Enabel

Executive Summary of the Joint End-term Review

Roll out the National Results-Based Financing Policy in Acholi Region, Uganda (USAID EHA) UGA180371T

and

Leveraging Strategic Health Financing for Universal Health Coverage, Uganda, UGA 2000311

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1 Presentation of the evaluation

Enabel is supporting the roll out of National Results Based Financing (RBF) Framework through the implementation of a project funded by USAID named Enabling Health in Acholi (EHA) covering four districts and one city council in Acholi. The main objective is “to reinforce the health system in the Acholi sub region in order to provide better health, financial protection and greater equity to the most vulnerable populations”. There are five specific result areas for this project.

The intervention ‘Leveraging Strategic Health Financing for Universal Health Coverage’ (LSF) came in as part of the Bridging program, approved on the 30th of September 2020 and agreement signed in May 2021. LSF project aims to support result-based financing as a key strategy to improve the provision of quality services, efficiency, and equity in recourse allocation and as a first step towards a third payment system of a public health insurance system. The LSF is reviewed in its second (of 3) implementation year. LSF project covers 13 districts in West Nile and 10 districts in Rwenzori.

By the time of the EHA and LSF-End Term Review (ETR), the Government of Uganda (GoU), through the MoH, had been developing a strategy for mainstreaming RBF into the Primary Health Care (PHC) grants under the Uganda Intergovernmental Fiscal Transfers (UgIFT) Program by the Ministry of Finance, Planning and Economic Development (MOFPED) 2023) and is presently embarking on efforts to institutionalize RBF. Result based financing, which had been scaled up at the national level under the Uganda Reproductive Mother and Child Health Improvement Programme (URMCHIP[1]) project, came to an end in Financial Year (FY) 2021/22, but the MoFPED has approved the mainstreaming of RBF into the PHC Non-Wage Recurrent grants with effect from 2023/24.

The purpose of this evaluation is the systematic and independent assessment of the on-going project EHA near to completion and the ongoing LSF. The evaluation is expected to contribute to:

- Decision-taking: recommendations and lessons learned from evaluations feed into present and future decisions of Enabel and stakeholders, from policy to operational intervention strategies and organisational results.
- Learning leading to knowledge generation and sharing based on objective evidence.
- Accountability: providing means of evaluating the performance of interventions and being reliably and transparently accountable for the use of resources and the results achieved or not achieved, while explaining the how and why.

Given that the ETR is assessing two projects in 10 days, the team considers that a flexible empirical approach capturing is more appropriate. The capitalization of existing knowledge and information is based both on primary data collection methods, including structured interviews, semi-structured interviews, online surveys, case studies, field observations and focus group interviews to investigate thematic questions in-depth. Secondary data are collected from documents, reports and studies.

[1] jointly financed by the Ministry of Health (MoH), with a $140 million World Bank loan, Global Financing Facility (GFF) and SIDA, to implement the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) Sharpened Plan

2 Results and conclusions

2.1 Performance criteria

The overall project performance is relatively good based on the OECD DAC performance criteria, scoring either A or B according to the criteria considered.

Relevance (score A)

The relevance of both projects is considered high. The EHA intervention is anchored in the Health Financing Strategy (HFS) 2016-2025, the RBF implementation framework, Universal Health Coverage (UHC) Road Map for Uganda, as well as the MoH Strategic Plan 2020/21 – 2024/25. The intervention is also fully relevant to the priorities of Belgium (Human rights & Gender, Maternal & Child health and Family Planning, Digitalisation, Inclusive growth and Environment) and Uganda, as per the Ugandan policy documents (National Development Plan III, National Health Policy III, where human capital development, including health, is a fundamental enabler for development and progress.

The LSF project intervenes in priorities identified by MoH, consisting essentially in sexual and reproductive health, with focused support to Neonatal care in HCIVs and hospitals, blood bank including blood collection and emergency services, with the design of ambulance call and dispatch centres and the set-up of a training and simulation centre, in close alignment with the new EMS policy and support of coordination and management.

EHA and LSF projects both have a strong RBF component while contributing to build on UHC. With RBF as backbone, they assure the provision of quality services, efficiency and equity in resource allocation towards a third-payment system of a public health insurance system. Both EHA and LSF projects under review are designed and implemented with the MoH to strengthening essential public health functions in support of the achievement of UHC agenda (SDG 3). The UHC intends to keep health care services affordable while expanding coverage to reach those most in need, as well as increase the quality and diversity of interventions to promote well-being and healthy lifestyles.

Coherence (score A)

EHA is designed in synergy with Regional Health Integration to Enhance Services in North Acholi (RHITES-N), on district supervision, clinical mentorship and health facilities training. The RBF mechanism provides financial incentive for quality of care.

EHA complements URMCHIP to rollout RBF countrywide. Both support the National RBF unit. The LSF intervention as a Bridging program is in synergy with EHA and previous PNFP and ICB2, and the 'Strategic Purchasing of Health Services in Uganda' project (SPHU) supporting the RBF unit in the Department of Planning. And support Emergency Medical Services (EMS) and referrals with emphasis on SRH.

Efficiency (score B)

EHA brings with RBF a source of much-needed revenue at primary care level in an under-funded health system. It is to be considered as an add-on component of payment systems, while focusing on expanding areas of potential gain and ensuring better integration and institutionalisation. Accountability at all levels, also induced by leading staff rotations, project procurement rules, changing MoH construction regulations, and the pandemic all contributed to delays. Nevertheless, in the last quarter and due to project and financial flexibility much or the delay was caught up or still ongoing in execution. The execution rate to date 30.06.2023 is 87%.

For the LSF project the execution rate to date is 67,5%. The remaining funds under result 3 are assigned to the call and dispatch centre, the tender in process of finalization. Both projects are

flexible in budget and activities. In EHA 10% unused RBF budget was reallocated to construction (Atiak Out-Patient Department OPD). The total grant value was consequently adjusted, as presented during the Steering Committee (SC).

Effectiveness (score A)

Financial management and leaders' capacities were enhanced and boosted self-esteem, leading to quality services. Self-conducted performance review meetings and regional quality improvement committee meetings enable to develop quality improvement strategy.

EHA contributes to an RBF taskforce and RBF steering committee to develop an RBF model in the post URMCHIP period, with Enabel supporting RBF mainstreaming training material. LSF continues strengthening the RBF unit and RBF main streaming (RBF 3.0).

Due to complementarity and organizational and financial flexibility, as well as common results as there are strengthened management capacity in MoH and districts, RBF implementation, linked to quality services, some of the LSF activities cannot be separated from EHA results. There is continuity between both projects and increased effectiveness of common results.

LSF improved a high number of HCIV on maternal and neonatal care and emergency services. Solar power sources contribute to functioning laboratories, NICU in HCIV, and storage of blood for the Comprehensive Emergency Obstetric and New-born Care services (CemonC) services, incubators, oxygen concentrators and functional blood bank services. LSF contributes to SRH, training, equipment and infrastructure for safe delivery, and FP.

Effectiveness is often hampered by the lack of essential staff in HFs, staffing gaps and DHT cadres, due to absenteeism and transfer, often politically induced. RBF indicators and reporting are not all aligned to routine HMIS creating a less efficient parallel system.

Impact (score B)

Short duration of the project and health system weaknesses, mainly related to Human Resources in Health (HRH) and drug supplies, as well as withdrawal of staff motivation and incentives, reduce the potential impact of RBF to provide quality services.

Sustainability (score B)

Health system strengthening, learning and finance management capacity building increase motivation of staff and are a pathway towards sustainability and improved quality services.

2.2 Specific questions

Is there any difference in approach between Enabel and other implementing partners? If so which one and how does it affect the result?
Differences with other projects, using performance-based financing, are notable in previous URMCHIP, Enabel and other supply driven projects versus the EHA demand driven project. Further in thematic scope and indicators, geographical coverage, timeliness of procedures, disbursement and procurement, support and supervision roles, efficiency and salary incentives.

To what extent did the interventions adapt to the changes in context? If so which one and how does it affect the result?
A large contribution to facility-based deliveries was the improvement of emergency transport, strengthened during COVID-19. This was taken up in the LSF project increasing capacity in emergency referrals.
Comparison of annual DHIS2 PHC outputs show comparable results of URMCHIP or slightly better for EHA, at a higher cost. Most outcome indicators exceed the national average, while client satisfaction improved by 7.3% from 2021 to 2023.

Is the Performance evaluation of Service Units independent? What type of support by Enabel and Are performance scores given?
According to the World Bank report[2], though EDHMT members were trained in RBF verification, there were claims that mixed skill of teams compromise objectivity of quality assessment. Causes include district health team (DHT) human resource gaps in many districts, poor district ownership of the program and poor mobilization of DHMT staff.

When quantitative and qualitative evaluation take place: Over what period is it announced?
From the interview with the RBF unit resulted that next revision should increase the quality indicators. 20% of the indicators should be pure quality mainstream indicators from which half should respond to client satisfaction.

Have improvised unannounced evaluations or site visits/supervisions been organised?
The evaluation team considers this as a missed opportunity to have independent quality supervision visits complementing the routine verification. Additional unannounced visits to HFs by experienced clinicians, and spot checks by district HMT better follow up quality.

Has community assessment been introduced, and are the indicators regularly adapted?
There is participation of VHTs in identifying mothers requiring assistance especially when using grants remunerate transport. In some of the visited HFs, involvement of HUMCs, and VHTs is weak. Community assessment and community capacity building with indicators can increase outreaches and improve RBF scores and earnings to finance this primary level.

Is the performance measured, and when, of technical PBF unit and subunits, including district and regional offices?
Was the PBF Procedures Manual and tools last revised, and do periodic revisions take place to correct and capitalize?
The current RBF unit consist of one person and one LSF support. There are regional coordinators, district and HFs RBF focal persons, no RBF subunits. The RBF team has been downsized ant the end of URMCHIP and in the transition to national roll out. This happens in the same period that recent interesting experiences should feed in into the RBF training guidelines and a manual be developed. There are no revisions so far.

Transversal and horizontal themes

It was not clear if clinical staff was trained in patient centred care including gender or human rights. Disaggregation of data on equity and gender can be improved. Both results 4 in EHA and LSF are environment minded and climate friendly.

[2] Word Bank, *Quantitative and Qualitative Review of Results Based Financing in Uganda Evaluation Report*. 2021

3 Recommendations

Continue HS management training and financial management over all levels. Include leadership training with acceptable duration and embedded on-job mentorship program with MoH management, framed by RRH.

Maintain and **strengthen systems of staff motivation**, improving infrastructure, equipment, drug availability, CME, with a respectful autonomy of decision and accountability. Recruitment of additional staff should go in pair with staff containment.

Involve community (HUMCs, HMB) at all stages, set priorities in design down to assessment. Include training and empowerment to negotiate political arbitrary staff mutation and strengthen role in primary maternal delays. Develop the **demand side of quality services with the community**, e.g. client satisfaction approaches to improve quality.

Regional RBF supervisors need to provide strict oversight and supervision with skills mix of district verifiers to ensure integrity and **objectivity of the quality assessments.** Include supervising spot checks by district HMT, and supervisors with clinical skills to induce quality services. Skilled auditors need decent transport facilities, and better focus on results rather than expenditure details and administrative procedures.

RBF unit to be sustained by all partners beyond their project time with trained regional subunits, supporting the regional RBF officers and network of focal persons. Revise and update the indicators for community assessment, develop to study the health benefits.

Incentive or alternative **mechanism to purchase essential medicines** to bridge gaps created by chronically failing NMS[3].

Further develop and **integrate emergency services** with firefighters, police, marines.

4 Lessons learned

The capitalization briefs and additional operational research and documentation contribute to a tailormade national roll-out in preparation to NHIS.

Financial management skills motivate through understanding development of goal-oriented planning and linked budgets. Financial staff trained to apply adequate control systems and comfortable in using budgets learn and apply efficiency and value for money, while taking initiatives for revenue generation.

RBF incentives and more autonomy lead to staff motivation for management initiative and increased quality and productivity. Quality also comes with appropriate maintained equipment, decent infrastructure and housing, training and continuous medical education. HR management improves with regular and mentored meetings, clear staff schedules and constructive supervision.

Strong community involvement (HUMC, HMB) facilitates the backup of strong facility and district leadership, as observed in two HFs where political induced, inopportune arbitrary staff mutation is contained.

The time span for behaviour change in leadership skills, quality improvement and well applied autonomy exceeds 5 years.

[3] BMAU Briefing Paper 15-15 - Continuous stock-outs of medical supplies in Uganda. What are the root causes? June 2015