RESULT REPORT 2015

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

Acronyms

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

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

1 Intervention at a glance

1.1 Intervention form

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

Outputs	**Result 1**	**MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies.**

	Result 2	**MB and PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions.**
	Result 3	**District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations.**
	Result 4	**MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities.**
	Result 5	**PNFP HC III and IV of the regions of West Nile and Rwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF.**
	Result 6	**PNFP hospital care of West Nile and Rwenzori is more accessible for the population without loss of quality of care through RBF.**
Year covered by the report		**2015**

1.2 Budget execution

	Budget	Expenditure		Balance	Disbursement rate at the end of year 2015
		Previous years	Year covered by report (2015)		
Total	**€ 8 000 000**	***N/A***	**833 892 €**	**6 825 963 €**	**15%**
Output 1	301.950	4.548 €	52.191	249.212 €	**19%**
Output 2	163.200	71 €	38.788	124.343 €	**24%**
Output 3	42.000		12.432	29.568 €	**30%**
Output 4	69.000		42.509	46.491 €	**48%**
Output 5	2.248.600		3.280	2.225.321 €	**0%**
Output 6	1954.600		30.932	1.923.668 €	**2%**
Common costs related to the activities	1.305.200	108.242 €	245.398	1.082.700 €	**25%**
General means	1.623.800	227.283 €	390.223	992.591 €	**38%**

1.3 Self-assessment performance

The project started in July 2014 by the recruitment of a start up consultant. The implementation of activities started with the recruitment of the Technical Assistants. While it's too early to assess the project impact, some achievement has been registered in specific outcomes such as support to the Ministry of Health (MoH) Public Private Partnership for Health (PPPH) Unit (Node) and Medical Bureaus, but also the development of the National Results Based Financing (RBF) framework. Little progress has been registered at regional level especially Health facilities, although some efforts have been made to improve the basic structural standards in the health facilities to foster the quality of services. The major challenge so far is the slow progress in the operationalization of the RBF taskforce at the MoH. The taskforce has the responsibility of developing the National RBF Framework, implementation manual and tools. The curriculum developed for the RBF and Cost study as part of the capitalisation of the project outcome will also be submitted to the task force and Health Sector Budget Working Group for the review.

1.3.1 Relevance

	Performance
Relevance	A

The project supports the Private Not-For Profit (PNFP) subsector at 3 levels of the Health system. Anchored at the MoH's Directorate of Planning and Development, the PNFP project is working to strengthen the MoH's capacity in reviewing, disseminating and using the PPPH policy and implementation guidelines by reinforcing the capacity of the Public-Private Partnership (PPP) unit (Node) in the MoH.

Strengthening the partnership between PNFPs and MoH at national level implies providing the needed support to the Medical Bureaus, who represent 75% of the facility-based PNFP units, about 23% of the Health facilities in the country and 40% of the production of Health services. The project support will provide technical and financial assistance to the PNFP coordinating bodies, so that they can fulfil their advisory, technical and regulatory role towards their affiliated health facilities and regional coordination bodies.

With the support from the central level, these health facilities will be able to offer to the communities in their respective catchment area the access to health services they need – preventive, promotive, curative, rehabilitative and palliative – without risking catastrophic payments or impoverishment.

To achieve these objectives, and take a step toward Universal Health Coverage (UHC) goals in respect of the constitution of Uganda, the PNFP project will implement several interventions to enhance the implementation of the MoH policies and strategies, especially:

- The "Guidelines for Designation, Establishment and Upgrading of Health" Units (MoH, 2011) to improve access to the Uganda National Minimum Health Care Package (UNMHCP) without loss of efficiency in resources allocation.
- The accreditation process as recommended by the "Quality Improvement Strategic plan" (MoH, 2010)
- The output subsides as recommended by the second National Health Policy (NHP II) and the MoH draft Health Financing Strategy (HFS).

1.3.2 Effectiveness

	Performance
Effectiveness	A

The theory of change developed by the PNFP project outlined three major interventions:

1. Developing and implementing a health coverage plan in the Districts and Health Sub Districts (HSDs) to enhance the geographic access to the health services. This will contribute to the rationalisation of health infrastructure investments to ensure that they effectively and efficiently contribute towards improved health service delivery
2. Setting up a joint accreditation process for Public and PNFP health facilities will strengthened continuous quality improvement and strategic management of health service processes, hence contribute to the improvement the quality of care and the responsiveness of Health Facilities.
3. Taking advantage of the development of a national RBF framework to establish a third party payment mechanism in Uganda's health sector will improve patient's financial access to services. With a focus on indigents and most vulnerable populations – mother, children and adolescent, it will also enhance financial protection of households. Moreover,

it may prepare the ground to the establishment of a health trust fund, and in the long run, the development of the National Health Insurance Scheme as planned in the MoH HFS.

These interventions are fully supported by the MoH Directorate of Planning and Development and the PNFP Medical bureaus. The full achievement of the project outcome is very likely in terms of quality and coverage.

The project had the requisite staffing necessary to carry out project activities effectively. However, the National Technical Assistants at regional level (West Nile and Rwenzori region) resigned during the year 2015. The absence of the Technical Assistants resulted in the delay in the development of the District coverage plans and Health Facilities business plans. Nevertheless, the cost study and the implementation of the RBF procedures are ongoing.

1.3.3 Efficiency

	Performance
Efficiency	B

To avoid delay in procurements and other activity transactions, the project team sought and obtained budget modifications to allow for most common costs related to the activities to be put under Belgian Development Agency (BTC) management. This led to quicker decision making and implementation of activities. Almost all planned activities were carried out successfully. Nevertheless the RBF grant agreement with the District Local Government and the Memoranda of Understanding with the Health facilities were delay by the administrative prerequisite of the BTC headquarter.

1.3.4 Potential sustainability

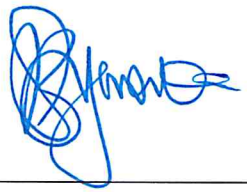
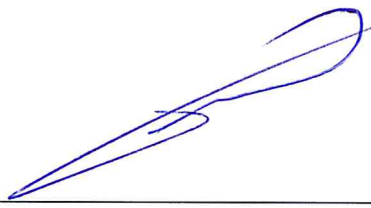
	Performance
Potential sustainability	A

To ensure full ownership of the intervention by the partner institutions, the design of the RBF framework have been delay to have the MoH stewardship. A RBF task force has been set up by the MoH to develop a RBF framework that is part of the country HFS interventions. While taking in account the best practices in RBF observed in other Low and middle Income Countries, the RBF mechanism will prepare the third party payment by financing the recurrent costs of the Health facilities after a comprehensive cost study. This cost study will inform the costing of packages for RBF to avoid underfinancing of health facilities, which leads to production of poor quality of services, knowing that poor quality is always more expensive to the community than safe and unharmed health services. The subsides given to the health facilities will be in line with what the Government and other donors can afford in the medium term all over the country.

The success of the project in the promotion of the quality of services (effectiveness, efficiency, safety, access to health) may be a good argument for the (BTC) in the policy dialogue in the health sector. Other Development Partners may accept the use of RBF mechanism, and in the future, build with the Government of Uganda a trust fund to finance the universal access to health in the country.

1.4 Conclusions

- The project has spent considerable time in preparing health facilities to take on RBF. The start up phase included preparing tools, guidelines and frameworks. This is time consuming but necessary for proper implementation of RBF in the long term.
- Project has taken the necessary steps to ensure full local ownership of the intervention, hence the sustainability.
- Project missions, meeting and discussions with partner institutions has shown that the project's intervention (and its logic) is well understood, aligned with the national and Belgian policies and strategies, and very relevant.

Dr. Sarah Byakika Ag. Commissioner, Planning Ministry of Health Project Manager MoH/BTC PNFP Project.	Dr. Thomas Galbert Fedjo Tefoyet International Technical Assistant Project Co- Manager MoH/BTC PNFP Project
	

2 Results Monitoring

2.1 Evolution of the context

2.1.1 General context

The general context remained largely unchanged. There was no key evolution in sector policy or decentralization policy. In the last quarter of the year, the country began preparations for general elections but this did not affect the general political and socio-economic environment to warrant change . There was no organizational change in any of the partner institutions.

2.1.2 Institutional context

The project is anchored at the Directorate of Planning and Development in the MoH. The project manager was the Director of Planning and Development up to the end of 2015. The comissioner of planning have been appointed as project manager since January 2016.

2.1.3 Management context: execution modalities

The project financial and activity plans were all executed to a desired level. During the year, budget modifications were approved by the Steering Committee and this faciltated ease of conducting activties. The modifications related to transfer under BTC management the organization of workshops and other advocy activities, hence avoid delay due to the local regulations on procurement and fund transfer.

2.1.4 Harmonisation context

The Belgian Embassy will take the lead in the policy dialogue with other bilateral Development Partners in 2016 to move towards a new joint financing mechanism that puts more emphasis on results and earmarks budget support and/or basket funds with well-defined outputs and M&E systems.

The MoH has taken a step to design a RBF framework to be rolled out at national level. This framework will be piloted for the PNFP health sub-sector at district level in 2 region by the PNFP project. To provide more scienfic background and technical orientation to all stakeholders (MoH at central and district level, NGOs, PNFP and Development Partners) who might be involved in RBF initiatives, the PNFP project organized an International Orientation Workshop on RBF in Uganda, and invited experts from abroad and from RBF pilot projects implemented in Uganda by other Development Partners.

The project is also harmonizing with other Development Partners with regards to supporting the MoH in implementing the PPPH policy. Both BTC and USAID are supporting the set up and functionalising of the PPPH unit (Node) in the MoH. In order to avoid duplication and maximize efficient use of resources, BTC and USAID have coordinated their support and the PPPH unit (Node) is preparing a multiannual strategic plan.

2.2 Performance outcome

2.2.1 Progress of indicators

The project team conducted a baseline study. To enhance the ownership of the process and contribute to the capacity building of various stakeholders, the baseline study was conducted by the Medical Bureaus, the project technical assistants and the District Health management Teams in West Nile and Rwenzori. The report was approved by the Steering Committee held in July 2015. As observed from the tables below, the project performance indicators are in line with the MOH M&E framework as the project hopes to supplement Government of Uganda efforts to meet its health related targets.

As part of the baseline study but also to feed the elaboration of District Health Coverage plans, an important activity was conducted in the first semester of 2015 to generate information the project wishes to use in planning and execution of activities: a complete assessment of health facilities. This assessment collected detailed information and identified gaps in infrastructure, equipment and human resources in both Public and PNFP health facilities in the 15 districts covered by the project. The outcome was a comprehensive database that will guide the project, medical bureaus and districts on the investment needs of health facilities.

Outcome: PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.					
Indicators	**Baseline value**	**Value year 2015**	**Value year 2016**	**Target year 2017**	**End Target**
Total value of debt in PNFP health facilities enrolled into RBF	**7.1bn**	**7.1bn**			**3.5bn**
Reported maternal death	**106**	**89**			**20**
Reported under-five death	**1647**	**1567**			**300**
% deliveries in health facilities	**40%**	**56%**			**80%**
Contraceptive Prevalence Rate	**15%**	**18%**			**50%**
Evolution of fee levels in PNFP health facilities	**43,922**	**39,456**			**22,000**

The indicators related to health service delivery have been reported on using the available district and health facility data from the regions of intervention. They cannot however be attributed to the project activities since funding to the health facilities has not yet started.

2.2.2 Analysis of progress made

The progress towards attainment of the targets is still minimal. Most of the indicators above were premised on the effect of RBF. It was not possible to start RBF in 2015 and therefore the various indicators have not been assessed and can't be reported on.

2.2.3 Potential Impact

With PNFP facilities contributing about 40% of health outputs and receive from the Government only 20% of the total expenditure of the health facilities. Investing in their recurrent cost will have an important added value in term of improvement of access to and quality of health in the intervention area. In Rwenzori and West Nile, the project works with 15 District Health Offices (DHOs), PNFP Coordination Bodies and about 72 PNFP health facilities.

It supports the districts (DHO and DHMT) and HSDs in their capacity to provide technical assistance to all health facilities by performing joint supervision and planning activities with the PNFP CBs. Accredited PNFP health centres III and IV and hospitals are supported in providing better quality healthcare in a more affordable manner through a RBF mechanism.

The RBF mechanism in the health sector is an innovative fund allocation mechanism in which payments to health care providers are made following the achievement of specific outcomes. It is a mechanism that renders health service providers responsible for their performance granting greater spending autonomy, with real decentralization of decision-making, combined with a financial motivational aspect. The MoH has identified the RBF as a viable strategy to improve performance in Uganda's public health sector and looks with particular interest to this project to provide further input in the discussion. The introduction of such RBF mechanism in the PNFP sub-sector in the Rwenzori and West Nile region will serve as a model for the MoH on how to institutionalize a national RBF mechanism to support the overall public health sector in Uganda. The long term objective is to create a National Trust Fund funded by contributions of the GoU and Development Partners through basket funding. Such a National Trust Fund would manage the financial resources, contract health facilities and control service delivery.

2.3 Performance output 1

2.3.1 Progress of indicators

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

2.3.2 Progress of main activities

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

2.3.3 Analysis of progress made

In 2015, the project contributed to the setting up of the PPPH unit (Node) (equipment and furniture), supported the daily running of the office activities and ensured its functionality. The PPPH unit (Node) at MoH is the central coordination unit and gateway through which PNFP health facilities should interface with the Government of Uganda. The creation and functionality of the PPPH Unit (Node) at MoH has been supported through regular PPPH Technical Working Group meetings, an excellent avenue for private health care providers, not only the PNFPs but the wider private health sector, to interface and engage in constructive dialogue with the MoH. The PPPH policy and PNFP PPPH implementation guidelines were printed, presented at the regional health forum meeting and distributed to all stakeholders. The PPH unit (Node) undertook various supervison visits to districts mainly to monitor the implementation of PPPH policy at decentralised levels. The project also supported the PPPH unit (Node) to start consultations to develop a PPPH implemenatation strategic plan for the country.

Two international study visits to Tanzania and Benin where organized. The Tanzania workshop explored country experiences in RBF implementation while the Benin meeting focused on enhancing the capacity of Information Communication Technologies (ICTs) in health care service delivery and RBF verification. These workshops were attended by MoH and Medical Bureaus

officials. As part of capacitity building in the MoH, one Senior Planner has been supported to undertake an international course on PPPH in the USA.

2.4 Performance output 2

2.4.1 Progress of indicators

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

2.4.2 Progress of main activities

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

2.4.3 Analysis of progress made

Uganda Catholic Medical Bureau (UCMB) and Uganda Protestant Medical Bureau (UPMB) have been implementing accreditation processes in the facilities under their umbrella with different tools and criterias. The project supported the Medical Bureaus to elaborate joint accreditation procedures, accepted by all stakeholders and applicable in both public and PNFP health facilities in the future. An initial assessment using this tool resulted in only one hospital passing the accreditation creteria. A second assessment will be conducted in the first quarter of 2016.

Identification of training and equipment needs for the Medical Bureaus was done and several challenges identified especially at regional coordination offices. The project supported all the Medical Bureaus to equip their offices. Significant efforts were put on organisational developent of Uganda Muslim Medical Bureau (UMMB) and Uganda Orthodox Medical Bureaus (UOMB). A consultant was procured to support UMMB to develop its strategy for the next 5 years. UOMB organised its first Annual General Meeting and opened a coordination office away from the hospital premises. Some additional ICT equipment will be provided in 2016 especially for regional coordination offices.

The Project also supported all Medical Bureaus to carry out support supervision of their facilities, followed up the recommendations of the accrediation process and worked with hospitals to cover the gaps in preparation for the next round of assesment. UOMB specifically was supported to conduct accreditation assessment in all facilities under its umbrella, but outside the project areas, using the tools developed by the project. This was significant for UOMB to build its systems of coordination, introduce the culture of quality improvement in its health units, and strengthen its membership strategy by streamlining the membership accreditation system.

2.5 Performance output 3

2.5.1 Progress of indicators

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

2.5.2 Progress of main activities

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

2.5.3 Analysis of progress made

In collaboration with the Institutional Capacity Building (ICB) project, the PNFP project organised the regional health forum which brings together all stakeholders in the health sector in the region. The PNFP project has ensured that all PNFP representatives (Hospitals Directors and PNFP Coordinators) attend these meetings initiated by the ICB project, to enhance the public private partnership at regional level as regional performance is discussed and owned by all stakeholders.

District Health Teams were trained to design coverage plans that helps to rationalize the resources allocation and ensure that all segments of the population have physical access to healthcare. Preliminary work was done to assess district health needs, elaborate a work plan and complete the coverage plan. The first drafts of the coverage plan were expected in the second quarter of 2015 but only 3 districts over 15 could deliver. The process of developing coverage plans will be resume after the recrutment of the new Regional Technical Assistants.

PNFP regional coordinators were also facilitated to carry out, with the DHMTs, the self assesment of health facilities in their regions.

2.6 Performance output 4

2.6.1 Progress of indicators

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

2.6.2 Progress of main activities

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

2.6.3 Analysis of progress made

Significant progress on this intervention was registered in 2015. An international workshop to orient the main stakeholders in Uganda's health sector on RBF was organised in February 2015. Subsequent workshops followed. In July 2015, the MoH put in place a Task force as part of the Health Sector Budget Working Group to purposely focus on developing a framework for the RBF in the health sector. A workshop was organised with all stakeholders (World Bank, WHO and MoH) to discuss and agree on the key principles of RBF. A Consultant was hired by MoH, with financial support of the World Bank country office, to draft the national RBF framework. This framework is expected in the first quarter of 2016.

To foster the culture of quality improvement in the health facilities, Joint accreditation procedures for PNFP facilities were developped with the support of the project. The tools are actually used by the the PNFP coordinating bodies at central and regional level.

The project hired consultants to develop a training curriculum on RBF. The training could not be conducted before the appraisal of the RBF execution agreement template by the BTC Headquater and the office of sollicitor general. The advocacy and communication activities were also posponed for the same reasons.

2.7 Performance output 5

2.7.1 Progress of indicators

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

2.7.2 Progress of main activities

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

2.7.3 Analysis of progress made

It is premature to make any progess analysis of these outputs. RBF has not yet started at Health Centre level and therefore most of the indicators could not be attributed to project intervention. The values reported for 2015 are from district data and includes public health facilities contribution.

The coverage rate are quite good for some indicators, and justify the choice of the RBF framework to focus on the quality improvement issues as well as the quantity outputs in the Health facilities. The regional coordinators and DHMTs were then supported to conduct the supervision activities and train the Health facility manager in the self assesments of quality and service organization.

2.8 Performance output 6

2.8.1 Progress of indicators

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

2.8.2 Progress of main activities

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

2.8.3 Analysis of progress made

In the intervention area at regional level, there are 8 General Hospitals and 72 HCs under PNFP Medical Bureaux. Evidence from field visits and review of their financial reports show that many of these PNFP health facilities are indebted. All interactions with the in-charges pointed out a financial dire situation of the facility and the problem of financial accessibility of the rural population to health care. The project is supporting the health facilities managers to conduct a cost study in hospitals and health centres. This cost study will inform the costing of RBF indicators, but also the elaboration of business plans and the decisions on user fees in the PNFP facilities. The first part of the cost study in 2015 was conducted through literature review and expert opinion. This study shows hypothetical costs of health care services in a standard environment. Actual cost studies at facility level were postponed to 2016. At the end of the exercicise, the draft of the cost study curruculum developped by the project wil be handed over to the MoH.

Only prequalified health facilities will qualify for the RBF. The project carried out an assessment of 9 Hospitals and 3 HC IVs in June 2015. Only Virika Hospital in Rwenzori Region was qualified.

The accreditation showed a good performance of almost all hospitals except one, with majority of them getting conditional accreditation. The major gaps identified related to insufficient equipment and human resources.

Through supporting the Medical Bureaus and the MoH to conduct rigorous supervision and mentoring, the project hopes to improve capacities in all hospitals and conduct a reassessment exercise before introducing RBF in early 2016 in all Hospitals and HC IVs.

All hospitals and HC IVs that passed the condtional accredition received medical equipment and HMIS registers as part of preparation for RBF enrollment. The project also started the computerisation of all hospitals. Initial training and installation of a software to manage patient files was done in all hospitals. Hardware equipment like computers will be installed in 2016. The desire is to have electronic patient records across alll hospital departments.

2.9 Transversal Themes

2.9.1 Gender

The project took full account of gender, in particular the health status of pregnant women, young mothers and children, in its start-up phase. All hospitals but one received hospital equipment that will boost maternal and child health services. A total of 10 delivery beds among other equipment were provided to the hospitals during the year. Other medical equipment included caesarean section instrument sets, baby incubators, manual vacuum aspirators, etc. The project has also designed its RBF guidelines to ensure maternal services receive a higher subsidy and increase the outputs of the HIV clinics. This will ensure that more women access better healthcare services.

2.9.2 Environment

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

2.9.3 HIV/AIDS

The activities related to HIV are supported at health facility level. As mentioned in chapter 2.7 and 2.8, the implementation of these activities are yet to start.

2.10 Risk management

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

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

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 2: Some Medical Bureaux do not have the required technical, structural and financial competences	September-14	DEV	Medium	Medium	Medium Risk	Capacity building activities	NTA	June-18	A training needs assessment was done in all the MBs. Each MB has a capacity building plan.	In progress
						Build synergies with scholarship program to increase competences	ITA	Decembe r-15	There is a good collaboration with SDHR	
						Elaboration of guidelines and standardization of tools	NTA	June-16	A joint support supervision tools is being developed. Accreditation tools are being harmonized	
Output 3: Weak leadership and management skills of multiple actors at regional level	September-14	DEV	Low	Medium	Low Risk	Contribute to The regional Health Forum	ITA		The regional Health Forum is an opportunity for cross exchange and cross fertilization between the District team	In progress
						Organize training and supervision	Project Manager		The project is supporting joint supervision of PNFP regional coordinator and District health management team	
						Strengthening the District team by the grant agreement	Project manager		Support activities of the District Health Management team are include in the grant agreement	
Output 4: Delays in gaining consensus on a national model for result based financing	September-15	OPS	Medium	Medium	Medium Risk	Use of available structures within MOH in the RBF institutional arrangements	ITA	June-16	An RBF taskforce has been set up by the Budget technical working group to whom it report	In progress
						Engagement of all stakeholders especially MOH and development partners	ITA	June-16	The RBF principles have been adopted by the Budget support technical working Group The RBF framework for Uganda will be adopted in early 2016	

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 5: High technicality and need for financial control.	September-14	FIN	Medium	Medium	Medium Risk	Recruitment of a financial controller at central level and financial staff in the Regions	RAFI		The Financial controller and 2 financial officer will contribute to the training of the Financial staff at District level	In progress
						Developed business plans as condition	ITA		Business plan template to be developed in	
						Regular audits by the project	NTA	December-16	Financial, IT and drugs management assessment are conducted at least once a year in all hospitals and HCIVs	
Output 5: PNFP health centers refuse to lower the user fees	September-14	DEV	Low	Low	Low Risk	Conduct cost study in all health facilities to establish standard cost of care	ITA	March-16	curriculum for cost study already developed The Health facility manager will be train in the costing in Q1 2016	In progress
						Offer assistance in developing realistic business plans	ITA	June-18	The Health facility manager will be train in the use of the cost study result to improve the business plan in 2016	
						Include the maximum user fee rate for the services that are subsidized by the project fund	ITA		The rate will be submit to the Medical bureaus and the RBF Task force	

Identification of risk or issue			Analysis of risk or issue			Deal with risk or issue			Follow-up of risk or issue	
Risk description	Period of identification	Category	Likelihood	Potential impact	Total	Action(s)	Resp.	Deadline	Progress	Status
Output 6: PNFP hospitals refuse to lower the user fees	September -14	DEV	Low	High	Medium Risk	Conduct cost study in all health facilities to establish standard cost of care	ITA	March-16	curriculum for cost study already developed	In progress
						The Health facility manager will be train in the costing in Q1 2016		Feb 2016		
						Offer assistance in developing realistic business plans	ITA	June-18	The Health facility manager will be train in the use of the cost study result to improve the business plan in 2016	In progress
						Include the maximum user fee rate for the services that are subsidized by the project fund	ITA		The maximum user fees have been agreed upon with the Health facility manager. The rate will be submit to the Medical bureaus and the RBF Task force	In progress
Output 6: MoH and donor community to not provide long-term financial means.	September -14	DEV	Medium	Medium	Medium Risk	Support donor coordination and contribute to the setup of a Health Basket fund	Project director			In progress
						Development of a realistic roll out plan for the Result based Financing	ITA			
						Support MB efforts to develop sustainability plans	NTA	Dec 2016		

3 Steering and Learning

3.1 Strategic re-orientations

The strategy outlined in the project's TFF remains valid and relevant. This strategy is imbedded in the Health Sector Development Plan. It's also in line with the MoH draft HFS and the Health Sector Quality Improvement Framework and Strategy Plan.

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

3.2 Recommendations

Recommendations	Actor	Deadline
Harmonise the elaboration of the coverage plans with ICB II to avoid double financing	*Health program coordinator*	*June 2016*

3.3 Lessons Learned

Lessons learned	Target audience
Organising RBF training at national level for the implementers may not be relevant if the financing strategy of the country is not well defined. The training will probably improve the knowledge of the participants, but not the skills in the RBF implementation in general, and the purchasing provider split in particular	Result Based Financing implementers at national and international level
A cost study at health facility level is important in the management of the RBF budget, but also to have the Health facility managers and other stakeholder on board. It ease the advocacy for the Result Based Financing	Result Based Financing implementers at national and international level
The accreditation procedures may be easily implemented for private health facility. The tools and procedures have to be adapted for the roll out in public facilities.	Health Policy makers and health services managers

4 Annexes

4.1 Quality criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

4.4 How well is the intervention contributing to institutional and management capacity?		
	A	Intervention is embedded in institutional structures and has contributed to improve the institutional and management capacity.

4.2 Decisions taken by the Steering Committee and follow-up

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

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

	Decision				Action			Follow-up	
N°	**Decision**	**Identification period**	**Source***	**Actor**	**Action(s)**	**Resp.**	**Deadline**	**Progress**	**Status**
2	SC 2:	Feb-15			Finalize the PNFP result report 2014	ITA	Immediate	Report was finalized and submitted	CLOSED
					Submit a preliminary baseline report	ITA	31-03-15	Draft Baseline report submitted	CLOSED
					Each MB to nominate a focal person to participate in the project	MB executive secretary	Immediate	Each MB has nominated a focal person to participate in project activities	CLOSED
					Review the work plan and budget with The project Manager	ITA	Immediate	Work plan and budget were discussed with Director Planning	CLOSED
					Hold an extra ordinary meeting of the Steering Committee to approve work plan and budget	Project manager	To be determined after consultations	Awaiting confirmation from Director planning	CLOSED
					MOH to give a specific date for the launch of the project	Project Manager	To be determined after consultations	Awaiting confirmation	OPEN
3	SC3	Jun-15			Organize project launch	PM	01-08-15	MOH yet to give date	OPEN
					MOH to appoint focal persons to the project technical team from Department of quality Assurance, planning and clinical services	PM	02-08-15	Done for Quality Assurance and Planning	ONGOING
4	SC4	Nov-15			The RBF prequalification assessment tools should be validated by various stakeholders especially Quality Assurance Department of MOH	PM	01-12-15	tools were validated by Quality Assurance MOH	CLOSED
					The project should focus on the 4 major Medical Bureaus (UCMB, UPMB, UMMB, and UOMB) at central level. UCBHCA be excluded to avoid overstretching the project	PM	Immediate		CLOSED

4.3 Updated Logical framework

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

4.4 MoRe Results at a glance

Logical framework's results or indicators modified in last 12 months?	No.
Baseline Report registered on PIT?	Yes.
Planning MTR (registration of report)	03/2017 (estimate)
Planning ETR (registration of report)	04/2018 (estimate)
Backstopping missions since 01/01/2012	20/10/2014 – 25/10/2014. 18/07/2015 – 26/07/2015 21/01/2016 – 27/01/2016

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

4.6 Communication resources

N/A.