project activities are sustainable if recurrent costs are met (e.g., some problems with ambulance management, as the fuel provided is limited and the beneficiary districts' CAOs may not agree to finance operations and maintenance). The HMDC will possibly survive if granted a different status enabling it to raise fees and retain revenues to sustain its activities. The new challenges of the e-learning strategy may have not been fully appreciated and the needed strategic view not developed with the necessary degree of analysis of implications and amount of work and investments required. Additionally, the HMDC future depends on the approval of its forthcoming strategic plan and the possible upgrade of its institutional setting to become a (semi)autonomous entity, or a cost and responsibility centre within the MoH.

The technical sustainability is more problematic**.** The MoH and the districts continue to rely on the project on a mere ad-hoc basis, in the absence of required innovations to achieve strategic health system objectives and to sustain the health system under the current constraints. The health sector is rather fragmented which again leads to sustainability issues; to address this, innovative and creative solutions should be sought and enforced. The ICB project has not been able to present viable options for reengineering the current situation. In terms of procurement, the project did well from the efficiency viewpoint; however, the decision to take procurement off the control of the MoH relevant section reduces their potential capacity improvement and seems contradicting the ICB project philosophy.

The project's centralized decision-making is negatively affecting its support to districts, whose capacity to access the project resources is limited. This contradicts the demand driven strategy the project has adopted.

The project has suffered from many delays until the Steering Committee decided to apply Belgian law for most procurement. Some of the procurement system assessment recommendations have been implemented, while other key recommendations need further action as shown above.

6.1.5 Coherence

Belgium supports the health sector through the ICB project, budget support, a scholarship programme, and its support through the Institute of Tropical Medicine, Antwerp (ITM).

The budget support co-finances the Conditional PHC grant to districts. DHP have temporarily suspended budget support following corruption scandals, and it will shortly be decided whether to resume this support. Meanwhile, the MTR team has the impression that the ICB project mainly fills gaps. Even if budget support resumes, the ICB project could complement the Conditional PHC grant towards capacity building and strengthened leadership.

So far, 69 MPH scholarships have been financed. These have not been linked to the project, though. It is intended to institute bonding from 2014 onwards. It is not recommended that this bonding be linked to project sites, but rather to explicit leadership and capacity building needs in the country.

So far, there is no collaboration with the Makerere University/ ITM Fellowship programme on health systems development.

There is good collaboration with the USAID funded Uganda Capacity project, whereby the project has funded a number of their courses. There is little collaboration with the World Bank supported Health Systems Strengthening project, and little or no collaboration with most other capacity building projects.

6.1.6 Impact

It is appreciated that impact on population health is out of the ICB project scope. Therefore, the impact of this project may be assessed on four areas.

First, individual managerial and organizational skills have been strengthened to varying degree. Regional and district levels seems to have benefitted from limited support, while virtually no support was provided at sub-district level, and very little at the MoH HQ.

Second, the improved qualities of services that supported decision makers/ managers are able to deliver seem to be well appreciated at the peripheral level, with further expectations for the future. However, the central MoH does not seem to have been capacitated in improving its leadership and capacity to drive the sector beyond the traditional operations. Decision-making processes do not seem to have improved.

Lastly, it is too early to assess the impact of the commodity and material inputs, e.g. of the ambulances on case-fatality ratios of emergencies and on an improved referral system. The possible impact that electronics may have on the quality and coverage of training remains to be assessed, but there are positive signs on new developments (e-learning), that need to be carefully discussed before launching. In fact, there are serious implications in terms of technical capacities of the HMDC and peripheral hubs, acceptability and usability by potential beneficiaries, costs and a revenue (provided the HMDC gains autonomy and is enabled to retain fees and reinvest revenues).

It should further be noted that the institutional capacity of the sector to advocate for health inclusion in all other sectors has not been considered.

6.2 Transversal themes

So far, no special attention has been paid to gender issues and children's rights (except for the supply of ambulances, which have the potential to reduce maternal mortality). Yet, gender cuts across sectors, and importantly all the departments of the MoH.

Environmental issues will be taken into consideration when developing the RRH Master plans. It should be noted that the newly built Regional Reference Hospital in Arua, West Nile, has not been opened since its completion two years ago (because the population has made a court case about the drainage of its waste water in the nearby lake).

6.3 HARMO-criteria

Alignment. The project formulation was fully aligned to the health sector strategic plan and the national health policy. Both documents have been updated after the initial formulation. However, the accompanying project logframe was not updated accordingly. Not surprisingly, this management tool is little used, and the project attempts to align its activities to the annual work-plans. However, these annual work-plans are at times only published in the last quarter of the Fiscal Year, thus defeating their usefulness.

The project does for the most part no longer use the national procurement system. The procurement using the Belgian law has drastically increased the project short-term efficiency, but fails to build the capacity of the PDU, thus defeating the project purpose of capacity building. The lack of criteria-based district and RRH funding further weakens the national budgetary and planning capacity.

Harmonisation. The ICB project is embedded in the MoH and harmonized with other donor supported actions. However, it has, like any other project, a separate budget line in the MoH annual Work-Plan. While facilitating attribution and enhancing its visibility, this approach may increase fragmented planning. The project is perceived as a potential ad hoc service provider for any MoH office, rather than an authoritative partner.

Discussions with the World Bank and USAID have led to the geographic concentration of the ICB project in two regions, where limited technical and educational activities from other stakeholders are currently being implemented. The project has virtually taken over former DANIDA regions

The project team seems to have little dialogue with UN agencies, especially WHO, whose technical role may be obscured by the relative plethora of donors delivering substantial financial and technical resources (including, recently, the GFATM and GAVI, after its reactivation). The MTR team was told that donor coordination has weakened over the years. Several donors have been reported having different channels to provide support and TA and still different implementation modalities. One specific objective for the ICB project may well have been the reorganization of the MoH capacity to lead the sector and drive Donors.

Result-based management. So far, there seems to be mainly activity-based management, rather than results-based management. For example, the log frame indicators are not used and no targets have been set for the various output and process indicators. The opportunity offered by the newly established performance agreement of the various levels of governance is equally not yet used to link financing to performance.

Mutual responsibility is not well established, as the project is mainly perceived as a funding agency, and less as a collaborative venture towards the achievement of common objectives and shared, mutual responsibilities.

Ownership. The project enjoys a high visibility, especially since the delivery of the ambulances and at first sight, has a high ownership. Unfortunately, this ownership can by and large be attributed to its funding of ad hoc, more or less pressing, needs. There is little ownership of transformational capacity building and leadership goals. In the project sites, the ownership is negatively affected by the poor communication on the progress of planned interventions, and by the sometimes perceived lack of involvement in funding decisions, which are once again made ad hoc, without objective criteria and a long term vision.

This project clearly shows the inherent weaknesses of project approach, emphasizing the need for sector budget support, once the main fiduciary conditions are met.

7 Organisation and management

7.1 Structure and staffing of the intervention

Governance. The governance structure consists of a project Steering Committee and Central and Regional Project Implementation Committees (C-PIC, R-PIC). Their functions are given in the MTR Terms of Reference (see annex 1).

The Steering Committee provides oversight of the project execution and deals with major policy issues. It did not function adequately during the first year, whereby meetings were delayed and minutes were not signed. It functions well since the appointment of the new senior leadership at the MoH.

The central PIC continues to be rather dysfunctional, with infrequent meetings, sometimes unproductive due to the absenteeism of key players: this is an indicator of interest and commitment that should be carefully assessed, and reasons clarified[37]. The regional PICs aiming at integrating demand from and support to, district and facility management became well established.

Structure. The project is co-managed, with the MoH being responsible for implementation and BTC being co-responsible according to the BTC/MoH guidelines and procedures. This approach seems adequate. The Permanent Secretary MoH is the project Director) and the BTC Resident Representative the project co-Director. The Director of Health Services (Planning and Development) and the BTC Technical Advisor assume the Project Direction as Manager/Coordinator and Co-manager.

The project is ingrained in the existing health sector structures, and collaborates extensively with several policy and professional counterparts, such as MoH Departments and Divisions, District Health Officers and Facility Managers, mainly at hospitals and at HC IV. However this dialogue is limited to the health sector, without expanding its potential capacity as a health advocate with other Ministries or Local Authorities impacting on the health system. This is possibly due to the limited vision of and failure to align with, the sector policy documents that the Ugandan Government has adopted.

Increased focus on key areas that are essential for the MoH to meet its mission is proposed so as to increase the Ministry's capacity to assist Districts and provide guidance and assistance to the sector. The key condition to reorient support and assistance is that the Steering Committee accepts a more focused scope of work for the project and meets the essential staffing requirements, recruiting high level experts or outsourcing such functions to existing recognized competent entities (such as research and/or academic centres). The project may be able to indicate acceptable solutions and provide initial funding to allow for a quick start.

The current procurement procedures are problematic, and may be reoriented towards the original design, now that the relevant department has been revitalized by recent and positive changes in the MoH organization.

Staffing. The TFF foresaw one TA and one project officer. The TA joined the project since its inception. His workload has reportedly increased due the absence of a Health Advisor at the BTC representation (from March 2011 to March 2012). The project officer was recruited in May 2012, together with a project accountant. A procurement officer joined in September 2012 and a junior TA to support the proposed HMDC e-learning programme in August 2012. This project team was intended to promote demand in line with the project logic and to support the implementation of MoH activities in response to this demand. However, the team became increasingly an implementer itself.

[37] The Annual Report 2011 commented that: "From July to December 2010, the project tried to become established within MoH, built the required networks and identified capacity for issues to be addressed. There appears to be increasing differences in interpretation of the objectives between BTC and MoH officers"

This was especially true after the procurement responsibilities were transferred from the Ugandan MoH Procurement and Disposal Unit to the project, based on Belgian laws. The current project staffing situation does not match this new situation which requires a finance and administrative TA to alleviate the duties of the health TA.

It is obvious that reshaping of the project and focusing on key areas that are essential for the MoH to meet its mission impacts on the project national and international staffing profile. More staff may be needed at each crucial angle of the system, while investing massively on the skills and capacities of district teams. A strong alliance (and not a competition) with the academic sector is strongly recommended, by means of execution contracts and viable outsourcing procedures.

Even the HMDC, Mbale, current staff is definitely not sufficient to implement even a fraction of pipelined technical activities that their SIP has identified.

Staffing must be linked realistically to activities by:

- Strengthening the capacity and skills of the existing human capital in the services, to meet new tasks by means of targeted TA and intensive training and stewardship;
- Identifying expertise in the sector, but external to the civil service, who can be recruited to support implementation until vacant positions are filled; and
- Contracting existing professionally qualified entities to execute non-core activities (provided the overall governance and oversight remain with the sector managers at the MoH HQ and regional and district levels)

The project must join forces and share resources with other HDP to conduct such an analysis, given its complexity and the need to rely on indigenous capacities rather than massive recruitment of technical assistance.

When none of the above conditions can be met, the project will have two possible solutions: either to drop related activities, or to refocus on the root causes of impediment, down-sizing expectations and investing differently (and certainly not on equipment and commodities that unavailable human resources will not be able to maintain and use appropriately).

7.2 Resource management

The project budget execution is given in the Table below.

Table 8: Financial execution in Thousands Euros against the annual planning as per Q1, 2013

Funds modality	2.010	2.011	2.012	2.013	Total
«Régie»* Finance Planning	534	19.433	1.746	104.226	125.939
«Régie» Actual expenditure	3.548	11.878	146.522	11.173	173.121
«Régie» Execution %	**66%**	**61%**	**84%**		**137%**
Co-Management** Finance Planning	58	174	591	610	1.433
Co- Management Actual expenditure	12	70	207	90	379
Co- Management Execution %	**21%**	**40%**	**35%**		**26%**
Total Project Finance Planning	111	369	2.337	1.652	4.468
Total Project Actual expenditure	47	189	1.672	202	2.110
Total Execution %	**43%**	**51%**	**72%**		**47%**

*"Régie" refers to procurement under Belgian law
**Co-management refers to procurement under Ugandan law

As it can be seen from Table 8, only € 2,110,000 had been spent by end February 2013: this is 26.9% out of the total project budget of €7,850,000. Half of the expenditures (€1,056,000) was for the procurement of vehicles and ambulances, excluding the costs of service contract, insurance, and their staff training. It is projected that expenditure will be €2,700,000 (34%) by the close of the financial year (June 2013). The low execution of the budget has been attributed to:

- Procurement delays, under Ugandan and to a lesser extent under Belgian law;
- Delays in recruitment of a Project Officer and Project Accountant;
- MoH ownership of implementation (the ICB project is not an implementing partner) whereby activities are covered by a workplan that is implemented following MoH procedures. For example, in 2011 delays in budget approval caused underfunding and delay of many activities during the first quarter (July – September). By the end of December, the MOH had not yet consolidated its workplan for the FY 2011/2012;
- A requirement of advance management and accountability by GoU financial procedures before funds are advanced;
- Ministry versus project priorities, availability of MOH officers, and complicated procedures affect the execution rate of project activities within the specified time.

The balance of project funds could be easily absorbed if the project would grant funds to districts through execution agreements as the simplified simulation below show.

The following assumptions are used in the simulation:

- Funds are allocated in proportion to the population (in reality, needs and performance should equally be taken into account);
- The past duration of the project is estimated from April 2011, after the Technical Review mission, and not since its inception;
- The project implementation period is extended for 1 year until end 2015, this is 2.5 years;
- The MoH HQ and General Means expenditures continue at their current rate, thus not yet taking into account the proposal to recruit additional Technical Assistance; and,
- HMDC expenditures are included in the regional expenditures.

At the MoH HQ, €372,935 was consumed out of a budget of €928,711. If we assume that activities only took off from April 2011 (after the Technical Review mission), this means approximately €160,000 per year, or approximately €400,000 for the remaining 2.5 years.

The General Means consisting mainly of project personnel costs had a budget of €1,018,000 and €365,00 has been used, so that €911,00 will be needed for the remaining 2.5 years.

This gives a total balance of € 3,839,000 for both regions, calculated as follows:

Table 9: Simulated estimation of project budget balance available for both regions and HMDC

Item	Budget/Expenditure	Balance
Total Project Budget:	**7,850,000**	
Expected expenditure by end FY 2012/2013	-2,700,000	
Balance by end FY 2012/2013		5,150,000
Expected expenditure for MoH until December 2014	-400,000	
Expected expenditure for General Means until December 2014	-911,000	
Balance to be used for both regions and HMDC		**3,839,000**

If this balance is allocated proportionally to the population of both regions, and assuming that IST/CPD is included in the district operations, this would mean that 55% of the total balance of €3,839,00 is allocated for West Nile (€2,094,000) and 45% for Rwenzori (1,745,000). As the table below shows, this would mean less than €1 per capita during 2.5 years and on average only €102,000 per district per year. These amounts would be less if an additional TA is recruited. These grants compare favourably to the current district disbursements.

Districts can clearly absorb more than this amount, and additional SIDA funds, as suggested to the reviewers might be welcome under those circumstances.

Table 10: Simulated estimation of yearly project district grant amount

	West Nile	Rwenzori
Population	3,000,000	2,500,000
# Districts	8	7
# Counties	77	68
Budget allocated proportional to the population	2,094,000	1,745,000
Budget per District for 2.5 years	€261,750	€249,286
Budget per District per year	€104,700	€99,714

7.3 Planning and implementation

7.3.1 Planning

The planning of the project was meant to be demand-driven, so as to promote its alignment to the policies and priorities of the MoH and the decentralized levels.

The preliminary capacity building needs assessment as foreseen in the TFF was not undertaken on the premise that it had been done severally in the past. A somewhat inadequate preparatory and inception phase has put the project in a difficult initial situation, where lack of clarity seemed to dominate. Major changes in the MoH organization and - possibly - diverse counterpart expectations worsened this situation. The risks outlined in the TFF were not considered at the inception and subsequently addressed. This led to divergences between the TA and the MoH governance, and to a very limited support at the subnational levels. The Technical Review Mission helped to reshape the project and to make it more understandable and acceptable. However the project failed to update the logframe and to devise new activities and indicators logically leading to meeting general and specific objectives. Activities were planned and implemented with no real strategic perspective. They merely responded to occasional demand and needs expressed by different counterparts, and were not always linked to each other in a functional or logical manner. .

The project did well in procuring commodities; these are needed and will be used at the appropriate level of the system. The project did less well in orienting and stimulating the demand for those services and commodities that are required to achieve the project's main purpose: strengthening planning, leadership and management capacities. Capacity building of the MoH requires strong Government commitment to harmonize its organizational set-up to its current needs, and to align its four key constituencies, Finance, Health, Local Government and Civil Service. It is probably at this level that the project may have found a scope. The limited horizon and narrow views under which the project operated, explain the missed opportunities and the project limited influence in promoting intersectoral advocacy to achieve the normative changes needed by the sector, both at the central, and (even more) at the subnational level as well as by the HMDC. This needs strengthening of the on-going Sector Wide Approach (SWAp) and a high level policy dialogue to which the project may contribute.

As discussed in section 4.3, the support provided to the HMDC is a clear example of how the project is directed to support residual issues, rather than being a crucial and preferred partner in devising plans and developing strategies in close collaboration with the interlocutors and decision makers[38]

The project did well in providing training and mentorship to improve planning capacities at the district level. The draft district plans accessed by the MTR team are appropriate and of reasonable quality. District teams have expressed their frustration with the national level aggregation of their plans and the late disbursement of funds due to chronic delays in the adoption of the National (costed) Plan.

The current training opportunities offered by and through the HMDC are possibly the best feasible, given the context, and the vision to scale up training by electronic distance education means, is sound. However, a detailed and revised feasibility plan is needed to improve otherwise unrealistic expectations.

The sub-district level is, instead, generally poor, with some exceptions where other partners are also acting (such as in good performing areas of Rwenzori region, compared to a few neglected areas of West Nile). The Project was clear in opting to provide support to the districts, and this is possibly the only viable alternative. At this stage, the Project may try to invest additional resources to meet urgent needs of the sub-district levels, if and when the current discussion on possible reforms of those levels is concluded, Additionally, the Project may try to become an active member of that discussion, generating the field based and theoretical evidence needed to influence decision-making on the subject.

7.3.2 Implementation

Implementation of activities took place with major delays at the inception. Expenses were then oriented to the procurement of goods and commodities, rather than on building staff capacities and improving their skills.

On the latter aspect, several budgeted activities appear questionable, although they were cleared by the project governance, such as the participation of secretaries to international training courses, or attendance to international conferences by MoH staff. Whereas the tactical justification for these initiatives is understandable, the actual impact on the Project objectives is clearly negligible. Additionally, several educational or networking events, such as workshops and seminars that were conducted in resorts and hotels could have taken place in the HMDC premises, using the existing capacity of the centre, thus contributing to build its credibility and save substantial financial resources.

[38] (the drafted SIP is not realistic within the current situation and no alternative options have been formulated, it needs Cabinet papers that the MoH seem to be very reluctant to promote and the HMDC status is not addressed by any policy documents accessed by the MTR team).

When estimating the (major) proportion of financial resources devoted to commodities vis-à-vis (the limited) expenses in the “soft” areas of training, stewardship and mentoring, several questions are inevitable on how the Project tried to gain its position in the sector and what was the scale of priority adopted when financing and implementing some actions rather than others. At the same time, in fact, several crucial angles of the system are suffering from lack of resources, constrained support and very limited skills and expertise, such as the MoH sections already identified, and the regional and district activities aiming at building staff capacities. Also basic logistic resources are needed (and are addressed by the project, but support is still pending), fostering districts’ creativity and alternative courses of action. Dedicated grants may be needed to ensure implementation, besides the current public budget, as well as a critical assistance in advocating for health sector support within the Local Government structures. This may become one key area of concentration for the Project, otherwise doomed to provide goods, rather than support to leadership, based on innovation and strategic capacity.

7.4 Monitoring, evaluation, documentation and reporting

The project reports adequately and timely, according to the BTC reporting requirements. Quarterly reports consist of a spread sheet indicating the implementation status of activities against the work-plan and include a rolling, adjusted quarterly operational and financial planning. The 'annual reporting' format seems to change over time. The formats provide a quick overview of what was done and the resources used, and allow for rescheduling of activities according to need or capacity to implement. They provide a self-assessment of relevance, efficiency, effectiveness, potential impact and sustainability and challenges. The format does however not show progress on the achievement of indicator targets.

Several repetitions in reports are also seen, but are deemed inevitable, as many activities are carried over to the next quarter when they are not completed (and very few have been completed to date).

Possible areas of improvement include reporting on progress on targets, risk analysis, and strategies conceived to meet and prevent those risks. Alternative courses of action are almost never explored. The project can seemingly not orient demands or interpret MoH requests with a focus on the expected end-results and propose alternative strategic options for discussion at the Steering Committee level, where “business as usual” seems to be the dominating approach.

7.5 Technologies

The Project procured and deployed technologies, which are aligned with the current MoH and local authorities’ absorption capacity. Based on the TFF provisions that specifically exclude ‘large investments’, health centre IVs in both regions were supported with small-scale investments in infrastructure upgrading and rehabilitation. The referral system was supported with the provision of ambulances at HC IV and General Hospital level in both regions.

Vehicles were also procured to allow for proper and reliable supervision. However, running costs (for fuel and maintenance) were only partially met, limited support was provided by the project, and local authorities were not required to make commitments on their use and maintenance as a precondition to delivery. As a result, CAOs may accept or reject the DHOs’ request for fuel support, even if this relates to emergency ambulance operations.

Equipment provided consists basically of electronics, such as laptops, desk computers and accessories, office furniture, vehicles. The project is rightly supporting the national emergency policy drafting which will set the guidelines for ambulance use and deployment, thus consistently framing the medical evacuation procedures.

The MTR team feels that the support provided is justified, but may not fit fully in the project mission and scope of work. Alternative courses of action could have been followed rather than providing vehicles, a traditional and very acceptable way to increase the volume of assistance and commit financial resources, requiring perhaps a different perspective in terms of suitability and sustainability (e.g., through leasing contracts with charities and local vehicle managers, as done in other similar contexts).

Small maintenance works observed at the HMDC and in the MoH HQ are in line with the project philosophy and were especially needed to improve the HMDC physical infrastructure. The physical works could have been directed to, e.g., upgrading dormitories and latrines, still very far from standards required to host major events, though usable by current resident students. This discrepancy is possibly due to the lack of a wider perspective on the opportunities and vision for the HMDC, unfortunately not recognized as the prime host for trainings, workshops and seminars promoted by the project, as already described elsewhere in this report.

Additional technologies are expected to be procured and installed to support the capacity for surgery and invasive procedures at the local level in the two focus regions. Although this may not be very relevant to the main project mission, the lack of alternative support in a key area for the system credibility may justify the investment. Related training will also be appropriately provided to improve staff skills.

Future plans to support the HMDC e-learning project may require a very detailed feasibility study that looks in a very comprehensive way at technologies and ICT equipment needed at the HMDC and at the two regional hubs identified by the HMDC with the project support. Long term hosting of digitalized learning materials, the staff capacity to generate and deliver original materials and to adapt existing documents and courses already available from the web[39], the improvement and reliability of connectivity and band width are just a few issues that HMDC and the Project may like to consider before embarking in such a programme. The MTR team was told that acceptability of e-learning was estimated high in a preliminary survey. However, experiences from other contexts suggests that compliance and completion rate of recruited learners may be very low if the educational strategy does not suit potential learners' community requirements and is not customized accordingly. In particular, it appears that the Project did not appreciate the implications for, e.g., synchronous[40] and asynchronous modalities and for recruitment and training of remote tutors, possibly based in established and experienced e-learning centres that can be twinned to support the HMDC capacity. In this respect, the original Expected Result 7 may be implemented to provide assistance and science-based practical experience to the HMDC and its satellite hubs. ICT requisites seem adequate and connectivity is estimated fair from the central to level IV facilities.

One particular issue on technologies is related to the actual disposal of dismissed equipment and vehicles. This is a constant and serious "orphan" constraint that causes the accumulation of non-functioning wrecks in compounds and service rooms. The project may support the design of a simple and legally acceptable procedure by which adequate disposal is considered and operated. The importance and potentially negative environmental impact of non- usable medical and non-medical equipment and vehicles must not be underestimated, especially considering the public access to hospitals and health facilities premises.

[39] A non exhaustive list of resources readily available and freely downloadable can be found at: http://www.pitt.edu/~super1/, or at: http://www.classesusa.com/schools/30661-page1.cusa, or at: http://www.openculture.com/freeonlinecourses, to make a few examples (accessed May 2013)

[40] See, e.g.: http://net.educause.edu/ir/library/pdf/EQM0848.pdf (accessed May 2013)

7.6 Networking and synergies with other projects

The on-demand modality is appropriate and the MTR team did not observe overlapping or duplication of efforts and support. At the project onset, subnational areas and activities were selected with criteria including the mapped presence of other programmes and HDPs. Implementation modalities and alignment to the national policies and standards prevented discrepancies and allowed for a relevant and consistent support by the project.

The current coordination mechanisms operated by the MoH seem to be rather weak and may need specific project support to allow for added collaborative value, which is still not visible. HDPs' experiences on, e.g. distance education supported by USAID[41], on TA on leadership and planning provided by the World Bank, and on governance by WHO do not seem to be fully appreciated.

Over the years, SWAp has weakened[42],[43],[44]. HDPs have made their best not to overlap or duplicate efforts, but do not really act in a collaborative and synergistic network, capable to promote the exchange and wider dissemination of technical and operational skills. The expected cross-fertilization of field experiences does not seem to take place at the subnational level, where a silos mode of operation seems to prevail.

One reported major problem is the suspension of the health sector budget support modality that constrains synergies, as required strengthening of coordination mechanisms do not seem to have been revitalized and enforced by the MoH. The project may like to consider investing in the leadership role that the MoH should keep in this area, and devise a strategy and solid procedure allowing, e.g., for pooling at least the support to provide TA and equipment/ commodities by different Partners.

The MTR team recommends strongly that the capacity of national academic institutions to promote CPD activities contracted by the MoH is fully explored, and that execution contracts to those entities is considered as an alternative to in-house delivery of (possibly poorer quality) events.

At the same time, collaboration between the sectors appears insufficient and needs to be targeted appropriately, as foreseen by the national policies and strategies, but very poorly operated in practice. The project may generate guidelines and good practice examples, thereby stimulating demand by the MoH or by higher authorities.

Health literacy campaigns to advocate for the health sector with the MoFPED, Local Governments, and Education should be established and operated systematically to raise attention and to champion for investments in the sector.

CAOs and other key stakeholders should be definitely educated to understand the principles and justifications for investment and support.

At the same time, the private sector, both not for profit and for profit should be included in the strategic design to improve the quality and capacity of the health system. There are hardly any actions to recruit the business sector, possibly due to obsolete ideological attitudes (sic).

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[41] See: End-of-Project Evaluation of the Capacity Project, Prepared for USAID/Uganda, March 2010; and DISH website (http://www.ugandadish.org/) with, e.g., a designed strategy accessible at: http://www.ugandadish.org/resources/DistanceLearning.shtml

[42] The Uganda Health SWAp: New approaches for a more balanced aid architecture? London, Örtendahl, C. (2007), HLSP Institute

[43] Global Health Initiatives and aid effectiveness: insights from a Ugandan case study, Valeria Oliveira Cruz and Barbara McPake, Globalization and health 2011,7:20

[44] Why politics matter: Aid effectiveness and domestic accountability in the health sector - A comparative study of Uganda and Zambia; International Institute for Democracy and Electoral Assistance (International IDEA), Leni Wildand Pilar Domingo, 2012

This is a clear missed opportunity that the project may like to address, given the potential support that private for profit entities can pay if a proper partnership platform is designed and if health regulation is further strengthened, in collaboration with health professionals and patient/consumer organizations. The MoH leadership and capacity in this specific area seems to be simply non-existing. Collaborative work with the World Bank may help identifying good practices that can be adapted to the Ugandan context.

8 Conclusions and recommendations

8.1 Main findings

This conclusion attempts to answer the main review questions highlighted in the MTR Terms of Reference.

8.1.1 Main evaluation criteria

Strengthening and building of institutional capacities and leadership is very **relevant**. It meets a genuine need and corresponds to the stewardship objective of the HSSIP.

The project **efficiency** is low, though improving. The project had a painfully slow start. The first year was literally lost, due to internal MoH problems, until the entire MoH top management was replaced. The technical review mission held in April 2011 provided a much needed reorientation in implementation modalities, especially with the creation of a central and two regional implementation committees which meet monthly, the appointment of a new project coordinator at the rank of Director (Health Planning and Development), and the geographic expansion to two full regions, where service delivery is supposedly integrated.

The project **effectiveness** is equally low, as few outputs have been achieved to date.

The potential **impact** remains equally very low, as no transformational change is to be expected from a project, which has so far mainly concentrated on supply of services and goods and provided training, without affecting the wider socio-political environment and the effectiveness of organizational arrangements.

The potential **sustainability** is relatively good in economic and financial terms, but poor in technical and institutional terms, as an ad hoc approach has been used so far.

8.1.2 Project logframe

The TFF logframe was appropriate, but has unfortunately not been updated in the course of the project, in response to the Second National Health Policy, the new HSSIP, and the addendum to the agreement when SIDA became a delegated partner. The logframe is in actual fact no longer used. A new logframe is therefore needed, aiming especially at regrouping of result areas, and generating consistent indicators. The logframe as discussed in this evaluation report could be used to this effect, with possibly a splitting of the regional level result into two, one for Rwenzori region and a second for West-Nile region. Thus, the results could be formulated as follows:

- Result 1: The MoH Department of Health Planning is strengthened so that it can better plan health services in liaison with the other directorates and departments.
- Result 2: Strengthened organizational and institutional capacity for health service delivery at regional level;
- Result 3: Strengthened Health Manpower Development Centre (HMDC);

  Or alternatively:

  Result 3: Strengthened capacity to meet the IST/CPD needs in the health sector;
- Result 4: a scientific support team accompanies the capacity building process in the Ugandan health sector.

Result 1 focused insufficiently on a few areas, to be determined in consultation with the MoH and HDP, for example at Joint Review Meetings. Clear areas of needs include:

- MoH Planning Division, where staff shortage and limited skills impact heavily on the timing and quality of, e.g., the National Plan formulation and adoption. The current lengthy process to adopt the Plan impacts on the quarterly budget transfers to districts, which often lose the final disbursement in the fourth quarter due to the closure of financial year when expenditure reporting is still incomplete;
- MoH Resource Centre, which is also targeted by other Development Partners, but whose analytical capacity and skills in providing the necessary evidence in support of policy decision making and in support of the planning cycle seem quite constrained;
- The foreseen Policy Analysis Unit[45] whose role in diagnosing sectoral challenges and devising innovative solutions could be specifically supported by the Project, establishing it as a hub for decision-making and concerted dialogue with MoFPED and MoLG; or
- MoH Procurement Division;

This focus on one or two areas does not exclude the need to network with most if not all Departments of the MoH and other stakeholders.

Result 2 relate to the sub-national level where little attention has been paid on key entities. Comprehensive Regional, District and possibly sub-district (master) plans aligned to the HSSIP, including the joint support of all stakeholders operating in the area have not been developed.

The service delivery managers in the districts and regional hospitals regret the lack of creativity of their counterparts and the lack of MoH protection when piloting innovative and locally relevant solutions to current management problems. Their frustration in proposing different courses of action are reportedly never captured by the project. A shift in focus towards meeting requests coming from the service delivery front-line may help the project to become more responsive, impacting better on concrete challenges, while promoting innovations that can be eventually transferred to other areas and elaborated by the MOH to become part of the national policy dialogue.

District performance varies widely, and peer exchanges have been little or not applied.

Result 3 is currently seen in terms of strengthening the HMDC, created in 1982. It has since its onset been donor driven and has never been sustainable once the donor withdrew. It has no legal statute, its land tenure is uncertain, lacks vision, and is insufficiently staffed both in skills and number. The MoH has not really assessed in-service training or continuing professional development needs and modes of delivery. Continuing Professional Development is mostly project driven, as is the case with the ICB project, and does not promote institutional strengthening. A Strategic Investment Plan for HMDC has been drafted, even though no national IST/CPD strategy exists, thus potentially pre-empting viable alternative options, e.g. subcontracting the IST/CPD to existing public, PNPF or private for profit institutions or academia, or restricting HMDC to a regulatory role. HMDC has embarked on e-learning without fully realizing its implications, and approaching e-learning from the technological point of view rather than its course content.

The alternative formulation for Result 4 leaves the option to continue to invest in HMDC only, or rather to broaden the matter to an improved overall training strategy. This second scenario might even allow overhauling completely the role of HMDC to become a training steward, rather than a mere training institute, leaving the option to subcontract the actual training to third parties. It should also be clarified whether the IST/CPD should relate only to capacity building and leadership or to all fields.

Result 4, scientific support has not been accessed yet, even though it is internationally recognized that a minimum proportion of any health budget has to be spent on health research and evidence

[45] Reference is made to the MoH Organogram adopted by the HSSIP, 2010/11 – 2014/15

building. The opportunity to collaborate with the Makerere/ ITM fellowship programme on health system strengthening has equally not been taken.

It is probably best to look in the first instance to a national scientific institute, supported in a second instance by an international institution.

Indicators are not used and no targets have been established. There are a multitude of indicators at specific objective level, which makes their overall interpretation difficult. It is proposed to take only a few composite indicators at specific objective level. These could be the progress in the ranking of the District League Table, which could be expanded to regional Table on the one hand, and Facility or Sub-district Table on the other hand. These latter would be more useful at results level. A second specific objective indicator could relate to the overall, national average improvement of the marks on League Table, and/or on the planning capability of the MoH. The indicators at results level and the main intervention areas should be decided in a participatory manner.

8.1.3 Ownership

There are mixed ownership signals. The project continues to suffer from a lack of common understanding of what capacity building entails, as the capacity building and leadership interventions are insufficiently backed up by a strong theoretical underpinning.

At MoH HQ level, the project attempts to adhere to the MoH annual planning, which is testing as these plans are only available by the third or even last quarter half of the Fiscal Year. This planning is budget-driven rather than set by objectives and results. Moreover, the individual budget plans are not integrated into the departmental plans, leading to a fragmented approach. The project has not supported a MoH capacity building, leadership and organizational development needs assessment on the premise that past attempts by the MoH and the MoPS had failed. The capacity building is so-called demand-driven, which might well turn out to equate to a lack of long-term vision. So far, the project has no clear idea and no strategies on how to create and formulate relevant demand, which is a major weakness. This has resulted in scattered, mostly ad hoc interventions. The current approach to intervene in most if not all departments of the MoH does not help either.

The delivery of ambulances, transport, equipment and services, and the on-going training have created a momentum of goodwill for the project, and the proposed regional level (see below) form a window of opportunity to initiate in-depth organizational changes, which can only happen by using and strengthening to the extent possible the current system, rather than bypassing it.

8.1.4 Decentralized implementation

The decentralized implementation of the support to the RRH, the districts and health sub-districts for the two regions remains inadequate, even though it greatly improved with the establishment of the Regional Implementation Committees. The health institutions, especially at district and sub-district level are grossly underfunded as only 7% of the government funds reach those levels. Any additional funding to these levels is thus most welcome. However, funding is disbursed from the MoH HQ without objective criteria. This weakens, rather than strengthens the current district and RRH grant system, and compromises its sustainability, thus weakening their capacity to plan and manage their own strategy. Managers are not incentivized, as the system is perceived as arbitrary instead of being objectively verifiable needs-based or performance-based.

The local district strengths are insufficiently tapped. Thus, though the district performance is often poor, there is a great variation, with some encouraging examples.

For example, Kabarole district where Fort Portal is located in Rwenzori ranked third in the national District League Table in FY 201/2011, and first in FY 2011/2012. Thus, 90% of its deliveries are

institutional based against a national average of 57%. This contrasts with Ntoroko, located in the same region, which ranks 103 out of 112 districts, showing that peer exchange could become a powerful capacity building tool. Another cross-fertilization tool could be a closer collaboration between the public, PNPF and private sectors. Some examples may illustrate the importance: the Uganda Catholic Medical Bureau has the only health facility accreditation system in Uganda; in FY 2009/2010, 23% of Total Health Expenditure was spent with public sector providers, against 48% and 28% with private and PNFP sector providers.

The rapid increase in number of districts has rendered their supervision from the MoH HQ next to impossible. Districts are often only superficially supervised once or twice a year, where this should happen on a quarterly basis. The Regional Performance Monitoring Teams, which will shortly be established by the Global Fund Round 10 health system strengthening project, presents an opportunity for the project to pilot jointly the expansion of these Teams to regional coordination, support, supervision, and monitoring and evaluation centres. This regional approach, which has been advocated at all levels, could significantly enhance the decentralized performance.

8.1.5 Implementation modalities

The current project implementation modalities make it difficult or impossible to access project funds at lower level, whilst the capacity at MoH HQ for the wide roll-out of training to all facilities is limited or non-existent, and does not strengthen institutional managerial and leadership capacity building as alluded to above. The Technical Assistant spends up to 80% of his time on administrative duties, leaving hardly any time for creative and innovative planning and technical advice.

The project becomes more and more an implementation unit aiming at short-term results, focusing on budget execution, and using traditional project approach at the expenses of long-term institutional capacity building and strengthening processes and organizational development and change. There is however no easy solution, as the virtual procurement paralysis has illustrated. Procurement under Belgian law has therefore rightly been extended. The need to continue to strengthen the national procurement system, and possibly to revert to its use should however be kept in mind.

This project shows that there are no easy solutions to capacity building. Sector budget support has been temporarily suspended because of corruption problems. At the same time, the project mode with its gradually increasing separate implementation modalities for the sake of short-term efficiency may be counter-productive for capacity building.

It remains however possible and necessary to work with a logical framework, as long as the results are formulated in sufficiently broad terms and comply with the HSSIP strategic results, and that the indicators are grafted on the national indicators. In those circumstances, the logframe becomes an aid to results based cooperation.

Besides the above specific issues highlighted in the MTR terms of reference, the HMDC and scientific support merit a special mention.

8.2 Recommendations

8.2.1 Institutional issues

1) **MoH and Project**: Review and update the institutional assessments of the MoH conducted so far taking into account the prevailing budgetary and civil service constraints
2) **MoH**: Reorient the Resource Centre and the Quality Assurance Department to strengthen their support to the periphery
3) **MoH**: reformat the MoH HQ annual work plan incorporating the project interventions into the departmental activties, while assigning a column for the funder, either a specific project or the Government. This will avoid a fragmentation of interventions.
4) **Project**: Support the development of a gender-based budgeting and the development of a strong MoH gender desk **Project**: At the MoH HQ, reorient the Resource Centre and the Quality Assurance Department to provide needed support to the periphery, taking advantage of the installed ICT infrastructure in the RRH and districts
5) **Belgian Embassy**: Resume budget support for the health sector if the Joint Assessment Framework has been satisfied in order to increase the health sector budget and enhance policy dialogue
6) **Cabinet**: Grant a (semi-) autonomous status to the HMDC while the MoH remains its regulator and main client. This is vital for the sustainability of the Centre and should enable HMDC to issue certificates, raise and retain revenues through fees and other means, and invest in its infrastructure and technical capacity.
7) **Local Government**: Grant HMDC land title deeds;

8.2.1 Project scope

8) **Project**: Prioritize capacity building and leadership interventions at the MoH HQ, investing in one or at the most two Divisions with the greatest potential impact on service delivery. The most likely candidate is the Department of Planning
9) **Project**: Focus on building capacity and leadership skills at the peripheral level and emphasize building dialogue between the various tiers of the healthcare system, including the health sub-district level. Ensure that at least 70% of the budget is used for the periphery
10) **Project**: Ensure the local leadership buy-in by:
    a. Supporting regional coordination and governance mechanisms. Regional Health Assemblies along the lines of the National Health Assembly could be piloted to this effect;
    b. Supporting technically the District Stakeholders Meetings;
    c. Building the capacity of hospital management boards and Health Unit Management Committees (HUMC), e.g. through exchange visits, training where needed and strengthening community demands; and
    d. Building the capacity of the extended district health management teams, and the district social services committee members through similar means as above.
11) **Project**: Establish a dialogue between the MoH and the BTC representation to identify opportunities for innovative PPP schemes, e.g. outsourcing non-core services as promoted in the National Health Policy.

12) **MoH and Project**: promote exchange and peer learning between districts through study visits and other innovative approaches

13) **Project, MoH**: Encourage and support the piloting of local scale innovative initiatives of the service managers, for example regional league table, facility league table, community monitoring of health worker attendance, etc.

8.2.2 Project planning

14) **Project**: Redesign the ICB project and formulate an updated project logframe by end Q3 2013. This logframe should follow the HSSIP 2010/11-2014/15 principles and objectives, limit the number of priority areas, and be based on the action plans of the beneficiary district, the RRH, and the identified MoH HQ support areas. The proposal given in the main findings of the conclusion (see below) could be used as a guide

15) **MoH, BTC and Project**: Pilot in collaboration with the forthcoming Global Fund supported "Regional Performance Monitoring Teams" a regional level structure to ease coordination in line with key innovations proposed in the HSSIP, the MoH Quality Improvement Framework (QIF) and Strategy, 2011, and the regional ambulance network setup by the project:

    a. Use the Community Health Departments (CHDs) at the Regional Referral Hospitals as a deconcentrated office for the MoH HQ; The CHDs implement regional activities such as EPI supported by WHO and are therefore seen to have a regional mandate. The CHD could be strengthened including with additional manpower to develop a regional support and coordination plan.

    b. Expand the Regional Implementation Committee to include the major health stakeholders from the public and private sector;

    c. Consider appointing a high level administrative and financing officer or team coordinator in both regions, who could eventually be taken over by the MPS as the Global Fund is planning to do

16) **Project**: Assist the beneficiary districts to develop a medium term strategic plan and a costed rolling work plan integrating all inputs from the Government, HDP, and PNPF for FY 2013/2014 based on the budget foreseen in the Non-Wage Conditional PHC Grant plus additional ICB project funding. This systems approach would thus replace the current ad-hoc project funding

17) **Project**: Assist the beneficiary Regional Referral Hospitals to:

    a. finalize their medium term Investment Plan and hospital master plan by end of 2013; and

    b. develop a recurrent hospital expenditure work plan for FY 2013/2014 based on the budget of the RRH allocation formula plus ICB funding based on the same formula.

18) **MoH**; Develop a national IST/CPD training strategy based on a thorough situation analysis of training needs and potential providers from the public, PNPF, NGO or private sector, whether academia or others.

19) **MoH:** Outline the role of HMDC, either as a training institute and/or as a provider of IST/CPD consultancy services to the MoH and other stakeholders/clients

20) **MoH:** review the HMDC Strategic Investment Plan in view of the above two recommendations, and submits a final draft to the Cabinet for approval and implementation;

21) **Cabinet**: Approve or amend the HMDC Strategic Investment Plan (SIP) taking into account the need to progress in realistic, implementable steps and to invest in innovation and knowledge, so that HMDC becomes a reputable institution able to attract innovative or project financing from the Health Development Partners (HDP), other donors and the private sector.

22) **MoH and Project**: generate evidence by supporting health managers to conduct operational and scientific research in collaboration with national and international academic institutions;

8.2.3 Implementation and monitoring modalities

23) **MoH and BTC**: Extend the project implementation period until June 2015, subject to the Logframe revision and the approval of the MTR recommendations

24) **MoH and BTC**: Recruit an administrative and financial TA. He/she should:

   a. Assist with the implementation of project financial and administrative duties thus relieving the current TA, enabling him to fulfil his public health duties;

   b. provide, in conjunction with the foreseen Public Finance Management Advisor of the BTC Representation, policy/expert advice on procurement, supply chain management at the MoH HQ;

   c. provide, in conjunction with the foreseen Public Finance Management Advisor of the BTC Representation, policy/expert advice at the interface between the MoH and the MoLG at regional and district level;

   d. Develop a roadmap towards resuming procurement according to the Ugandan law instead of the current “régie” system.

25) **BTC HQ**: Consider adapting the annual reporting format to include a reporting on the achievements of the indicator targets

26) **Project:** Assist HMDC to develop an advocacy plan once it becomes sufficiently clear that the above recommendations will be implemented. Advocacy may include the need to concentrate most MoH events at the HMDC once the guestroom and other residential facilities have been properly refurbished, taking into account transport and per diem costs.

27) **Project**: Strengthen the communication line and feedback between the project and the beneficiary entities at the periphery, e.g. by publishing project documentation on the MoH/BTC website and establishing a regional electronic discussion forum; and

28) **MoH** and **HMDC:** Proceed in a careful, phased manner with the planned establishment of an e-learning system by:

   a. revitalizing and strengthening the current HMDC Distance Education Unit, possibly with the virtualization of learning materials

   b. commissioning a detailed economic and operational feasibility study;

   c. developing a national sound, costed strategic plan;

   d. initiating small scale pilot activities while building the system, based on existing best practices.

29) **Project:** If, and only if the above HMDC sustainability pre-conditions have been met, accompany and coach HMDC in its endeavour to establish an e-learning centre by sponsoring needed studies, providing documentation, and networking with existing CPD programmes and systems, and supporting twinning mechanisms with qualified entities who manage e-learning.

30) **MoH and Project**: collaborate with the MakSPH/ITM Fellowship Programme in health systems management.

8.2.4 Project funding

31) **Project, BTC, LG and RRH**: Decentralize the ICB project funding mechanism through:

    a. Execution agreements with the beneficiary local governments based on their action plan. The LG will then be expected to make sub-grant agreements with the various institutions according to their annual work plans ; and

    b. Execution agreements with the Regional Referral Hospitals based on their annual work plans.

    These execution agreements should be in the form of activity and performance based Memoranda of Understanding

32) **MoH, LG and Project**: Link the project funding to the Performance Agreement between the DHO and the CAO, and the forthcoming (from FY 2013/2014 onwards) hospital, HC IV managers and corresponding LC Chairs

33) **RRH**: Fund the RRH Community Health Departments as per the guidelines 2003

34) **BTC and MoH**: Operationalize a bonding scheme for the BTC scholarship programme to areas of high need within and outside the assisted regions. It is not recommended that this bonding be linked to project sites, but rather to a particular leadership and capacity building needs in the country.

9 Annexes

9.1 Annex 1: Terms of reference

Introduction

The Institutional capacity building in planning, leadership and management in the Ugandan health sector (HPLM) started in June 2010 in Uganda. In accordance with the Technical and Financial File (TFF) of the project, an external Mid Term Review (MTR) is planned half way of project implementation. The MTR is a global external assessment of the project progress and performance.

The conclusions and the recommendations of the MTR will support the Steering Committee (SC) to take the appropriate decisions regarding future implementation. It will also allow BTC to assess whether any additional support and monitoring is needed till the end of the project.

Intervention background

Agreements

The project is part of the 2009-2012 Indicative Cooperation Programme (ICP), signed between Belgium and Uganda.

The project Specific Agreement was signed on 11th December 2009 by Uganda and Belgium for a 5 year period and a total amount of €6 500 000. The project is implemented by the Ministry of Health of Uganda and the Belgian Development Agency (BTC) (UGA 09 017 11).

In July 2011, the Swedish International Development Cooperation Agency (SIDA) signed a Delegation Agreement with BTC, where SIDA agrees to co-finance the project for an amount of €1.350.000 and delegates the implementation to BTC (UGA10 023 1T).

The project's total budget is **€7.850.000.**

Following on an exchange of letters between the Belgian and Uganda governments, it was agreed on the 6th of February 2012 to extend the duration of **the Specific Agreement** from 5 to 6 Years **(December 2009 - December 2015).**

The project implementation started on the 16th June 2010 and a technical review of the project took place in April 2011. The Steering Committee (October 2011), approved the extension of the project period, but maintained the original project implementation period (48 months) (June 2010 – June 2014), which should be reviewed during the MTR.

Context

During the period of the Ugandan **Health Sector Strategic Plan II** (HSSPII 2005-2010), the health sector performance indicators deteriorated consistently. Several review studies and evaluations pointed out the weak leadership and management (L&M) in the sector as the main bottlenecks for performance improvement. It was concluded that addressing the L&M capacity gap was a prerequisite for increasing the financial support to the health sector (SBS). This led to the formulation of this Institutional Capacity Building project within the Belgian – Ugandan Cooperation in 2009. Several other health development partners simultaneous included attention to L&M strengthening is their support to the sector (e.g. USAID and the World Bank supported Uganda Health Systems Strengthening Programme).

At the beginning, the project faced difficulties with the involvement of the MOH as leadership positions at MOH HQ were vacant.

During the first year of the project (July 2010-June 2011), 'institutional change' took place within the Ministry of Health. A new Permanent Secretary, as well as a new Planning Director, were appointed and gradually the new leadership started to have an impact. After the 2011 elections, a new (technical) Minister of Health and a new Director General were appointed, completing the full top-management for the sector. The project was involved in this change process and - despite very limited expenditures made during this period - the 'organization development' objective was met and created a more fertile environment in which the project could support the planning, leadership and management development in the sector.

During the second year of the project's implementation (July 2011 – June 2012), more involvement was obtained within MOH centrally and in the two project implementation regions. However, project implementation and execution faced delays due to prolonged procurement procedures (PDU MOH). In order to accelerate implementation, the Steering Committee meeting approved another budget modification on April 16, 2012, transferring a substantial amount for project procurements from the Co-management to the BTC-Management modality. Simultaneously an external Procurement Assessment has been conducted in order to identify and address the bottlenecks in the system. Project implementation and execution did improve, although delays are still experienced.

The start of the third implementation year (July – December 2012) has seen increased activity, with a strong focus on procurements. The emphasis of project implementation will need to be directed more to activities in the implementation regions and less at central MOH support.

The Mid-Term Review is foreseen to take place in the period March - April 2013. The findings of the MTR will support the project in achieving its execution objectives (short-term output orientation), without losing its original mandate of 'institutional capacity building' (long-term impact orientation).

Project objectives and results

Overall Objective	To improve effective delivery of an integrated Uganda National Minimum Health Care Package.
Specific Objective	The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels.
Résulta 1	The MoH is strengthened in its organisational and institutional capacity.
Résulta 2 *Modification*[46]	One selected Regional Referral Hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity. *Regional approach: support to all Health Districts and General Hospitals*
Résulta 3 *Modification*[47]	One further Regional Referral Hospital (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity. *Regional approach: support to all Health Districts and General Hospitals*
Résulta 4	District management teams are strengthened in their managerial capacity, leadership and planning functions

[46] Steering Committee October 2011

[47] Steering Committee October 2011

Résulta 5	A comprehensive approach on capacity building of HSD management teams is operational.
Résulta 6 *Modification*[48]	Two training centres/demonstration sites for capacity building of HSD management teams are functional *Focus on support towards re-vitalisation of Health Manpower Development Centre in Mbale (East Uganda), including satellite training centres in two HICB implementation regions.*
Résulta 7	A scientific support team accompanies the capacity building process in the Ugandan health sector.

Strategy - Management – Organisation

Strategy

The strategy of the project is focused on 'institutional' rather than 'individual' capacity building. It is using the framework of capacity strengthening at different levels in the health sector: central Ministry of Health Head Quarters (MOH HQ), two Regional Referral Hospitals (RRH), District Health Services (DHS) and the General Hospitals (GH) and lower health facilities within them. Capacity building activities are perceived in a hierarchical pyramid with all layers being important for performance strengthening (i.e. tools, skills, staff & infrastructure, structures & systems and the local context).

Management

Project Direction: Permanent Secretary MOH (project Director) & BTC Resident Representative (project co-Director

Project Management: Director Health Services (Planning & Development) MOH (Project Coordinator/Manager) & BTC Technical Advisor (Co-manager).

Project Support Staff: Project Officer and a Project Accountant.

The project was formulated under co-management modality with MOH responsible for implementation and BTC being co-responsible (BTC/MOH guidelines and procedures).

Organisation

Implementation is planned and implemented by the health sector structures: MOH departments and divisions, District Health Officers and Facility Managers. These stakeholders are organized through a central and two regional Project Implementation Committees (PIC). The regional PICs provide a platform for district and facility interactions and became well established. The central PIC is rather weak and meeting infrequently. The project team supports the implementation of MOH activities, but is increasingly developing into an implementer itself.

Governance structures – central and regional level:

<u>ICB Project Steering Committee</u> (Frequency of meetings: quarterly)	
Chair:	Permanent Secretary MOH (ICB project Director)
Members:	DG; Directors MOH; MOFPED; MOLG; BTC ResRep. (ICB project co-director); SIDA 1st Secretary Health;
In attendance:	Project Coordinator (PC) / Technical Advisor (TA)
Secretariat:	Project Team (PC / TA)

[48] Steering Committee October 2011

Central Project Implementation Committee (C-PIC) (Frequency of meetings: monthly)	
Chair:	Director Health Services (Planning & Development) / ICB Project-Coordinator
Members:	Commissioners: Planning, Quality Assurance, Clinical Services
	Ass. Comm.: Quality Assurance, Planning, Budget & Finance, Resource Centre, Clinical Services, Infrastructure, Pharmacy, HRM and HRD.
	Regional and District representatives
Secretariat:	Project Team (PC / TA)

Regional Project Implementation Committees (R-PIC) (Frequency of meetings: Quarterly)	
Chair:	Hospital Director RRH
Members:	DHOs; HSDs; PC; TA; PNFPs
In attendance:	Other departmental heads; other regional stakeholders
Secretariat:	RRH Team

The detailed functions of the implementation Committees are as follows:

- Participate in the project planning process in order to ensure appropriate, balanced and unbiased prioritisation
- To advice on the annual work plan's activities and timeframe. The content of the plans remains the responsibility of the project secretariat and eventually MoH and LG authorities.
- To advice on proposals for important changes in the budget, to be presented to the steering committee
- To advice on proposals for change in project design, policies and procedures described in the TFF to improve effectiveness of implementation.
- To advice on changes in implementation modalities, for presentation to Steering Committee
- To advice on and contribute to the progress reports.

Purpose of the Mid Term Review

The overall objective of the mid-term review is to assess the progress of the project activities against planning (efficiency), the responsibility of the MOH in the project implementation (Ownership) and the extent to which the results and objectives are going to be achieved during the remaining course of the intervention (effectiveness).

The MTR will assess in particular:

- How does the MOH HQ's responsibility in the project implementation materialize? Is the ownership adequate, if not why?
- How is the project dealing with decentralised implementation?
- Are the implementation modalities described in the TFF (the way the project operates) adapted to the environment (central ministry)? Is it the right operating approach to allow the project to be actually results and objectives oriented? If not why?

- To what extent are the Logical Framework and its indicators adapted to the recent changes in the project and the actual situation to best respond to the identified beneficiaries' needs?

The mid-term review will formulate recommendations for the second half of the project on eventual adaptations/reorientations in the implementation both at operational level (methodology, means,…) and strategic level (activities, outcomes) that are considered necessary. It will emphasize on the mechanisms that have been / or should be put in place to ensure ownership and efficiency. These recommendations will be formulated both at the level of the partner and at the project level.

Recommendations should be concrete and feasible during the remaining time of the project.

Stakeholder involvement during the Mid-term review

- BTC Representation Office: Representative Resident, Programme Officer
- MOH HQ: Project Director (Permanent Secretary MOH); Project Coordinator (Director Planning & Development MOH); members Central – Project Implementation Committee
- Rwenzori Region: members (all or selected) of the Regional Project Implementation Committee (Director Regional Referral Hospital, District Health Officers; Superintendants General Hospitals)
- West Nile Region: members (all or selected) of the Regional Project Implementation Committee (Director Regional Referral Hospital, District Health Officers; Superintendants General Hospitals)
- Health Manpower Development Centre: Ass. Commissioner HR Development; Ag head HMDC; Junior Assistant HMDC
- The Attaché for International Cooperation (Directorate General for Development),
- SIDA
- Other donor agencies and development partners active in the sector and related capacity building activities (USAID, or the World Bank supported Health Systems Strengthening Programme,…),
- Any other stakeholder, the MTR may consider important to the successful achievement of this exercise.

Criteria to be studied

Basic criteria

The MTR should analyse the basic criteria and in particular the following:

Relevance

Taking into account the evolutions/difficulties at the MOH/DHO/Health facilities and the project scope extension (Full regional inclusion (all districts in both West-Nile and Rwenzori regions) as well as the Health Manpower Development Centre (HMDC) in Mbale), the MTR shall examine to what extent the project's relevance has been hampered by this evolution and why. Recommendations on the adequacy of the project logframe and its indicators will be made.

Efficiency

The MTR should look at the physical and financial progress of the project to explain any delay, constraints or problems and make recommendations on approaches and necessary means to overcome any delays and constraints encountered.

More particularly, the MTR shall examine to what extent the project has been directed in an efficient way during the covered period and in particular the way roles and responsibilities of the different actors (both within the MOH responsible departments and the project team itself,) have been shared and pursued by each of them.
The feasibility of decentralizing part of the project's implementation -as perceived in the formulation- should also be looked at considering the existing difficulties/barriers and make recommendations as to the best way forward for the project implementation.
Procurement having been an issue throughout the project and financial execution rate is really low, the MTR shall assess to what extent the project's parties have managed to find appropriate solutions and shall make recommendations for the remaining period of the project.

Effectiveness

The MTR shall examine to what extent the project is likely to achieve the expected results at the end of the project with the necessary quality level and to which extent progress has been made towards achievement of outcomes.

The MTR should look into what obstacles and barriers might have deviated the project from its results/objectives and why. The appreciation by stakeholders and beneficiaries shall be an important element of this analysis. The MTR shall make recommendations to enhance the effectiveness of the project.

HARMO-criteria for strengthening aid effectiveness

HARMO criteria will be looked at and more particularly the one of ownership.

In the project Technical and Financial File (TFF) the implementation of project activities is foreseen to be responsibility of Ministry of Health. The scope of the project was reviewed and was broadened to full regional inclusion (all districts in both West-Nile and Rwenzori regions) as well as the Health Manpower Development Centre (HMDC) in Mbale. This resulted in a gradual change of the project secretariat (Coordinator and TA) into a "Project Management Unit", rather than supporting the responsible departments with their own implementation of activities. This is a different direction than described in the TFF and the capacity of the project secretariat is falling short for this expanded workload.

Transversal themes

Transversal themes gender and environment will particularly be looked at.

Period and duration of the review

It is envisaged that the MTR will begin as soon as possible and preferably in April.

A maximum number of days to carry out the MTR is suggested below but modifications can be proposed if this will improve the quality or efficiency of the mid-term review mission.

	Travel days	Field Mission **(in partner country)**	Europe **(or outside partner country)**
Principal Expert (1) Team Leader	2	14	7
Principal Expert (2)	2	14	2
Non Principal Expert		14	2

Course of the review

The MTR Principal Expert (1) will be responsible for the following activities:

1. Briefing at BTC HQ and at the BTC Representation
   Discussion of the MTR purposes, programme and methodology.
2. Review of the documents.
3. Field visits in Uganda (implementation region and HMDC Mbale)
4. Data collection at the level of the beneficiaries, the project staff, the authorities and the partner institutions.
5. De-briefing of the Steering Committee (JLCB) / MOH / Restitution workshop with stakeholders at the end of the field mission at BTC representation in Kampala and hand over of the Memorandum (Aide-mémoire)
7. Drafting of the MTR-report and transmission to BTC HQ.
8. De-briefing at BTC HQ
   Presentation of findings, conclusions and recommendations.
9. Integration of BTC and field comments in the MTR report.
10. Drafting of the final report and sending to BTC HQ.
11. Finalisation of administrative and financial formalities.

Composition of the team

A reference team supports the MTR team and consists of the following members:

In the partner country:

- ⇨ Mr Nebeyu SHONE, Resident Representative at BTC Representation in Kampala, Uganda.
- ⇨ Ms. Rose Kato, Programme Officer at BTC Representation in Kampala, Uganda.

In Belgium:

- ⇨ Mrs Julie HERTSENS, Operations Advisor at BTC HQ in Brussels,
- ⇨ Mr Paul BOSSYNS, Health Advisor at BTC HQ in Brussels.

The MTR-team consists of the following members:

- ⇨ Principal Expert (1), Team Leader
- ⇨ Principal Expert (2)
- ⇨ Non Principal Expert

Profiles & responsibilities of the Consultants

Principal Expert (1), Team Leader – Public Health expert

Profile

- Specialised in institutional Capacity Building projects in the health sector
- Specialized in programme management (min. 5 years as programme manager) and implementation modalities.
- Extensive experience in cooperation project evaluations
- Familiar with BTC implementation modalities and participative approach highly desirable.
- Fluent in English (speaking and writing).

Principal Expert (2) – Public Health expert

- Specialised in Organisational Health development or equivalent
- Expertise in health system strengthening, institutional change, change management
- Specialised in decentralisation in the public health sector

Non Principal Expert

Profile

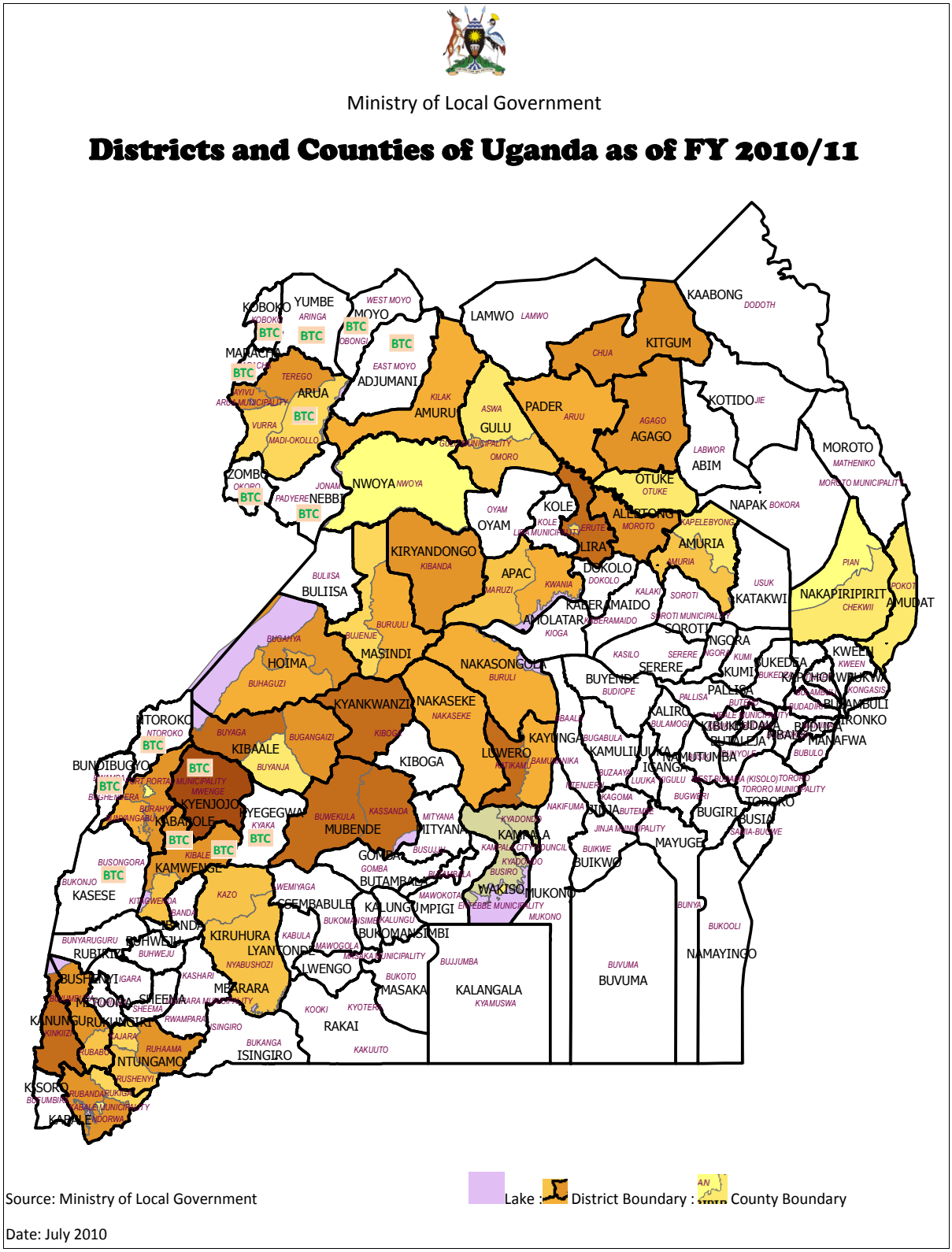
- Master Degree in Public Health or equivalent
- Extensive knowledge of the health sector in Uganda (in particular regarding existing strategies and implementation in the context of decentralisation)
- Specialised in health management with an expertise in health organisational development
- Large experience in evaluation of governance/public sector programmes
- Familiar with the participative approach.
- Speaks and writes fluently in English.

9.2 Annex 2: Original logical framework

	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
General objective: "To improve effective delivery of an integrated Uganda National Minimum Health Care Package"			
Specific objective: The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels			
Result 1: The Ministry of Health is strengthened in its organisational and institutional capacity	• Reform plan in execution • Number of people trained by the project • Number of field visits for ➢ Coverage plan development ➢ Master plan designing ➢ Procedures manual identification • MoH Procedures manual in place • Support supervision policy paper renewed • Established procedures for training coordination	• Project Progress reports • Procedures manual • Planning manual • Annual work plan for the MoH • Framework for support supervision • Evaluation reports • Meeting minutes • Interviews	• Sanction/approval by the top and senior management at the MoH to conduct the activities required. • Availability and interest and willingness by MoH top managers and senior managers to participate and cooperate
Result 2: One selected regional referral hospital (Fort Portal) and two general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity	• Strategic plans incorporating master plans in place • Hospital mandate reflects efforts for complementary role definition • Number of support supervisions realised respecting new policy in the matter • Number of people trained	• Project Progress reports • Strategic plans • Master plans • Annual work plans • Evaluation reports • Meeting minutes	• Sanction/approval by the MoH and district authorities to conduct the activities required. • Availability and interest and willingness by hospital managers to participate and cooperate
Result 3: One further regional referral hospital (Arua) and two additional general hospitals, located within the catchments area of the RRH, are strengthened in their institutional and organisational capacity	• Strategic plans incorporating master plans in place • Hospital mandate reflects efforts for complementary role definition • Number of support supervisions realised respecting new policy in the matter • Number of people trained	• Project Progress reports • Strategic plans • Master plans • Annual work plans • Evaluation reports • Meeting minutes	• Sanction/approval by the MoH and district authorities to conduct the activities required. • Availability and interest and willingness by hospital managers to participate and cooperate

	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
Result 4: District management teams are strengthened in their managerial capacity, leadership and planning functions	• Number of people trained • Number of support supervisions to GH realised • Number of support supervisions to HSDMT realised • Strategic plan developed, followed and discussed with LG • Level of understanding of coverage and master plans for strategic planning	• Project Progress reports • Minutes from meetings • Annual work plans. • Evaluation reports • Interviews	• Sanction/approval by the District authorities to conduct the activities required. • Key stakeholders willing to cooperate
Result 5: A comprehensive approach on capacity building of sub-district management teams is operational.	• Number of HSDMT members trained • Coverage plans, master plans and procedures manual reflected in strategic and yearly plans • Coverage plans discussed with LG authorities • Number of HSDMT meetings held • Number of HC II and III supervised by HSDMT	• Project Progress reports • Minutes from meetings • Annual work plans and reports • Coverage plans • Master plans • Evaluation reports	• Sanction/approval by the MoH to conduct the activities required. • Key stakeholders willing to cooperate
Result 6: Two training centres/demonstration sites for capacity building of health sub-district management teams are functional	• Number of HSDMT members trained in training centres • Number of training sessions held • Number of HC II and II up to quality standard for receiving trainees • Evaluation of the first 2 years of functioning • Status training centres clarified	• Training sessions evaluation reports • Project Progress reports • Field visits and observation • Evaluation report • Interviews • Policy note	• Sanction/approval by the MoH and district authorities to conduct the activities required. • Identified HSDs/ key stakeholders willing to cooperate
Result 7: A scientific support team accompanies the capacity building process in the Ugandan health sector	• Policy paper on support supervision refined and approved • Policy paper on referral system refined and approved • Complementary roles of health facilities better defined and approved in policy paper • Continuous training policy for health personnel refined	• Evaluation reports • Minutes from meetings/seminars • Policy documents • Interviews	

9.3 Annex 3: Map of project area



9.4 Annex 4: List of persons / organisations consulted

Name	Function	Affiliation
Mr. Nebuye Shone	Resident Representative, BTC	BTC
Dr. Vincent Oketcho	Chief of Party, Uganda Capacity Program	HDP
Malin Krook	First Secretary, Swedish Embassy	HDP
Dr. Juliet Bataringaya	WHO, Country Advisor-Health Systems Development	HDP
Ludo Rochette	Attaché	HDP Belgian Embassy
Mr. James Ikabat	Ag Head HMDC	HMDC
Mr. Vincent Vanderputten Junior TA HMDC	Junior Assistant BTC	HMDC
Mr. Johnathan Kitanda	Senior Health Training Officer, HMDC	HMDC
Mr. Nyeko Ponziano	Ass. Comm Accounts, MOH	MoH
Dr. Jackson Amone	Ass. Comm. Clinical Services, MOH	MoH
Mr. Allie Kibwika-Muyinda	Ass. Comm. HRD	MoH
Dr. Sarah Byakika	Asst. Commissioner Quality Assurance	MoH
Dr. Jacinto Amandua	Commissioner Clinical Services, MOH	MoH
Dr. Henry Mwebeza	Commissioner QA	MoH
Dr. Isaac Ezati	Director Planning, MOH/Project Coordinator	MoH
Dr Asuman Lukwago	Permanent Secretary / Project Director	MoH
Mr. Godfrey Erukwaine	Principal Procurement Officer, MOH	MoH
Mr. Vincent Bagambe	Quality Assurance Manager/GF Focal Coordination Office	MoH
Ms. Josephine Kirungi	Consultant Procurement	Project
Mr. Vincent Vanderputten	Junior Assistant BTC	Project
Mr. Godfrey Yiga	Project Accountant	Project
Mrs. Ann Mary Otedor	Project Officer	Project
Dr. Hans Beks	Technical Assistant	Project
Mr. Godfrey Manga	Assistant DHO, Adjumani district	West-Nile
Dr. Patrick Anguzu	DHO Arua district	West-Nile
Mr. Santos Kenyi	DHO Koboko district	West-Nile
Mr. Ronald Ocaatre	DHO Maracha	West-Nile
Dr. Jimmy Opigo	DHO Moyo district	West-Nile
Dr. Jacor Oyema	DHO Nebbi district	West-Nile
Dr. Benard Odu	Director Arua Regional Referral Hospital	West-Nile
Ms. Harriet Thumitho	for DHO, Zombo district	West-Nile

Mr. Micheal Ojja	for M/S Adjumani Hospital	West-Nile
Mr. Micheal Odur	Hospital Admin, Arua Regional referral hospital	West-Nile
Ms. Mary Assumpta	Hospital Admin, Maracha Hospital	West-Nile
Dr. Franklin Idi	M/S Moyo Hospital	West-Nile
Mr. Charles Kissa	M/S Nebbi Hospital	West-Nile
Ms. Nancy Sally Obiru	Principal Nursing Officer, Arua RRH	West-Nile
Mr. Apelima Rahim	Representing DHO, Yumbe District	West-Nile
Mr. Pius Okethwengu	Representing Nyapea Hospital	West-Nile

9.5 Annex 5: List of documents and reports consulted

ICB Project

Addendum to TFF, UGA 09 017 11
Annual project report 2011
Annual project report 2012
Exchange of Letters, 16 December 2012
ICB Newsletter, April 2013
ICB-MOH Work plan 2012/13
Procurement Assessment at MoH HQ, Arua and Fort Portal RRH
Project formulation report
Project Identification Document
Project Technical and Financial File
Quarterly project operational planning and progress reports
Steering Committee meetings minutes

MoH

A study of Health Sector Reforms in Uganda: Lessons for the HSSIP, Achest, August 2011
Aid and Health Sector Performance in Uganda, Cordaid, 6 July 2011
Annual Health Sector Performance Report, 2011/2012, MoH
Assessment of the Essential Medicines Kit-Based Supply System in Uganda, May, MoH/USAID Sure Programme
Concept paper GFATM on Shifting to Regional Health Zones Supervisors
Global Fund 10th Round Regional Performance Monitoring Component
Guidelines for Community Health Departments for Hospitals, MoH
Health Sector Quality Improvement Framework and Strategic Plan 2010/11 – 2014/15, December 2011
Health Sector Strategic Plan II, 2005/06 – 2009/10
Health Sector Strategy and Investment Plan (HSSIP, 2010/11 – 2014/15
Health Systems Reforms in Uganda: Processes and Outputs, Institute of Public Health Makerere, Health Systems Development Programme, LSHTM, 2006
Human Resources for Health Country Profile, Uganda, Africa Health Workforce Observatory, WHO, EU, October 2009
Joint Annual Review Report, Health Sector Budget Support HSSIP – UGA 1202 511 (UGA 09012211), BTC
National Health Accounts FY 2008/2009 and 2009/2010, MoH, March 2013
National Policy on Public Private Partnership in Health, 7th March, 2012
Project Appraisal Document on a proposed credit to the Republic of Uganda for a Uganda Health Systems Strengthening Project, 24 April, 2010
Report of the Parliamentary Committee on Health on the Ministerial Policy Statement for the Health Sector for the FY 2012/2013, August 2012
Second National Health Policy, 2010
Service Availability Mapping (SAM), The Republic of Uganda, MoH in collaboration with WHO, 2006
The Second National Health Policy, July 2010
The Uganda Case Study: Enhancing Health Worker and Health System Performance, Global Health Workforce Alliance, 2010
Uganda Health System Assessment, April 2012, Abt Associates, USAID, Makerere School of Public Health, Health Systems 20/20

MoPS

Guidelines for Performance Agreements for Directors, Heads of Dept., Deputy Chief Administrative Officers and Deputy Town Clerks, MoPS, April 2011

Performance Agreements for PS, Chief Administrative Officers and Town Clerks, MoPS, June 2010

MoLG

Annual Report 2011, Local Government Finance Commission

MoFEDP

Primary Health Care (PHC) Grants Guidelines Financial Year 2011/2012

HDP

Aide Memoire: The 18th Govt. of Uganda and Development Partners' Health Sector Joint Review Mission, 24-26 September 2012

Briefing: Repositioning Resource Centre for Evidence Based Decision-making, Prepared by partners who support strategic health information in Uganda, undated

Common position among development partners under the Joint Budget Support Framework (JBSF) in Uganda on the suspension of budget support, undated

Compact between Government of Uganda and Partners for Implementation of the HSSIP, July 2010

Joint Appraisal Framework Matrix Indicators, extract

MoH Pre-JRM Field Visits 2012: Rwenzori Team Report

Literature on Capacity Building

Capacity Development Practice Note, UNDP, June 2008

Governing for Better Health, A Targeted Literature Review, May 2012, USAID Leadership, Management and Government Project

Institutional Assessment and Capacity Development, Why, what and how, EC, September 2005

Menu of Indicators on Management and Leadership Capacity Development, USAID, MSH, May 2006

Systemic Capacity Building: A Hierarchy of Needs, Health Policy and Planning; 19(5): 336-345

The Capacity Development Results Framework: A Strategic and Results-Oriented Approach to Learning for Capacity Development, World Bank Institute, June 2009

9.6 Annex 6: Questionnaire administered

This self-assessment questionnaire is intended to have an insight in the capacity and leadership functions of the health sector, which the ICB project is meant to support. Most questions therefore relate in the first instance to the capacity and leadership functions within the sector, while some questions are more directed to the ICB support.

Please tick the appropriate column, "yes", "somehow", or "no" with an X. We would further greatly appreciate it if you could give as many comments as you wish in the last column so as to clarify the issues.

Place of work

Please indicate with an x your place of work:

	Clinical function	**Management Function**	**Support Function**
MOH Headquarters:			
Regional Hospital:			
General Hospital:			
District or sub district:			

Please indicate whether you are a member of any of these committees:

Member of Central Project Steering Committee	
Member of Central Project Implementation Committee	
Member of Regional Implementation Committee	

Part I: Self-assessment

In this first part of the questionnaire, we would like to have some information about your personal status and your opinions or preferences:

		Yes	**Somehow**	**No**	*Please explain especially if your answer has been "somehow" or "no"*
1	I have been involved in the ICB project				
2	I understand the objectives of the ICB project				
3	I have a written job description				
4	I feel competent to perform my function				
5	I feel motivated to perform my functions				
6	I make decisions using available knowledge and data				
7	I participate(d) into drafting following documents:				
	a. Guidelines				
	b. Manuals				

		Yes	Somehow	No	*Please explain especially if your answer has been "somehow" or "no"*
	c. *Policy papers*				
	d. *Strategic plans for HQ, hospitals, district, sub district,*				
	e. *Others, explain*				
8	I would like to participate in the peer review of performance of institutions/departments				
9	I prefer to attend only certified courses				
10	I believe academia should be contracted to provide in-service training and continuing professional development				

Part II: Institution or Department assessment

		Yes	Somehow	No	*Please explain*
11	Owns the ICB project				
12	Has benefited from similar interventions supported by other donors (if YES explain when and which intervention)				
13	Is involved in the project implementation				
14	Has been enabled to assess its capacity				
15	Has developed a clear vision of its roles and functions in the sector				
	a. *This vision takes into account decentralisation issues*				
	b. *These roles and functions require organisational reforms*				
16	Has been supported in its organisational reform				
17	Has been strengthened in the formulation of policies and regulations				
18	Has been strengthened in implementing and monitoring its policy and regulatory framework				
19	Has been strengthened in inter-sectoral collaboration				
20	Has been strengthened in intra-sectoral collaboration (eg referral system, collaboration with academia and research institutes				
	Has strengthened planning capacities				

21	Has adopted an evidence-based approach for decision-making				
22	Has developed formal partnerships with the private sector				
23	Has improved its monitoring/supervision capacities				
24	Is supported in the definition of its training needs				
25	Has a gender-sensitive approach				
26	Has been supported in acquiring the equipment needed to comply with its roles or functions				
27	Would benefit from peer reviews				

In this second part, we would like to hear whether in your opinion, your institution or department:

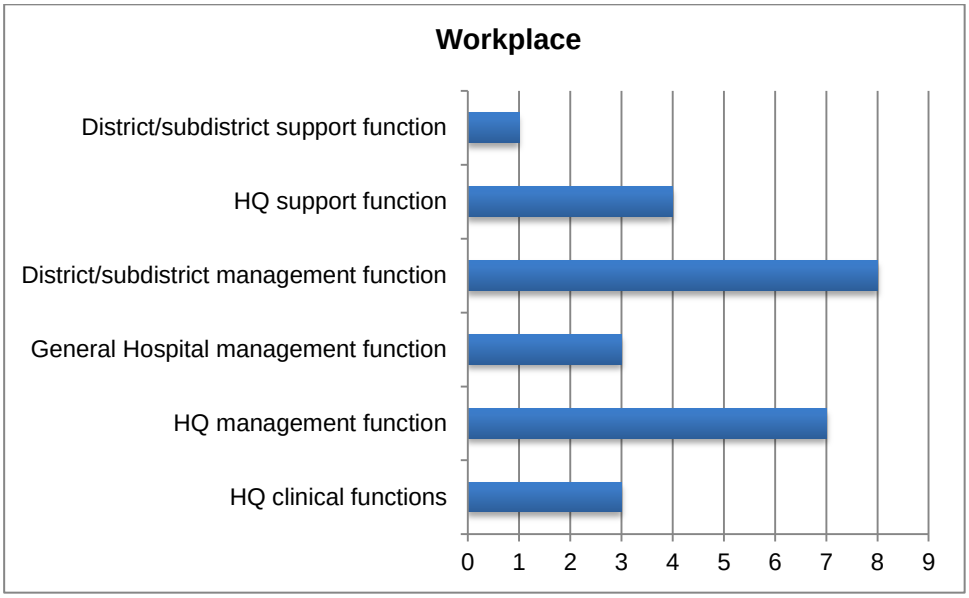
Part III: Conclusion

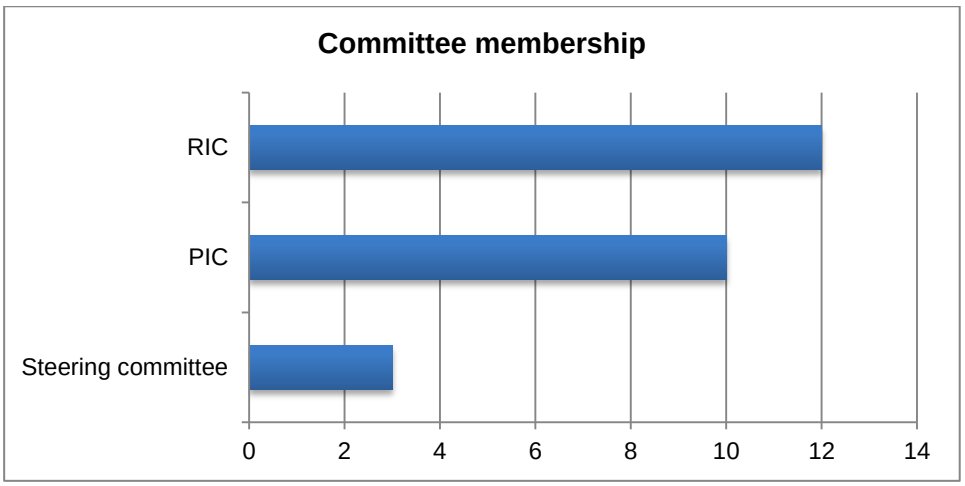
As a conclusion, how would you summarize the impact of the ICB project on your institution/department and on your personal capacity

28	What is working well and why?	
29	What has not worked well and why?	
30	If you had to replicate the process which aspect would you retain/improve/modify??	

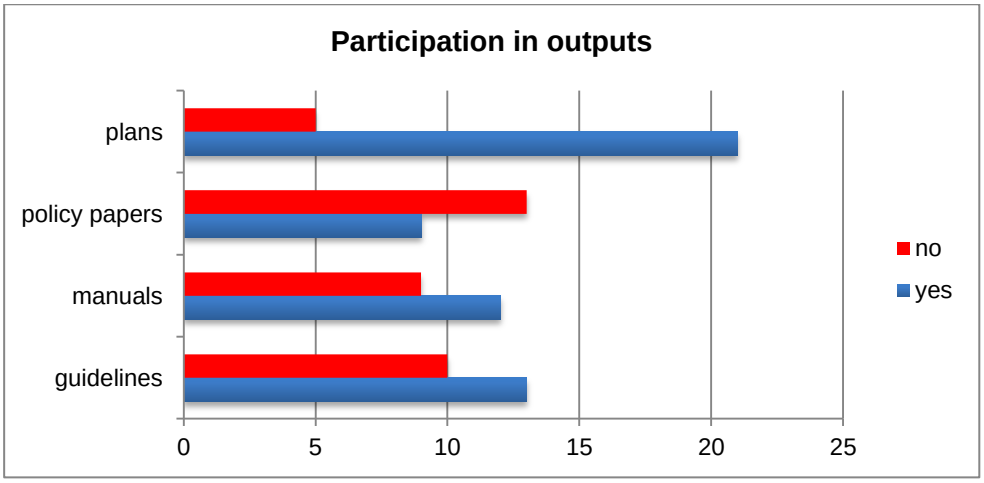
QUESTIONNAIRE ANALYSIS

Frequency distribution, (27 respondents, 06 May 2013)






Self assessment 4 - 6
EB decisions
motivation
competence
0
5
10
15
20
25
no
#
yes


Participation in outputs
plans
policy papers
manuals
guidelines
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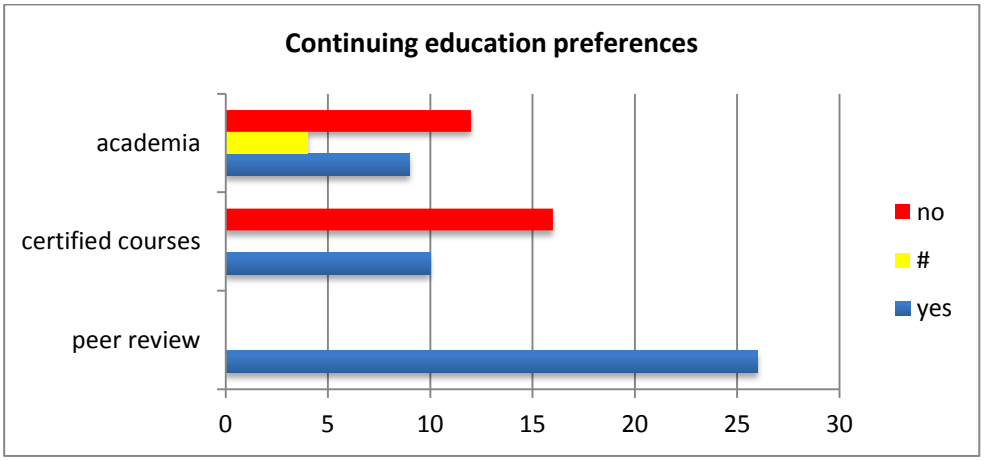
25
no
yes


Continuing education preferences
academia
certified courses
peer review
0
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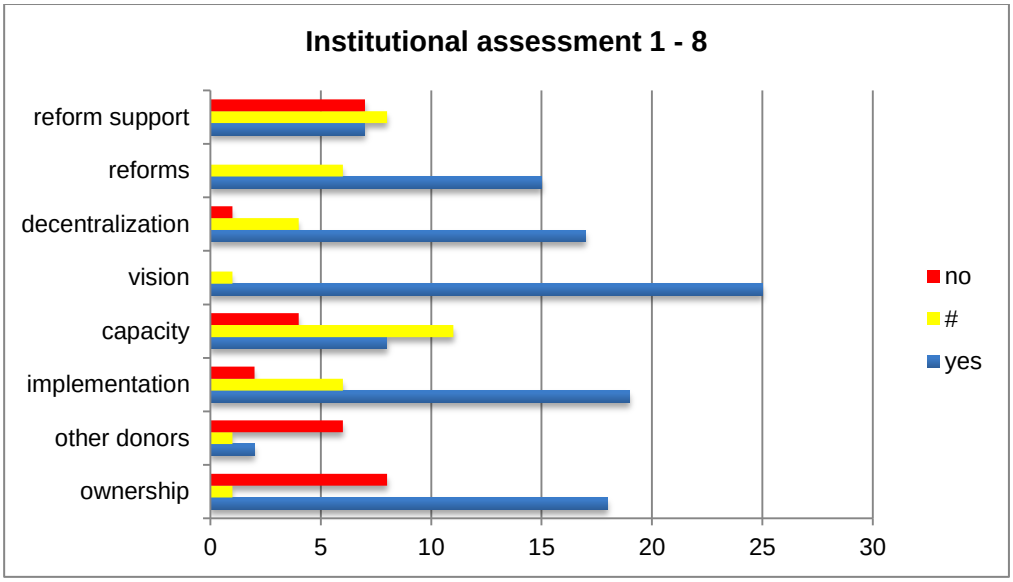
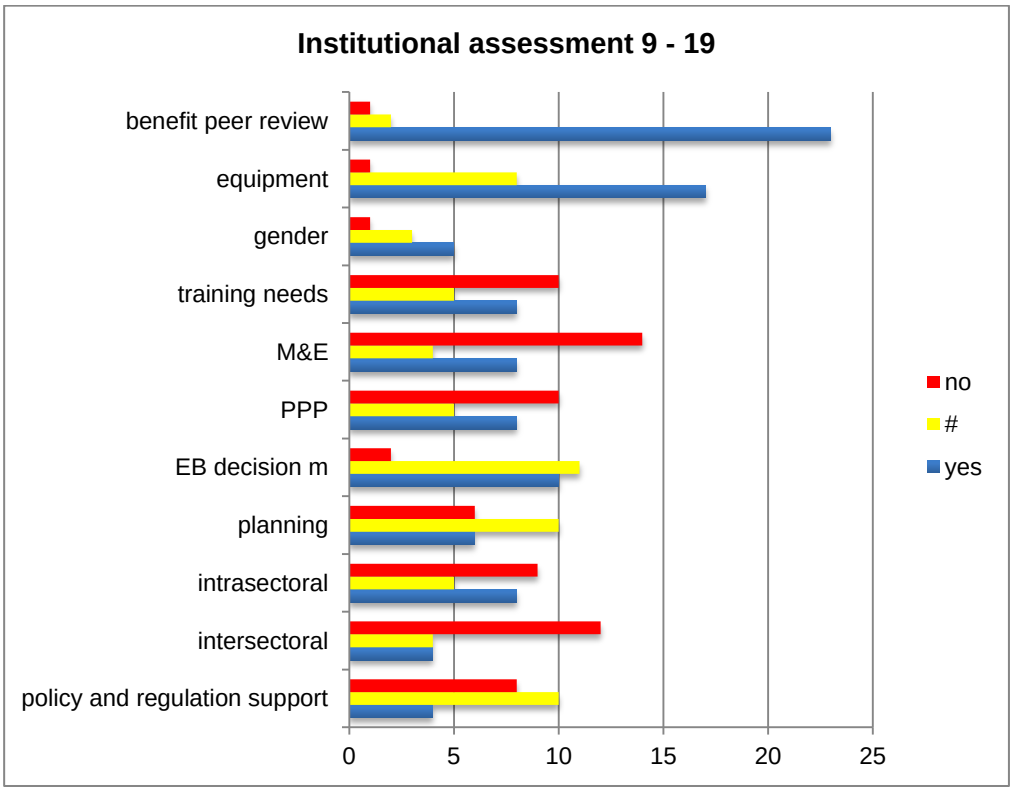
yes





Open ended answers

Self-assessment

- I have never been oriented in the project activities
- I still needs to build more capacity in leadership, management and planning in terms of skills
- It does not necessarily have to be academia. They may lack the actual experience related to implementing the activity
- In-service training should be skills enhancement oriented and not theoretical as is the norm with most academic training
- While certification can be a nice bonus, I do not necessarily need a certificate for everything.

- I think in some cases the delivery of training as part of ICB activities can be useful/needed
- Results orientedness motivates me but there are also demotivators like limited equipment and financing to perform roles
- Learning is not only through certification
- Good, but other professional bodies can also be contracted to provide CPD.
- Both certified and non-certified courses are crucial especially in developing competencies of health workers for better service delivery. Whereas the certified courses are good in academic advancement; most of the in-service courses aimed at improving competencies of health workers may not be certified and yet they play a key role in helping health workers acquire new skills / updates in service delivery.
- In my opinion; In-service training /continuing professional development training can be best facilitated by experienced hands on trainers who can relate the academic knowledge to the real and practical situations based on their experience. This makes the training meaningful to the trainees because, the training courses can be focused in solving practical problems in the service delivery other than making them academic and repetitive of what was covered in the formal training schools.
- The key involvement has been in supporting timely availability of funds for project activity
- ICB objectives should be more regularly articulated in relation to the Ministry's vision and objectives
- We are yet to implement any ICB activities in the hospital

Institutional assessment

- Creating an (semi-)autonomous status for "new HMDC" is one of the key concerns.
- Inter-sectorial cooperation, for example with Education, has been lacking, in my view, although this could be because there are other more immediate concerns.
- Yes, most support has been infrastructure and equipment and the project has been very willing in supporting with most infrastructural/equipment issues (wall fence, small renovations, new furniture, new IT equipment, etc.).
- Small improvements here and there (see 'support with equipment') are needed and are also done, but equally important (if not more) is that more resources/effort should be put into improvement of organizational structure, institutes strategy, staff capacity (new staff, train staff, etc.), change management, etc.
- Strengthen through the leadership and management 6 month course that 6 DHT members attended.
- Ambulance and utility double cabin has been procured for the District. Theatre equipment are in a process
- Own assessment of capacity has been enabled to a small extent, however it is part of subsequent interventions
- The building of capacity for Biostatisticians in data analysis and reporting is a step in that process of adoption of evidence based approach for decision making
- Directives have only been given by MOH and passed down to districts to implement without much support
- We are in the pipeline to have this capacity strengthened further. As of now we have been participating in planning leadership and management meetings (More less like mentorship) for the implementation of the project being guided by the Central project team. Plans under way for the formal training.
- Strengthen departments support supervision functions
- Planning capacities strengthened somehow but based on old skill but this is bound to improve should the leadership and management training under the ICB project get implemented.

- Logistics (transport) is yes (ambulance, and double cabin car) but other equipments (photocopiers at hospital and District health office, repair of x-rays and supply of ultra sound machine at hospital, strengthening of solar power at Hospital and District health office, assorted equipments at Mungula HC IV etc are yet to be accomplished.
- The project has been slow in supporting the district to determine catchment populations of health units that is meant to set targets and monitor performance of individual health units.
- We have a picture of what we should do, and know that the project can support us to achieve them.
- The project has been slow in the actual implementation of activities that are planned and agreed on. Unless there is an extension of the project period especially considering that time was lost at the beginning, we may not gain as much as we would have liked.
- Retain: Frequent meetings and reviews of performance
- Improve: More objective assessment of transport needs for District Health Office; the speed of implementation of planned interventions
- Local government (LG) planning cycle starts from bottom up. The needs are appraised by the relevant committees of the council and are approved by the council. They monitor implementation and take critical alternative decisions. This is the concept of ownership to the LG. The current approach through the regional committee (a technical committee) hangs above the LG and postures the LGs as recipients.
- There is adequate knowledge on what works and how decentralisation would function better but local governments have limited discretion of choices to enhance performance or their roles
- Local governments can not reform themselves but only wait to be reformed; eg, a Health Sub district is to have only One Midwife and wait for public services to change that decision even if your district priority was to improve reproductive health. You have to do that with that structure.
- Generally there is no incentive to undertake training need assessment, as the districts do not have the resources to sponsor the identified need. But is an exercise that ought to be done,

Conclusions

- Institutional support in terms of office equipment to offices
- Building capacities for staff in the mainstream depts has been very minimal. Procurement unit needs support
- The project objectives were well introduced and coordination meeting take place as schedule. This was because committed leadership from both the donor and the government
- Improve the area of training and empower MOH staff to handle different activities
- Implementation of activities is sometimes hampered by conflicting view points between the Activity leader and the Project staff
- Procurement is taking unnecessary long and selection of identified need for implementation for each district by ICB is at snail pace
- I would retain the demand-driven and flexible nature of the Project but give more authority to Departments/Divisions in designing and implementing activities.
- Redress to transport and referral system has worked well because transport has been procured and is being utilized. The planning by District Team was done swiftly
- The disbursement of funds for Activities in the District has delayed just like the procurement of other goods and services because of Government procedures.
- Retain central procurement of big works/plants/services by MOH. Improve on disbursement of funds to the District Local Governments. Involve more District Structures in planning and M/E of district based activities.
- Retain the interval of coordination meeting, which is rotational in terms of venue. From immense demands of each district ICB should make selection and schedule of its implementation, which

should be communicated to all. Indicative Planning Figure of the project should be communicated earlier to stop district from sending ambitious demand, besides being very clear of priority area at the time of inception of the project

- Regional meetings keep implementers fully updated and able to make timely decisions
- Consider funding based on exact gaps based following a needs assessment
- The involvement of all the districts in planning for the activities
- Agreeing on priority activities to be done in the coming quarter
- Reviewing of implemented activities in our quarterly meetings
- Provision of work tools; Management and leadership training refresher and operational research for decision making appropriate financial allocation
- Regional approach to issues is promoting learning through benchmarking
- Demand driven approach to support is promoting innovativeness e.g. ambulance committees, customer care trainings, quality of care surveys etc
- Undertaking needs assessment to guide allocations/support working well
- Adoption of Belgian system for procurement. Ugandan system cumbersome and often fails to deliver
- Initial delays have been extensive; most support activities yet fully taking off
- Centralised financing makes implementation at district level unpredictable. It also makes integration into district development plans difficult.
- Retain: Demand driven approach and regional approach to issues
- Improve: Improve learning by exposure/exchange visits to developed/well established health systems in Africa or other continents
- Regular quarterly regional coordination meetings to update districts on the progress of the project implementation
- Tools (logistical support) have been availed to the district: Adjumani district has received 2 brand new vehicles (1 state of the art ambulance for Adjumani hospital and 1 double cabin car for the DHO for supervision)
- The district has also received a submersible pump for the General Hospital and is in use.
- The received consultants who came to assess solar system needs at District Health office, Adjumani Hospital and Mungula HC IV
- Lost time (close to a whole year of project life span lost without any interventions due unclear project objectives at start).
- Project design that restricts interventions at only District Health Office, General Hospital, and HC IV leaving out of lower level health facilities (levels IIIs and IIs). This affects the “demand driven” strategy of the project thus districts that have priorities for improvement of institutional capacity at lower level health facilities other than the above three are bogged down. e.g. in Adjumani district, one of the key Institutional Capacity priorities is to enhance disease prevention activities at community level (through HC IIs and IIIs). In achieving this, the district has already recruited 18 Environmental Health staff (5 Health Inspectors and 13 Health Assistants) while 7 more Health Assistants are being recruited to give a total of 25 Environmental Health staff. The main challenge now is lack of transport (motorcycles) for these cadres that play a very vital role in disease prevention.
- Slow procurement process
- Redesign the project to extend to lower level health units (especially HC IIIs).
- Decentralise procurement of items or equipments below a certain threshold at district level.
- Support to HMDC’s functions, development of a 5-year strategic investment and development plan, and procurement of equipment and materials and deployment of Technical Assistant to support in the establishment of e-learning project.
- Understanding of the project’s scope and areas of possible support. Being a new type of project, It was quite challenges in deciding which areas to request for support.

- Development of HMDC's training staff capacities in facilitating leadership and management courses. HMDC staffs are involved in developing training materials for a six months course for leadership and management of lower level health managers. In line with this approach, there was a plan for HMDC to review and adopt the contents of course developed by AMREF for all African countries to enrich what already exists. A two weeks trainer of trainees (TOT) workshop for the same course was conducted with support from BTC. Unfortunately, none of HMDC's training staff participated in this TOT.
- The flexibility and demand driven concept is very good and should be promoted.
- The lifetime span of the project needs to be adjusted to cater for the lost time and to enable implementation of planed activities. This will enable realisation of the project outcome and impact; being Institutions Capacity Building Project.
- Emphasis appears to be on the two regions with not much at the centre. This has limited appreciation of the project at this level.
- The level of integration of ICB work into the Ministries can be increased.
- The ambulance service is working very well because it has a different approach. It's now a moving clinic which has in the few months reduced Maternal Mortality by a very good percentage. Generally every bit that the project has supported is working very well because it stepped in the gaps, which government was unable to address and those are the real Institutional Challenges. This project is feasible and very well appreciated and owned in my District. If funds could allow it MUST be retained to achieve its Objectives.
- Review and broaden the approach of demand driven, Invest in Staff training as well as the tools to be used to improve service delivery. Improve on the aspect of timeframe in implementing the project activities.
- The participatory way of needs Identification through presentation of concepts has been excellent. It has helped committee member to harmonise their expectations with the key results areas.
- Appraisal of needs and final implementation decision comes from the national level. Some project decisions are taken outside the committee with the potential of creating differences in the same health block; e.g. some trainings in Yumbe and Arua RR hospital. The approach to ambulance services could have been done better. E.g. District with ambulances to be refurbished and equipped to the same level as those who did not have and were to receive new ones. The operational costs in terms of fuel and maintenance did not have to go to only new vehicles. The context for this intervention could have been discussed better and I think there was no consensus.
- The needs Identification phase is excellent, needs appraisal and decision making process and consensus building practices need to be improved or modified. There need to be a deliberate effort for LG buy in to the project.
- The demand driven nature of the project because the needs can be customized
- Some important aspects of capacity building are ineligible because they are at level were the project does not operate. The project stops at HCIV when PHC is mostly delivered at HCIII level
- The demand driven nature as most projects are prescriptive. The management committees as it make the project decision-making, information flow and monitoring participatory. It even provides for peer review.