EXECUTIVE SUMMARY

MTR UGA1402811 ICB 2

The ICB II Project

The BTC's 'Institutional Capacity Building Project in Planning Leadership and Management in the Uganda Health Sector – Phase II' (ICB II) aims at strengthening the planning, leadership and management capacities of public health staff, particularly at local government level, in two of Uganda's 12 health regions. It started in July 2015 and is foreseen to end in December 2018. It follows a previous capacity building project and is complementary to the 'Institutional Support for the Private-Non-For-Profit Health Sub-Sector to Promote Universal Health Coverage in Uganda' (PNFP project), that started in 2014. Both projects pilot and test a results-based financing (RBF) approach, the PNFP project in PNFP facilities and the ICB II project in public facilities. Other key interventions of the ICB II project are the establishment of regional-level inter-district coordination structures, the development of a sustainable ambulance services model, improving district-level health services planning using GIS software, and introducing e-health systems. An additional project, the Strategic Purchasing of Health Services (SPHU) project, will start in brief and will complement and continue the activities of the ICB II and PNFP projects.

The mid-term review

A mid-term review (MTR) is a standard tool in the monitoring and evaluation of interventions implemented by the Belgian Development Cooperation. The objective is to complement the monitored information of a project with an independent in-depth review that provides answers mainly to the "how" and "why" questions. Its function is to support strategic and operational steering; contribute to learning by analysing what works, what does not work and why; and ensure accountability by supplying the donor, partner and other internal actors an external assessment of the progress made. The overall performance is evaluated by assessing the five OECD-DAC criteria (relevance, effectiveness, efficiency, impact, and sustainability) and the four transversal themes and horizontal aspects (gender, environment, results oriented steering, and monitoring). In addition, the MTR was requested to assess four specific evaluation questions.

The MTR of the ICB II project was done by a team of the hera/Aedes consortium comprising one international and one national public health expert. It started at the end of October 2017 with a documentation review, a briefing meeting at the BTC head office and preparatory calls with the Project Management Team (PMT). The team conducted the field mission between October 31 and November 21. It comprised a combination of the review of all relevant documents, semi-structured interviews of key stakeholders and beneficiaries, and visits to a selected number of health facilities. At the end, all information was triangulated to formulate responses to the evaluation questions and these were presented to the stakeholders and beneficiaries during a feedback workshop. Overall, the MTR went according to plan without any major challenges.

Key findings

Relevance

All topics addressed by the project respond to real existing needs, the project's strategies are in line with the national policies and strategies, well aligned with other development partners' (DPs) interventions, and in line with the Belgian priorities and BTC's strategic approach. The MTR team therefore assigned the maximum score of 'A' for the criteria Relevance.

Efficiency

Overall the project is efficiently implemented, the inputs are efficiently used, the quality of most outputs is good, and the organisational structure is adequate. However, most activities started with important delays, some of the planned activities will probably not be implemented, the quality of some outputs is

less than expected and the organisational alignment with the PNFP project is sub-optimal (see Specific Evaluation Question 3). The MTR team therefore assigned a score of 'C' for the criteria Efficiency.

The effective start of most activities was delayed, and they are 6 months or more behind schedule. The reasons are multiple, tools expected to have been developed by the PNFP project were not yet finalised, the development and signing of agreements and the selection of RBF-eligible facilities took longer than expected, modalities for drug procurement still had to be developed, … As a result, budget expenditure was only 29% at the end of September 2017. The project obtained a 6-months no-cost extension of the implementation period and therefore believes it will be possible to complete all essential activities efficiently. The MTR team believes that there is a high probability that some of the activities can only be completed during the next, SPHU project.

The ICB II project was very ambitious in its design. Many activities were listed as 'possible' activities and several of these will not be implemented because of insufficient available funding or because they are not considered a priority. The project took a strategic decision to focus first of all on the core of the project, the piloting of the RBF approach. The MTR team supports this decision. Nevertheless, other activities such as the institutionalisation of the regional inter-district coordination structures, the piloting of a more sustainable ambulance services model, the introduction of e-health systems, the use of QGIS software for district planning, and in particular the capitalisation, remain important as well and should be done, either during the ICB II project or the following SPHU project.

The tested RBF model appears to be of good quality and to follow international recommendations and guidelines, although the project needs to fine-tune it as the pilot goes along, and to resolve some challenges. The most important challenges are the delays in the verification process and the disbursement of funds to the facilities. Delays occur at all steps of the process and the reasons are multifactorial. Some might be growing pains, but other more structural. The project needs to carefully document and assess these reasons, resolve them where possible, or revise the timeline if unavoidable. Some components of the model, such as a periodic external audit or certain performance assessment tools, are currently not part of the pilot, and need to be tested as well.

The MTR team endorses the decision to give a particular focus to improving the availability of drugs and other medical supplies through additional procurements at the Joint Medical Stores, using the RBF funds. However, also this model needs fine-tuning.

The only outputs so far of the training of five staff members of the Ministry of Health (MoH) in the Quantum-GIS are district maps with the location of the health facilities and their 5km perimeter (coverage maps). This adds little value to what was already existing and is insufficient. The software offers much more potential that still needs to be exploited.

The continuous training (mentorship) of staff of general hospitals and health centres IV, by specialists of the regional referral hospital, encounters important challenges. According to MoH regulations, specialists have to be paid a daily fee for this type of activity and this conflicts with BTC policies and was not foreseen by the project.

Effectiveness

The project will without doubt have a substantial effect on the improvement of quality of care at those facilities supported through the RBF, but not in the entire districts or regions (see Specific Evaluation Question 1). The effect of other activities, such as the regional inter-district structures, the coverage maps and the national-level capacity strengthening is more difficult to assess or will be limited. The MTR team assigns a score of 'B' for the criteria Effectiveness.

The RBF had only just been initiated, but even so facilities claimed that it already resulted in increased staff motivation and service use. The greatest effects of the RBF are expected to be on an improved availability of drugs and medical supplies, and better conditions in terms of small equipment and infrastructure. The expected effect on improved staff skills is less obvious. Facilities do currently not appear to intend using their funds for training, and improved skills will need to be achieved through continuous training by the District Health Teams (DHTs).

The regional inter-district coordination structures, the quarterly regional health fora and the annual regional joint review meetings, are highly appreciated and districts claim they help in improving their planning, although that it is difficult to assess if this is effectively so. The effect of the coverage maps still has to be seen, and the project acknowledges that the activities to enhance the capacity at the level of the MoH are insufficient to have a strong effect.

Impact

The project will greatly contribute to the development of a national strategy and modalities for RBF, and possibly as well on the development of policies for ambulance services and regional structures. To what extent this will have the expected impact described during the project's design, which is that the planning, leadership and management capacities of public health staff – particularly at local government level – will be strengthened, is less clear. The MTR team assigns a score of 'B' for the criteria Impact.

Sustainability

Important steps are being made towards a sustainable RBF model and to a lesser extent towards regional inter-district structures and hopefully also towards a more sustainable ambulance services model (see Specific Evaluation Question 4). Nevertheless, none of these are currently already fully sustainable. The MTR team assigns a score of 'B' for the criteria Sustainability.

The RBF approach has been adopted as a national strategic purchasing mechanism and the piloted RBF model served as inspiration for the national RBF framework. Several other DPs are showing interest in supporting the roll-out of the model, and two have already committed funds for covering an additional 74 districts. Also, the government of Uganda committed funds for the RBF in the next SPHU project. Nevertheless, these financial inputs are still insufficient to ensure a complete national long-term coverage.

While the importance of having an intermediate level between the central MoH and the districts is recognised by all, sustainability of the piloted regional structures is currently still challenged by the absence of the institutionalisation of this level.

Transversal and horizontal aspects

Gender and environment are indirectly addressed by the project through a particular focus on women's health and on waste management in the RBF indicators. They were however not directly mainstreamed in each step of the implementation.

Results oriented steering, through the steering committee, is properly done, and the project correctly reports on the progress made using the appropriate tools. However, the project's logical framework is not always pertinent, and the choice of the indicators sometimes inadequate. The TFF mentions that a realistic evaluation approach is to be applied, but this did not really happen.

Specific evaluation questions

1. Results of discrepancy between area of intervention and available budget

The available budget was insufficient to achieve full coverage of the RBF in the two health regions, and the project opted to focus on those health facilities that achieved the highest scores in the baseline assessment. Only 40 facilities are being supported, representing 20% of all facilities. This creates without doubt important geographical inequity. The justification is that it is a pilot project and not to be institutionalised as such. However, also the national RBF framework applies the same strategy and there is a substantial risk that the RBF will result in a focus towards the stronger facilities and a neglect of the weaker and smaller facilities. The MTR team did see no signs of plans or interventions to strengthen and ensure the quality assurance mechanisms to improve quality of care at facilities non-eligible for RBF. The exclusion of facilities is often on the basis of not having all required departments or staff. This is perceived as unfair because facilities do not have control over this, and it does not imply that the quality of care of the offered services is insufficient to be eligible for RBF.

2. The RBF will produce a rich amount of data through its monitoring system (large amount of indicators)

The RBF model generates an abundance of quality indicators. The facilities use the information to improve their services, but at district and national level they are currently mostly used for the calculation of the amounts to be disbursed. No further analysis is done, and the data are not integrated in the existing health information management systems. The project is in the process of developing an electronic platform to ease the collection, storage and verification of the data and link the RBF indicators to the MoH's HMIS. It is not clear if the platform will also allow additional analyses.

3. ICB II and PNFP are designed as a single global support programme strengthening the health system in the construction of a national health insurance system

The ICB II project is complementary to the PNFP project, with similar objectives and activities. The desire of BTC was therefore to have both projects function as one programme. During the design of ICB II the organisational structure was as much as possible aligned with and integrated in the organogram of the PNFP project. Both projects share the same MoH Programme Manager, project steering committee, and financial staff. Only the technical staff remained parallel at equal level. It was hoped that the technical staff would come to (informal) arrangements and divide the tasks according to expertise, but this was not successful, mostly because of personal conflicts. Despite this lack of integration, the MTR team did not observe an important negative effect on the performance of the ICB II project.

4. Sustainability of the ambulance-services

The previous ICB project had initiated a support to 15 ambulances located at either hospitals or district health offices, and this support is continued in the ICB II project. They receive monthly 100 litres of fuel, and the costs of insurance, maintenance and tyres is reimbursed. This is clearly substitution and not sustainable. The intent is therefore to develop a more comprehensive and sustainable system for emergency evacuations during the current project. At the time of the MTR, first steps had been taken and the project is planning a pilot in four of the 15 districts, in close collaboration with the newly established Department of Emergency Medical Services of the MoH. It was said that the pilot will include testing alternative financing mechanisms, such as using RBF funds and community contributions through village insurance schemes.

Conclusions

- The project is addressing relevant issues, in line with national priorities and complementary to other support
- The project start was delayed, and some activities might not be completed. It is expected that the essential activities will be finalised, but some might have to be continued in the next SPHU project
- The attempt to make of the PNFP and ICB II projects one comprehensive programme has only partially succeeded, but this does not hamper a successful implementation of the projects
- The progress of the project is periodically correctly reported using the appropriate tools, but the logical framework is somewhat incoherent, and the progress indicators sometimes poorly chosen
- The RBF pilot is still in its initial phase and overall performing well, although that it needs fine-tuning. Especially the delays in verification and fund reimbursements need to be addressed
- The use of RBF indicators at HF-level is good, but use at district and national level need to be improved, by integrating it in the existing structures
- The choice to only support a limited number of HFs is defendable, considering the project as a pilot, but care has to be taken that this approach is not institutionalised in the national framework
- RBF will result in better quality services, but not all intended aspects of quality of care might be improved, and it has to be ensured that all aspects are addressed
- Promising steps have been made towards a sustainable national RBF model, but further mobilisation of long-term resources is needed
- The regional inter-district coordination structures are highly appreciated, but need to be institutionalised to guarantee sustainability

- The support to the ambulance services is continuing in a non-sustainable manner, but first steps have been taken towards piloting an alternative, sustainable model
- The Quantum-GIS software still has to show its full potential and be applied for health service planning
- The mentorship programme is still starting up, but faces already some important challenges
- More support is needed in strengthening the national level in playing their role in the management of the supported programmes
- Capitalisation of the lessons learned has already started, but will need more attention in the coming years

Main recommendations

1. For the project, during the capitalisation, to carefully assess the effect of the RBF not only on the supported health facilities, but also on not-supported health facilities, and for the MoH, together with the project and other DPs, to align the RBF with quality assurance strategies applied at facilities non-eligible for RBF.
2. For the project to carefully assess what activities are still realistically possible before the end of the project, what activities can be postponed to the SPHU project, and what activities can be cancelled.
3. Fort the project to further fine-tune the RBF modalities, analyse in-depth the causes of the delays, and possibly revise the timelines.
4. For the project to carefully plan the capitalisation, identify the most essential topics, document them well, conduct the appropriate analyses and disseminate the lessons learned.
5. For the MoH to take steps towards establishing regional-level technical capacity hubs, and for the project to continue lobbying