Enabel

Final Narrative Report

UGA 1603611 Establishing a Financial Mechanism for Strategic Purchasing of Health Services in Uganda (SPHU) Uganda

Belgian development agency

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0 Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti-Retroviral Therapy
AVSI	Association of Volunteers in International Service Foundation
(e) DHMT	(extended) District Health Management Team
DHO	District Health Office/officer
DRC	Democratic Republic of Congo
EHA	Enhancing Health in Acholi
EMR	Electronic Medical Record
Enabel	Belgian development agency
ETR	Ed Term Review
FP	Family Planning
FY	Financial Year
GDP	Gross Domestic Product
GH	General Hospital
GoU	Government of Uganda
HC	Health Center
HDP	Health Development Partners
HFQAP	Health Facility Quality of Care Assessment Program
HSDP	Health Sector Development Plan
HUMC	Health Unit Management Committee
ICB-HPLM2	Institutional Capacity Building in Health Planning Leadership and Management
IDI	Infectious Disease Institute
IEC	Information Education Communication
IICM	International Intervention Co-Manager
IPT	Intermittent Presumptive Treatment
IT	Information Technology
JRM	Joint Review Mission

(D)LG	(District) Local Government
MakSPH	Makerere School of Public Health
MAM	Moderate Acute Malnutrition
MB	Medical Bureaus
M&E	Monitoring & Evaluation
MoFPED	Ministry of Finance Planning and Economic Development
MoE	Ministry of Education
MOH	Ministry Of Health
MoLG	Ministry of Local Government
MoU	Memorandum of Understanding
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NTA-TL	National Technical Assistant – Team Leader
OPD	Out-Patient Department
PHC	Primary Health Care
PMTCT	Prevention of Mother To Child Transmission
PNC	Post Natal Care
PNFP	Private Not For Profit/ Institutional support for the private not-for-profit health sub-sector to promote universal health coverage in Uganda
RBF	Result Based Financing
RRH	Regional referral Hospital
RW	Rwenzori (region)
SC	Steering Committee
SDG	Sustainable Development Goals
SDHR	Support to Development of Human Resources
SPHU	Strategic Purchasing of Health services in Uganda
SRH (R)	Sexual and Reproductive Health (Rights)
TB	Tuberculosis
TFF	Technical and Financial File
TWG	Technical Working Group
UgIFT	Uganda Intergovernmental Fiscal Transfers Programme

UGX/UgSh	Ugandan Shillings
UNICEF	United Nations Children's Fund
URMCHIP	Uganda Reproductive Mother and Child Health Improvement Programme
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank
WHO	World Health Organization
WN	West Nile (region)

1 Intervention form

Title of the intervention	**Establishing a Financial Mechanism for Strategic Purchasing of Health Services in Uganda (SPHU)**
Code of the intervention	**UGA 1603611**
Location	**Uganda**
Total budget	**EUR 6,000,000**
Partner institution	**Ministry of Health**
Start date of the Specific Agreement	**December 13, 2017**
Start date of the intervention/ Opening steering committee	**September 26, 2018**
Expected end date of execution	**May 31st 2021 (initial date 30th June 2020)**
End date of the Specific Agreement	**June 13, 2021**
Target groups	**Direct beneficiaries are the Ministry of Health, the Medical Bureaux, the district health office and Public and PNFP facilities in Rwenzori and West Nile region. Indirect beneficiaries are the rural population, particularly the poorest and most vulnerable.**
Impact	**Contribute to Universal Health Coverage in Uganda following a Rights Based Approach.**
Outcome	**Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and PNFP Health Services, with a particular focus on women, children and other vulnerable groups.**
Outputs	**Output 1: The equitable access to quality health care at public and PNFP HC IIIs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point.**
	Output 2: The equitable access to quality health care at public and PNFP General Hospitals & HC IVs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point.
	Output 3: The capacity of Health Districts to manage the quality of care, the right to health and the integrated local health system is strengthened.
	Output 4: The capacity of MoH to steer the implementation of the health financing strategy is strengthened.

2 Self-evaluation of performance

2.1 Relevance

	Performance
Relevance	A

The priority areas of the Belgian cooperation in the Health Sector in Uganda are Human rights & Gender, Maternal & Child health and Family Planning (FP), Digitalisation. SPHU fits within this view as it aimed to increase the access and affordability to quality health care for the entire population and in particular for vulnerable groups. SPHU activities and monitoring took particular attention to maternal & child health, family planning and digitalisation.

SPHU is in line with the Uganda Vision 2040[1]. It also aligns with the long-term strategic vision of the Ugandan health sector as laid out in the National Development Plan II[2], whereby particular attention is given to "human capital development as fundamental enablers for socio-economic transformation of the country" and places a strong emphasis on investing in the promotion of people's health and nutrition.

SPHU responds to the national priorities and respects the National Health Policy II[3]. The project supported the implementation of the Health Sector Development Plan 2015/16-2019/20 whereby specific attention is given to the achievement of the health-related Sustainable Development Goals (SDG). It is also aligned with the National Financing Strategy 2016-2025 and the Result Based Financing Framework 2016. SPHU was implemented according to the principles laid down in the Memorandum of Understanding (MoU) signed by the GoU and the HDPs in 2005.

In summary the intervention remains fully relevant to the priorities of Uganda and Belgium, and highly relevant to the needs of the population.

2.2 Effectiveness

	Performance
Effectiveness	B

The expected **outcome** of SPHU was "To build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing Mechanism for Public and Private Not-for-Profit Health Services, with a particular focus on women, children and other vulnerable groups." It is important to notice that while the length of the intervention was too short – 2 years – to arrive at significant changes by itself, the project built on and consolidated the work and achievements of the two previous interventions implemented by Enabel in Uganda from 2015 to 2018, with similar geographical and activities scope.

As a matter of fact, SPHU increased the capacity at the MoH and at peripheral levels on strategic purchasing through RBF: the MoH developed and adopted a National RBF Framework and the

[1] Republic of Uganda (2007) Uganda Vision 2040 Available at https://www.greengrowthknowledge.org/sites/default/files/downloads/policydatabase/UGANDA%29%20Vision%202040.pdf

[2] Republic of Uganda (2015) Second National Development Plan (NDPII) 2015/16 – 2019/20 (2015) Available at http://npa.go.ug/wp-content/uploads/NDPII-Final.pdf

[3] Republic of Uganda, Ministry of Health (2010) 2nd National Health Policy (NHP II) Available at http://library.health.go.ug/publications/policy-documents/second-national-health-policy-2010

necessary contracting and monitoring tools for RBF implementation, also thanks to the contribution of the interventions implemented by Enabel. In 2018, the MOH established a RBF unit within the Planning Department, strengthening the institutionalization of the RBF intervention within the health system structures. SPHU contributed to the progressive nationwide rollout of RBF together with the World Bank (WB)-funded URMCHIP and USAID-funded project Enhancing Health in Acholi (EHA).

Most result indicators improved, with some fluctuating and some stabilizing. Health services management indicators (regular supervision, joint review meetings, implementation of continuous professional development plan, updated strategic plans, etc.) improved, highlighting the consistent effort and effect of the intervention on strengthening the health system.

Not all the expected outputs were fully realized, even though this may not be unexpected, considering that many were not fully under the control of the intervention and are linked to a lot of other contextual factors.

Overall, SPHU has had a satisfactory effectiveness. Its implementation contributed to the increase in quality and access to health services, improvement of management practices at the levels of the MoH, LG/DHO, and health facilities, and supported the implementation and national roll out of the National RBF framework.

2.3 Efficiency

	Performance
Efficiency	B

Integration of PNFP and ICB-HPLM2 interventions into one "follow-up" intervention (SPHU) has enhanced efficiency of Enabel support in the health sector in Uganda. The design of SPHU as a single intervention has contributed to reducing some of the inefficiencies highlighted in the End Term Review of the PNFP and ICB-HPLM2 interventions related to staffing, use of resources, and coordination and communication between the Enabel intervention teams and other stakeholders.

The transition process and preparatory activities, including recruitment of International Health Financing expert and Intervention Co-manager, at the start of SPHU project in 2018 initially delayed the implementation of activities. This is reflected in the low disbursement utilization in December 2018 (4.5%), increased to 76% by the end of December 2019, 98% by the December 2020, and expected to be 100% at the end of May 2021. The operational closure phase, initially expected to last from January to June 2020, was extended by 3 months due to the delays caused by the Covid-19 pandemic, which slowed down and prevented some field activities. Funds which could not be utilized were redirected towards the Covid-19 response in support of the national efforts.

SPHU inputs have been managed adequately and some inefficiencies related to verification process and payment of RBF funds at the beginning of the project have been addressed by transferring the responsibility to organise and finance the verification mission from the DHOs to Enabel Regional teams and by deploying a web-based platform, digitalizing data entry, verification, invoicing and reporting processes.

In summary, SPHU was satisfactorily efficient. Its inputs were available in time and within budget limits; most activities were on schedule and the few delayed had no significant impact on the delivery of the expected outputs. Most outputs were delivered in time and of good quality, contributing to the planned outcome.

2.4 Potential sustainability

	Performance
Potential sustainability	B

The sustainability of interventions has several dimensions:

1. Financial and economic sustainability: in the short-medium term, the economic sustainability was addressed by developing facility sustainability plans before the end of the intervention (e.g. mobilization of additional resources from income generation activities, efficiency gains, etc.) and the transition of SPHU supported facilities to the URMCHIP RBF scheme, implemented by the GoU financed through a World Bank loan, and grants from Global Financing Facility (GFF) for Every Woman Every Child and Swedish International Development Aid (SIDA). Facilities anyway, especially PNFP, experienced a decrease in income, due to the delay in the effective implementation of the transition and the difference in the URMCHIP RBF model, which incentives less indicators especially at hospital level, determining a possible decrease in the amounts of incentives. This threatens the viability especially of PNFP facilities, with the possible consequence of increase in user fees and decrease of financial accessibility. After URMCHIP, it is likely the RBF intervention will be mainstreamed into the GoU funding mechanisms under the UgIFT programme, also supported by a World Bank loan designed to improve the adequacy and equity of fiscal transfers and improve fiscal management of resources by LG for the health and education services. In the long term, sustainability of RBF remains a concern and will depend on increase of public budget allocation to the health sector and reduction of donor dependency through development and implementation of alternative health financing strategies.

2. Policy and institutional support: There is strong support at policy and institutional level for scaling-up the implementation of RBF in Uganda. The Health Financing Strategy (HFS) 2015/16-2024/25 recommends "to move away from relying on mainly input-based purchasing towards more Results Based Financing." RBF is considered as a purchasing method that can promote more efficient use of resources and promote strategic purchasing of cost-effective service. Several RBF schemes have been implemented in Uganda over the last two decades, and lessons from these projects have guided the development of a National RBF Framework for the Health Sector which has contributed to institutionalizing RBF. The policy is for RBF to be scaled-up to cover the entire country, as a first step towards the establishment of a third-party payment mechanism, and to prepare the base for the implementation of National Health Insurance Scheme in Uganda.

3. Ownership by local stakeholders: SPHU has achieved good ownership by local stakeholders, mainly driven by the participatory and joint implementation approach adopted, its administrative structure embedded into the national services, co-management with the MoH, and close collaboration and integration of activities at district level and between the public and PNFP sectors.

4. Institutional and management capacity: SPHU contributed to reinforcing institutional and management capacity of local stakeholders. A lot of emphasis was put on capacity building, in line with the approach of the previous interventions, especially in leadership and management areas at district level.

In conclusion, there are good foundations for the benefits accrued by the intervention to continue in the short and medium term, with long-term sustainability depending on the government's strategic choices towards health sector financing.

2.5 Conclusions

- SPHU integrated 2 previous interventions implemented by Enabel - "Institutional Capacity Building in Health Planning Leadership and Management" (ICB-HPLM2) and "Institutional support for the PNFP health sub-sector to promote universal health coverage (UHC) in Uganda" (PNFP): the continuity and consistency of approach allowed consolidation of the achievements and of positive changes within the health system.
- SPHU used a comprehensive and action-research based approach, and demonstrated that RBF can contribute to health system strengthening. Its implementation contributed to the increase in quality and access to health services, and improvement of management practices at health facilities and district level in the areas of human resources, financial and data management.
- SPHU has positively influenced policy at national level, contributed to strengthening the capacity of the MoH to steer the health financing strategy by supporting the RBF Unit in the Department of Planning, Financing and Policy of the MoH, and providing evidence, based on implementation research, which contributed to the continuous learning on RBF.
- SPHU contributed positively to the progress towards UHC in alignment with national and international commitments and priorities. Its strong ownership by local stakeholders, the participatory and joint implementation approach with the MoH, and the focus on institutional and management capacity building will contribute to the sustainability of the impact, in spite of the likely challenges in financial sustainability.

National Execution Officer	Intervention Manager Enabel
Dr. Sarah Byakika Kyeyamwa	Dr. Monica Imi 04/06/2021

3 Assessment of the intervention strategy

3.1 Evolution of the context

3.1.1 General and institutional background

The political situation in Uganda has remained stable for the duration of the intervention implementation, except for sporadic disorders during the last months of 2020 due to impending elections, which anyway did not significantly affect activities, since most were completed by September 2020.

From an economic point of view, prior to the Covid-19 outbreak, structural transformation was driving a decline in poverty, despite a slowdown in average economic growth over the last decade, but the Ugandan economy remains highly vulnerable to shocks, as seen in the rise in poverty following the 2016/17 drought.

On this substrate of vulnerability, the Covid-19 pandemic hit at the beginning of 2020 and had a very significant impact. Following the outbreak, the national lockdown and the spill over effects of the global economic disruption, the country experienced an important economic downturn. The GDP in FY20 grew at less than half than the previous year, and it is expected to grow at similar level in FY21, and the medium-term outlook for Uganda has worsened considerably. The economic slowdown, and an unequal response to Covid-19 (targeting mainly the urban population and the formal sector) is likely to increase poverty levels and inequalities within the country.

The budget allocated to the health sector, both in absolute terms and in % of the total government budget, remains below the internationally agreed target, as shown in the table below.

Year	Health Budget	Growth	Total Gov't Budget	Growth	Health as % of total budget
2015/16	1,271	-1%	18,311	22%	6.9%
2016/17	1,827	44%	20,431	12%	8.9%
2017/18	1,950	6.7%	29,000	42%	6.7%
2018/19	2,373	18%	32,700	13%	7.2%
2019/20	2,589	9.1%	32,661	-0.12	7.9%
2020/21	2,781	7.4%	36,109	10.56%	7.7%

Health financing is still inadequate and largely donor-dependent, with a total per capita health expenditure at only USD 53 per capita compared to an estimated USD 84 required to deliver the essential package of services. Only 15% comes from Government, 42% from donors, and the rest from out of pocket expenditure. Off-budget financing dominates the direct public (donor and Government) spending, largely ear-marked for specific interventions such as HIV/AIDS, TB, Malaria, sexual and reproductive health (SRH) and health infrastructure, distorting public sector efforts and leaving many priority healthcare interventions not effectively attended to. In addition, the flow of funds outside the government fiscal transfer system is often inequitably distributed and difficult to track.

The institutional framework has remained constant, with the health sector oriented by two key documents: The National Health Policy (NHP) 2011-2020 and the Health Sector Development Plan (HSDPII) 2015/16-2019/20. Unfortunately, as per the Annual Performance Report of FY 19/20, the health sector has been able to achieve HSDP targets for only 5 out of the 42 HSDP indicators. The poor performance in many health-related indicators can be attributed to challenges

like the extreme weather events (draught in 16/17 and like the heavy rains and floods 1in 18/19) and the Covid-19 pandemic in addition to internal health system issues including inadequate funding.

The Covid-19 epidemic in particular has significantly affected service utilization due to a combination of access (physical, due to the limitations to movement, but also financial) and availability constraints, with the already scarce health system resources refocused on the Covid-19 response often at the expense of the other health priorities, both at government and partners' level. Indeed, the annual health sector performance report for FY 2019/20, several outcome and output indicators stagnated or even worsened (IPT2, under5 vitamin A coverage, immunization coverages, facility deliveries, hospital admissions, maternal and under 5 hospital death rates) compared to the previous year.

Last but not least, Uganda has a very high population of refugees, linked to the vicinity of war-torn countries like South Sudan, DRC and Burundi, and the open policy of the Government: the country hosts more than a million refugees of with more than half being in districts supported by SPHU, especially in West Nile, posing an additional strain on the local health system.

3.1.2 Management context

3.1.2.1 Partnership modalities

The intervention works in close cooperation with the Strategy and Development Directorate of the MoH, the Health Sector Budget Working Group (HSBWG), and the National RBF Task Force. The core activity of the intervention is the implementation of RBF in the regions of West Nile and Rwenzori.

In 2018, grant agreements with 35 HC III, 3 HC IV and 8 General Hospitals (GHs) were signed. In addition, a Memorandum of Understanding for maintenance of 23 vehicles used for the activities of intervention in Rwenzori and West Nile region, was also signed: this covered not only the intervention vehicles and motorbikes used for intervention activities but also the ambulances provided by the previous interventions, and which are key in the implementation of the referral system.

In 2019, grant agreements were signed with 65 HC III, 8 HC IV, and 12 GHs from Rwenzori and West Nile regions.

All the above contracts terminated on 31st December 2019.

3.1.2.2 Operational modalities

At the central level, the intervention is anchored in the Department of Planning, Financing and Policy of MoH, led by the Commissioner Health Services for Planning Financing and Policy - Dr. Sarah Byakika. This contributes to ownership and sustainability of the intervention by the MoH, and facilitates discussion of necessary actions in the strategic areas.

The Steering Committee (SC) is the decision-making body of the intervention. It also serves as a platform for discussion between the involved Ministries (Health, Finance, Local Government) and other represented stakeholders as the Medical Bureaus. The chairperson of the Steering committee is the Permanent Secretary, MoH.

SPHU maintained regular meetings of the Steering Committee (nine meetings in February 2021) assuring the steering of the intervention in a very participatory manner: activities, indicators and means of verification, financial resources and modifications were discussed then approved by the SC before implementation. From the beginning of the Covid-19 pandemic, discussions were held virtually and decision were ratified through exchange of letters or during virtual meetings.

The intervention participates in the activities of various MoH Technical Working Groups (TWG), e.g. HSBWG, Governance, Supervision, Policy & Regulation (GOSPOR) TWG, RBF Taskforce established by the MoH, and collaborates with various health development partners through the relevant fora.

At the level of Rwenzori and West Nile intervention regions, the intervention is anchored in the District Health Offices and Health Facilities, and works in close collaboration with the regional officers from the Medical Bureaus.

Administratively, there are three offices: a central one at the MoH in Kampala and two regional offices, one in Fort Portal (Rwenzori Region) and another in Arua (West Nile Region). The central office team is led by an International Intervention Co-Manager (IICM) who oversees the entirety of the intervention in close collaboration with the National Intervention Co-Manager, the Commissioner Policy Planning and Financing. There are two other international staff at the central office: An International Health Finance Expert and an International Finance and Contracting Coordinator. Each Regional Office is led by a National Technical Assistant-Team Leader (NTA-

TL). The Kampala intervention office is responsible for general management of intervention activities, including organisation of public tenders, maintenance of vehicles, organisation of training activities and conferences, etc. The Rwenzori and West Nile intervention offices support the DHMT in implementation of RBF activities at the level of District Health Offices and Health Facilities.

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

The chosen operational modalities have remained completely appropriate for the expected results of the intervention. No challenges in the operation of the intervention have been encountered.

3.2 Significant changes to the intervention strategy

The Theory of Change of this intervention is centred around RBF, not only as a strategic financing mechanism, but as a system strengthening intervention able to elicit fundamental and lasting changes.

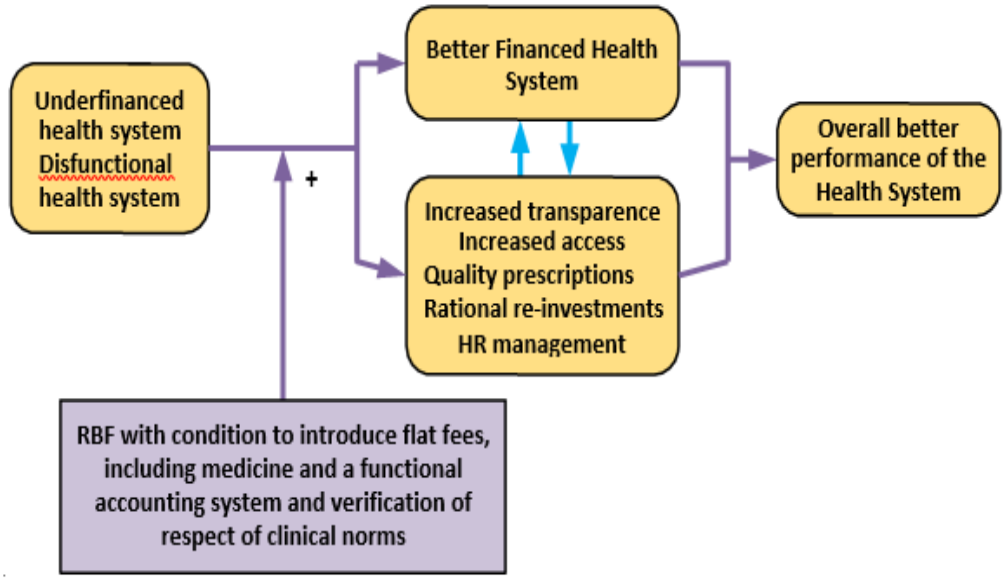


Figure 1: RBF as the motor for systemic change

The intervention logic depicted above, which was used also in the previous interventions, did not undergo significant changes during the intervention life span.

Two modifications compared to the original TFF took place:

1. In January 2019, following a backstopping mission by the Enabel Health Unit Coordinator, the outcome and outputs indicators cited in the Technical Financial File (TFF) were reviewed. The results of this review were presented to the SC and the MoH gave its non-objection with regards to the utilisation of these updated indicators in February 2019. A minor modification in the wording of result 3, and the final list of activities to be implemented, were also presented ad approved. The changes and their rational are detailed in annex 1a and 1b

2. In March 2020, a strategic reorientation of the SPHU intervention was requested by the MoH, in view of the Covid-19 pandemic, so that resources for non-essential activities could be redirected with the Covid-19 response of the country (see annex 2), in particular towards the purchase of infrared thermometers and communication activities. This was discussed and approved by the SC. In addition, planned support to facilities in terms of mentorship and equipment/supplies was re focused on epidemic responsiveness equipment and skills. These activities could take place after the strict lock down was lifted, from June to September 2020, and in order to complete them the contracts of regional staff were extended for 3 months, till 30th September 2020. A summary of the activities supported is presented in the table below.

Activity area	**Details**
Equipment and supplies	800 infrared thermometers
	Infection prevention supplies to Zombo Maracha Moyo districts plus Arua RRH
Training/ mentorship	Training of 150 HWs about triage, identification and management of suspects (Zombo, Moyo , Maracha)
	Mentorship and training in infection prevention for HC4 and General Hospitals in Zombo Maracha and Moyo districts
	Training of Health workers at border posts in COVID screening and testing as well as WASH (Zombo Maracha Moyo districts)
Communication/ sensitization	Rwenzori: 1 day training for 2 VHT members/village (5424 trainees) on preventive measures against Covid-19
	Translation in local language and distribution of COVID IEC materials for WN districts in 4 dialects (Lugbara, Madi, Alur and English)
	Broadcasting on radio and TV preventive messages

Lastly, following a request from MoH, the contracts for the NTA of West Nile and of one driver, and the implementation period for activities were extended up to May 2021, to provide technical support to the transition process of West Nile facilities to URMCHIP and to support the same in the whole region. While SPHU covered the salaries of the staff and some few activities especially targeting the transition processes, URMCHIP covered the running costs of routine RBF-related activities. Thus was aimed at ensuring a smooth transition and maximize knowledge transfer from SPHU to URMCHIP/MoH team.

4 Achieved results

4.1 Performance of outcome

Outcome: Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and Private Not For Profit (PNFP) Health Services, with a particular focus on women, children and other vulnerable groups

4.1.1 Achieved indicators

Progress indicators/markers[4]	Base value	Final target	Final value attained
	2016		**2019**
1. Tested and updated RBF model, accepted by MoH and GoU as the national model, available	No (0)	Yes (1)	Yes (1)
2. % of the national health budget which is output- based	0%	>25%	< 3%
3. Utilisation rate for curative consultation at HC III level, total and gender-disaggregated	177,80 / 1000 (R) 161,47 / 1000 (W)	+20%	186.68/1000 (R) 172.69/1000 (W)
4. Hospitalisation rate for HC III level health facilities, total and gender-disaggregated*	12% (R) 11% (W)	**+10%**	17% (R) 13% (W)
5. Hospitalisation rate for GH and HC IV level, total and gender-disaggregated, in RBF supported health facilities*	32% (R) 25% (W)	**+10%**	28% (R) 35 % (W)
6. Percentage of RBF supported GH and HC IV, which implement strategic plans	38% (R) 25% (W)	**100%**	100% (R) 100% (W)
7. Strategic plans for GH and HC IV institutionalized as National Policy	No	**Yes**	Yes

** These indicators could not be calculated as rates per 1,000 population, because the exact number of population served by the HC III, HC IV, and GH was not always known. Therefore, Outcome Indicators 4 and 5 have been calculated as percentages, reflecting hospitalisation rates out of total number of outpatient visits.*

4.1.2 Analysis of the achievement of the outcome

SPHU increased the capacity of the MoH and districts and facilities to implement a strategic purchasing mechanism: a national RBF framework was approved in 2016 and RBF has been rolled out all over the country following a standardised national model, which is adopted by the MoH URMCHIP and, with some modification, by the Enabling Health in Acholi Project. SPHU consolidated the learning from the previous RBF implementing interventions through

capitalization exercise supported by Makerere School of Public Health (annex 3) and disseminated the results during a symposium held in November 2019 (annex 4).

From a policy point of view RBF is firmly established, in quantitative terms the role of output based financing is still overall limited. Exact financial data are not available, but according to the report on tracking off-budget financial resources in the health sector5, only 3% to the total health budget expenditures from government and donors (including on and off budget) has been channelled through URMCHIP and Belgian interventions which are mainly (but not exclusively) output based.

Utilization indicators generally improved but due to the patchy geographical coverage and poorly defined catchment areas it is difficult to fully assess them in terms of absolute numbers, also considering the number of other factors involved, e.g. the large presence of refugees in the areas, the development of community activities (West Nile) such as community management of certain illnesses (malaria, diarrhoea, etc.) and, possibly, increase of quality of care at the lower level (HC III referring less, for example) decreasing hospital admission rates.

Utilization rates in the supported facilities improved in RBF supported facilities more than in non-RBF supported for most of the incentivized services, as demonstrated by the increasing contribution of RBF supported facilities to overall district performance (table 1). Notable exceptions are TB and ART services, which are targets of vertical support programmes and do not seem to have benefitted significantly from RBF support. The % increase was also limited for inpatient services and family planning, the latter probably linked to the high number of PNFP facilities not offering modern contraception.

Indicators	**2016**	**2017**	**2018**	**2019**
New OPD U5	33%	38%	41%	45%
New OPD > 5	32%	34%	36%	37%
MAM U5	8%	28%	39%	60%
Active on ART	45%	45%	46%	45%
Complete TB Treatment	53%	45%	38%	37%
ANC 4	38%	40%	40%	40%
Deliveries	34%	41%	44%	45%
PNC 6 Days	38%	60%	65%	68%
PNC 6 weeks	38%	50%	55%	57%
Complete Immunization	36%	43%	45%	50%
FP Users	24%	23%	24%	28%
Admissions <12	85%	84%	83%	85%
>12 Admissions	86%	86%	84%	85%
Referrals not in labour	71%	83%	90%	82%
Referrals in labour	80%	86%	89%	86%
Minor Surgery	92%	67%	78%	83%
Major Surgery	87%	91%	93%	87%

Table 1: % contribution of RBF supported facilities to overall district performance from 2016 to 2019

RBF also significantly improved governance and management processes: for example, s*trategic plans* for health facilities (GH and HC IV) were developed with the support of the intervention and they are now incorporated in the planning guidelines.

[5] "Tracking off-budget financial resources in the health sector FY2019/20" – MOH/UNICEF

4.2 Performance of output 1

Output 1: The equitable access to quality health care at public and PNFP HC IIIs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point.

4.2.1 Achieved indicators

Indicators	Base value	Final target	Final value attained
	2016		**2019**
1.1 Percentage of RBF supported HC III in the targeted districts which obtain a score of at least 4 stars to the Quality of Care Assessment of the MoH	N/A (R) N/A (W)	>75%	N/A (R) 0 (W)
1.2 Percentage of institutional based deliveries which meet the MoH quality standards in RBF supported HC III	80% (R) 75% (W)	80%	95% (R) 93%) (W)
1.3. Percentage of RBF supported HC III providing modern family planning services	42% (R) 58% (W)	100%	42% (R) 58% (W)
1.4 HIV/AIDS care and treatment services, including PMTCT, are integrated and functioning according to MoH quality norms in RBF supported HC III	100%	>95% >85%	100%

4.2.2 Analysis of the realisation of the output

Activities related to this outputs focused on the support to selected HCIII to comply with accreditation criteria through technical assistance, capacity building and provision of basic equipment, and implementation of the RBF approach including internal audit and district based performance analysis.

Access (utilization of services) increased in the RBF supported facilities as shown in the outcome section. The quality of care improved in the supported facilities, even though consistent data from the standard national Quality of Care assessment programme (HFQAP) are lacking due to irregular implementation of the yearly assessment, linked to budgetary constraints, and an assessment in 2019 in West Nile showed no RBF supported HC III reached 4 stars (the bar is anyway quite high with this tool).

On the other side, the quality of care as assessed using the RBF system, as shows by the % of key outputs meeting quality standards, had a noticeable improvement during the intervention.

All RBF supported units	% cases meeting quality description by MOH		
Indicators/period	**2017**	**2018**	**2019**
New OPD under 5	42.6%	84%	88%
MAM U5	138%*	85.5%	49.1%*
ANC4 visits	53.2%	81.9%	85.2%
Deliveries	60.6%	92%	94.8%
Complete immunization	52.5%	85%	75.1%
New FP users	32.3%	72%	70.8%

Family planning (FP) and HIV services coverage remained substantially unchanged, both having already reached maximum levels. To be noticed, health facilities under the Uganda Catholic Medical Bureau (UCMB) do not provide modern FP services, and HIV/AIDS care and PMTCT are already integrated in all health facilities thanks to the consistent MOH effort and support from other development partners.

4.3 Performance of output 2

Result (Output) 2: The equitable access to quality health care at public and PNFP General Hospitals & HC IVs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point.

4.3.1 Achieved indicators

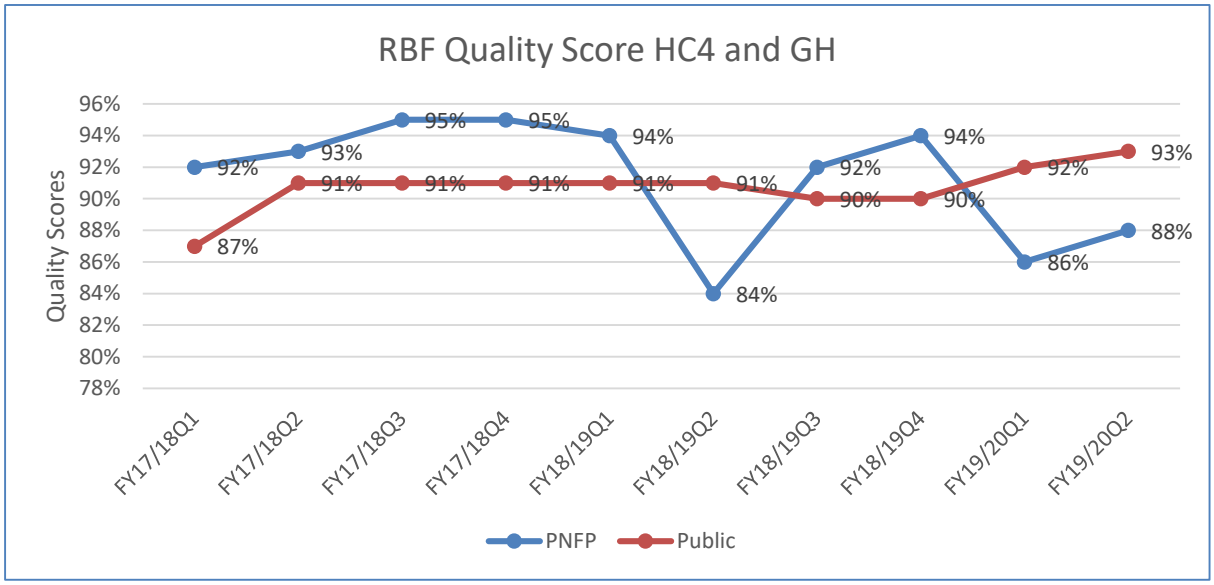
Indicators	Base value	Final target	Final value attained
	2016		**2019**
2.1 Percentage of RBF supported GH and HC IV in the targeted districts which obtain a score of at least 4 stars to the Quality of Care Assessment of the MoH	N/A (R) N/A (W)	**>85%**	N/A (R) 0 (W)
2.2 Percentage of RBF supported GH and HC IV in the targeted districts that experience essential drugs out-of-stock for any of the 6 tracer medicines in a month	30,8% (R) 62,8% (W)	**<5%**	28,57% (R) 33,33% (W)
2.3. Percentage of RBF supported public GH and HC IV in the targeted districts with a functional e-patient file system	0%	**100%**	100% (5 public GH and 4 public HC IV)

4.3.2 Analysis of the realisation of the output

Activities related to this output focused on supporting the selected facilities to meet RBF requirements (through technical assistance, capacity building and provision of key equipment) and implement the RBF approach. In addition, the consolidation of the e-patient file system in 9 pilot facilities initiated during the previous interventions was included as a key strategy for improvement of patient management, with the objective of creating a viable opportunity for learning and capitalization.

Utilization generally increased as shown in the outcome section.

Regarding quality, as for the HC III, HFQAP surveys has not regularly been performed so consistent data are lacking, and the 2019 assessment in West Nile region demonstrated no facilities achieved 4 stars. On the other side, the quality score as per RBF quarterly assessments remained fairly high. To be noted that the PNFP sector has usually a slightly higher quality score but a higher variability in the quality score, possibly related to the higher financial instability and dependency on RBF incentives.



Stock out rate of key tracer medicines, a key quality indicator, has moderately decreased in both regions, but is much higher in West Nile than Rwenzori (possibly due to the increase demand linked to the massive refugee influx).

The e-patient file system, as a key intervention to improve clinical management and so quality of services, initiated during the previous interventions, was installed in 9 pilot health facilities in Rwenzori and West Nile regions, including 5 public GH and 4 public HC IV. Training of health professionals was conducted, and utilisation had started in all the 9 targeted facilities. Many challenges have anyway been noted (late start, short time of implementation, lack of basic computer skills, power and connectivity challenges, presence of multiple fragmented e-patient file systems in the same facility) which pose a big threat to sustainability.

4.4 Performance of output 3

Output 3: The capacity of Health Districts to manage the quality of care and the integrated local health system is strengthened.

4.4.1 Achieved indicators

Indicators	Base value	Final target	Final value attained
	2016		2019
3.1. Percentage of RBF supported HC III, HC IV, and GH in the targeted districts which implement a Continuous Professional Development plan	68,0% (R) 42,3% (W)	75%	97% (R) 93% (W)
3.2 Percentage of HC III, HC IV, and GH in the targeted districts which have received supportive supervision visits of the DHMT in a quarter	82,5% (R) 58,5% (W)	100%	100% (R) 96,0% (W)
3.3 Percentage of PNFP health facilities (HC III, HC IV and GH) supervised by the Medical Bureaus	73,0% (R) 50,0% (W)	75%	94% (R) 100% (W)
3.4 The District Strategic Plans are compliant with the National Health Planning Guidelines in RBF districts	0% (R) 0% (W)	100%	100% (R) 100% (W)
3.5 Percentage of reduction of debt of RBF supported PNFP HC III, HC IV, and GH in the targeted districts	100% (R) 92% (W)	Reduction by 25%	100% (R) 100% (W)
3.6. Regional Joint Review Missions of the MoH organised in Rwenzori and West Nile regions	0% (R) 0% (W)	100%	67% (R) 100% (W)

4.4.2 Analysis of the realisation of the output

Activities related to this output focused on support to planning and supervision activities at district level, clinical mentorship and training by regional hospital specialists, contribution to the running costs of the emergency evacuation system as a key quality component for maternal and childcare, and strengthening of the regional performance review fora.

Capacity of districts to manage effectively and efficiently the local health system has improved as shown by the improvement of all these “process” indicators for both the public and PNFP sectors: consistent supervision by both the DHMT and the medical bureaus was ensured for all health units; capacity building through in service training was implemented; and all the supported districts

developed strategic plans in line with the planning guidelines, as a key tool to guide planning and implementation of service delivery.

RBF support has also a significant effect on the financial viability of PNFP facilities, as shown by indicator 3.5.

Finally, the organization of regional joint review missions (JRMs) is a success story of the intervention, which reflects institutionalisation of regional JRM particularly in the West Nile region. Mentioned meetings were organised by the RRH, and were attended by the District and facility representatives of all health facilities in the region, both RBF supported and non RBF supported, and HDPs, active in the region. Initially, Enabel supported 100% of the JRM costs. Since 2018, other implementing partners have progressively been involved and stepped up their contribution, allowing Enabel to decrease its support to 40-50% of the initial amount and creating a sustainability roadmap.

4.5 Performance of output 4

Output 4: The capacity of MoH to steer the implementation of the health financing strategy is strengthened.

4.5.1 Achieved indicators

Indicators	Base value	Final target	Final value attained
	2016		2019
4.1 Percentage of RBF invoices paid with a delay of over 3 months	N/A	NA	4%
4.2 RBF exit strategy of SPHU intervention elaborated and submitted to the MoH	No	NA	Yes

4.5.2 Analysis of the realisation of the output

The National RBF Framework was approved in 2016 and a RBF unit in MOH was established in 2018, thanks also to the efforts and contributions of the previous Enabel interventions.

SPHU continued to provide support to the MOH by developing and implementing a RBF digitalized system, which allowed quick processing of RBF data and reduced delays in submission of invoices and payments of incentives, and provided timely and accurate data for informed decision making. Indeed, the delays of payment of RBF invoices, reported in the beginning of the SPHU intervention, have been practically eliminated. The experience demonstrated the benefits of the digitalization and the MOH is indeed planning to adopt the approach for the national RBF system.

Beside the digitalized RBF management tool, the intervention also introduced other innovative approaches like the inter-district verification (to reduce bias and conflict of interest of eDHMT verifying their own district/facilities) which, in as much has not been adopted by MOH, provides a possible alternative approach to the district based verification.

SPHU also engaged Makerere school of public health in a capitalization exercise to consolidate the Enabel-MOH experience accrued by the different interventions in West Nile and Rwenzori, in order to contribute to the refinement of a national RBF model. The capitalisation study results have been presented in the high-level Capitalisation Symposium "Result Based Financing in Uganda: Impact, Lessons Learnt and Implications for Policy and Practice" on November 27, 2019

Ensuring sustainability is a fundamental in the implementation of a viable health financing strategy and SPHU engaged with MOH and local counterparts (districts and facilities) in the formulation of exit strategies to ensure the achieved gains would be sustained.

5 Synergies and complementarities

The intervention "Strategic Purchasing of Health Services in Uganda" (SPHU) was a two-year follow-up intervention of two previous interventions "Institutional Capacity Building in Health Planning Leadership and Management" (ICB-HPLM2) and "Institutional support for the private not-for-profit health sub-sector to promote universal health coverage in Uganda" (shortly known as PNFP) implemented in 17 districts of West Nile and Rwenzori regions between 2014 and 2018.

The end-term review (ETR) of both interventions (ICB-HPLM2 and PNFP) was done jointly from November 2018 to January 2019 when these interventions were coming to an end, and SPHU had recently started. These two interventions were designed to pilot RBF as an element of health systems strengthening (HSS) in both the public and the PNFP sub-sectors. They were implemented in the context of new strategic health financing initiatives in Uganda which needed additional support for piloting and roll-out. In summary, the programmatic approach was building on the achievements and dynamics of the ICB HPLM 1 & 2 and the PNFP interventions.

SPHU established also synergies with 2 multi-sectoral interventions of Enabel portfolio:

- the SDHR intervention (Support to Development of Human Resources), which addresses the main problems related to human resources skills gaps in strategically selected beneficiary organisations, particularly in the priority sectors of the Belgian Development Cooperation (Health, Education and Environment). The health sector benefitted through scholarships for master and undergraduate programmes, long-term courses (e.g. leadership training for DHO, proposal writing training for hospital managers) and short term trainings, spanning from computer skills, to various aspects of management, M&E, leadership and supervision, and clinical trainings. Detailed lists are presented in Annex 5 and 6.
- Study and Consultancy Fund, a non-earmarked budget facility for financing studies and consultancies in order to support ongoing sectoral or thematic interventions and their institutional partners in preparing strategy notes, innovative research, etc. and eventually to prepare for future interventions. The following studies/consultancies were supported:
    - Regulatory Impact Assessment of the Second National Health Policy
    - Uganda Health Sector Basket Fund Design Framework.
    - Development of diagnosis related group & ambulatory patient groups based payment mechanism.
    - Client satisfaction survey assessment tool for the health sector (2019)
    - The Patient Safety Study
    - Feasibility Analysis Community Based Health Insurance Scheme Structures and their integration in the National Health Insurance Scheme
    - Support to Covid-19 National Risk Communication Plan

5.1 With third-party assignments

Enabel is executing the USAID EHA intervention, which is a third-party assignment with a budget of USD 11 million, funded by the USAID. The objective of this intervention is "To reinforce the health systems in the Acholi sub region in order to provide better health, financial protection and greater equity to the most vulnerable populations".

The USAID EHA intervention is implemented in Gulu, Nwoya, Amuru, and Omoro districts. The intervention has five output areas: (i) Increase the equitable access to quality health care services

at public and PNFP Health Facilities in the Acholi sub-region, using RBF as an entry-point; (ii) Strengthen the regional emergency referral system; (iii) Improving the capacity of Health Districts to manage the quality of care, the RBF procedures and verification functions; (iv) Address the infrastructural gaps of health facilities in order to create a viable platform for quality service delivery; and (v) Improve the process of learning, innovations and co-creation of a sustainable RBF approach to contribute to the conception of a robust national RBF system.

The USAID funded intervention was launched in October 2019 and is built around strategies and approaches very similar to SPHU, and its implementation is being shaped by the lessons learned, and summarized in the capitalization report and the End of Term Evaluation. Thanks to the overlapping period, there have been ample opportunities for exchange and learning between the teams of the 2 interventions, and SPHU staff provided precious support and technical advice to the EHA team. Part of the staff of the EHA team transitioned from SPHU.

Enabel has executed the intervention "Proposal to Reinforce the Sexual and Reproductive Health / Family Planning with a Health System Strengthening Approach in the West Nile Region". This third-party assignment had a budget of EUR 55,608 and was funded by the Ministry of Foreign Trade and Development Cooperation of the Kingdom of the Netherlands. The final study report "Assessment of the Potential of RBF Programme to Increase Access to and Uptake of Quality Family Planning and Modern Contraceptive Needs" has been presented in May 2019.

5.2 Other synergies and complementarities

Synergies and complementarities have also been developed with a number of other development partners, *in primis* the World Bank, which has been funding the roll out of RBF all over the country, including taking over the SPHU supported district. The RBF model implemented is different but stems from the experience and lessons learned of SPHU. In the last few months of SPHU implementation, one NTA (in West Nile) specifically worked with the MOH RBF unit to facilitate transition and implementation of URMCHIP in West Nile and maximize the knowledge transfer from the SPHU experience to MOH RBF unit.

At regional level, strong collaboration has been established with the regional partners as IDI, UNICEF, AVSI etc, supporting districts in service deliveries. The organization of co-funded Joint review Meetings in West Nile is one of the most notable outputs of this collaboration.

Strong partnership has been established with Makerere University school of Public Health, which led the capitalisation of experience of PNFP, ICB II, and SPHU interventions. The positive impact of interventions in the strategic areas of health service utilisation, health system management, financial management, human resources, medicines and health supplies, data quality and use has been documented and widely disseminated through a capitalisation study report and evidence briefs.

The capitalisation study results have been presented in the high-level Capitalisation Symposium "Result Based Financing in Uganda: Impact, Lessons Learnt and Implications for Policy and Practice" on November 27, 2019. The symposium has been attended by the representatives of the MoH, MoFPED, DLG, MB and HF, Embassy of the Kingdom of Belgium to the Republic of Uganda, USAID, and HDPs.

6 Priority themes

6.1 The environment and climate change

Environment is a priority theme for the Belgian cooperation. The SPHU intervention does not include activities expected to have a significant negative environmental impact and so the issue of environment and climate change did not feature specifically, but it was mainly addressed by encouraging various actions at facility level such as ensuring the availability of clean water, the installation of solar panels or improving the collection, segregation and adequate treatment of biomedical wastes. These actions were reinforced and evaluated during the performance assessments/verifications by SPHU.

6.2 Gender

In the SPHU, gender is addressed via the activities related to reproductive and maternal health (ref. Results 1 & 2) rather than through explicitly targeted activities. Indeed, ante-natal care, assisted institutional deliveries (inclusive access to caesarean sections and blood transfusion), and post-natal care increased; family planning was less impacted due to restrictions in Catholic PNFP health facilities; access to medicines and laboratory exams at curative care services and hospitalisations also increased. HIV/AIDS prevention and care, inclusive PMTCT, exist in all health facilities, independent of SPHU as they are taken care by the MoH and other HDPs already for a long time. Nonetheless, SPHU monitors indicators related to these activities. At curative care and OPD clinics, gender is routinely registered but, unfortunately, it is not taken into account within the RBF information system, preventing the analysis of gender-disaggregated data as it was instead foreseen in the M&E framework.

We must recognise, however, that gender was not proactively mainstreamed in the intervention following the recommendations from the ETR of the two previous Enabel interventions and guidelines from the Belgian Cooperation, and the intervention did not identify areas where gender could be addressed, and no specific actions were taken to address the FP needs of women attending Catholic PNFP facilities. Indeed a study conducted in 2019 in West Nile by the International Centre for Reproductive Health[6], focused on family planning services, identified multiple bottlenecks and shortcomings in family planning service provision, both at demand and supply side.

6.3 Decent work

The RBF intervention aims, among many other objectives, at improving human resource management at facility level and at increasing job satisfaction through multiple pathways: the bonus received through RBF, availability of equipment and medicines to effectively perform their function, upgrading and maintenance of infrastructures, capacity building through training, mentorships and supervision.

The quality assessment tool at facility and district level includes assessment of human resource management practices, working environment, and occupational safety programme, highlighting gaps for action. RBF also fosters teamwork and collaboration among staff, creating positive dynamics at all levels.

6.4 Digitisation

SPHU continued the several digitalisation efforts the PNFP and ICB II had already initiated:

- the development and deployment of a digitalized RBF system which supported in improving timeliness and quality of invoicing and reporting. While the system is not

[6].Enabel Family Planning study West Nile, Uganda. 11 April 2019. International Center for reproductive Health (ICRH) – Ghent university

anymore in use because the URMCHIP model is different, the benefits were so evident that URMCHIP is in the process of developing one using a similar approach;

- the development of a comprehensive Electronic Medical Record (EMR) system, and its deployment in 9 pilot sites (HCIV and GH), which implied provision of IT equipment, connectivity, and training and supervision. The expected benefits are improved administrative, financial, medicine and data management but also clinical management.

As noted by the users and intervention team, utilisation of e-patient file systems has been negatively affected by a number of challenges: frequent disruptions of electric power supply and internet connectivity, low computer literacy of health professionals and their reluctance to use informational technologies, lack of technical capacities to perform the basic tuning and service of equipment at the level of health facilities, and lack of funds for purchasing of consumable materials.

At the end of 2019, the e-patient file system had been deployed in 6 health facilities in Rwenzori (3 HC IV and 3 GH) and 3 health facilities in West Nile (I HC IV and 2 GH) regions but sustainability is questionable also because of the existence of multiple un-coordinated digitalization initiatives at facility level and limited ownership at national level.

7 Sustainability

SPHU has achieved strong ownership by local stakeholders, mainly driven by the participatory and joint implementation approach adopted by SPHU, its administrative structure embedded into the national services, co-management with the MoH and regular meetings of the SC, which allowed shared decision-making and steering of the intervention's activities. SPHU contributed to reinforcing the institutional and management capacity of local stakeholders. The emphasis put on capacity building with multiple adequate methodologies (trainings, mentorship, supervision, peer learning, etc.) were often cited as key elements.

There is a strong support at policy and institutional level for scaling-up the implementation of RBF in Uganda. The Health Financing Strategy (HFS) 2015/16-2024/25 recommends "to move away from relying on mainly input-based purchasing towards more Results Based Financing." RBF is considered as a purchasing method that can promote more efficient use of resources and promote strategic purchasing of cost-effective services. Several RBF schemes have been implemented in Uganda over the last two decades. Lessons from these interventions have guided the development of a National RBF Framework for the Health Sector which has contributed to institutionalizing RBF and strengthening strategic purchasing. In line with the HFS and the National RBF Framework, the policy is for RBF to be scaled-up to cover the entire country in a phased manner, as a first step towards the establishment of a third-party payment mechanism.

Financial and/ economic sustainability of the intervention is the main concern given the current health financing context in Uganda.

In the short term, the following interventions were put in place:

- an exit strategy was developed jointly by the SPHU team and key stakeholders to ensure sustainability of SPHU. The process of development of the exit strategy started in June 2019, with the organization of two exit strategy workshops at regional level, followed by

consultations with the MoH and MBs to identify key priorities and activities to be implemented during the phase out. A key element of the exit strategy has been the development of Sustainability Plans at health facilities to improve financial sustainability. Health facilities managers (with the support of DHMTs) were tasked to identify strategies to mobilize additional resources and/or improve efficiencies in order to avoid a funding cliff following the termination of the RBF grant agreements on 31st December 2019. The strategies elaborated by the health facilities include amongst other: improving efficiencies/economies; development of community-based (voluntary) health insurance (CHI); establishment of private wards at GH and HC IV; and other medical or non-medical income generating activities (restaurant, guesthouse, farming, etc.). It is however unlikely that these strategies will be sufficient to compensate for the loss of income following the end of the grant agreements, given the important share of RBF subsidies represented in the overall budget of supported facilities, in particular for PNFP units.

- Another key element of the SPHU exit strategy is the transfer of RBF supported health facilities in Rwenzori and West Nile regions to URMCHIP. While the phase over from SPHU to URMCHIP will undeniably contribute to the sustainability of SPHU achievements in the short term, some concerns remain in terms of sustainability in particular with regards to the provision of non RMNCAH interventions that are not included in the URMCHIP funded RBF scheme.

In the medium-term, the sustainability of the intervention will depend on the increase of the public budget allocation to the health sector, in absolute and relative terms, through the non-wage PHC grant system, and on the support of the WB trough the Uganda Intergovernmental Fiscal Transfers Programme (UgIFT). UgIFT has been designed to improve the adequacy and equity of fiscal transfers and improve fiscal management of resources by LG for the health and education services. IDA funds will be used to support recurrent (non-wage) and development grants to both sectors. As a result of this additional funding, it is projected that in 2021/22, annual conditional grants for health will be 65% higher in nominal terms compared to their 2016/17 levels. The DPFP at the MoH is considering using a share of the additional funding for RBF grants.

In the long term, the sustainability of RBF will depend on the increase of the public budget allocation to the health sector in absolute and relative terms, and on shifting the priorities from input-based to output-based financing. The implementation of the NHIS, in line with the HFS, has the potential to contribute to the sustainability of RBF by strengthening resource generation, financing and stewardship of the health care system.

8 Lessons learned

8.1 Successes

SPHU, together with the predecessor interventions PNFP and ICB-II, contributed successfully to policy changes by supporting the MoH to develop and roll out a national RBF approach, as a system-strengthening tool aimed at increasing quality efficiency and equity, but also as a first step to output-based financing. A functional National RBF Unit has been established at the MoH, in order to support a nationwide RBF implementation within the framework of the MoH URMCHIP intervention. The RBF approach is now going to be mainstreamed through the UgIFT programme, which plans to include an output-based approach within the inter-governmental fiscal transfers.

The implementation of the RBF intervention, associated with targeted direct support in terms of provision of equipment and capacity building, achieved significant improvements in the following areas:

- Health system management: training, capacity building and mentorship programmes initiated by Enabel improved the capacity and skills for the districts and facilities to effectively manage and supervise teams and programmes for improved health service delivery. The RBF programme re-invigorated governance structures at health facilities that had been functioning sub optimally. Hospital Boards and Health Unit Management Committees (HUMCs) were given resources to enable routine meetings and strengthen their supervisory and accountability roles at the respective facilities. Finally, RBF enabled broader involvement of all health workers in strategic planning and decision making at the facilities and districts. This increased stakeholder involvement, ownership, accountability, and skill development.
- Financial Management: the RBF programme enhanced the capacity of facility staff to develop annual business plans and budgets with allocations that prioritized key performance and quality improvement areas. Additional resources were generated by facilities through the enhanced strategic planning coupled with reductions in user-fees that made services affordable. RBF also helped to facilitate capacity and systems for sound and robust financial management, and transparency in resource use. For example, facilities displayed financial disbursements, financial allocations and expenditures, etc. on noticeboards. These displays cultivated a high level of trust from clients, staff, community, and other stakeholders.
- Service utilization, quality of care and patient centeredness: RBF programme enhanced service utilization. There was an increase in the number of clients accessing RBF supported facilities under the programme, and this was majorly linked to the reduction in user fees in the PNFP facilities, hence costs became more affordable for most of the community members, and the improved quality of care: more attention was given to the need of patients; better attitude towards users (providers more receptive, friendly reception, attentive listening, etc.); standard operating procedures (SOP) were updated and followed; in-service training; availability of laboratory exams and medicines; referrals done with ambulance; and improved maintenance, hygiene and treatment of waste in the facilities.
- Data quality and use: RBF built capacity and incentives for data capturing, management, and use. This increased the timeliness, completeness, and quality of data, as data was at the key in reimbursement: health facilities would not be reimbursed unless they presented verifiable data upon which a payment would be made. An infrastructure was established for robust data, including procuring computers, conducting regular performance assessment meetings, and periodic performance review meetings to ensure that the facility was on track in its performance.

- Medicines and Supplies Management: The RBF programme enhanced the availability of medicines and health supplies and reduced unnecessary stock-outs. Facilities were provided an opportunity to mitigate any stock-outs through an autonomous procurement of medicines and supplies. The availability of medicines thus increased quality and effectiveness of care and patient satisfaction.
- Human Resources for Health: RBF programmes improved staff planning, staffing levels and significant reductions in absenteeism. Resources available through RBF led to an improved ability to attract staff, incentivize and retain them. A number of facilities reported having hired additional staff to mitigate the increased service demands. Additionally, programmes for capacity building of staff were initiated, and this improved the ability of health workers to improve their performance and provide responsive services.

The intervention fostered the partnership between the public and PNFP sectors: while ICBII and PNFP addressed one subsector each, SPHU integrated the two, increasing exchange and collaboration. Both sides were integrated within the RBF mechanism, increasing exchange and collaboration through shared mechanisms as verification, audits, supervision and performance review.

8.2 Failures

The intervention had a limited geographical coverage in terms of number of facilities supported (around 30% of existing facilities in the two regions) and number of districts per region (half of them), limiting the potential impact at local level and creating inefficiencies due to geographical spread.

The issue of full sustainability remains an unmet challenge, in particular for the PNFP sector: the delays in transition to URMCHIP and the more limited scope in the URMCHIP model means that PNFP will most likely see a reduction in RBF incentives which will negatively reflect on their financial viability and may cause an increase in user fees, negatively affecting provision of and access to care.

Sustainability of the e-patient file system is another significant challenge the intervention encountered. The system was developed in 9 health facilities, and among the other e-patient file systems being developed in Uganda, SPHU's is the only one, at present, which is integrated, helping the comprehensiveness of caring for the patient. Advantages are however overwhelmed by many challenges difficult to overcome. The implementation of e-patient files started very late within the already short time span of the intervention and it is an expensive and challenging activity given many essential logistic problems (disruptions of electric power supply and Internet connectivity), lack of technical capacities to perform the basic tuning and maintenance of equipment at the level of health facilities, low computer literacy of health professionals. On the top of this, at present, there are around six implementers of e-patient files in Uganda, resulting in various systems functioning at the same time with no alignment and interoperability between them. On the contrary, competition between systems is not facilitating implementation.

The intervention also failed to take into consideration the recommendations from the End Term Review of the previous interventions to mainstream gender in the intervention planning and implementation did not identify areas where gender could be addressed, e.g. no specific actions were taken to address the FP needs of women attending Catholic PNFP facilities. Indeed, the increase in family planning is not as significant as in other services, probably linked to the fact that a sizeable number of the supported facilities did not offer modern family planning methods. A study by Ghent university conducted in West Nile in 2019, highlighted a lack of substantial impact

of RBF on family planning services and the need of a more comprehensive approach addressing bottlenecks at both demand and supply side.

8.3 Strategic learning questions

As indicated in the Annual Result Report 2019, the following strategic learning questions have been addressed by the intervention:

1. To which extents has the intervention achieved its impact, i.e. "Contribute to Universal Health Coverage in Uganda following a Rights Based Approach", and to which extent has the intervention achieved its outcome, i.e. "Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and PNFP Health Services, with a particular focus on women, children and other vulnerable groups". Answers to this question have provided in the report "Capitalisation of Enabel ICB II and PNFP Health Interventions in Uganda" (Annex 3) and by the End of Term Review of SPHU intervention (annex 7), and are the subject of this Final Narrative Report.

2. What are the recommendations for the implementation of the USAID-funded intervention "Roll out the national 'Results-based financing policy' in the Acholi Sub-Region, Uganda (UGA180371T-USAID-HEALTH)"? This was one of the evaluation questions addressed in the End Term Review (annex 7). A summary of some key recommendations is presented below:
    - Build on lessons learned from the capitalization of ICB/HPLM2, PNFP, and SPHU interventions and integrate elements that contributed to their success such as: the use of action research approach, RBF verification by peers from other districts, quality embedded quantitative questionnaires for assessing health care providers, focus on mentoring/coaching, maintain and reinforce digitalised management of RBF, among others.
    - Mainstream gender and review the intervention's data collection tools to ensure availability of gender disaggregated data.

3. What are the recommendations for potential future Enabel interventions in the health sector in Uganda? Which priorities should be included in the Enabel Country Programme for the Republic of Uganda? Answers to this question have been provided in the contributions of the SPHU intervention team to the strategic documents of the Enabel Representative Office in Uganda and by the End Term Review of the SPHU intervention (annex 7). Some key recommendations are presented below:
    - Keep the learning by doing, sustained mentorship, and the general action research approach, and make it more explicit.
    - Transversal themes such as Gender, Environment and Human Rights need to be considered in design, budget, implementation and monitoring of the intervention.
    - Attention to geographical and population coverage in the design of the intervention (for instance, better to cover a whole region instead of some facilities in two regions).
    - Access to health services and actions for vulnerable groups needs to be better monitored.
    - Include indicators and/or frameworks for assessing equity.
    - Give more attention to community participation and empowerment (e.g. feedback mechanisms and involvement, user platforms as in Benin, etc.).
    - Give more attention to health promotion and preventive activities.

Inventory of documented experiences	Documentation products (available material per experience)
Study report	Enabel Family planning study West Nile, Uganda. 11th April 2019. Emilie Peeters. International Centre for Reproductive Health (ICRH) – Ghent University
Capitalisation	Capitalisation of Enabel ICB II & PNFP Health Projects in Uganda – April 2019 AUTHORS: Enabel RBF Implementation Team SUPPORTED BY Team from Makerere University School of Public Health
Symposium	Knowledge Sharing Symposium on Results Based Financing - Proceedings Report - 27th November 2019

8.4 Summary of lessons learned

Lessons learned	Target group
RBF is an effective system-strengthening intervention and can achieve significant results in terms of service utilization and quality of care through increase in availability of resources and improvement in managerial practices including HR management, financial management and data management.	MoH, Enabel, HDPs
The action research and adaptation/innovation approach, with the "learning by doing" and the continuous reflection and dialogue with involved stakeholders, contributed to the translation of implementation experiences into policy changes and innovations.	Enabel
Investment in capacity building and system strengthening, using a participatory approach and with focus on local ownership and involvement, has the potential to achieve significant and durable change in practices which will enhance sustainability of the achieved results.	Enabel
Transversal themes like gender, equity and community empowerment and involvement needs to be given more explicit attention from the design and planning phase. More attention should be given to SRH services in particular family planning, in particular a comprehensive approach addressing barriers at both demand (community) and supply (provider) level.	Enabel
Digitization of health system should be addressed through a multi-sectoral approach. The MoH, in cooperation with the MoICT, NITA-U, MoE, MoLG, DHO and MB, should support the health facilities in the creation of basic conditions for IT equipment operation. Safe rooms, uninterrupted electric power supply, internet connectivity, and training of users in basic IT literacy should be provided before implementation of ambitious IT projects, such as e-patient files.	Enabel, MoH

9 Recommendations

Recommendations	Actor
In consideration of the challenge of financial sustainability of the health sector in the medium long term: - Continue lobbying for increase in the public budget allocation to the health sector, in terms of percentage of GDP and in absolute terms. The minimum Total Health Expenditure of USD 84 per capita per year, recommended by the WHO, should be targeted. - The right mix of taxation, payment of individual health insurance premiums, and user fees should be found to generate resources for proper functioning of the health system and increase accessibility of health services for all population groups. - The feasibility of implementation of health insurance should be studied and the most appropriate health financing strategies for Uganda should be identified.	GOU, HDPs
Continue to invest in long term system strengthening interventions, focusing on capacity building and improvement of management practices, including financial, HR and data management, to achieve sustainable gains in service delivery. Maintain the approach of strong partnership, participation and local ownership.	Enabel
Continue, through action research approach, adaptation, innovation and dialogue, to work towards the development of a national robust RBF system and its mainstreaming into the routine financial system, taking into account the accumulated experience and evidence from multiple stakeholders. Consider providing technical support to MOH RBF program since RBF is now a national programme.	MoH Enabel
Explicitly include gender, equity and community empowerment and participation in intervention design and implementation, and consider the inclusion of more direct support to SRH(R) services including demand creation through community based interventions.	Enabel
Invest in digitalization only within well-defined national strategies and plans to ensure sustainability.	Enabel

10 Annexes

10.1 Quality criteria

For each of the criteria (Relevance, Efficiency, Effectiveness and Potential Sustainability) a number of sub-criteria and statements about these sub-criteria have been formulated.

By choosing the statement that fits your intervention best (add an 'X' to select a statement) you can calculate the total score applicable to that specific criterion (see below for calculation instructions).

1. RELEVANCE: extent to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries.				
Calculate the total score for this quality criterion as follows: at least one 'A', no 'C' or 'D' = A; two 'B's = B; at least one 'C', no 'D' = C; at least one 'D' = D				
Assessment of RELEVANCE: total score	**A**	**B**	**C**	**D**
	X			
1.1 What is the current degree of relevance of the intervention?				
X	**A**	Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group.		
…	**B**	Still fits well in national policies and Belgian strategy (without always being explicit), reasonably compatible with aid effectiveness commitments, relevant to target group's needs.		
…	**C**	Some issues regarding consistency with national policies and Belgian strategy, aid effectiveness or relevance.		
…	**D**	Contradictions with national policies and Belgian strategy, aid efficiency commitments; relevance to needs is questionable. Major adaptations needed.		
1.2 As presently designed, is the intervention logic still holding true?				
X	**A**	Clear and well-structured intervention logic; feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable).		
	B	Adequate intervention logic although it might need some improvements regarding hierarchy of objectives, indicators, Risk and Assumptions.		
	C	Problems with intervention logic may affect performance of intervention and capacity to monitor and evaluate progress; improvements necessary.		

	D	**I**ntervention logic is faulty and requires major revision for the intervention to have a chance of success.

2. EFFICIENCY OF IMPLEMENTATION TO DATE: extent to which the resources of the intervention (funds, expertise, time, etc.) have been economically converted in results.				
Calculate the total score for this quality criterion as follows: at least two 'A's, no 'C' or 'D' = A; two 'B's = B, no 'C' or 'D' = B; at least one 'C', no 'D' = C; at least one 'D' = D				
Assessment of EFFICIENCY: total score	**A**	**B**	**C**	**D**
		X		

2.1 How well are inputs (financial, HR, goods & equipment) managed?		
	A	All inputs are available on time and within budget.
X	**B**	Most inputs are available in reasonable time and do not require substantial budget adjustments. However there is room for improvement.
	C	Availability and usage of inputs face problems, which need to be addressed; otherwise results may be at risk.
	D	Availability and management of inputs have serious deficiencies, which threaten the achievement of results. Substantial change is needed.
2.2 How well is the implementation of activities managed?		
	A	Activities implemented on schedule.
X	**B**	Most activities are on schedule. Delays exist, but do not harm the delivery of outputs.
	C	Activities are delayed. Corrections are necessary to deliver without too much delay.
	D	Serious delay. Outputs will not be delivered unless major changes in planning.
2.3 How well are outputs achieved?		
	A	All outputs have been and most likely will be delivered as scheduled with good quality contributing to outcomes as planned.

X	**B**	Output delivery is and will most likely be according to plan, but there is room for improvement in terms of quality, coverage and timing.
	C	Some outputs are/will be not delivered on time or with good quality. Adjustments are necessary.
	D	Quality and delivery of outputs has and most likely will have serious deficiencies. Major adjustments are needed to ensure that at least the key outputs are delivered on time.

3. EFFECTIVENESS TO DATE: extent to which the outcome (specific objective) is achieved as planned at the end of year N				
Calculate the total score for this quality criterion as follows: at least one 'A', no 'C' or 'D' = A; two 'B's = B; at least one 'C', no 'D' = C; at least one 'D' = D				
Assessment of EFFECTIVENESS: total score	**A**	**B**	**C**	**D**
		X		

3.1 As presently implemented what is the likelihood of the outcome to be achieved?		
	A	Full achievement of the outcome is likely in terms of quality and coverage. Negative effects (if any) have been mitigated.
X	**B**	Outcome will be achieved with minor limitations; negative effects (if any) have not caused much harm.
	C	Outcome will be achieved only partially among others because of negative effects to which management was not able to fully adapt. Corrective measures have to be taken to improve ability to achieve outcome.
	D	The intervention will not achieve its outcome unless major, fundamental measures are taken.

3.2 Are activities and outputs adapted (when needed), in order to achieve the outcome?		
	A	The intervention is successful in adapting its strategies / activities and outputs to changing external conditions in order to achieve the outcome. Risks and assumptions are managed in a proactive manner.
X	**B**	The intervention is relatively successful in adapting its strategies to changing external conditions in order to achieve its outcome. Risks management is rather passive.

	C	The intervention has not entirely succeeded in adapting its strategies to changing external conditions in a timely or adequate manner. Risk management has been rather static. An important change in strategies is necessary in order to ensure the intervention can achieve its outcome.
	D	The intervention has failed to respond to changing external conditions, risks were insufficiently managed. Major changes are needed to attain the outcome.

4. POTENTIAL SUSTAINABILITY: The degree of likelihood to maintain and reproduce the benefits of an intervention in the long run (beyond the implementation period of the intervention).

Calculate the total score for this quality criterion as follows: at least three 'A's, no 'C' or 'D' = A; maximum 2 'C's, no 'D' = B; at least three 'C's, no 'D' = C; at least one 'D' = D

Assessment of POTENTIAL SUSTAINABILITY: total score	**A**	**B**	**C**	**D**
		X		

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.
X	**B**	Financial/economic sustainability is likely to be good, but problems might arise namely from changing external economic factors.
	C	Problems need to be addressed regarding financial sustainability either in terms of institutional or target groups costs or changing economic context.
	D	Financial/economic sustainability is very questionable unless major changes are made.

4.2 What is the extent of ownership of the intervention by the target groups and will it last after the external assistance ends?

	A	The Steering Committee and other relevant local entities are strongly involved in all stages of implementation and are committed to continue producing and using results.
X	**B**	Implementation is based in a good part on the Steering Committee and other relevant local entities, which are also somewhat involved in decision-making. Likeliness of sustainability is good, but there is room for improvement.

	C	The intervention uses mainly ad-hoc arrangements and the Steering Committee and other relevant local entities to ensure sustainability. Continued results are not guaranteed. Corrective measures are needed.
	D	The intervention depends completely on ad-hoc entities with no prospect of sustainability. Fundamental changes are needed to enable sustainability.
4.3 What is the level of policy support provided and the degree of interaction between intervention and the policy level?		
X	**A**	Policy and institutions have been highly supportive of intervention and will continue to be so.
	B	Policy and policy enforcing institutions have been generally supportive, or at least have not hindered the intervention, and are likely to continue to be so.
	C	Intervention sustainability is limited due to lack of policy support. Corrective measures are needed.
	D	Policies have been and likely will be in contradiction with the intervention. Fundamental changes needed to make intervention sustainable.
4.4 How well is the intervention contributing to institutional and management capacity?		
	A	Intervention is embedded in institutional entities and has contributed to improve the institutional and management capacity (even if this is not an explicit goal).
X	**B**	Intervention management is well embedded in institutional entities and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible.
	C	Intervention relies too much on ad-hoc entities instead of institutions; capacity building has not been sufficient to fully ensure sustainability. Corrective measures are needed.
	D	Intervention is relying on ad hoc entities and capacity transfer to existing institutions, which could guarantee sustainability, is unlikely unless fundamental changes are undertaken.

10.2 Updated Logical framework and/or Theory of Change

The letter of non-objection to review and update of TFF chapter 3.4. and 3.5., signed by the Ministry of Health, as well as the revised chapters, are presented below. The detailed explanations of the changes are in the additional Annex 1a and 1b.

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IN ANY CORRESPONDENCE ON
THIS SUBJECT PLEASE QUOTE NO. ADM.100/244/23

THE REPUBLIC OF UGANDA

Ministry of Health
P. O. Box 7272
Kampala
Uganda

28th February, 2019

International Intervention Co-Manager
Enable/SPHU Project
Ministry of Health

UGA 1603611: REVIEW AND UPDATE OF THE SPHU TECHNICAL AND FINANCIAL FILE (TFF): CHAPTER 3.4 "RESULTS AND PROPOSED ACTIVITIES" AND CHAPTER 3.5 "INDICATORS AND MEANS OF VERIFICATION"

Reference is made to the recent submission of the project TFF for approval to the Steering Committee Meeting that took place on 11th February 2019.

Please receive the Ministry of Health no-objection to changes to the reviewed and updated TFF modified *Chapter 3.4 "Results and Proposed Activities" and Chapter 3.5 "Indicators and Means of Verification"*

Thanking your usual cooperation.

Dr. Sarah Byakika
FOR: PERMANENT SECRETARY

c.c Resident Representative
c.c Financial and Contracting Coordinator

3.4. Expected results and proposed activities – updated version

Result 1: The equitable access to quality health care at public and PNFP HC IIIs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point	
Activity	**Support the selected HCIII health facilities, according to the district coverage plan, to comply with RBF accreditation criteria**
Sub-activity	Provide investments for new HC IIIs and for priority needs of already enrolled HC III
Sub-activity	Support selected HCIII health facilities in implementation of business plans
Sub-activity	Procure a list of basic material needed (CEMONC), with a particular focus on child and reproductive health care (including contraceptives)
Activity	**Implement the RBF approach at the level of the accredited HC III**
Sub-activity	Sign new grant agreements to continue RBF financing
Sub-activity	Assure RBF verification and monitoring
Sub-activity	Assure continuous training and mentorship of districts regarding RBF implementation
Sub-activity	Assure a joint analysis at district level of the performance of health facilities enrolled in RBF together with the major stakeholders in relation to health (including civil society and local authorities)
Sub-activity	Support the governmental internal audit system at the level of DLG to audit utilisation of RBF funds

Result 2: The equitable access to quality health care at public and PNFP General Hospitals & HC IVs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point	
Activity	**Prepare General Hospitals & HC IVs to receive RBF**
Sub-activity	Support priority hospitals and HC-IV to update their business plan
Sub-activity	Reinforce the basic requirements for equipment
Activity	**Implement the RBF approach at the level of selected public and PNFP General Hospitals & HC IVs**
Sub-activity	Continue RBF activities in selected public and PNFP health facilities
Activity	**Consolidate implementation of a functional e-patient file system in selected public and PNFP hospitals & HC IVs**
Sub-activity	Support implementation of a functional system of e-patient files
Sub-activity	Capitalise on the experience of implementation of e-patient files in selected nine health facilities

Result 3: The capacity of Health Districts to manage the quality of care and the integrated local health system is strengthened	
Activity	**Support reviewing of the annual district plans based on the analysis of the coverage plans, and in line with the district development plan**
Sub-activity	Support the bottom-up planning at district and HSD level (health sub-district)
Activity	**Improve the management and quality of care of the health facilities through RBF verification, supportive supervision and in-service training by the DHMT**
Sub-activity	Organise the verification, supportive supervision, and continuous training activities
Sub-activity	Assure specific monitoring of the PNFP Health facilities by the Medical Bureaus and MoH
Activity	**Assure continuous training of Health Facilities by the (general/ regional) hospital staff**
Sub-activity	Support coaching and mentorship by regional hospital specialists
Activity	**Support the national system of evaluation and ranking of health districts, including community assessments**
Activity	**Support maintenance of vehicles used for SPHU project activities, based on MoU**
Sub-activity	Capitalise on the experience of operation of the evacuation system, created by the ICB I and II projects
Activity	**Support quarterly and annual regional health reviews in the Rwenzori and West-Nile regions**
Sub-activity	Reinforce the functioning of the quarterly Regional Fora and regional planning

Result 4: The capacity of MoH to steer the implementation of the health financing strategy is strengthened	
Activity	**Support the RBF unit in the Planning department of the MoH**
Sub-activity	Assure capacity building of the RBF teams
Activity	**Enhance the capacities of the MoH to utilise the digitalised RBF information system for evidence-based decision making**
Sub-activity	Support the utilisation of the digitalised RBF information system
Activity	**Refine the national RBF model based on the pilot experience in Rwenzori and West-Nile in collaboration with stake-holders concerned**

Sub-activity	Capitalise/consolidate the Enabel-MoH experience in Rwenzori & West Nile

Section 3.5. Indicators and Means of Verification –updated version

Impact: Contribute to Universal Health Coverage (UHC) in Uganda following a Rights Based Approach	
No.	Impact indicators
1.	Maternal Mortality Ratio (336 per 100,000 live birth)
2.	Neonatal Mortality Rate (27 per 1,000)
3.	Infant Mortality Rate (43 per 1000)
4.	Under 5 Mortality rate (64 per 1000)
5.	Total Fertility Rate (5.4 live births per woman)
6.	Adolescent Pregnancy Rate (25%)

Outcome: Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and Private Not For Profit (PNFP) Health Services, with a particular focus on women, children and other vulnerable groups	
No.	Outcome indicators
1.	Tested and updated RBF model, accepted by MoH and GoU as the national model, available
2.	% of the national health budget which is output- based
3.	Utilisation rate for curative consultation at HC III level, total and gender-disaggregated
4.	Hospitalisation rate for GH and HC IV level health facilities, total and gender-disaggregated
5.	Hospitalisation rate for GH and HC IV level, total and gender-disaggregated, in RBF supported health facilities
6.	Percentage of RBF supported GH and HC IV, which implement strategic plans
7.	Strategic plans for GH and HC IV institutionalized as National Policy

Output 1: The equitable access to quality health care at public and PNFP HC IIIs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point	
No.	Output 1 indicators
1.	Percentage of RBF supported HC III in the targeted districts which obtain a score of at least 4 stars to the Quality of Care Assessment of the MoH
2.	Percentage of institutional based deliveries which meet the MoH quality standards in RBF supported HCIII
3.	Percentage of RBF supported HC III providing modern family planning services

4.	HIV/AIDS care and treatment services, including PMTCT, are integrated and functioning according to MoH quality norms in RBF supported HCIII

Output 2: The equitable access to quality health care at public and PNFP General Hospitals & HC IVs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point	
No.	Output 2 indicators
1.	Percentage of RBF supported GH and HC IV in the targeted districts which obtain a score of at least 4 stars to the Quality of Care Assessment of the MoH
2.	Percentage of RBF supported GH and HC IV in the targeted districts that experience essential drugs out-of-stock during > 7 days for 6 tracer medicines
3.	Percentage of RBF supported public GH and HC IV in the targeted districts with a functional e-patient file system

Output 3: The capacity of Health Districts to manage the quality of care and the integrated local health system is strengthened	
No.	Output 3 indicators
1.	Percentage of RBF supported HCIII, HCIV, and GH in the targeted districts which implement a Continuous Professional Development plan
2.	Percentage of RBF supported HCIII, HCIV, and GH in the targeted districts which have received supportive supervision visits of the DHMT at least 3 times per year
3.	Percentage of supportive supervision visits completed by the Medical Bureaus, actual vs. planned
4.	The District Strategic Plans are compliant with the National Health Planning Guidelines in 17 districts
5.	Percentage of reduction of debt of RBF supported PNFP HCIII, HCIV, and GH in the targeted districts
6.	Regional Joint Review Missions of the MoH organised in Rwenzori and West Nile regions

Output 4: The capacity of MoH to steer the implementation of the health financing strategy is strengthened	
No.	Output 4 indicators
1.	Percentage of RBF invoices paid with a delay of over 3 months
2.	RBF exit strategy of SPHU project elaborated and submitted to the MoH

Section 7.1 Logical framework

	Intervention logic	IOV (See. section 3.5)	sources (See. 3.5)
OG	Contribute to Universal Health Coverage (UHC) in Uganda following a Rights Based Approach		
OS	Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and Private Not For Profit (PNFP) Health Services, with a particular focus on women, children and other vulnerable groups		
R1	The equitable access to quality health care at public and PNFP HC IIIs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point		
R2	The equitable access to quality health care at public and PNFP General Hospitals & HC IVs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point		
R3	The capacity of Health Districts to manage the quality of care and the integrated local health system is strengthened		
R4	The capacity of MoH to steer the implementation of the health financing strategy is strengthened		

Result 1: The equitable access to quality health care at public and PNFP HC IIIs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point				**Means**	**Budget**
R1	**A1**		**Support the selected HCIII health facilities, according to the district coverage plan, to comply with RBF accreditation criteria**		
		s1	Provide investments for new HC IIIs and for priority needs of already enrolled HC III		
		s2	Support selected HCIII health facilities in implementation of business plans		
		s3	Procure a list of basic material needed (CEMONC), with a particular focus on child and reproductive health care (including contraceptives)		
R1	**A2**		**Implement the RBF approach at the level of the accredited HC III**		
		s1	Sign new grant agreements to continue RBF financing		
		s2	Assure RBF verification and monitoring		
		s3	Assure continuous training and mentorship of districts regarding RBF implementation		
		s4	Assure a joint analysis at district level of the performance of health facilities enrolled in RBF together with the major stakeholders in relation to health (including civil society and local authorities)		
		s5	Support the governmental internal audit system at the level of DLG to audit utilisation of RBF funds		

Result 2: The equitable access to quality health care at public and PNFP General Hospitals & HC IVs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point				Means	Budget
R2	**A1**		**Prepare General Hospitals & HC IVs to receive RBF**		
		s1	Support priority hospitals and HC-IV to update their business plan		
		s2	Reinforce the basic requirements for equipment		
R2	**A2**		**Implement the RBF approach at the level of selected public and PNFP General Hospitals & HC IVs**		
		s1	Continue RBF activities in selected public and PNFP health facilities		
R2	**A3**		**Consolidate implementation of a functional e-patient file system in selected public and PNFP hospitals & HC IVs**		
		s1	Support implementation of a functional system of e-patient files		
		s2	Capitalise on the experience of implementation of e-patient files in selected nine health facilities		

Result 3: The capacity of Health Districts to manage the quality of care and the integrated local health system is strengthened				Means	Budget
R3	**A1**		**Support reviewing of the annual district plans based on the analysis of the coverage plans, and in line with the district development plan**		
		s1	Support the bottom-up planning at district and HSD level (health sub-district)		
R3	**A2**		**Improve the management and quality of care of the health facilities through RBF verification, supportive supervision and in-service training by the DHMT**		
		s1	Organise the verification, supportive supervision, and continuous training activities		
		s2	Assure specific monitoring of the PNFP Health facilities by the Medical Bureaus and MoH		
R3	**A3**		**Assure continuous training of Health Facilities by the (general/ regional) hospital staff**		
		s1	Support coaching and mentorship by regional hospital specialists		
R3	**A4**		**Support the national system of evaluation and ranking of health districts, including community assessments**		
R3	**A5**		**Support maintenance of vehicles used for SPHU project activities, based on MoU**		
		s1	Capitalise on the experience of operation of the evacuation system, created by the ICB I and II projects		
R3	**A6**		**Support quarterly and annual regional health reviews in the Rwenzori and West-Nile regions**		
		s1	Reinforce the functioning of the quarterly Regional Fora and regional planning		

Result 4: The capacity of MoH to steer the implementation of the health financing strategy is strengthened				Means	Budget
R4	**A1**		**Support the RBF unit in the Planning department of the MoH**		
		s1	Assure capacity building of the RBF teams		
R4	**A2**		**Enhance the capacities of the MoH to utilise the digitalised RBF information system for evidence-based decision making**		
		s1	Support the utilisation of the digitalised RBF information system		
R4	**A3**		**Refine the national RBF model based on the pilot experience in Rwenzori and West-Nile in collaboration with stake-holders concerned**		
		s1	Capitalise/consolidate the Enabel-MoH experience in Rwenzori & West Nile		

10.3 Decisions taken by the Steering and monitoring committee

In 2018, 2 steering committee meetings were organized. A summary of the key issues is presented below.

Decision to take		Period of Identification		Source
GoU co-financing obligation		January 2018		Specific Agreement
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
Communication made to MoFPED on commitment to fulfil Government obligation on co-financing.	MOH	-	Followed up in December 2018 and February 2019	Closed in 2020

Decision to take		Period of Identification		Source
PNFP Grant transition to SPHU		September 2018		PSC minutes
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
The exit strategy undertaken was effected for all districts and HF, apart from Koboko and Ntoroko.	MoH, Enabel Project Team	September 2018	Approved and Realised	Closed

Decision to take		Period of Identification		Source
Organisation assessment		October 2018		PSC minutes
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
The Kasese and Nebbi districts were assessed at the beginning of the exercise since they were subject to signing immediately for funding under the SPHU project from June 2018. The remaining districts followed suit.	MoH, Enabel Project Team	November 2018	Approved and Realised	Closed

Decision to take		Period of Identification		Source
Changes in management of verification visits		December 2018		PSC Minutes
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
Responsibility for verification of HF has been shifted from DHO to Enabel Regional offices.	Enabel Project Team	December 2018	Approved and Realised	Closed

Decision to take	Period of Identification	Source
Maintenance of vehicles	December 2018	PSC Minutes

Action(s)	Responsible	Deadline	Progress	Status
An MoU has been signed between Enabel and the MoH to allow the SPHU project to maintain the vehicles until December 31, 2019.	Enabel Project Team	December 2018	Approved and Realised	Closed

Decision to take		Period of Identification		Source
SPHU organisational diagram		December 2018		PSC Minutes
Action(s)	Responsible	Deadline	Progress	Status
The updated organisational diagram of the SPHU project has been approved.	Enabel	December 2018	Approved and Realised	Closed

In 2019, two SC meetings were organised, on February 11, 2019 and on May 15, 2019. A summary of the SC decisions is presented below. The SC scheduled for December 3, 2019, was cancelled at short notice by the Chairperson - Undersecretary of the MoH. Its proposed decisions have not been approved and are not reflected in the present report.

On January 16, 2020 the Enabel Representative Office in the Republic of Uganda addressed a letter to the MoH, requesting clarifications on approval of the proposed decisions of SC or rescheduling of the SC for Quarter 1, 2020.

Decision to take	Period of Identification	Source
	February 11, 2019	Steering Committee

The PSC has reviewed the changes to the TFF Chapter 3.4 "Results and proposed activities" and Chapter 3.5 "Indicators and means of verification", elaborated by the project team in collaboration with the Enabel Coordinator Health Unit, Mr. Paul Bossyns in January 2019.				
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
Present the proposed changes with detailed explanations to the Intervention Manager, Dr. Sarah Byakika for comments and approval by exchange of letters.	Dumitru Maximenco	February 28, 2019		Completed
Approve the proposed changes.	Sarah Byakika	February 28, 2019		Completed

Decision to take		**Period of Identification**		**Source**
The PSC has been updated on allocation of EUR 1,5 million contribution of the GoU to implementation of the Specific Agreement by the representative of the MOFPED.		February 11, 2019		Steering Committee
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
Follow up on allocation of EUR 1,5 million GoU contribution for implementation of the Specific Agreement UGA 1603611 N.N. 1272.	Sarah Byakika	N/A	The MoH has sent several letters to the MoFPED, reminding and following up on allocation of EUR 1,5 million GoU contribution for implementation of the Specific Agreement UGA 1603611 N.N. 1272.	In progress (closed in 2020)
Follow up on allocation of EUR 1,5 million GoU contribution for implementation of the Specific Agreement UGA 1603611 N.N. 1272.	Dumitru Maximenco	N/A	Enabel has sent several letters to the MoH reminding and following up on allocation of EUR 1,5 GoU contribution for implementation of Specific Agreement UGA 1603611 N.N. 1272. On March 6, 2019 the Embassy of the Kingdom of Belgium has organised a meeting with the MoFPED to follow up on this issue.	In progress (closed in 2020)

Assist the MoH in completing of forms, required by the MoFPED for allocation of EUR 1,5 million GoU contribution for implementation of the Specific Agreement UGA 1603611.	Dumitru Maximenco	October 31, 2019	The project team has provided technical assistance to the Ministry of Health in elaboration of project proposal for utilisation of EUR 1,5 million contribution of the Republic of Uganda to implementation of Specific Agreement UGA 1603611 N.N. 1272. The Ministry of Health has submitted the project proposal to the Ministry of Finance, Planning, and Economic Development on October 18, 2019.	Completed

Decision to take		Period of Identification		Source
The PSC has decided to approve the Result Reports 2018 of the ICB II, PNFP, and SPHU projects by exchange of letters, due to the tight schedules and high workload of the PSC members.		February 11, 2019		Steering Committee
Action(s)	Responsible	Deadline	Progress	Status
Integrate comments of the PSC members in the Results Reports 2018, present the Results Report for the signature of the MoH.	Dumitru Maximenco	February 28, 2019		Completed

Decision to take		Period of Identification		Source
The PSC has reviewed and approved the proposal to utilise the unspent amount of EUR 160,000 from the PNFP project budget for the activities of the SPHU project.		May 15, 2019		Steering Committee
Action(s)	Responsible	Deadline	Progress	Status
Plan utilisation of EUR 160,000 for the activities of the SPHU project, implement the plan.	Dumitru Maximenco	N/A		Completed

Decision to take		Period of Identification		Source
The PSC has reviewed and approved the updated RBF manual, template for the Grant Agreements, reporting guidelines and requirements, and penalties to be used by RBF supported health facilities.		May 15, 2019		Steering Committee
Action(s)	Responsible	Deadline	Progress	Status
Implement the updated RBF manual, template for the Grant Agreements, reporting guidelines and requirements, and penalties to be used by RBF supported health facilities.	Dumitru Maximenco	N/A		Completed

Decision to take		Period of Identification		Source
The PSC has reviewed the proposed budget modification and has approved it.		May 15, 2019		Steering Committee
Action(s)	Responsible	Deadline	Progress	Status
Implement the approved budget modification.	Dumitru Maximenco	N/A		Completed

Decision to take		Period of Identification		Source
The PSC has recommended organisation of Capitalization Symposium for ICB II and PNFP projects, and SPHU implementation experience in the end of November 2019.		May 15, 2019		Steering Committee
Action(s)	Responsible	Deadline	Progress	Status
Organise the Capitalisation Symposium in cooperation with the Makerere University School of Public Health.	Paolo Reggio D'Aci	November 29, 2019	The high-level Capitalization Symposium has been organised on November 27, 2019. The symposium has been attended by the representatives of the Ministry of Health, District Local Governments, Medical Bureaus, Embassy of the Kingdom of Belgium, USAID, and various Health Development Partners. The major results achieved by of PNFP, ICB II and SPHU projects have been presented.	Completed

Decision to take		Period of Identification		Source
The PSC has recommended informing the RBF supported health facilities about committed funds until SPHU project completion for a proper financial planning.		May 15, 2019		Steering Committee
Action(s)	Responsible	Deadline	Progress	Status
Draft the Exit Strategy, present the draft for review and approval of the MoH.	Paolo Reggio D'Aci	December 20, 2019	Regional workshops in Rwenzori and West Nile regions have been conducted to elaborate the project Exit Strategy, and its draft has been shared with the MoH for discussion.	Completed
	Sarah Byakika			In Progress

Officially inform the RBF supported health facilities about the SPHU project Exit Strategy.		December 20, 2019		

In 2020, 4 meetings took place of which 3 virtual. Key issues and decisions is presented below.

Decision to take		Period of Identification		Source
Extend the intervention implementation until June 30, 20		05/12/2019		Steering committee
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
Extend the SPHU intervention implementation until June 30 2020	Maximenco Dumitru	15/12/2019	SPHU intervention implementation has been extended up to June 30, 2020	Completed

Decision to take		Period of Identification		Source
Implement strategic reorientation of the SPHU intervention as per MOH request		26th March 2020		Steering Committee
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
Enabel to stop all non-essential activities which cannot be implemented under the present epidemiological situation	Project team	Immediate		Completed

Budget to be reallocated for purchase of screening equipment	Arnaud Truyens	Immediate	800 infrared thermometers purchased and handed over	Completed

Decision to take		Period of Identification		Source
Reallocation of 1.5 EUR million contribution of the GOU to implementation of the Specific Agreement N.N. 1272 for counteracting of the COVID19 pandemic		15th May 2020		Steering Committee
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
The Ministry of Finance, Planning and Economic Development and MOH to communicate to Enabel and Embassy of Belgium	MOFPED and MOH		In August 2020 Uganda authorities officially informed the Belgian Embassy that they were not able to release the 1.5M EUR counterpart funding	Completed

Decision to take		Period of Identification		Source
Extension of contract of staff till 30th September 2020		May 2020		Steering
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
Extend contract of SPHU staff to allow completion of project activities delayed by the strict lock down	Enabel mgt.	Immediate	Contracts were extended till 30th September 2020	Completed

Decision to take	Period of Identification	Source

Approve extension of project implementation till May 2021 to provide technical assistance to RBF programme		June 2020		MOH request
Action(s)	**Responsible**	**Deadline**	**Progress**	**Status**
Extend contract of National TA of West Nile in order to provide technical assistance of implementation of RBF in the region	Enabel	NA	Contract for 1 NTA and 1 driver extended till 31st May 2021	Completed

10.4 Complete monitoring matrix

Outcome: Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and Private Not For Profit (PNFP) Health Services, with a particular focus on women, children and other vulnerable groups			
Progress indicators/markers[7]	**Base value**	**Final target**	**Final value attained**
	2016		**2019**
1. Tested and updated RBF model, accepted by MoH and GoU as the national model, available	No (0)	Yes (1)	Yes (1)
2. % of the national health budget which is output-based	0%	>25%	< 3%
3. Utilisation rate for curative consultation at HC III level, total and gender-disaggregated	177,80 / 1000 (R) 161,47 / 1000 (W)	+20%	186.68/1000 (R) 172.69/1000 (W)
4. Hospitalisation rate for HC III level health facilities, total and gender-disaggregated*	12% (R) 11% (W)	**+10%**	17% (R) 13% (W)
5. Hospitalisation rate for GH and HC IV level, total and gender-disaggregated, in RBF supported health facilities*	32% (R) 25% (W)	**+10%**	28% (R) 35 % (W)
6. Percentage of RBF supported GH and HC IV, which implement strategic plans	38% (R) 25% (W)	**100%**	100% (R) 100% (W)
7. Strategic plans for GH and HC IV institutionalized as National Policy	No	**Yes**	Yes

Output 1: The equitable access to quality health care at public and PNFP HC IIIs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point.			
Indicators	**Base value**	**Final target**	**Final value attained**
	2016		**2019**
1.1 Percentage of RBF supported HC III in the targeted districts which obtain a score of at least 4 stars to the Quality of Care Assessment of the MoH	N/A (R) N/A (W)	>75%	N/A (R) 0 (W)
1.2 Percentage of institutional based deliveries which meet the MoH quality standards in RBF supported HC III	80% (R) 75% (W)	80%	95% (R) 93%) (W)
1.3. Percentage of RBF supported HC III providing modern family planning services	42% (R) 58% (W)	100%	42% (R) 58% (W)

1.4 HIV/AIDS care and treatment services, including PMTCT, are integrated and functioning according to MoH quality norms in RBF supported HC III	100%	>95% >85%	100%

Result (Output) 2: The equitable access to quality health care at public and PNFP General Hospitals & HC IVs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point			
Indicators	**Base value**	**Final target**	**Final value attained**
	2016		**2019**
2.1 Percentage of RBF supported GH and HC IV in the targeted districts which obtain a score of at least 4 stars to the Quality of Care Assessment of the MoH	N/A (R) N/A (W)	**>85%**	N/A (R) 0 (W)
2.2 Percentage of RBF supported GH and HC IV in the targeted districts that experience essential drugs out-of-stock for any of the 6 tracer medicines in a month	30,8% (R) 62,8% (W)	**<5%**	28,57% (R) 33,33% (W)
2.3. Percentage of RBF supported public GH and HC IV in the targeted districts with a functional e-patient file system	0%	**100%**	100% (5 public GH and 4 public HC IV)

Output 3: The capacity of Health Districts to manage the quality of care and the integrated local health system is strengthened			
Indicators	**Base value**	**Final target**	**Final value attained**
	2016		**2019**
3.1. Percentage of RBF supported HC III, HC IV, and GH in the targeted districts which implement a Continuous Professional Development plan	68,0% (R) 42,3% (W)	**75%**	97% (R) 93% (W)
3.2 Percentage of HC III, HC IV, and GH in the targeted districts which have received supportive supervision visits of the DHMT in a quarter	82,5% (R) 58,5% (W)	**100%**	100% (R) 96,0% (W)
3.3 Percentage of PNFP health facilities (HC III, HC IV and GH) supervised by the Medical Bureaus	73,0% (R) 50,0% (W)	**75%**	94% (R) 100% (W)

3.4 The District Strategic Plans are compliant with the National Health Planning Guidelines in RBF districts	0% (R) 0% (W)	**100%**	100% (R) 100% (W)
3.5 Percentage of reduction of debt of RBF supported PNFP HC III, HC IV, and GH in the targeted districts	100% (R) 92% (W)	**Reduction by 25%**	100% (R) 100% (W)
3.6. Regional Joint Review Missions of the MoH organised in Rwenzori and West Nile regions	0% (R) 0% (W)	**100%**	67% (R) 100% (W)

Output 4: The capacity of MoH to steer the implementation of the health financing strategy is strengthened.			
Indicators	**Base value**	**Final target**	**Final value attained**
	2016		**2019**
4.1 Percentage of RBF invoices paid with a delay of over 3 months	N/A	**NA**	**4%**
4.2 RBF exit strategy of SPHU intervention elaborated and submitted to the MoH	No	**NA**	**Yes**

10.5 Resources in terms of communication

In this optional annex interventions should list all available materials (articles, books, videos, etc.) regarding the effects of the intervention on the beneficiaries, including studies, knowledge-building reports or (scientific) publications. The use of materials with client-centred approaches ('story telling') is greatly appreciated. Also indicate which documents or publications are related to strategic learning.

No.	Name of resource	Type of resource	Related to strategic learning
1.	Capitalisation of Enabel ICB II and PNFP Health Projects in Uganda	Report	Yes (Annex 3)
2.	Does Results-Based Financing improve health service utilization and patient centeredness? Experiences from the Enabel RBF programme in West-Nile and Rwenzori regions in Uganda	Evidence brief	Yes (Annex 9)
3.	Effect of the Enabel RBF programme on Health System Management	Evidence brief	
4.	Results-Based Financing and improved financial management: Experiences from the Enabel RBF Programme in Uganda	Evidence brief	
5.	Effect of Enabel RBF Programme on Human Resources For Health (HRH)	Evidence brief	
6.	Effect of Enabel RBF programme on medicines and health supplies	Evidence brief	
7.	Effects of Enabel RBF Programme on Data Quality and Use	Evidence brief	
8.	Knowledge Sharing Symposium on Results-Based Financing - Proceedings Report	Symposium – proceeding report	Yes (Annex 4)
10.	QUALITY LOW-COST HEALTH CARE SERVICES BENEFITING RWENZORI AND WEST NILE REGION	Newspaper article New Vision	No (Annex 8)
9.	SPHU exit video	Video	No (Annex 9)

10.6 Personnel of the intervention

Personnel (title and name)		Sex (M/F)	Term of employment (start and end date)
Support staff, recruited locally by Enabel:	Kangwire Rebecca	F	Interim Accounts Assistant 16/09/2019 – 30/09/2020.
	Twesige Patrick	M	Driver 19/09/2019 – 30/09/2020
	Kabasinguzi Patience	F	Account Assistant 01/06/2019 -30/09/2020
	Numawanya Polly	M	Driver 08/05/2018 – 30/09/2020
	Othieno Moses	M	Driver 10/10/2017 – 31/05/2021
	Tebajjukira Anna	F	Finance Admin officer 03/04/2018-30/09/2020
	Bumbi Herbert	M	National Technical Assistant West Nile 20/09/2018 – 30/09/2020
	Musabe Richard	M	National Technical Assistant – West Nile 03/08/2018 – 31/05/2021
	Bahireira Sylvia	F	National Technical Assistant Rwenzori 03/09/2018 – 30/09/2020
	Mwesige Charles	M	Driver 05/01/2015-30/09/2020
	Tumwizere Gideon	M	Account Assistant 01/06/2019 – 30/09/2020
	Kusemererwa Abel	M	Database manager 05/11/2018 –31/12/2019
	Ikara John	M	ICT officer 18/03/2019 – 31/12/2019
	Apeduno Annet Grace	F	Finance and Admin officer 24/08/2015 –31/12/2019
	Kazibwe Twaha Baker	M	Driver 29/03/2016-31/12/2019
	Anek Dora	F	Project Management Assistant 01/09/2014 – 31/12/2019
	Olaja Gideon	M	National Technical Assistant – Rwenzori 01/06/2017- 31/12/2019
International experts (Enabel):	Truyens Arnaud	M	International Financial and Administrative Officer (RAFI) 17/06/2019 – 31/12/2019
	Inge Dumortier	F	International Financial and Administrative Officer (RAFI)
	Maximenco Dumitru	M	International Intervention Co-Manager 5/11/2018-31/12/2019
	Reggio D'Aci Paolo	M	International Health Financing Expert 18/06/2018-18/03/2020

10.7 Public procurement

Enabel no Number	Tender Title	Budget line	Status	Advert date	Type of contract	Applicable legislation	Awarding date	End date implementation	Final amount of signed contract (UGX)	Date of closure	Comments
SPHU 001	ICT EQUIPMENT & FURNITURE	20202/Z0201	Completed	09/03/2018	Simplified	Belgian	30/03/2018	30/03/2018	22,000,000	30-3-2018	THIS WAS NOT ONE PROCUREMENT BUT SEVERAL PAYMENTS BELOW 2500€ see lpos SPHU001 , SPHU002 & SPHU003
SPHU 002	PHONE TABLETS	A0403	Completed	23/08/2018	Simplified	Belgian	30.06.2018	06.09.2018	12,850,000/-	06.09.2019	
SPHU 003	PHONE TABLETS	A0403	Completed	03.11.2018	Simplified	Belgian	13.11.2018	15.11.2018	38,550,000/-	16.11.2018	Procurement on icb ii
SPHU 004	MED EQUIPMENT WARR & MUNGULA		Abandoned and relaunched as SPHU 007								
SPHU 005	PHONE TABLETS		Abandoned and relaunched as SPHU006								
SPHU 006	PHONE TABLETS	A0403	Completed	05.02.2019	Simplified	Belgian	14.02.2019	13.3.2019	30,756,700/-	13.3.2019	Prices are VAT Incl.
SPHU 007	MED EQUIPMENT WARR & MUNGULA	A0202	Completed	12.2.2019	Simplified	Belgian	13.03.2019	17.7.2019	84,435,000	17.7.2019	Prices are VAT EXC
SPHU 009	ENGINE REPALCEMENT 2KD		Completed	22.02.2019	Simplified	Belgian	14.03.2019	14.03.2019	18,000,000		Procurement done by LPO see LPO SPHU068 in LPO register and LPO file
SPHU 010	ENGINE REPALCEMENT 1HZ for UG4191M		Completed	22.02.2019	Simplified	Belgian	13.03.2019	13.03.2019	27,000,000	23.3.2019	Procurement done by LPO see LPO SPHU066 in LPO register and LPO file

SPHU 011	ICT EQUIPMENT	Z0201	Completed	20/05/2019	Simplified	Belgian	18/06/2019	03/07/2019	22,750,000	28.6.2019	Prices are VAT EXC
SPHU 012	Capacity development services	A0304	Completed	No advert. Used framework agreement for SDHR project	Simplified	Belgian		12.9.2019		12.9.2019	Prices are VAT EXC
SPHU 013	Medicines for opthalmic clinic outreach	A0202	Abandoned and relaunched as SPHU 14								
SPHU 014	Medicines for opthalmic clinic outreach	A0202	Completed	30.7.2019	Simplified	Belgian	5.8.2019	5.8.2019	19,795,000	5.8.2019	Prices are VAT EXC
SPHU 015	Assorted ICT equipment to upgrade e-filing system for several health centers	A0204	Completed	29.10.2019	Simplified	Belgian	18.9.019	12.12.2019	57,960,000		Prices are VAT EXC
SPHU 017	Medical equipment spareparts	A0202	Completed	5.9.2019	Simplified	Belgian	17.9.2019	11.11.2019	18,436,000	11.11.2019	Prices are VAT EXC
SPHU 020	Medical equipment for Ngombe HC III	A0303	Abandoned								Prices are VAT EXC
SPHU 021	Purchase of infrared thermometers	A0202	Completed	10.4.2020	NPWithoutP	Belgian	15/5/2020	06/10/2020	96,000,000	10/6/2020	Prices are VAT EXC
SPHU 022	Purchase of infrared thermometers (second batch)	A0202	Completed	15.6.2020	Simplified	Belgian	26.7.2020	16.7.2020	10,000,000	16.7.2020	Prices are VAT EXC
SPHU 023	purchase of medical supplies for COVID 19 response in Arua RRH	A0202	Completed	22.6.2020	Simplified	Belgian	9.7.2020	23.7.2020	70, 150,000,	23.7.2020	Prices are VAT EXC
SPHU 024	printing of IEC materials for COVID 19 awareness in Arua	A020701	Completed	22.6.2020	Simplified	Belgian	9.7.2020	25.7.2021	14,400,000	25.7.2021	Prices are VAT EXC

10.8 Grants

Region	District	Org Name	Project	Grant code	Grant Start Date	Grant End date
Rwenzori	Bundibugyo	DLG Bundibugyo	SPHU	SPHU_Bundibugyo_020	2019-01-01	2019-06-30
Rwenzori	Bundibugyo	DLG Bundibugyo	SPHU	SPHU_Bundibugyo_032	2019-07-01	2019-12-31
Rwenzori	Kabarole	DLG Kabarole	SPHU	SPHU_Kabarole_022	2019-01-01	2019-06-30
Rwenzori	Kabarole	DLG Kabarole	SPHU	SPHU_Kabarole_034	2019-07-01	2019-12-31
Rwenzori	Kamwenge	DLG Kamwenge	SPHU	SPHU_Kamwenge_023	2019-01-01	2019-06-30
Rwenzori	Kamwenge	DLG Kamwenge	SPHU	SPHU_Kamwenge_035	2019-07-01	2019-12-31
Rwenzori	Kasese	DLG Kasese	SPHU	SPHU_Kasese_025	2019-01-01	2019-06-30
Rwenzori	Kasese	DLG Kasese	SPHU	SPHU_Kasese_037	2019-07-01	2019-12-31
Rwenzori	Kyenjojo	DLG Kyenjojo	SPHU	SPHU_Kyenjojo_024	2019-01-01	2019-06-30
Rwenzori	Kyenjojo	DLG Kyenjojo	SPHU	SPHU_Kyenjojo_036	2019-07-01	2019-12-31
West Nile	Adjumani	DLG Adjumani	SPHU	SPHU_Adjumani_015	2019-01-01	2019-06-30
West Nile	Adjumani	DLG Adjumani	SPHU	SPHU_Adjumani_027	2019-07-01	2019-12-31
West Nile	Arua	DLG Arua	SPHU	SPHU_Arua_016	2019-01-01	2019-06-30
West Nile	Arua	DLG Arua	SPHU	SPHU_Arua_028	2019-07-01	2019-12-31
West Nile	Maracha	DLG Maracha	SPHU	SPHU_Maracha_017	2019-01-01	2019-06-30
West Nile	Maracha	DLG Maracha	SPHU	SPHU_Maracha_029	2019-07-01	2019-12-31
West Nile	Moyo	DLG Moyo	SPHU	SPHU_Moyo_018	2019-01-01	2019-06-30
West Nile	Moyo	DLG Moyo	SPHU	SPHU_Moyo_030	2019-07-01	2019-12-31
West Nile	Nebbi	DLG Nebbi	SPHU	SPHU_Nebbi_026	2019-01-01	2019-06-30
West Nile	Nebbi	DLG Nebbi	SPHU	SPHU_Nebbi_038	2019-07-01	2019-12-31
West Nile	Zombo	DLG Zombo	SPHU	SPHU_Zombo_019	2019-01-01	2019-06-30
West Nile	Zombo	DLG Zombo	SPHU	SPHU_Zombo_031	2019-07-01	2019-12-31
Rwenzori	Bunyangabu	DLG Bunyangabu	SPHU	SPHU_Bunyangabu_021	2019-01-01	2019-06-30
Rwenzori	Bunyangabu	DLG Bunyangabu	SPHU	SPHU_Bunyangabu_033	2019-07-01	2019-12-31

10.9 Specific Cooperation Agreements

Not applicable.

10.10 Equipment

List of equipment acquired during intervention

Type of equipment	Cost (UgSh)		Date of delivery		Remarks
	Budget	Actual	Budget	Actual	
01 SHREDDING MACHINE		3,823,200		30/3/2018	
2 LAPTOPS DELL 5480, 23" MONITORS, 6U NETWORK RACK DOCKING STATION, KEYBOARD AND MOUSE		13,110,000		30/3/2018	
FURNITURE – 7 LOCKABLE BOOKSHELVES & 1 KITCHEN CABINET		5,230,000		30/3/2018	Office use
26 x (BACK COVER FOR 10' + MICRO SD 16 GB + SCREEN GUARD FOR 10' + TECNO TAB DROIPAD 10D)		30,756,700		19/02/2019	
MEDICAL EQUIPMENT FOR WARR HC IV and MUNGULA HC IV - Hot air oven (2) - Infant warmer (2) - Patient monitor (1) - Instrument trolley (2) - Hysterectomy set (2) - Laparotomy set (2) - Pulse oximeter (2) - Head torches (6) - Surgeon's chair (4) - Fridge (1) - Oxygen concentrator (1) - Resuscitator manual adult (1)		84,435,000		3/06/2019	

- Ultrasound machine (1)					
TECHNO PHONE TABLETS		12,850,000		6/9/2019	IT EQUIPMENT FOR RBF VERIFICATION FOR WEST NILE AND RWENZORI
8 PRINTERS, 6 DESKTOPS, 18 WIRELESS ACCESS POINTS, 9 TABLETS, 5 METERS OF CAT 6E PATCH CORDS, SWITCH		51,835,000		22/11/2019	EQUIPMENT FOR UPGRADE OF E-PATIENT FILLING IN 09 HC FACILITIES IN RWENZORI AND WEST NILE
COVID MEDICAL SUPPLIES		70,150,000		25/7/2020	EMERGENCY RESPONSE TO HEALTH FACILITIES IN WEST NILE
800 Infrared thermometers		196,000,000		16/07/2020	Support to National Covid19 response
ICT equipment (5 laptops, 1 colour printer)		23,593,839		04/03/2021	