BTC UGANDA

# ANNUAL REPORT 2010, JULY – DECEMBER 2010

## PROJECT UGA 0901711: INSTITUTIONAL CAPACITY BUILDING IN PLANNING, LEADERSHIP AND MANAGEMENT IN THE HEALTH SECTOR IN UGANDA

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## Abbreviations / Acronyms:

| | |
|---|---|
| BTC | Belgian Development Agency |
| CHS(P) / ACHS(P) | Commissioner Health Services (Planning) / Assistant CHS(P) |
| DHP | Department of Health Panning |
| DHS(P&D) | Director Health Services (Planning & Development) |
| GH | General Hospital |
| HCIV | Health Centre IV(4) |
| HICB | Health – Institutional Capacity Building |
| HSD | Health Sub-District |
| HPD | Health Planning Department |
| ICB | Institutional Capacity Building |
| (I)TA | (International) Technical Advisor |
| JLCB (SC) | Joint Local Consultative Body (Steering Committee) |
| M&E | Monitoring & Evaluation |
| MOFPED | Ministry of Finance, Planning and Economic Development |
| MOH | Ministry of Health |
| MOLG | Ministry of Local Government |
| PA | Project Accountant |
| PDU | Procurement and Disposal Unit |
| PIC | Project Implementation Committee |
| PIO | Project Implementation Officer |
| PLMP | Planning, Leadership and Management Project |
| PPDA | Public Procurement and Disposal of Assets |
| PS | Permanent Secretary |
| QAD | Quality Assurance Department |
| RR | Resident Representative (BTC Uganda) |
| RRH | Regional Referral Hospital |
| SIDA | Swedish International Development Agency |
| TFF | Technical & Financial File |
| UNMHCP | Ugandan National Minimum Health Care Package |
| | |

# 1 Project form

DGDC intervention number: 3008322

BTC code: UGA 09 017 011

Partner institution: MoH (Department of Planning)

Duration of Specific Agreement: 5 years

Duration of the intervention: 4 years

Partner's contribution: In kind

Belgian contribution: 6 500 000 EUR

Intervention sectors: Health (DAC 12110)

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".

Results:
1. The MoH is strengthened in its organisational and institutional capacity.
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.
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.
4. District management teams are strengthened in their managerial capacity, leadership and planning functions.
5. A comprehensive approach on capacity building of HSD management teams is operational.
6. Two training centres/demonstration sites for capacity building of HSD management teams are functional
7. A scientific support team accompanies the capacity building process in the Ugandan health sector.

# 2 Summary

## 2.1 Analysis of the intervention

| Intervention logic | Efficiency | Effectiveness | Sustainability |
|---|---|---|---|
| **Specific objective:** ”The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government Levels”. | C | D | X |
| 1. The MoH is strengthened in its organisational and institutional capacity. | | | |
| 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. | | | |
| 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. | | | |
| 4. District management teams are strengthened in their managerial capacity, leadership and planning functions. | | | |
| 5. A comprehensive approach on capacity building of HSD management teams is operational. | | | |
| 6. Two training centres/demonstration sites for capacity building of HSD management teams are functional | | | |
| 7. A scientific support team accompanies the capacity building process in the Ugandan health sector. | | | |

| Budget | Expenditure per year | Total expenditure year 2010 | Balance of the budget | Execution rate |
|---|---|---|---|---|
| **€ 6,500,000=00** | N/A | € 154,468.87 | € 6, 345,531.13 | 2 % |

## 2.2 Key points

## 2.3 Lessons learnt and recommendations

| Recommendation |
|---|
| Revision of TFF: i.e. co-managment structure clarity and role of TA. Project Manager and ass. Project Manager |
| Reformulation – total budget increase SIDA. Review of scope, scale and duration |
| Include budget line for Project Accountant |
| Include budget line for operational and management project costs |
| Ensure all aspects related to scope and scale are included in reformulation (e.g. operational costs both recurrent and capital, health economics, geographic regions, PNFP, etc) |
| Improve internal and external communication. |
| Address inefficient meeting culture as priortiy (i.e. management skills training) |

| Lesson learned |
|---|
| Co-management modality to be clearly understood by both parties and other stakeholders involved before start of project. |
| Formulation of TFF should not be rushed and adequate validation and verification should take place before final approval |
| Clear, frequent and open communication within project management, to ensure common understanding and identify potential problematic issues at an early stage |

# 3 Evolution of the context

The Planning, Leadership and Management Project (PLMP) was launched during its first Steering Committee meeting on June 16th, 2010, which simultaneously marked the start of the project implementation period.
An International Technical Advisor for the project was recruited starting May 1st, 2010 and he made an orientation mission to Uganda from June 7th to 21st, 2010[1] and reported to the MOH on July 3rd, 2010.

Institutional Capacity Building (ICB) is a complex process and evolves in more or less 3 different stages:
The diagnostic or inception phase (up to 6 months) is a phase of thorough analysis of the organization, attention on internal functioning and internal and external relation building.[2]
The planning phase partially overlaps with the diagnostic phase. This should result in the writing of a 'procedures manual' for the organization, which will guide the future project implementation. Activities, budgeting and performance indicators will be defined in a work plan.
The implementation phase consists of the actual project activities, with constant monitoring and adjustments.

The start of the project was promising with the establishment of a Project Management Secretariat. The designated Project Manager (Acting Director Planning / Commissioner Planning) delegated the management responsibility to the Acting Assistant Commissioner Planning, who is now the Assistant Project Manager. Regular (weekly) secretariat meetings were scheduled.
An Implementation Committee was also formed, consisting of representatives of other MOH departments and divisions, which is meeting quarterly. An organizational framework for the project management was drafted in an early stage of the project, describing the role and responsibilities of the secretariat, implementation committee and Steering Committee.
MOH assigned an accountant to handle the project co-management accounts, although a proposal is made to recruit a project accountant under the PLMP budget.
Project procedure guidelines for financial management, procurement procedures, etc. were also drafted, but not yet finalized.

Due to various reasons, a smooth and swift continuation of the first phase of the PLM project was not possible, which lead to anxiety within the project management team. Some of the problems faced can be named institutional, on which the project had little influence:

- The Ministry of Health and the Planning Department specifically is understaffed as related to the responsibilities assigned to them. All staff is relatively overloaded and it is therefore difficult to adhere to

[1] Introduction Report, June 2010 (see Annex)
[2] TFF page 25

planned or scheduled activities. The priority of the Planning Department during the first period of the project was with the completion of the Health Sector Strategic and Investment Plan (HSSIP) and the compilation of the Annual Health Sector Performance Report for 2010. Both processes have been long and tedious and they do require a thorough evaluation and review. The Assistant Project Manager is also the responsible officer for the introduction of a Social Health Insurance scheme in Uganda, which has his highest priority.

- SIDA allocated additional funding to the PLMP, through delegated cooperation with BTC. A reformulation proposal was made for presentation to the Steering Committee for approval. The meeting of the Steering Committee in December however was postponed due to internal MOH discussions on the modalities of how the delegated cooperation should be managed.
- The project is designed to be embedded within the Ministry of Health structure, specifically in the Department of Planning. Its implementation should therefore be fully integrated with the MOH routine activities. However, the formulation of the interventions as a project under co-management, makes that the perception within MOH is that of a 'traditional' project. It has its separate structure and budget which are in line with, but parallel to the MOH. The project is not yet an integrated part of the departments' work-plan, but is still perceived as additional to it.
- At MOH head quarters, the absence of a functioning top leadership structure has evolved into an atmosphere of competition, friction and conflicts. Communication between departments or between divisions within the same department is often poor and mandate structures are not clear or not respected. As departments were run relatively autonomous, coordination of activities and collaboration is poorly developed. As some top leadership positions are now filled (i.e. deputy Permanent Secretary, Director Health Services (Planning & Development, Special Presidential Advisor on Health and Population), the internal communication and coordination should be strengthened as a matter of priority, in which the PLM project can play a facilitating role.

Other elements can be named internal 'start-up' problems in the understanding and execution of co-management modalities of the project:

- Although project accounts were opened at the Bank of Uganda for managing the co-management funds, procedures and errors at various levels made that operationability of the co-management accounts was delayed by nearly 5 months. A first transaction could only be made by December 3rd, 2010.
- The recruitment procedure of a Project Officer was not clearly defined from the start of the project and did meet various obstacles. Two internal procedures were rejected by Health Service Commission and Human Resource Management Division MOH respectively, while an external procedure was delayed due to

availability of members of the interview panel, and is still not completed.

- The project uses the Procurements and Disposal Unit (PDU) at Ministry of Health and follows the PPDA guidelines. The first experiences have learnt that the procedures are lengthy and the project can face delays at several steps in the procurement cycle. At the moment two requests for newspaper adverts are delayed by over a month, due to irregular meeting frequency of the Contracts Committee.

Towards the end of 2010, the project management team encountered some fundamental problems. There was a difference in interpretation of the status of the project document (TFF), the co-management modality was difficult to implement and there was increasing anxiety at MOH about the delays in the implementation of project activities.
The discussion on the modality in which the SIDA contribution was to be managed and the management of accountability queries by BTC, contributed to a climate of ‘opposing’ parties (MOH versus BTC).
In this negative atmosphere, gossip and hearsay added to a deterioration of the relationship between the Technical Advisor and the Project Manager and Assistant Project Manager. A letter with complaints about the project execution and the TA was written by MOH to the Representative of BTC o December 14th, 2010.

A second Steering Committee meeting took place on January 11th, 2011 and a number of the operational and communication problems were discussed. A technical committee was assigned to develop a proposal for the TFF revision, based on the specific observations, findings and recommendations from the inception period.
Before a third (special) Steering Committee meeting is scheduled, a budget modification proposal will be developed and presented to BTC for validation. This will contain the budget implications of the reformulation of the project to accommodate the delegated contribution by SIDA, the proposed adjustments in the TFF and the work plan and budget for 2011.

During the difficult first phase of the project, the BTC Uganda office has been very helpful in supporting the project. The Resident Representative (RR) and the Programme Officer (PO) were never tired of answering questions and explaining procedures. The Local Administrative Officer (LAF) and Office Manager were very supportive with the monthly FIT reporting and with the various procurement needs. Especially during a period of tension within the project management team, the RR was an effective supporter and mediator.

# 4 Analysis of the intervention

## 4.1 Institutional anchoring and execution modalities

Institutional anchoring score: Appropriate
Execution modalities: Not very appropriate

The Belgian Government is one of the Development Partners that supports the health sector in Uganda through budget support, in line with the Paris Declaration principles on donor harmonization and alignment. However, parallel to the budget support, the PLMP has been designed as a project under co-management. This is a relatively new concept to the Ministry of Health and has been in need of clarifications. The MOH has developed a Long-Term Institutional Arrangements (LTIA) framework and fitting the co-management modalities within it is meeting challenges. The project has been placed within the MOH, specifically the Department of Planning. This should ensure adequate MOH ownership of the implementation of the project. As the Permanent Secretary is the Project Director and chair of the Steering Committee, there is appropriate institutional anchoring.

Execution under co-management requires team work and understanding of all roles and responsibilities. This is not yet optimally developed within the project management team. The responsibility of the Technical Advisor as project co-manager is at times conflicting with his role as TA within the Ministry. In theory, the project modality is mostly administrative, as the implementation of project interventions takes place through the Department of Planning with the MOH.
In reality however, the understanding of project modalities is more traditional, resulting in regular ad-hoc requests for activities or sponsorships outside the project management. The operational and management framework of the Ministry of Health, does not yet actively involve the project in key areas, such as intra-departmental collaboration and coordination or organizational planning and review. The execution modality is therefore not yet very appropriate, and will need to evolve further during the period of the project.

## 4.2 Specific objective

The specific objective for the project was formulated as: “The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels”.
This should facilitate the achievement of the general objective, formulated as: “To improve effective delivery of an Integrated Uganda National Minimum Health Care Package (UNMHCP)”.

The project results are directly related to the specific objective and are linked to different levels in the health sector. In the Project Identification Document (March 2009), the focus of analysis was on lack of knowledge and skills of health staff members at all levels in the health sector, as well as on the need for strengthening management systems (e.g. HMIS, M&E and Supervision).
In the TFF the focus is on "institutional" rather than on `individual` capacity building. This implies that the capacity of an institution (or sector) is more than the sum of the capacity of all sub-units, but also depends on the quality of the relations and collaboration between the sub-units[3].
A restructuring of the Ministry of Health has been discussed within MOH and was presented to the Government of Uganda. However, the GOU has recruited an international consultancy firm for the restructuring of the entire civil service and the health sector restructuring is being reviewed within this assignment.

Both the outcome of the restructuring process and the implementation success of the project interventions will determine if the specific objective will be met.

### 4.2.1 Indicators

The tables[4] below lists the indicators for the specific objective as described in the project document. These will be reviewed based on the new Health Sector Strategic and Investment Plan (HSSIP 2010/11 – 2014/15).

| N° | Category | Indicator | Baseline value 03/04 | 2006/07 target | 2009/10 target | Data source |
|---|---|---|---|---|---|---|
| 1. | Input | % of PHCCGs released on time to the sector | 97% | 100% | 100% | MoH/MoFPED reports |
| 2 | Process | Proportion of districts, submitting quarterly assessment reports | 5% | 40% | 90% | HMIS reports |
| 3. | Process | % of facilities without any stock out of first line anti-malarial drugs, measles vaccine, Depo-Provera, ORS and cotrimoxazole | 40% | 55% | 80% | HMIS/reports records review |
| 4. | Process | % of population residing within 5kms of a health facility (public or PNFP) | 72% | 80% | 85% | 1. Mapping of health facilities<br>2. Population based surveys |

[3] TFFpage 24.
[4] TFF page 56

| 5. | Process | % of the health units by level providing all components of the UNMHCP | N/A | N/A | N/A | To be determined locally |
|---|---|---|---|---|---|---|
| 6 | Process | % of health units providing EMOC | 14% | 30% | 60% | HMIS en surveys |
| 7. | Output* | % of children <1 yr receiving 3 doses of DPT/Pentavalent vaccines | 84% | 87% | 90% | HMIS |
| 8. | Output* | Proportion of approved posts that are filled by health professionals | 68% | 85% | 90% | Annual HU/district reports |
| 9. | Output | Couple Year Protection (CYP) | 223,686 | 325,407 | 494,908 | HMIS |
| 10. | Output | Urban /rural specific HIV sero-prevalence rates | 6.2% | | 4.4% | ANC reports ACP reports |
| 11. | Output* | % of deliveries taking place in a health facility (GoU and NGO). Deliveries supervised by a health worker | 24.4% | 35% | 50% | HMIS UDHS |
| 12. | Output* | Total GoU and NGO/Capita OPD utilization per year | 0.72 | 0.90 | 1.0 | HMIS/record review |
| 13. | Output | Caesarean section per expected pregnancies (Hospital) | 1.5% | 7% | 10% consult RH | HMIS reports & records review |
| 14. | Output | Proportion of TB cases notified compared to expected | 49% | 60% | 70% | NTLP reports |
| 15. | Output | Proportion of TB cases that are cured | 62% | 80% | 85% | NTLP records |
| 16. | Output | Proportion of pregnant women receiving a complete dose of IPT2 | 24% | 50% | 75% | HMIS |

The following routine indicators from the districts and hospitals are related to the various health MDGs. They are also related to the specific objective because they indicate how the system as a whole is functioning. They cannot be related to specific activities or results.
Although they are all routine indicators collected in the HMIS system, the completeness and quality of data in the national system is very poor.

| Description of indicator | Source of verification |
|---|---|
| **Maternal health** | |
| Expected number of deliveries / HSD | HMIS |

| | |
|---|---|
| Assisted deliveries at HC II, II, IV level **+ rate (%)** | HMIS |
| Number of C-Sections in the district + **rate (%)** | HMIS |
| Number of ruptured uterus and institution-based maternal mortality / Number of C-sections in the district | HMIS |
| | |
| **Child care** | |
| Number of children receiving DPT before first birthday + **rate (%) + compared with national level** | HMIS |
| % children covered with measles vaccine before first birthday + compared with national level | HMIS |
| **% CHILDREN VACCINATED AT HC II AND III COMPARED WITH TOTAL NUMBER OF CHILDREN VACCINATED IN THE DISTRICT** | HMIS – specific calculations needed |
| Number of severely malnourished children diagnosed | |
| | |
| **Health facility performance** | |
| Referral rate (new cases) HC II and III to HC IV or GH | HMIS – specific calculations needed |
| Utilization rate curative care HC II and III related to catchment area population | HMIS |
| Number of outpatients in HC IV, GH, RRH | HMIS |
| Number of new outpatients in HC IV, GH, RRH | HMIS |
| Number of return visits in Outpatients in HC IV, GH, RRH | HMIS |
| Number of hospitalised patients / time (excluding maternity normal deliveries) in HC IV, GH, RRH | HMIS |
| Bed occupancy rate (excluding maternity normal deliveries) in HC IV, GH, RRH | HMIS |
| Average length of stay (excluding maternity normal deliveries) in HC IV, GH, RRH | HMIS |
| Drugs out of stock (see HSSP data collection) | HMIS |
| Number of management meetings and % according to norms | HMIS – specific calculations needed |
| Supervision DMT to HSDMT (% realized according to norms) | HMIS – specific calculations needed |
| Supervision HSDMT to HC II and III (% realized according to norms) | HMIS – specific calculations needed |

### 4.2.2 Analysis of progress made

As the project is in its inception and planning phase, no progress towards the specific objective can be assessed at this point in time. The weaknesses in the national HMIS make a reliable interpretation of the indicators above very difficult. The national HMIS system is currently under review and the review and improvement process will be actively supported through the project, in the districts and heath facilities in Fort Portal and Arua regions.

Methodology used during inception / diagnostic phase of project, was one of active participation an observation. The various component were:

- Full participation of Technical Advisor with all MOH activities (e.g. department of Planning, TWG HRH and SMER)
- Introductory meetings with MOH officers and HDPs and other stakeholders
- Document reviews
- Semi-structures (participatory) observations (e.g. HSSIP, AHSPR, JRM processes).

As a result a number of observations, important for the project were made, which are listed below in summary:

- Top leadership positions at MOH have been vacant for some time. Departments are functioning rather independently, without adequate interaction or coordination with other departments. The project TA did not participate yet in any Senior Management meetings, which are supposed to serve as an internal coordination platform.

- Participatory observations confirmed the earlier findings (in e.g. Mid-Term Review and JANS review IHP+). The necessary procedures and guidelines are available, but problems in management do arise by non-compliance to them! Examples are the lack of follow-up of recommendations after supervision, poor respect of HMIS reporting requirements, deviation from procurement procedures, poor respect of planning cycle, inadequate meeting practices.

- Many Capacity Building and Health Systems strengthening activities are proposed and approved by MOH. Coordination is of all initiatives is difficult to organize. As there are overlapping areas between PLMP and WB project, need for coordination is there but still inadequate.

- Meeting skills in MOH are very poorly developed. Meetings are often chaotic and respect for time-keeping is limited. Meetings are inefficient due to a variety of poor practices: deviation from pre-set agenda, poor time-management, porr recording practices, frequent rescheduling, inadequate number of meeting rooms, inadequate composition of members, unproductive respect to hierarchy, etc.). Especially the skills for chairing meetings are poorly developed within a number cadres of MOH (e.g. allowing contributions outside agenda or after subject has been closed, etc).

- The structure and management modality of the PLM project are not yet adequately aligned with the MOH systems. For both operational and financial planning and monitoring, the MOH used the Financial Year (July – June), while BTC uses calendar years (January – December). This creates misunderstandings on timing of activities or reports. The alignment of FIT with the GOU / MOH accounting systems

was observed as a priority. Alignment of FIT with MOH Chart of Accounts was done with support BTC HQ.

- The observed practices in planning and management at MOH HQ and specifically within the Department of Planning support the need for skills development in many of the staff members. Inadequate basic management skills are the cause of a number of inefficiencies within the MOH. E.g. the inefficient meeting practices complicated procedures lead to overuse of staff time which makes people feel overloaded.

- Task completions and quality are often considered the same. Due to the GOU monitoring systems, there is emphasis on activities ‘done or not-done’ and on budget allocation ‘spend or not-spend’. This creates a culture of ‘ticking’ of activities without simultaneous attention for the quality of the activity or its impact.

### 4.2.3 Risks and Assumptions

**Risk Analysis 2011 – Health Planning, Leadership and Management:** The project implementation period started in June 2010 with its launch at the first Steering Committee meeting. It has faced some operational challenges that have delayed the visible implementation of project activities in its first 6 months. Bank transactions from the project accounts were only possible from the beginning of December 2010 and the procedure for the recruitment of a Project Implementation Officer has still not been completed by MOH.

1. “The start-up phase of any project is always challenging, but more when the project involves national level and several decentralised stakeholders. How the variety of stakeholders will be brought on board is crucial right from the onset of the project” (BTC Uganda Action Plan 2010). This challenge still requires attention and support from the BTC Uganda office, on how implementation in the two ‘demonstration regions’ will be organized.

2. New officials have taken up leadership positions in the Ministry of Health (Deputy PS, Director Planning and Special Presidential Advisor on Health and Population) and their impact still needs to be established. This will shift the influence on policy and operations back from the Commissioners’ level to the top-management level. It is likely that also the political leadership will be replaced after the coming elections in February 2011. This could also have an effect on the project planning and implementation.

3. Delegated cooperation by SIDA to the PLM project will be effective from beginning 2011 and this will affect the planning of the 2011 (and following

years) activities. Despite the fact that the absorption capacity of the project was already a concern under the BTC funding only, a request for extending the implementation period is not being considered by the Ministry of Health / HPD. This will create pressure to reach spending targets, which could compromise quality of interventions.

4. Mutual understanding of the management and operating modalities of “co-management” is essential for project implementation. This has been a challenge during the first period of the project and will require continuous attention (and support) by BTC Uganda office.

5. The functioning of the project management team has been negatively affected by tensions in the personal relationships between the various members. This has resulted in accusations and an exchange of letters. Some of the underlying causes for this have been discussed by the Steering Committee, but it will require continuous efforts from all sides to strengthen the internal and external communication and to build and maintain effective relationships.
Although the Commissioner Health Planning is the designated Project Manager, he has assigned the actual task to the Acting Assistant Commissioner Planning. However, the Ag ACHS(P) is not able to allocate adequate time and attention to the PLM project, due to his additional duties related to the introduction of Social Health Insurance and the establishment of a Health Economics and Systems Institute (HESI).

6. Coordination of L&M activities within MOH (especially with the World Bank project) will face continuous challenges and it is important to avoid a competitive atmosphere. It is proposed to establish a “Leadership and Management Task Group” under the HRH Technical Working Group for coordination purposes, but most importantly guidance will have to be provided by top management at MOH.

7. The Technical & Financial File for the project is not clear on the financial arrangements concerning the project management costs (transport, stationary, welfare, etc.). Within MOH exists a culture of project task allowances for activities undertaken within projects. As the PLM project is implemented by the Department of Planning, it is considered as part of the routine activities. This could however negatively affect motivation to participate, especially as these allowances do exist within the World Bank project. In the ongoing reformulation and the action planning, clear guidelines and budgets need to be included for these operational costs.

### 4.2.4 Quality criteria:

| | Score | Comments |
|---|---|---|
| **Effectiveness:** Degree to which the specific objective is achieved as planned at the end of year 2010. | D | Much effort towards project management modalities and administrative delays; identification of leadership and management challenges; no capacity strengthening interventions yet. |
| **Efficiency:** Degree to which the resources of the intervention (funds, expertise, time, etc.) have been converted into results in an economical way (assessment for the whole of the intervention) | C | Time loss due to administrative and procedural delays; limited amount of funds used due to administrative delays; time and effort spend on (co-) management structure and understanding. |
| **Sustainability:** The degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention). This includes the degree of likelihood according to which the net advantages are susceptible to withstand the risks. | X | |
| **Relevance:** The degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries. | B | Planning, leadership and management challenges are clearly observed within MOH and project functioning; need for project objective to be well understood; existing variety in project expectations. |

Score key:

| | |
|---|---|
| A Very satisfactory | : no extra effort is necessary |
| B Satisfactory | : efforts have to be reinforced |
| C Unsatisfactory | : measures should be taken |
| D Very unsatisfactory | : measures are necessary |
| X Criteria has not been assessed | |

### 4.2.5 Impact:

The overall goal of the health sector is “to attain a good standard of health for all people in Uganda in order to promote a healthy and productive life”.

To achieve this, five strategic objectives have been stated[5]:

1. Scale-up critical interventions

[5] HSSIP, page 52 (November 2010)

2. Improve access and demand
3. Accelerate quality and safety improvements
4. Improve efficiency and budget effectiveness
5. Deepen health stewardship.

The general planning, leadership and management strengthening through institutional capacity building will improve performance of the sector as a whole and the project will therefore contribute to the sectoral objectives.

### 4.2.6 Lessons learnt and recommendations[6]:

Recommendations:

| Recommendation | Source | Who | Time | Status |
|---|---|---|---|---|
| Revision of TFF: i.e. co-managment structure clarity and role of TA. Project Manager and ass. Project Manager | TFF | Project Manager / Project Co-Manager / BTC RR | Q1 2011 | On-going |
| Reformulation – total budget increase SIDA. Review of scope, scale and duration | TFF | Project Manager / Project Co-Manager / BTC RR | Q1 2011 | On-going |
| Full re-formulation of the project document by external consultants, in case internal revision does not lead to common understanding and action. | Identification document (March 2009) / TFF | PS MOH (project director) / RR BTC (project co-director) | Q1-Q2 2011 | To be considered |
| Include budget line for Project Accountant | TFF | Project Manager / Project Co-Manager / BTC RR | Q 1 2011 | On-going |
| Include budget line for operational and management project costs | TFF | Project Manager / Project Co-Manager / BTC RR | Q1 2011 | On-going |
| Ensure all aspects related to scope and scale are included in reformulation (e.g. operational costs both recurrent and capital, health economics, geographic regions, PNFP, etc) | TFF – Reformulation darft | Project Manager / Project Co-Manager / BTC RR | | |
| Improve internal and external communication. | | Project Management team | Q1 2011 | On-going |

[6] - Recommendation: A decision to be taken, to the attention of a user of the annual report
- Lessons learned: A new insight (or know-how) – new knowledge drawn from the intervention and applicable in similar contexts

| Address inefficient meeting culture as priortiy (i.e. management skills training) | | Project Management team | Q1-2 2011 | |
|---|---|---|---|---|

Lessons learnt:

| **Lesson learned** | **Public** | **Capitalisation in the project cycle** |
|---|---|---|
| Co-management modality to be clearly understood by both parties and other stakeholders involved before start of project. | BTC HQ; MOH | Check mutual understanding during all steps of project cycle, but especiially before implementation start. |
| Formulation of TFF should not be rushed and adequate validation and verification should take place before final approval | BTC HQ | All aspects to be verified for mutual understanding to avoid implementation obstacles |
| Clear, frequent and open communication within project management, to ensure common understanding and identify potential problematic issues at an early stage | MOH; BTC | |

## 4.3 Result 1: The MOH is strengthened in its organizational and institutional capacity.

### 4.3.1 Indicators

| **Result:** The MOH is strengthened in its organizational and institutional capacity. | | | | | Progress: |
|---|---|---|---|---|---|
| **Indicators** | **E** | **G** | **Baseline** | **Progress year 2010** | **Comments** |
| Reform plan in execution | | x | 0 | C | MOH restructuring plan reviewed by GOU; inception phase of project |
| Number of people trained by the project | | x | 0 | X | |
| Number of field visits for: coverage plan development | | | 0 | X | |
| Number of field visits for: master plan designing | x | | 0 | B | |
| Number of field visits for: Procedure manual identification | | | 0 | X | |
| MOH procedures manual in place | | | 0 | X | |
| Support supervision policy paper renewed | | | 0 | B | TOR consultancy for review completed |
| Established procedures for training coordination | | | 0 | X | |

E and G: Indicator sensitive to Environment or Gender
Progress: A Very satisfactory, B Satisfactory, C Unsatisfactory, D Very unsatisfactory

### 4.3.2 Evaluation of activities

A chronogram is included in the TFF (pages 82-83), which is used in this report to assess the progress of planned activities against work plan. As the first period of the project period is dedicated to diagnosis and planning, few activities have been included in the first year of the chronogram. As work has been done related to a number of the planned activities, this will be indicated in each result section.
The chronogram as included in the TFF will be replaced by the operational annual work plans during the implementation phase of the project.

| Activities | Progress: | | | | Commentaries (only if the value is -) |
|---|---|---|---|---|---|
| | ++ | + | +/- | - | |
| 1. Taking into account the recent initiatives already taken in this field, the MoH engages in a capacity assessment and capacity building exercise with a specific focus on leadership, management and planning. | | + | | | |
| 2. Based on the conclusions of the capacity assessment exercise, the MoH provides individual in-service trainings for several of its staff members and creates the material environment needed to support capacity. | | | +/- | | |
| 3. Develop a procedures manual for the MoH. | | | | | |
| 4. The MoH reviews and updated its support supervision framework. | | + | | | |
| 5. The MoH coordinates all efforts in the field of capacity building in the areas of management, leadership and planning. | | | | | |
| 6. The MoH implements its policy on the use of technical assistance in the sector including the modalities for creating a pooled funding mechanism. | | | | | |
| 7. The MoH designs a policy and provides modules specific for each type of health facility enabling the organisation of introduction periods for newcomers in management positions in the system. | | | | | |
| 8. The MoH organises the monitoring and two-yearly evaluation of the progress. | | | | | 2012 |

### 4.3.3 Analysis of progress made

Most activities are foreseen to be implemented after the inception and planning period of the project. The contribution to the project by SIDA made it necessary to reformulate the project document.

Progress has been limited in all result areas due to operational delays at the project management level, such as in-operational accounts until December 2010, and no recruitment of a project officer until date.

Various drafts of a work-plan for financial year 2010 – 2011 have been produced and a number of activities have started, but do not have a visible result (e.g. inventory of various training activities or development of terms of reference).

A ‘MOH leadership and management capacity assessment’ has been foreseen to be done under the WorldBank supported Uganda Health Systems Support Programme (UHSSP). The implementation of the UHSSP is also facing implementation delays and it is not clear when the assessment is supposed to be conducted. In the M&E Technical Working group a USAID supported Health Systems Assessment (HSS) was introduced in October, but it is not clear when this will take place.

The MOH / DHP insists on an urgent implementation of leadership and management capacity building interventions at the top and senior management cadre at MOH HQ. Consultations are made with a Swedish Institute with broad experience in similar trainings in the public service in Zambia.

#### 4.3.4 Risks and assumptions

See section 4.2.3.

#### 4.3.5 Quality criteria

Not applicable yet

#### 4.3.6 Budget execution

Co-management accounts became only operational on December 3, 2010. Only a limited amount of expenditure could be processes in the last month of the year.
Some activities that would under normal circumstances be administered under co-management have been charged under ‘regie’ or ‘BTC-own management’ in order for the project to progress in its first months.

#### 4.3.7 Lessons learned and recommendations

See section 4.2.6.

## 4.4 Result 2: One selected Regional Referral Hospital (Fort Portal) and two General Hospitals, located within the catchment area of the RRH, are strengthened in their institutional and organizational capacity.

### 4.4.1 Indicators

| **Result:** One selected Regional Referral Hospital (Fort Portal) and two General Hospitals, located within the catchment area of the RRH, are strengthened in their institutional and organizational capacity | | | | | Progress: |
|---|---|---|---|---|---|
| **Indicators** | **E** | **G** | **Baseline** | **Progress year 2010** | **Comments** |
| Strategic Plan incorporating master plans in place | x | | 0 | B | |
| Hospital mandate reflects efforts for complementary role definition | | | 0 | X | |
| Number of support supervisions realised respecting new policy in this matter | | | 0 | X | N/A |
| Number of people trained | | x | 0 | X | N/A |

E and G: Indicator sensitive to Environment or Gender
Progress: A Very satisfactory, B Satisfactory, C Unsatisfactory, D Very unsatisfactory

### 4.4.2 Evaluation of activities

| Activities | Progress: | | | | Commentaries (only if the value is -) |
|---|---|---|---|---|---|
| | ++ | + | +/- | - | |
| 1. The three hospitals engage in a capacity assessment exercise. | | | +/- | | Unable to conduct adequate assessment visits due to operational constraints |
| 2. The three hospitals go through an organisational reform process based on the capacity assessment results. | | | | | |
| 3. Assist the hospitals in the development of a procedures manual. | | | | | |
| 4. Assist the hospitals in the development of a strategic plan taking into account the results of the institutional capacity assessment. | | + | | | Priority of MOH / DHP, for allocation of development funds by MOFPED |
| 5. Assist the hospitals in their yearly planning exercise taking into account the strategic plan and the result of the institutional capacity assessment. | | | | | |
| 6. Develop a master plan for each hospital. | | + | | | (see under 4) |
| 7. The hospitals organise the monitoring and two-yearly evaluation of the progress. | | | | | |
| 8. Presenting experiences and results in a training workshop for hospital management teams and MoH. | | | | | |

### 4.4.3 Analysis of progress made

An introductory visit to Fort Portal (Ruwenzori) region was made in June 2010. A second (planning) visit was only scheduled in September 2010, due to other commitments of assistant Project Manager.
All districts and hospitals participated in a one-day workshop and orientation visits were made to Bundibunyo and Kasese districts, including Bundibunyo, Kilembe Mines and Bwera hospitals.
Follow-up of the planning visit was severely hampered by financial accountability issues of the first visit, which at this point in time are still not resolved.

It was agreed that the priority for Fort Portal region should be:

a) Support to the development of strategic and investment plan for FP RRH

b) Support to the development of a functioning Community Health Department, as entry point for the PLMP regional activities (followed up in November 2010).

The project supported a consultative 2-day meeting with all Regional Referral Hospitals, in order to harmonize the processes at various hospitals in developing strategic, investment and master plans for the facilities. As a result a standardized format for the Strategic and Investment Plans (SIPs) was developed and both Fort Portal and Arua RRH are actively supported.

#### 4.4.4 Risks and assumptions

Not applicable yet

#### 4.4.5 Quality criteria

Not applicable yet

#### 4.4.6 Budget execution

See note under 4.3.6.

#### 4.4.7 Lessons learned and recommendations

Not applicable yet

## 4.5 Result 3: One selected Regional Referral Hospital (Arua) and two General Hospitals, located within the catchment area of the RRH, are strengthened in their institutional and organizational capacity.

### 4.5.1 Indicators

| **Result:** One selected Regional Referral Hospital (Arua) and two General Hospitals, located within the catchment area of the RRH, are strengthened in their institutional and organizational capacity | | | | | Progress: |
|---|---|---|---|---|---|
| **Indicators** | **E** | **G** | **Baseline** | **Progress year 2010** | **Comments** |
| Strategic Plan incorporating master plans in place | x | | 0 | B | |
| Hospital mandate reflects efforts for complementary role definition | | | 0 | X | |
| Number of support supervisions realised respecting new policy in this matter | | | 0 | X | N/A |
| Number of people trained | | x | 0 | X | N/A |

E and G: Indicator sensitive to Environment or Gender
Progress: A Very satisfactory, B Satisfactory, C Unsatisfactory, D Very unsatisfactory

### 4.5.2 Evaluation of activities

| Activities | Progress: | | | | Commentaries (only if the value is -) |
|---|---|---|---|---|---|
| | ++ | + | +/- | - | |
| 1. The three hospitals engage in a capacity assessment exercise. | | | +/- | | Introduction visit September 2010 |
| 2. The three hospitals go through an organisational reform process based on the capacity assessment results. | | | | | |
| 3. Assist the hospitals in the development of a procedures manual. | | | | | |
| 4. Assist the hospitals in the development of a strategic plan taking into account the results of the institutional capacity assessment. | | + | | | (see under result 2) |
| 5. Assist the hospitals in their yearly planning exercise taking into account the strategic plan and the result of the institutional capacity assessment. | | | | | |
| 6. The hospitals organise a monitoring and evaluation workshop. | | | | | |
| 7. Develop a master plan for each hospital. | | + | | | (see under result 2) |

### 4.5.3 Analysis of progress made

An orientation and introduction visit to West Nile Region was made in September 2010, with visits to the RRH, Yumbe and Arua districts including visits to a number of health facilities (Yumbe Hospital, HC IV, HC III). In the TFF, support and activities in West Nile region are only foreseen to take place from 2012 onwards.

The rational for this phased implementation schedule is two-fold:

- Institutional Capacity Assessment, Capacity Building and organizational reforms are concepts that develop over time. By implementing activities in one region before another, one will be able to test a certain approach first in one region, which could be copied to another region if successful or amended if not successful.
- The project management needs to be established and find its place within the Ministry of Health and the health sector. Starting simultaneous in two regions will be a high demand on the project capacity and might lead to inadequate support, guidance and monitoring in both regions.

As the project implementation period is short in relation to the objective, it is proposed to include Wets-Nile / Aua region in project activities from an

earlier stage. This is considered in the project planning for 2011, with support to the planning process at the Regional Hospital, indentifying and including a PNFP General Hospital in the project and starting the capacity assessment at the various levels.
Collaboration with the MU_SPH programme on District Capacity strengthening (in collaboration with ITM) is also being developed.

#### 4.5.4 Risks and assumptions

Not applicable yet

#### 4.5.5 Quality criteria

Not applicable yet

#### 4.5.6 Budget execution

See note under 4.3.6.

#### 4.5.7 Lessons learned and recommendations

Not applicable yet

## 4.6 Result 4: District Management Teams are strengthened in their managerial capacity, leadership and planning functions.

### 4.6.1 Indicators

| **Result:** District Management Teams are strengthened in their managerial capacity, leadership and planning functions | | | | | Progress: |
|---|---|---|---|---|---|
| **Indicators** | **E** | **G** | **Baseline** | **Progress year 2010** | **Comments** |
| Number of people trained | | x | 0 | x | N/A |
| Number of support supervisions to General Hospitals realised | | | 0 | X | N/A |
| Number of support supervisions to HSDMTs realised | | | 0 | X | N/A |
| Strategic plan developed, followed and discussed with LG | | | 0 | X | N/A |
| Level of understanding of coverage and master plans for strategic planning | | | 0 | X | N/A |

E and G: Indicator sensitive to Environment or Gender
Progress: A Very satisfactory, B Satisfactory, C Unsatisfactory, D Very unsatisfactory

### 4.6.2 Evaluation of activities

| **Activities** | **Progress:** | | | | **Commentaries** (only if the value is -) |
|---|---|---|---|---|---|
| | ++ | + | +/- | - | |
| 1. Districts are engaging in an institutional capacity assessment. | | | +/- | | Planning meeting Fort Portal region |
| 2. Districts accompany general hospitals in their capacity assessment and building process. | | | | | |
| 3. Districts accompany HSD management team in their capacity assessment and building process. | | | | | |
| 4. District develop and negotiate with the LG authorities a strategic plan based, on the results of the HSD and GH capacity building plans including the coverage and master plans developed at that level. | | | | | |

### 4.6.3 Analysis of progress made

All districts in Fort Portal region participated in a one-day planning meeting (September 2010). Due to the operational obstacles in the project management, no follow ups have been made yet.
Activities under this result area were not included in the chronogram for the first year.

### 4.6.4 Risks and assumptions

Not applicable yet

### 4.6.5 Quality criteria

Not applicable yet

### 4.6.6 Budget execution

See note under 4.3.6.

### 4.6.7 Lessons learned and recommendations

Not applicable yet

## 4.7 Result 5: A comprehensive approach on capacity building of HSD management teams is operational

### 4.7.1 Indicators

| **Result:** A comprehensive approach on capacity building of HSD management teams is operational | | | | | Progress: |
|---|---|---|---|---|---|
| **Indicators** | **E** | **G** | **Baseline** | **Progress year 2010** | **Comments** |
| Number of HSDMT members trained | | x | 0 | X | N/A |
| Coverage plans, master plans and procedure manual reflected in strategic and yearly plans | | | 0 | X | N/A |
| Coverage plans discussed with LG | | | 0 | X | N/A |
| Number of HSDMT meetings held | | | 0 | X | N/A |
| Number of HC II and III supervised by HSDMT | | | 0 | X | N/A |

E and G: Indicator sensitive to Environment or Gender
Progress: A Very satisfactory, B Satisfactory, C Unsatisfactory, D Very unsatisfactory

### 4.7.2 Evaluation of activities

| Activities | Progress: | | | | Commentaires (only if the value is -) |
|---|---|---|---|---|---|
| | ++ | + | +/- | - | |
| 1. Support the ongoing capacity building for HSD management teams based on the modules developed by MoH / WHO. | | | | - | |
| 2. 10 HSDs (+ related district) engage in a capacity assessment exercise (Five HSDs per catchments area of the RRHs under result 2 and 3). | | | | | |
| 3. The HSDs engage in an organisational reform process based on the capacity assessment results. | | | | | |
| 4. The HSDs are supported by the MoH in the first year plan following the assessment. | | | | | |
| 5. The HSDs organise the monitoring and an evaluation workshop after 2 years of implementation. | | | | | |
| 6. Develop a coverage plan for 10 HSDs. | | | | | |
| 7. Develop master plan for each HC IV. | | | | | |
| 8. MoH capitalises the experiences and translates them into the sector policy. | | | | | |

### 4.7.3 Analysis of progress made

Activity 1 (support to ongoing HSDMT training) was included in the project chronogram in year 1, as the capacity of planning, leadership and management skills at this level is considered very important as well as very weak.
A training curriculum for Health Sub-District Management teams was developed and has been used by MOH for a number of training sessions. Attempts have been made to obtain information on these trainings (e.g. sub-districts teams trained, number of participants, costs involved, evaluation of training and impact), but very little could be traced. Although the HR Development division is mandated to implement these trainings, the coordination and implementation has been placed in the Planning division (both within the Department of Planning). The reason for this shift is not clear.
In 2007 an evaluation was conducted by the DHRH programme. However, the report was not shared until recently and the recommendations have not been implemented.

Involvement of national health training institutions in this type of trainings is proposed within the project activities to crate adequate local capacity for sustainability of interventions. This should be based however on a clear review of the previous experiences and should answer the identified needs and weaknesses in the HSD management.
It is also very important to consider the future status, position of functions of Health Sub-Districts in the health sector, in relation to the increasing number of Districts.

#### 4.7.4 Risks and assumptions

Not applicable yet

#### 4.7.5 Quality criteria

Not applicable yet

#### 4.7.6 Budget execution

See note under 4.3.6.

#### 4.7.7 Lessons learned and recommendations

Not applicable yet

## 4.8 Result 6: Two training centres / demonstration sites for capacity building of HSD management teams are functional.

### 4.8.1 Indicators

| **Result:** Two training centres / demonstration sites for capacity building of HSD MTs are functions | | | | | Progress: |
|---|---|---|---|---|---|
| **Indicators** | **E** | **G** | **Baseline** | **Progress year 2010** | **Comments** |
| Number of HSDMT members trained in training centres | | x | 0 | X | N/A |
| Number of training sessions held | | | 0 | X | N/A |
| Number of HC II and III up to quality standard for receiving trainees | | | 0 | X | N/A |
| Evaluation of the first 2 years of functioning | | | 0 | X | N/A |
| Status training centres clarified | | | 0 | X | N/A |

E and G: Indicator sensitive to Environment or Gender
Progress: A Very satisfactory, B Satisfactory, C Unsatisfactory, D Very unsatisfactory

### 4.8.2 Evaluation of activities

| Activities | Progress: | | | | Commentaires (only if the value is -) |
|---|---|---|---|---|---|
| | ++ | + | +/- | - | |
| 1. Build training facilities and equip for receiving a maximum of 15 participants and 2 outside trainers at a time. | | | | | |
| 2. Based on previous activities formulate a comprehensive approach for further capacity building activities for HSD and district management teams. | | | | | |
| 3. Establish training modules and programmes. | | | | | |
| 4. The HC and hospital(s) that will receive course participants for their practical training are prepared and work up to standards. | | | | | |
| 5. Organise 3 training sessions with each 12 participants in a first year in the two centres. | | | | | |
| 6. The MoH defines a long-term status and a sustainable financing mechanism for the centres, based on the findings of an in-depth evaluation of the impact of the courses on the management performance of the SHD MT. | | | | | |

### 4.8.3 Analysis of progress made

Activities under this result area are only foreseen to take place from year two onwards. Assessment of potential training sites has not yet started

### 4.8.4 Risks and assumptions

Not applicable yet

### 4.8.5 Quality criteria

Not applicable yet

### 4.8.6 Budget execution

See note under 4.3.6.

### 4.8.7 Lessons learned and recommendations

Not applicable yet

## 4.9 Result 7: A scientific support team accompanies the capacity building process in the Ugandan health sector

### 4.9.1 Indicators

| **Result:** A scientific support team accompanies the capacity building process in the Ugandan health sector. | | | | | Progress: |
|---|---|---|---|---|---|
| **Indicators** | **E** | **G** | **Baseline** | **Progress year 2010** | **Comments** |
| Policy paper on support supervision refined and approved | | x | 0 | X | N/A |
| Policy paper on referral system refined and approved | | | 0 | X | N/A |
| Complementary roles of health facilities better defined and approved in policy paper | | | 0 | X | N/A |
| Continuous training policy for health personnel refined. | | | 0 | X | N/A |

E and G: Indicator sensitive to Environment or Gender
Progress: A Very satisfactory, B Satisfactory, C Unsatisfactory, D Very unsatisfactory

### 4.9.2 Evaluation of activities

| **Activities** | **Progress:** | | | | **Commentaires** (only if the value is -) |
|---|---|---|---|---|---|
| | ++ | + | +/- | - | |
| 1. An expert team composed of national and international experts supports the MOH in organizing the capitalization process between the operational and policy level of the MOH. | | + | | | TOR finalized |
| 2. Facilitate the policy dialogue between the operational and policy level of the MOH | | | | | |

### 4.9.3 Analysis of progress made

Understanding the objective of a scientific support team accompanying the project, required some consultations outside and discussions within the project management team.
Terms of Reference have been drafted and, although the TOR had been

circulated within MOH, very few comments or contributions were made. It was an item for the Implementation Committee meeting in November 2010, were the TOR was adopted without further discussion.
A distribution plan for the TOR for Scientific Support was agreed, but has not yet been implemented.
Delays in procedures with PDU have stopped the advert form being published in the national news paper. As other media (websites BTC, MOH, direct mailing) are supposed to be used simultaneously, the deadline for submission needs to be postponed.

The role of national (health and training) institutions is important, but should not be confused with their role as partners in the implementation of the project activities (especially capacity building in the form of trainings). Scientific support, in terms of guiding and advising on the direction and quality of the project and as a ‘think tank’ to stimulate innovations and debate, requires broad technical skills and experience, which can not only be delivered by national institutions.

#### 4.9.4 Risks and assumptions

Not applicable yet

#### 4.9.5 Quality criteria

Not applicable yet

#### 4.9.6 Budget execution

See note under 4.3.6.

#### 4.9.7 Lessons learned and recommendations

Not applicable yet

# 5 Beneficiaries

As the project is in its diagnostic and planning phase, no concrete benefits or changes can be identified at this stage.

Potential beneficiaries of the project can be distinguished however into different types:

1. The society at large / the population of Uganda:
   The eventual benefit of achieving the general objective ("To improve effective delivery of the UNMHCP") will be the people in Uganda that are in need of health services. Improvements in service indicators and health status indicators will be reflected in the long term.

2. The partner institution, the Ministry of Health, will benefit from the project through the strengthening of its organizational, institutional and managerial capacity. The first phase of the project has assisted so far in identifying the strengths and weaknesses in MOH capacity. However, concrete changes cannot yet be reported on

3. Health workers / managers at various levels of the health sector. During the course of the project implementation numerous health workers will benefit from the project through enhancement of planning, leadership and management skills. This can be through direct training of health workers, but also through the effects of more effective planning, leadership and management at other levels in the sector. Concrete actions that can be noted already are the support to the (strategic) planning process at all Regional Referral Hospitals.

4. Universities and other training institutions will benefit form involvement with the ICB project, through skills development, interaction with other (international) institutions, and experience in supporting the health sector in planning, leadership and management.

The TFF describes the potential beneficiaries as follows (3.5., page 61):

- Principle beneficiaries will be the managers at different levels of the health system in Uganda (MOH HQ, operational, hospital and sub-district)
- Universities and health training institutions
- Ultimate beneficiary is the people of Uganda.

# 6 Follow-up of the decisions taken by the Steering Committee

The project Steering Committee held its inaugural meeting on June 16th, 2010 and was chaired by the incoming Deputy-Permanent Secretary of the Ministry of Health.
This is considered the start of the implementation period of the project, which was defined in the TFF as being of 4 years duration.

A second Steering Committee meeting was scheduled on December 8th, 2010, but postponed by MOH due to internal discussions on modalities concerning the delegated cooperation by SIDA.

In the first Steering Committee meeting, it was emphasized that the PLM project should contribute to reversing the bad image of the health sector. The ultimate effect of the project should a growth of capacity of the sector as a whole.

An agreement was reached between SIDA, BTC and MOH on a delegated contribution to the PLM project, which was approved by MOFPED. The project management was tasked with reformulating the project scope to accommodate the increase in total funding. The reformulation was proposed and is awaiting Steering Committee approval.

# 7 Annexes

### 1. Logical framework:

No updated version yet – awaiting Steering Committee decision on expansion of scope and scale of project (delegated cooperation SIDA).

### 2. M&E activities:

- Steering Committee meetings (June 16th, 2010 and January 11th, 2011)
- Implementation Committee meetings (August, and November, 2011)
- Backstopping support BTC HQ (inclusion of GOU Chart of Accounts in FIT).

### 3. "Budget versus current (y – m)" Report –separate file

### 4. Introduction report TA (June 2011):

### 5. Reformulation proposal PLMP (SIDA delegated Cooperation) - version 01/12/2010:

**Annex 4 – Annual Report:**

## INTRODUCTION REPORT – Institutional Capacity Building in Planning, Leadership and Management in the Ugandan Health Sector

### 1. Introduction:

After engaging the International Technical Advisor by BTC in May 2010, the Ministry of Health in Uganda requested for the start of the project as soon as possible. It was therefore agreed that the TA would travel to Uganda for a two-week introduction mission, before his definitive relocation to Uganda at the beginning of July 2010.
The objectives of the mission, which took place form June 7th to 20th 2010, were as follows:

- Introduction to BTC Uganda
- Introduction TA to MOH Uganda
- Field visit Fort Portal
- Meetings with bilateral partners and other stakeholders involved in CB
- Launch of project - 1st Steering Committee Meeting
- Work plan initiation for year 1
- Logistic preparations (e.g. office, equipment orders, housing).

### 2. Outputs of the mission:

As can be seen from the work programme (Annex 1), most of the objectives were addressed. The TA was able to obtain a good initial understanding of the working environment and the execution in the (public) health sector. Especially the field visit to Fort Portal region was very educational and illustrative of management challenges at the service delivery level. A narrative report of the field visit is attached (Annex 4).
Courtesy calls were made to officials within the Ministry of Health (including Permanent Secretary) and at the Belgian Embassy (Ambassador, 1st Secretary Health).

The project was officially launched during the first Steering Committee meeting, which was chaired by the (new) Deputy Permanent Secretary and facilitated by the Ag. Director Health Services (P&D). Representatives from both Ministry of Local Government and Ministry of Finance attended the meeting (Annex 5).
Once the project was launched, a contribution was made to the MOH Workplan for 2010 / 2011 to ensure smooth operation of the start-up phase.

A number of stakeholders involved in Capacity Building initiatives in the health sector were visited. The TA was introduced to the First Secretary Health at the Swedish Embassy, and the delegated support from SIDA to the MOH / BTC project was discussed. SIDA is also the current chair of the Health Development Partners group (HDP). The TA was also introduced to the Senior Health Specialist at the World Bank, responsible for the 'Uganda Health Systems Strengthening project'. The DANIDA support to the health sector was discussed with their Senior Health Advisor.
Scheduling more stakeholders meetings proved difficult and will take place in July.

At the end of the mission, debriefing meetings were conducted at MOH with the Ag. Director Health Services (P&D) and at BTC with the Resident Representative.

## 3. Actions to be taken

### 3.1. Actions to be taken by TA:

- List project office equipment to be ordered by BTC Uganda
- Propose draft schedule for starting period (July – September 2010)

### 3.2. Actions to be taken by BTC Uganda:

- Order and receive project vehicle (Toyota Prado, expected arrival July 2010)
- Collaborate with MOH on recruitment of Project Officer

### 3.2. Actions to be taken by MOH Uganda:

- Allocate office space for project TA and project officer
- Start recruitment process of ‘project officer’ (in collaboration with BTC Uganda)

## 4. Conclusion:

The introduction mission has been extremely helpful for the stakeholders involved. The TA obtained a more in-depth understanding of the health sector in Uganda and was provided with much background documentation. The MOH has been anxiously waiting for the start of the project, which now took place with a successful first Steering Committee meeting.
The TA is very grateful for the wonderful reception in Kampala by both BTC Uganda and the Ministry of Health. The introductions have been very cordial and constructive and the expectations of the project are high. I would like to thank the Ag. Director Health Services (P&D), Dr Runumi, for assisting the TA during the introduction period and the logistical support provided. I would also like to thank the BTC Representative, Mr Goekint, for all the support and hospitality during the period of the visit. I am looking forward to a successful collaboration over the next 4 years.

Kampala 19 / 06 / 2010.

Dr. Hans Beks

**Annex 5 - Annual Report:**

**Project UGA 09 017 11: "Institutional Capacity Building in Planning, Leadership and Management in the health sector in Uganda" / "Planning Leadership and Management Project (PLMP)".**

**PROPOSAL FOR PROJECT REFORMULATION**

## 1. Introduction:

The Technical and Financial File (TFF) for the project was developed during the second half of 2009 and a bilateral agreement between Ministry of Health and BTC was signed in December 2009.

The project period is set at 5 years (2010 – 2014), with an implementation phase of 4 years. The available budget through BTC is EUR 6.5 million, of which EUR 5.542.000 is under co-management arrangement and EUR 958.000 under 'General Means' ('Regie').

An International Technical Advisor (ITA) was recruited as per May 1st, 2010 and joined the MOH by July 1st, 2010. The first three months have been an intensive period of information gathering, the development of personal relations and networking and interaction with the various stakeholders within MOH (e.g. various departments, Regional Referral Hospitals, District Management Teams, etc.) and outside (e.g. Health Development Partners).

The project document (TFF) is considered to be a guiding document. The proposal includes an inception period for systems, organizational and institutional assessments in order to ensure that the project interventions will be directed towards the priority areas to yield optimal results. It was therefore foreseen that the project formulation would require some revisions, before actual implementation phase could start.

The Swedish International Development Agency (SIDA) delegates the balance remaining from their contribution to the former 'Partnership Fund' of SEK 13. 5 million (Valorised at 1.440.630€) to the PLM Project, rather than developing a separate Institutional Capacity Strengthening intervention. SIDA contribution co finances the existing PLM project and comes on top of the part initially financed by Belgian cooperation. Both Swedish and Belgian contributions will be fully merged and no earmarking is foreseen. Negotiations between MOH, SIDA and MOFPED resulted in government approval and a bilateral agreement between SIDA and BTC is being developed.
Although SIDA will delegate the management of the contribution to BTC, there is an interest to ensure that their contribution addresses some key interest areas for the Swedish government.[7]
SIDA will also become a member of the Steering Committee.

During the formulation of the TFF in 2009, the focus of the project was on the

[7] SIDA will put special attention on training and capacity-building relating to sexual and reproductive health and rights, financial management and accountability measures.
There is need to limit the scope as PLMP cannot cover everything; Reproductive Health is already included in the UHSSP (World Bank) and will not be considered within the scope of the PLMP.

public (and not the private) health sector. As a result of more in-depth discussions at MOH, it was realised that the interventions will have a greater impact when they are directed to the health sector as a whole and that the Private-Not-For-Profit sector will have to be incorporated.

With this in mind, the MOH is required to propose options for the project reformulation, with an increase in project budget from 6.5 to 7.85 million Euros. The revision is to be approved in Steering Committee, before the bilateral agreement between SIDA and BTC can take effect. In the case of extending the project implementation period, there is also need for a revision of the bilateral agreement between the governments of Belgium and Uganda.
A number of options will be proposed in this concept note, indicating the scope and possible budget consequences, as well as the advantages and disadvantages of each option.

### 2. Management modalities:

Implementation modalities mentioned in the original TTF (UGA 0901711) remain valid (BTC/MOH guidelines and procedures).

The current Technical and Financial File contains some errors and omissions that require change through the Steering Committee meetings.

The partner institution for the PLMP is the MOH, specifically the Department of Planning. In the TFF (section 5.1.) the "Director Planning" is included as project manager. However, this should read the "Commissioner Planning".

The TFF does not have a provision to employ a designated Project Accountant. Experience in the first period of the project has shown that the financial management of the project accounts is challenging. The accounts department at MOH is understaffed and procedures are being delayed as a consequence. The financial management uses the Financial Information Tool (FIT), as implemented with all BTC funded projects. This requires extra time on implementation from the accounting staff. Transformation of the project budget to the GOU Chart of Accounts is foreseen to take place soon and will require extra input from accounting staff. It is therefore proposed to include the position of a "Project Accounting Officer" in the project budget.

The project implementation is guided by the agreement between GOU and LDPG (2009) on standard rates of allowances. This is however not providing adequate guidance on the facilitation of project activities (e.g. running costs like transport, stationary and office supplies, support for specific project activities outside the normal schedule of duties or for covering incidental transport costs for meetings and workshops within Kampala). An operational guideline will need to be developed and included in the project document.[8]

### 3. Implementation period:

SIDA and DGCD will both receive reports referring to the entire project's implementation period.

**[8] Uganda HSS Programme (WB) has a specific budget line for project management activities**

The Government of Belgium recently directed that extensions of approved projects are no longer possible. However, due to the changes in project budget through the delegated contribution by SIDA, a negotiation for extension can be considered. At a later stage in the project period, this might not be possible anymore.

- Rational: The original project implementation period of 4 years is considered to be ambitious. Achieving and demonstrating impact improvements through Institutional Capacity strengthening is a long-term process. With an increase in scale and budget, the absorption capacity of the project will be further challenged. Administrative procedures in planning and procurements are known to take time and prolonging the implementation period therefore will allow for spreading of activities and expenditure over time. This will support improved quality of work and accountability.
  However, given the aim of the project to build Health Systems and Institutional Capacity by the end of the four years, it should be possible to absorb the available resources within the project implementation period. The reformulation includes an increased role for local and International stakeholder institutions (e.g. Universities), which will be mandated to support MOH in various aspects of the project (i.e. in-service capacity building, research and supervising / supporting training demonstration centres). This would contribute to improved sustainability of achievements and can continue even after the project. If in the initial 4 years this partnership is strengthened, there would be no need for extension.

  Consequences: Any extension of the implementation period will require an administrative procedure to modify the bilateral agreement between the GOU and Government of Belgium and will have to be reflected in the Agreement on Delegated Cooperation between SIDA and BTC.
- Budget implications: Extension will require a relatively small increase in 'project management budget' (e.g. extension of project staff, running costs). No extension will of course not have additional budget consequences.

## 4. Proposal - components for inclusion:

Various consultations within and outside MOH, have provided inputs to the proposal for revision of the project scope (areas to be included), the scale (number of facilities) and the duration.
In general the scope of the project was determined during the formulation phase in a broad consultative process and the re-formulation should not deviate from its original intention.

### 4.1. Inclusion of PNFP sector in PLM Project:

- Rational: As this was recognized as an omission in the original project formulation, this is considered a priority. Not only will PNFP facilities in the two implementation regions be included for support under the project, but there will also be a focus on strengthening the

collaboration and relation building between the public and the private-not-for profit sector organizations.

- Consequences: A third General Hospital from the PNFP sector will be identified for support in both implementation regions. In consultation with the Medical Bureaux, a programme for strengthening the inter-bureaux collaboration and planning, leadership and management skills will be developed. The implementation of the new national Public Private Partnership for Health policy (PPPH) will be supported in the two implementation regions.
- Budget implications: Including PNFP General Hospitals will require approximately an additional EUR 100,000=00 / hospital in each regions, while support to the Medical Bureaux is estimated at EUR 200,000=00 (total **EUR 400,000=00)**

### 4.2. Operational and management support MOH HQ:

- Rational: specific operational support for MOH HQ is not comprehensively included in current TFF budget. Supporting an adequate and comfortable working environment for increased productivity needs to be considered.
- Consequences: As the project is embedded within the department of Planning, the working environment of the department needs to provide for logistical support to the various divisions. Planning and management functions are affected by constraints in IT equipment and access to a departments LAN (for internal communication, sharing of information and shared printing facilities) and this requires additional investment.
  There is also need to budget for 'project running', which was not included as a budget line in the original project document. Costs of office stationary and supplies, local transportation, etc., can be considered as well. Similar operational support is required for other contributing departments and divisions (i.e. Quality Assurance, HR Management, and Clinical Services
- Budget implications: **EUR 359,664=00**

### 4.3. Capacity building logistical support for RRHs and General Hospitals

- Rational: Although "support to create a proper working environment" is included in the TFF (Result areas 2 and 3, activity 2), the investment needs at health facilities are substantial. The existing recurrent and capital funds for health facilities, are insufficient to cover all the needs and allocation priority is given to service delivery areas over management needs.
- Consequences: Investments in management operational support is required for the implementing hospitals, in order to achieve results. (this will include support for transport, minor renovation, computers or other accessories and furniture).
- Budget implications: an additional amount of **EUR 200,000=00** is proposed to allocate to logistical support to hospitals.

TFF section 4.3.2.*:"...MOH receives important budget support and hence disposes of a national budget that should enable procurements of the necessary equipment..."*
*"The project proposes that an amount should be fixed per institution for investments directly related to the future performance of the institution".*

### 4.4. Strengthening Operational Research component

- Rational: Through the establishment of a Scientific Support Committee, the project will be assisted in safeguarding quality and the exposure to new and different initiatives in the area of Institutional Capacity Building. In the project document a focus on ´capitalisation´ of experiences is included, to ensure that experiences gained and lessons learnt will find their way eventual into health policies. Research in health systems development is receiving relatively little attention and the project could provide an ideal forum for this aspect.
- Consequences: Many partners in the health sector are interested in systems support and capacity building. It is important to document all the experiences and look for synergies as well as possible gaps. More active (prospective) research activities could be included during the implementation period of the project. Both national and international academic institutions could collaborate with MOH on this. One possible area for active research proposals could be in "health economics", covering e.g. the development and introduction of Social Health Insurance, financial management systems and accountability measures (*Note: these are also some of the areas of key interest for the Swedish Government support to Uganda).*[9]
- Budget implications: With the relatively limited scope of the PLMP, funding for health systems research will have to be sourced from outside. An additional budget of **EUR 150,000=00** is estimated for supporting the developing and initiating research projects.

### 4.5. Gender mainstreaming in health:

- Rational: the TFF (section 6.2) devotes attention to gender, as a cross-cutting theme within the project. Uganda has an operational National Gender Strategy since 1997 and recently reported favourably on their achievements towards the MDG on gender[10]. However in the heath sector, gender is still not considered fully in planning, implementation and evaluation of health services.
- Consequences: the project is proposing to strengthen the sensibilisation on Gender mainstreaming in health, by supporting the development of a specific gender health policy, its implementation through supporting activities that ensure gender equality aspects are recognized and addressed throughout the health sector.
- Budget implications: **EUR 100,000=00**

### 4.6. Health National institutions to be included as stakeholders to provide a supportive arm to the Planning Department in Capacity building (see annex 1)

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[9] After a presentation to Top Management Committee (March 2010), the Planning Department was given a go ahead to establish a Health Economics and Systems Institute (HESI). This will be mandated to review health system reform processes and propose solutions in response to current as well as emerging health system challenges in various aspects of planning, leadership, management, health economics, research and other forms of capacity building.

1.1 [10] Goal 3: Promote gender equality and empower women

- Rational: The three national academic institutions (MUST, UMU and MU-SPH) have broad experience and an established relationship with the MOH. For sustainability purposes it is imperative that these institutions are involved in the process from the start. The TFF acknowledges that the Impact and results from this project are more long term, even beyond the proposed 4 years. Investing in the sustainability of this investment is therefore crucial.
- Consequences: Mbarara University of Science and Technology (MUST) , Uganda Martyrs University, Makerere University School of Public; these institutions can be sub-contracted under the PLMP framework in areas of capacity building.
- Budget implications: for the development of such a framework and for facilitating its implementation, an additional budget of **EUR 100,000=**00 is proposed.

## 5. Additional proposal options:

### 5.1. Development / support to Regional Health Level:

- Rational: The development of a regional level in the health sector is included in the new 5-year Health Sector Strategic and Investment Plan (HSSIP). Due to the increased number of districts and municipalities, the adequate management of quality health services from the central ministry if facing increasing problems. In line with the national developments towards more decentralised administrative systems, the health sector will expand its regional functions. A proposal to support this is also included under Global Fund ATM, round 10.
- Consequences: In the existing TFF, working through a regional approach has been included, with a central focus on supporting the Regional Referral Hospitals RRHs). The specific activities required for this are not yet well defined and it is proposed to initially strengthen the functioning of the Community Health Departments at the RRHs). Activities will be targeted to supporting and expanding the existing regional functions, staffing, infrastructure and equipment, etc. This support will eventually lead to the definition and development of a regional health level, separated from the RRH. A feasibility (and development) study is proposed under the project.
- Budget implications: the funding of activities under the regional approach are included in the budget lines for MOH Capacity Building (A.01.01) and under Institutional Capacity Building in the two identified project regions (A.02.02 and A.03.02)

### 5.2. Inclusion of National Referral Hospitals:

- Rational: The PLMP has a focus on planning, leadership and management strengthening, at all levels within the health sector; from MOH HQ down to health centre service delivery levels. In both implementation areas there will be support for the different systems at the Regional Referral Hospitals. The capacity gaps in planning, leadership and management systems were identified at all levels of the health sector and strengthening is therefore needed at all levels. Through the Permanent Secretary, the management of Mulago National Referral Hospital requested to be included in the PLMP support.

- Consequences: Interventions in planning, leadership and management will be developed to target towards hospitals at regional and district level. During this process, it will be possible to ensure that national referral hospitals can benefit from and contribute to these experiences. The development of facility strategic and master plans or the revision of supervision framework, are examples where national hospitals could be included. Support to infrastructure and equipment at national hospitals will be beyond the scope of the project
- Budget implications: no additional funds are required for supporting selective activities in planning and leadership strengthening at National Referral Hospital level. These are included under MOH Capacity Strengthening budget line (A.01)

### 5.3. District Health Team management training:

- Rational: The PLMP has a strong focus on capacity building of health management teams. Revision of and support towards training for hospital managers is included in the TF. The training of Health Sub District management teams (HSD MTs) is also prominent, with revision and support towards the training programme. Additionally it is proposed to develop demonstration – training sites in each implementation region at HC IV level, to provide opportunities for on-the-job training for new HSD managers. There is however little attention on capacity building for the District Management teams.
- Consequences: A selected number of districts in the two regions will be supported directly with the planning processes, as well as indirectly through the support to the General Hospitals and the development of the regional functions. However, specific review and revision of district health managers training could be considered for support. This could be done in collaboration with national academic institutions, as described before.
- Budget implications: additional funds for supporting selective activities in planning, leadership and management strengthening at District level are not required. These will be funded under the District Management Strengthening component (A.04).

## 6. Summary of budget estimates related to scope expansion:

| Option | Budget estimates (EUR) – proposal | Notes: |
|---|---|---|
| PNFP inclusion | **400,000** (100,000 / hospital / region; 200,000 support medical bureaux) | Add PNFP hospitals in implementation regions; strengthening / support to Medical Bureaux |
| Revise and include Office support for the MOH Centre | **359,664** | Logistical support to the divisions of HPD, QA and HRM/D; including transport, computers and other accessories / furniture |
| Revise and include Capacity building logistical support for | **200,0000** | Will include support to transport, minor renovation, computers and other accessories and furniture (covered in |

| | | |
|---|---|---|
| 2 RRH, 4 Gen. Hosp. | | TFF) |
| Strengthen Operational research perspective | **150,000** | E.g. SHI, Financial Mgt; accountability measures, etc |
| Strengthen engendering of the sector | **100,000** | Crucial to meet constitutional obligations |
| Including MUST, UMA and MU-SPH as stakeholders | **100,000** | Sustainability |
| Extension period of 1 year | | The aim of PLMP is to build institutional capacity. Absorption of all funds (BTC / SIDA) is foreseen within existing project implementation period of 4 years. |
| Development of regional health level | | Start with feasibility study; (This is provided for in the current TFF); included in the budget lines for MOH Capacity Building (A.01.01) and under Institutional Capacity Building in the two identified project regions (A.02.02 and A.03.02) |
| Include National Referral Hospitals | | Selective activities (e.g. support planning process; leadership strengthening).This is included in the existing budget provision in the TFF; included under MOH Capacity Strengthening budget line (A.01) |
| Management training District Health Management Teams | | Specific activities to be determined (e.g. review, revision and support). This is part of the current formulation. |
| **BTC administrative costs** | **130,966** | 10% of SIDA's contribution |
| **Total additional budget:** | **1,440,630** | **Eur : SEK = 1 : 9.37** (Nov. 26. 2010) |

## 7. Conclusion:

The increase in project budget through the delegated funding by SIDA will be formalised by the signing of a bilateral agreement between SIDA and BTC. It is necessary that the Ministry of Health directs the two HDPs in the formulation of the required revisions of the project scope, scale and duration. This paper will first be discussed by the members of the project implementation committee. When the proposal is finalised, it will be presented to the Project Steering Committee (December 8th, 2010) for final approval. The detailed planning and budgeting of activities will be finalized after Steering Committee approval of the proposals for inclusion in the Technical and Financial File and the annual MOH work plans.

MOH Uganda, 01/12/2010.