Enabel

FINAL REPORT

Institutional Capacity Building in Planning, Leadership & Management in the Uganda Health Sector Phase II (ICB II)

UGA 1408211

Belgian development agency

enabel.be

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Acronyms

CBR	Core Borrowing Rate
DHMT	District Health Management Team
DHO	District Health Office
DM	Database Manager
Enabel	Belgian Development Agency
EUR	Euro
FY	Financial Year
GH	General Hospital
GIS	Geographical Information System
HC III	Health Centre level III
HC IV	Health Centre level IV
HDP	Health Development Partner(s)
H.E.	His Excellency
HF	Health Facility
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HMDC	Health Manpower Development Centre
ICB II	Institutional Capacity Building Project in Planning Leadership and Management in the Uganda Health Sector – ICB Phase II
IHFE	International Health Finance Expert
IMF	International Monetary Fund
IICM	International Intervention Co-Manager
MB	Medical Bureau
MEA	Monitoring and Evaluation Assistant
MoFPED	Ministry of Finance, Planning, and Economic Development
MoH	Ministry of Health
MTR	Mid Term Review
NTA	National Technical Advisor
NTA-TL	National Technical Advisor – Team Leader

PFC	Project Financial Controller
PFP	Private for Profit
PNFP	Private non for Profit
PSC	Project Steering Committee
QGIS	Open-source, cross-platform desktop Geographic Information System
RAFI	International Finance and Contracting Coordinator
RBF	Results Based Financing
RH	Referral Hospital
SPHU	Establishing a Financial Mechanism for Strategic Purchasing of Health Services in Uganda
SRHR	Sexual and Reproductive Health and Rights
TFF	Technical and Financial File
TWG	Technical Working Group
URMCHIP	Uganda Reproductive Mother and Child Health Improvement Program
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank

Intervention form

Intervention name	Institutional Capacity Building in Planning, Leadership & Management in the Uganda Health Sector Phase 2 (ICB II)
Intervention Code	UGA 1408211
Location	Uganda: Kampala, West Nile region and Rwenzori region
Budget	EUR 5,000,000
Partner Institution	Ministry of Health
Date intervention start /Opening steering committee	July 28, 2015
End date Specific Agreement	July 28, 2019
Target groups	Ministry of Health, public Health Facilities and institutions in Rwenzori and West Nile region, personnel of these facilities, population of Rwenzori and West Nile
Impact	To further improve effective delivery of an integrated Uganda Minimum Health Care Package
Outcome	To strengthen the planning, leadership & management capacities of (public) health staff – particularly at local government level. This should include the provision of quality services within an integrated health system
Outputs	1. The quality of care at general hospital and HC IV is strengthened
	2. District health offices and management teams are strengthened in their capacity to manage integrated district health systems and to strengthen quality of care
	3. Integrated regional network of Health Facilities in place
	4. The normative role of the MoH is strengthened
Total budget of the intervention	EUR 5,000,000
Period covered by the report	2015 - 2018

Global appreciation

Describe your global appreciation of the intervention (max 200 words):
The project has strengthened the capacity of Ministry of Health, District Health Offices, and Health Facilities to use the Results Based Financing approach, and has introduced this approach as a health financing reform on the national agenda. The project has contributed to an increase of accessibility and quality of health services for the general population. At the level of Health Facilities, especially in the public sector, the project has increased the motivation and awareness of accountability for performance of health system managers and health professionals. This has resulted in better procurement of medicines and health supplies, more efficient resource allocation and management, and improvements to infrastructure of Health Facilities. At the level of the Ministry of Health and District Health Offices, the project has initiated review and improvement of current practices in strategic areas, such as health system governance; medicines and health supplies; data quality and verification; utilisation, equity and patient-centred care; financial management; and human resource management. The National Results Based Financing Framework, developed by Ministry of Health with the support of the project, has been recognised by national stakeholders, including Health Development Partners, and is being implemented nationwide. The project has been an important step in the process of accelerating the movement towards universal health coverage in Uganda.
Score your global appreciation of the intervention:
The project anchorage in the institutional context and the execution modalities have remained fully relevant to needs of the health sector of the Republic of Uganda. The global appreciation of intervention is satisfactory.

National execution official	Enabel execution official
Dr. Sarah Byakika	Dr. Dumitru Maximenco

PART 1 : Results achieved and lessons learned

1 Assessing the intervention strategy

1.1 Context

General context. The political situation in Uganda has remained stable. In April 2017, the Ugandan forces have been withdrawn from the Central African Republic, where they have been fighting the Lord's Resistance Army for the past five years. In December 2017, the Parliament has removed the age-limit for presidential candidates, clearing the way for H.E. President Museveni to run for another term.

From 1990 to 2015, the under-five mortality rate dropped from 175 to 64 per 1,000 live births, and the average life expectancy increased from 43 to 63 years. The total fertility rate remains relatively high, at the level of 5.4. The yearly population growth rate is 3 percent .

Ugandan economy has been projected to grow by 5.0 – 5,5% in FY 2017 / 2018, and the outlook for the future remains even more positive. The government's positive sentiments about the economy are shared by the World Bank and IMF.

The Bank of Uganda has reduced its CBR from 16% in April 2016 to 9% in February 2018. The core inflation rate has dropped from 5% to 1,9% in the same period. The commercial bank lending rates on shilling denominated loans have fallen by 5.0%, from 24% in June 2016 to 19% in January 2017.

The public debt as a percentage of Gross Domestic Product has risen from 25.9% in FY 2012/13 to 38.6% in FY 2016/17. A further increase to 42.6% is expected in FY 2019/20. If not managed well, the increasing public debt may slow the economic development of Uganda .

Institutional context. At the central level, the project has been anchored in the Planning and Development Directorate of the MoH, led by Dr. Sarah Byakika, the Ag. Commissioner Planning. This has contributed to ownership and sustainability of the project by the MoH, and has facilitated discussion of necessary changes in the strategic areas.

At the level of Rwenzori and West Nile project regions, the project has been anchored in the District Health Offices and Health Facilities. In 2017, two new districts were created: (i) Bunyangabu district in Rwenzori region, formerly part of Kabarole district; and Pakwach district in West Nile region, formerly part of Nebbi district. As a result, one additional health facility from Rwenzori region was enrolled into the RBF project.

The project has participated in the activities of various MoH Technical Working Groups (TWG), e.g. Health Sector Budget Working Group, Supervision, Monitoring Evaluation & Research TWG, RBF Taskforce established by the MoH, and has collaborated with Health Development Partners present in Uganda.

The project has established cooperation with the Makerere University School of Public Health, in order to capitalize the project experience with participation of the MoH, Medical Bureaus, District Health Management Teams (DHMT), and health professionals. Two capitalization workshops have been organized. The first workshop identified the strategic areas for capitalization, such as: health system governance; medicines and health supplies; data quality and verification; utilisation, equity and patient-centred care; financial management; and human resource management. The second workshop systematised the available experience in strategic areas. The capitalized project implementation experience will be discussed in a high-level symposium in April 2019.

Execution modalities context. In terms of budget execution, 2/3 of the total project budget have been managed by the project to facilitate execution of routine activities and public tenders. The budget lines for RBF payments, which accounted for 1/3 of the budget, have been co-managed by the MoH to increase ownership of project results.

In terms of implementation of project activities, the Planning and Development Directorate of the MoH has created the National RBF Task Force, which has been a part of the Health Sector Budget TWG. With the support of the project, the Directorate has designed the National RBF framework, has ensured its acceptance by the national stakeholders and Health Development Partners, and has advocated for its implementation at all levels.

The Directorate has organised supportive supervision visits to RBF implementing Health Facilities, training of health system managers and health professionals, and has validated RBF invoices from the participating Health Facilities.

The Kampala project office has been responsible for general management of project activities, including organisation of public tenders, maintenance of vehicles, organisation of training activities and conferences, etc.

The Rwenzori and West Nile project offices have supported the DHMT in implementation of RBF activities at the level of District Health Offices and Health Facilities.

Enabel Headquarters has provided methodological and backstopping support to the project team. Enabel Representative Office in Uganda has provided guidance in implementation of Enabel procedures in the context of specific project activities.

Harmo-dynamics context. The ICB II project has closely collaborated with the Private Not-For Profit (PNFP) project, with which it has shared office space, resources, and personnel. The ICB II project has been able to progressively integrate its activities with those already established by the PNFP project. This integration has resulted in development of the Strategic Purchasing for Health in Uganda (SPHU) project, which is being implemented according to the Specific Agreement No. 1272 between the Kingdom of Belgium and the Republic of Uganda.

The experience of ICB II and PNFP project implementation has been used to establish cooperation with the USAID. As a result, the USAID has approved a grant to Enabel of

USD 11,000,000 for implementation of RBF activities in Acholi region. The grant agreement has been signed on January 22, 2019.

The RBF approach, developed by the PNFP and ICB II projects, is used by the URMCHIP program funded by the WB.

1.2 Important changes in intervention strategy

The ICB II project has been a development of the ICB I project (2010 – 2015), which aimed at strengthening the planning, leadership and management capacities of health system managers, with a focus on local government level.

The strategy of the ICB II project was to capitalize on the results of ICB I project, elaborate and pilot the RBF framework in public Health Facilities of Rwenzori and West Nile regions, in close coordination with the PNFP project.

No changes to the intervention strategy have been made during project implementation.

2 Results achieved

2.1 Monitoring matrix

The TFF section "Indicators and Means of Verification" of the ICB II project has not been updated in the beginning of project implementation. Although a baseline study has been completed, no systematic data collection and reporting of indicators has been done afterwards.

This situation has been discussed during the backstopping mission of Enabel Coordinator Health Unit, Mr. Paul Bossyns. It has been agreed that the SPHU project, which has taken over the activities of the PNFP and ICB II projects, will update the respective section of TFF, will collect the indicators, and will report them starting with 2016.

2.2 Analysis of results

2.2.1 To what extent will the intervention contribute to the impact1 (potential impact)?

Achievement of the impact "To further improve effective delivery of an integrated Uganda Minimum Health Care Package" requires improvements of all pillars of the Ugandan health system, i.e. (i) Service delivery, (ii) Health workforce, (iii) Health information systems, (iv) Access to essential medicines, (v) Financing, and (vi) Leadership and governance.

The project has contributed to achievement of mentioned impact through development of a National RBF framework and its implementation modalities, and has strengthened the planning, leadership and management capacities at the level of the District Health Offices and RBF implementing Health Facilities.

Considering the short project duration and the limited number of RBF implementing facilities, its contribution to the mentioned impact may be appreciated as limited.

2.2.2 To what extent has the outcome been achieved?

The project outcome "To strengthen the planning, leadership & management capacities of (public) health staff – particularly at local government level. This should include the provision of quality services within an integrated health system" has been achieved in pilot regions at the level of RBF implementing facilities mostly.

To strengthen the planning, leadership and management capacities, the project has concluded grant agreements with RBF implementing Health Facilities. A system of verification of compliance of Health Facilities with the terms and conditions of grant agreements has been implemented. After verification and validation of verification results, RBF funds were transferred to Health Facilities.

This arrangement has encouraged Health Facilities to elaborate performance improvement plans, and has improved motivation and morale. These positive changes

[1] Terminology : Impact = General Objective ; Outcome = Specific Objective; Outputs = Expected Result

have been confirmed by the management and health professionals from RBF implementing facilities.

Project implementation experience has proven the verification process to be time and human resource demanding, but not sufficiently focused on use of verification and monitoring data for better management and decision-making. The effectiveness of rules for use of RBF income for quality improvements has been limited, because all health facility income is deposited in a single bank account and is fungible. However, institutionalization of verification process should be regarded as an important achievement on the way of implementation of formal accreditation and certification of Health Facilities.

Grant agreements have been concluded with the Districts. Under grant agreements, the DHMT personnel has been involved in organisation of verification visits, validation of verification results, organisation of supportive supervision and training activities, etc. This involvement has contributed to strengthening of planning, leadership and management capacities of DHMT personnel.

Considering the involvement of all DHMT members in project activities, the contribution of the project to achievement of outcome may be appreciated as good.

2.2.3 To what extent have outputs been achieved?

The project aimed to achieve four outputs. Achievement of outputs, based on implementation of proposed activities, is presented below.

Output 1. The quality of care at general hospital and HC IV is strengthened included five activities: (i) Develop regional coverage plan for general hospitals and HC IV; (ii) Support priority hospitals and HC-IV to realize a strategic plan; (iii) Support basic requirements for quality of care; (iv) Improve drugs and medical supplies managements; (v) Introduce e-patient files; and (vi) Implement RBF approach in general hospitals and HC-IV.

The output has been achieved partially. Coverage maps have been produced. Five MoH specialists have been trained in GIS and QGIS in Belgium. Three personnel per district have been trained in use of QGIS for development of coverage plans in Rwenzori and West Nile regions.

The project has defined a comprehensive process for development and implementation of strategic plans and annual performance improvement plans at the level of Health Facilities.

The project has supported this process through organisation of several training sessions. As a result, the strategic plans and annual performance improvement plans have been developed and implemented by all RBF implementing Health Facilities.

The HC III have received donations of medicines and supplies of EUR 135,000 value. HC IV and GH have received medical equipment of EUR 90,811 value. 15 tablets for verification teams in the pilot regions have been purchased. Digitization of RBF activities has not been fully completed.

The MoH has adopted the recommendation to allow Health Facilities to use a part of RBF funds to purchase additional medicines from the Joint Medical Stores.

The contract with Uganda Chartered Healthnet has been signed, and pilot implementation of patient e-files has started.

Implementation of RBF strategy was started in five public GH and four public HC IV.

Output 2. District health offices and management teams are strengthened in their capacity to manage integrated district health systems and to strengthen quality of care included six activities: (i) Interpret coverage plan for HC III and II; (ii) Adjust district development plan according to coverage plan conclusions; (iii) Support basic requirements for quality of care; (iv) Implement RBF financing through execution agreement; (v) Assure quality of care through support supervision and continuous training; and (vi) Improve ambulance services and referral system at district level.

The output has been partially achieved. The HC III participating at the RBF activities have received IT equipment. The project has also supported functioning of ambulances in Rwenzori and West Nile pilot regions.

The ICB II project has provided grants of a total value of EUR 1,680,539. Grants of EUR 90,060 has been provided to 16 districts, EUR 772,388 have been provided to 31 HC III, EUR 341,173 - to 4 HC IV, and EUR 476,918 - to 5 GH.

Output 3. Integrated regional network of Health Facilities in place included four activities: (i) Establishment of regional project team; (ii) Organize quarterly regional health forum in the Rwenzori and West Nile regions; (iii) Install a coordination body for integrated referral system; (iv) Support continuous training from regional hospital specialists.

The output has been partially achieved. Activities 1 and 2 have been implemented. Two regional project teams have been created and have established good collaboration with DHMT in all districts of Rwenzori and West Nile regions. The teams have organised quarterly Regional Health Forums and yearly Joint Review Missions, with participation of the MoH representatives. The Mid Term Review (MTR) has noted that: "The regional inter-district coordination structures, the quarterly regional health fora and the annual regional joint review meetings, are highly appreciated and districts claim they help in improving their planning."

Activities 3 and 4, creation of coordination body for integrated referral system and support continuous training of specialists from regional hospital have not been implemented.

Output 4. The normative role of the MoH is strengthened included four activities: (i) Ensure overall management and governance of the project within MoH; (ii) Capitalize from field experiences developed in Rwenzori and West Nile regions; (iii) Strengthen continuous training policies and modalities; (iv) Develop a model and strategies for a social health insurance.

The output has been partially achieved. The project office has been established, and all international and national personnel have been recruited. A Project Management Team and a Project Technical Team have been created at the MoH, and the Project Coordinator has been appointed.

The Makerere University School of Public Health has been contracted to support the capitalisation and documentation process for the ICB II and PNFP projects. Two capitalisation workshops have been organised, with participation of main project stakeholders.

The first capitalisation workshop was organised on August 9-10, 2018. It generated six topics for capitalisation: (i) Health system management; (ii) Human resource management; (iii) Financial management; (iv) Utilisation, equity, and patient centered care; (v) Medicines and health supplies; and (vi) Data quality and verification process.

The second capitalisation workshop was organised on November 28-29, 2018. It included a document writing session, and has produced draft documents on the above mentioned capitalisation topics.

The final versions of documents will be presented to the MoH and will be discussed in a high-level symposium in April 2019.

On April 26, 2017 the Special Partner Committee has decided that no further funding will be provided to the Health Manpower Development Centre (HMDC) from the Belgian Cooperation. As the HMDC was foreseen to be the mayor counterpart for the project concerning activities to strengthen continuous training policies and modalities, this activity has been cancelled.

The Law on Social Health Insurance has not been passed by the Parliament yet. The funds budgeted for development of a model and strategies for a social health insurance have been used for more urgent matters that contributed to achievement of Output 4.

A study tour of MoH team to Cameroon was organised to study RBF implementation experience. The delegation of the MoH also participated at the International Symposium on Quality Improvement in London, and presented a poster on Ugandan experience in implementing quality improvement.

2.2.4 To what extent did outputs contribute to the achievement of the outcome?

Each project output has made its important specific contributions to achievement of project outcome. Outputs 1 and 2 have brought significant improvements in quality of care at the level of Health Facilities and have strengthened the managerial capacities of the DHMT. Output 3 has strengthened coordination between DHMT within the pilot regions. Output 4 has strengthened coordination between the MoH and the DHO and has contributed to development of a common vision of RBF implementation at central and local levels.

2.2.5 Assess the most important influencing factors. What were major issues encountered? How were they addressed by the intervention?

The most important influencing factors are presented below.

Excessive decentralisation of health services delivery, lack of regional level health system management, duplication of health services delivery by public and private Health Facilities. Delivery of health services is decentralized according to the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997). However, the standard definition of region has not yet been developed, and the regional health administrations have not been established. In this situation the MoH has to work directly with the DHO and perform the administrative tasks which otherwise could be normally performed by the regional health administrations. The intervention has advocated for decentralisation of management functions to the regional level, however, with limited results.

Lack of legal framework for rationalization of health services delivery, suboptimal planning and allocation of limited health system resources. Lack of clear definition of regions and regional health administrations does not allow for a rational planning of network of public Health Facilities. This problem is further aggravated by operation of private Health Facilities, which attract patients and absorb their financial resources. Presence of multiple Health Facilities of same level within the same coverage areas makes implementation of unified service delivery strategies and quality standards difficult. The intervention has supported the MoH in implementation of health service coverage maps and plans. Due to lack of legal framework and novelty of proposed approach, the results were limited.

The major issues encountered during project implementation are presented below.

Limited utilisation of indicators for evaluation of progress to achievement of outputs. Although the Baseline Study has been completed and the indicators have been updated, no systematic data collection process has been implemented. This has resulted in limited evidence of achievement of project outputs. The intervention has identified necessary improvements to the data collection and analysis process, and will implement them in the framework of the SPHU project.

Suboptimal organisation of verification activities at district level. Verification of compliance of Health Facilities with provisions of grant agreements is a very important step in validation of invoices and authorising of grant payments. Delayed verification visits have resulted in delayed validation and processing of invoices, and delayed receipt of funds by the RBF implementing Health Facilities. The intervention has identified ways to improve verification activities and has implemented necessary changes to the agreements with Districts.

Suboptimal financial reporting requirements for RBF grants. For public Health Facilities, RBF funds accounted for up to 95% of revenues under the budget line "other funding". However, the RBF funds were not earmarked, and no separate reporting of utilisation of RBF funds and follow-up of compliance with conditions of grant agreements was possible. The Health Facilities have been, in fact, required to report on utilisation of funds received from all donors, and not only from Enabel. This requirement has resulted in labour-intensive and time-consuming account reconciliation procedures, which have caused systematic delays of disbursement of

grant payments to RBF implementing Health Facilities. The situation was better in case of PNFP Health Facilities, which had to use the same reporting template they present to their MB quarterly to account for utilisation of RBF funds.

2.2.6 Assess the unexpected results, both negative and positive ones

The intervention did not bring any unexpected results.

2.2.7 Assess the Integration of Transversal Themes in the intervention strategy

The intervention has been supposed to focus on following transversal issues: (i) Gender; (ii) Sexual and reproductive health and rights (SRHR); and (iii) HIV/AIDS, according to the priorities set by the National Health Policy II.

Integration of transversal issues in the project activities has not been done due to lack of Enabel guidelines. The specific progress markers have not been measured.

2.2.8 To what extent have M&E, backstopping activities and/or audits contributed to the attainment of results? How were recommendations dealt with?

The backstopping and audit activities, organised during project implementation, as well implementation of respective recommendations and contribution to achievement of project results are presented below.

Backstopping mission of Dr. Paul Bossyns, July 7 – 13, 2016. The recommendations on implementation of baseline study, defining of role of HMDC, implementation of coverage plans, strengthening of interaction with the PNFP project, improvement of drug policies and provision, digitalisation, and elaboration of chronic disease policies have been fully implemented and have contributed to achievement of project outputs.

Mid of Term Review mission of Mr. Yves Lafort and Ms. Jennifer Wanyana, October 21, 2017 – November 21, 2017. The recommendations on strengthening of National RBF Framework, strengthening of project management capacities, capitalisation of project experience have been fully implemented and have contributed to achievement of project outputs.

End of Term Review mission of Ms. Meg Braddock, Mr. Matthieu Anthony, and Mr. Edgar Mulogo, November 19, 2018 – February 12, 2019. The mission has concluded that:

• The project led to better understanding of key health quality issues by many participants in both the public and PNFP health sectors, and increased awareness of accountability for performance.

• The RBF pilots have clearly shown the potential gains in service quality and staff motivation which arise from increasing autonomy for resource allocation at facility level, especially in the public sector. Increased resources and autonomy in their allocation enable all the Health Facilities to respond better to specific local needs.

• The projects contributed to implementation of the policies and strengthened the institutional structures. RBF is now firmly in place on the national agenda, and collaboration between the two sub-sectors has improved at all levels.

Mission recommendations on implementation of cost studies, strengthening of DHMT, use of information for management, review of quality assurance system, dissemination of lessons learnt have been used to design the SPHU project, which has integrated the activities of PNFP and ICB II projects.

Audit mission, Deloitte Consulting and Advisory, May 2018. The mission has concluded that: (i) ICB II Financial Report presents fairly, in all material respects, the actual expenditure incurred and revenue received for the Project for the period from September 1, 2015 to December 31, 2017 in conformity with the applicable Contractual Conditions; and (ii) ICB II Project funds provided by Enabel have, in all material respects, been used in conformity with the applicable Contractual Conditions. No financial findings have been reported.

The Internal Control Findings have been used to strengthen the RBF verification process, project management, and human resource management practices.

Audit report, Deloitte Consulting and Advisory, November 2018. The final report has not been received yet.

3 Sustainability

3.1.1 What is the economic and financial viability of the results of the intervention? What are potential risks? What measures were taken?

The economic and financial viability of intervention results remains questionable. An improvement of quality of health services has been noted in all RBF implementing Health Facilities. However, this has not resulted in an increase of total per capita health expenditure, public and private, and has not produced qualitative changes in financing of RBF implementing Health Facilities. The potential relation between the increased quality of health services and the increased revenues of Health Facilities requires further analysis.

The potential economic and financial risks for RBF implementing Health Facilities are presented below.

Further improvement of quality of health services, investments in infrastructure, medical equipment, and personnel would require resources, which may not be available in the health system budget and from user fees. The project has addressed this risk by advocating for utilisation of 5-year Strategic Plans and financial projections for Health Facilities. Considering the relatively short duration of the project and the high rate of managerial personnel turnover in Health Facilities, the results have been limited so far.

Cessation of RBF funding may lead to financial collapse some of the RBF implementing Health Facilities. This risk has been addressed by Enabel by extending implementation of RBF activities until December 31, 2019. This risk has been addressed by the project by undertaking development of RBF exit strategy. The strategy will be elaborated in 2019 and extensively discussed with the MoH, DHO, and Health Facilities.

3.1.2 What is the level of ownership of the intervention by target groups and will it continue after the end of external support? What are potential risks? What measures were taken?

The intervention is owned by the MoH, DHO, and RBF implementing Health Facilities in Rwenzori and West Nile pilot regions.

The MoH has developed the National RBF Framework, which has been recognised by national stakeholders and Health Development Partners, and has been implemented nationwide. The MoH has established the National RBF unit, which validates the invoices of Health Facilities and performs high-level supervision of RBF implementation. MoH ownership is presently limited to political and technical support, and has not yet been reflected in the health system budget.

The DHO have created teams of evaluators and have provided methodological support to RBF implementing Health Facilities.

The RBF implementing Health Facilities have elaborated and have implemented Performance and Quality Improvement Plans.

The potential RBF implementation risks are presented below.

The scope of RBF activities will remain broad, the vision of RBF implementation will not be sufficiently developed, the connections of RBF with the Universal Health Coverage and Health Insurance concepts will not be clearly defined. In cooperation with the Makerere University School of Public Health, the project has capitalised the experience of RBF implementation in Rwenzori and West Nile pilot regions. The capitalisation results have been presented to the MoH and Health Development Partners. This activity has established a platform for high-level policy dialogue, which may be useful in identifying improvements in the strategic areas of health system governance; medicines and health supplies; data quality and verification; utilisation, equity and patient-centred care; financial management; and human resource management. The capitalisation results may be used to define the role of RBF in reforms of health system of Uganda.

The Regional Health Administrations, capable to support health reforms, will not be established in the near future. Health system management will remain centralised at the MoH level. The project has advocated for decentralisation of management functions to the regional level, however, with limited results.

Planning of health system resources utilisation, functioning of referral and emergency care systems at regional and district levels will remain suboptimal. Duplication of health service provision by public and private Health Facilities will persist. The project has developed the coverage maps, has advocated for implementation of coverage plans, and has trained a number of MoH employees in utilisation of mentioned tools. Utilisation of coverage maps and plans is in the beginning of its implementation, and has had a limited impact on planning of health services delivery so far.

RBF grant procedures, including verification of Health Facilities and financial reporting, will remain complex and resource demanding. To speed up implementation of RBF activities, the project has advocated for payment for verification visits from the project budget rather than from the budget of DHMT. Although this solution is very likely to improve organisation of verification visits in the framework of SPHU project, it lacks long-term sustainability. The project has advocated for simplification of financial reporting requirements. Although the proposed solution is very likely to reduce payment delays, care should be taken to reduce the risk of non-compliance with financial management and accounting standards.

Utilisation of Performance and Quality Improvement Plans by the Health Facilities will only be linked to RBF activities. The project has advocated for utilisation of Performance and Quality Improvement Plans by the Health Facilities regardless of RBF grants, and has supported Health Facilities in this respect. However, if RBF funding will not be available in the future, the Health Facilities may abandon utilisation of mentioned plans.

The capacity of Health Facilities to absorb RBF funding will remain limited. The project has supported the Health Facilities in developing Strategic plans and making investments in infrastructure and medical equipment. To become sustainable, the technical capacity of Health Facilities should be developed, and sufficient funds for investment in infrastructure and medical equipment should be available in the health system budget.

The RBF indicators will not be correctly reported, the RBF grants will be utilised for activities not included in Performance and Quality Improvement Plans. The project has organised regular control mission to reduce this risk. To become sustainable, this solution is to be taken over by the DHMT.

3.1.3 What was the level of policy support provided and the degree of interaction between intervention and policy level? What are potential risks? What measures were taken?

The MoH has supported the intervention through establishing of the National RBF Unit, has supported development and implementation of National RBF framework. The project has collaborated with the National RBF Unit on a permanent base, and has regularly updated the MoH about progress of the project activities in Project Steering Committee (PSC) meetings. The project team did not identify any potential risks related to mentioned collaboration modalities.

3.1.4 How well has the intervention contributed to institutional and management capacity? What are potential risks? What measures were taken?

The project has contributed to strengthening institutional and managerial capacity at the level of National RBF Unit, DHO, and DHMT through involvement of partners in planning and implementation of project activities. The project team did not identify any potential risks related to building of institutional and management capacity of project partners.

4 Learning

4.1 Lessons Learned

The project team should be fully mobilised by the beginning of project implementation. The organisational diagram should be updated soon after beginning of project implementation. All needed project personnel, especially the key personnel, should be recruited as soon as possible.

The project team should be trained in the most important Enabel procedures in the beginning of project implementation. Short-term specific training sessions and on-the-job training should be organised on most important issues, such as financial management, procurement, logistics, communication, database management, etc.

The key TFF sections should be updated in the beginning of project implementation. A team review of the following TFF sections is highly necessary to ensure good understanding and ownership of project activities by all team members: Expected results and proposed activities; Indicators and Means of Verification; Risk Analysis; Financial Resources; Logical Framework; Budget. The updated TFF sections should be discussed at the PSC meeting and approved by the MoH.

The regional project teams should actively participate in elaboration or regional working plans and assume responsibility for implementation of project activities at regional level. The project activities should be decentralised to the levels of regional project offices, based on the principle of subsidiarity. The central project office should focus on general project management and execution of payments, which cannot be done at the level of regional project offices. The regional project offices should focus on implementation of project activities in cooperation with local partners and execution of payments within their mandate.

Regular interaction between central and regional project offices should take place. The IICM, PFC, and IHFE should regularly visit the regional project offices to oversee project implementation and check compliance with financial management and reporting requirements. They should assess the potential impact of mentioned requirements on project implementation delays. The NTA-TL and NTA should participate at the PSC meetings and regularly update the central project office on project progress.

A proper data collection routine should be established, individual responsibilities for reporting of logical framework indicators should be assigned. Update of TFF section "Indicators and Means of Verification" should include a check of data collection feasibility with members of regional teams and respective departments of the MoH, defining the periodicity of reporting of indicators, and assigning individual responsibilities. Dedicated personnel, i.e. the DM and MEA should be employed for continuous collection and processing of data. Delegation of data collection and processing tasks to DM and MEA will allow most efficient

utilisation of working time of NTA-TL and NTA for implementation of project activities.

4.2 Recommendations

Recommendation	Relevance	Source	Target audience
Define the strategic goals for the health system of Uganda, e.g. implementation of Universal Health Coverage, Health Insurance, etc.	Country strategy	ICB II Project	Government of Uganda, MoH
Define the role of RBF in achievement of strategic goals.	Country strategy	ICB II Project	Government of Uganda, MoH
Define the levels of organisation of health system in Uganda. Consider establishing of regional health authorities.	Country strategy	ICB II Project	Government of Uganda, MoH
Define the role of coverage plans and maps in planning of health system development at regional and district levels.	Sector strategy	ICB II Project	MoH
Define the purpose and expected outcome of application of RBF tool in Health Facilities.	Sector strategy	ICB II Project	MoH
Define the optimal modalities to implement RBF tools in Health Facilities of different levels.	Sector strategy	ICB II Project	MoH
Define the exit strategy to ensure a smooth transition from SPHU funding of RBF activities to budget funding.	Sector strategy	ICB II Project	MoH

PART 2: Synthesis of (operational) monitoring

1 Follow-up of decisions by the JLCB

No.	Decision	Actions	Status
1.	Financing Strategy for Extension period beyond June 2018 to enable smooth transition to SPHU project.	In Liaison with Head office, arrangements were made to have this effected.	Completed.
2.	Exit Strategy to concentrate on specific (sub) districts in order to demonstrate the effects of RBF on the (sub) district system if all Health Facilities (HCIII, HCIV, hospital).	Letter sent to the districts on this and subsequent meetings organised in the two respective regions.	Completed.
3.	Capitalisation and communication of the achievements interventions. This process will also contribute to reinforcing the visibility of the Enabel health sector support in Uganda, which is necessary in view of the next PIC.	Organised a national workshop to communicate what has been capitalised in the current Enabel RBF interventions, both at regional and national level, with all relevant stakeholders.	Completed.

2 Expenses

Budget vs Actuals (Year to Date) of UGA1402811

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

Budget Version: **E01**
Currency : EUR
YtD : **Report includes all valid transactions, registered up to today**

	Status	Fin Mode	Amount	Start - 2018	Expenses 2019	Total	Balance	% Exec
A SPECIFIC OBJECTIVE			4.349.750,00	3.223.746,33	**278,37**	3.224.024,70	1.125.725,30	**74%**
01 The quality of care at hospital and HC IV is strengthened			1.556.500,00	1.024.334,57	**0,00**	1.024.334,57	532.165,43	**66%**
01 Develop regional coverage plan for general hospitals and HCIV		REGIE	35.500,00	39.108,49	**0,00**	39.108,49	-3.608,49	110%
02 Support priority hospitals and HC-IV to realize a business plan		REGIE	62.000,00	55.154,47	**0,00**	55.154,47	6.845,53	89%
03 Support basic requirements for quality of care		REGIE	425.000,00	376.774,23	**0,00**	376.774,23	48.225,77	89%
04 Improve drugs and medical supplies managements		REGIE	54.000,00	51.753,75	**0,00**	51.753,75	2.246,25	96%
05 Introduce e-patient files		REGIE	190.000,00	26.572,61	**0,00**	26.572,61	163.427,39	14%
06 Implement RBF approach in general hospitals and HC-IV		COGES	790.000,00	474.971,02	**0,00**	474.971,02	315.028,98	60%
02 District health offices and management teams are			1.692.500,00	1.191.428,75	**278,37**	1.191.707,12	500.792,88	**70%**
01 Interpret coverage plan for HCIII and II		REGIE	2.500,00	5.634,72	**0,00**	5.634,72	-3.134,72	225%
02 Adjust district development plan according to coverage plan		REGIE	21.000,00	15.579,95	**0,00**	15.579,95	5.420,05	74%
03 Support basic requirements for quality of care		REGIE	175.000,00	180.221,63	**0,00**	180.221,63	-5.221,63	103%
04 Implement RBF financing through execution agreements		COGES	900.000,00	463.637,56	**0,00**	463.637,56	436.362,44	52%
05 Assure Quality of care through support supervision and		REGIE	302.000,00	253.345,97	**278,37**	253.624,34	48.375,66	84%
06 Improve ambulance services and referral system at district		REGIE	292.000,00	273.008,92	**0,00**	273.008,92	18.991,08	93%
03 Integrated regional network of health facilities in place			398.600,00	345.006,85	**0,00**	345.006,85	53.593,15	**87%**
01 Regional project team		REGIE	239.600,00	227.740,20	**0,00**	227.740,20	11.859,80	95%
02 Organize quarterly regional health forum in the Ruwenzori and		REGIE	137.000,00	106.619,60	**0,00**	106.619,60	30.380,40	78%
03 Install a coordination body for integrated referral system		REGIE	0,00	0,00	**0,00**	0,00	0,00	?%
04 Support continuous training from regional hospital specialists		REGIE	22.000,00	10.647,05	**0,00**	10.647,05	11.352,95	48%
04 The normative role of the MoH is strengthened			702.150,00	662.976,16	**0,00**	662.976,16	39.173,84	**94%**
01 Ensure overall management and governance of the project		REGIE	583.400,00	587.867,54	**0,00**	587.867,54	-4.467,54	101%

	Status	Fin Mode	Amount	Start - 2018	Expenses 2019	Total	Balance	% Exec
02 Capitalize from field experiences developed in Ruwenzori and		REGIE	74.000,00	40.782,75	**0,00**	40.782,75	33.217,25	55%
03 Strengthen continuous training policies and modalities		REGIE	9.000,00	6.821,82	**0,00**	6.821,82	2.178,18	76%
04 Develop a model and strategies for a social health insurance		REGIE	35.750,00	27.504,05	**0,00**	27.504,05	8.245,95	77%
X BUDGETARY RESERVE (MAX 5% OF TOTAL ACTIVITIES)			7.850,00	0,00	**0,00**	0,00	7.850,00	**0%**
01 budgetary reserve			7.850,00	0,00	**0,00**	0,00	7.850,00	**0%**
01 Budgetary reserve Co-management		COGES	7.850,00	0,00	**0,00**	0,00	7.850,00	0%
02 Budgetary reserve BTC management		REGIE	0,00	0,00	**0,00**	0,00	0,00	?%
Z GENERAL MEANS			642.400,00	604.724,31	**23.565,89**	628.290,20	14.109,80	**98%**
01 Staff costs			406.800,00	390.037,30	**0,00**	390.037,30	16.762,70	**96%**
01 International administrative and finance Responsible (RAFI)		REGIE	270.000,00	260.876,21	**0,00**	260.876,21	9.123,79	97%
02 Support staff		REGIE	136.800,00	129.161,09	**0,00**	129.161,09	7.638,91	94%
02 Investments			13.400,00	12.871,92	**0,00**	12.871,92	528,08	**96%**
01 Office and ICT equipment		REGIE	13.400,00	12.871,92	**0,00**	12.871,92	528,08	96%
03 Running costs			89.200,00	107.127,08	**-227,16**	106.899,92	-17.699,92	**120%**
01 Office recurrent costs		REGIE	60.400,00	74.247,30	**-227,16**	74.020,14	-13.620,14	123%
02 Missions		REGIE	28.800,00	32.879,78	**0,00**	32.879,78	-4.079,78	114%
04 Audit and monitoring and evaluation			93.000,00	61.165,81	**23.793,05**	84.958,86	8.041,14	**91%**
01 Evaluation & Monitoring		REGIE	70.000,00	56.299,41	**0,00**	56.299,41	13.700,59	80%
02 Audit		REGIE	19.000,00	0,00	**23.793,05**	23.793,05	-4.793,05	125%
03 Backstopping		REGIE	4.000,00	4.866,40	**0,00**	4.866,40	-866,40	122%
10 VAT			40.000,00	31.509,27	**0,00**	31.509,27	8.490,73	**79%**
01 VAT_Regie		REGIE	40.000,00	31.509,27	**0,00**	31.509,27	8.490,73	79%
		REGIE	3.302.150,00	2.889.862,06	**23.844,26**	2.913.706,32	388.443,68	88%
		COGEST	1.697.850,00	938.608,58	**0,00**	938.608,58	759.241,42	55%
		TOTAL	5.000.000,00	3.828.470,64	**23.844,26**	3.852.314,90	1.147.685,10	77%

	Status	Fin Mode	Amount	Start - 2018	Expenses 2019	Total	Balance	% Exec
02 VAT_comgt		COGES	0,00	0,00	**0,00**	0,00	0,00	?%
99 Conversion rate adjustment			0,00	2.012,93	**0,00**	2.012,93	-2.012,93	?%
98 Conversion rate adjustment		REGIE	0,00	2.012,93	**0,00**	2.012,93	-2.012,93	?%
99 Conversion rate adjustment		COGES	0,00	0,00	**0,00**	0,00	0,00	?%

3 Disbursement rate of the intervention

Source of financing	Cumulated budget	Real cumulated expenses	Cumulated disbursement rate	Comments and remarks
Direct Belgian Contribution	5.000.000	3.852.315	77%	
Contribution of the Partner Country	x	x	x	
Other source	x	x	x	

4 Personnel of the intervention

Function	First name	Last Name	M/F	Start	End	Type	ICBII	Status of contract
Project co-manager	Tony	De Groote	M	01.03.2016	30.09.2018	International	100%	terminated
Project manager	Sarah	Byakika	F	01.01.2016	31.12.2018	National Seconded	35%	SPHU to Dec 2019
Driver	Baker	Kazibwe	M	29.03.2016	31.12.2018	National recruited	100%	SPHU to Dec 2019
Driver	Gideon	Tumwizere	M	13.06.2016	31.12.2018	National recruited	100%	SPHU to Dec 2019
Driver	Polly	Nuwamanya	M	08.05.2018	31.12.2018	National recruited	100%	SPHU to Dec 2019
Driver	Jovin	Opoka	M	03.10.2017	13/3/2018	National recruited	100%	terminated
Project Accountant	Angella	Ikalebott	F	03.10.2016	30.01.2018	National recruited	100%	terminated
Finance and Contracting Coordinator	Inge	Dumortier	F	10.01.2015	31.12.2018	International	50%	SPHU to Dec 2019
Financial Project Controller	Julius	Ssekamyombya	M	05.10.2015	31.05.2016	National recruited	50%	terminated
Financial Officer	Grace	Apeduno	F	01.02.2018	30.06.2018	National recruited	50%	PNFP up to June 2019
Management Assistant	Dora	Anek	F	01.12.2015	31.12.2018	National recruited	50%	SPHU to Dec 2019
Financial Project Controller	Lydia	Namulondo	F	01.06.2016	31.12.2018	National recruited	50%	SPHU to Dec 2019

NTA RW	Sylvia	Bahiheira	F	03.09.2018	31.12.2018	National recruited	100%	SPHU to Dec 2019
NTA WN	Herbert	Bumbi	M	17.09.2018	31.12.2018	National recruited	100%	SPHU to Dec 2019
NTA Health System Strengthening West Nile	Joseph	Wamala	M	1/06/2016	30/06/2016	National recruited	100%	terminated
NTA Health System Strengthening Rwenzori	Elisa	Rutahigwa	M	1/06/2016	30/06/2016	National recruited	100%	Terminated
Driver West Nile	Sam	Odwe	M	7/06/2016	30/06/2018	National recruited	100%	Terminated

5 Public procurement

Enabel No.	Tender Title	Budget line	Procedure	Status	Company	Comments
ICB 001	Fleet tracking system for project vehicles	Z_03_01	Simplified procedure	On going	Fleet Monitoring Systems ltd	Amount exclusive of VAT
ICB 002	Purchase of 2 vehicles for the regions	A_03_01	Framework contract	Completed	Toyota	Enabel HQ framework contract
UGA 285	Purchase of city vehicle	A_03_01	Negotiated procedure without publication	Completed	Cooper Motors Cooperation	
UGA 289	Consultancy for diagnostic of the drugs and medical supply management in Health Facilities and districts in Rwenzori and West Nile regions	A_01_04	Negotiated procedure without publication	Completed	AEDES scrl	
ICB 003	Training in GIS and elaboration of coverage plans for West Nile and Rwenzori region	A_01_01	Framework contract	Completed	Afrika Museum van Tervuren	Enabel HQ framework contract
UGA 294	Purchase of city vehicle	A_04_01	Negotiated procedure without publication	Completed	Cooper Motors Cooperation	

UGA 321	Purchase medicines and medical supplies for initial donation to selected HC IV and Hospitals	A_01_03	Negotiated procedure with publication	Completed	Joint Medical Stores	
UGA 321	Purchase medicines and medical supplies for initial donation to selected HC III	A_02_03	Negotiated procedure with publication	Completed	Joint Medical Stores	
ICB 004	Purchase of IT equipment for selected HC III in Rwenzori and West Nile regions	A_02_03	Framework contract	Completed	HQ framework	
UGA 338	Development of e-patient file system and installation and training in selected GH and HC IV	A_01_05	Negotiated procedure without publication	On going	Uganda Chartered Healthnet	
ICB 005	Consultancy digitalisation RBF	A_01_03	Framework contract	On going	Bluesquare	Enabel HQ framework contract
UGA 330	Purchase of medical equipment for HC IV and General Hospitals in Rwenzori and West Nile regions	A_01_03	Negotiated procedure with publication	Completed	Pacific Diagnostics Ltd.	
ICB 006	Purchase of small medical material	A_02_03	Simplified procedure	Completed	Meridian	
ICB 007	Purchase of laptops for RBF focal points	A_02_03	Framework contract	Completed	HQ framework	

ICB 008	Purchase of Tablets for digitalization	A_01_03	Simplified procedure	Completed	NEWTECH COMPUTERS &ELECTRONICS LTD	
ICB 009	Purchase of Program Sign posts	A_02_05	Simplified procedure	Completed	Mecron Enterprises Ltd	
UGA340	Support to capitalization	A_04_02	Negotiated procedure without publication	Awarded	Makerere University	
UGA321bis	Purchase medicines and medical supplies for initial donation to selected HC III	A0103 A0203	Negotiated procedure with publication	Completed	Joint Medical Stores	
UGA 367	Purchase of hardware for e-patient file (66% on ICB2)	A_01_05	Negotiated procedure with publication	Awarded	IT Office	
ICB 010	Insurance for Ambulances and Utility Vehicles	A_02_06	Simplified procedure	Awarded	Jubilee Insurance	On going
ICB 012	Ebola kits	A0104	Simplified procedure	Completed	Gulf E.A Phamaceuticals	Split between PNFP (60%) & ICBII (40%)

6 Public agreements

Region	Org Name	Project	Grant code	Grant Start Date	Grant End date	Budget Component A - Euro	Budget Component B - Euro	TOTAL Budget grant - Euro
Rwenzori	DLG Bundibugyo	ICB II	ICBII_Bundibugyo_001	2018-04-01	2018-12-31	120.624	6.646	127.270
Rwenzori	DLG Kabarole	ICB II	ICBII_Kabarole_002	2017-07-01	2018-12-31	61.508	9.387	70.895
Rwenzori	DLG Kamwenge	ICB II	ICBII_Kamwenge_003	2018-07-01	2018-12-31	164.641	11.553	176.194
Rwenzori	DLG Kasese	ICB II	ICBII_Kasese_004	2017-07-01	2018-12-31	269.983	12.775	282.758
Rwenzori	DLG Kyegegwa	ICB II	ICBII_Kyegegwa_005	2017-07-01	2018-12-31	27.655	5.120	32.775
Rwenzori	DLG Kyenjojo	ICB II	ICBII_Kyenjojo_006	2017-07-01	2018-12-31	246.813	10.423	257.236
West Nile	DLG Adjumani	ICB II	ICBII_Adjumani_008	2017-07-01	2018-12-31	111.217	8.373	119.590
West Nile	DLG Arua	ICB II	ICBII_Arua_009	2017-07-01	2018-12-31	48.049	10.253	58.302
West Nile	DLG Maracha	ICB II	ICBII_Maracha_001	2017-07-01	2018-12-31	21.644	5.333	26.977
West Nile	DLG Moyo	ICB II	ICBII_Moyo_012	2017-07-01	2018-12-31	198.799	13.493	212.292
West Nile	DLG Nebbi	ICB II	ICBII_Nebbi_013	2017-07-10	2018-12-31	167.149	6.933	174.082
West Nile	DLG Zombo	ICB II	ICBII_Zombo_015	2017-07-01	2018-12-31	118.071	9.700	127.771
Rwenzori	DLG Bunyangabu	ICB II	ICBII_Bunyagabu_016	2018-01-01	2018-12-31	11.447	2.950	14.397

7 Equipment

Equipment No.	Equipment type	Equipment cost, EUR
ICB 002	Toyota	22,371.22
ICB 002	Toyota	22,371.22
UGA 294	Suzuki	22,000.00
UGA 285	Suzuki	23,821.05
PR2016-007051	Synology	1,430.00
PR2016-006747	Dell	1,521.00
MOH/ICB/17	Dell	1,521.00
MOH/ICB/17	Dell	1,521.00
MOH/ICB/023	Dell	814.86
LPO 222	NIKON	630.67
LPO222	HP	279.07
LPO 016	Office Desk Ge140	384.00
LPO 015	Air mesh Chair W/headrest	271.00
LPO 015	Air mesh Chair W/headrest	271.00
LPO 228	FILLING SHELF	300.00
LPO 228	OFFICE DESK	325.00

LPO 228	OFFICE CHAIR	425.00
ICB 004	31 PC M710S I5-7400 8 GB	14,000.00
ICB 004	29 Projector 3 LCD Eb-w29	14,000.00
ICB 004	14 Ricoh MP 301 SP	6,338.00
ICB 004	44 Laptop Prim'5 L560 20F2	30,368.00

8 Original Logical Framework from TFF :

	Logical of the intervention	Indicators	Baseline	Sources of verification	Hypotheses
GO	Global objective To further improve effective delivery of an integrated Uganda Minimum Health Care Package				
SO	Specific objective The planning, leadership and management capacities of (public) health staff – particularly at local government level, are strengthened	• Business plans for hospitals are institutionalised at national level • District health plans, as developed by the ICB project are institutionalised at national level • The national supervision approach is adapted	0 (Target: 1 policy adapted) 0 (Target: 1 policy adapted) 0 (Target: 1 policy adapted)	Minutes of workshops on the matter Ministerial decisions and recommendations Procedure manuals	International donor agencies are willing to follow in the RBF approach as proposed by the MoH/Belgian cooperation International donors are willing to step into a basket fund like aid mechanism to co-finance RBF and to work in the long term towards universal public health insurance.

R 1	Result 1 The quality of care at hospital and HC IV is strengthened	• Number of HC IV providing the full package of hospital care as defined by RBF • Number of HC IV and GH with approved business plans • % of essential drugs out-of-stock during > 1 week • % of personnel having followed sufficient continuous training according to national requirements.	37% Target 75% 0 Target : 75% 53% Target 75% 10% Target 50%	• Hospital business plans and yearly plans • RBF control reports • National health information system	The MoH and districts alike understand the need for rationalisation of the health pyramid and the way forward through district coverage plans The MoH has sufficient technical authority on local governments to convince them on district health coverage plan approach The MoH has sufficient political power and organised technical arguments to reform essential drug distribution policies and re-orientation of free health care subsidies (evolution from input-based to output-based national financing
R 2	Result 2: District health offices and management teams are strengthened in their capacity to manage an integrated district health system and to strengthen quality of care	• Access to FP services, including access to modern contraceptives, are integrated and 75% of all HC III and supported HC II provide the service. • HIV care and treatment services, including PMTCT, are integrated and functioning at 95% of performance or more conform RBF norms • HC III based deliveries have	30 % contraceptive prevalence rate (Target : 35 %) 36% Target : 60% Baseline not available at this stage		The MoH has sufficient technical authority on local governments to convince them on district health coverage plan approach The MoH has sufficient political power and organised technical arguments to reform essential drug distribution policies and re-orientation of free health care subsidies (evolution from input-based to output-based national financing International donor agencies recognise the opportunity created by RBF

		increased and the average quality is > 75 % of performance according RBF norms			approach to integrate successfully HIV care.
		• Number and % of HC III per district providing the complete minimal package of care • Composed Quality of care indicator according RBF procedures for HC III performance is reached in > 75% of the HC III and supported HC II in both regions. • Degree of implementation of the integrated district plan (financial absorption capacity of the districts relative to the execution agreements)	Baseline not available at this stage Baseline cannot be determined before introduction of RBF procedures Baseline cannot be determined before introduction of RBF procedures		
R 3	Result 3: Integrated regional network of Health Facilities is in place	• National vision on Regional coordination developed • Regional coordination for ambulance services is functional	0 0 Target : 2	• Concept notes and minutes of meetings on the matter • Minutes of the regional coordination meetings • District statistics on emergency evacuations	

R 4	Result 4: The normative role of the MoH is strengthened	• RBF implemented in 70 % of HC IV and GH in the 3 regions • National RBF policy approved • At least 6 strategic topics of attention of the ICB II project have been subject of a national reflection exercise (workshop, reflection paper, policy note). The capitalisation includes reflections on the crosscutting issues (gender, SRHR and HIV/AIDS).	o o o Target : 6	• Minutes of national workshops on the matter • Manuals and procedures defined on RBF • Minutes of meetings between donor agencies on the matter • Illustration of strategic topics (see chapter 2)	

	Activities to reach Result 1	Means	Belgian Contribution
R 1	Result 1 The quality of care at hospital and HC IV is strengthened		Costs in Euros
A 1.1	A.1.1 Develop regional coverage plan for general hospitals and HCIV	• 1 workshops per district for reviewing the data and completing the coverage plans • Printing the updated plans • 2 regional workshops	35.500
A 1.2	A.1.2 Support priority hospitals and HC-IV to realize a business plan	• Short term international consultancy (1 international and 2 national consult) • Visits in the regions to perform the work • 2 regional workshops	58.000
A.1.3	A.1.3 Support basic requirements for quality of care	• Basic equipment (on the base of need assessment) • Basic ophthalmological equipment 2 hospitals • short course according to managerial or clinical needs	370.000
A 1.4.	A.1.4 Improve drugs and medical supplies managements	• Short term international consultancy (1 international and	54.000

		2 national consult) • Visits in the regions to perform the work	
A 1.5	A.1.5 Introduce e-patient files	• National consultancy work to set-up the system (2 national consultants) • Purchasing of hardware and network according to needs • training	204.000
A.1.6	A.1.6 Implement RBF approach in general hospitals and HC-IV	• Financing general hospitals and HC-IV	900.000

	Activities to reach Result 2	Means	Belgian Contribution
R 2	Result 1 District health offices and management teams are strengthened in their capacity to manage integrated district health systems and to strengthen quality of care		Costs in Euros
A 2.1	A.2.1 Interpret coverage plan for HCIII and II	• 1 workshops per district for reviewing the data and completing the coverage plans • Printing the updated plans	31.500
A 2.2	A.2.2 Adjust district development plan according to coverage plan conclusions	• 1 workshops per district for reviewing the data and completing the coverage plans	30.000
A.2.3	A.2.3 Support basic requirements for quality of care	• Basic equipment (on the base of need assessment)	150.000
A 2.4.	A.2.4 Implement RBF financing through execution agreements	• Financing health centres	900.000
A 2.5	A.2.5 Assure Quality of care through support supervision and continuous training	• Training to supportive supervision (One workshop per district) • mentorship (T&S - 15 exchanges a month)	102.000
A.2.6	A.1.6 Improve ambulance services and referral system at district	• subsidies for ambulance services • National consultancy to plan districts emergency systems	162.000

	Activities to reach Result 3	Means	Belgian
R 3	Result 3 Integrated regional network of Health Facilities in place		Costs in Euros
A 3.1	A.3.1 regional project team	• 1 National Technical Assistant in each of the 2 Regions • Investment : 2 vehicles • Maintenance, fuel and insurance of vehicles (3)	269.600

A 3.2	A.3.2 Organize quarterly regional health forum in the Rwenzori and West Nile regions	• 3 monthly meetings	36.000
A.3.3	A.3.3 Install a coordination body for integrated referral	☐	
A 3.4.	A.3.4 Support continuous training from regional hospital specialists	• mentorship of clinical specialists (T&S - 15 exchanges a month) • setting-up teleconference (material etc)	92.000

	Activities to reach Result 4	Means	Belgian
R 4	Result 4 The normative role of the MoH is strengthened		Costs in Euros
A 4.1	A.4.1. Capitalize from field experiences developed in Rwenzori and West Nile regions	• Topping-up for national co-director • Technical orientation and follow-up comitee 3 monthly meeting • Scientific follow-up and evaluation of the various strategies implemented • Yearly capitalisation workshop at MoH level (1 day) and final (3	141.500
4.2	A.4.2 strengthen continuous training policies and modalities	• Short term national consultancy	24.000
A.4.3	A.4.3 develop model and strategies for a social health insurance	• Short term international consultancy • Transport (Flights, etc) for study tour • Accomodation (5 people * 7 days * 3 trips) for study tour • T&S allowances for study tour	78.750

9 Complete Monitoring Matrix

Not applicable.

10 Tools and products

The project has established cooperation with the Makerere University School of Public Health, in order to capitalize the project experience with participation of the MoH, Medical Bureaus, District Health Management Teams (DHMT), and health professionals. Two capitalization workshops have been organized. The first workshop identified the strategic areas for capitalization, such as: health system governance; medicines and health supplies; data quality and verification; utilisation, equity and patient-centred care; financial management; and human resource management. The second workshop systematised the available experience in strategic areas. The capitalized project implementation experience will be discussed in a high-level symposium in April 2019.