



RESULT REPORT 2017

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

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Acronyms

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

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

1 Intervention at a glance

1.1 Intervention form

Intervention title	Institutional Support for the Private-Non-For-Profit (PNFP) health sub-sector to promote universal health coverage in Uganda.
Intervention code	UGA1302611
Location	Uganda: Kampala, West Nile region and Rwenzori region.
Total budget	€ 8 000 000
Partner Institution	Ministry of Health
Start date Specific Agreement	13 May 2014
Date intervention start /Opening steering committee	27 June 2014
Planned end date of execution period	31 December 2018
End date Specific Agreement	13 May 2020
Target groups	• Ministry of Health and Medical Bureaux • PNFP health facilities and institutions in West Nile and Rwenzori region. • Rural population of West Nile and Rwenzori region, in particular the mothers and children.
Impact¹	Contribute to strengthen service delivery capacity at district level to effectively implement PHC activities and deliver the UNMCHP to the target population.
Outcome	PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.

¹ Impact refers to global objective, Outcome refers to specific objective, output refers to expected result

Outputs	Result 1	MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies.
	Result 2	MB and PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions.
	Result 3	District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations.
	Result 4	MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities.
	Result 5	PNFP HC III and IV of the regions of West Nile and Rwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF.
	Result 6	PNFP hospital care of West Nile and Rwenzori is more accessible for the population without loss of quality of care through RBF.
Year covered by the report		2017

1.2 Budget execution

	Budget	Expenditure		Balance	Disbursement rate at the end of year 2017
		Previous years	Year covered by report (2017)		
Total	€ 8 000 000	2 685 347	2 177 321	3 137 332	61%
Output 1	274 953 €	164 586	56 804	82 560	73%
Output 2	183 200	114 766	57 902	10 532	94%
Output 3	67 000	20 918	29 678	13 404	79%
Output 4	89 000	59 415	13 887	34 523	68%
Output 5	2.196.600	298 619	566 927	841 054	51%
Output 6	1 979.600	346 148	816 383	1 351 069	46%
Common costs related to the activities	1.305.200	669 231	246 339	539 770	63%
General means	1.623.800	1 011 663	389 401	264 043	83%

1.3 Self-assessment performance

After 3 years of implementation, there is optimism that PNFP project objectives have been largely met. The introduction of Result Based Financing (RBF) mechanism in 46 PNFP facilities in 2016 enabled the project to achieve its broad objective of increasing Private Not-For Profit (PNFP) facility outputs and patients' accessibility to quality health care through a strengthened Ministry of Health (MoH)-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system. Utilisation of health services increased by 18% in RBF supported PNFP facilities compared to 2016. Quality of care improved significantly with 90% of health facilities maintaining 4 stars of quality rating (PNFP Project database).

The project continued to provide technical and financial assistance to four Medical Bureaus (MB) and their regional coordination offices, so that they can fulfil their advisory, technical and supervisory roles towards their affiliated health facilities. The Bureaus have been central in the definition and execution of the RBF agenda. This enabled the project to seamlessly integrate the RBF into the health facilities plans thus increasing ownership and sustainability.

The partnership between PNFPs and MoH is strong. With a functional Public Private Partnership in Health Unit and other PPPH structures, the PNFPs find it easier to coordinate and collaborate with the Government structures both at central and decentralised levels. During

2017, the MoH for instance responded to the request of the MBs to channel 50% of the PHC grants to the PNFPs through medicines subsidy accessed through Joint Medical Stores. This initiative by the MBs with the support of Government will ensure that PNFP facilities provide quality medicines to the population thus improving on quality of care. The monthly PPPH technical working group meetings were supported by the project throughout the year and participation of the MBs was at 100%. This high participation was reported in other partnership structures like the Health Policy Advisory Committee and other relevant for a.

At regional level, the districts (District Health Teams (DHT and District Health Management Teams (DHMT)) and Health Sub-districts (HSDs) were supported in their capacity to provide technical assistance to all health facilities by performing joint supervision and planning activities with the PNFPs (private not for profit coordinating bodies). At regional level, efforts have been made to improve the basic structural standards in the health facilities to foster the quality of services, hence to meet the basic structural standard required to enter the RBF program initiated by the project.

At the end of 2017, 46 health facilities were implementing RBF and three facilities were already qualified to sign agreements effective January 2018. After 6 quarters of implementing RBF, health facilities now fully understand the requirements and benefits of the program.

1.3.1 Relevance

	Performance
Relevance	A

Anchored at the MoH's Directorate of Planning and Policy, the PNFP project also operates at regional level to strengthen the local health system. This twin anchorage at central and regional level is an opportunity to apply the lessons learned from the field, to improve the MoH's capacity in reviewing, disseminating and using the PPPH policy and implementation of guidelines, and in implementing the country RBF framework.

The project does not only aim to pilot the strategic purchasing of health services as prescribed by the country Health Financing Strategy, but also to strengthen the overall health system at District and National level. The implementation of RBF in 15 Districts is totally in line with GoU Health Financing Strategy and with PPPH policy and implementation guidelines. The allocation of funds to the health facilities based on the quantity and quality of the services delivered improves equity, efficiency and effectiveness in the use of resources.

The RBF program addresses the key challenges identified in the second National Health Policy (NHP II) and support the roll out of the strategies defined in the Health Sector Development Plan (HSDP).

The RBF framework is also relevant to the PNFP health subsector mission and core values: to take care of the most vulnerable people. The PNFP facilities are a significant stakeholder in health service delivery in the country since they represent about 23% of the Health facilities in the country and 50% of the production of Health services. They however receive from the Government about 20% of their total revenue through Primary Health Care (PHC) grants². By

boosting their income through the RBF grants, the project goes a long way in the improvement of access to quality of health services to the served population.

1.3.2 Effectiveness

	Performance
Effectiveness	A

The activities planned in 2017 were fully supported by the MoH Directorate of health Services and the PNFP MBs. The achievement of the project outcome is very likely in terms of quality and coverage despite minor limitations.

The project had conducted a Mid Term Review (MTR) in 2016 whose report recommended several changes to make the RBF system effective. In 2017, the project team implemented these recommendations, mainly the review of the verification tools and capacity building of the District and Health Facility Teams. Reporting templates were simplified and further inductions conducted with staff at facility level. This improved the quality of reporting at health facility level and likewise at District level. Validation of invoices at national level has somewhat become easier and faster in 2017 compared to 2016. The project team continued to put more focus on supporting health facilities to improve their quality score (overall quality assessment + quality of outputs) and this has resulted into more patients accessing quality care.

Nevertheless, there are still challenges with financial management especially at lower level health facilities (Health Centre (HC) IIIs). The weakness is structural in nature given the relative smaller size of these institutions and the lack of qualified personnel managing finances. The project finance team will invest more time in 2018 to support HC IIIs to improve capacity in financial reporting.

1.3.3 Efficiency

	Performance
Efficiency	B

The project had all the financial resources needed during the year to implement activities. Minimal budget modifications were done with the approval of the Steering Committee. All project staffs were available during the year and fully executed their tasks. The National Technical Assistant (NTA) for Rwenzori region resigned in the first quarter of the year. He was immediately replaced by an equally qualified candidate who found systems already in place and was provided support by the ICB II colleague in the region.

Activities were planned and executed on schedule. Persistent delays in RBF reporting, verification, validation and payments remain. These delays were observed to be at all stages of the RBF cycle and efforts were made to reduce the turnaround time of facilities being verified and receiving their payments. The cost of verification has been kept very low by using DHMTs. The quality of the verification however remains a challenge. In 2018, the project team will induct an expanded group of verifiers per district with the intention of having a large pool of staff available to make verification quicker and more efficient.

1.3.4 Potential sustainability

	Performance
Potential sustainability	B

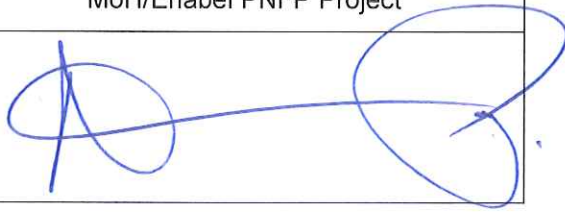
A donor driven strategy as the RBF pilot project cannot be financially sustainable. Nevertheless, the major interventions outlined by the project theory of change will contribute to the capacity building of the MoH to oversee and regulate the health sector. For this reason, some of the project interventions have been designed to be implemented even without the RBF.

Developing and implementing a health coverage plan in the Districts and HSDs to enhance the geographic access to the health services will contribute to the rationalisation of health infrastructure investments to ensure that they effectively and efficiently contribute towards improved health service delivery. The tools developed by the PNFP project are used by the MBs out of the intervention area. The same tools will be used to roll out the RBF in other districts by the Uganda Reproductive Maternal, Neonatal Child and Adolescent Health Services Improvement project (URMCHIP) funded by the IDA loan and GFF (Global Financing Facility) grant and Sida (Swedish International Development Aid). It's hoped that in the future, the accreditation process for Public and PNFP health facilities will become a routine in the health system as foreseen in the MoH quality improvement strategy, regardless the implementation of the RBF, to strengthened continuous quality improvement and strategic management of health service, hence contribute to the improvement the quality of care and the responsiveness of health facilities.

Taking advantage of the development of a national RBF model to define a complete package of service for the entire population and entitlement in PHC services users will improve the transparency and equity in the allocation of public funds in the health sector. The RBF model has been designed to establish strategic purchasing of health services, and introduce the payment for results approach in Uganda's health sector in order to convince the donors and the Government of Uganda (GoU) to rise more funds for the health service delivery. By demonstrating the achievements in service coverage, population coverage and financial protection of the population, including the most vulnerable (mother, children and adolescent), the project may give an argument to the Belgian Cooperation in the policy dialogue in the health sector. Other donor may accept the pooling of resources to implement the RBF program, and in the future, build with the GoU a trust fund to finance the universal access to health services in the country.

1.4 Conclusions

- The project remains relevant to the GoU, the PNFP MBs and the population of Rwenzori and West Nile regions.
- The piloting of RBF as a financing mechanism has been successful. The National RBF framework, designed with the support of the project and adopted by the MoH has become a national guide for other development partners to scale up RBF in other areas of Uganda. The MoH needs to be supported further to set up an RBF unit which currently is a missing link.
- The implementation of the national PPPH policy has been possible with the support of the project. At national level, the functionality of the PPPH Unit has enabled the MBs to have more proactive engagements with the MoH. The RBF at district level has made the implementation of PPPH policy more visible. DHMTs participating in the verification and supervision of PNFP facilities on quarterly basis have increased more interaction between the two sides. Districts appreciate more the challenges and the contribution of the PNFP subsector in delivering healthcare to Ugandans.

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2 Results Monitoring

2.1 Evolution of the context

2.1.1 General context

The general context remained largely unchanged. There was no key evolution in sector policy or decentralization policy in 2017. Uganda experienced a stable political and socio-economic environment during the year despite isolated cases of civil upheaval during the constitutional amendment debates. There was no structural organizational change in any of the partner institutions. The top leadership of the MoH provided the required support for the implementation of the project.

2.1.2 Institutional context

The project falls under the Directorate of Planning and Policy in the MoH. The Project Coordinator is the Acting Commissioner Health Services, Planning. The Directorate will in 2018 house the National RBF Unit which will act as strategic purchaser of the health services in the country. This is an opportunity for the future scale up and institutionalization of RBF in the health sector.

2.1.3 Management context: execution modalities

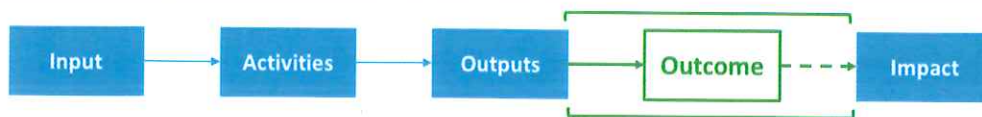
The project financial and activity plans were all executed to a desired level. Budget modifications were approved by the Steering committee and this facilitated the execution of activities. The project experienced challenges in payment of RBF payments which are under Co-management modality. The challenges related to delays in disbursements of RBF funds to Health facilities. These delays were manifested at all levels of RBF cycle – including late reporting by health facilities, delayed verifications, and bureaucratic payment processes at MOH. Mitigation measures were put in place to minimise such delays. .

2.1.4 Harmonisation context

The RBF model implemented by the project is harmonised with the relevant national policies in particular the HFS and the National RBF framework. The model has also been adopted by the other projects in particular the MoH URMCHIP funded by the World Bank, GFF and Sida for maternal and child health.

The project also works with other Development Partners with regards to supporting the MoH in implementing the PPPH policy. Both Enabel and USAID support the operations of the PPPH Node in the MoH. In order to avoid duplication and maximize efficient use of resources, Enabel and USAID Private Health Support Program coordinated their financial and technical support to the PPPH Unit.

2.2 Performance outcome



2.2.1 Progress of indicators

Outcome: PNFP output and patients' accessibility to quality health care have increased through a strengthened MoH-PNFP partnership with regards to the financial, human resources and functional aspects of the Ugandan health system.					
Indicators	Baseline value	Value year 2015	Value year 2016	Target year 2017	End Target
Total value of debt in PNFP health facilities enrolled into RBF	7.1bn	7.1bn	6,4bn	4bn	3.5bn
Reported maternal death	106	89	85	80	20
Reported under-five death	1647	1567	1317	1200	300
% deliveries in health facilities	40%	56%	50%	65%	80%
Contraceptive Prevalence Rate	15%	18%	37%	40%	50%
Evolution of fee levels in PNFP health facilities	31 905	40 516	46 066	35 000	22,000

The indicators related to health service delivery have been reported for the period from July 2016 to June 2017, using the available district and health facility data from the regions of intervention.

2.2.2 Analysis of progress made

There has been remarkable progress in the performance of the indicators at macro level. With the start of RBF grants, the level of debt in PNFP facilities in the two regions of Rwenzori and West Nile has greatly reduced. PNFP facilities incur debts mostly related to drug supplies which they acquire from Joint Medical Store on credit. Due to low revenues from user fees and Government subsidies, PNFPs always had had high debts. This trend is however changing with the RBF funding as the facilities use earned funds to purchase essential medical supplies and avoid falling into debt. Likewise, the evolution of user fees charged in PNFP facilities has greatly reduced. This is attributed to a contractual condition in the RBF agreement that compels facilities to reduce and or abolish their fees.

Other indicators like reported maternal death, under-five deaths and deliveries improved significantly. RBF puts emphasis on rewarding good quality. The project invested in routine quality assessments and trainings which raised the skills and changed attitudes of facility staff. Besides, RBF relies on a credible and reliable health information system. Improvements in the quality of data recording and documentation at facility level may explain the dramatic changes if compared with previous years.

2.3 Performance output 1

2.3.1 Progress of indicators

Output 1: MoH is strengthened in its capacity of reviewing, disseminating and using the PPPH policy and implementation guidelines in partnership with PNFP facilities and organizing bodies.					
Indicators	Baseline value	Value year 2015	Value year 2016	Value year 2017	End Target
% of approved posts filled by trained health workers.in PNFP facilities	58%	63%	63%	65%	80%
% of PNFP health facilities implementing the national SRH/HIV policies.	90%	92%	93%	93.5%	98%
Amount of GoU budget (conditional grant) allocated to PNFP health sub-sector.	17bn	17bn	17bn	15bn	18bn

2.3.2 Progress of main activities

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

2.3.3 Analysis of progress made

During 2017, capacity development of the PPPH Node continued with focus at District level. Training of district PPPH focal persons was conducted for 70 districts in the country. The PPPH technical working group meetings were conducted monthly. The PPPH Node staff with the participation of the MoH Planning department conducted monitoring visits to 32 districts supporting district health departments to coordinate and streamline private sector issues. The strengthening of the PPPH Node at MoH has provided through regular PPPH Technical Working Group meetings, an excellent avenue for private health care providers, not only the PNFPs but the wider private health sector, to interface and engage in constructive dialogue with the MoH. The country PPPH strategic plan was approved by the PPPH technical working group in 2017.

The funding to the PNFP subsector by GOU through PHC conditional grants declined to 15bn after a number of health facilities were deleted from the beneficiary list due to failure to meet the required standards. The funding modality also changed with 50% of the funds going into a credit line for Medicines at JMS, while 50% of the grant is disbursed to health facilities to meet operational costs.

2.4 Performance output 2

2.4.1 Progress of indicators

Output 2: MB and PNFP Coordination Bodies are functional and strengthened in their organizational as well as partnership functions.					
Indicators	Baseline value	Value year 2015	Value year 2016	Value year 2017	End Target
% of prequalified health facilities	0	8%	64%	86%	80%

2.4.2 Progress of main activities

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

2.4.3 Analysis of progress made

In 2017, MBs remained available and were instrumental in the execution of various project activities. The project concluded the prequalification assesment of all PNFP facilities. 49 facilities out of a target of 52 facilities qualified to join the RBF program. The project supported the MBs to supervise and support their health facilities in preparation for the prequalification.

Identification of training and equipment needs for the MBs was done and several challenges identified especially at regional coordination offices. The project supported all the MBs to equip their regional offices with furniture and IT equipment to ensure full functionality of regional coordination offices. Uganda Muslim Medical Bureau for instance did not have functional regional offices despite have appointed regional coordinators and health facilities in those regions.

Significant efforts were put on organisational developent of all MBs with funding of their accreditation processes. The Project also supported all MBs to carry out on quarterly basis support supervision from central level to regional level, and from regional level to health facilities. All these support visits were jointly organized with MoH Quality Assurance Department.

2.5 Performance output 3

2.5.1 Progress of indicators

Output 3: District HMT are strengthened in their capacity to support all health facilities in their territory without any discrimination for PNFP facilities and organizations.					
Indicators	Baseline value	Value year 2015	Value year 2016	Value year 2017	End Target
% of villages with trained VHTs per district.	91%	93%	95%	96%	95%
Number of health coverage plans completed.	0	0	0	15	15

2.5.2 Progress of main activities

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

2.5.3 Analysis of progress made

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

The development of District coverage maps was finalised with the support of ICB II. Each district now has a coverage map. Development of coverage plans is still ongoing and will be more pronounced in 2018.

Exchange activities between districts at regional level was anticipated to take place after the start and operationalisation of RBF. This will be organised in 2018 mainly as part of peer learning with well performing districts/health facilities visiting or being visited by their weak counterparts from other districts or regions.

2.6 Performance output 4

2.6.1 Progress of indicators

Output 4: MoH has a model and a vision on how to institutionalize a national RBF mechanism to support the district health system irrespective for government or PNFP facilities.					
Indicators	Baseline value	Value year 2015	Value year 2016	Target year 2017	End Target
RBF model accepted by MoH and GoU as the national model, available.	0	0	1	1	1
Number of districts nation-wide joining the RBF scheme.	0	0	15	16	20

2.6.2 Progress of main activities

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

2.6.3 Analysis of progress made

Most activities under this result area were executed in the first two years of the project. This was meant to prepare for the RBF scheme to operate smoothly. An RBF model was designed in 2015 with all the required tools and templates. After a year of implementation, the model and tools are still valid and need no revision. The project continued however to build capacity of staff at MoH level to understand RBF and strategic purchasing of health care in general. The project supported 3 staff of the MoH to undertake an international training in RBF in Mombasa Kenya.

Communication activities to promote RBF will be conducted in 2018 after concrete results (data) from RBF has been realised.

2.7 Performance output 5

2.7.1 Progress of indicators

Output 5: PNFP HC II, III and IV of the regions of West Nile and Rwenzori are fully implementing the health care package as foreseen in the national health policy and this in an affordable manner for the catchment population through RBF.					
Indicators	Baseline value	Value year 2015	Value year 2016	Value year 2017	End Target
% of PNFP health centres delivering the full HIV package for maternal and child health and HIV/AIDS (including MTCT).	61%	58%	72%	90%	85%
% of PNFP health centres without any stock-outs of 6 tracer medicines.	83%	87%	88%	90%	100%
% of health centres IV with functioning theatre (providing EMOC).	100%	100%	100%	100%	100%
% of children under one year immunized with 3 rd dose Pentavalent vaccine.	99%	96%	96%	85%	99%
% of pregnant women attending 4 ANC sessions.	30%	47%	56%	58%	80%
% of pregnant women who have completed IPT2.	44%	45%	55%	65%	80%
% of eligible person receiving HIV therapy.	70%	68%	72%	117%	70%

2.7.2 Progress of main activities

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

The data reported for 2017 are from district data and includes public health facilities contribution.

2.7.3 Analysis of progress made

A significant achievement in all the indicators towards the targets was observed but notable in the areas of HIV, Immunization and Antenatal care (ANC) services. This picture was facilitated by a number of undertakings including orientation trainings of facility managers and selected staff in the provision of quality care in accordance to the agreed standards included in the RBF frame work. To attempt to make the services affordable, all the PNFP facilities reduced the user fees and also introduced a flat rate payment system that made the services more affordable to the majority of the population who are poor. Secondly the introduction of the flat fees made the services more predictable by the population thereby making it possible for the primary

beneficiaries to plan their health care expenditures accordingly. As result the incidences of financial shocks are increasingly being reduced among the population.

Furthermore, in the one year of implementation, the greatest proportion (>60%) of RBF subsidies was spent on maternal and child health services which translated into addressing the health needs of the most vulnerable section of the population.

During the FY 2016/2017 year of RBF implementation, all PNFP HCs provided the full HIV package for maternal and child health and HIV/AIDS (including MTCT). There was a common pattern of stock out of measles vaccine and fansidar during the first 2 quarters of the year. This may be attributed to stock nationally for the measles vaccine at that time.

Health facility incharges and selected staff were trained and supported to develop business plans/ performance improvement plans for 2016/2017. Health facilities generated performance targets and projected income estimates of their earnings from the RBF program during the year of implementation.

Verification was arranged by the district health office and verified requests for payments submitted to the Project Office through the regional Enabel office for validation and payment.

Following each verification, the verification teams provided feedback to the management and entire staff to announce the verdict of the verification and emphasized areas for inclusion in the quality improvement plan for the subsequent quarter.

Technical support missions were made to health facilities alongside the district RBF focal persons to further build the health facility staff in RBF implementation process, including HMIS reporting declaration and preparation of the various reporting tools.

2.8 Performance output 6

2.8.1 Progress of indicators

Output 6: PNFP hospital care of West Nile and Rwenzori is more affordable for the population without loss of quality of care through RBF.					
Indicators	Baseline value	Value year 2015	Value year 2016	Value year 2017	End Target
% of referred patients among out-patient department (OPD) clients.	1%	1%	4%	3.5%	10%
Ratio number of referred deliveries / total deliveries within the hospital.	0.6	0,29	0,23	0.3	0.7
% of post-surgery infections.	2.5%	1.3	1.75	0.12	0.5%

2.8.2 Progress of main activities

Progress of <u>main</u> activities	Progress:			
	A	B	C	D
1 Prepare the PNFP hospitals for initiating RBF.				
2 Finance PNFP hospitals through RBF.				
3 Experiment with urban primary care centres outside the hospital environment.				

2.8.3 Analysis of progress made

Overall during 2017, there was marked increase in the utilization of health services by threefold as observed from the facilities on the RBF program. This was facilitated by ensuring affordability through the introduction of flat fees and the lowering of the user fee tariffs. This is consistent with the hypothesis that once the financial barriers are reduced, more patients access care.

The facilities also implemented very rigorous quality improvement initiatives as observed in the QI plans and the amount of investment to improve and maintain quality. The Hospitals being the large volume facilities invested up to about 15% of their subsidies in QI activities but more time was invested in the supervision of the entire production process.

The percentage of referred patients among outpatient department clients in the general hospitals stood at 3.5%. Among the contributing factors was the improved utilization and functionality of the lower level health facilities in the catchment population.

The ratio of referred deliveries to total deliveries in the PNFP general hospitals during year 2016/2017 was 0.3. It seems pregnant women prefer to deliver in the nearby functional lower health facilities, HC IIIs and HC IVs offering quality maternity services moreover also at reduced user fees. The referred deliveries are the cases of complicated pregnancies requiring specialist care like eclampsia. Otherwise a majority of caesarian sections are handled at PNFP HC IVs.

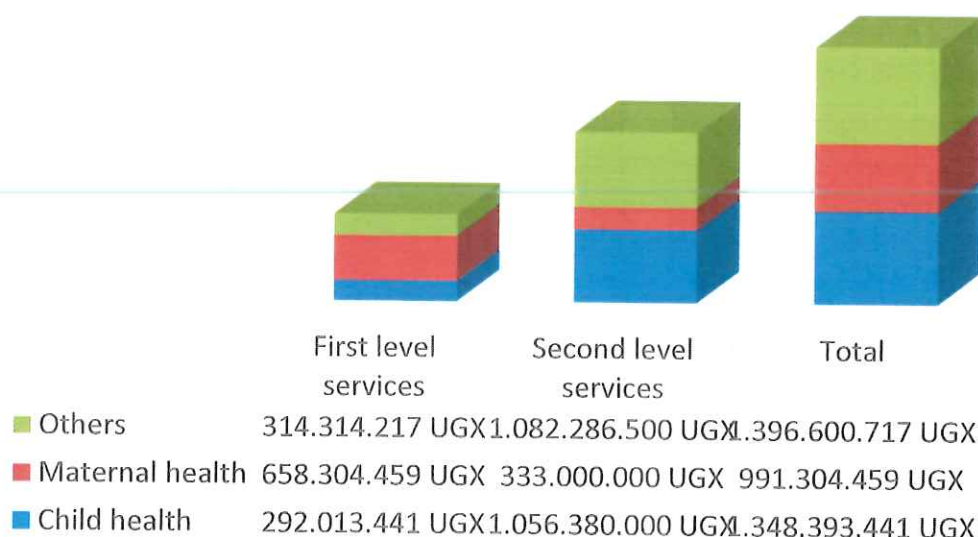
The indicator on post-surgery infections, a measure of quality of surgical services has been difficult to assess since it is also not captured and reported in the routine HMIS tools of the health facilities. However, in RBF quarterly quality assessments of surgical services organization in general hospitals and HC IVs, surgery departments of general hospitals have always scored highly in the assessment indicating their readiness and assurance of providing quality services.

2.9 Transversal Themes

2.9.1 Gender

The project took full account of gender, in particular the health status of pregnant women, young mothers and children. Six of the RBF indicators address accessibility of health services. The tariffs set for these are highest. This was deliberate to promote women's reproductive health challenges in the country. Performance of these indicators have improved greatly as seen in the below chart.

Proportion of funds allocated to Maternal and Child health



2.9.2 Environment

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

2.9.3 HIV/AIDS

Although there is almost no uncovered cost at health facility level to conduct the activities related to HIV, the diagnosis and treatment of HIV patients is included in the list of indicators to be rewarded by the RBF.

2.10 Risk management

Analysis of risk or issue			Deal with risk or issue		Follow-up of risk or issue				
Risk description	Period of identification	Likelihood	Potential impact	Total	Action(s)	Res p.	Deadline	Progress	Status
Output 1: MoH, and in particularly PPP unit understaffed.	June-15	High	Medium	High Risk	Recruitment of a Data Assistant	ITA	March-16	A data Assistant was recruited with support of USAID Private Health Program	Terminated
					Training of current PPPH staff		July-18	Project to support PPPH staff to train in PPP issues in 2018	In progress
Output 1: MoH, PPP unit lack an elaborated vision on the role of the PPP unit	September-14	Low	High	Medium Risk	Elaboration of a strategic plan		July-17	Project supported PPPH unit to develop a strategy	Terminated
Output 1: MoH does not engage in a sincere partnership with PNFP	September-14	Low	High	Medium Risk	facilitate dialogue between the two partners.	NTA	Continuous	Dialogue ongoing through the PPPH TWG quarterly meetings	In progress

Output 2: Some Medical Bureaux do not have the required technical, structural and financial competences	September-14	Low	High	Medium Risk	Capacity building activities	NTA and ITA	June-18	UMMB and UOMB have developed clear organisational structures and strategy	Terminated
Output 3: Weak leadership and management skills of multiple actors at regional level	September-14	High	Medium	High Risk	Presence of NTAs for coaching, mentorship and technical assistance	NTA and ITA	June 18	NTAs present in the regions and providing support to districts	In progress
Output 4: Large scope of the project and strategies and procedures not yet developed					Use existing synergies with ICB project	ITA	June-18	Holding of joint regional meetings and developing health district coverage plans	In progress
					Gradual scaling-up of the RBF	ITA	June-18	45 Health facilities are currently enrolled in RBF program. 3 facilities started effective January 2018. No additional facilities are foreseen in the program	In progress
Output 4: Feasibility of workload for verification and validation of RBF grants	Medium	Low	Low Risk		Evaluation after first quarter of RFB payments	NTA and ITA	2017 Q1		In progress

Output 5: Insufficient skill to implement the interventions that required high technicality and financial control.	Medium	Medium	Medium Risk	NTA in the region are conducting coaching and supervision activities	NTA	Dec 18	In progress
				Availability of financial staff in the Regions	FCC	Dec 18	In progress
				Regular audits by the project	FCC	Dec 18	In progress
		Potential impact	Total	Action(s)	Res p.	Deadline	Progress
Output 5: PNFP health centres refuse to lower the user fees	Likelihood			Offer assistance in developing realistic business plans	ITA and NTA	June-18	In progress
				Monitor the user fees in health facilities	NTA	Dec-18	In progress
				Performance improvement plans were developed			
				Refreshment training conducted			
				Technical assistance continuously given			
				Done as part of verification process			

Output 5: PNFP health centres do not have enough skills to manage the subsidies	Medium	Medium	Medium Risk	Quarterly support and control missions	Project Manager	Dec-18	Control missions and audits are planned as provided by the RBF implementation manual Feed-back to beneficiary facilities on quarterly basis	In progress
				Multiple occasions for verification and feed-back	Enabel and MoH	Dec-18	NTA are members of verification teams Counter verification and audits are planned	In progress
Risk description	Likelihood	Potential impact	Total	Action(s)	Res p.	Deadline	Progress	Status
Output 5: MoH and donor community do not provide long-term financial means	Medium	High	High Risk	Support donor coordination develop a long-term vision perspectives for donor agencies	ITA	Dec-18	Participation in the Budget Support technical Working Group The roll out plan strategy is included in the RBF implementation manual The RBF is part of the country Health financing strategy	In progress
				Organize international workshop on RBF to do advocacy	ITA	June-18	An international workshop on RBF is planned in 2018	In progress
Outputs 5 and	Medium	high	High Risk	Strict	RAF	Dec 18	Continuous activity	In

6: Delay in reporting and/or incomplete reporting of facilities for RBF grants				follow up of grant procedures	I				progress
Outputs 5 and 6: False reporting by facilities and /or DHMT verification team	Low	Low	Low Risk	Support to the District health Teams in financial management	RAF I	Dec 18	Continuous activity	In progress	In progress
				Support the DHMT and facilities contract management	RAF I	Dec 18			
				Multistakeholder verification team	NTA	Dec 18	These risks are inherent to RBF projects. There are mitigated by the specific RBF design piloted by the PNFP project.	In progress	In progress
				Participation of NTA in the verification		Dec 18			
				Counter verification by the central level		Dec 18			
Outputs 5 and 6: Misuse of RBF funds	Low	Medium	Low Risk	Strict control mechanisms set up	RAF I and FCC	Dec 18	The RBF Implementation manual give to the Fund Holder the right	In progress	In progress

[illegible]

Risk description	Likelihood	Potential impact	Total	Action(s)	Res p.	Deadline	Progress	Status
Output 6: PNFP hospitals refuse to lower the user fees	Low	Low	Low risk	Promote experience sharing with the health facilities that have lowered their user fees	NTA	Dec-18	Most hospitals are willing to lower user fees save for specialized and private patients	In progress
Output 6: Budget overshooting or underconsumption of RBF grants	Low	Low	Low Risk	Accurate estimation of RBF income for the Health facilities	FCC	Dec 18	While offering technical assistance to the health facilities, the project RAFI and financial team will support them to estimate the RBF income and analyze the quarterly financial report	In progress
				Strict monitoring of RBF grants expenditure	RAFI	Continuous		In progress
				Addenda to the grants if needed	RAFI	April 18		In progress

3 Steering and Learning

3.1 Strategic re-orientations

The strategy outlined in the project's TFF remains valid and relevant. This strategy is imbedded in the HSDP. It's also in line with the HFS and the Quality Improvement Strategy developed by the MoH.

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

3.2 Recommendations

Recommendations	Actor	Deadline
<i>Define and discuss an end of support exit strategy with the PPPH Unit as the project enters its final year</i>	NTA and PPPH unit	June 2018
<i>Define and discuss an end of support exit strategy with the Medical Bureaux as the project enters its final year</i>	NTA and medical Bureaux	June 2018
<i>Review the current grants with 49 Health facilities and determine in consultation with ICBII and the districts, which of them will be transitioned to SPHU project. Define and implement an exit strategy for facilities that may not be transitioned to SPHU project.</i>	NTAs	June 2018
<i>Conduct a prequalification assessment for all health facilities before renewal of contract for FY2018/19</i>	NTAs	May 2018
<i>Address delays in disbursement of RBF funds to health facilities</i>	FCC, MOH	Immediate
<i>Provide more rigorous support to health facilities in financial and grants management</i>	FCC, MOH, MBs	Continuous

3.3 Lessons Learned

Lessons learned	Target audience
Limitations in HR both at district and facility level affects RBF implementation. PNFP health facilities still experience high staff turnovers which affects the project as trained staff leave the facility	District local governments

Staff incentives have greatly motivated staff to perform better. In facilities which adopted a fairer system of distributing incentives, staff were more than happy and will to invest in more time.	Health facility Management to ensure staff incentives are equitably distributed

4 Annexes

4.1 Quality criteria

1. RELEVANCE: The degree to which the intervention is in line with local and national policies and priorities as well as with the expectations of the beneficiaries				
<i>In order to calculate the total score for this quality criterion, proceed as follows: 'At least one 'A', no 'C' or 'D' = A; Two times 'B' = B; At least one 'C', no 'D' = C; at least one 'D' = D</i>				
Assessment RELEVANCE: total score	A	B	C	D
1.1 What is the present level of relevance of the intervention?				
A	Clearly still embedded in national policies and Belgian strategy, responds to aid effectiveness commitments, highly relevant to needs of target group.			
1.2 As presently designed, is the intervention logic still holding true?				
A	Clear and well-structured intervention logic; feasible and consistent vertical logic of objectives; adequate indicators; Risks and Assumptions clearly identified and managed; exit strategy in place (if applicable).			

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

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

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

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

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

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

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

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

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

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

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

4.4 How well is the intervention contributing to institutional and management capacity?	
B	Intervention management is well embedded in institutional structures and has somewhat contributed to capacity building. Additional expertise might be required. Improvements in order to guarantee sustainability are possible.

4.2 Decisions taken by the steering committee and follow-up

Decision			Action			Follow-up	
Decision	Identification period	Actor	Action(s)	Resp.	Deadline	Progress	Status
SC 0: before arrival of project staff	Jun-14		Recruitment of International Technical Assistants	Enabel	end of July 2014	ITA took office first week of September 2014	CLOSED
			Recruitment of National Technical Assistants	Enabel	end of August 2014	3 have been recruited	CLOSED
			Procurement of project vehicles	Enabel	End of August 2014	4 project vehicles have been procured	CLOSED
			Identification of office space in MoH	MoH	End of August 2014	Office space in MoH was allocated and the project has occupied the office	CLOSED
			Launch project	MoH and Enabel	Jan-15	Will be held at the end of february at Maracha Hospital	ONGOIN G
			Contract consultant for start-up project	Enabel	Jul-14	Consultant was contracted on July 1st 2014.	CLOSED

SC 1:	Feb-15						Finalise the PNFP result report 2014			Immediate	Report was finalised and submitted	CLOSED	
							Submit a preliminary baseline report			31-03-15	Draft Baseline report submitted	CLOSED	
							Each MB to nominate a focal person to participate in the project			Immediate	Each MB has nominated a focal person to participate in project activities	CLOSED	
							Review the workplan and budget with MOH			Immediate	Workplan and budget were discussed with Director Planning	CLOSED	
							Hold an extra ordinary meeting of the steering committee to approve workplan and budget			To be determined after consultations	Awaiting confirmation from Director planning	CLOSED	
SC2	Jun-15						MOH to give a specific date for the launch of the project			To be determined after consultations	Awaiting confirmation from Director planning	OPEN	
							Organise project launchThe major launch can take place in Kampala with major stakeholders while another one can take place in the regions.	PM		01-08-15	MOH yet to give date	ONGOING	

					PM	02-08-15	Done for Quality Assurance and Planning	
SC3		Nov-15		MOH to appoint focal persons to the project technical team from Depts of quality Assurance, planning and clinical services	PM	01-12-15	tools were validated by Quality Assurance MOH	CLOSED
				The RBF prequalification assessment tools should be validated by various stakeholders especially Quality Assurance Dept of MOH	PM		Done	
				The project should focus on the 4 major Medical Bureaus (UCMB, UPMB, UMMB, and UOMB) at central level. UCBHCA be excluded to avoid overstretching the project	PM			
SC4		Feb-16		PPPH Unit should utilise various avenues to disseminate policy guidelines	PPPH		Continuous activity	
				PPPH Unit should summarise the PPPH policy and guidelines and print a popular version	PPPH	01-06-16	ongoing activity	
				Finalise the RBF manual	PM	01-02-16	Done	
				Finalise the PNFP result report 2015 for final approval	PM	01-02-16	Done	

			Ministry of Health to produce a position paper to justify why the project should procure equipment and medicines from JMS	PM			Discussions held with Medical Bureaus and PPPH unit	
SC5	Oct-16		Project to support Health facilities get a non objection from BTC to start RBF		NTA		Done	
			MOH and Ministry of Local Government to conduct advocacy to promote secondment of staff to PNFP facilities				ongoing activity	
SC6	Feb-17		The project should handle RBF payments faster to avoid delays	PM			Validation and payment processes are improving, but there are still delays at districts level	
SC7	Jun-17		The project should prepare addenda to agreements with hospitals that require additional funds by 30th June 2017. Districts to sign the addenda before end of June 2017.	PM			Addenda to contracts were prepared and districts signed with MOH. Affected hospitals also signed MOUs with their respective districts	CLOSED

			The Steering committee approved the modifications to the budget and the extension of the project from June 2018 to December 2018.	PM		Modifications to be reflected in the project workplan and budget.	
SC8	Nov-17		The project National Technical Assistant based in Kampala to act as Project Co-manager till recruitment of Programme Manager.	RR	01-12-17	Done	
			Project to hire a local audit firm to conduct external audit in all facilities that received RBF funds for the FY2016/17	FCC	01-03-18	TOR developed, procurement of audit firm to start	
			The project should include within their workplan a component of financial training for the facilities i.e. basic financial training.	FCC	01-03-18	Activity included in project workplan	

4.3 Updated Logical framework

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

4.4 More Results at a glance

Logical framework's results or indicators modified in last 12 months?	No.
Baseline Report registered on PIT?	Yes.
Planning MTR (registration of report)	01/2017: Done
Planning ETR (registration of report)	11/2018 (estimate)
Backstopping missions since 01/71/2014	20/10/2014 – 25/10/2014.
	18/07/2015 – 26/07/2015
	21/01/2016 – 27/01/2016
	20/07/2016 – 27/07/2016

4.5 “Budget versus current (y – m)” Report

Budget vs Actuals / Commitments (Year to Date) of UGA1302611

Project Title : Institutional support for the private-non-for profit (PNFP) health sub-sector to promote universal health coverage in Uganda
 Budget Version: E01
 Currency : DGD
 YTD : Report includes all valid transactions, registered up to today
 Comm Balance : The remaining balance of the registered commitments

	Status	Fin Mode	Amount	TID expenses	Balance	Comm Bal	Est. Balance	%	% Est
A Specific Objective									
01 MoH is strengthened in its capacity of policy and implementation guideline			4,876,175.00	2,840,034.00	2,333,141.00	2,183,732.12	147,408.88	52%	97%
01 Support the planning, management and administration of the PPP unit in the REGIE			303,850.00	221,390.19	82,559.81	30,179.25	52,380.56	73%	83%
02 Review PPPH related policies and guidelines			96,300.00	82,247.08	38,952.32	23,271.22	13,681.10	83%	88%
03 Disseminate policies and guidelines and do advocacy through communication			0.00	0.00	0.00	0.00	0.00	7%	7%
04 Perform field visits			0.00	0.00	0.00	0.00	0.00	7%	7%
05 Organize country study tours			0.00	0.00	0.00	0.00	0.00	7%	7%
06 Perform technical and scientific follow-up and evaluation to feed policy design			0.00	0.00	0.00	0.00	0.00	7%	7%
07 Review PPPH related policies and guidelines			70,000.00	58,211.29	11,788.71	0.00	11,788.71	83%	83%
08 Disseminate policies and guidelines and do advocacy through communication			36,000.00	27,295.34	7,744.66	1,820.11	5,924.55	78%	83%
09 Perform field visits			24,000.00	23,544.45	455.55	3,127.02	-2,672.37	98%	111%
10 Organize country study tours			51,700.00	42,430.25	9,313.75	0.00	9,313.75	82%	82%
11 Perform technical and scientific follow-up and evaluation to feed policy design			24,000.00	7,965.18	16,304.82	1,980.00	14,344.82	32%	40%
02 Medical Bureaus and the PNFP Coordination Bodies are functional and			183,300.00	172,068.45	10,531.55	293.30	10,238.35	94%	94%
01 Support the installation and equipment of MB			60,000.00	57,455.97	2,544.13	0.00	2,544.13	98%	98%
02 Support exchange, coordination and cross-fertilizing activities between MB			0.00	0.00	0.00	0.00	0.00	7%	7%
03 Support of MB to PNFPB through supervision, workshops and meetings			0.00	0.00	0.00	0.00	0.00	7%	7%
04 Support exchange, coordination and cross-fertilizing activities between MB			52,000.00	49,539.80	2,460.40	293.30	2,167.20	96%	96%
05 Support of MB to PNFPB through supervision, workshops and meetings			71,300.00	65,672.98	5,527.02	0.00	5,527.02	92%	92%
03 District and Subdistrict Health Management Teams are strengthened in			64,000.00	50,595.92	13,404.08	0.00	13,404.08	75%	75%
01 Perform supervision activities and joint meetings between DHO and PNFPB			0.00	0.00	0.00	0.00	0.00	7%	7%
REGIE			4,246,300.00	3,185,352.92	1,050,947.18	286,035.56	765,911.62	75%	81%
COGEST			3,753,700.00	1,687,315.37	2,088,384.63	2,013,324.49	73,059.14	44%	68%
TOTAL			8,000,000.00	4,882,668.19	3,117,331.81	2,279,361.05	855,970.76	61%	89%



Budget vs Actuals / Commitments (Year to Date) of UGA1302611

Project Title : Institutional support for the private-non-for profit (PNFP) health sub-sector to promote universal health coverage in Uganda

Budget Version: E01

Currency: DGD

YtD : Report includes all valid transactions, registered up to today

Comm. Balance : The remaining balance of the registered commitments

	Status	Fin Mode	Amount	TtD expenses	Balance	Comm. Bal.	Est. Balance	% Ex%	% Est
02 Organize exchange activities between districts at regional level		COGES	0.00	0.00	0.00	0.00	0.00	0%	0%
03 Perform supervision activities and joint meetings between DHO and PNFP		REGIE	33,000.00	17,588.10	15,411.90	0.00	15,411.90	53%	53%
04 Organize exchange activities between districts at regional level		REGIE	31,000.00	33,007.82	-2,007.82	0.00	-2,007.82	108%	108%
04 MoH has a model and a vision on how to institutionalize a national RBF			107,825.00	73,302.40	34,522.60	3,102.08	31,420.52	68%	71%
01 Review existing and past RBF related experiences and policies in Uganda		COGES	12,000.00	9,800.67	2,199.33	0.00	2,199.33	80%	80%
02 Design a RBF scheme to fund PNFP health facilities		COGES	8,000.00	11,440.10	-3,440.10	0.00	-3,440.10	143%	143%
03 Train management and health professionals in RBF		COGES	0.00	0.00	0.00	0.00	0.00	0%	0%
04 Implement the RBF procedures and tools		COGES	0.00	0.00	0.00	0.00	0.00	0%	0%
05 Develop and conduct communication and advocacy activities		COGES	0.00	0.00	0.00	0.00	0.00	0%	0%
06 Train management and health professionals in RBF		REGIE	30,000.00	21,061.02	8,938.98	102.08	8,836.90	70%	71%
07 Implement the RBF procedures and tools		REGIE	40,000.00	30,816.76	9,183.24	3,000.00	6,183.24	77%	85%
08 Develop and conduct communication and advocacy activities		REGIE	7,000.00	383.85	6,616.15	0.00	6,616.15	5%	5%
09 Review existing and past RBF related experiences		REGIE	10,825.00	0.00	10,825.00	0.00	10,825.00	0%	0%
05 PNFP HC II, III and IV of the regions of West Nile and Ruwenzori are fully			1,706,800.00	865,545.80	841,254.20	849,742.11	-8,887.91	51%	101%
01 Elaborate a complete health coverage plan per district, including HC II, III and		COGES	0.00	0.00	0.00	0.00	0.00	0%	0%
02 Support yearly planning, taking into account the conclusions and projections		COGES	0.00	0.00	0.00	0.00	0.00	0%	0%
03 Build the skills of PNFP HC staff for RBF to function in their facility		COGES	0.00	0.00	0.00	0.00	0.00	0%	0%
04 Finance PNFP health centres through RBF		COGES	1,513,800.00	701,204.97	812,595.03	830,932.31	-18,537.28	46%	101%
05 Elaborate a complete health coverage plan per district, including HC II, III and		REGIE	38,000.00	32,061.26	5,938.74	16,344.20	-10,405.46	84%	127%
06 Support yearly planning, taking into account the conclusions and projections		REGIE	50,000.00	29,750.87	20,249.13	0.00	20,249.13	60%	60%
07 Build the skills of PNFP HC staff for RBF to function in their facility		REGIE	105,000.00	102,488.60	2,511.40	2,465.60	45.80	96%	100%
		REGIE	4,248,300.00	3,195,352.82	1,052,947.18	266,035.56	785,911.62	75%	81%
		COGEST	3,753,700.00	1,667,315.37	2,086,384.63	2,013,325.48	73,059.14	44%	98%
		TOTAL	8,000,000.00	4,862,668.19	3,137,331.81	2,278,381.05	858,970.76	61%	89%



Report is prepared by the Ministry of Health and Family Welfare, Uganda, on 15/08/2018

Budget vs Actuals / Commitments (Year to Date) of UGA1302611

Project Title : Institutional support for the private-non-for profit (PNFP) health sub-sector to promote universal health coverage in Uganda
 Budget Version: E01
 Currency : DGD
 YtD : Report includes all valid transactions, registered up to today
 Comm. Balance : The remaining balance of the registered commitments

	Status	Fin Mode	Amount	TtD expenses	Balance	Comm. Bal.	Est. Balance	%	% Est
06 PNFP hospital care of West Nile and Ruwenzori is more affordable for the									
01 Perform and implement the conclusions of a hospital care coverage and care		COGES	2,513,800.00	1,182,531.24	1,351,068.76	1,302,415.48	48,653.28	46%	98%
02 Conduct costing studies per hospital and do comparative costing studies		COGES	0.00	0.00	0.00	0.00	0.00	?	?
03 Prepare the PNFP hospitals for initiating RBF		COGES	0.00	0.00	0.00	0.00	0.00	?	?
04 Finance PNFP hospitals through RBF		COGES	2,220,100.00	938,554.70	1,280,545.30	1,182,393.18	98,152.12	42%	86%
05 Experiment with urban primary care centres outside the hospital environment		COGES	0.00	0.00	0.00	0.00	0.00	?	?
06 Perform and implement the conclusions of a hospital care coverage and care		REGIE	2,500.00	2,356.19	143.81	0.00	143.81	84%	84%
07 Conduct costing studies per hospital and do comparative costing studies		REGIE	20,000.00	19,762.99	237.01	0.00	237.01	99%	99%
08 Prepare the PNFP hospitals for initiating RBF		REGIE	91,000.00	88,703.43	22,296.57	25,344.43	-3,047.86	75%	103%
09 Experiment with urban primary care centres outside the hospital environment		REGIE	180,000.00	132,153.93	47,846.07	64,877.87	-46,831.80	73%	126%
B COMMON COSTS DIRECTLY RELATED TO THE ACTIVITIES/RESULTS									
01 Results			1,455,340.00	915,570.13	539,769.87	92,828.93	447,140.94	63%	63%
01 Scientific follow-up and evaluation of the various strategies implemented		REGIE	1,455,340.00	915,570.13	539,769.87	92,828.93	447,140.94	63%	63%
02 Short term international and national consultancies		REGIE	41,000.00	17,421.80	23,578.20	1,914.19	21,664.01	42%	47%
03 National technical Assistant (Policy analysis and M&E)		REGIE	250,000.00	125,821.88	124,178.12	87,714.74	36,463.38	50%	85%
04 1 National Technical Assistant in each of the 2 Regions		REGIE	139,223.00	104,232.84	34,990.16	0.00	34,990.16	75%	75%
05 Basic equipment HC (on the base of need assessment)		REGIE	233,200.00	161,911.74	71,288.26	0.00	71,288.26	86%	86%
06 Basic equipment hospitals(on the base of need assessment)		REGIE	134,000.00	88,336.36	47,663.64	0.00	47,663.64	84%	84%
07 Vehicles		REGIE	353,800.00	187,371.50	166,428.50	3,000.00	163,428.50	53%	54%
08 Maintenance, fuel and insurance of vehicles		REGIE	80,517.00	81,252.78	-735.78	0.00	-735.78	101%	101%
09 Financial and Admin Officer in each of the 2 Regions		REGIE	73,800.00	34,709.09	39,090.91	0.00	39,090.91	47%	47%
		REGIE	120,000.00	84,165.62	35,834.38	0.00	35,834.38	70%	70%
REGIE			4,246,300.00	3,185,352.82	1,060,947.18	266,035.56	795,911.62	75%	81%
COGEST			3,753,700.00	1,887,315.37	2,086,384.63	2,013,325.49	73,059.14	44%	86%
TOTAL			8,000,000.00	4,882,668.19	3,117,331.81	2,278,361.05	858,970.76	61%	89%



Report is correct - Commitments up to Date of 25/10/2011. Printed: Wednesday 11 February 2011

Results Report

Budget vs Actuals / Commitments (Year to Date) of UGA1302611

Project Title : Institutional support for the private-non-for profit (PNFP) health sub-sector to promote universal health coverage in Uganda
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	Status	Fin Mode	Amount	TtD expenses	Balance	Comm. Bal.	Est Balance	%	% Est
10 Missions			30,000.00	32,346.52	-2,346.52	0.00	-2,346.52	100%	108%
C VAT REFUND			40,000.00	44,337.49	-4,337.49	0.00	-4,337.49	111%	111%
01 VAT Refund Regie			40,000.00	38,822.56	1,177.44	0.00	1,177.44	97%	97%
01 VAT Refund Regie		REGIE	40,000.00	38,822.56	1,177.44	0.00	1,177.44	97%	97%
02 VAT Refund Cogest			0.00	5,514.93	-5,514.93	0.00	-5,514.93	?	?
01 VAT Refund Cogest		COGES	0.00	5,514.93	-5,514.93	0.00	-5,514.93	?	?
X RESERVE BUDGET (MAX 5% OF TOTAL ACTIVITIES)			377.00	0.00	377.00	0.00	377.00	0%	0%
01 Reserve budget			377.00	0.00	377.00	0.00	377.00	0%	0%
01 Reserve budget co-management		COGES	0.00	0.00	0.00	0.00	0.00	?	?
02 Reserve budget BTC direct management		REGIE	377.00	0.00	377.00	0.00	377.00	0%	0%
Z GENERAL MEANS			1,625,108.00	1,358,728.57	266,381.43	0.00	266,381.43	83%	83%
01 Staff costs			1,273,719.00	1,127,144.90	146,574.10	0.00	146,574.10	88%	88%
01 International Technical assistant (Co-manager)		REGIE	720,000.00	684,129.31	35,870.69	0.00	35,870.69	95%	95%
02 International administrative and finance Responsible (RAFI)		REGIE	360,000.00	276,199.97	83,800.03	0.00	83,800.03	77%	77%
03 Accountant		REGIE	48,000.00	41,713.66	6,286.34	0.00	6,286.34	87%	87%
04 Secretary		REGIE	419.00	712.75	-293.75	0.00	-293.75	170%	170%
05 Drivers (4)		REGIE	78,800.00	74,899.51	2,100.49	0.00	2,100.49	97%	97%
06 Project financial controller		REGIE	38,000.00	36,997.25	1,002.75	0.00	1,002.75	97%	97%
07 FinAdmin & Logistic support		REGIE	15,500.00	12,882.45	2,607.55	0.00	2,607.55	82%	82%
08 ATI procurement		REGIE	15,000.00	0.00	15,000.00	0.00	15,000.00	0%	0%
02 Investments			70,789.00	63,780.13	7,008.87	0.00	7,008.87	90%	90%
01 Reserve budget		REGIE	4,246,300.00	3,195,352.82	1,050,947.18	265,035.56	785,011.82	75%	81%
02 Reserve budget co-management		COGEST	3,753,700.00	1,687,315.37	2,066,384.63	2,013,325.48	73,059.14	44%	98%
TOTAL			8,000,000.00	4,862,668.19	3,137,331.81	2,278,381.05	858,970.76	61%	89%



Budget & actuals / Commitments report to Date: 01/05/2018 - Period of summary: 5 January 2018

Budget vs Actuals / Commitments (Year to Date) of UGA1302611

Project Title : Institutional support for the private-non-for profit (PNFP) health sub-sector to promote universal health coverage in Uganda
 Budget Version: E01
 Currency : DGD
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 Comm. Balance : The remaining balance of the registered commitments

	Status	Fin Mode	Amount	TtD expenses	Balance	Comm. Bal.	Est. Balance	%	% Est
01 Vehicle		REGIE	29,577.00	30,033.72	-456.72	0.00	-456.72	102%	102%
02 Office equipment		REGIE	17,832.00	8,885.44	7,946.56	0.00	7,946.56	55%	55%
03 IT Office equipment		REGIE	17,905.00	18,327.49	-422.49	0.00	-422.49	102%	102%
04 Office refurbishment		REGIE	5,475.00	5,553.48	-78.48	0.00	-78.48	101%	101%
03 Running costs			98,800.00	72,882.23	26,907.77	0.00	26,907.77	73%	73%
01 Maintenance, fuel and insurance of vehicles (1)		REGIE	43,200.00	36,020.09	7,179.91	0.00	7,179.91	83%	83%
02 Offices maintenance and supply		REGIE	28,800.00	22,078.70	6,721.30	0.00	6,721.30	77%	77%
03 Télécommunications (5 Mobile phones)		REGIE	21,600.00	12,418.62	9,181.38	0.00	9,181.38	57%	57%
04 Representation and external costs		REGIE	5,000.00	3,088.21	1,903.79	0.00	1,903.79	62%	62%
05 Financial costs (ledger fees including exchange loss)		REGIE	1,000.00	-921.39	1,921.39	0.00	1,921.39	-92%	-92%
04 Audit et Suivi et Evaluation			181,000.00	82,507.15	88,492.85	0.00	88,492.85	51%	51%
01 Evaluation & Monitoring		REGIE	100,000.00	49,793.05	50,206.95	0.00	50,206.95	50%	50%
02 Baseline		REGIE	30,000.00	38,918.62	1,083.38	0.00	1,083.38	98%	98%
03 Audit		REGIE	30,000.00	0.00	30,000.00	0.00	30,000.00	0%	0%
04 Backstopping		REGIE	21,000.00	13,787.48	7,202.52	0.00	7,202.52	68%	68%
99 Conversion rate adjustment			0.00	602.18	-602.18	0.00	-602.18	2%	2%
98 Conversion rate adjustment		REGIE	0.00	602.18	-602.18	0.00	-602.18	2%	2%
99 Conversion rate adjustment		COGES	0.00	0.00	0.00	0.00	0.00	2%	2%

REGIE	4,248,300.00	3,185,352.82	1,050,947.18	265,035.56	785,811.62	75%	81%
COGEST	3,753,700.00	1,887,315.37	2,088,384.63	2,013,325.49	73,059.14	44%	98%
TOTAL	8,000,000.00	4,882,668.19	3,137,331.81	2,278,361.05	858,870.76	61%	89%



Programme Support System - Health Data Management System (PDMS) - Version 3.0.0.0 - 13/04/2011

4.6 Communication resources

N/A

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